COGNITIVE PROCESSING AND STRESS INOCULATION THERAPIES, AND MARITAL SATISFACTION OF WOMEN WITH CHILDHOOD TRAUMA IN IBADAN, NIGERIA

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CERTIFICATION

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DEDICATION

This work is dedicated to the Lord Almighty, Maker of heaven and earth. To Him be all the glory forever. I am eternally grateful for His mercies, kindness and sustaining grace.

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ABSTRACT

Marital satisfaction, a disposition associated with perceived benefits, is used to evaluate the marital relationships to improve their marital quality. Reports have linked childhood trauma with low levels of marital satisfaction in women. Previous studies on marital satisfaction focused more on family and environmental factors than on interventions, such as, Cognitive Processing Therapy (CPT) and Stress Inoculation Therapy (SIT). This study, therefore, was designed to investigate the effects of CPT and SIT on marital satisfaction of women with childhood trauma in Ibadan, Nigeria. The moderating effects of personality types and spousal support were also examined.

The Vulnerability Stress Adaptation Model of Marriage and Theory of Personality Development served as the framework. The mixed methods of sequential explanatory design (QUAN ➔ qual) consisting of the pretest-posttest control group quasi-experimental with a 3x2x3 factorial matrix were adopted. Three out of 11 Local Government Areas (LGAs), with a large concentration of women attending Primary Healthcare Centres (PHCs) for prenatal and postnatal, were purposively selected. The women in the three PHCs were screened using the Childhood Trauma Questionnaire-short form (r=0.93) and those who scored 50.0% and above were selected. The intact centres were exposed to CPT (40), SIT (41) and the control (35) groups for eight weeks. The instruments used were Myers-Briggs Type Indicator-Short Version (r=0.97); Enrich Marital Satisfaction (r=0.77) and Spousal Support (r=0.96) scales. Three sessions of focus group discussion were held with married women. The quantitative data were analysed using analysis of covariance, estimated marginal means and Sidak pair-comparison test at 0.05 level of significance, while the qualitative data were content-analysed.

The participants' age was 29.70±6.06 years, and spousal support ($\bar{x}$=3.87) was high against the threshold of 2.50. There was a significant main effect of treatment on marital satisfaction of women with childhood trauma ($F_{(2;97)}$=27.98; partial η^2=0.37). The married women exposed to SIT had the highest marital satisfaction ($\bar{x}$= 50.02), against those in CPT ($\bar{x}$= 49.78) and control ($\bar{x}$= 37.06) groups. There was a significant main effect of spousal support on marital satisfaction of women with childhood trauma ($F_{(2;97)}$=11.51, partial η^2=0.19). The participants with moderate level of spousal support ($\bar{x}$= 50.69) benefitted more than those in the high ($\bar{x}$= 45.53) and low ($\bar{x}$= 40.64) levels. There was no main effect of personality types. There was a significant interaction effect of treatment and personality types on marital satisfaction of women with childhood trauma ($F_{(2;97)}$=3.10; partial η^2=0.06), in favour of introverted women from SIT group. The two-way interaction effects of treatment and spousal support; personality types as well as spousal support were not significant. The three-way interaction effect was not significant. High expectations constituted problems in marriage, while understanding each other's differences can improve marital satisfaction.

Cognitive processing and stress inoculation therapies enhanced marital satisfaction of women with childhood trauma in Ibadan, Nigeria. These two therapies should be adopted by marriage and family health practitioners, and other bodies involved with women affairs to improve marital satisfaction among women with childhood trauma.

Keywords: Married women with childhood trauma, Cognitive processing therapy, Stress inoculation therapy, Marital Satisfaction

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CHAPTER ONE
INTRODUCTION

1.1 Background to the study

Some of the problems experienced in various homes have led many people to express different types of prejudices against the marriage institution, to the extent that marriage is on the decline with divorce cases flooding various Courts of Law as cohabitation is on the rise (Adewale, 2015). Furthermore, the number of unmarried couples living together for fear of making marital vows which could end in divorce has grown from one million in 1970 to 18 million in 2016 (Stepler, 2017). In this regard, Stritof (2020) lists some characteristics of troubled and dissatisfied marriages as: clogged with a harmful emotional climate, lacking intimacy, repetitive use of words and actions meant to humiliate one's spouse, secrecy, loneliness, poor healthy boundaries, poor relationship maintenance strategies to ensure its stability, no hope for the future of the marriage and frequent high explosive conflicts. These anomalies have set in motion several biases and fears that some unmarried individuals have exhibited about making commitments to marriage. Regardless of these and other observations, people still marry and expect to be satisfied. This is because for marriage to make any impact, it should have some measures of satisfaction; that is, the man and his wife must experience their needs, hopes, and desires met within the confines of their relationship through feelings of gratification. Marital satisfaction, therefore, emulates how a spouse perceives the gains and losses of his or her marriage (Stone and Shackelford, 2007). This would imply that the more a spouse feels pressured by costs and burdens, the less satisfied he or she becomes in the relationship. This further indicates that, marital satisfaction demonstrates an authentic sense of gratification, fulfilment, and happiness experienced by a husband and wife whenever they evaluate various aspects of their matrimony. Moreover, it reflects

the interest that they have in their relationship and the deep fulfilment they experience with each other.

Marital satisfaction can be influenced by several factors. One of such is couples' sexual performance and the satisfaction derived from their carnal relations. Sexual satisfaction can be viewed as the preface of marital satisfaction because it is a fundamental element used in supporting family survival, existence, and mental health. Other factors like finances, parenting styles, partner's health, communication, friendly disposition, participating in decision-making, building healthy relationships with in-laws, and making time for leisure (Buss, 2003) are also integral to satisfaction in marriage. Again, Buss (2003) indicates that there is a well-established link between being married and the continuance of good health. This denotes that spouses who are more fulfilled with their relationships display stronger attachments like emotional connectedness and empathy when compared to those who are less satisfied. Similarly, marital satisfaction is associated with the act of joint religious activities (like praying together), and sharing similar religious beliefs as they create an awareness of the inviolability of their union.

A factor that could also intervene in the marital satisfaction of women is childhood trauma. Some couples who have difficulties in their marital satisfaction may not know that their problems could have stemmed from difficult childhood experiences. Childhood trauma may be viewed as a plethora of early adverse experiences such as neglect, physical, emotional, and sexual abuse possessing the ability to negatively impact an individual across the lifespan (Redd, 2017). These experiences might include personal or witnessed reports of neglect, abandonment, emotional assault, physical abuse and sexual molestation, also observing a family member being treated violently or viewing horrific brutality through the media could in like manner create traumatizing outcomes (Morin, 2019). As a result of this, childhood traumatic occurrences can be the origin of many social, emotional, and cognitive impairments that may cause increased risk of self-destructive behavioural patterns, risk of re-victimization, chronic health conditions, low life potential, and premature death. As the prevalence of early traumatizing experiences increase, the possibility of mental health challenges from childhood through adulthood could worsen causing difficulties in marriage and other relationships. This is because when delicate and significant phases of a child’s development is compromised, they can be some alteration of neurobiological functioning which could impact negative changes

in brain structure (Harat, Kiec, Rudas, Birski and Furtak, 2021). These evidences, therefore, suggest that childhood trauma is linked to physical, mental, as well as emotional symptoms with some individuals experiencing significant and enduring problems, while others may indicate minimal symptoms.

A thought-provoking review from the Nigeria Demographic and Health Surveys (NDHS, 2018) reveals that 53% of young women were reported to have been engaged in sexual activities before the age of 18 with several of them admitting to incidences of both physical and sexual violence. Similarly, Ekine (2020) estimates that more than half of the 13 to 24year olds who participated in the 2014 Violence Against Children Survey (VACS) showed that they were sexually violated between the ages of 6 to 11 with the girls more deeply affected socially, educationally and emotionally. Ekine (2020) also reiterates that violence at such early stages of life has more far-reaching consequences that devastate survivors, their families, and society with significant socio-economic impacts. Ekine (2020) concludes that in low-income communities including those within Nigeria, approximately one billion children between the ages of 2-17 have experienced physical, emotional, and sexual abuse since the Covid-19 pandemic. Moreover, Bakare, Asuquo, and Agomoh (2010) condemn the fact that though the female populace is about half of its population, abusive acts against women and girls in Nigeria have not been given sufficient attention by both individuals and the government.

Survivors of abuse tend to grow up developing feelings of fear, anxiety, distrust, intense sadness, suspicion, and rejection which can ultimately ruin relationships, especially marital ones. Studies like Nguyen, Karney, and Bradbury (2017) link dissatisfaction in marriage to early adversities. They explain that this can happen because the affected persons can demonstrate avoidance of intimacy, fear of being abused, and other interpersonal difficulties which can cause a depreciation of couple’s satisfaction. Childhood trauma can stimulate biological stress responses. The human biological system comprises different intermingling structures, which collaborate to direct the body's attention toward protecting the individual against environmental life threats. Based upon this, the individual’s system adapts a “fight, flight, or freeze” reaction. Cortisol levels therefore become elevated through the transmission of signals to neurons in the prefrontal cortex, hypothalamus, and hippocampus thus increasing activities in the sympathetic nervous system. Subsequently, these increases in catecholamine levels contribute to

changes in muscle strength, blood pressure, mental alertness, heart and breathing rate (Cherry, 2019). Hence, demonstrating that exposure to early stressors can disrupt the regulatory processes of the limbic-hypothalamic-pituitary-adrenal (L-HPA) axis across the life span in humans, even animals too.

Elaborating on signs and symptoms of childhood trauma, Hill (2013) identifies the behavioural symptoms as mood swings, insomnia, nightmares, appetite changes, hyper-vigilance, exaggerated startle responses, forgetfulness, self-harmful behaviours, hostility, truancy, substance abuse, and other delinquent behaviours. In addition, Hill (2013) lists some cognitive symptoms to include: poor self-worth, increased self-doubt, poor concentration, confusion/disorientation, perfectionism, intrusive thoughts, loss of interest in previously enjoyed activities, disturbing repeated flashbacks, poor motivation, and suicidal ideas. Furthermore, some social symptoms can consist of withdrawal, loneliness, irritability, intolerance, distrust, rage, violence, recklessness, talkativeness, and decreased interest in sex or intimacy. Some changes in behaviour like poor self-care, substance use and binge eating can also be manifestations of such challenges. In the passionate search for solutions to increase marital satisfaction, researchers like Gottman and Gottman (2017) have worked on how to solve problems of various disgruntlements among couples. They deduce that having skills-based programmes for preventing marital discord can promote satisfaction. These efforts notwithstanding, the problem of achieving satisfaction in marriage persists.

Some researchers like Sotude and Dindar (2015) have worked on marital satisfaction, however, they concentrated more on areas such as social security, age at marriage, age of spouses, duration of the union, number of children, self-efficacy, sexual self-efficacy, dyspareunia, general health, life satisfaction, and economic conditions. Again, the literature search showed little influence of cognitive processing and stress inoculation therapies on marital satisfaction of married women with childhood trauma. Therefore, considering the importance of marital satisfaction in promoting the success of marriages in society and the development of strong familial foundations, this study sought to find the effects of cognitive processing and stress inoculation therapies on the marital satisfaction of married women with childhood trauma.

Cognitive processing therapy (CPT) is a structured evidence-based treatment. It uses cognitive behavioural approaches which have sufficient resources that can help

clients acquire techniques to challenge, alter, and adjust irrational beliefs especially those connected to their traumatic experiences. The therapy was designed in 1988 by Resick, Monson, and Chard as a trauma-focused form of treatment. It has been an operative form of treatment in the reduction of traumatic stress symptoms due to a number of damaging circumstances like child abuse, war, accidents, and natural catastrophes (Resick and Schnicke, 1993).

Cognitive processing therapy deals with the stuck points in a way that can help clients acquire the skills to reinterpret, dispute, and change unhelpful beliefs related to the traumatizing experience. By doing this, the individual can generate a new understanding of the traumatic incidence which will lead to a reduction of its ongoing undesirable effects on the life of a person. While directing attention on the memory of the trauma, the individual begins to decrease the avoidance of the negative memory which in the long run helps in the reassessment of his/her belief system previously created by the disturbing event. By this, CPT sets out to accomplish four objectives which include: psychoeducation of the client about his/her symptoms and the way the treatment will help; enlightening the client about his/her psychological journey to recovery; imparting lessons to help him/her develop skills to challenge or question his/her irrational beliefs and helping the client to recognize how changes in his/her beliefs had occurred as a result of experiencing the traumatic event. Resick (2008*)* outlines the three steps for effective implementation of cognitive processing therapy as; psycho-education, processing traumatic experience, and reinforcing skills taught during therapy. Cognitive processing therapy has been used for women who developed PTSD from sexual violence but not much has been reported as regards its effects on the marital satisfaction of women with childhood trauma.

The second treatment used in this study is the Stress Inoculation Therapy (SIT) developed by Meichenbaum in the early 1970s. This therapy was developed with the aim of applying it like a "vaccine" for clients experiencing tension and distress. Like the CPT, SIT is a type of cognitive behavioural approach that not only prepares clients to properly handle future difficult events before they occur, but to also help them deal with current stressors with minimal distress. Stress inoculation therapy can be tailored to suit an individual's specific needs on a one-on-one, couple, family, or group basis. Since stress inoculation therapy can be often adapted to fit a client's personal needs, it could be

beneficial for people with a variety of challenges in areas such as mental, emotional, and physical health conditions. Again, SIT has the potency to treat various disorders, and a wide range of other concerns such as; anxiety disorders co-occurring with panic attacks, phobias, stress-related chronic mental illnesses, pain disorders, posttraumatic stress disorder (PTSD), anger, performance anxiety, trauma-induced depression, difficult life transitions as well as invasive surgical procedures.

Clients receiving stress inoculation therapy are treated in three phases. Before treatment commences however, the therapist would have to consider two primary factors when developing a treatment plan, which are: the type(s) of the stressor(s) the client is facing, and the client's current coping skills or available resources. The three distinct stages that the intervention can be broken into are: the conceptional education phase; the skills acquisition/rehearsal phase; and the application/follow-through phase**.** Studies have shown that SIT has the ability to reduce stress in married women because it can tackle issues of anxiety and depression by teaching healthy coping strategies (Khorsandi, Vakilian, Salehi, Goudarzi, and Abdi, 2016). This supports that SIT was designed as an anti-stress 'prophylaxes' to prevent stress-induced pitfalls (Dibdin, 2022). This study, therefore, used SIT as a psychological intervention on the marital satisfaction of women with childhood trauma. It is vital to note, however, that only a few studies have been carried out using SIT on marital satisfaction of women with childhood trauma in Nigeria, hence, there is a clear gap in research in this field.

Apart from the two interventions, the moderating variables in this study were personality types and spousal support on marital satisfaction of women who have been affected by childhood trauma. Personality types can be described as the different categories of individual behavioural tendencies. The link between childhood trauma and stress can partially be mediated by personality because individuals who have encountered early adversities can manifest emotion dysregulation, low-stress tolerance, loss of identity, frequent worry, poor self-image, anxiety, mood irregularities, relationship challenges combined with various forms of cognitive distortions (Resick, Monson and Chard, 2014). Again, their temperament can affect their relationships thereby affecting satisfaction. Moreover, trauma can produce extreme helplessness or shame affecting an individual in such a way that he/she could become inclined towards feelings of timidity, boisterousness, aggression, self-blame, self-pity and guilt. Similarly, the International

Statistical Classification of Diseases (ICD-10; 2002) states that 'enduring personality changes which can occur after catastrophic experience' (EPCACE) was fused as a diagnosis into its 11th edition as a type of complex posttraumatic stress disorder (cPTSD). EPCACE was also observed to be characterized by sexual dysfunction, guilt expressed by anger, hostility, and mistrust.

Spousal support is the establishment of physical, psychological and emotional activities essential for consolidating marital ties demonstrating its influence on satisfaction (Ebenuwa-Okoh and Osho. 2016). It is the type of support that is geared towards better functionality especially for those who are victims and survivors of childhood trauma. Since care and affection in relationships are important components which human beings use to build fulfilling deep-rooted bonds with their spouses, then patience can become a necessary channel for improving unions, especially in homes where spouses stressed by early disturbing experiences abound. This means that though the process of such relationships can be difficult, interactions could still be transformed into unique opportunities for spouses to stay closely knitted. Hence, the failure of husbands to give appropriate care to their wives who have experienced childhood trauma can lead to enduring distress in their relationships; consequently, spousal support is necessary. Another important means of recovery can be through professional help. Therapy can be a source of recovery that can stimulate the internal resources situated within these married women who have experienced childhood trauma.

Several studies on both national and international spheres like Lukman, Khan, Bichi, and Ibrahim (2020) have observed some causative factors of marital satisfaction, while others such as Bright, Dube, Hayden, and Gordon (2020) attempted numerous experimental designs, however, there is still a dearth of studies that investigated the effects of CPT and SIT on marital satisfaction of women with childhood trauma. Premised on this, this study sought to find the effects of cognitive processing and stress inoculation therapies on the marital satisfaction of women with childhood trauma. The moderating effects of personality types and spousal support were also examined.

1.2 Statement of the problem

Low levels of marital satisfaction are the reasons why many marriages are at the brink of collapsing. This is probably because of; too many expectations from partners, poor interpersonal skills, and childhood trauma. This is likely to affect the married female

population in such a way that they could carry different mental and emotional encumbrances of varied degrees into their homes so that when unexpected pressure sets in, like in-law interference or financial constraints, such stress can trigger some maladaptive behaviours which may reduce marital satisfaction. This can also result in outcomes such as domestic violence, separation, and divorce indicating the need for professional psychological intervention**.**

Furthermore, it has been observed that some couples in Nigeria may find it difficult to experience some level of marital satisfaction as they were raised in emotionally deprived environments. Some of such settings contribute to children being exposed to a wide range of predispositions to risk factors associated with childhood trauma. Such areas of early deprived forms of nurturance could include: disregard for their basic intellectual needs, extreme punitive 'disciplinary' measures, insufficient care, inadequate attention, verbal assaults, threats, destructive criticism, exposure to inappropriate sensual activities, rape, molestations and other forms of adverse circumstances eventuating into difficult challenges in adulthood. Although issues on mental health are gaining public attention, there is still a scarcity of studies on women's childhood trauma and marital satisfaction. This study, therefore, was designed to investigate the effects of cognitive processing and stress inoculation therapies on the marital satisfaction of women with childhood trauma.

1.3 Purpose and objectives of the study

The main purpose of the study was to investigate the effects of cognitive processing and stress inoculation therapies on the marital satisfaction of women with childhood trauma in Ibadan, Nigeria.

Specifically, the study set out to:

1. determine the main effect of treatment (cognitive processing and stress inoculation therapies) on the marital satisfaction of women with childhood trauma.
2. examine the main effect of personality types (extroversion and introversion) on the marital satisfaction of women with childhood trauma.
3. examine the main effect of spousal support (low, moderate, and high) on the marital satisfaction of women with childhood trauma.

4. assess the interaction effect of treatment and personality types on the marital satisfaction of women with childhood trauma.
5. investigate the interaction effect of treatment and spousal support on the marital satisfaction of women with childhood trauma.
6. ascertain the interaction effect of personality types and spousal support on the marital satisfaction of women with childhood trauma.
7. examine the interaction effect of treatment, personality types, and spousal support on the marital satisfaction of women with childhood trauma.

1.4 Hypotheses

The following seven null hypotheses were tested at 0.05 level of significance.

1. There is no significant main effect of treatment (cognitive processing and stress inoculation therapies) on the marital satisfaction of women with childhood trauma in Ibadan.
2. There is no significant main effect of personality types (extrovert and introvert) on the marital satisfaction of women with childhood trauma in Ibadan.
3. There is no significant effect of spousal support (low, moderate, and high) on the marital satisfaction of women with childhood trauma in Ibadan.
4. There is no significant interaction effect of treatment and personality types on the marital satisfaction of women with childhood trauma in Ibadan.
5. There is no significant interaction effect of treatment and spousal support on the marital satisfaction of women with childhood trauma in Ibadan.
6. There is no significant interaction effect of personality types and spousal support on the marital satisfaction of women with childhood trauma in Ibadan.
7. There is no significant interaction effect of treatment, personality types, and spousal support on the marital satisfaction of women with childhood trauma in Ibadan.

1.5 Research questions

The following research questions guided the focus group discussion in this study.

1. What precipitates marital satisfaction?

2. What precipitates marital dissatisfaction?
3. How does childhood trauma affect marital satisfaction?
4. What strategies are being used to facilitate satisfaction in marriages?
5. What is your personality type?
6. With your personality types, which strategies work for you?
7. What areas of spousal support can bring you marital satisfaction?

1.6 Significance of the study

The outcomes of this study would be of great advantage to the study participants, other traumatised married women, their spouses, psychologists, mental health practitioners, social workers, academia, professional bodies, and future researchers.

Policy makers need to be aware of the existence of the existence of the problems marriages can face due to childhood trauma. From this awareness, interventions such as CPT and SIT can be used to help the affected subgroup.

The findings of this study should improve the participants and their spouses' knowledge about their predispositions to childhood trauma. This study is expected to improve the participants and their spouses' perceptions of how to handle childhood trauma and to encourage them to make some adjustments in their marital satisfaction. Furthermore, it would help participants to explain to their husbands how to support them as they recover from their adverse childhood experiences.

The findings of the study would also be useful for counselling psychologists as it will equip them with information on how to handle and improve the marital satisfaction of women with childhood trauma as regards the use of cognitive processing and stress inoculation therapies. The academia, professional bodies, marriage counsellors and other research institutions, especially those relating to marriage and family life will be well-informed through this investigation on how to handle women's marital satisfaction, especially those that have experienced childhood trauma. The instruments on married women with childhood trauma should be useful for researchers, psychiatrists, and marriage counsellors to help in identifying and assisting women with childhood trauma. The findings would also be valuable reference material in the hands of policymakers on marriage and family life to help couples adjust, especially when they face marital dissatisfaction as a result of childhood trauma. Research of this type will also be useful in the area of child development. School owners, teachers, and child caregivers will learn

how to be cautious in handling children particularly those who have been exposed to experiences that can make them vulnerable in adulthood.

1.7 Scope of the study

The study investigated the effects of Cognitive Processing and Stress Inoculation therapies on the marital satisfaction of women with childhood trauma in Ibadan, Nigeria. Geographically, three local government areas are; Ibadan North-East (Iwo Road), Akinyele (Ojoo), and Ibadan North (Agbowo) were used in this study. The first local government area was Ibadan North-East which is also known as Ariwa-Ilaorun. It has its headquarters at Iwo Road. It also includes areas like Orita Bashorun, Iyaganku, Total Garden, and Monatan. In addition, the second local government area was Akinyele. Akinyele local government area shares boundaries with Afijo, its headquarters is at Moniya. The local government area is made up of some regions such as; Odogbo, Okeona, Orogun, Ojoo, Idi-Ose, Idi-Iroko, Ajibode, and Akobo. The third local government was Ibadan North. This area has its administrative operations in Agodi. It is surrounded by Akinyele, Egbeda, and Lagelu local government areas. It is also made up of various areas like Bodija, the University of Ibadan, Agbowo, University College Hospital (UCH), and Sango.

1.8 Operational definition of terms

The following variables were operationally defined:

Marital satisfaction

Marital satisfaction describes the degree to which women feel happy and content in their marriages to the extent that their needs and expectations are fulfilled.

Women with childhood trauma

These are women who experienced distressing occurrences during their childhood with damages of varied degrees lasting up to adulthood. Childhood trauma can be classified as incidences of neglect, physical, emotional, and sexual abuse.

Cognitive processing therapy

This is a trauma-focused form of cognitive behavioural therapy designed to treat trauma through cognitive reframing strategies. It focuses on the memory of the traumatising situation and how to reinterpret it.

Stress inoculation therapy

This is a non-trauma-focused cognitive behavioural approach packaged with action skills designed to treat stress-related challenges by enhancing resilience and self-confidence.

Personality types

Personality types not traits were used in this study. Personality types are the psychological classification of different women into the domains of extroversion or introversion. Extroversion refers to a personality type that is sociable, desires excitement, optimistic, and impulsive while introversion describes one that is quiet, reserved, pessimistic, having the ability to control emotions properly and plan appropriate actions.

Spousal support

Spousal support describes the type of support given by husbands to sustain their marital relationships with their wives who are survivors of childhood trauma.

CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

An extensive review of literature has been done in this chapter. The theoretical, empirical, and conceptual frameworks have been appraised as related to the study, focusing on marital satisfaction, childhood trauma, personality types, and spousal support.

2.1 Conceptual review

2.1.1 Concept of marital satisfaction

Human beings are born with a desire to interact. According to Maslow's hierarchy of needs, there exists in every human, a psychological hunger to belong, feel loved, and be accepted (Deckers, 2022) by others. A man and a woman, who perceive that they are suitable for each other, can be driven by the need to be together, urging them to tie the nuptial cord. Over time, they begin to evaluate the relationship seeking rewards in a process called cost-benefit analysis (CBA), a method frequently used in comparing and appraising the desirability of a decision (David, Ngulube, and Dube, 2013).

While couples assess themselves using the cost-benefit analysis, problems can arise when they perceive that the costs outweigh the benefits. In that way, heartfelt promises of 'eternal love' are rendered sour, thus causing devastating outcomes evidenced by the alarming rate at which numerous divorce suits fill court records (Ajala, 2018). Nigeria, as well as other nations like Russia, the United States of America, and Belarus have been categorised by the World Population Review (2019) as one of those with the highest rate of divorce cases. The Belarusian data is so high that Preiherman (2012) calls it 'the land of broken marriages.' It is obvious then that couples can enter into marriage with high hopes of fulfilment, happiness, lofty dreams of 'happily ever after' and a deep yearning for bliss (Oluwole and Umar, 2008) only to realise that both of them are far from being perfect.

Unmet needs and unfulfilled expectations in marital relationships can produce dissatisfaction, (Girma and Zewdu; 2019) cause stress, high levels of hostility, negative attitudes, and maladaptive behaviour (Robles, Slatcher, Trombello, Meghan, 2014), thereby defeating a key goal in marriage which is conjugal bliss. Marital satisfaction thus connotes an individual's assessment of his/her marriage (Schicka, 2015). It reveals what a spouse thinks are the perceived gains and losses of being married to a particular individual (Bradbury, Fincham, Beach, 2000). In addition, it is the quality of marriage void of frequent strain, stress, and displeasure. It is a state which reflects that couples with high levels of mutual satisfaction can have lowered levels of tension in their relationships, thus contributing to their determination to persevere despite the vicissitudes of life (Canel, 2013). Again, when couples are not satisfied in their marriages, their displeasure and frustration can generate conflicts which may serve as predictors of mental health challenges such as mood, and substance use disorders (Whisman and Baucom, 2011). Moreover, intense marital conflicts can produce heightened cardiovascular reactions which are linked to increased risks of cardiovascular diseases (Robles, Kiecolt-Glaser, 2003). On the whole, marriage is the primary source of sustenance available for both man and wife as a protective shield against life's physical and psychological hardships (Tavakol et al, 2016). It remains a means of consolidating life by boosting human culture and providing the necessary improvement required for a stable society (Preiherman, 2012).

2.1.2 Components of marital satisfaction

Marital satisfaction has some components. Regarding this, Bradbury, Fincham, and Beach (2000) designed an evidence-based study that modelled the key components of marital satisfaction as couples' interpersonal process and their milieu. Furthermore, this model was intended to enhance the comprehension of marital relationships.

The couple's interpersonal process comprises their bond, connection, and rapport. It describes an intimate, romantic, and passionate affection (Wong, Hall, Justice, and Hernandez, 2014) between a man and his wife. Miller (2012) claims that romantic feelings between married couples are often interconnected with rewards, costs, and comparisons. Rewards specify gains while costs indicate burdens and damages that produce unsatisfactory outcomes. Miller (2012) explains that comparison is the level of

expectation that spouses derive as they assess their relationship. Therefore, when comparisons are made, relationships high in cost are less satisfying than those low in cost (Stafford, 2005). In addition, Miller (2012) explains that the comparison level (CL) of a spouse is often influenced by past and/or present expectations, global evaluations, and opinions of family members and friends. This implies that the couple's interpersonal process can be affected by spousal assessment, evaluations made by their family members, as well as friends and acquaintances (Derlega, 2013).

It has been observed that keenly monitoring couples' interpersonal process is a strong mode of determining the nature of the problems they encounter in their marriages (Ticinovic, 2010). Taking this into consideration, clinical researches focusing on couples' interactions further reveal that strong emphasis is placed on the couple's behaviour during conflict and problem-solving. This is because distressed couples demonstrate high levels of negative interpersonal exchanges (Bradbury, Fincham, Beach, 2000). Moreover, Ahmadi, Ashraffi, Kimiaee, and Afzali, (2010) detect differences in both women and men's exchanges. They identify that wives' interpersonal processes can influence marital satisfaction in areas such as levels of intimacy, self-disclosure, and the desire to spend time together, whereas those of the males have different views as they long for the presence of a wife, sexual satisfaction, understanding gender roles and appropriate conflict resolution styles. Again, in their analysis, Bradley, Fincham, and Beach (2000) break down the various areas which make up the interpersonal process as cognition, affect, physiology, behaviour patterning and lack of impulse control (domestic violence).

In their discourse which focuses on the cognitive progression of couples' interpersonal engagements, Motamedi and Afrooz (2007) state that various models have been designed to explore spouses' thought patterns to comprehend marital problems, one of such is the cognitive model. According to them, this model clarifies that irrational beliefs and cognitive distortions are important indicators of the formation of some pathological symptoms. The model also explains that based on a stressful situation, an individual's distorted belief system will create inaccurate thought patterns causing negative emotions which will inevitably affect behaviour (Kleim, Ehlers, and Glucksman, 2012). These unprompted distressful thoughts which are centred on real or imagined schema can also be called 'automatic thoughts.' According to Boyd (2018), the process

of linking the relationship between thoughts, and feelings was established on the cognitive model, clarifying that cognition affects emotions and eventually behaviour. This is called the A-B-C theory which represents the following three elements:

A= Activating event: What was the situation that stirred the thoughts?

B = Beliefs: What are the beliefs that have formed these thoughts?

C = Consequence: What are the emotional and behavioural reactions that follow?

This model though emphasizes individual differences in cognitive vulnerability, it still shows that stressful event is processed and the subjective interpretation derived from them can distort the person's view of self, others, and the future. One's view of self could be in the form of certain maladaptive schemas depicting self-devaluating beliefs as the individual thinks, *I am unwanted*. Similarly, often suspecting others can also make the individual form beliefs that the world is a fearful place, producing thoughts like *people are wicked* and *no place is safe*. Furthermore, the person may have a foreboding that the future is bleak subsequently generating thoughts like, i*t's hopeless, I will never make it*, thus indicating the presence of pathological issues (Ball, 2007) which are resistant to recovery (Jari and Aghaee, 2017) except when tackled in therapy.

These maladaptive schemas can be triggered and activated even by common daily occurrences especially those that are stressful eventuating in unwholesome interactions and poor responses (Young, Klosko, and Weishaar, 2003). In addition to this, Young et al (2003) believe that maladaptive thought processes begin early in life and are based on five emotional unfulfilled needs: the yearning to be secure, loved, and accepted; the desire to feel competent and possess an identity; the longing to have the freedom to express normal emotions and needs; the desire to be spontaneous and have fun; and the wish to have realistic limits, self-control, and healthy boundaries.

In marital settings, Stone and Shackelford (2007) also recognize that there are some maladaptive inferential styles that couples reflect that can produce conflicts. One example of such is ascribing a spouse's negative behaviour to his/her personality instead of assigning it to the circumstances which could have led to the behaviour. These negative attributions which are more evident in conversations between couples can often result in domestic violence, withdrawal, and developing neurotic tendencies, bringing about confusion, conflicts, disconnection, dissatisfaction, then ultimately estrangement.

In psychology, the word ‘affect’ describes human emotions or feelings (Hogg, Abrams, and Martin, 2010). In their analysis, Duncan and Barret (2007) state that the affective domain is divided into three namely: Affective (feelings), Behavioural (interactions), and Cognition (thought) also known as (ABC). Affective-cognitive interactions show that emotions are products of perceptual evaluations (Dickerson, 2018) called cognitive appraisals, defined as how a person responds to and interprets stimuli in the environment. This has been found to affect mental health (Gomes, Faria, Lopes, 2016) as it includes causing stressful situations to be poorly appraised. Man loves to display this incredible energy called emotion (Cherry, 2019) that he uses to stir either positive or negative behaviour. He can express emotions through songs, paintings, poems, and stories (Passer and Smith, 2001) as media of communicating his internal state. This implies that individuals interpret pleasant or unpleasant situations of life based on their subjective experiences.

Naturally, human beings form the early basis of their emotions during childhood which inevitably affects interpersonal processes and feelings of satisfaction in their adult relationships (Zolfaghari, Fatehi, and Abedi, 2008). Studies like Lerner, Li, Valdesolo, and Kassam (2015), as well as Oosterwijk, Lindquist, Anderson, Dautoff, Moriguchi, and Barret (2013), state that emotions are integral parts of decision-making and planning. Some schools of thought posit that thoughts are necessary for emotions to occur while others argue that humans have a wide range of mental states not necessarily localized to different sections of the brain; implying that emotions can be subjective (Barrett, Mesquita, Ochsner and Gross, 2007) depending much on an individual’s moods and experiences.

There are six universal types of emotions namely: fear, disgust, anger, surprise, happiness, and sadness which can be experienced by anyone despite their race or culture (Eckman, 2005). It is concerning that Plutnik (2002) points out that feelings can be depicted as a ‘wheel of emotions’ because they can be combined, mixed, and even blended; for instance, a feeling such as joy combined with trust can produce love while anger and unmet expectations could translate to aggressiveness. Based on Eckman's (2005) identification of these basic types of emotions, Cherry (2019) notes that happiness which is a pleasant state characterised by feelings of joy, fulfilment, peace, satisfaction,

and well-being is what most people desire at work, marriage, and throughout life. Marital happiness is associated with increased longevity although the factors which contribute to it are complex and highly subjective (Lawrence, Roger, Zajacova, and Wadsworth, 2018). Conversely, marital unhappiness has been associated with different health outcomes like lowered immunity and low life expectancy (Ofole, 2015).

Sadness is classified by feelings of grief, moodiness, hopelessness, and listlessness, in addition to these, severe periods of such mental states could lead to depression (Cherry, 2019). Whisman, Uebelacker, Tolejko, Chatav, and McKelvie (2006) reveal that greater marital conflict is linked to depression and lower satisfaction. Couples with declining health and physical disability with low satisfaction reported often feeling continuous sadness (Bookwala and Franks, 2005). Similarly, prior studies of marital processes, like Proulex, Helms, and Buehler's (2007) state that sadness is a core component of clinical depression which is evidenced in relationship strain and linked to low spousal support as well as predicting marital dissatisfaction. In addition to this, various findings from investigations such as Agu and Nwankwo (2019) and Tas and Vural-Batik (2019) agree that spousal support could create an environment that can have raised levels of trust, peace, spiritual intelligence, forgiveness, less apprehension about the future, understanding and also reduced conflict.

Fear produces certain physiological responses like tense muscles, rapid, heavy breathing, and an increase in heart rate. It is an emotional reaction to a negative situation that can develop into a persistent and excessive dread for an object, person, or situation with the affected individual either becoming distressed or using avoidance coping mechanisms indicating anxiety (American Psychiatric Association, [APA] 2013). Fear can develop not only from an individual's personal experience, but also indirectly by watching a traumatic situation (Olsson, Nearing, and Phelps, 2006). According to Albrecht (2014), there are five types of fear namely: the dread of death; loss of autonomy; fear of being abandoned or rejected; fear of being humiliated, and the fear of being invaded or attacked. Furthermore, Albrecht (2014) claims that each of these types have triggers. For example, fear of death can be triggered by being afraid of fatal diseases, abusive persons, and tall buildings; while the fear of being attacked can be illustrated as feeling unsafe or losing a natural function like erectile dysfunction.

Furthermore, loss of identity because of being controlled, can lead to feelings of being suffocated, incarcerated, restricted, smothered by overprotective parents or spouses can cause this type of fear. Albrecht (2014) further expounds that when a spouse is fearful and mistrustful in a relationship, it can stir up the fear of intimacy as the agitated individual may feel vulnerable and uncertain of the future of the relationship; finally, the dread of being humiliated can make a person distressed because individuals like to feel loved, supported, relevant, wanted, other than shamed, insulted, mistreated and disgraced.

Sobral, Teixeira, and Costa (2015) explain from their study that two types of fear of intimacy can sabotage marital satisfaction namely: fear of losing self (FLS) and fear of losing the significant other (FLO). On the one hand, FLS refers to a context when a spouse might seem to be struggling with the fear of losing freedom, sense of self, and insecurity resulting in feelings of being trapped or controlled. On the other hand, in FLO, the spouse exhibits a fear of abandonment leading to the habit of surveillance and scrutiny. Their findings also show that there is a positive association in relationship satisfaction between both partners with FLS. However, a decrease in satisfaction was reported when one spouse with higher FLS was combined with a partner with lower FLO. Kasalova, Prasko, Holubova, Vrbova, Zmeskalova, Slepecky and Grambal (2018) observe that dissatisfaction in marriage can trigger the onset of anxiety disorder and can perpetuate the condition of distress disrupting daily functioning. Likewise, Caughlin, Houston, and Houts (2000) report findings from their 13-year longitudinal study, in which negative affectivity and fear were found to be frequently and persistently associated with marital dissatisfaction even in newlyweds and older couples.

Disgust as described by Eckman (2005) is the sense of revulsion, repulsion and repugnance. This emotion can be displayed by turning away, vomiting, or wrinkling the nose in response to the object of repulsions such as bad food, poor hygiene, infection, and even an offensive behaviour that an individual perceives to be immoral, unwholesome, or evil (Oaten, Stevenson, Case, 2009). Maintenance activities are strategies married people adapt in ensuring that satisfaction is sustained in their relationships to prevent distress, (Canary, Stafford, and Semic, 2002), in such ways as devoting time to proper self-care. In addition, Hennegan, Zimmerman, Shannon, Exum, OlaOlorun, Omoluabi, and Schwab (2018) state that eliminating foul mouth and odour through proper oral hygiene, taking

care of the armpit, vagina, and penis by bathing regularly are also indications of mental stability. Furthermore, a clean and well-groomed physical appearance is essential for relationship satisfaction as it can generate more sexual attraction to one another (Akingbade, 2015). An offensive behaviour that can arouse the feeling of disgust in marriage is also infidelity, since it produces devastating effects that can cause hatred, abhorrence, and detestation in the relationship (Scheeren and Wagner, 2018).

Anger is a universal emotion that is characterised by strong feelings of displeasure stirred up in a person either by real or imagined wrong often following a desire to retaliate (Warters, 2018). When an individual experiences anger due to an irritating situation, some physiological changes may occur such as: an increase in heart rate, elevated blood pressure, dryness of the mouth, muscle tension, tightening of the chest, and increased levels of adrenaline (DiGiuseppe and Tafrate, 2003). About the physiological effects of anger, Novaco (2000) observes that anger has many mental and physical consequences such as the inability to self-monitor, regulate and be objective. Thus, anger may cause a decrease in adaptive cognitive ability which can lead to unrealistic assessments and risky decisions (Lerner and Keltner, 2001). In addition to this, Novaco (2000) states that uncontrolled anger can negatively affect personal and social well-being, while Kassinov (2013) links anger with medical conditions like hypertension, cancer, suicide, and inflammation in old age. In view of this, Legg (2019) identifies some of the possible causes of anger as depression, obsessive thoughts followed by compulsive behaviour, alcoholism, insubordination, argumentative behaviour (diagnosed as oppositional defiant disorder), also impulsive and violent behaviour (known as intermittent explosive disorder). Warters (2018) establishes that there are three general types of anger namely: aggressive, passive, and assertive anger. Aggressive anger is directed at hurting others emotionally, physically, or psychologically whereas passive anger is internalised because the individual avoids dealing with the angry situation (Warters, 2018). Assertive anger is usually the best way to communicate angry feelings as it is respectful, goal-oriented, and non-threatening, therefore, in maintaining marital satisfaction, anger, resentment, and irritation must decrease so that forgiveness as well as kindness will increase (Kord, Khan, Sharbafshaaer, and Akhtar, 2018).

Surprise is a startled automatic response characterised by muscular tension when an event is perceived as harmful or unexpected (Cherry, 2019). This implies that surprise can be negative or positive (Noordewier and Breugelmans, 2013), hence expressing the difference between hope and reality. Tomasulo (2018) further mentions that a lack of positive surprise in marriages can cause boredom, and loss of passion leading to less engagement, stimulation, and satisfaction thus feelings of affection can decline when marital relationships become too predictable. Whiteman (2017) agrees with this by stating that when there is no change in the everyday behaviour of a married couple, a reduction in their satisfaction can occur.

According to Roy, Schum and Britt (2013), the first emotional response that infertile couples display as they discover their inability to conceive is surprise. They stress that this emotion eventually leads to grief, resulting in less marital satisfaction. Nevertheless, Rosenquist (2010) notes that marital satisfaction often declines dramatically when an unplanned pregnancy springs a surprise on some couples meaning that the first baby can bring a decrease in affection and an increase in conflict as they try to balance responsibilities within and outside the family. Barker (2017) expounds that couples who try to excite their spouses by introducing positive romantic elements of surprise into their relationships obtain a significant increase in their marital satisfaction. To Greene (2001) the element of surprise is the root of seduction. Surprise plays a great role in keeping married couples happy, however, Scot (2013) notes that spouses who have an inaccurate view of self, others and the world can live in a state of 'terrified surprise' or exaggerated startled response which can negatively affect satisfaction.

In the process of reacting to a threatening 'fight, flight or freeze' situation, there are some physiological responses that an individual can sense, such as sweating, shortness of breath, muscle tension, fast heart rates, and mouth dryness (Edmundson, 2012). Physiology is the study of how organisms perform their vital functions in health and disease (Webster's college dictionary, 2014). Hippocrates was known as the 'father of medicine' and the propounder of the Hippocrates' theory of the four humours. The theory views the body as containing four different types of fluids (black bile, phlegm, blood, and yellow bile) of which an imbalance in their ratio would cause sickness. Nevertheless, substantial progress has been made as physiology has discovered how parts

of the body work in relationship to one another (Newman, 2017). In the field of psychology, physiological functioning explains the relationship between the neural mechanisms of awareness and implementation through the involvement of the brain (Pinel, 2004) playing a vital role in shaping emotions (Pessoa, 2010). Therefore, married couples who experience positive emotions such as satisfaction, show better physical health outcomes compared to those who are less satisfied with their relationships (Stone and Shackelford, 2007). Kiecolt-Glaser and Wilson (2017) submit that married couples have better physical well-being than the unmarried because they enjoy a sense of belonging. Wilson and Oswald (2005) agree with this since their study shows that marital relationships can make spouses happier, healthier and less likely to indulge in risky behaviours.

Behaviour patterns can either be destructive or constructive (American Psychological Association [APA] 2001). Various parts of the human body can be used to express thoughts and feelings like joy in the form of a smile, or sadness in the form of crying; these are behavioural responses. Behavioural responses play an important role in marriage as they determine an individual's disposition and action given the particular situation (Ajayi, 2018). Destructive behaviours are negative and critical while constructive ones are non-judgmental, problem-solving, and supportive (Esere and Lukman, 2012). According to Stone and Shackelford (2007), the behaviour pattern most associated with low outcomes of marital satisfaction is demand versus withdrawal. They illustrate this with an example of a disagreeing couple; while the wife demands a change in the husband's interaction process, he feels criticised and withdraws from her to avoid any form of confrontation. This pattern of demand/withdrawal continues until there is total disengagement between the couple because both have become dissatisfied with the relationship.

Consistent destructive patterns of behaviours that hint at conflict, like shouting, name calling and criticising can, therefore, predict dissatisfaction which may result in divorce (Orbuch, Veroff, Hassan, and Horrocks, 2002). For this reason, patterned traits have strong implications for couples' assessments of their fusion especially those involving dissension (Kelly, Fincham, Beach, 2003). Also, steady high levels of intimacy patterns such as; time spent together, affection, and sexual activities, can increase marital

satisfaction, so, healthy behavioural patterns, healthy communication styles and conflict resolution skills could increase marital satisfaction (Canel, 2013). Besides this, individuals who are physically mistreated in relationships are predicted to be more likely dissatisfied than those in non-violent relationships (Stone and Shackelford, 2007). Domestic violence can take the forms of physical, sexual, and psychological abuse (Noah, 2000) which may be regarded in some societies as a right reserved for the husband's proper and culturally correct way of reacting (Oyediran and Isiugo-Abanihe, 2005). Violence is regarded as a problem against women. It is further recognized as a public health challenge with terrifying consequences which could affect their reproductive, physical, and psychological well-being (Benebo, Schumann, and Vaezghasemi, 2018). To this end, whenever husbands' substance use takes centre stage at home, it escalates into the mishandling of their wives who report that they are constantly living in perpetual fear of their partners (Wilson and Taft, 2015) because such husbands may lose the ability to control their impulses.

The couple's milieu is the second component of marital satisfaction. According to Bradbury, Fincham, and Beach (2000), the totality of environmental conditions, the circumstances affecting the growth and development within which the marriage operates as well as functions are the couple's milieu. They add that the milieu can include; where the couples live, their family history/biography, the presence/absence of children, financial issues, and life stressors. Where couples live is an important construct in their relationship. Traditionally, marriage entails that a husband and wife commit to living together so that through their legal and sacred union they can raise children, thereby creating strong bonds (Lashari and Lashari 2017; Animasaun and Fatile, 2011). Nevertheless, sharing one's life with someone else can be challenging because there can be a clash of values, personalities, needs, and desires (Tolorunleke, 2014) which can sometimes erupt into a conflict over issues like accommodation arrangements. Therefore, Belal and Gaheen (2016) indicate that a relationship was found between the place of residence, despair, and marital satisfaction.

Belal and Gaheen (2016) claim that there is a relationship between marital satisfaction as well as birth order, but Raetz (2011) disagrees with this mentioning that birth order has no significant influence on marital satisfaction. However, Stone and

Shackelford (2007) agree with Balel and Gaheen (2016) reiterating that the history of adult attachment styles shows some correlation signifying that some couples can be less satisfied than others based on their ordinal position in the family of origin. Furthermore, the absence or presence of children in a marital setting can change its context because it influences satisfaction (Stone and Shackelford, 2007). Again, Belal and Gaheen (2016) posit that a wife who has no child would experience pressure from her in-laws thereby decreasing marital satisfaction. Issues involving pregnancy, unequal share of domestic obligations, childrearing (Belal and Gaheen, 2016; Canel, 2013), number of children and infertility are significant factors in the issues of marital satisfaction (Adigeb and Mbua, 2015). Moreover, conflicts over monetary issues, lack of trust in the partner's ability to handle financial matters, problems with the family budget, and financial constraints can influence a couple's marital satisfaction (Canel; 2013). Stressful life events such as health issues (Ilo, 2014), childlessness, life transitions (Belal, and Gaheen, 2016), unemployment, loss of a dear one, and other life stressors may deplete spousal intimacy for the positive functioning of a relationship (Neff and Karney, 2009) further posing as difficulties in the couple's milieu.

2.1.3 Marital satisfaction and women

Animasaun and Oladeni (2012) argue that, though marriage is a unique institution that affirms the union between man and wife with the distinctive ability to support procreation, fulfil needs and regulate behaviour, it still has its problems, one of which is, how to maintain satisfaction (Tolorunleke, 2014). As a result of these difficulties, it has been observed that marital satisfaction can drop markedly over the first ten years and may continue to deteriorate progressively over time (Lavner and Bradbury, 2010). Marital satisfaction is a concept that evaluates the happiness and success of a couple's relationship (Tavakol, Nasrabadi, Moghadam, Salehiniya, and Rezaei, 2016). It is the attitude that a spouse has toward his/her marital relationship (King, 2016). The effects of marital satisfaction on women can either be positive or negative when dissatisfaction is apparent; with the corroding peak being separation and ultimately divorce (Tavakol et al, 2016).

Dimkpa (2010) elucidates from observation that when women are not happy in their homes, especially in African society, they can explore different approaches to

demonstrate this in a variety of ways, such as using traditional charms to obtain peace and happiness. The hopelessness such women experience stems from their lack of marital harmony which could be because there are conflicts in areas of finance, intimacy, commitment, and trust. Again, Dimpka (2010) argues that it is necessary to correct their irrational beliefs through counselling as this major setback can result in negative outcomes not only in their lives but their children's; hence paving the way for exposure to adverse experiences, lack of care and discipline (Kamaly, Dehgani and Ghasemi, 2014). Whenever children lack adult supervision, they can become defenceless against the various vices in society thereby resulting in poor physical, social, emotional, and cognitive performance in adulthood.

Women provide support for others. This reveals their desire for connectedness in relationships which is often less than what some may receive from their spouses (Rostami, Ghazinour, and Richter, 2013). The disconnect they experience can leave many women unfulfilled and unhappy even though satisfaction in marriage is meant to meet various physical and psychological needs (Kamaly, Dehgani, and Ghasemi, 2014). Other consequences of unmet needs include unresolved conflicts, lack of cooperation (Ilo, 2014), poor communication skills, murder, separation, and divorce (Animasahun and Fatile, 2011). Marital satisfaction indicates safety, peace, fulfilment, a positive attitude toward marriage, and increased sexual performance (Taghani, Ashrafizaveh, Ghanbari, and Tatari, 2019). Moreover, a reduction in women's sexual desire can also indicate a decline in marital satisfaction (McNulty, Maxwell, Meltzer, and Baumeister, 2019). Married women with psychological and psychiatric challenges as a result of stress have reported low satisfaction (Ostir, Ottenbacher, Fried, and Guralnik, 2007), thereby exposing the family to more health, social and economic challenges.

Reports such as Leykin, Roberts, and Derubeis (2011) as well as Roskar, Zorko, Bucik, and Marusiv. (2007) state that when women are depressed, they have difficulties in communicating, decision-making, and problem-solving which could create problems in marital relationships. That is why a decrease in marital satisfaction in women can cause self-blame, guilt, shame, and detachment (Drosdzol and Skrzypulec, 2009) affecting marital and overall mental functioning. In agreement with these studies, LaSov (2020) states that when individuals experience early traumatizing situations, they cause

wounds that can result in the creation of a false self. This implies that traumatized married women can present to others a self that is not reflective of who they truly are. Again, LaSov (2020) explains that negative self-talk and the feeling of victimization can make a married woman who has experienced trauma in childhood lose the power to choose to change the narrative of her life from defeat to victory. Furthermore, some married females find it difficult to resolve their anger easily; this can therefore make them constantly angry either in an implosive or explosive manner without actually understanding what triggered it. Consequently, this can evolve into aggressive or passive-aggressive behaviour. Also, a married woman experiencing symptoms of childhood trauma can react based on the level of the impact of the incident on her life because of triggers. Triggers can fetch and convey memories to parts of the brain as threats, pain, or fear (Lang, 1977). Though triggers can differ from one individual to another, a married woman's symptoms can be stimulated through one or more of the five senses of sight, sound, touch, smell, and taste. These sensory organs can arouse memories causing the woman traumatized by early adversities to react inappropriately, particularly in situations that are similar to the previously troubling event.

Vasser (2011) lists some common triggers as: the feelings of threat that can be aroused if someone who resembles an abuser is seen, or if an object used during the abuse is seen, unpleasant emotions and behaviours can be stirred, therefore, sight can stimulate feelings of threat. Again, if the place where the abuse occurred is seen, it can kindle feelings of fear. Moreover, Vasser (2011) states that certain sounds might be engrained from disturbing childhood experiences such that a whimper, whisper, footstep, tone of voice, scream, cry, or offensive words can serve as reminders of incidents rekindling sorrow, anger, or anxiety. Similarly, Vasser (2011) summarises experiences that can lead to distress as: the sense of smell, touch, and taste in terms of certain odours, fragrances, and aromas from people, places, objects, or substances such as alcohol, perfumes, cigarettes, and spices can trigger flashbacks, painful memories to the extent of causing nightmares. Additionally, some kinds of physical touches, someone's breath on a female survivor's skin, and physical proximity can spark off unwanted memories, leading to certain terrible reactions. Aside from this, any gustatory stimulation related to the abuse can also arouse negative thoughts and feelings (Vasser, 2011). Stowkowy,

Goldstein, McQueen, Wang, Kennedy, Sidney, Bray, Lebel, and Addington (2020) also submit that childhood trauma has significant consequences which is the reason Alvarez, Masramom, Foguet-Boreu, Tasa-Vinyals, Garcia-Eslava, Roura-Poch, Escote-Llobet and Gonzala (2021) including Yager and Kay (2020) explain that a history of childhood trauma and its impact has been associated with posttraumatic disorder and psychotic disorders.

2.1.4 Concept of trauma

According to the Substance Abuse and Mental Health Administration (SAMHSA, 2014) trauma is a public health problem that can happen because of abuse, neglect, loss, or any other psychologically damaging experience, affecting 67% of children before the age of 16. There are three main types of traumas; acute, chronic, and complex. Shapiro (2010) describes the acute type as occurring because of a single traumatic incident which is commonly associated with posttraumatic stress disorder while the chronic distressful events stem from traumatic experiences that are repeated and prolonged, such as domestic violence. Furthermore, complex trauma refers to cumulative, invasive, interpersonal exposure to adverse situations from events that are varied and multiple with quite extensive effects on both mental and physical health (Howell and Itzkowitz, 2016).

Morris (2018) describes trauma from Greek etymology as a *wound* while Kerig (2019) reiterates that it is a negative and emotionally painful occurrence affecting an individual's ability to function. Moreover, Freud (1926) posits that trauma denotes an event of severe psychological violence that has occurred in the life of an individual ushering in an influx of excitation too powerful for the human system to contain resulting in a disorganization of the psyche. Such an invasion is so powerful that it cannot be inhibited successfully through defence mechanisms such that the assault may cause rumination, helplessness, and repetitive bad dreams (Freud, 1926). Oboirien (2013) as well as Peden, Oyegbite, Ozanne-Smith, Hyder, Branche, Rahman, Rivara, and Bartolomeos (2010) further cite the World Health Organisation (WHO, 2008) as predicting that by the year 2020, trauma would become the leading global disease. Yet again, it has even been recognised and documented as the primary cause of childhood morbidity and mortality, displacing malnourishment. This is because all over the world, injuries and violence predominantly through abuse are responsible for the deaths of

young persons under age 18. Adimula and Ijere (2018) corroborate this by also stressing that in these recent times, childhood trauma is one of the main sources of death. Moreover, they note that it has become a common cause of global socio-economic burden, mortality, and disability. In addition to this, Sminkey (2019) mentions that WHO (1999) published a document exposing adverse experiences as a significant public health problem that should be given priority and much attention.

According to Diagnostic Statistical Manual for Mental Disorders (American Psychiatric Association; DSM-5, 2013), trauma is a direct personal encounter or a witnessed experience involving either actual or threatened death, serious injury, or sexual violence as a threat to one's physical integrity. Based on this definition, some researchers such as Adimula and Ijere (2008) assert that there are controversies over what can constitute a traumatic event. They state that while a collection of symptoms is arrayed in the International Classification of Diseases (ICD-10, 2002) and the Diagnostic Statistical Manual for Mental Disorder (DSM-5, 2013), there is still a cross-section of symptoms from different cultural and social settings in some communities which have not been identified and included in the ICD-10 and DSM-5 respectively. Furthermore, they acknowledge that some of the omitted parts which represent indelible scars on the minds of the Nigerian woman or girl child are; subordination, deprivations, discrimination, female genital mutilation, wife rape, polygamy, oppressive cultural practices toward widows, fertility deficiency, living below poverty levels, religious and social sanctions. Griffin (2012) likewise discloses that trauma possesses a subjective nature, as it includes the following three important elements: first, the event/circumstance; second, the individual's interpretation of the experience, and third, the effects of the event on him/her.

2.1.5 Forms of trauma

Brand and Kumar (2019) in their assessment maintain that trauma can take several forms like: child maltreatment, neglect, physical abuse, sexual assault, psychological abuse, domestic abuse, community-related stress (war, natural disasters like hurricanes, tornadoes, and earthquakes; terrorism, violence in school or neighbourhood such as armed robbery attacks, shootings, political upheavals), invasive medical procedures, and loss. Other forms of trauma by Adimula and Ijere (2018)

include: emotional/physical wounds from marital distress, female genital mutilation (FGM), witnessing violence, economic recession, domestic accidents, child military recruitment, and child marriage.

According to the SAMHSA (2014), trauma can be classified into two categories namely: human-caused trauma and nature-caused trauma. They explain that human traumatism can either be intentionally or unintentionally caused producing disturbance, pain, and suffering. The intentional causes could include terrorist attacks, armed robbery attacks, and war while the unintentional involve issues exposing the fallibility of human behaviour which can be detected in technological or mechanical errors, such as a collapsing bridge, or car crash. Furthermore, they clarify that natural traumatic events such as earthquakes, rainstorms, hurricanes, tornadoes, and floods are often viewed as mysterious 'acts of God' beyond human explanations. The following are clusters of traumata:

Individual trauma

Again, according to SAMHSA (2014), individual trauma is an adverse event that only occurs to one particular person. It could be acute (single), chronic (continuous), or complex (multiple). Examples are rape, physical attack, sexual assaults, chronic sicknesses, and life-threatening diseases. They add that survivors of individual trauma may feel isolated by the trauma or can keep the experience secret for fear of being stigmatized, hence making them avoid any forms of professional intervention. Again, they acknowledge that sometimes the shame the survivors' experience can distort their perceptions, thus making them feel feeble, guilty, and responsible for the incident. This can result in struggles with causation and assigning of blame as part of their attempt to make sense of the situation.

Group trauma

Group trauma, also known as collective trauma alludes to traumatic incidents whose effects are shared by a particular group of people (Garrigues, 2013). These can include vocational groups such as factory workers, military officers, police officers, or medical practitioners who face some form of danger due to the nature of their professions. Group members who survive traumatic experiences tend to hide details of their experiences within their association, forming allies, thus consequently viewing those

outside the faction as intruders. In doing this, a strong bond is built between members of the group, thereby disapproving of any affiliate seeking help from without. Any member who attempts to seek external aid is considered a violator of the group's confidentiality (SAMHSA, 2014).

Historical trauma

Another name for historical trauma is generational trauma. This can occur when certain tragic incidences of extreme magnitude affect an entire race or culture leading to a loss of their identity. Historical trauma has repercussions across generations, like grief, depression, anxiety, loss of cultural heritage, language, insecurities, violence, and substance abuse. Examples of these are the holocaust relating to the extinction of the Jews, the enslavement of Africans, and the forced evacuation and relocation of American Indians (Garrigues, 2013).

Direct or indirect exposure to trauma

Trauma can either be experienced directly or indirectly. Szogi and Sullivan (2018) describe direct trauma as a situation whereby an individual has personally experienced or witnessed an unpleasant and distressful event while indirect exposure refers to a disturbing event that was either heard of or learnt about.

Interpersonal trauma

These are negative events that occur among people familiar to one another like friends, spouses, parents, and children. Examples of such negative incidences that could occur in this category include; sexual assault, domestic violence, neglect, and elder abuse. Forms of abuse like physical, emotional, and sexual abuse can have detrimental effects on an individual's interpersonal functioning.

Intimate partner violence (IPV)

This involves a pattern of actual or threatened physical, sexual, and emotional abuse by one's intimate partner or spouse. Children remain the hidden victims of IPV as they are often exposed to witness the different forms of violence and abuse that can occur in a given setting. It is usually referred to as domestic violence. It may include any persons involved in a romantic relationship like spouses, lovers, dates, and fiances (Larsen, 2016). There is a strong correlation between children exposed to chronic

parental domestic violence and suicides combined with a wide range of psychopathological diseases to address.

Developmental trauma

This involves specific incidences that occur within a given developmental stage involving early adverse experiences such as neglect, physical, sexual, and psychological abuse thereby negatively affecting a child's physical, emotional, and mental health. Whenever trauma is experienced at a young age in the form of child abuse and neglect it negatively impacts an individual's well-being even into adulthood; therefore, child abuse and neglect are highly traumatizing experiences (Kraybill, 2018).

Community trauma

Tragedies can strike in communities eroding a sense of safety and security. This could involve gang robberies, kidnappings, hate crimes, physical or sexual assaults, torture, shootings, stabbings, toxicities, and infections. Examples of these are; Boko Haram attacks on some Nigerian communities like Buni Yadi in Yobe state, where 58 school boys were killed in their sleep; Chibok village in Borno state where 274 girls were abducted, and other villages where men were hacked and women raped (Lawal, 2019), leaving many children orphaned, displaced and traumatized.

Mass trauma

This can occur when trauma affects people in extremely large numbers with increasing rates of recurrence and severity (Hoffman and Kruczek, 2011). It could involve large-scale natural or human-caused disasters. Mass trauma could be so devastating that myriads of lives and properties, are lost resulting in a generally extended disruption of normal, stable routines and services. Some examples of mass trauma are; nuclear reactor meltdowns, terrorist bomb attacks, war, earthquakes, and global pandemics like the coronavirus (COVID-19).

2.1.6 Concept of childhood trauma

Childhood trauma is an endemic problem with deleterious and damaging consequences having long-lasting adult psychological and relational maladjustments. They include posttraumatic stress disorder (PTSD), anxiety, depression, personality disorders, eating disorders, emotion dysregulation, suicidal behaviour, attachment challenges, gender identity disorder, sexual and physical violence in intimate

relationships (Dugal, Bigras, Godbout, and Belanger, 2016). Jeronimus, Ormel, Aleman, Penninx, and Riese (2013) also emphasise that childhood traumatic experiences are physical, sexual, and psychological which can occur before a child reaches the age of 18 and are key causal factors in the development of psychiatric disorders. Bartlett and Sacks (2019) note that childhood trauma is a broad term revealing that an event initiating strong emotions has occurred to a child, inducing psychological symptoms such as helplessness as well as physiological indications like stomach aches, palpitations, and bedwetting. They outline the categories of some childhood trauma to include: neglect, grief, abandonment, sexual molestation, physical and emotional abuse.

2.1.7 Components of childhood trauma

Components of childhood trauma consist of a range of experiences that can occur to a child causing different levels of pain and distress. These can be like childhood abuse (physical, sexual, emotional abuse, and neglect) often resulting in long-term cognitive, social, emotional, and physical effects.

Gleaning from the description of child physical abuse communicated through the submissions of the World Health Organisation (WHO, 2006), it is a form of mistreatment involving the deliberate use of physical force against a minor either resulting in or having a high likelihood of harm, or threat to survival which is often demonstrated by hitting, beating, kicking, shaking, scalding, burning, poisoning, biting, suffocating, strangling and searing. Saunders and Goddard (2010) emphasise this postulation by stating that even the physical measures of punishing a child by smacking, spanking, pinching, biting, washing the mouth with soap, and demanding that a child remains in an awkward, distressing position for a long time are acts of physical abuse. They add that this is because there is a close connection between child physical abuse and adult mental health challenges. They further explain that concerns in mental health issues like re-victimisation, personality disorders, aggression, depression, anxiety, gambling, and substance use could arise, leading to abusive acts being perpetuated by a frustrated adult.

Williams (2019) and Theoklitou, Kabitsis, and Kabitsi (2012) maintain that child sexual abuse (CSA) refers to engaging a minor in a singular or series of sexual acts to derive sexual or financial satisfaction, the perpetrator being an adult or an older adolescent. They also disclose that forms of CSA could include: indecent display of the

genitals to a child, and showing pornographic materials to a minor. Broadley (2018) adds that having inappropriate physical contact with a child's genitals; indulging in sexual activities (including sexual intercourse) with a minor; the use of an under-aged child to produce pornographic materials; selling a child for sexual services such as child prostitution and child sex tourism are considered as forms of child sexual abuse. Thornton and Veenema (2015) therefore explain some of the adverse outcomes of CSA as: children having increased threats of sexually transmitted infections due to their undeveloped immune system, minors having multiple sexual partners, sexual dysfunctions, including more years of risky sexual behaviours and practices. Others include insomnia, self-blame, suicide, flashbacks, guilt, fear of objects associated with abuse, challenges with self-esteem, self-injury, somatic complaints, and chronic pain. The Department of Justice (2017), from their statistics also discloses that most perpetrators are familiar with their victims as 34% are the child's relatives (father, mother, sisters, brothers, uncles, aunts, or cousins) approximately 59% are the child's family friends, caregivers, and neighbours while only 7% are strangers.

Child psychological abuse which is also called emotional maltreatment (Broadley, 2018) is the intentional spoken or nonverbal activities by a child's parents, relatives, custodians or carer that can have the ability to bring about significant psychological damage to a minor (Black and Grant, 2014). Myers (2011) states that it involves making a child feel worthless, flawed, unwanted, and only useful at meeting the needs of others. Additional examples can include: terrorising, isolating, and denying emotional responsiveness to a child using behaviours such as ridicule, mockery, cynicism, scorn, humiliation, intimidation, and rejection (Lasov, 2020). While childhood psychological abuse can be as harmful as other forms of mistreatment, it is one of the most challenging and ubiquitous categories of childhood trauma which should be given the uppermost attention since they may be difficult to recognize and substantiate (Spinazzola and Hodgon, 2014). Survivors of this type of emotional abuse can display internalised or externalised anger, abnormal attachment development, self-blame, passivity, and learned helplessness (Lasov, 2020).

Child neglect describes a type of abuse that is as devastating and prevalent as childhood psychological abuse. It is the failure of a child's trusted family members or

custodian to provide attention, care, food, clothing, shelter, love, nurture, supervision, and other important resources necessary for the youngster to survive, to the extent that his/her well-being is threatened (Theoklitou, Kabitsis and Kabitsi, 2012). Moreover, Scot (2014) extrapolates six types of neglectful behaviour:

- Supervisory neglect: is characterised by a lack of attention which can lead to the child being exposed to sexual abuse, physical harm, or criminal conduct.
- Physical neglect: inclusive of the omission of performance in the provision of appropriate physical essential requirements like food, clothing, and shelter.
- Medical neglect: is when parents, guardians, or caregivers of a child intentionally refuse to provide appropriate and/or necessary medical care either through the failure to recognize the seriousness of the ailment or by withholding proper care.
- Educational neglect: is the failure to provide the child with an education and the required tools he/she will need to be part of an educational system. This includes preventing the child from going to school or not purchasing necessary educational items such as books and stationery for use.
- Emotional neglect: is the deliberate refusal to provide proper and adequate nurturing, love, care, encouragement and support for a child.
- Abandonment: the act of leaving a child alone for more than a reasonable period without proper arrangement for the presence of an age-appropriate caregiver.

Loughan and Perna (2012) expatiate that neglected children can experience delays in physical and psychosocial development, which can result in psychopathology. They state that individuals who are survivors of neglect have difficulty in forming or sustaining friendships, romantic and familial relationships. In the midst of this, Broadley (2014) relates that there is a salient point that raises concerns about cultural differences, consequently producing questions about crossing limits. Nevertheless, caution is advised as the ability to predict that a child is assuredly experiencing harm is still a complicated argument for strong consideration as Broadley (2014) once again stresses that the bottom line should be the availability of professionals to carry out proper and adequate assessments to ascertain whether abuse has occurred. Scot (2014) also points out that though poverty and neglect are closely associated, not all children from poor homes are neglected. Based on this, Scot (2014) also warns against considering neglect from a

gender perspective, as it is often portrayed in a prejudiced manner. Scot (2014) further explains that by doing so, the blame is shifted to the mothers while exonerating the equally guilty fathers who often feign ignorance. This can subsequently produce cruel men who fail to recognize their leadership roles and responsibilities in the family (Scot, 2014).

Many children are exposed to trauma every day in their homes, schools, and neighbourhoods, causing them significant physical, cognitive, and emotional long-term harm, lasting to adulthood (Redd, 2017). On account of this, Akinlabi (2016) observes that after interviewing a cross-section of young Nigerians, that the majority of them have been exposed to some traumatic experiences such as killings by gunmen, accidents, community violence, escalating rate of divorce, natural disasters, kidnappings, armed robberies and activities of terrorists. Again, there is often an inadequacy of records and/ or lack of data in Nigeria (Akinlabi, 2016) which does not permit the exposure of the degree of devastation that childhood trauma causes. Similarly, this inconsistency can compound the condition of the victims' issues thereby leaving the affected children and youths untreated and unheard. Akinlabi (2016) also estimates that about 65% of physical assaults and 86% of sexual molestations are hurled at this defenceless demography exposing them to risky behaviours such as sexual promiscuity, substance abuse, and criminality, portending a bleak future. Following this assertion by Akinlabi (2016), Olatosi, Ogordi, Oredugba, and Sote (2018) affirm by identifying some of the following barriers as reasons why suspected cases of childhood trauma (especially those related to child abuse and neglect) are not reported to appropriate authorities. This is as a result of: lack of professional skills in referral procedures, lack of proper clinical records such as photographs and radiographs, concerns about confidentiality by wards or parents of an abused child, fear of the consequences of the exposure to the abused child, lack of confidence in child protection services, and fear of the negative effect on the child's family, especially stigmatisation. They also implore that the provision of a bolstering, practical, trauma-informed curriculum in pediatric clinical settings especially for dental students would help in the early detection of traumatized children. This can assist in preventing further harm to the victims, in addition to ensuring that they are properly treated. Similarly, Butchart, Kahane, Harvey, Mian, and Furniss (2006) cite WHO (2002)

as stating that an estimated 31,000 death cases have been attributed to homicides, among 15-year-olds with millions of other dead children who had been victims of childhood adverse experiences whose demise were undetected and not investigated because of their relative social invisibility.

Nigeria has been struggling with numerous security issues such as the Boko Haram insurgencies. These have taken centre stage in public view, yet the violence against children which knows no bounds has been ignored. The ferocious acts against minors can occur within homes, schools, or whole communities with many of them experiencing some form of trauma before the age of 18 (NHDS, 2018). Similarly, the United Nations International Children's Emergency Fund (UNICEF, 2015) reports that six out of ten children in Nigeria experience some form of trauma before 18 years old with girls at a higher risk (Ekine, 2020) leaving many to cope without interventions. Furthermore, children are frequently exposed to different kinds of situations that can lead to early adverse experiences such as accidental falls, drowning, burns, and scalds due to environmental peril (Abubakar, Ahmed, Farouk, Gadanya, and Jimoh, 2018). Oyedele, Jegede, and Folayan (2016) review the negative impact of traumatic injury on children as decreasing their quality of life. Moreover, they report that this oddity is most prevalent in those with single, low socioeconomic status parents. This is in congruence with Olatosi, Orgodi, Oredugba, and Sote (2018) who support that Nigerian children from polygamous homes, large families, and low socioeconomic class where marital conflicts abound experience significant cases of neglect and forms of abuse resulting in trauma, with girls at a higher risk. Moreover, Owoaje, Ige, and Bamgboye (2011) reveal that 15 million Nigerian children are exposed to long hours of various forms of adversity such as sexual exploitation, human trafficking, and kidnappings under the age of 14. Girls are kidnapped and forced into child trafficking rings and then sent through dangerous routes as 'merchandise' to North Africa and Europe to serve as prostitutes under the care of 'madams' who expose their lives to severe hardships and pain (Odhiambo and Barr, 2019). Similarly, some children in Nigeria are exposed to the worst types of child labour such as roadside hawking, domestic servitude, armed conflicts, and herding livestock (Bureau of International Labour Affairs, 2018) exposing them to trauma. According to Loughan and Perna (2012), trauma can be a major setback for a child because most

human brain growth occurs during age six. They further reveal that various factors in a child's environment such as poverty and neglect can also damage maximum brain functioning.

Various ways that childhood trauma can affect and interfere with the systems of the body disturbing daily functioning to the extent of compromising an individual's physical and psychological wellbeing are:

- The immunity of the hormonal, endocrine, and other body systems can be corroded in gradual forms by trauma (Karr-Morse and Wiley, 2012), implying that it is a silent killer. Trauma triggers stress which also prompts impacts on the hypothalamic-pituitary-adrenal (HPA) axis which controls an individual's reaction to pressure (Siegal, 2012). Health issues like cancer, cardiovascular disease, obesity, diabetes, and asthma are associated with early life stresses (Karr-Morse and Wiley, 2012). Moreover, increased stress hormones can catalyse inflammations in different areas of the body, ushering in conditions such as fibromyalgia and osteoarthritis.
- An important clinical basis in tackling the impact of trauma on an individual is grounded on the understanding of the meaning that the survivor has attached to the incident. This can contribute to how he/she can process the incident, in that perceiving it as an act of *judgment* from God for past misdeeds can produce feelings like guilt, frustration, sadness, or fear causing some individuals to ask questions like *why me?* Others can even attempt to facilitate healing by concluding that he/she has survived for a *divine* purpose (Paulson and Krippner, 2007), thus ascribing some form of delusional superfluous importance to themselves.
- Both children and adults who have experienced trauma can develop negative or positive coping strategies to deal with the physical and/or mental effects of the harmful arousal of emotions, thoughts, including behaviours which can also occur as a result of any ill-fated situation (Howell and Itzkowitz, 2016).
- Trauma can cause hallucinations, seizures, and peculiar behaviour like mood-incongruent laughter, fear, and intense anger without reason for such demonstrations of feelings (Teicher, 2000).

- A history of childhood trauma is a strong predictor of mental health issues with diverse psychiatric diagnoses because it can manifest in many forms even with a wide range of comorbidity such as borderline personality disorder (Middleton, 2012).
- Violent attachment figures have a strong impact on the victimised child's internal representations of life resulting in patterns of fear and aggression (Schechter, Zygmunt, Coates, Davies, Trabka, McCaw, Kolodji, and Robinson, 2007).
- Akinlabi (2016) observes that when an individual is traumatised in childhood, certain functions and abilities are negatively affected including areas like; organising and maintaining a schedule, arranging in order of priority, making and following through with decisions, remembering important details, recognising appropriate behaviours or suitable responses, poor identity in adulthood and inability to control impulses.
- It is worthy of note that though childhood trauma can lead to psychosis, not all psychosis is trauma-induced nevertheless, it is a well-documented fact that adverse childhood experiences are potential risk factors for psychosis (Szalavitz, 2012).
- Feelings of deja vu (the unfamiliar seeming familiar) and jamais vu (the familiar appearing unfamiliar) are also identified as impacts that trauma can cause which are associated with disorders like: anxiety, depression, and schizophrenia (Neuman, 2013).
- Overwhelming disturbing childhood experiences can affect a person's identity which can cause severe impairment of a person's intra/interpersonal relationship (Middleton, 2012).
- Misconceptions about traumatic events and experiences can result in survivors being stigmatized, aggravating psychopathological symptoms and impeding intervention, as well as improvement (Schneider, Conrad, Pfeiffer, Elbert, Kolassa, and Walter, 2018).
- Financial budgets are stretched by health care services, psychological interventions, medications, and the burden of chronic co-morbidities (Kezelman, Hossack, Stavropoulos and Burley, 2015), thus affecting the family income.

2.1.8 Symptoms of childhood trauma in adults

Childhood trauma has symptoms with severity depending on individual differences. Fundamental characteristics such as; personality types, the type of trauma exposure, and the support received during the disturbing experience can also influence its intensity. This means that there can be various clinical ranges (low, moderate, severe) with a person experiencing one or more symptoms (Rossiter, Byrne, Wota, Nisar, Ofuafor, Murray, Byrne, and Hallahan, 2015). Though people tend to think that when an individual has faced an adverse experience as a child, he/she may not be able to remember it as an adult. Some persons may even expect them to *get over it* and *move on*, yet signs that trauma has occurred in childhood can persist for a long time (Morin, 2020). These misconceptions can have negative impacts on the health of the affected persons. They could have physical health issues like: heightened stress response, insomnia, and physical complaints without discernible medical proof (Thatcher, 2018). Emotionally and mentally, they might not be able to regulate their moods appropriately consequently producing anxiety, depression, low self-esteem, and self-destructive impulses, thus leaving a 'wounded child' within the adult (Teicher, 2000).

Survivors of childhood trauma can relive or re-experience negative events due to reminders known as triggers. Triggers can affect the sense of self, security, safety, and ability to regulate emotions and navigate relationships initiating the onset of some mental health challenges with symptoms like intense emotional lability, dysphoria, and panic attacks (Rossiter et al, 2015). Childhood trauma can also cause neurological impairments in adults which result in excessive internalising or externalising of feelings like: social inhibition, insecurity, insensitivity towards others, and aggression (Norman, Byambaa, Butchart, Scott and Vos, 2012) which can serve as warning signs or indicators of sequelae. Again, Thatcher (2018) groups these warning signs as emotional, physical, and behavioural symptoms which are: emotional indicators include: anger, unresponsiveness, excess suspicions, emotional outbursts, and panic attacks; physical signs include poor concentration, physical sickness, insomnia, lethargy, trembling, and night terrors, while behavioural symptoms could include impulsiveness, withdrawal from others, callousness, compulsion, and general disorientation.

Brandt (2017) highlights the four ways an individual can experience the aftermath of trauma: firstly, presenting a false self; childhood trauma victims often create and present to the world an untrue form of self that they feel will be more accepted. They do this to help them bury their emotional wounds and to create for themselves a sense of belonging. Secondly, victimhood thinking; some adults who have survived childhood adversity often view themselves as trapped and without choice, in so doing causing them to perpetually feel that they are victims of any circumstance. Thirdly, passive-aggressive; unhealthy expressions of emotions exhibited in a home setting, like, anger demonstrated in a suppressed or indirect way can affect a child's understanding of the manner that anger should or should not be displayed. Fourthly, passivity; individuals who have suffered from being uncared for as children can become adults who are afraid to express their thoughts and feelings for fear of being abandoned again. A passive stance could deprive them of reaching their full potential or enjoying genuine close associations.

In addition to these, Thompson and Wilkinson (2010) state that survivors may manifest physical symptoms such as poor eye contact, altered speech patterns, chronic fatigue, panic attacks, shallow breathing, chronic back pain, hypervigilance, restlessness, exaggerated startled responses, body numbness, fainting, and dry mouth as a result of childhood trauma. Furthermore, an individual who has experienced childhood trauma can eventually find themselves in abusive relationships, having trouble trusting others, being manipulative, struggling with thoughts of being controlled, having an unhealthy dependency on others, feeling powerless, having the fear of rejection, feeling inadequate, and not living one's dreams for fear of failure.

2.1.9 Trauma and stress-related disorders

Kapfhammer (2014) reviews the adjustments made by the diagnostic statistical manual of mental disorders (DSM-5, 2013) to include a separate group called trauma and stress-related disorders which exclude them as any form of anxiety disorders. These trauma and stress-related disorders are a set of emotional and behavioural problems which can occur from childhood traumatic and stressful experiences.

According to DSM-5 (2013), this group includes:

- Posttraumatic stress disorder (PTSD): can be characterized by symptoms such as persistent anxious thoughts, flashbacks, insomnia, hypervigilance, nightmares,

panic attacks, anxiety attacks, stomach pains, depression, headaches, and avoidance of external reminders or triggers.

- Acute stress disorder (ASD): individuals with ASD have symptoms similar to PTSD. ASD can however occur within the first month of negative life experience. Early intervention can interrupt its risk of becoming a full-blown PTSD diagnosis.
- Adjustment disorder (AD): can be described as an inappropriate or negative reaction to a change occurring within three months of the detectable stressor; for instance, a sudden requirement to move house or a divorce suit can trigger such reactions. Symptoms among others may include: intense sadness, crying, and feelings of hopelessness. Adjustment disorder can occur by presenting with symptoms such as: intense worry, nervousness, and fear of parting from an attachment figure. In addition, adjustment disorder can include poor conduct like; violation of others' rights, aggression, and violation of societal norms/rules and regulations. Unspecified adjustment disorder as a subtype could manifest as social withdrawal.
- Reactive attachment disorder (RAD): this describes the disorder inherent in an individual who is emotionally withdrawn, and may show little or no emotional responses in situations where such is expected. For instance, a lack of penitence, guilt, or regret after being reprimanded for a negative behaviour can explain this impairment. Children who have suffered from neglect are likely to develop RAD.
- Disinhibited social engagement disorder (DSED): individuals with this disorder are strangely open to interactions with people who they are not familiar with. Furthermore, they can be overenthusiastic about forming connections with strangers.
- Dissociative identity disorder (DID): categorized by two or more personality states.
- Dissociative amnesia: characterized by the inability to recall important personal details and information that should not ordinarily be forgotten.
- Depersonalization/derealization disorder: describes a detachment (dissociation) from reality, typically consisting of the feeling of being an outside observer (depersonalization) in a strange environment (derealization).

- Persistent complex bereavement disorder (PCBD): includes preoccupation with the deceased and the circumstances of death by manifesting significant reactive distress in ways out of proportion to socio-cultural norms and marked difficulty in accepting the loss.
- Social/identity disruption: a person who experiences a clinically high degree of intense sorrow and pain to the point that he/she displays a desire to die to be with the deceased could be diagnosed with social or identity disruption. Consistent feelings of emptiness and detachment from others since the loss could present as a symptom.
- Unclassified and unspecified trauma disorders: these are traumatic responses that do not fit into any of the aforementioned diagnostic categories.

2.1.10 Personality types

Ancient Greek thinkers like Hippocrates attribute four temperaments to man's personality; these are sanguine (the free and positive), choleric (the proud and fiery), melancholic (the concerned and thoughtful), and phlegmatic (the reasonable and tenacious) with people exhibiting at least one of the four (Fazeli, 2012). Hippocrates further theorises that these temperaments are associated with four body fluids which are referred to as humours whereby the sanguine is related to red blood from the heart, the choleric is linked with yellow bile from the liver, the melancholic is associated with black bile from the kidney and the phlegmatic is connected with white phlegm from the lungs (Lecci and Magnavita, 2013). These attributes may seem primordial but can serve as a fundamental framework on which several investigations on personality can be founded; which is that people have traits and enduring patterns of thinking, feeling, and behaving which can be connected to genetic influences (Eysenck and Eysenck, 1985).

According to Funder (2001), personality in psychology addresses the three dimensions of an individual's thoughts, emotions, and behaviour within one's environment. McLeod (2017) also states that a person's personality includes moods, attitudes, interests, and opinions expressed in his/her social interactions. It is the comprehensive form of man's affect, while cognition also involves desires which lead to behaviour, both inherent and acquired (Revelle, 2013), demonstrating how he conducts himself in society. In this sense, personality describes overt or covert cognitive processes,

emotional structures, and behavioural patterns combined with other psychological mechanisms to form the characteristics of an individual (Funder, 2001) and their behaviour (American Psychological Association, [APA] 2017). It is imperative to note that behaviour involves a relationship between an individual's core character traits along with situational variables indicating significant roles that biological and environmental impacts (nature and nurture) can play in moulding human personality (Weiss, Bates, and Luciano, 2008).

Psychologists have, for a large part of centuries been intrigued about man's personality. To this end, numerous attempts amid controversies have been made by scholars such as Freud, Jung, Maslow, Eysenck, Goldberg, and Cartell to explain that though people are unique they are flanked by various psychological forces (Friedman and Schustack, 2016) which are demonstrated in their behaviour. Some like Eysenck (1967) believe that personality originates primarily from physiology and genetics, while others like Maslow (1943) consider a humanistic viewpoint. These various schools of thought have driven psychologists into chiselling four broad categories of theoretical perspectives to comprehend personality, namely; psychoanalytic, trait, humanistic, and social cognition.

The psychoanalytic perspective of personality was developed by Freud (1923) who believed that personality comprises three elements of the mind; firstly, the id which is the demanding, impulsive, aggressive, and irrational unit (Thornton and Argoff, 2009). It is a selfish infantile component that seeks immediate gratification, motivating the individual to pursue pleasure (Lapsley and Stey, 2012). The ego is the second component. It represents a sense of self-regulation of the libidinal drives in the id to suit the requirements of reality (Lapsley and Stey, 2012). The third part is the superego which represents one's idealized self-image. It is the conscience or moral compass that helps an individual to maintain his/her sense of morality as a strong motivator of behaviour to the extent that it can sometimes produce feelings of guilt as it is a harsh judge (Schetz and Szubka, 2012). Undeterred by its rich contribution to knowledge in the field of psychology, Freud's structural theory of personality has undergone several disapprovals such as lacking scientific bases, being demographically represented by restricted cohorts

as the empirical samples are highly individualized, no standard line of treatment plan and ambiguous methods of data collection (Beystehner, 2001).

Another theory is the trait. A trait can be described as moderately established characteristics that combine to make an individual behave in ways that are peculiar to him/her (Fajikowska and Kreitler, 2018). Unlike the psychoanalytic or humanistic approaches, trait theory focuses on variances that exist between one individual and another. In 1936, Gordon discovered that the English language contains more than 4,000 terms such as outgoing, kind, gentle, aggressive, friendly, mean, and orderly to describe an individual's personality. Therefore, the traits were categorised into three stages called cardinal, central, and secondary traits (Fleeson and Jayawickreme, 2015). Shultz and Shultz (2017) explain cardinal traits as characteristics that are identical to an individual's descriptive terms such as 'Christ-like' to symbolize peace while 'Einstein' might represent intelligence. They also note that central traits are major qualities that can be used to describe a person's character using terms such as 'jovial, anxious', and 'funny', while secondary traits are attitudes like 'intolerance' or 'patience' which one can exhibit under certain circumstances. Many researchers have endeavoured to improve the trait theory. Studies like Fiske (1949), Norman (1963), Goldberg (1993) also Costa and McCrae (1992) expanded knowledge on the theory, thereby resulting in the development of the 'big' five classifications (Power and Pluess, 2015).

The big five personality traits, also known as the ocean model, are factors in which several related qualities and characteristics fit into representing a range between two extremes (Goldberg, 1993). These five categories are described as follows: openness, conscientiousness, extroversion, agreeableness, and neuroticism (Cherry, 2019).

The openness trait, on the one hand, can be described as profound and complex; therefore, individuals who are high in this attribute have characteristics such as: openness to new experiences, creativity, imagination, and insight, with a preference for variety, ability to demonstrate high intellect, engage in hobbies and like to meet new people (Lebowitz, 2016). On the other hand, the extreme range will include a dislike for change, resisting new experiences, having little or no imagination, and a lack of creativity. Conscientiousness is a characteristic that describes a tendency to control impulses using behaviours that display socially accepted qualities such as persistence, resourcefulness,

orderliness, consistency, organization, reliability, planning, and thoroughness. Those low in quality are impulsive, unreliable, erratic, and rash. Though extroversion and introversion traits are central domains in some spheres of personality, they are often viewed on the continuum, implying that being high in one element could mean being low in the other. These two qualities were derived from Jung (1921) who believes that every human being has either an extroversion or introversion dominant side. Extroversion is linked with being sociable thus manifesting talkativeness, having a knack for adventures, friendliness, cheerfulness, and appreciation of the outdoors, while introversion is more inclined towards being reserved, quiet, thoughtful, reflective, introspective, and contemplative. Agreeableness demonstrates high-level traits like friendliness, consideration, sympathy, support, tactfulness, and kindness (Thompson, 2008) while also demonstrating altruism, modesty, empathy, and cooperation. The lower-level traits can include characteristics like manipulation, selfishness, hard-heartedness, callousness, showing a lack of empathy, being immodest, and having an unhealthy competitive spirit (Kaufman, Yaden, Hyde, and Tsukayama, 2019). Power and Pluess (2015) affirm that neuroticism is characterized by unhappiness, irritability, anxiety, moodiness, sadness, and emotional instability. They also add that those high in neurotic traits experience a lot of stress, with dramatic mood swings, getting easily upset, feeling fretful, anxious, and worrying about several issues, while persons low in neuroticism can be emotionally stable, usually relaxed, barely sad, and hardly anxious.

The humanistic approach emphasises humanism, highlighting the importance of human values and dignity. The perspective was driven through the work of Maslow and Rogers who focused on experiences such as creativity, self-efficacy, free will, and the innate drive toward self-actualisation (Clay, 2002). The humanistic theory of personality considers that individuals achieve their full potential by moving from basic needs to self-actualisation which Ismail and Tekke (2015) summarise as: human responsibility or self-control, self-worth and the importance of personal growth. Again, Maslow (1943) is recognized for the work on hierarchy of needs. This theory presented in pyramid form explains that man has common needs which can be met in a particular order ranging from survival to self-actualisation. It is important that each level must be achieved before moving to the next for instance, physiological needs ought to be met before safety

requirements can be attained. Furthermore, this is, according to Maslow (1943) followed by the yearnings for love, together with a sense of belonging which has to be met so that esteem and self-actualisation desires can be realized. Maslow examined the term 'self-actualisers' observing that it represents successful achievers on earth and those who have attained a high level of psychological health and functioning. Maslow's ideas have however been criticized for lack of empirical evidence and having inclinations toward cultural biases, hence their inability to be universally applied (McLeod, 2015).

Rogers' humanistic personality theory (1946) stresses that importance of the self-actualising tendency is that it can shape self-concept through growth and improvement. This shows that man is creative; therefore, all his behaviour is motivated by self-actualising tendencies (Rogers, 1946). Based on his interaction with his environment, an individual then forms a pattern of perception and value known as self-concept. A positive self-concept enables an individual to accept who he/she is and views the world as a safe place, while a person with a negative self-concept is not happy about who he/she is. Furthermore, Rogers (1946) divides self into two components, namely; the ideal self and the real self. The ideal represents who the individual intends to be while the real self, reveals who he/she is. Rogers considers the need to achieve consistency between the two selves explaining that they can be achieved through regularly being the two selves. High congruence can generate a greater sense of self-worth and a productive life. Conversely, when there is a great discrepancy between the ideal and real self, which is called incongruence, then maladjustment can be experienced. In light of this, Rogers clarifies that people brought up in an environment with no unconditional positive regard, where love and worth are not present, can experience an intrapersonal discord. Rogers' principle like Maslow's theory was also criticised for its lack of empirical evidence and depth (McLeod, 2015).

The social cognitive theory of personality is another theoretical explanation of the uniqueness of human character and its causal processes. It was founded on the premise that people are agents of human development, adaptation, and change (Bandura, 1977). Originally known as the social learning theory (SLT), the social cognitive theory of personality came into existence through further research. Through this study, Bandura tried to understand complex psychosocial learning processes, especially emphasizing that

social influences can demonstrate how people learn from others (Williams and Cervone, 1998). Bandura (1986) stresses that it is based on two key structures. The first is that, human functioning is a product of the interaction of forces comprising man, his environment, and the influence of both forces on his behaviour. The second key is that through cognitive abilities, people can act as their agents of development. He, therefore, recapitulates that observation, along with modelling can play a key role in shaping personality as a result of the interaction and influence of these three factors; person (personal factors like attitudes and skills), environment (external social stimulus), and behaviour (conditioned by consequences and rewards). Whilst behaviourists explain that learning can occur as a result of conditioning, reinforcement, and punishment, Bandura (1977) argues that learning can take place merely by observing the actions of others debunking the claim which accepts that only external reinforcement can significantly influence behaviour (Overskeid, 2018; Fryling, Johnston, and Hayes, 2011). In light of these arguments, Bandura (1977) stresses that internal reinforcements derived from a sense of accomplishment (self-efficacy) can also serve as a significant motivation (Cook and Artino, 2016) for behaviour. This highlights the importance of an individual's cognitive process in a learning situation since it involves subjective responses like attention, retention, practice, and motivation (Fryling, Johnston, and Hayes, 2011). Bandura's theory is criticised for focusing basically on the process of learning while neglecting other important factors like biological processes and emotional concerns (LaMorte, 2019) which are equally vital in determining personalities.

Allport (1937) points out that there are two keys to studying personality, namely: nomothetic and idiographic. This clarifies that researchers who adopt the nomothetic approach focus on universal laws which they use in classifying numerous individuals, and assessing them, thus establishing principles based on their behaviour. This technique is scientific involving experiments, quantitative data, and statistical analysis referred to as traits (McLeod, 2019). Again, Allport explains that while the nomothetic approach classifies people in groups, the idiographic examines them in particular individualistic ways. The method of research of the idiographic approach includes qualitative data, unstructured interviews, case studies and autobiographies subsequently referred to as types (McLeod, 2019). These two approaches (traits and types) are systematically

designed to characterize individuals. However, they are achieved through different means because while the trait theory claims that there is a continuum leading from introversion to extroversion, the type approach views people from two perspectives as extroverts or introverts. Jung (1921) affirms that these are basic personality classes, which people nevertheless, can display to some degree. Again, according to Jung (1921) introversion, on the one hand, is characterized by qualities like thoughtfulness, a preference for privacy, and a reserved nature reinforced by spending time alone, while on the other hand, extroversion is observed as demonstrating such attributes as: sociability, assertiveness, excitement, novelty seeking and displaying an eagerness to be the centre of attention. It is remarkable to observe that, the differences between introverts and extroverts can be detected in different settings, contexts, and processes like social milieus, interactive processes, decision-making methods, and biological spheres.

The interest of the introvert is usually introspective, while the extrovert will respond to external influences. This means that the extrovert and introvert are a set of multifaceted and broad personality constructs which reveal that these personality types display varying tendencies and responses, such that they are at differing ends of a spectrum. In social settings, for example, introverts direct their energy inwards while extroverts exhibit theirs outwardly. The implication is that extroverts could enjoy more social interactions while introverts would seem reserved. In other words, while extroverts are socially dependent, thriving on the energy around them, introverts become socially withdrawn, thriving on their inner energy but avoiding the stimulation which can be derived from social crowds. In communication processes, the extrovert maintains a strong social visibility (Jung, 1921), while the introvert may be seen as shy or timid. The extrovert tends to be conversational, often maintaining eye contact in comparison to the introvert; so, this makes the former inadvertently exude more confidence which Wilmot, Wanberg, Kammeyer-Mueller, and Ones (2019) call the *extroversion advantage*. This is because extroverts possess an innate ability to display friendliness and amiability, whereas the introvert would struggle with starting conversations.

Lei, Yang, and Wu (2015) are consistent with Eysenck's (1967) findings that personality types could be investigated from a neurobiological perspective. Their results indicate that extroverts have a lower baseline cortical arousal (amount of brain activity)

than introverts. This implies that extroverts are minimally aroused, hence the constant search for external stimuli to increase their cortical levels, while introverts demonstrate a high arousal level, giving them the ability to process more information. Similarly, in 1997, an investigation was carried out by Fischer, Wik, and Fredrickson using a positron emission tomography (PET) scan on the brains of both introverted and extroverted individuals. It was discovered that introverts had more flow of blood in their frontal lobes along with the anterior thalamus, whereas in the extroverts, the flow was detected in the temporal lobes and posterior thalamus, thus reaffirming the postulations of Jung (1921). Jung also reiterated that introverts incline toward their inner environment, which is called the *inner libido*, while extroverts gravitate towards the *outer libido* (Jung, 1921). Again, the brains of extroverts pay more attention to faces than those of introverts. This means that extroverts are more likely to have better social relations than introverted individuals. Furthermore, though extroverts seem quite outgoing and gregarious, their high sensation-seeking patterns could make them more susceptible to risky sexual tendencies than introverts. In addition to this, even adolescent extroverts have been linked with other hazardous behaviours such as substance abuse, reckless driving, gambling, and wild partying (Saxena and Puri, 2013). Moreover, Wei (2020) submits that though introverts may possess low sensation-seeking inclinations, their reflective nature could place them at the risk of evoking feelings of pessimism, deprivation, low self-esteem, and anxiety especially caused by loneliness.

After the translation of Jung's book in 1921 into the English language, Myers (1962) designed the Myers-Briggs Type Indicator founded on the author's conceptual theories of personality. According to them, the extroversion and introversion personality types are categories assigned to individuals which can be broken into several cognitive functions so that each domain produces a four-letter acronym amplifying their mental processes (Lilienfeld, Lynn, and Lohr, 2014). Therefore, extroversion (E) introversion (I) focus on the personality type; sensing (S) iNtuition (N) describe the way the individual assimilates information; thinking (T) feeling(F) indicate how the individual makes decisions and judging (J) perceiving (P) show how the individual deals and interacts with the world (Myers and Myers, 1995). Cherry (2021) further clarifies this by explaining that each dichotomy is classified into four-letter codes with unique themes: ISTJ-the

inspector; ISTP-the crafter; ISFJ-the protector; ISFP-the artist; INFJ-the advocate; INFP-the mediator; INTP-the thinker; INTJ-the mastermind; ESTP-the persuader; ESTJ-the director; ESFP-the performer; ESFJ-the caregiver; ENFP-the champion; ENFJ-the giver; ENTP-the debater and ENTJ-the commander. Murie (2010) also highlights that the Myers-Briggs Foundation designed the following components consisting of strengths, weaknesses, and marital relationship qualities of individuals with the aforementioned 16 cognitive frameworks: The ISTJ (introvert, sensing, thinking, and judging) is known as the inspector. Individuals with these mental characteristics are planners and have orderly, well-organized lifestyles. Their strengths include being logical, responsible, persistent, and practical while their weaknesses reveal that they can be insensitive, fault-finding, and judgmental. In their marital relationships, the ISTJ individual emphasizes commitment. They are supportive, preferring to spend time with family, but their inability to freely express themselves can make significant others see them as insensitive.

This is followed by the ISTP (introvert, sensing, thinking, and perceiving) called the crafter. These individuals are curious, independent, reserved, and result-oriented. Their strengths are found in their ability to be reflective, easygoing, proactive, and proficient. Their weaknesses include risk taking, indicating that they may indulge in reckless decisions and actions. They easily get bored and may seek extremely exciting activities which produce unhealthy outcomes. They are difficult to understand because they do not easily share their feelings with others (similar to the ISTJ). They have a strong desire to be independent and like unconventional settings (dislike societal norms). As nonconforming as they seem, their relationships thrive on respect. They find it difficult to adhere to strict regimens because they are highly independent, so they may have challenges with overprotective spouses. They cherish their privacy and hate to feel controlled. This can pose an obstacle for ambitious female ISTPs in patriarchal societies where marriages are male-dominated. The ISTPs usually have a strong need to be alone sometimes which can be misinterpreted by a spouse as being withdrawn or arrogant. Another category is the ISFJ (introvert, sensing, feeling, and judging) known as the protector. Those with these characteristics are usually eager to offer emotional warmth and support. It is the opposite of ENTP (extroverted, intuitive, feeling and perceiving). Their strengths include the dislike of bothering others with their life challenges because a

strong aspect of being an ISFJ entails listening and supporting others. They are kind, hardworking, and hardly seek rewards for their contributions to the well-being of others. Their love for tradition keeps them protective of values and customs. They are reliable, sensitive, detailed, and thorough. Their weaknesses are similar to other introverts like the ISTJ and the ISTP who tend to struggle with expressing their feelings. They are rigid about their beliefs and tend to dislike change. They are not quarrelsome because they like to avoid confrontations. They sacrifice their own needs as a way of making others happy while they neglect their interests. In marital relationships, the ISFJs define marriage as a listening relationship. They are faithful and committed to their spouses. ISFJs can be compassionate towards significant others, even when they abuse or take advantage of them. The ISFJ's quiet, introverted nature can make their spouses feel ignored and disregarded.

The ISFP (introvert, sensing, feeling, and perceiving) is referred to as the artist; persons who possess these functions challenge traditional norms and expectations. They are impulsive and spontaneous, yet peaceful. Their strengths include being dedicated to standards and committed to principles. They live in the moment by collecting new information and using them to their advantage. Their sense of creativity helps them to be able to recall and evoke the past through powerful images, sights, and sounds. They have a love for nature which makes them enjoy the outdoors. Their weaknesses, however, are that they often fail to recognize their strengths, skills, and talents. Again, ISFPs can feel a sense of shame when they cannot achieve their goals. In the area of marital relationships, individuals with ISFP traits can be seen as rash and careless by their spouses because of their spontaneity. Their focus in marriage is appreciation. Furthermore, the spouses of ISFPs must ensure that healthy boundaries are created because ISFPs' sensitive nature can make them avoid conflicts sometimes at the expense of telling the truth. Like other introverts, they struggle with expressing their needs and feelings. Another feature is that of the INFJs (introvert, intuition, feeling, and judging). They are known as the advocate. Although individuals with these qualities are creative, gentle, caring, and empathetic, they are reserved with a strong sense of focus and have high moral standards. This is the opposite of the features of persons with ESTP characteristics. Some strengths of the INFJs are that they are sensitive to the needs of others and like to plan early in to make

decisions without stalling. They value deep relationships and may not have a large circle of friends who tend to be valuable to them. They are good at expressing themselves, nevertheless, they cherish their privacy and seek out meaning in all areas of their lives. They are skilled at understanding other people's feelings. Conversely, their weaknesses are that they make decisions based on their insights. This can make them seem narrow-minded as others' views are shunned. People with INFJ traits can be described as deep and complex. They are high achievers, perfectionists and frequently need to retreat and recharge. They have high behavioural expectations which can make people pretentious around them. In their marital relationships, the INFJs crave and thrive on support along with emotional intimacy from their spouses. They are passionate and emotionally intense people. They are at optimal performance when they marry significant others with similar values like sincerity, honesty, integrity, and authenticity. The crucial area in marital relationships for INFJs is sensitivity, this is because INFJs feel misunderstood, hence they have inner-struggles and grapple with a great deal of loneliness. The INFJs place a high premium on availability, understanding, and togetherness. Their empathetic and sensitive qualities make them admirable communicators. They can sometimes be observed as being stubborn as well as unyielding, which others may perceive as irascible and exhausting.

Another category is the INFP (introversion, intuition, feeling, and perceiving) also called the mediator. Their ability to negotiate qualifies them as mediators because they treasure peace, security, and harmony. Like most introverts, they also value their privacy as social situations can drain their energy. They are reserved like the INFJs. They focus on the future, thus enabling them to see the 'bigger picture.' This means that they give interpretations of a given situation based on their overall understanding, hence they omit details. Details seem to cause distractions for them. Their strengths are that they are loyal and devoted. They stand by their beliefs and principles, so often times, they like to work alone. They are good mediators because they help those in conflict to resolve their arguments. Their weaknesses are that their desire to be alone can be misunderstood as shyness. They make decisions based on values than logic. They can be overly uncompromising. During quarrels, INFPs can become irrational because they only focus on their emotions. They prefer to express their feelings through writing. As regards their

marital relationships, INFP individuals approach matrimony with a strong sense of dedication and support. Furthermore, because they are idealists, they have high expectations which cause their spouses to struggle to live up to their high standards. They crave deep intimate romantic moments in marriage but at the same time, they hold back their emotions. This can be conflicting. They are overly sensitive to real or imagined criticism even though they try to create harmony in their home and the environment.

The INTJ (introversion, intuition, thinking, and judgment) is identified as the architect. This is because they are highly analytical, logical, and artistic. They like to plan ahead of time, therefore, they work with schedules. Their strengths set them apart as those who take criticism well. They are thoughtful and attentive. They are self-confident and hardworking. They like thinking about the future and exploring possibilities. They make decisions based on logic. They also work better alone, as INTJs are capable of being self-directed. They tend to have the ability to interpret complex information and implement the data they gather. They do not run away from conflicts but face their challenges squarely. As commendable as their strengths may seem, the INTJs also have weaknesses, some of which are that they may seem unfriendly and aloof, so forming new friendships can be highly challenging for them. The practical side of the INTJ individual can make him/her not affectionate, thus making others feel they are unresponsive and uncaring. In marital relationships, however, the INTJs are devoted with a strong sense of commitment, making their marriages successful. They take commitment seriously, choosing partners who can fit into their value system, traits, and qualities. Their strength in relationships can also be observed in how they handle confrontations in healthy ways.

The INTP (introverted, intuitive, thinking, and perceiving) is known as the thinker because individuals in this cluster are thoughtful, quiet, and reserved. They value logic and intellect above feelings. The hallmark of the INTP's strength is objectivity. They are also loyal, analytical, yet affectionate. They are highly imaginative and abstract thinkers which enables them to process information in unconventional ways. They are not easily offended when criticized because they enjoy working with people who understand the importance of feedback. Their weaknesses include: INTPs may seem insensitive and detached because of their highly analytical and logical side. They tend to doubt themselves often. They are loners who enjoy flexible schedules, so, following other

people's rules might be difficult for them. They can make decisions without considering the emotional consequences that their choices might have on others. In marriage, INTPs thrive when their spouses are not easily offended, especially during their interactive processes. This is because they are open, direct, uncompromising, and honest which can appear rude to those who do not understand them. Their spouses also need to understand that from time to time, the INTPs will desire independence in their marriage. They keep their thoughts to themselves because of the fear of being seen as vulnerable. They feel uncomfortable in tense and emotional situations because they are not too good at understanding the feelings of others. Their strongest virtue in marriage is sincerity.

An ESTP (extroversion, sensing, thinking, and perceiving) is viewed as the persuader because of its motivating, eloquent, and energetic nature. Individuals with these characteristics can be described as dramatic, never boring, playful, gregarious, outgoing, and sociable. They do not appreciate planning because they are good at improvising, which reveals the creative and innovative part of them. Their strengths include: good social skills, the ability to be observant, action-oriented, and resourceful. ESTPs can observe details that others overlook. They can also be bold, adventurous, self-assured, and fluent. These qualities have empowered them to know what to say to sway the opinion of others in their favour. Similarly, they are skilful at understanding and interpreting others' nonverbal language. A few of their weaknesses are that they are often impulsive, reckless, competitive, dramatic, and easily bored, therefore making commitments difficult for them. Like some other features, they dislike routine, making them always seeking for action and fun. They live in the 'here and now' of the moment, which may not help them have long-term goals, thus making them seem impulsive, irresponsible, and lacking a futuristic approach to life. Their marital relationships can be dramatic, as ESTPs are naturally flirtatious. They are engaging, exciting to be with, and spontaneous. These qualities can be misconstrued as inappropriate if their spouses fail to understand them. This might result in a lack of trust and complaints of infidelity. It would therefore be helpful if their spouses have similar traits, passions, and interests. Their strong points in marriage are spontaneity and fun, as they desire not just significant others, but playmates.

An ESTJ (extroversion, sensing, thinking, and judging) is referred to as the director. Individuals with these characteristics place a high premium on tradition, norms, and customs. They are known for impartial decisions because the ESTJ will carefully consider facts, logic, and realities to make objective and rational decisions. The strengths of persons who are ESTJ include; reliability, responsibility, logicality, and assertiveness. In addition to these, they are committed to obeying rules, and dedicated to standards and visions. They are principled with a strong sense of justice. They are security conscious, self-confident, hardworking with strong leadership skills. They are outgoing bringing joy to social situations and events they attend. Their weaknesses include: being opinionated, narrow-minded, inflexible, aggressive, and impatient. They can also seem argumentative and domineering. They crave security because of their love for structure. In marital relationships, ESTJs blossom based on mutual trust, loyalty, and respect. Family is an important part of life to them. They are good at remembering social events like birthdays, anniversaries and holidays, therefore, can become good at planning exciting social and family events. They only commit to spouses who are faithful to them.

An ESFP (extroversion, sensing, feeling, and perceiving) is called the performer. They are adventurers who love to explore and desire to learn new things. They are free-spirited people who like to be the centre of attraction. The following are the strengths of the ESFPs: understanding other people's feelings so they can respond appropriately; the ability to motivate and mobilise others for global, international, national, or local courses. They are admired for their charm and charisma, so people perceive their company as being pleasurable. A few of the ESFP weaknesses are that they do not like structured or solitary places. They also dislike being criticised because it makes them feel belittled. In the marital sphere, ESFP individuals need spouses who are open-minded and open to new experiences. They are generous people who should avoid having spouses who are miserly or stingy as this could cause misunderstandings.

An individual with ESFJ characteristics (extroversion, sensing, feeling, and judging) is known as the caregiver. The ESFJ caregiving qualities can be described as outgoing, loyal, organized, generous, and compassionate. Their strengths demonstrate that they are encouragers who bring out the best in others. They enjoy helping others, especially the less-privileged which explains their generous nature. They are organised

and conscientious, which means that others can rely on them. Their weaknesses show that although they want to see others grow, they expect to be rewarded for their kindness. They also desire to impress others, consequently ESFJs can put up performances to that effect. They can be overbearing and controlling in a high-handed manner. They seek approval and validation from others. They are impulsive and befriend people at face value. The ESFJs are intolerant of change; this is because when situations are not certain, ESFJs can become insecure and anxious. In marriage, they are devoted and faithful to their spouses. They feel particularly loved when they are shown a lot of affection. Their asset is intimacy and commitment, nevertheless, insecurity can cause them to have overwhelming feelings of doubt leading to marital distress.

The ENFP (extrovert, intuition, feeling, and perceiving) is known as the champion. These ENFP individuals are delightful, creative, and stimulating to be around. They are gifted at generating ideas and resourceful suggestions. Their strengths include; sympathy, strong communication skills, caring, and being highly creative. One major area of weakness is that ENFPs can procrastinate. Furthermore, they can also be easily distracted, making it difficult for them to be organized. Individuals with ENFP need constant approval and support from others before accomplishing goals. They reason emotionally relying much on their feelings, sentiments, and moods. They also struggle to follow rules. In marriage, they crave for much emotional support. This means that the spouses of ENFPs need to be patient and understanding. Again, an ENFJ (extroversion, intuition, feeling, and judging) is referred to as the giver because those with these characteristics are strong extroverts who are ardent lovers of people. Their supportive and altruistic traits cause them to often derive personal satisfaction from encouraging others. Their strengths include having a wide circle of friends. In addition, they are organized, persuasive, affectionate, altruistic, and empathetic, implying that they are also good at resolving conflicts. The weaknesses of the ENFJs include: their approval-seeking attributes, overly sensitive feelings, manipulative flaws, overprotectiveness, rigidity, stubbornness, and inability to compromise. They like predictable schedules since they are rigid. They do not like asking for help and can get too absorbed in other people’s lives to the point that they feel overwhelmed. In their marital relationships, ENFJs can feel stressed by the display of intense emotions by their partners because they tend to

personalize others' problems. Spouses of ENFJs may find them caring, but their overly delicate feelings can bring some conflicts. Their desire to struggle on their own may make them seem secretive and arrogant. Moreover, since they become too involved in other people's problems, altercations can arise in their marital relationships. Their belief and trust in others can make their spouses view them as naïve, blind optimists.

The ENTP (extroversion, intuition, thinking, and perceiving) is appreciated as the debater. Persons who fit into the ENTP descriptions are curious, full of ideas, interested in innovations, creative, and like exploring new horizons. Their strengths include being outstanding conversationalists, who like engaging others in debates because they value knowledge. They relentlessly pursue their goals despite obstacles. They aim at understanding people and the world around them. However, one aspect of their weakness is that they have too many ideas void of plans on how to implement them. They may seem careless and laid back because they delay in making decisions. They can be argumentative to the extent that they may seem unfriendly and unfocused. They dislike following routines, and schedules or making plans because they do not like to feel controlled. In marital settings, the ENTP's negligent and unfocused traits can reduce marital quality; however, their skills at interacting lovingly can endear them to their spouses. Again, their argumentative abilities can make their partners feel that they are aggressive, hostile, and quarrelsome. They are non-conformists who seek to find expression in all that they do, consequently, this can make them struggle to keep schedules. Based on this, their spouses may assess them as irresponsible. In addition to this, the ENTPs' inability to keep promises can be less assuring for their spouses.

Another class of MBTI cognitive functions is the ENTJ (extroversion, intuition, thinking, and judging) known as the commander. This set of people is endowed with exceptional verbal skills. They like to have a sense of predictability and control which drives them to plan, however, they are not doubtful or afraid of change. The ENTJs are gifted with the ability to be assertive, confident, candid and outspoken. They can instruct and guide people, making others look up to their leadership skills. They are commendable at making decisions. Like some other extroverts, some ENTJ's weaknesses also abound. They can be impatient, demanding, self-willed, self-centred, aggressive, intolerant, and insensitive. They also jump to conclusions without checking for facts. The

ENTJs outspokenness can be insolent to others even without such intentions. The ENTJs marital relationship thrives on honesty. Their impatience which can often make them hasty may eventually lead to poor outcomes such as disrupting their harmonious marital experience. Again, people with ENTJ spouses may feel that they are cruel and insensitive because they hide their emotions so that people do not view them as weak. Regardless of their weaknesses, ENTJs are committed to making their relationships work. The breakdown of these analyses by the MBTI can be achieved in two ways: first, it can help to assign personality types whether extrovert or introvert; secondly, it can help to reveal an individual's dominant cognitive functioning by explaining their character traits within their marital domains.

2.1.11 Spousal support

According to Nguyen, Karney, and Bradbury (2017), individuals with a background history of childhood trauma are linked with relationship difficulties, however, it is not established whether the behaviour of their spouses can aggravate or buffer these challenges. On the contrary, Madigan, Racine, and Tough (2018) argue that compassion can serve as a protective element that can be used to promote resilience in families with people who have experienced difficult childhood. They reiterate that support from the spouse of a survivor can be a key tool for change and overall well-being. According to Harper (2017), support is derived from the Latin root word *supportare* meaning to carry up, to bring forward; inferring that, it is an act of receiving aid, help or assistance to enable an individual fulfill his/her function in life and remain relevant. Spousal support, therefore, is the provision of care, help and sustenance by one's spouse using marriage maintenance strategies such as emotional (understanding, togetherness, concern, attentiveness, responsiveness) and physical (display of affection, hand holding, engaging in recreational activities together, genuine involvement in areas of spouse's interest) activities which are necessary for strengthening marital relationships, decreasing conflicts, reducing distress, thereby keeping notions of dissolution away (Ebenuwa-Okoh and Osho, 2015). This further affirms that spousal support plays a strong role in enhancing romance in marital relationships.

Spousal support indicates the existence of certain types of sustenance that couples provide to maintain their marital relationships as it predicts better mental health

outcomes, especially for those who are survivors of childhood trauma though self-directed growth is a major factor in promoting a couple's satisfaction (Feeney, Veet, Jakubiak and Tomlinson, 2017). Based upon this, personal growth can help relationships thrive because each spouse takes the initiative to discover ways that can improve the union. According to Yildrim (2004), there are five components of spousal support; instrumental, emotional, informational, appraisal, and validity. Instrumental support in marriage refers to tangible positive assistance which spouses receive from each other in order to offer a helping hand, for example, childcare, house chores, provision of transportation, helping with errands, or financial aid (Seeman, 2008). Instrumental support has been documented as a source of integration for couples as it reduces stress, anxiety, improves their standard of living and mortality (Swartz, 2009) with outcomes such as, women more involved in the maintenance of marital relations (Sarkistan and Gerstel, 2004). Furthermore, it includes spending time together in physical care in times of sickness or offering financial aid.

Emotional support in marriage involves providing genuine encouragement, attention, empathy, trust, reassurance, love, and compassion. This could be in the form of physical gestures and/or verbal expressions of care and affection. They can also come from other sources, such as religious activities shared by the couple (Legg, 2020; Agu and Nwankwo, 2019; Buss, 2003) like praying together. Emotional needs are longings that bring profound joy when they are fulfilled, but then can cause frustration when unmet. Some of these needs include friendship, trust, affection, honesty, openness, commitment, and faithfulness (Harley, 2011). Females are more comfortable with giving and receiving emotional support than men. Some wives in the bid to receive attention can magnify their feelings or circumstances by exaggerating their need for support. If the man does not respond aptly, the woman might begin to nurse feelings of rejection and disregard, thereby affecting their adaptive process. This is because, to her, his lack of involvement would mean that he is not interested in her and the relationship. For this reason, Pascale and Primavera (2017) explain that men are more prone to providing instrumental support while their wives are more emotionally inclined. Similarly, they assert that emotional support can be important for both spouses in times of stress, intense sadness, and loneliness as a means to foster intimacy as well as a sense of belonging.

They also emphasise that achieving satisfaction in marriage through emotional support would require fidelity, loyalty, commitment, and seeing each other in a positive light (Pascale and Primavera, 2016).

It is important for spouses to provide informational support for each other. According to Ko, Wang and Xu (2013), this type of support can be life-changing. They indicate that some couples struggle with healthy communication styles, so sharing vital information can become a problem. Some common causes of unwholesome communication practices in marriages are poor listening skills, harsh voice tones, insecurities (competitive attitudes), unrealistic expectations, jealousy, secrecy, malice, unempathetic attitudes, selfishness, hostile facial expressions, and gestures. This can lead to the inability to have conversations about their ideas, make suggestions, and give healthy counsel to each other in the union. Consequently, this could result in financial constraints, verbal attacks, infidelity, neglect, bias, ineffectual plans, stagnancy, and misdirection; all of which could affect marital harmony. This type of support from spouses consists of kind suggestions, valuable advice, honest details, reliable facts and figures.

Appraisal support in marriage includes the provision of assessment that is useful for healthy self-evaluation. This type of spousal assistance is shown through expressions of encouragement, kindness, sincerity, security, and empathy (Scott, 2020): however; it can be negative, causing undesirable emotions. This indicates that in marriage, some spouses can seek and accept information that confirms who they perceive themselves to be so that they can maintain a consistent view of self (Sacco and Phares, 2001). Personal and spousal appraisals can either shape emotional well-being or form distressful feelings both playing a complex role in marital satisfaction (Carr, Cornman, and Freedman, 2016). Again, validity support in marriage is a powerful tool that can build stable unions. It is an act of conveying respect, attention, trust, and admiration from one spouse to another. It also refers to acknowledging the rationality behind what another person is saying without necessarily accepting the logic (Bidwell, 2013). Validity spousal support, on the one hand, would require that couples should listen reflectively and emphatically while on the other hand, invalidation may be demonstrated through minimizing, ridiculing, judging, or ignoring their spouses. This form of spousal support according to Bidwell (2013) can

reduce negativity in marriage such as anger, arguments, resentment, self-defence, and verbal attacks by establishing couples' emotional bond, healthy communication styles, and friendliness. Validation includes spouses showing confidence in one another, understanding each other's feelings, and respecting one another's opinions; making appraisal more acceptable. Supportive exchanges within marriages, therefore, occur as a result of shared opinions, dreams, memories, ideas, concerns, and challenges, consequently, affecting the way that spouses perceive each other.

2.1.12 Cognitive Processing Therapy (CPT)

This is an empirically supported intervention designed to help individuals recover from trauma-related conditions such as PTSD (Stickley, Sopchak, and McCord, 2023). It is a treatment, which is endowed with the elements of cognitive behavioural therapy (CBT). It also has certain unique goals, one of which is, exposing how distressing events, like assault and molestation can impact an individual's views of life, preventing recovery, thus requiring cognitive restructuring (Healy, Walter, and Chard, 2015). Cognitive behavioural therapy, as its name implies, is a combination of two result-oriented psychological themes namely the behavioural and cognitive constructs. Each construct lends its postulations to the structured components of CPT thus enriching it with strategies designed to decrease the identified symptoms, teach new coping skills, and open up new possibilities (Resick, Monson and Chard, 2017). Cognitive processing therapy is, therefore, a trauma-focused treatment connotating that it directly addresses disturbing memories, thoughts, feelings, and behaviours related to a given traumatic event using science-based psychological constructs to reinterpret 'stuck points', thereby producing recovery even after sessions are ended (Ragsdale, Watkins, Sherrill, Zwiebach and Rothbaum, 2020).

According to Tull (2019), CPT was developed by Resick, Monson, and Chard in 1988 based on the belief that symptoms from adverse experiences can stem from a conflict between pre-trauma and post-trauma beliefs about self, others, and the world. Pre-trauma and post-trauma beliefs could be like; a person who believes that nothing harmful can happen to him/her as 'the world is a peaceful place' where everyone is happy, consequently, following the aftermath of a traumatic incidence could have a change of mind, thinking that *the world is a violent place where no one is happy.*

Moreover, these conflicts or 'stuck points' occur because of the effects of trauma and may cause self-blame, denial, or guilt (Healy et al, 2015). Resick, Monson, and Chard (2017) also believe that these distorted beliefs about themselves, others, and the world often occur in the bid for survivors to make sense of the tragic event.

Cognitive processing therapy is a 'talking' therapy typically consisting of 8 to12 sessions with each lasting for 60 to 120 minutes in which clients are encouraged to label activating traumatic events, thoughts, and feelings while the therapist helps them consider the context and facts of the event through Socratic questioning techniques (Resick, Monson, Chard, 2010). According to Healy et al (2015), a Socratic dialogue is important in achieving a well-organized CPT delivery. Tracing its origins from the early Greek philosopher Socrates, they explain that it is based on the belief that individuals who discover knowledge for themselves, as opposed to those who are being told what to do, have more tendency to retain new information; as thoughtful questioning can draw out good reasoning. They, therefore, conclude that CPT uses Socratic questioning or dialogues to enable the client to assess the authenticity and accuracy of his/her trauma-driven thoughts. Resick, Monson, and Chard (2008) state that the six types of Socratic questions with some examples are:

- Clarifying concepts; what do you mean when you say…?
- Probing assumptions: how did you come to this conclusion that….?
- Probing reasons: are these reasons you have given good enough?
- Questioning viewpoints: is there an alternative way of looking at this?
- Probing implications: what would happen if you put aside that belief?
- Questioning the question: what would my response mean to you?

Cognitive processing therapy can be delivered through individual or group sessions with written or non-written trauma accounts (Healy et al, 2015). There is, however, another short trauma report called the 'impact statement.' This is a written narrative briefly describing what the traumatic experience means to the client and how it has affected the self, others, and the world (Sobel, Resick, and Rabalais, 2009). The therapy was initially developed as a group therapy for female victims of sexual assault (Resick, and Schnicke, 1992). Studies like Ragsdale, Watkins, Sherrill, Zwiebach and Rothbaum (2020); Resick, Monson, and Chard (2016); as well as Iverson, King,

Cunningham, and Resick (2015) show its efficacy in trauma survivors with clinical indications of PTSD from toxic childhood experiences with evidence of decrease in symptoms (Holmes, Johnson, Suvak, Sijercic, Monson, and Stirman, 2019). Cognitive processing therapy is grounded on two major theories namely: the social cognitive theory of posttraumatic stress disorder (Benight and Bandura, 2004) and the bio-informational theory of emotional imagery (Lang,1977).

The bio-informational theory of emotional imagery states that imagery storage and processing is coded in the memory generating certain types of feelings and behaviour. Therefore, any stimuli that is charged with feelings can activate a system of stored information, thereby eliciting certain types of behaviour. However, the social cognitive theory of posttraumatic stress disorder explains that absorbing distorted thought patterns from a traumatic experience into irrational beliefs about self as well as others can negatively impact a person's emotions and behaviour (Bares, 2015). Similarly, Zalta (2016) reaffirms that there is a change in the way that information is processed by an individual after a traumatic experience. People often attempt to integrate the information derived from the event by doing any of the following three; assimilate, accommodate, or over-accommodate (Zalta, 2016). When individuals assimilate, they absorb new pieces of information to corroborate them with their former beliefs resulting in maladaptive patterns like self-blame (Healy et al, 2015). An example of a client is displaying assimilation using self-blame is: *I have never been smart.* Again, such a client can move from assimilating to accommodating patterns either from an adaptive or maladaptive stance (Alade, 2015). The process of accommodating would therefore involve modifying previous views to absorb new learning experiences (Zalta, 2016). An example of an unhealthy way of accommodating an experience can be: *it would never have happened if I had prevented it; so, I take responsibility for my stupidity*. This is an unhealthy accommodation attitude that can result in self-hate, on the contrary, an example of a healthy accommodative process could be: *even if I had tried to prevent it from occurring, it could have happened anyway because I cannot be in control of every situation.* In addition to this, Zalta (2016) describes another process called over-accommodation. It is the process of totally changing one's initial views by overgeneralizing the experience. This may result in beliefs like *the world is a totally insecure place* or *no one is*

dependable. One major goal of CPT is to assist clients to achieve more balanced accommodating beliefs by reducing both maladaptive assimilated and over-accommodated patterns since they can lead to harmful opinions about self, others, and the world (Holliday, Holder, and Suris, 2018). The National Centre for PTSD (2016) identifies the four essential components of CPT as:

- Educating the client about trauma signs, and the goals of the treatment.
- Informing the client about his/her thoughts and feelings.
- Enabling the client to recognize his/her pre/post-trauma beliefs.
- Teaching the client how to develop skills to challenge his/her maladaptive thought patterns.

Again, Resick et al (2017) reiterate the following activities in their updated treatment manual as:

- Psychoeducation on trauma (defining trauma and highlighting the symptoms)
- Identification of assimilated and over-accommodated beliefs
- Acquisition of skills to challenge these cognitive beliefs through daily practice
- Client's conceptualisation of the traumatic events through writing the impact statement and/or trauma account by stating how the disturbing occurrence changed their beliefs about themselves, others, and the world. Clients are required to consider what they think about issues regarding: safety, trust, intimacy, power, and esteem. This is important because adults who have experienced childhood trauma have been linked to maladaptive beliefs damaging the domains of trust, safety, power/control, intimacy, and esteem (Tull, 2021).
- Cognitive distortions should be discovered and challenged by the therapist.

2.1.13 Stress Inoculation Therapy (SIT)

The Canadian psychologist, Meichenbaum developed Stress Inoculation therapy (SIT) in the early 1970s. Johnson (2009) describes it as a complex form of cognitive behaviour therapy (CBT) incorporating various strategies such as: psycho-education, goal setting, problem-solving, coping skills, guidelines, and relapse prevention, all of which can be modified to fit any population. Tull (2019) explains that it is a 'talk therapy' that can teach an individual some coping skills to manage anxiety from stress-related

conditions such as childhood trauma. In addition to this, Tull (2019) believes that a successful adaptation to these coping skills obtained from SIT can promote resilience to future stressors. It is a non-trauma-focused treatment as it does not directly target painful memories associated with traumatic experiences (Watkins, Sprang, and Rothbaum, 2018) as CPT does.

Escalante (2022) explains that the hospital vaccine scenario can be useful in explaining the concept of *inoculation* from which this therapy is adapted. The approach has a similar procedure to administering a vaccine against a disease to enhance the body's ability to respond quickly in defence once it is exposed to that same sickness. In the same vein, the skills developed from stress inoculation therapy can enhance one's reaction to trauma-related reminders, cues, or symptom triggers (Tull, 2019). According to Meichenbaum and Deffenbacher (1988), SIT has three sequential phases which are: initial conceptualization, skills training/acquisition, and application/follow through. They explain that the initial conceptualization involves assessment and education. Moreover, in this phase, they emphasize that a warm relationship (therapeutic alliance) should be developed between the client and therapist. This is to ensure that through a proper evaluation, the nature of the client's challenges can be identified and appraised. Next, the client is educated about the nature and effects of the problem, its stressful symptoms, and how effective SIT can be. Secondly, skills training and acquisition is the stage that targets the development of a repertoire of coping skills. Thirdly, rehearsal, application of skills, and follow-through is the phase that grants the client the opportunity to practice coping skills acquired in the course of the treatment.

Regarding the treatment format, Johnson (2009) outlines the elements included in the conceptualisation stage:

- Interview/assessment
- Psychoeducation: explaining the concept of the area of complaint
- Identify the client's stressors and already existing coping abilities
- Identify defaults in the client's coping mechanisms
- Reassure the client that his/her response to the stress caused by the experience is expected.

Busari (2014) summarises that the goal of the first phase is to enable the client to discern that there is a connection between his/her thoughts, feelings, and behaviour as what causes stress originates from what the individual thinks (catastrophic thoughts) and says (self-defeating statements) to him/herself in times of stress.

Johnson (2009) identifies the goals of the second phase as teaching cognitive, emotional, and behavioural skills which can help the individual to manage undesirable feelings through the following techniques:

- Cognitive restructuring using a Socratic style of questioning, positive self-talk, assertiveness, thought-diversion (physical distraction) and thought-stopping skills (mental distraction).
- Relaxation and visualisation exercises are also necessary for reducing tension and pressure.
- Problem and solution-focused coping strategies consist of identifying problems, matching them with desired goals, then reducing them to easy manageable and achievable steps.

Uzoechina (2016) expounds that the strategies could be described as emotion-focused since they are directed at reducing negative emotional reactions (fear, excessive argument, and impatience) or problem/solution-focused as they can help individuals to recognise, and classify their problems with relevant solutions. The clients are taught to identify whether their challenges need an emotion-focused strategy or a problem and solution-focused approach. Furthermore, Tull (2019) explains that in Stress inoculation therapy, the emotion-focused strategy includes deep breathing exercises, guided therapeutic imagery, and muscle relaxation techniques. Uzoechina (2016) also mentions that these emotion-focused skills should have the following three steps: firstly, recognizing body signals that indicate that one is about to experience a stressful situation; secondly, understanding that these body signals serve as cues for the individual to start relaxing; thirdly, the individual can relax by focusing his/her attention on different groups of muscles starting from the face, neck, arms and down to the legs. A necessary aspect of these exercises is to establish coping skills that can help the client gain control over impulse responses as a means to regulate or manage negative thoughts and feelings (Uzoechina, 2016).

The third phase of the stress inoculation therapy, according to Busari (2014) begins once the individual has developed new coping skills like positive self-statements, attention diversion procedures, and problem-solving skills. Dibdin (2022) recapitulates that it entails the following:

- Applying the adaptive skills
- Using emotion-focused and problem-solving skills when in stressful situations
- Relapse prevention
- Knowing when to apply the newly acquired skills
- Maintaining the new skills
- Involving the support system in the reinforcement and practice of new skills
- Reinforcing an optimistic, positive yet realistic attitude.

Predicated upon this, Busari (2014) reiterates that it focuses on role plays and rehearsals of simple repetitive practices of new coping routines, and new self-statements to boost new coping skills along with other habits to enhance the tolerance of any future stressful situation. Spears (2019) maintains that SIT can increase the client's self-confidence and can help him/her to develop coping skills based on the type and uniqueness of the situation. The therapy can run for 8-12 sessions, lasting between 20 to 90 minutes involving either an individual or group arrangement (American Addiction centre, 2021).

2.2 Theoretical Review

This study was reviewed using the Vulnerability Stress Adaptation (VSA) model of marriage by Karney and Bradbury (1995) and the theory of Personality Development by Freud (1923).

2.2.1 The Vulnerability Stress Adaptation Model of Marriage

To be vulnerable denotes an inability to endure the effects of an unfavourable situation within an environment (Bergman, 2019). The different types of vulnerabilities are emotive, cognitive and social. Social vulnerability is the incapacity of individuals to survive the disturbing impacts of the societal stressors that they are exposed to (Ballesteros, 2008). Emotional vulnerability determines that there are uncertain and risky conditions that can produce emotions such as shame, fear, disappointment, and grief

which Brown (2012) suggests can be converted to sources of love, courage, and resilience through therapeutic interventions. Cognitive vulnerability describes a pattern of invalid and irrational thoughts which can cause an individual to become predisposed to psychological challenges (Reskind and Black, 2005). The erroneous beliefs which are shaped by life-threatening experiences can produce maladaptive responses that can increase one's susceptibility to mental illness. In the study of mental health, it has been discovered that this type of vulnerability is established on the framework underpinning various models such as schema and attachment (Young, LaMontage, Dietrich, and Wells, 2012). Again, it is reported that the study of psychological pressure can improve the understanding of how psychopathological diseases develop in individuals (Cohen, Janicki-Deverts, Doyle, Miller, Frank, Rabin, and Turner, 2012), thus promoting management and intervention programmes. Furthermore, in examining concerns that can lead from stress to psychopathology, Oatley, Keltner and Jenkins (2006) submit that a singular or series of life events that may disrupt one's equilibrium could lead to the development of a disorder causing wreckage of both mind and body (Cohen et al, 2012). The vulnerability-stress psychological construct is therefore based on different approaches which attempt to explain that there exists an interaction between vulnerability and stress that can advance into psychopathological disorders including mood, and substance disorders (Ormel, Jeronimus, Kotov, Riese, Bos, Hankin, Rosmalen and Oldehinkel, 2013).

According to Selye (1950), a human being's response to stress can involve three stages. These stages which are referred to as the General Adaptation syndrome (GAS), comprise the following processes which are called: the alarm reaction, the resistance stage, and the exhaustion phase. The initial stage (the alarm reaction stage) refers to symptoms of the body with fight or flight responses. During the resistance stage, the body struggles with the hormonal (high cortisol levels) and physiological responses (raised blood pressure) unleashed in the first stage. It seeks to restore its equilibrium. However, if the pressure persists, the body does not return to equilibrium but remains in stress response mode; when an individual whose body's responses do not return to normal continues to encounter stress over time, he/she will feel drained, depleted, and worn-out. This is called the exhaustion stage. A person at the exhaustion stage will probably

complain of lethargy (loss of drive), fatigue, anxiety, depression, as well as other psychological and physical health conditions. In addition to this, Grandcolas (2015) views adaptation as a primitive characteristic which most organisms have and use to survive through their behavioural, psychological, and structural systems.

The Vulnerability Stress Adaptation (VSA) model of marriage was developed by Karney and Bradbury in 1995 (Karney, 2010). According to Karney and Bradbury (1995), the VSA model is a framework for comprehending the active and complex processes of marriage. They posit that the model is divided into three basic elements namely: enduring vulnerabilities, stressful conditions, and adaptive processes. Karney (2010) affirms that these parts are either positively or negatively influenced by spouses' susceptibilities and life stressors. In considering enduring vulnerabilities, Karney and Bradbury (1995) describe them as stable traits which spouses bring into marriage, such as irrational beliefs, problematic behavioural qualities, and emotional challenges arising from childhood trauma (Karney, 2010). The adaptive process as Magno (2011) claims, displays the way spouses respond to each other. Karney (2010) reaffirms that this process can directly affect how marital satisfaction can change over time. Some examples demonstrating how spouses respond to each other are: healthy/unhealthy problem-solving attitudes, forgiveness, perceived spousal support and aggression ((Sakmar, 2015). Stressful events, however, are chronic or acute situations that can produce distress to spouses (Bradbury, 1995). In addition, Karney (2010) identifies that long or short-term stressful circumstances that spouses encounter, whether in the workplace, home, or neighbourhood can account for discrepancies in marital satisfaction. As a result of this, Eysenck (2000) concludes that distressed people can be associated with stressful marital relationships.

Van Der Troost (2005) explains that Karney and Bradbury (1995) developed longitudinal studies reviewing 115 marriages. They aimed at gaining some insights into spouses' marital satisfaction and to also observe how marriages achieve different outcomes over time. This led to their conclusion that an unhappy childhood and maladaptive behaviours could lead to negative marital outcomes; however, positively inclined variables like adaptive behaviours would yield promising results in terms of satisfaction and stability (Eysenck, 2000). Furthermore, Van Der Troost (2005) reveals

that the VSA model hinges on four schools of thought, but, those applicable to this study are social exchange, crisis, and attachment theories. Moreover, the findings of Karney and Bradbury (1995) and Karney (2010) reiterate that couples with significant levels of enduring vulnerabilities, who pass through stressful circumstances will encounter a hard time maintaining their marriages.

2.2.2 The foundational perspectives of the vulnerability stress adaptation model of marriage

2.2.2.1 Social exchange theory

This theory was birthed from the studies of Thibaut and Kelley (1959) who maintain that marriages grow, develop, depreciate, and dissolve as a result of an unfolding process of exchange, thus emphasizing the dependency of couples on their relationships and the desire for their needs to be fulfilled (Fine and Harvey 2013). This further reveals that a cost and reward exchange can exist between spouses (Mcray, 2015) generating economic, social, and psychological behavioural outcomes. Levinger (1976) as cited by Eysenck (2000) expounds on this idea submitting that the way marriage is perceived by a spouse (that is, subjective probability) as satisfactory depends on the following three factors:

- The attractions that exist in the relationship, like sexual satisfaction and emotional support.
- The barriers posing as obstacles to abandoning the marriage, such as social, religious, and financial pressures.
- Attractive alternatives, such as the presence of a more desirable partner.

Drawing from these factors, Levinger (1976) once more cited by Eysenck (2000) highlights that marital satisfaction does not necessarily predict subsequent marital dissolution because couples who are dissatisfied may have strong barriers holding them back from leaving the relationship, even with attractive alternatives to serve as motivations.

There have been studies like Story, Karney, Lawrence, and Bradbury (2004) buttressing that persons from families characterised by conflict, dissatisfaction, and dissolution can show more contempt in their marriages than those without such experiences. In the same vein, Neff and Karney (2004) accentuate that people's cognitive

instabilities affected by the pressures of life may cause a decline in relationship satisfaction. This is because the stressors can influence some persons' thoughts and feelings to the extent that they could believe their partners are solely responsible for the problems existing in their marriages. Also, Gottman and Levenson (2002); Tan, Tan, Hashim, Lee, Ong, and Yaacob (2019) state from their findings that couples' problem-solving attitudes and skills, which are demonstrated during misunderstandings, mediate between stressful life events and relationship functioning.

Based on the VSA model and social exchange theories, the following questions were developed:

- How relevant are spouses' support to each other?
- How are they able to cope with stressors in life?
- What are the benefits and costs they can perceive in their relationships?
- Do these perceptions support or hinder their relationships?
- How do they cope with these perceptions?
- What are the negative exchanges that show an ineffective adaptive process?
- Are there attractive alternatives affecting adaptation?

The responses to these questions will indicate if couples with effective adaptive systems despite their vulnerabilities and life stressors can experience a satisfying marriage while those with maladaptive processes are susceptible to stress, particularly since their enduring vulnerabilities add to the declining satisfaction (Karney and Bradbury, 1995). In their critique of the social exchange theory, Karney and Bradbury (1995) further reveal that the major reason this theory is popular is that many types of variables can be infused into its framework, especially within the concepts of attractions and barriers. Nevertheless, they fault the theory for not addressing how changes in marriages occur, where the perceptions of costs originate from, and its inability to explain how couples who enter into their relationship gratified become either more or less satisfied over time.

2.2.2.2 Crisis theory

The word crisis is obtained from the Greek term 'krisis', describing any event which can result in an unstable and risky situation thereby negatively affecting an

individual, group, community, or society (Bundy, Pfarrer, Short, Coombs, 2017). It is represented by two Chinese characters ‘wei’ meaning ‘danger’ and ‘ji’ describing a ‘budding moment’ indicating that it is a crucial point when resources should be combined to bring about a positive change (Mair, 2008). Some crises are personal, like involving the loss of a loved one, injuries from a crash, traumatic incidents like sexual assault, battering, divorce, being a victim of a robbery, or a terrifying medical diagnosis; while others could be more extensive such as community disasters (Roberts, 2000) or a global pandemic (Haque, 2020).

According to Karney and Bradbury (1995), the crisis theory was formulated by Hill (1949) to explain how families react to stressful situations. They also mention that in his ABC-X model, Hill strove to understand why some couples could face adverse situations courageously, while for others, their relationships declined. Furthermore, they explain that in the ABC-X model of stressful events, A stands for the (traumatising) situation; B represents availability of resources to the spouses; C means the spouses’ interpretation of the situation; while X implies that there is a likelihood of the situation escalating into crisis. The variables B and C will define whether the adverse event A will produce X a crisis (Rosino, 2016). The model has been reviewed through further research to include other important factors like the couple’s social support, their coping process, resources developed to meet the demands of the crisis, additional stressors, and the likelihood of an adaptive process during the crisis. This is called the double ABC-X model (Rosino, 2016).

Roberts (2000) defines crisis as a state of imbalance characterised by confusing emotional conditions, erratic behaviours, and somatic complaints leading to a state of hopelessness persisting regardless of the victim’s problem-solving approach and willingness to return to the state of equilibrium. James and Gilliland (2001) in their crisis intervention model explain that it is the perception that an individual has about an experience, an event, or a situation that makes it an ‘intolerable difficulty’ exceeding his/her coping mechanism. Caplan (1961) reiterates that individuals are in crisis when they face insurmountable difficulties that defer the use of traditional problem-solving methods. Carkhuff and Berenson (1977) also expatiate this by affirming that a ‘crisis becomes a crisis’ when an individual has no solution to a disturbing situation.

According to McDonald (2016), a crisis is formed in an individual's life when these three elements are observed:

- An undesirable incident occurs causing a feeling of distress
- The distress will produce the inability to function properly
- The individual then adapts coping skills which may fail to improve life.

Conversely, when an individual is supported through a critical situation with appropriate resources, their functioning may return to what their previous state was before the distressful event occurred (Cherry, 2019). However, when support is not sought or offered (McDonald, 2016), the individual's functioning declines (Walsh, 2013), resulting in devastating outcomes.

Caplan (1961) draws some attention to the five stages of crisis which a person experiences: i) disturbed equilibrium, ii) rise in tension, iii) disruption of daily living, iv) may go into depression, and v) all problem-solving strategies fail, ensuing in mental collapse or breakdown. However, James and Gilliland (2017) hold a different view, insisting that crisis can cause a positive change in beliefs and values as people learn from their experiences (James and Gilliland, 2013). Considering this, James and Gilliland (2017) further recap the four stages as thus: i) disturbed equilibrium, ii) grief, iii) working through the problem with support, and iv) restoration of equilibrium.

There are different types of crises:

- Developmental crises can occur when the natural process of life causes stress or strain, for instance, life transitions such as pregnancy or adolescence (McDonald, 2016).
- A situational crisis is a sudden, unpredicted, and overwhelming event that is beyond an individual's control, for example, a car crash.
- Existential crises refer to situations of inner conflicts caused by regret or sorrow over the loss of time (Price, 2011), direction, or purpose. It involves a deep sense of regret because targets and goals were not achieved. This could lead to suicide (McDonald, 2016) or other outcomes like:
  - Biological coping: this is the way the individual's body expresses its state of instability. It could manifest as gastrointestinal issues, heart problems, or blood pressure challenges (Walsh, 2013).

– Psychological coping: the individual could make use of negative alternatives to deal with the distress and pervasive thoughts he/she may be struggling with. This, on the one hand, can be by the use of avoidance mechanisms and substance abuse. On the other hand, a positive strategy will include problem-solving methods and solution-focused approaches to assist the individual in the crisis to build resilience, regain focus and resume proper functioning (Walsh, 2013).

Understanding the crisis theory and its practice can be useful as a means of intervention with significant benefits for individuals who have been struggling with cognitive distortions caused by stressful situations in life (Thompson, 2014; Walsh, 2013). The VSA model, therefore, expatiates that those stressful events, infused with the couple's enduring vulnerabilities (background variables and traits brought into marriage), manifest in their level of activities resulting in an effective or ineffective interactive process. Consequently, if the process is ineffective, it could result in disharmony, however, if effective, it could build resilience (Peterson and Bush, 2012), thereby producing satisfaction. Karney and Bradbury (1995), in conclusion, commend the crisis theory as one of the few theories which reveal that important changes could occur in the marital relationship however, they argue that it failed to specify the mechanisms of these changes in marital processes, an area which the VSA model expounds. The model also criticizes the theory for not appreciating that certain problems may have been derived from early life experiences. Some important questions that the VSA model and crisis theory ask are:

- What are the events that have caused stress to the couple?
- How did the situation become a crisis?
- What interpretation have they given the incident?
- What resources do they have at their disposal to make positive changes?
- How effective have the resources been?
- What can they say they have learnt from the occurrence?

Again, the ability of couples to respond to these questions will reveal their adaptation process. It will indicate what types of changes have occurred, which are either

conditioned towards resilience, along with an inner strength or weakness and disintegration.

2.2.2.3 Attachment Theory

This theory owes its existence to the work of Bowlby in the 1960s who believed that the need for an individual to attach is facilitated by an infantile desire to be sheltered from harm (Lander and Duschinsky, 2013) and the yearning to be nurtured sensitively (McLeod, 2017). Attachment is, therefore, a profound and long-lasting emotion linking individuals across time and space (Bowlby, 1982; Ainsworth, 1970;). It examines the significance of the child's relationship with at least one parent, considering the responsive father or mother as a safe base (McLeod, 2017). Attachment is an adaptive process that improves and increases a child's chances of survival (McLeod, 2017) whereby failure to form early secure attachments can result in maladaptive behaviour in adulthood and throughout the life span. Furthermore, studies like Rokita, Dauvermann, and Donohoe (2018) have found that the early childhood are critical for the development of attachment relationships therefore exposure to traumatic events at such a period can have a profound effect on cognitive, social and emotional development.

Ainsworth's (1970) assessment using children between the ages of 12-18 months, expanded Bowlby's work which emphasized the incredible ability of attachment to impact individuals across the lifespan. Attachment is described as an unfamiliar phenomenon with profound effects on children (Ainsworth and Bell, 1970). Adults who are diagnosed with various mental illnesses such as posttraumatic stress disorder (PTSD) often display attachment problems which could have been caused by childhood trauma (Cherry, 2019). In addition to this, Ainsworth (1970) lists three major attachment styles as: secure attachment, ambivalent-insecure, and avoidant-insecure which were later extended to romantic contexts by Hazan and Shaver (1994). Cherry (2019), Rivera (2018), and Fraley (2018) further classify them into four adult styles, namely: securely attached, anxious-preoccupied, dismissive-avoidant, and fearful-avoidant.

According to Levy (2017), secure attachment has the following characteristics: low on avoidance, low on anxiety, not preoccupied with the relationship, not afraid of rejection, and not uncomfortable about intimacy. Van Buren and Cooley (2002) verify that because anxious-preoccupied individuals seek high levels of intimacy and attention,

they are suspicious as well as distrustful. They also state that anxious-preoccupied people desire frequent validation and responsiveness from their spouses which invariably make them seem too demanding. Simpson and Rholes (2017) report that individuals with the dismissive-avoidant attachment style prefer to maintain an independent lifestyle giving the impression that they do not require any close relationships when in actuality, they fear rejection. They passively avoid romantic ties whenever they feel they are becoming close to people of the opposite sex. Firestone (2013) submits that fearful-avoidant persons have some inner conflicts; both desiring emotional closeness and withdrawing from it at the same time. Like the dismissive-avoidant, the fearful-avoidant individuals may seem secretive as they tend to suppress their feelings. Staughton (2019) stresses that those individuals who have experienced childhood trauma like sexual abuse could develop this type of attachment style. The fearful-avoidant attachment style has also been linked to borderline personality disorder, posttraumatic stress disorder (PTSD), anxiety, and depression (Hopper, 2018).

Moreover, as emphasised by this theory, marital success or failure can be affected by enduring aspects of family history, early attachment figures, and early experiences (Hopper, 2018). The theory also exudes its strength in the ability to consider the continuity of marital relationships over the life span, hence drawing attention to the role of unconscious urges, and background history as determinants of spouses' behaviour, thus indicating that unmet attachment needs can lead to the dissolution of the union (Karney and Bradbury, 1995). Additionally, Karney and Bradbury (1995) allude that the weakness of the theory exists in its inability to offer a synopsis of the challenges and decline of marital relationships over time. Nevertheless, attachment theory has implications for psychopathological disorders such as depression (Stevenson-Hinde and Hinde, 2015). The following questions are raised from the VSA model and the attachment theory which couples should consider:

- What is the family history of each individual in the relationship?
- What are their attachment styles?
- What early life experiences led to this?
- How do their attachment styles affect their adaptation processes?
- What unmet emotional needs can affect their relationships?

Responses to these questions will also explain how their personal history and early life experiences can affect their marital relationships. Centred on these three principles, the VSA model gives a strong structure to clarify the concerns of poor marital outcomes by explaining the process by which marriages pass through deterioration over time. The model explains that the couple's enduring vulnerabilities, the stressors they experience in their union, their interpretation of the stressors, and the resources at their disposal to help each other are an intricate interplay of factors that can influence the increase or decrease of marital satisfaction.

2.2.3 The Theory of personality development

The second theory this study is anchored on is the theory of personality development by Freud (1923). Lantz and Ray (2021) state that before explaining the theory of personality development, Freud initially formed some postulations implying that the mind can function on three levels of consciousness namely: the conscious, preconscious, and unconscious states. The conscious state refers to the period when an individual is aware of thoughts, ideas, emotions, and motives. Preconsciousness involves the ability to recall memories that can be carried into the state of consciousness but the unconscious mind is different, as it concerns thoughts, feelings, desires, and reactions that the individual has no memories of, which are probably repressed because the recollection can cause pain. These inhibited and curbed feelings from childhood are often the foundation of psychological problems. This not only explains how devastating the issues of childhood can be, but further reveals that they may cause the mind to struggle with unresolved matters.

In addition to this, Freud (1923) concedes that personality is developed from three elements: id, ego, and superego which were translated from the German language as 'das Es' (the it), 'das ich' (the I) and 'uber-ich' (over-I) respectively. These three components produce the complex nature of human behaviour. The id involves infantile drives; the superego functions as the moral compass, while the ego operates based on realistic principles. Based on this explanation, the id refers to the primitive aspect of the psychic structure, consisting of sexual and aggressive desires. It is essentially an individual's biological, yet unconscious instincts motivated by pleasure and instant gratification;

regarded as the covert part of personality, submitting only to the principles of pleasure (Cherry, 2018).

Freud (1933) reiterates that the id is the dark and remote part of man's nature, encapsulating secret needs, inexpressible desires, or sexual drives manifesting through neurotic symptoms. However, the ego, by contrast is the decision-making aspect of personality which attempts at viewing life from a rational and realistic point. Furthermore, the superego enables the individual to perfect his character by embracing the moral principles and tenets of society. Based on these three interacting agents in the psyche model, from childhood, personality is shaped. According to Freud (1923), any imbalance between these components can lead to a maladjusted and defective personality with a tendency to experience negative feelings (McLeod, 2019) maintaining that the ego (self) can be trapped between the id (instant gratification) and the super ego (moral compass) making them engage in a never-ending conflict, leaving the ego with the option of seeking for balance through various defence mechanisms.

In the course of life's stages, Freud (1937) also expounds that there are five psychosexual developmental phases which include: the oral, anal, phallic, latency, and genital phases (Sauerteig, 2012). In these stages, a child undergoes struggles between pressure and pleasure which have to be resolved to create a balance between personal desires and societal beliefs. Incidentally, the child's success or failure at scaling through the test each stage generates will ultimately lead to the development of personality. Again, the failure of a child to be fulfilled and satisfied in the sequence of the psychosexual phase results in dissatisfaction called fixation (Sauerteig, 2012). At any point, fixations can create excessive fear, worry, and uneasiness which could continue into adult life as neurosis. Fixations, nevertheless, can occur when the different areas of the body in charge of erogenous zones are repressed, making the individual feel discontented, frustrated, and unfulfilled. Fixations can also occur if the person's needs are so fully met that he or she refuses to leave that particular psychological stage because of overindulgence (Sauerteig, 2012). In addition to this, Lantz and Ray (2021) classify the following as the five stages of Freud's psychoanalytic theory of personality development (1937), along with each corresponding age range, erogenous body part, and the clinical consequences:

Oral stage: the age range is from birth to one year with its erogenous zone as the buccal cavity. Gustation is the centre of preference for the infant. The initial affection and closeness of a baby to the one that provides satisfaction to his oral needs is usually his mother. If the ideal amount of stimulus is not available for him/her, the libidinal energy fixates on the oral mode of gratification, resulting in subsequent suppressed agitative or inactive tendencies. Oral stimulation is the reflex that strengthens trust and safety which binds the child to the caregiver or mother, especially during nurturing. Oral fixation can also generate challenges in an individual, such as eating disorders, poor drinking habits, smoking, and biting.

Anal stage: the age at this stage is between 1-3 years old. The bowel and bladder are the psychosexual energies of this phase because toilet training is a sensitive task; the child has to be able to control his or her body's natural urges. Parents and caregivers also become active in training the child to help them learn to control the libidinal energy from the mouth to the anus. At this stage, negative experiences can stem from either a punitive parent or one tolerant of deviant behaviour. The child who faces constant reprimands and shame could grow into a despondent adult with an excessive ability to react to criticisms from others anytime he or she fails to perform optimally. This can lead to an anal-retentive nature characterized by rigidity, and obsession. Conversely, permissive parents who enable deviant behaviour can result in an anal-expulsive trait, characterized by an untidy, destructive, and extravagant adult. However, adults who had more positive early experiences at this phase become productive, integrative, creative, and competent adults.

Phallic stage: begins from 3-6 years old. The libidinal energy involved is the genitalia. At this stage, a child becomes more aware of pleasurable genital stimulation. The child also becomes conscious of the differences between the male and female gender. At this point, young boys begin to experience the Oedipus complex, manifesting as obsessions with their mothers and may think of their fathers as rivals. Similarly, the Electra complex describes a parallel set of feelings experienced by young girls causing some rivalry between them and their mothers for the attention of the fathers.

Latent stage: starts from 6 - 12 years old. During this stage, the dormant sexual feelings are quieted so the child can direct his or her attention on areas of interest, such as school, friendship, and extra-curricular activities. Success at this phase will produce a

sense of confidence; however, challenges may generate an inability of the child to form healthy relationships as an adult. No erogenous zones were identified.

Genital stage: begins from ages 13-18 years old. This is the final phase of psychosexual development characterised by sexual arousals. Furthermore, the child's ego becomes fully developed, even as he or she is subsequently experiencing rising hormone levels, sexual drives, and seeking independence. The ability to create meaningful and lasting relationships can help make the child's sexual desires and activities healthy or positive. An adolescent who experiences instability during this period becomes maladjusted, thus he or she will not be able to develop healthy relationships. In all, the main thrust is that the unconscious mind can shape personality as the stages progress from one phase to another. The Freudian theory of personality development still stands out as a resourceful professional tool in exploring and identifying the root cause of psychological distresses, particularly those caused by early adverse situations.

2.3 Empirical review

2.3.1 Cognitive processing therapy and marital satisfaction

Cognitive researchers of marital satisfaction argue that couples' beliefs about their marriages (which could be logical or illogical) play a significant role in the attitude displayed toward their spouses (Khatamsaz, Forouzandeh, and Ghaderi, 2017). Also, various cognitive approaches unanimously agree that individuals who are exposed to certain negative circumstances during childhood can develop maladaptive thought patterns enduring to adulthood, hence affecting their views about themselves, others, and the world (Reskind and Black, 2005). Khatamsaz et al (2017) also take into account that these early maladaptive schemas can set the tone for personal and relationship problems affecting marital satisfaction. Furthermore, Amirpour, Badri, Aghayousefi, Alipour, and Zare (2017) in their study affirm that the administration of CPT in the enhancement of marital satisfaction proved significant while it was observed to be effective in reducing the effects of trauma, such as avoidance coping strategies (denying or minimizing stressors).

Murray, Augustinavicius, Kaysen, Rao, Murray, Wachter, Annan, Falb, Bolton, and Bass (2018) believe that based on CPT's focus on cognitive reframing and its ability to reduce the avoidance of triggers, it is also useful for challenging negative beliefs about

self and others in individuals who have encountered devastating childhood experiences. Married women who were reported to have maladaptive thoughts due to sexual molestation, and who voiced out beliefs like *I am not relevant in my home* were found to significantly change after intervention (Iverson et al, 2015). Cognitive processing therapy focuses on 5 cognitive areas which can be invaded by stuck points. Stuck points are negative views that individuals form about life affecting the cognitive parts. These domains which include safety, trust, intimacy, power/control, and esteem issues, can arouse childhood attachment styles (Breuninger and Teng, 2017) such that dependency either on substances or relationships can be formed as coping mechanisms. These stuck points are inflexible highlighting various negative core belief systems. Some examples of such stuck points by Marques, Eustis, Dixon, Valentine, Borba, Simon, Kaysen and Wiltsey-Stirman (2016) depicting challenges in the aforementioned domains are: *I have never felt safe so I am always alert and anxious* (safety issues); *many human beings are liars, therefore, I don't trust anyone* (trust issues); *anything can happen to me as I have no control over my life* (power/control issues); *I am damaged goods because of the unfortunate incident* (esteem issues); *if I get close to others, I will get hurt as they will leave me* (intimacy issues).

Women who have received CPT have demonstrated great improvements in their outlook on trauma and their future because of some reductions in symptoms like fear, worry, sadness, poor motivation, intrusive thoughts, avoidance, and numbing which are associated with childhood trauma (Lenz, Bruijn, Nina and Bailey, 2014). It has also been linked to a significant decrease in hopelessness and sleep disturbances, which are predictors of positive changes in symptoms of trauma (Gutner, Casement, Stavistsky, Gilbert, Resick, 2013). In addition, Galovski, Harik, Blain, Elwood, Gloth, Fletcher, and Davila (2016) recommend that CPT can be used for women with high levels of dissociation and depersonalisation, employing Socratic questioning to give priority to assimilation. Owing to the important role of sexual satisfaction in marriage, CPT has been used as a successful stigma reduction intervention for women who have survived sexual violence and who are burdened with depression, anxiety, and other psychological challenges (Murray et al, 2018).

According to Martin, Taft, and Resick (2007), marriages in which marital rape occurs are significantly high in dissatisfaction, causing negative health outcomes like gynaecological problems, through which CPT provided promising results. This intervention has proven to be an effective evidence-based treatment for women who have difficulties navigating social, occupational, marital, and familial functioning especially due to childhood trauma. Studies like Murray et al (2018), Alade (2015) as well as Resick and Schnicke (1992) attest to the efficacy of CPT on female survivors of sexual abuse; however, they did not work on the marital satisfaction of women struggling with the challenges caused by childhood trauma. Again, CPT was primarily designed for individuals who can read and write in the English language, nevertheless, this study included those who could fluently express themselves in the Yoruba language.

2.3.2 Stress inoculation therapy and marital satisfaction

Akbari and Khodadadi (2013) in their study which sought to investigate the effects of stress inoculation therapy on improving women's marital satisfaction, affirm that living with a spouse who is struggling with the consequences of a traumatic experience can cause an increase in marital conflicts, stress and conversely, a decrease in satisfaction. In their conclusion, they draw that the use of SIT to improve marital relationships can be linked to a rise in satisfaction and a reduction in conflicts. Again, Hojjat, Hatami, Rezaei, Noroozi and Talebi (2016) observe from their research that marital satisfaction is an important factor in couples' quality of life since it has become increasingly connected to healthcare. They confirm that those who have been exposed to devastating occurrences as children usually manifest certain dysfunctional modes of survival and hence will need help acquiring effective coping skills. They also adduce from their study that the coping skills they can obtain from SIT can help individuals deal with difficult situations by boosting their self-confidence, and managing stressors better, thereby enhancing functionality (Tull, 2019).

Shalkouhi, Vantankhah, and Bahri (2015) describe infertility as one of the complex issues of marital life which can produce some psychological stress leading to anxious and depressive thoughts, causing marital dissatisfaction. The researchers further submit that though infertility, irrational belief, and stress can be seen as a complex vicious cycle, SIT has proven to be effective in alleviating the pressure resultant from the

circumstances because it can build a high level of strength, perseverance, and tenacity in facing life stressors. They maintain that despite the difficulty the couples may face, the therapy can build up some resilience that could help them believe in themselves again. Bahaodini and Zandekarimi (2018) also show that SIT is effective for cognitive and emotional regulation in vulnerable married female adolescents because of its ability to produce constructive emotional regulation skills like planning, and organising their affect, rather than a poor ability to tolerate distress. In addition to this, Jackson, Baity, Bobb, Swick and Giorgio (2019) reaffirm that the SIT practice can decrease symptoms of PTSD and depression, hence improving life performance.

Furthermore, for many women, having their babies for the first time is a major transitional life occurrence that could require adaptive skills, as the change can create some emotional disturbances, subsequently affecting marital satisfaction (Odinka, Nwoke, Chukwuorji, Egbuagu, Mefoh, Odinka, Amadi, and Muomah, 2018). Moreover, during pregnancy, some women experience changes that may result in stress and a decline in couples' marital satisfaction; this can deteriorate into mental health challenges like postpartum depression lasting for a long time (Salehi, and Shahhosseini, 2017). Similarly, Khorsandi, et al (2015) view SIT as an intervention that can significantly decrease the stress levels of pregnant women. They further explain that since the therapy provides these women with coping strategies such as muscle relaxation techniques, deep breathing exercises, use of imagery, and cognitive restructuring skills, it demonstrates that SIT was not only beneficial for reducing maternal stress, but it also can increase marital satisfaction and save the unborn child, by preventing him/her from early life infections and an adverse immune system development in later life (Ramratnan, Lockhart, Visness and Calatroni, 2021).

There is a relationship between marital satisfaction and job stress in professions such as nursing, an occupation that is known to have high risks involving danger, severe fatigue, work shifts, exposure to trauma, and infectious diseases (Barzideh, Choobineh, and Tabatabaei, 2013). In addition, Augusto-Landa, Lopez-Zafra, Berrios-Martos, and Aguilar-Luzon (2008) detect that these work-related stressors can increase marital dissatisfaction causing problems in intimacy to the extent that conflicts increase between the workplace and home generating negative mental and physical health outcomes

(Shahraki, Mardani, Sanchuli and Hamedi, 2010). Even married female bankers are not left out of work-marital stress, as they also encounter many job stressors such as: customers' complaints, schedule pressures, and heavy workload causing a lack of sexual interest, a reduction in shared activities, ultimately leading to poor marital satisfaction outcomes (Fawole and Isiaq, 2017). To this end, Agusto-Landa et al (2008) identify that married career women who are faced with job stressors, report low marital satisfaction, therefore, would need professional interventions.

Spears (2019) then, reiterates that SIT can be beneficial to female professionals in high-stress jobs affecting their marital, mental, and physical conditions implying that the treatment plan which SIT provides can be adapted to suit anyone's specific needs to yield significant changes in the cognitive and emotional areas of behaviour. In this way, the treatment can enhance pre-frontal cognitive control and other adaptive functioning so that resilience is developed as well as emotional regulation skills (Parker, Buckmaster, Lindley, Schatzberg and Lyons, 2012). In their experimental study performed on 30 married women, Rabiee, Zahrakar, and Farzad (2019) record that SIT was effective in reducing a specific emotional aspect of marital dissatisfaction known as couple burnout. They further add that the intervention can manage some consequences of couple burnout like physical and mental fatigue. As a result of this, they recommend it as an appropriate intervention for enhancing marital relationships.

2.3.3 Personality types and marital satisfaction

The personality types of extroversion and introversion are central constructs in the theories of human personality which have been applied in various forms like: McCrae and Costa's big five model, Eysenck's three-factor model including Cartell's 16 personality factors. Jung (1921) introduced these concepts into the field of psychology to describe a continuum, implying that individuals can have variants of both personality types and yet maintain a dominant category. There are numerous differences between extroverts and introverts, in that individuals with extroverted personality types prefer clothing that is well-embellished, colourful, and attractive, while introverts would rather choose practical, comfortable, and less ostentatious attires (Sharma, 1980). Extroverts are more likely to choose more energetic music as opposed to introverts (Rentfrow and Gosling, 2003). Again, there is a link between extroversion and happiness (Myers, 1992)

while introverts are associated with moodiness. Extroverts also tend to have high levels of esteem while introverts may be perceived as boring, and intelligent (Guy-Evans, 2021).

Some studies like Sayehmiri, Kareem, Abdi, Davland, and Gheshlagh (2020), and Karney and Bradbury (1995) affirm that behavioural qualities could influence marital satisfaction. Since individuals get married with different personality types, it can therefore be concluded that marriage is the bonding of two different personalities (Gholizadeh, Hasan, and Jalil, 2010). Similarly, Sadeghi, Mootabi, and Dehghani (2016) state that in marriage, if the emotional connection of the personality types does not occur, as Gholizadeh et al (2010) envisage, then personality types may act as stressors in marriage. Consequently, personal values, principles, and attitudes can serve as predictors of marital bliss (Chehreh, Ozgo, Aboiaali, and Nasiri, 2018).

According to Myers and Briggs (1995), four main areas of conflict can arise in marriage between individuals of different personality types. The first area is the struggle between the extrovert and the introvert. Based on these types, they explain that conflicts can arise when the ‘outward’ extrovert and the ‘inward’ introvert cannot support each other’s differences. Secondly, the couples’ ability to either ‘sense’ or use instincts can expose their different sides. This process reveals that while the sensing individual concentrates on details, the intuitive spouse prefers to deliberate on the overall situation. Again, this could cause clashes if the couple cannot appreciate their differences. Thirdly, in considering a ‘thinking’ as opposed to a ‘feeling’ couple, they state that the feeling spouse usually desires helpfulness, while the thinker would rather be given suggestions and ideas to proffer solutions. A lack of understanding of these differences could result in marital distress. Fourthly, they also explain that while assessing ‘judging’ versus ‘perceiving’ couples, they noticed that while the judging spouse likes structure, the perceiver wants to make decisions based on facts and details, this area can also be a source of misunderstanding among couples. Couples tend to have higher marital outcomes when they understand how they function psychologically.

Older studies like Lester, Haig, and Monello (1989) associate husbands’ extroversion with reduced marital satisfaction; however, Barelds (2005) attributes positive correlations between extroversion and marital satisfaction. Meanwhile, Gattis,

Berns, Simpson, and Christensen (2004) report no link between extroversion and marital satisfaction. Interestingly, this correlates with recent findings like Fattahi and Homabadi (2017) which did not also find any significant relationship between personality types and marital satisfaction. From their study, Kilman and Vendemia (2013) report that couples with similar personality types are associated with higher levels of satisfaction, whereas those with some levels of impulsivity predict a reduction in marital satisfaction. They also recognise that personality can be adjusted, therefore the success of marriage would require that both spouses may have to work on their weaknesses, tolerate and support one another so that they can mutually benefit from their relationship. Furthermore, motivations, responsibilities, and roles may shift in marriage as couples transit from one phase of life to another implying that what could have gratified them ab initio may change over time (O'Rourke, Claxton, Chou, Smith, and Hadjistravropoulos, 2011), losing any importance.

2.3.4 Spousal support and marital satisfaction

Marriage according to Khan and Aftab (2013) is a two-way transactional process in which sharing and caring occur between a husband and wife to the extent that they feel loved, enjoy a sense of belonging, have mutual respect for one another, and above all satisfaction with the relationship. Tas and Vural-Batik (2019) define marital satisfaction as the degree of pleasure obtained by couples through environmental appraisals that can raise personal evaluations. They explain that the environmental assessments could include: ambition, educational background, income, equality, and working status, while the personal assessments consist of: affection, sexual satisfaction, and self-expression. Therefore, perceived low levels of spousal support can affect marital satisfaction (Yedirir and Hamarta, 2015) causing depression, disagreements, and weakening marital ties (Khan and Aftab, 2013) while perceived high levels can strengthen the relationship (Ryan, Wylie, and Smith, 2014).

Marital satisfaction can be experienced in the degree of spousal support which Stone and Shackelford (2007) describe as a process that is significantly linked with healthy marital maintenance skills with outcomes such as overall health for both spouses. By this same token, they state that spouses who provide good forms of support such as communicating feelings of love and admiration while eliminating resentful as well as

hurtful words (Tolorunleke, 2014) inevitably contribute to their partners' marital satisfaction. In light of this, Ofole (2015) reiterates that marital satisfaction can be linked to lower risks of health problems with spousal support being a stronger indicator of satisfaction for women than men (Rostami, Ghazinour, and Richter, 2013). Spousal support is, therefore, a means whereby spouses can provide physical and psychological resources needed by their significant others to buffer the adverse effects of life stress, so that satisfaction and the overall quality of the relationship are sustained (Chi, Tsang, Chan, Xiang, Yip, Cheung, and Zhang, 2011). Furthermore, though spouses can turn to others in their social network for support of different types, spousal support remains an important source of satisfaction, since being fulfilled in marriage is linked with greater well-being for both males and females (Robles, Slatcher, Trombello and McGinn, 2014), spouses expect their partners to be available for them, as their social network cannot compensate for lack of spousal care and companionship (Rostami et al, 2013).

Monin and Clark (2011) also mention that women provide more support than they receive in their marital relationships considering that they tend to invest more in the union. Consequently, this exposes them to more suffering when conflicts arise: as females still struggle with harmful gender-based cultural norms existing in some societies. Again, they report that the unification between women and men is often seen as unevenly balanced, with females feeling less supported than males. Their findings further reveal that married women reported such emotions as anxiety, sadness, and anger more frequently than men. This implies that married women may encounter undue hardship from being the primary actors of relationship maintenance strategies, a responsibility that has been associated with stress, and acrimony as offshoots of displeasure about obligations, attentiveness, and commitment (Monin and Clark, 2011). Patterson (2003) identifies the four corroding effects that stress can have on married women as: firstly, damaging their process of adaptation, secondly, decreasing intimacy, thirdly, poor coping skills, and lastly, an increase in health challenges.

Rostami et al (2013) state that men view their wives' need for support as significantly related to the strong desire for a sense of belonging, emotional care, self-expression, and respect. They further clarify that since women are more prone to revealing and expressing their feelings, their activities are driven by matters such as

intimacy, empathy, and self-disclosure in their marital relationships. Monin and Clark (2011) again observe that married women more than men, expect and desire more reciprocated responsiveness, a behaviour which they refer to as *communal responsiveness.* They further describe it as the level at which an individual feels genuinely committed to the welfare of his/her spouse, thereby attending to his/her needs as a necessity. They also mention that it could include providing instrumental and emotional support. Rostami et al (2013) describe instrumental support as the resourceful use of time, money, and energy to render help while emotional succour includes empathy, understanding, trust, care, and love expressed towards a spouse. According to them, other additional forms of support are; informational assistance which could be rendered to a spouse in the form of sharing vital details, instructions, suggestions, and advice aimed at advancing the course of a marriage partner; finally, appraisal support which involves evaluative feedback, not destructive criticism and cynicism.

Recommending modes of support which couples can provide for one another, Ebenuwa-Okoh and Osho (2016) highlight the following: physical closeness and affection (kissing, hand holding, hugs, and sexual activities), confidentiality (keeping each other's secrets, trust exuding feelings of safety and respecting each other's privacy), sympathy (appropriate displays of sorrow and regret), prayer time (praying together as a couple or making intercessions on behalf of a spouse), expressing concern and interest (enquiries after wellbeing, interest in spouse's work or business). They also maintain that comforting their spouse with reassuring deeds and comments, providing esteem support by complimenting their spouse (through acceptance, admiration, appreciation, and encouraging remarks), playtime (time to talk, hold pleasant conversations, laugh and playfully tease each other) validation (recognizing and affirming spouse's worth, feelings, opinion, and relevance), stress reduction through attentiveness, and also a willingness to help, especially without being told to in times of difficulty, will positively correlate with high levels of marital satisfaction.

During the honeymoon phase of marriage, husbands, and wives genuinely care and cater to each other's needs but as time goes on, the satisfaction they derive from those actions begins to fade as they become absorbed in other matters of interest, such as childbearing and financial obligations linking marital satisfaction and spousal support

with couples' connectivity and progress (Khan and Aftab, 2013). Furthermore, when spouses can perceive affectionate responsiveness in their union, it influences how intimate the relationship feels. Even though married people can turn to others in their social network for different kinds of assistance, reinforcements, and validation, spouses continue to exist as the most significant source of support for each other (Walen and Lachman, 2000). Again, Ebenuwa-Okoh and Osho (2016) agree with this, reaffirming that support from other sources cannot necessarily give what is lacking in the marital relationship as spouses are meant to often interact on a level of intimacy that cannot be obtained from others.

Supportive spousal behaviour such as love, affection, companionship, and care, when demonstrated by couples will increase their marital satisfaction; the more it is demonstrated, the higher the satisfaction, conversely, the lower the support, the lower the marital satisfaction (Khan and Aftab, 2013). In addition to this, Akinwumi (2017), like other researchers, detects that many marriages start with good intentions. However, these studies remain inconclusive as to which factors are responsible for the instabilities observed in unions, therefore, making it necessary for more research in this area. The study of spousal support and marital satisfaction is therefore necessary for deciphering the reasons why many marriages fail (Gallimore, Hughes, and Geldhauser, 2006) and how childhood traumatic experiences can exacerbate already existing difficulties in marriage (Landers, Dimitropoulos, Mendenhall, and Zemanek, 2020). Childhood trauma can promote not only the early onset of disorders, but may contribute to social impairment, poor academic performance, correlating with school dropout and juvenile delinquency (Widom, 2017). To this end, Erfanian (2018) reiterates that childhood trauma can substantially determine the development of psychiatric and physical disorders with implications for the victims, families, and society (Walsh, McLaughlin, Hamilton, and Keyes, 2017).

The existence of symptoms of childhood trauma within a couple's relationship is significantly associated with high marital discord, dissatisfaction, high rates of divorce, and poor family adjustment (Redd, 2017). Some studies which examined the abuse history of couples like Bigras, Daspe, Godbout, Briere, and Sabourin (2016), and Walsh et al (2017) proffer that early trauma correlates with increased marital disruptions and

lower marital satisfaction. The presence of this form of trauma in a spouse's life generates vulnerabilities in the marital relationship which could increase the risk of recreating trauma in the next generation (Siegal, 2013). Smith-Marek, Cafferky, Dharnidhaka, Mallory, Dominguez, High, and Mendez (2015) also show some evidence through their study that the impact of directly experiencing and witnessing traumatic incidences in one's childhood can result in the affected adult becoming a perpetrator of intimate partner violence (IPV). Individuals who are directly affected by turbulence tend to organise their family life as adults around their trauma. This indicates that when adverse experiences are present in one's family history, people with such vulnerabilities are more likely to choose those with similar patterns as partners (Redd, 2017) leading to more accumulation of the negativity. While different aspects of spousal support have been explored by numerous researchers, its existing mediating roles on CPT, SIT, and marital satisfaction have not been exhaustively discussed in literature. Again, though these scholars have meticulously deliberated on marital satisfaction, CPT, SIT, spousal support, and personality types, they have not investigated how childhood trauma can affect the marital satisfaction of women, the gap that this study has filled.

2.3.5 Relevance of the vulnerability stress adaptation model and the theory of personality development to the study

The vulnerability stress adaptation model (Karney and Bradbury, 1995) was designed as a framework to model various marital situations which include examining the interaction and effects between psychopathological symptoms and marital satisfaction. The model portrays that in marriage, spouses who have significant enduring vulnerabilities can encounter stressful marital situations and employ poor maladaptive processes to cope with their circumstances, meaning that they are likely to be dissatisfied. Researchers such as Langer, Lawrence, and Barry (2008) and Marshall, Jones, and Feinberg (2011) expound that couples with disturbing childhood experiences have poor attitudes towards their spouses thus exhibiting poor coping skills such as nagging, withdrawal, and suspicion. The VSA can help researchers demystify and interpret why changes in marital satisfaction may either occur or remain stable over time.

The three important elements in the VSA model which this study elucidates are: enduring vulnerabilities, stress, and adaptation. Enduring vulnerabilities refer to married

women's susceptibility to mental health challenges through their exposure to childhood trauma. These persistent early susceptibilities can bring attributes like fear, anxiety, and depression which could be transferred into their marriages thus producing dire consequences like, the inability to maintain schedules, difficulty in analysing problems, suspicion, over-eating, smoking, fear of abandonment, suicidal thoughts, poor impulse control, failure to understand social cues and inability to provide socially acceptable responses in regular life situations.

Stress, which is the second element, worsens vulnerabilities. Stress can be described as challenges in life that married women may face daily that can cause an overwhelming surge of negative thoughts and feelings. Stress and marital satisfaction are concerns that over time have received much attention in research. This is because stress is a threat not only to marital satisfaction but to all spheres of life. Stress can appear in marriage in the form of worry, fear, desperation, distrust, or intense sadness and can be aggravated by marital challenges causing cynicism, disrespect, pressure, insecurities, and infidelity, which in the long run can account for poor marital satisfaction. Some other misgivings that exist as factors which decrease marital satisfaction are: unresolved marital issues, financial constraints, exhausting household responsibilities, and unfulfilled expectations. When these demanding situations co-occur with trauma-related stress symptoms, they could cause domestic violence, suicide, and other forms of disturbing circumstances consequently decreasing the level of marital satisfaction (Weinberg, Besser, Zeigler-Hill and Neria, 2018). These challenges could have some negative impacts on the adaptive process, which is the third element. Adaptation is characterised as the bond which couples experience while they build their lives together. It is a behaviour that empowers an individual with the ability to adjust appropriately to change and to successfully cope with challenges in the environment. Furthermore, it is a process that is associated with behavioural skills, emotional balance and positive cognitive appraisals that build resistance to stress enhancing satisfaction thus stabilising marriage; while De Carvalho, Pereira, Frozi, Bisol, Ottoni, and Lara (2015) confirm that childhood trauma can be linked to maladaptive character traits. They also explain that events which express childhood vulnerabilities were significantly associated with internalising stressful situations and having difficulties with self-expression, implying that there can be pre-

trauma and post-trauma behaviour. Again, they confirm that this was observed mostly in survivors of emotional abuse and neglect. In addition, they report that physical, emotional and sexual abuse was linked with high novelty seeking. Female survivors of childhood sexual abuse and neglect often suffer from symptoms such as depression, anxiety, low self-esteem, and anguish over life events (Lindert, von Ehrenstein, Grashow, Gal, Braeler and Weisskopf, 2014). Therefore, childhood trauma is a severe menace that can contribute to weaknesses, producing high-stress levels which predict more dysfunctional attitudes and character (Akbaba, Essizoglu, Kosger, and Aksaray, 2015).

Three out of the four perspectives presented in the model are essential to this study. These are: social exchange, crisis, and attachment theories which serve as the plinth for the VSA model. Through the lens of social exchange theory, the VSA model can project the correlation between behavioural exchanges and marital satisfaction. It simplifies the fact that exchange in marriage could lead to either positive or negative responses to the extent of influencing marital satisfaction. It also describes that in such exchanges whereby the cost outweighs the benefit, there will be a significant dearth of fulfilment and contentment causing stress.

As long as those behavioural exchanges are left unmanaged, they can result in intense discords, thereby corroding relationship satisfaction. The crisis framework, according to Karney and Bradbury (1995) accepts that there are diverse types of life events that couples will encounter that could affect their interactive processes making them feel that their union is in 'danger.' Any turbulence that seems too tough for any couple to surmount creating profound effects on their lives, is a crisis. This could occur because of conflicts in work-life balance, unresolved marital issues, and poor physical health. Again, from the view of the attachment theory, VSA observes that some established attachment traits can provoke stress, affecting the couples' ability to obtain marital satisfaction. Consequently, this infers that married women's attachment styles can influence the way they interpret trauma, and how they try to recover from tension utilising various coping strategies to manage their situations. In this study, enduring vulnerabilities are conceptualized as childhood difficulties such as physical, emotional, sexual abuse, and neglect, linked to stress, causing a maladaptive process, resulting in a decrease in marital satisfaction. The crisis theory further reveals that these early

vulnerabilities can determine how couples respond to stress by considering the patterns of rise or decline in marital satisfaction. It also describes how spouses' combined efforts can cushion the negative effects of trauma-related stress symptoms and the help they can render to one another to manage the negative effects of fearful life events on marital satisfaction. The social exchange theory, on the other hand, explains that spouses' adaptive process exhibited as the ability to solve problems, display support, employ relationship maintenance strategies, and provide care can become affected by unresolved issues or unstated expectations.

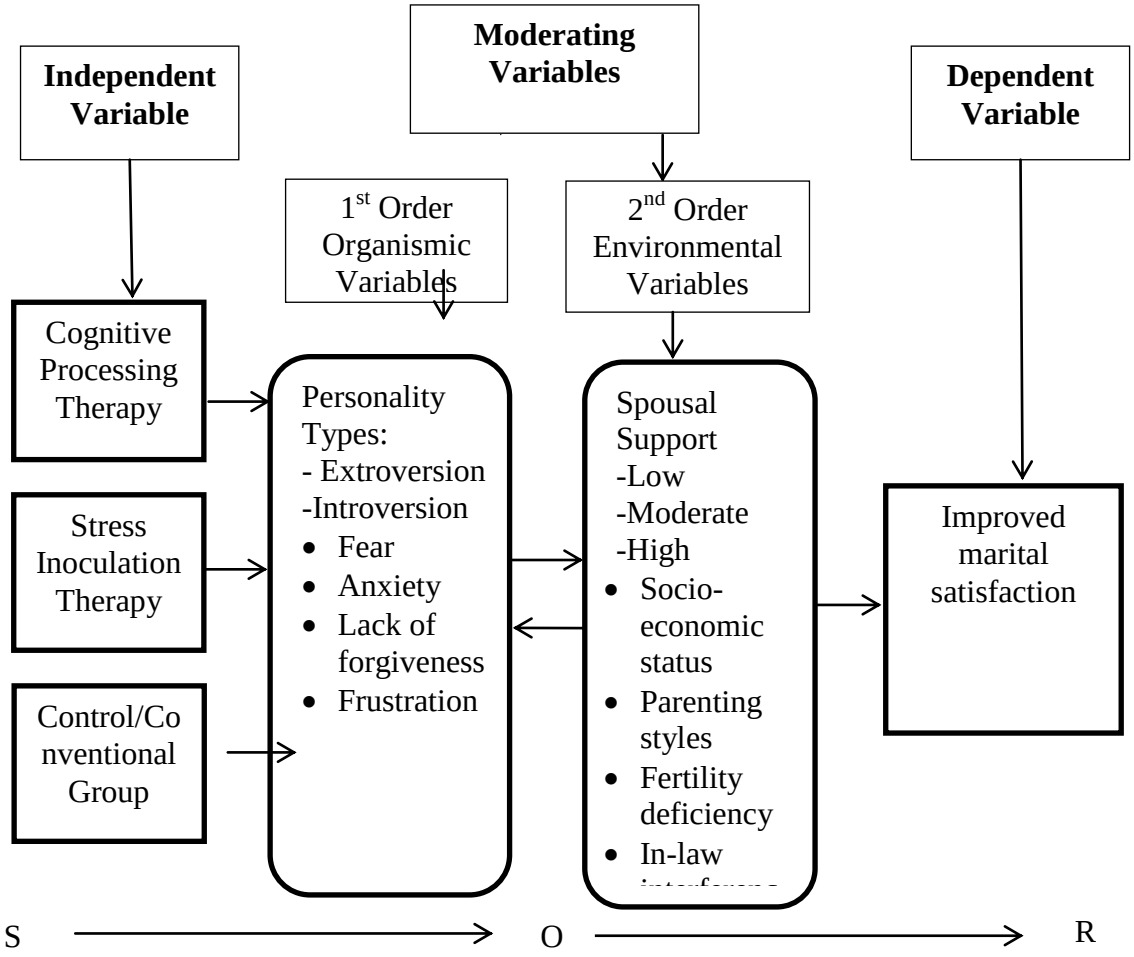
The theory of personality development by Freud (1923) lays much emphasis on how unconscious conflicts occur among the parts of the mind. The theory furthermore explains that human behaviour is produced from the interactions that take place within the fundamental structure of three psyche structures of the mind which are the id, ego, and superego. Moreover, Freud (1937) clarifies that childhood occurrences can greatly impact adulthood since fear, anxiety, and depression are deeply engrained in the memory of an individual with early traumatic experiences. This consequently means that the protective shield which preserves the human mind as a filter could be tarnished. When this happens, the restrainer is compromised, making the ego system incapable of defusing any onslaught of tension (Freud, 1937). This stress tends to vortex the individual into a state of helplessness (Freud, 1926). Subsequently, this demonstrates that the theory can help explain the origins of psychopathologic sequelae stemming from the effects of early adverse on the individual's vulnerable ego system. In light of this, Gullo (2012) describes anxiety, addictions, and eating disorders as functions of weak inhibitory systems which can be a result of early stress on the brain of the developing child. Freud (1937) once more emphasises that unconscious motives, fears, and desires can drive a person's behaviour to the extent that he or she can develop some defence mechanisms which can include denying reality, avoiding painful memories (repression/suppression), and outwardly opposing what they inwardly crave (reaction formation) causing intra-psyche conflicts which can lead to mental illness. To this end, Freud (1923) stresses the significance of childhood experiences in moulding the character, disposition, and behaviour of an individual. These postulations have over time provided a framework for

researchers of marriage, child, and family studies to reflect, modify as well as develop more theories to further advance investigations in these areas.

2.4. Conceptual model for the study

The conceptual model of this study had three variables namely; independent, intervening, and dependent. The independent variables consisted of the interventions which were used by the researcher to observe their effects on the dependent variable. The independent variables were cognitive processing and stress inoculation therapies while the two moderating variables were personality types (extroversion and introversion) and spousal support which, according to literature, can have significant influences on marital satisfaction. These variables were further classified into organismic (1^{st} order) and environmental (2^{nd} order) factors.

The dependent variable, marital satisfaction, is the measurable behavioural outcome expected to take place as a result of the effective manipulation of the independent variables (CPT and SIT).



Key:

S - Stimulus

O – Organism

R- Response

Fig. 2.1 Conceptual Model:

Source: Researcher (2021)

CHAPTER THREE
METHODOLOGY

This chapter focuses on how this study was executed. This includes the description of the research design, the study population, sample, sampling techniques, instrumentation, inclusion criteria, the procedure for data collection, synopsis of activities in the experimental groups, control of extraneous variables, method of data analysis, and ethical consideration.

3.1 Design

The study adopted the mixed methods of Sequential Explanatory Design. This involved the collection of both quantitative and qualitative data followed by analysis. Priority was, however, given to the quantitative data while the qualitative findings were integrated at the interpretation phase of the study. The qualitative data was used to explain, interpret, contextualize and describe in detail unexpected results from the quantitative findings. The quantitative was a pretest-posttest, control, quasi-experiment with a 3 x 2 x 3 factorial matrix. The first three represent the treatment: Cognitive Processing Therapy, Stress Inoculation Therapy, and the control, the next 2 levels represent personality types: extroversion and introversion, while the last 3 represent spousal support: low, moderate, and high.

The three variables are juxtaposed in Table 3.1.

Table 3.1 A 3 x 2 x 3 factorial matrix on Marital Satisfaction of married women with childhood trauma.

Treatment	**Personality Types**					
	Extrovert			**Introvert**		
	Spousal Support					
	Low	**Moderate**	**High**	**Low**	**Moderate**	**High**
Cognitive Processing Therapy	6	3	7	6	9	9
Stress Inoculation Therapy	6	6	6	4	7	12
Control	6	3	7	4	7	8

The qualitative was carried out through Focus Group Discussion (FGD). Table 3.1 showed the three types of variables used in this study:

Independent variables - the treatment packages which were examined at three levels:

- Cognitive processing therapy
- Stress inoculation therapy
- Control (with no treatment)

There were two moderating variables: types of personality and spousal support. Personality types were examined at two levels:

- Extroversion and
- Introversion

Spousal support was examined at three levels. Percentile rank was used to categorise spousal support into three:

- Low
- Moderate and
- High support

The dependent variable was marital satisfaction.

3.2 Population

The population for the study comprised married women with childhood trauma in Ibadan. This included women who have been married between 1-10 years and had disturbing childhood experiences such as neglect, physical, emotional, and sexual abuse. They also included women who could interact in English and/or Yoruba languages and who attended primary healthcare centres (PHCs) in three of the eleven urban local government areas in Ibadan.

3.3 Sample and sampling techniques

The sample comprised 116 married women in Ibadan who had been exposed to trauma during their childhood. The sampling was done in four stages: local government areas, the centre, the participants, and assigning treatment /non-treatment groups. There are eleven urban/semi-urban local government areas in Ibadan namely; Ibadan North, Ibadan North East, Ibadan North West, Ibadan South East, Ibadan South West, Ido,

Akinyele, Ona Ara, Oluyole, Lagelu and Egbeda. Three local government areas (Ibadan North East, Akinyele and Ibadan North) were purposively selected based on a large number of Primary Healthcare centres available in the local government areas. Similarly, the PHCs were purposively selected based on how large the number of women available for the study was and how conducive the locations were for intervention.

A screening test was administered to 205 married women in the three locations using the Childhood Trauma Questionnaire-short form (CTQ-SF/MEQ). The purpose of the screening test was to identify women who had experienced childhood trauma. The CTQ-SF/MEQ has 28 items with a minimum score of 28 and a maximum of 140. Respondents who scored 50.0% and above of the distribution were used in the study, while those who scored below did not participate. A total of 116 married women (married between 1-10 years) who received medical services at Primary Healthcare Centres of the selected local government areas were eligible for participation in the study. The centres were randomized into CPT, SIT, and control groups respectively.

Table 3.2 Sampling Distribution for the Treatment

	N
Iwo Road Centre (CPT)	**40**
Ojoo Centre (SIT)	**41**
Agbowo Centre (Control)	**35**

Ten participants from each of the two treatment centres (CPT and SIT) making a total of twenty women, took part in the Focus Group Discussion. They were purposively selected through voluntary and active participation.

3.4 Inclusion Criteria

The following criteria were used in selecting married women. These included married women:

- who as children, experienced physical, emotional, sexual abuse or neglect, however, without severe traumatic stress symptoms;
- who were registered in Primary Healthcare services (Iwo Road, Ojoo, and Agbowo), Ibadan, Oyo State;
- who have been married between 1 to 10 years;
- who were both physically and emotionally fit to participate in the study;
- who could write/express themselves in English and/or the Yoruba language.

3.5 Control of extraneous variables

The researcher guarded against the effects of extraneous variables by considering the following:

- appropriate randomisation of the participants into the two treatment and non-treatment groups.
- adherence to the inclusion criteria.
- effective use of the 3 x 2 x 3 factorial matrix and the analysis of covariance (ANCOVA) statistical tool.

3.6 Instrumentation

Two categories of instruments were used: response and stimulus instruments. There were five types of response instruments, namely:

- ENRICH Marital Satisfaction (EMS) Scale
- Myers-Briggs Type Indicator-Short version (MBTI-SV)
- Spousal Support Scale (SSS)
- Childhood Trauma Questionnaire-Short Form (CTQ-SF/MEQ) for screening
- Focus Group Discussion Schedule (FGD)

The five response scales were interpreted to the Yoruba language by experts in the language. This was to enable the participants who can speak, read, and write in Yoruba language only to have the opportunity to understand the sessions as well as respond appropriately to the scales.

The three stimulus instruments were CPT, SIT (treatment), and Control (non-treatment) packages. There were also three training manuals for the stimulus instruments:

- Cognitive Processing therapy
- Stress Inoculation therapy
- Control

The three stimulus instruments were discussed in subsection 3.8.

3.6.1 ENRICH marital satisfaction (EMS) scale

The ENRICH (Evaluation and Nurturing Relationship Issues, Communication and Happiness) Marital satisfaction scale is a 15-item instrument adapted from Fowers and Olson (1993). The focal point of the instrument is based on how spouses perceive marital satisfaction in their union. The authors used a Likert scale of 5 points: 5= Strongly agree, 4= Agree, 3= Neutral (Undecided), 2= Disagree and 1 =Strongly disagree. In this study, the instrument was used on married women who have experienced childhood trauma intending to test the level of satisfaction in their marriages. Some of the items were: *my partner and I understand each other; I have some needs that are not being met by our relationship.* The scale consisted of 5 items described as idealistic distortions which were overly positive evaluations of marriage thus denying the existence of challenges, for example; *my partner completely understands and sympathises with my every mood* while the other 10 domains like *I have some needs that are not being met by our relationship* were based on marital quality (See Appendix 1). Raw scores were calculated by the reverse. Its concurrent validity was .73 with a Locke-Wallace Marital Adjustment test measuring common areas of satisfaction and conflict in marriage. This instrument was revalidated using 31 married women who were not part of the samples of the main study. The Cronbach alpha of .771 (See Appendix 13 A and B) was established indicating that the instrument is valid and reliable because it (Cronbach alpha) showed a measure of construct validity and internal consistency of the rating scale. Three items were removed because they correlated negatively with the scale. Examples were: *our relationship is a*

perfect success; my partner and I understand each other perfectly. This left a total of 12 items.

3.6.2 Myers-Briggs type indicator-short version (MBTI-SV)

The MBTI-SV scale was adapted from Myers (1962). It is a 20-item instrument that helped to identify an individual's personality type (extrovert or introvert). For each domain, the respondent was expected to indicate (circle a/b) as it best described their personality. Examples of some items were: *a) you like to use up energy so you enjoy groups or b) you conserve energy so you enjoy one on one; a) you interpret life events factually or b) you look for meaning and possibilities in life events* instead of *a) expend energy, enjoy groups or b) conserve energy, enjoy one on one; a) interpret literally or b) look for meaning and possibilities.* Some words like *literally, and reticent* were replaced with *factual* and *quiet* respectively. Furthermore, to be able to categorize participants into extrovert or introvert types, serial numbers which were given to them during the screening exercise were used to identify their responses. Based on this, higher scores between the two indicated the dominant proxemics to each personality type (See Appendix 2). The instrument was administered to 31 married women who were not part of the main study to validate it. The Cronbach alpha of .965 (See Appendix 14) was established showing that the instrument is valid and reliable. This indicated that Cronbach alpha showed a measure of construct validity and internal consistency of the rating scale. No items were removed.

3.6.3 Spousal support scale (SSS)

This instrument which was also adapted from Yildrim (2004) was previously developed in the Turkish language with responses comprising: *appropriate for me; particularly appropriate for me,* and *not appropriate for me*. It was designed to measure the perceived support that spouses think they gain from each other. It was translated to English Language using *Google Translate* by the researcher; thus some of the items were rewritten. For instance, *it cares about my vision and wishes* was changed to *my spouse cares about my goals, desires, and visions.* In this study, the Likert scale of 5=Every time, 4= Frequently, 3= Sometimes 2= Rarely 1= Never was used. The respondents were asked to tick (√) the appropriate column that best describes their opinion on each of the

items. They were further informed that their responses would be treated with the utmost confidentiality. The instrument consisted of five dimensions namely: emotional, informational, validation, appraisal, and instrumental support. Section A included the respondents' background information such as age, religion, tribe, and years of marriage. Section B had 27 items. Some of the items were: *my husband does not really understand; my spouse hides many things from me; he does not share with me.* The responses of the participants were categorized into three using percentile ranks. Those who were between the lowest scores and 33.3% were categorized as low support; those between 33.4% and 66.7% were grouped as moderate support while those in the percentile 66.8% to 100% were regarded as high support (See Appendix 3). The instrument was administered to 31 married women who were not part of the main study to validate the instrument. The Cronbach alpha of .959 (See Appendix 15) was established showing that the instrument was valid and reliable; again, this is an indication that the Cronbach alpha showed a measure of construct validity and internal consistency of the rating scale. No items was removed.

3.6.4 Childhood trauma questionnaire-short form (CTQ-SF)

The CTQ-SF was developed by Bernstein, Stein, Newcomb, Walker, Pogge, Ahluvia, Stocks, Handelasman, Medrano, Desmond, and Zule (2003). It was adapted as a screening tool to measure for childhood trauma history of the participants in the study. **Note:** The title of this instrument in Appendix 4 is tagged 'Marriage Enhancement Questionnaire' (MEQ) to prevent any form of embarrassment, stigmatization, or fear the participants could experience as a result of taking part in the study. Four areas of childhood trauma (physical, emotional, sexual abuse, and neglect) were measured. Questions were asked about some of the early traumatising experiences the participants had as they were growing up as young children and teenagers between ages 1-17. For each question, the respondents were expected to circle the number that best described how they felt. Although some of these questions were personal, the respondents were expected to try to answer as honestly as possible. The answers were kept confidential and anonymous. The response format was 1= Never true, 2= rarely true, 3= sometimes true, 4= often true, and 5= very often. Examples of the questions were: *I knew that there was someone to take care of me and protect me. People in my family called me names like*

stupid, lazy, or ugly were changed to *some people in my family called me names like stupid, lazy, or ugly.* The Marriage Enhancement questionnaire (originally CTQ-SF) has 28 items with a minimum score of 28 and a maximum of 140. The scale was used to screen those who had experienced childhood trauma from those who had not. Those women who did were identified by their scores on this scale. Any married woman who scored 50.0% and more than the main value was categorized as having childhood trauma while those who had minimum scores to mean scores were not considered for this study. The instrument was administered to 31 married women who were not part of the main study to validate the instrument. The Cronbach alpha showed a measure of construct validity and internal consistency of the rating scale with the established value of .932 (See Appendix 16) indicating that the instrument was valid and reliable. None of the items was removed.

3.6.5 Focus group discussion guide

The Focus Group Discussion (FGD) guide was used to interrogate the findings of the quantitative data. Five main questions which focused on marital satisfaction, personalities, spousal support, and coping marital strategies (See Appendix 5) were discussed. The FGD guide was given to experts in qualitative research for face validity.

3.7 Procedure for data collection

A letter of introduction was obtained from the Head of the Department of Counseling and Human Development Studies, Faculty of Education, University of Ibadan (see Appendix 19). Copies of the letter were presented at the Oyo State Ministry of Health, Secretariat, Ibadan, and at the offices of the local government health authority in charge of the three Primary Healthcare centres (Ibadan North East, Akinyele, and Ibadan North). Ethical approvals to ensure adherence to ethical principles as well as standards were obtained from both the Oyo State Ethical Review Committee, Ministry of Health, Secretariat, Ibadan and the Social Sciences and Humanities Research Ethics Committee, University of Ibadan, Oyo State (see Appendix 20). The offices of the local government health authority then issued letters (see Appendix 21) that were submitted to the Primary Healthcare centres (Iwo Road, Ojoo, and Agbowo).

An informed consent form emphasizing the voluntariness and confidentiality of the study was issued in English and Yoruba languages by the researcher. The researcher also visited the centres to get acquainted with the health workers and participants. Those visitations also briefly informed them about the purpose of the study and its benefits. In addition to this, they were verbally assured that all responses would be treated with utmost confidentiality and anonymity. The participants were also informed that they were free to withdraw from the study any time they wished to. The study was carried out in four stages of activities: pre-sessional, pre-test, intervention, and post-test. In the course of pre-sessional activities, letters of introduction were obtained; research assistants who were fluent in English and Yoruba languages were recruited and trained with manuals (both English and Yoruba versions) based on the use of the stimulus instruments (cognitive processing, stress inoculation therapy and control). The screening of the participants (using Childhood Questionnaire-Short Form; MEQ) was done at the pre-sessional stage. The three selected centres were assigned to the treatment and non-treatment groups, using random sampling (two experimental and one control group).

At the pre-test stage, the following instruments were administered to the participants in the three groups: ENRICH Marital Satisfaction (EMS) scale; Myers-Briggs Type Indicator-short version (MBTI-SV); Spousal Support Scale (SSS); Childhood Trauma questionnaire-short form (MEQ). All response instruments were translated from the English language to the Yoruba language. Before the commencement and use of the treatment packages, the participants were encouraged to complete and sign an informed consent form (see Appendix 12). This form informed them about their right to participate or not. Furthermore, it explained that the study was a cost-free intervention with no risks involved. In addition to this, the researcher emphasized that they were free to opt out of the study any time they chose to. At the intervention stage, the two experimental groups were exposed to the eight sessions of the treatment packages while the control group did not have any treatment. Each session lasted for an average of 60 minutes. The first group was exposed to cognitive processing therapy while the second group was familiarized with stress inoculation therapy and the control group was given no treatment. At the post-test stage, the ENRICH was administered to the participants in

the three groups. The scores of the participants in the three groups were collated for data analysis.

At the end of the interventions, 20 participants (10 from each group) were purposively selected to take part in three sessions of the focus group discussion based on their voluntary and active participation. The discussions focused on marital satisfaction, childhood trauma, personality types, spousal support, and marital coping strategies. The different dimensions of the themes were broken into seven questions. The participants were informed beforehand that the sessions would be recorded and pictures would also be taken in the course of discussions. However, they were assured that their identities would remain hidden and undisclosed.

A research assistant was trained to serve as a moderator to facilitate discussions in the groups. Again, rules guiding the conduct of participants and the facilitator during the FGD sessions were read. They were told that every participant was free to express themselves, however, no one was allowed to be intimidated. The importance of confidentiality was reiterated. Participants were also informed that no answer would be judged as right or wrong; therefore, each person's perspective would be respected. Finally, they were informed that negative or judgmental comments would not be allowed. General and simple questions were asked to initiate contributions from each person. The moderator was empathetic about the issues of childhood trauma that were raised and also ensured that the quiet and shy participants were involved in the discussion; however, this was done without pressure. The moderator also expressed appreciation to the participants for their comments and responses which made interactions interesting and purposeful.

3.8 Synopsis of the treatment packages

Experimental Group One: cognitive processing therapy (CPT) without the trauma account.

Session 1: General introduction, orientation, and pre-test administration.

Session 2: Psychoeducation; introduce CPT and the 3Rs goals (recognize, reinterpret, and recover), recognition of problematic thoughts, feelings, and behaviour. Identification of stuck points, and writing the first impact statement.

Session 3: Considering how thoughts and feelings emerge after a traumatic incident considering safety issues with self, spouse, and others.

Session 4: Challenging negative beliefs pertaining to trust issues with self, spouse, and others.

Session 5: Evaluating negative beliefs affecting intimacy issues with self, spouse, and others.

Session 6: Challenging negative beliefs involving power /control issues with self, spouse, and others.

Session 7: Disputing negative beliefs relating to esteem issues with self, spouse, and others. Writing the second impact statement.

Session 8: Review of therapy, post-test administration, appreciation, and conclusion.

Experimental Group Two: Stress Inoculation Therapy (SIT)

Session 1: General introduction, orientation, and pre-test administration.

Session 2: Psychoeducation; explain the meaning of childhood trauma and how it affects the thoughts, as well as feelings, of an individual, including how there is a link between thoughts, feelings, and behaviour.

Session 3: Introduction to SIT and the purpose/benefits of the intervention.

Session 4: Clarification on how to identify triggers and minimize the effects of stress symptoms through the use of action and coping skills.

Session 5: Explanations and training on action skills; progressive muscle relaxation, deep breathing exercises, guided imagery techniques, and thought diversion strategies.

Session 6: Discussions and training on coping skills; positive self-talk, assertiveness techniques, thought-stopping skills, and problem-solving approaches. Role play (1) was simulated to follow through with discussions and training. The role play (1) was summarized to the Yoruba language for the non-English speaking participants. Various types of cognitive distortions along with using cognitive restructuring techniques in forming and establishing neural pathways were highlighted.

Session 7: Application of action and coping skills to problem-related situations through role play (2). Again, the summary of role play (2) was done in Yoruba language for the non-English speaking participants.

Session 8: Review of therapy, posttest administration, appreciation, and conclusion.

Experimental Group Three: Control (with no treatment)

Session 1: Introduction and pretest

Session 2: The discussion was on journalism; its definition, types, functions, and purpose were examined.

Session 3: Post-test and conclusion.

3.9 Data analysis

For the quantitative aspect of the study, the analysis of covariance (ANCOVA) was the major statistical tool. It was used to partial out the initial mean differences between the three groups. Since there were differences in the post-test scores, estimated marginal means were used to estimate the strength of the differences; moreover, the direction of differences was determined using Sidak post-hoc pair comparison analysis. In addition, the interaction effect was significant thus requiring a graphical representation to determine the nature of the interaction. For the qualitative component, the recorded discussions were transcribed, and content analysed. These helped to further probe and evaluate the quantitative data, thus enhancing a more profound understanding of underlying intricacies existing in the marital institution.

3.10 Ethical consideration

Ethical approval: This was sought from the Oyo State Ethical Review Committee, Ministry of Health, Secretariat, Ibadan, and the Social Sciences and Humanities Research Ethics Committee of the University of Ibadan, Oyo State.

Confidentiality of data: Information which was obtained from the participants will be kept strictly confidential. Names were not required from the participants. Numbers were assigned to them to merge the pre-test and post-test scores which nevertheless will not be used to trace the participants. Hence, the information provided in the research instruments remains anonymous.

Beneficence: The findings of this study were beneficial to the participants because it helped to provide an understanding of how marriages decline especially since solutions were proffered as to how they can be sustained. This study included two treatment packages which were designed to improve the quality of life of those participating. The participants acquired enduring coping skills to enhance their marital satisfaction which

could improve as they adhere to the tenets of the two interventions: cognitive processing and stress inoculation therapies.

Non-maleficence to the participants: The study did not pose any threat or danger to the participants.

Voluntariness: The participants were free to withdraw their participation in the study any time they wished to do so. They were not forced or persuaded to continue against their wish.

Procedure was translated: The procedure was translated to the Yoruba language by experts for the benefit of the non-English language-speaking participants.

CHAPTER FOUR
RESULTS AND DISCUSSION

This chapter presents the results obtained from the study. This is done based on the analysis of the seven hypotheses formulated for the study and the results of the qualitative (FGD) data. Explanations have also been given following the findings of previous empirical studies.

4.1 H_O1: There is no significant main effect of treatment (cognitive processing and stress inoculation therapies) on marital satisfaction of women with childhood trauma in Ibadan.

To test this hypothesis, Analysis of Covariance (ANCOVA) was used to analyse the post-test scores of the marital satisfaction of women with childhood trauma in Ibadan using the pre-test scores as covariates. This was to ascertain if the post-experimental differences were statistically significant.

The summary of the analysis is presented in Table 4.1.

Table 4.1. Summary of 3x2x3 analysis of covariance (ANCOVA) post-test for marital satisfaction of women with childhood trauma in Ibadan

Source	Sum of Squares	Df	Mean Square	F	Sig.	Partial Eta Squared
Corrected Model	7295.981	18	405.332	6.430*	.000	.544
Intercept	9424.758	1	9424.758	149.511*	.000	.607
PRE EMS (Covariate)	119.739	1	119.739	1.899	.171	.019
Treatment	3527.016	2	1763.508	27.976*	.000	.366
Personality Type	226.375	1	226.375	3.591	.061	.036
Spousal Support	1451.227	2	725.613	11.511*	.000	.192
Treatment * Personality Type	391.282	2	195.641	3.104*	.049	.060
Treatment * Spousal Support	397.846	4	99.461	1.578	.186	.061
Personality Type * Spousal Support	230.285	2	115.143	1.827	.166	.036
Treatment * Personality Type *Spousal Support	38.122	4	9.530	.151	.962	.006
Error	6114.597	97	63.037			
Total	259511.000	116				
Corrected Total	13410.578	115				

R Squared = .544 (Adjusted R Squared = .459)

Key: *Sig at 0.05

Table 4.1 revealed that there was a significant main effect of treatment on marital satisfaction of women with childhood trauma in Ibadan ($F_{2;97} = 27.98$, $P < 0.05$, $\eta^2 = 0.37$). This means that there was a significant difference in the mean scores of the marital satisfaction of women with childhood trauma in Ibadan exposed to cognitive processing therapy (CPT) and stress inoculation therapy (SIT), when compared with the control group. Hence, the null hypothesis stated was rejected. The table also showed a contributing effect size of 37.0%. This implies that 37.0 % of the variance in marital satisfaction of women with childhood trauma in Ibadan was accounted for by the treatment (CPT, SIT, and control). This also means that cognitive processing therapy (CPT) and stress inoculation therapy (SIT) are both effective forms of intervention on the marital satisfaction of women with childhood trauma in Ibadan. To further provide some information on marital satisfaction of women with childhood trauma in Ibadan among participants in the three groups (CPT, SIT, and Control), it was imperative to determine the magnitude of the mean scores of the participants in each of the treatments and the control group. Therefore, the estimated marginal mean score was calculated and presented in Table 4.2

Table 4.2 Estimated marginal mean

			95% Confidence Interval	
Treatment	**Mean**	**Std. Error**	**Lower Bound**	**Upper Bound**
CPT	49.782	1.357	47.089	52.474
SIT	50.015	1.308	47.420	52.610
Control	37.062	1.430	34.223	39.901

The following observations were made from Table 4.2; showing that married women exposed to SIT had the highest marital satisfaction (50.02) followed by CPT (49.78) and control (37.06). To determine the direction of the differences, Fisher's LSD was not suitable for use in this study because the number of participants for the three levels of experimental and control groups was not equal. In addition, even though Bonferroni is widely used, Sidak post-hoc analysis possesses more statistical strength (King and Eckersley, 2019). Sidak also has tighter bounds than Bonferroni (Lee, Dunis, Lowe and Anders, 2016); therefore, it was more suitable as presented in Table 4.3.

Table 4.3 Sidak post-hoc analysis showing differences in the treatment groups

		Subset for alpha = 0.05	
	N	**1**	**2**
CPT	**40**	49.782	
SIT	**41**	50.015	
Control	**35**		37.062

The following observations were made from Table 4.3:

(i) There was no statistically significant difference in the post-hoc test mean scores obtained by participants in the CPT and SIT treatment groups on marital satisfaction of women with childhood trauma in Ibadan. However, the participants in the SIT group (Mean = 50.02) benefited slightly more than those in the CPT group (Mean = 49.78).

(ii) There was a significant difference in the post-hoc test mean scores obtained by participants exposed to SIT and the control group. The mean scores of participants in SIT (Mean = 50.02) were significantly better than those in the control group (Mean = 37.06) on marital satisfaction of women with childhood trauma in Ibadan.

(iii) There was a significant difference in the post-hoc test mean scores obtained by participants exposed to CPT and the control group. The mean scores of participants in CPT (Mean = 49.79) were significantly better than those in the control group (Mean =37.06) on marital satisfaction of women with childhood trauma in Ibadan.

This showed that there was a significant difference between the mean scores of participants in CPT, SIT and those in the control group. Also, SIT was more effective in the two groups than the control group, thus indicating that the intervention had the greatest potency on the marital satisfaction of women with childhood trauma in Ibadan than CPT and control groups.

4.2 H_O2: There is no significant main effect of personality types (Extrovert and Introvert) on marital satisfaction of women with childhood trauma in Ibadan.

The results from Table 4.1 showed that there was no significant main effect of personality types on the marital satisfaction of women with childhood trauma in Ibadan ($F_{1, 97} = 3.591$, $P > 0.05$, $\eta^2 = 0.036$). This means there is no significant difference in the mean scores of personality types on marital satisfaction of women with childhood trauma in Ibadan. Hence, the null hypothesis two was not rejected.

4.3 H_O3: There is no significant effect of spousal support (low, moderate and high) on marital satisfaction of women with childhood trauma in Ibadan.

The results from Table 4.1 showed that there was a significant main effect of spousal support on marital satisfaction of women with childhood trauma in Ibadan ($F_{2, 97}$ = 11.51, $P < 0.05$, η^2= 0.192); meaning that there was a significant effect of spousal support **(**that is; low, moderate and high) on the marital satisfaction of women with childhood trauma in Ibadan. Hence, the null hypothesis three was rejected. Table 4.1 also displayed a contributing effect size of 19.2%. This means that 19.2% of the variance in marital satisfaction of women with childhood trauma in Ibadan was accounted for by spousal support.

Furthermore, to provide information on the extent to which spousal support on marital satisfaction of women with childhood trauma in Ibadan among participants at the three levels (low, moderate, and high), the magnitude of the mean scores of the participants in each of the levels was computed as shown in Table 4.4. Consequently, the estimated marginal mean was calculated and presented in Table 4.4.

Table 4.4 Estimated marginal mean

			95% Confidence Interval	
Spousal support	**Mean**	**Std. Error**	**Lower bound**	**Upper bound**
Low	40.636	1.465	37.729	43.543
Moderate	50.691	1.473	47.767	53.615
High	45.532	1.172	43.206	47.857

Table 4.4 confirmed that the mean score of participants with moderate spousal support (50.69) was the highest, therefore, showed utmost marital satisfaction. This was followed by those who had high spousal support (45.53) and lastly, by those with low spousal support (40.67). To determine the direction of differences, Sidak post-hoc analysis was used as presented in Table 4.5.

Table 4.5 Sidak Post-Hoc analysis showing differences in spousal support levels

	Subset for alpha = 0.05		
	1	**2**	**3**
Low	40.636		
High		45.532	
Moderate			50.691

The following observations were made in Table 4.5.

(i) There was a statistically significant difference in the post-hoc test mean scores of the marital satisfaction of married women with childhood trauma in Ibadan in the low, moderate, and high levels of spousal support. It however confirmed that the participants in the moderate levels (Mean = 50.69) benefited significantly more than those in the high levels of spousal support (Mean = 45.53).

(ii) There was a significant difference in the post-hoc test mean scores of participants with moderate and low levels of spousal support. Furthermore, the participants with moderate levels of spousal support (Mean = 50.69) on marital satisfaction of women with childhood trauma in Ibadan significantly scored better than those with low levels of spousal support (Mean = 40.64).

(iii) There was a significant difference in the post-hoc test mean scores of participants with moderate spousal support compared to participants with high and low levels of spousal support. The participants in high and low levels of spousal support had Mean = 45.53 and 40.64 respectively. This indicated that there was a significant difference between the score of participants in moderate, high, and low levels of spousal support in the marital satisfaction mean score. While those in moderate and high showed more marital satisfaction of women with childhood trauma in Ibadan than those with low-level spousal support.

4.4 H_O4: There is no significant interaction effect of treatment and personality types on marital satisfaction of women with childhood trauma in Ibadan.

The results from Table 4.1 revealed that there was a significant interaction effect of treatment and personality types of marital satisfaction of women with childhood trauma in Ibadan ($F_{2,97} = 3.104$, $p < 0.05$, $\eta^2 = 0.060$), and the hypothesis was, therefore, rejected. This showed that the combination of the therapies (CPT and SIT) and personality types (introvert and extrovert) have a significant interaction effect on marital satisfaction of women with childhood trauma in Ibadan. The interaction effect was explained using the following graph.

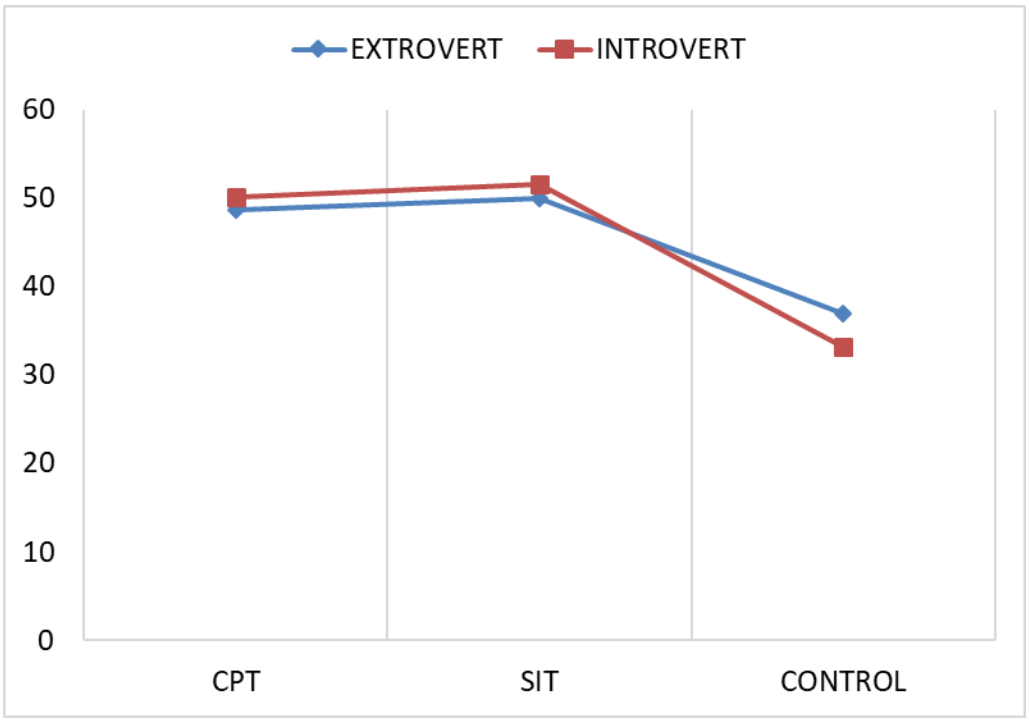


Figure 4.1 Interaction Effect of Treatment (CPT, SIT, and Control) and Personality Types (extroversion and introversion) on marital satisfaction of women with child hood trauma, Ibadan.

Figure 4.1 shows the interaction effect of treatment (CPT, SIT, and Control) and personality types (extroversion and introversion) on marital satisfaction of women with childhood trauma in Ibadan. The interaction is disordinant because introverted participants in the treatment groups were leading in CPT and SIT, but those in the control group scored lower.

Furthermore, introverted participants, benefited more from CPT and SIT as it helped to improve their marital satisfaction more than the extroverted participants. On the other hand, extroverted participants were more enhanced in marital satisfaction than the control group.

4.5 H_O5: There is no significant interaction effect of treatment and spousal support on marital satisfaction of women with childhood trauma in Ibadan.

The results from Table 4.1 confirmed that there was no significant interaction effect of treatment and spousal support on marital satisfaction of women with childhood trauma in Ibadan ($F_{4, 97} = 1.578$, $p > 0.05$, $\eta^2 = 0.061$). The null hypothesis was therefore not rejected.

Table 4.6 Juxtaposing Treatment and Spousal Support

	Spousal Support		
Treatment	**Low**	**Moderate**	**High**
CPT	46.17	51.33	50.81
SIT	44.5	54.23	52.11
CONTROL	31.00	43.80	34.93

This indicated that the interaction of the therapies (CPT and SIT) with spousal support (low, moderate, and high) was not significant in the marital satisfaction of women with childhood trauma in Ibadan.

4.6 H_O6: There is no significant interaction effect of personality types and spousal support on marital satisfaction of women with childhood trauma in Ibadan.

The results from Table 4.1 indicated that there was no significant interaction effect of personality types and spousal support on marital satisfaction of women with childhood trauma in Ibadan ($F_{2, 97} = 1.827$, $p > 0.05$, $\eta^2 = 0.036$).

Table 4.7 Juxtaposing personality type and spousal support

	Spousal support		
Personality type	**Low**	**Moderate**	**High**
Extrovert	42.0	54.08	45.1
Introvert	39.5	48.26	47.34

The implication is that personality types and spousal support have no interaction effect on the marital satisfaction of women with childhood trauma in Ibadan. Hence, hypothesis six was not rejected.

4.7 H_O7: There is no significant interaction effect of treatment, personality types, and spousal support on marital satisfaction of women with childhood trauma in Ibadan.

Table 4.1 revealed that there was no significant interaction effect of treatment, personality types, and spousal support on marital satisfaction of women with childhood trauma in Ibadan ($F_{4, 97} = 0.151$, $p > 0.05$, $\eta^2 = 0.006$).

Table 4.8 Juxtaposing treatment, personality types, and spousal support

	Extrovert			Introvert		
	Spousal Support			Spousal Support		
Treatment	**Low**	**Moderate**	**High**	**Low**	**Moderate**	**High**
CPT	46.17	52.67	49.29	46.17	50.89	52.00
SIT	45.17	55.17	49.67	43.5	53.43	53.33
CONTROL	34.67	53.33	37.00	25.5	39.71	33.13

This meant that the combination of treatment, personality types, and spousal support had no interaction effect on marital satisfaction of women with childhood trauma in Ibadan. Thus, the hypothesis seven was not rejected.

4.8 Qualitative analysis of the data obtained (FGD):

Focus group discussion (FGD) was conducted using 10 respondents from each group (CPT and SIT), a total of 20 women. The following questions were used to generate discussions and elicit responses among the participants:

1)What precipitates marital satisfaction?

2) What precipitates marital dissatisfaction?

- How has it affected someone you know?
- How has it affected you?

3) How does childhood trauma affect married women?

- How has it affected someone you know?
- How has it affected you?

4) What strategies are being used to facilitate satisfaction in marriages?

5) What is your personality type?

6) With your personality type, which of these strategies work for you?

7) What areas of spousal support can bring you marital satisfaction?

4.9 Qualitative analysis of the data obtained in the focus group discussion

The focus group discussion was conducted to gather in-depth insight into marital challenges and to also explain the quantitative data. A total number of 20 participants, ten women from both CPT (group 1) and SIT (group 2) took part in the focus group discussion. Three sessions were conducted. Respondents were identified using the identification numbers that were given initially during the screening exercise.

Cognitive processing therapy (Group One)

All respondents were females married between 1-10 years. The FGD was held on Friday, the 12th of November, 2021 at the PHC of Iwo Road, Ibadan North East Local Government Area. Each session lasted for 30 minutes, beginning at 10:00 am and ending at 11:30 am.

Session one

The respondents were asked to explain what they perceived as marital satisfaction and dissatisfaction. Many agreed that relationship satisfaction involved happiness, while dissatisfaction was described as an unhappy state, characterized by feelings of disappointment, sorrow and displeasure especially based on couples' needs not being met in their marriages.

What precipitates marital satisfaction and dissatisfaction?

Respondents 8 (30 years), 6 (26 years) and 55 (28 years) stated that love, trust, provision from the husband, agreeing on issues together and contentment can produce marital satisfaction, while mistrust, quarrelling, stinginess, and a distraught countenance could produce marital dissatisfaction.

Respondent 2 (33 years) revealed that forced marriages could also cause dissatisfaction. Respondent 56 (29 years) agreed to this, adding that it could even cause mental health issues, misunderstandings and divorce.

How has it affected you? How has it affected someone you know?

Respondent 2 (33 years) observed that someone she knows who is affected by dissatisfaction was often unhappy and moody.

Respondent 68 (31 years) said, *for me, I am satisfied with my marriage and happy because there is love. We can agree on issues and we have the same interests. We can even help each other. We love each other and we love our child too.* Respondent 8 agreed with this, reiterating that she is equally happy because, *anything we want to do, we discuss it together before we do it.*

Session Two

How does childhood trauma affect marital satisfaction?

All respondents agreed that childhood trauma can affect married women and their ability to be satisfied. Respondents 13 (33 years) and 69 (30 years) commented that it can bring unhappiness, fear, anxiety, and their attitude towards life becomes *too serious*, thus making them seem rigid, hostile or unfriendly. Again, Respondent 69 (30 years) reiterated that anytime they remember the unfortunate incident, they could withdraw from

others. She listed such incidents as accidents, robbery and maltreatment from relatives or friends.

How has it affected you? How has it affected someone you know?

Respondents 56 (29 years), 13 (33 years) and 55 (28 years) spoke about their personal experiences. They described how they each felt ignored by some trusted adults who did not monitor them properly, thereby leading to accidents. They stated that those accidents have caused feelings of fear and anxiety. Respondent 7 (24 years) revealed that an armed robbery attack which took place when she was a child, has caused her much fear and anxiety about life. She added that she sometimes does not sleep well because any unfamiliar noise at night would make her feel tensed and afraid. Respondent 2 (33 years) stated that this was true because living in anxiety has made her oversensitive as she was terribly affected by her mother's verbal assaults in childhood. Conversely, Respondent 15 (28 years) explained that her mother's encouraging words and oriki (accolades in Yoruba language) like calling her *the child of a warrior* has made her able to face the challenges of life, especially marital tensions. Most respondents agreed that childhood trauma has caused several difficulties in their lives and those of people they know, such as low self-esteem, anxiety and living with painful memories.

Session Three

What strategies are being used to facilitate satisfaction in marriages?

Respondents emphasized loneliness and lack of contentment as reasons that homes are destroyed; while togetherness, agreement and doing what can make an individual happy can produce harmony. When the respondents were asked to list what could make an individual happy, Respondents 8 (30 years), 68 (31 years) and 13 (33 years) listed some as: eating well, sleeping well, and visiting friends. Respondents 2 (33 years), 68 (31 years), and 55 (28 years) also added to the list by stating that dressing well, respecting one's husband, forgiveness, patience, having some source of livelihood as well as living peacefully with others like extended family members, could bring satisfaction in marriage.

What is your personality type?

With your personality type, which marital coping strategies work for you?

Respondent 56 said:

> I like people praising me while I am busy and I like people begging me when I am angry. My husband knows this and does just that. Again, when I am angry, I like to confide in someone else other than my husband. This has helped me in my marital relationship (**FGD, CPT, 29 years, PHC Iwo Road, Saturday 12th of November, 2021**).

Respondent 55 (28 years) stated that talking about her grievances have also helped her to overcome the challenges in her home. She further explained that her husband understands her, so it is helpful. Respondent 2 (33 years) however, brought a different dimension. She explained that even though she is a gentle person who gets anxious in crowded places, she can get very angry. She said she finds it difficult to forget past faults done to her by others. She added that though she is working on these feelings, she still sees herself as hot-tempered. When she was asked how she copes with this attitude in her marriage, her response was *everybody minds their own business.*

Respondent 69 (31 years) asserted that she is an outspoken person who becomes enraged when apologies are made in a bid to keep her from expressing herself. She explained further that what she wants to say has to be said and she added, *if parties involved do not feel like talking to me thereafter, I will not mind. It also works for me in my marriage.* Respondent 8 (30 years) revealed, *I like to shout. I hate hypocrisy. I hate lies. I like it when my spouse tells me the truth and also when he understands when I feel hurt.* As a rejoinder to the clarification given by Respondent 8 (30), Respondent 13 declared that:

> Before marriage, I could keep malice with people for years. I have kept malice with a friend for five years, but I stopped this after marriage. I try to be patient with my husband though I still keep a record of offences. My husband helps me by patiently settling issues that hurt me (**FGD, CPT, 33 years, PHC Iwo Road, Saturday 12th of November, 2021**).

To this, respondent 68 highlighted that:

> It is my husband that does the keeping of wrongdoings. He can keep malice for years. When he is angry with me, he will not eat nor sleep in our bed, though he will keep money for our upkeep. When we initially got married, I would frequently beg him each time he

> said I wronged him but now I leave him till he gets over his annoyance. I understand him so it works for us (**FGD, CPT, 30 years, PHC Iwo Road, Saturday 12th of November, 2021**).

Respondent 56 acknowledged this as she pointed out:

> My husband is like that, whenever I plead with him too much over whatever it is that upsets him, he seems to become more hostile. So, I stopped begging him. Usually, when he is tired of sulking, his mood improves (**FGD, CPT, 29 years, PHC Iwo Road, Saturday 12th of November, 2021**).

What areas of spousal support can bring you marital satisfaction?

Respondent 13 (33 years) said that support especially during pregnancy like financial aid, good food, and helping with other children in the house can be helpful. Respondent 2 (33 years) observed that some husbands are only more patient and compassionate when their wives are pregnant, but this should be corrected. Women should be treated well like queens even when not pregnant.

Respondents 56 (29 years), 15 (28 years) and 6 (26 years) commented that sex would be better if spouses were more patient. They also agreed that helping with domestic chores would be appreciated; however, Respondent 13 (33 years) retorted that this would make people say that the man is a weakling or the wife is practising witchcraft.

Respondent 69 (30 years) confessed that her spouse is a better cook while Respondent 55 (28 years) claimed that her husband is the opposite. She further admitted that it had been a source of misunderstanding in their home. However, she added that recently he has been making some attempts to help with some kitchen chores.

Several participants agreed that lack of patience and forgiveness can destroy marital harmony. In addition to this, all respondents admitted that understanding each other's differences, displaying affection, giving financial support, assisting with domestic chores, demonstrating appreciation and interest in their wives' well-being can improve their marital satisfaction.

Stress inoculation therapy (Group Two)

All respondents were females married between 1-10 years. The FGD was held on Saturday, the 11th of December, 2021 at the PHC of Ojoo, Akinyele Local Government Area. Each session lasted for 30 minutes, beginning at 10:00 am and ending at 11:30 am.

Session One

The respondents were asked to describe marital satisfaction and dissatisfaction. Respondent 47 (23 years) summarized it as *what one can do in marriage that can bring fulfilment while dissatisfaction would bring lack of fulfilment.* All respondents agreed that this description resonated with them.

What precipitates marital satisfaction and dissatisfaction?

Respondent 1 (26 years) said that when a woman is properly cared for to the extent that she is happy and has peace of mind, then one can say she has marital satisfaction. Respondent 32 (32 years) further listed some of those things that can bring such happiness and peace of mind as financial availability, understanding and healthy communication styles between spouses. In addition to this, she stressed that financial setbacks and constraints can lead to marital dissatisfaction. Respondent 9 (22 years) supported the statement made by Respondent 1(26 years) by confirming that *peace in the house* can lead to marital satisfaction.

Furthermore, respondent 1 (26 years) remarked that marital rape can cause dissatisfaction. This was accepted as a major problem as participants concluded that it was fast becoming prevalent though many affected women were ashamed and afraid to disclose or seek help. Respondent 4 (24 years) also said that frequent misunderstandings, especially caused by a lack of sexual satisfaction and contentment can lead to challenges in the home.

Respondent 41 (25 years) commented that lack of respect especially for the husband and members of his (extended) family can lead to domestic violence or maltreatment. Respondent 1 again remarked that an unemployed man begging his wife for *pocket money* (allowance) will be difficult to respect. This statement was accepted by most of the respondents. Respondent 23 believed that:

> At the time people get married, everything seems fine, but after a while, it shows on the man or woman whether they are happy or not. Even if they can pretend that all is well, the crack begins to show when they have children. People can easily tell when there is something wrong because there is a child in the family. The child will say all that is happening at home. There was a child in my class

> while I was still a nursery and primary school teacher; the child's behaviour made us know that she has a happy home. She was so well-behaved and respectful. Everybody liked her (**FGD, SIT, 30 years, PHC Ojoo, Saturday 11th of December, 2021**).

Respondent 29 (26 years) believed that when one has peace of mind, then supporting one another in marriage will be easy and there will be minor misunderstandings. She added that, when one is unhappy in marriage, aggression is common.

How has this affected you? How has this affected someone you know?

Respondent 4 (24 years) revealed that her marital satisfaction *is not yet 100%, nor is the dissatisfaction 100%* but *it is on middle level.* She explained that endurance, contentment and not comparing herself with others have helped her. In addition to this, she stated that:

> If my husband gives me or not, I am okay. Before marriage, I hated the *shawa* fish (herring) because it is so bony, but during the Covid-19 pandemic, there was nothing we could do but buy it. I ate it because that was what my husband and I could afford. So, I think expecting too much and not accepting reality can bring problems in marriage (**FGD, SIT, 24 years, PHC Ojoo, Saturday 11th of December, 2021**).

> Then Respondent 47 said: For me if a husband is there for his wife, performing all that is expected of him like showering her with love instead of being abusive, can go a long way to make her happy. If he does not care about her situation especially showing no regard for her in pregnancy, there may be little satisfaction. What I can personally say about satisfaction is that once the husband can meet his wife's expectations like assisting her in every possible way, there will be peace. Okay, everything is not about money but showing love, care and spending time is what a woman also wants in marriage. Again, commitment and unity are also necessary. An experience I have though not directly mine is about my sister. When she lost her baby, I saw that her husband discharged all his duties properly. This to me, is highly commendable (**FGD, SIT, 23 years, PHC Ojoo, Saturday 11th of December, 2021**).

Session Two

How does childhood trauma affect marital satisfaction?

All the participants agreed that childhood trauma can affect married women and their marital relationships.

Respondent 21 (38 years) said, *like me, my father and mother loved each other so much. My father cared so much for me, but the time he began to cheat on my mother, things changed and became complicated. He started to maltreat my mother.* From then, she emotionally began to describe how she and her siblings went through this childhood trauma. She revealed that her father went to the extent of physically abusing her mother while she was pregnant. One day, he beat her so much that she was badly injured and urgently rushed to the hospital. Even with that experience, he still did not care about her. She further disclosed that o*ne day, at one o'clock in the morning, she ran away with us. My mother's family eventually got her a house. Later on, the family got tired of taking care of us and sent us all back to my father.* Moreover, she explained that when they returned to their father, things got worse because by then, he had married another wife. While in her father's house, her mother tried to poison herself and all of her siblings, but she was caught. She concluded that infidelity destroyed her parents' marriage. She stressed that she will never remain married to a man who decides to cheat on her or make her life miserable. She accepted that currently, she is experiencing trust issues. She claimed that though she tries not to think of how painful the experiences were, she is trying to heal from the past, as she knows family challenges, such as hers can be damaging.

How has it affected you? How has it affected someone you know?

Respondent 21 (38 years) said that as a result of what she went through in the hands of her father and other relatives, it has made her not close to any family member as she trusts no one. She tearfully claimed that the wounds of the past are still fresh in her mind. She disclosed that she would rather be alone than mingle with others. When asked why, her response was *I don't want trouble.* She reemphasized that she has absolutely intolerance for infidelity. Several respondents sighed in understanding and kind consideration. To answer the previous question, Respondent 1 commented:

> About the question asked as to how it has affected someone I know, I actually know a lady who was affected by childhood trauma. She was raped. This led to her hatred for men and so she never got married. She got pregnant from the unfortunate incident. Her child was affected because she saw him as a product of rape. She had little or nothing to do with her child as he was brought up by his grandmother. The boy grew up to dislike his mother for what he perceived as hostility towards him for no just cause. When he was done with his NYSC (National youth service corp) and was getting ready to marry a beautiful girl, he decided he wanted to disgrace his mother and bring out the matter in the open. He, therefore, took his pain to a radio show summoning his mother to give explanations for her detachment. He did this so that he could reveal her treacherous behaviour. His mother was contacted. She turned up and began to explain the circumstances of his birth. The boy regretted his actions stating that he should have sought a better route to express his pain. The girl he wanted to marry broke off the engagement saying that they could never be happy together (**FGD, SIT, 26 years, PHC Ojoo, Saturday 11th of December, 2021**).

Most respondents reacted to this in shock saying that the situation could have been handled better. Furthermore, they all acknowledged that the effects of childhood trauma can be extensive with profound consequences like depression, high blood pressure and constant marital disputes. Nevertheless, they also recognised that with appropriate support from the husband, the struggling wife may recover and their relationship can thrive.

Session Three

What strategies are being used to facilitate satisfaction in marriages?

Respondent 29 (26 years) felt that *there must be dos and don'ts in marriage. This should entail what spouses should do and not do as the best thing is to do whatsoever your husband expects of you.*

Based on this, Respondent 32 (32 years) stated that; e*ndurance and commitment are important. Don't try to prove stubborn, it will only increase contention.*

> Respondent 24 also observed that: Some occupations, like the banking profession may prevent some women working as bankers from having satisfaction in their marriages. Leaving the house at 3:30 in the morning and returning home late at night can badly affect their family. When I was working in a big company, I almost ruined my marriage. Married women should do jobs that can ensure

> that they can care for their families properly (**FGD, SIT, 26 years, PHC Ojoo, Saturday 11th of December, 2021**).

Respondent 1 disclosed that her present environment is affecting her marriage. She lamented that many youths in her neighbourhood are addicted to *"Colorado*" (a street name for the synthetic variant of marijuana).

> She reaffirmed: It's scary! When I took up extra work to bring money, my first son was admitted to the hospital for infection because I was not taking note of how badly he was being treated in school. I blamed myself much but there were constant financial issues putting pressure on my marriage (**FGD, SIT, 26 years, PHC Ojoo, Saturday 11th of December, 2021**).

What is your personality type?

With your personality type, which marital strategies work for you?

Respondent 23 (30 years) explained that *some of us are outgoing while others like to be indoors.* Respondent 4 (24 years) said that she likes going out which she claimed her husband appreciates about her. In light of this, Respondent 32 (32 years) stated that she does not like being bored. She commented that if she is not going out, then she resorts to using her phone. She concluded that she is a sociable person who constantly likes to have company. She said that her husband also likes the way she is.

Respondent 29 (26 years) explained that she is the opposite, as she prefers to be on her own. She stated that her husband seems to be able to cope with that. She also admitted that people say she can be secretive, which her husband has complained about but has since come to terms with it as her personality.

What areas of spousal support can bring you marital satisfaction?

Respondent 4 (24 years) said that trying to understand each other has helped her marriage. Nevertheless, she added that a spouse who does not participate in household chores can be difficult to live with or even please. Many respondents seemed to agree with this. Respondent 1 (26 years) said she felt that having to work hard to help support the home financially does not allow her to have some time with her spouse. She also complained that some *seductive* females pursue married men distracting them from fulfilling their marital responsibilities.

Respondent 47 (23) felt that money is not everything. She explained that she would like her spouse to show a balanced way of respect for her thereby motivating her to improve

in all her endeavours and to remain faithful to their vows. She also added that *helping others outside the home, like friends, neighbours and extended family members yet treating those inside (that is the wife as well as children) with contempt is deceitful.* All respondents agreed unanimously with this respondent's comment. Respondent 23 (30 years) said, *Spouses keeping their secret issues private and not washing their dirty linen in public, but making some effort to work on their weaknesses can experience peace and harmony.*

All respondents agreed that consideration, acceptance, understanding including support from their spouses like helping with household chores, helping to care for the children, showing affection, being faithful to marital vows and financial assistance would make their marriages more satisfactory.

4.10 Discussion and summary of findings

Hypothesis One: There is no significant main effect of treatment (Cognitive processing and Stress inoculation therapies) on marital satisfaction of women with childhood trauma in Ibadan.

The hypothesis was rejected as revealed in Table 4.1. There was a significant main effect of treatment (Cognitive Processing and Stress Inoculation therapies) on marital satisfaction of women with childhood trauma in Ibadan. This indicated that both cognitive processing and stress inoculation therapies were effective means of treatment on marital satisfaction of women with childhood trauma. This agreed with the findings of Amirpour et al (2017) who reported significant effectiveness of Cognitive Processing therapy on marital satisfaction of war veterans with posttraumatic stress disorder. Again, Bashpoor (2012) indicated that CPT can improve the marital satisfaction of women who survived exposure to infidelity. In light of this, Murray et al (2018) explained that CPT's capacity to focus on cognitive restructuring and reducing avoidance of trauma-related stimuli in individuals who have experienced disturbing events such as childhood trauma can demonstrate its usefulness through challenging negative beliefs about self, as well as others (Monson and Shaider 2014).

Before intervention, Iverson et al (2015) explained that some married women who attested to certain overgeneralized maladaptive thoughts due to childhood trauma, and who also uttered some core negative beliefs, were found to significantly change after treatment.

This was seen in one of the participant's before/after impact statements (see appendix 11, CPT impact statement 1) written by Respondent 38 (25 years), who was sexually molested by a close male friend of the family whom she was very familiar with. She was still a Nursery/Primary school pupil at the time the incident occurred. According to her:

> The traumatic experience left me with trust issues from my childhood, but now I am working on it. When bad things happen, it can take a while to get over the pain and feel safe again but with self-help methods and other strategies taught during the programme, I have discovered at this time that it is possible to recover. As a wife, I am more welcoming to my husband's jokes and sexual advances, something I used to find difficult to do. I feel a lot safer now because I can trust my husband and others better (I**mpact statement, CPT, 25 years, PHC Iwo Road**).

This finding therefore corroborated the work of Iverson et al (2015).

Moreover, Resick, Monson and Chard (2017) buttressed the fact that women who received CPT have reported remarkable improvements in the interpretation of their childhood traumatic events because the intervention produced more self-compassion, making them more hopeful about their future. This report was supported by the findings of this study. Lenz et al (2014) agreed, stating that there would often be remarkable reductions in anxiety, sadness, intrusive thoughts, avoidance and emotional numbing which have been associated with early traumatizing experiences. Additionally, CPT has been known to significantly decrease hopelessness and record improvement in sleep disturbances (Gutner et al, 2013) also linked to early challenges. Similarly, Galovski, Harik, Blain, Elwood, Gloth, Fletcher and Davila (2016) recommended that CPT can be used to assist distraught women using Socratic questioning techniques while giving precedence to beliefs of assimilation and over-accommodation. Moreover, based on how important sexual satisfaction is to marriage, CPT has been used as a successful stigma-reduction intervention for women who have survived sexual violence, since it can induce depression, anxiety, guilt, shame, self-blame and other psychological damages (Murray et al, 2018). Cognitive processing therapy, therefore, has proven to be an effective evidence-based treatment for women who have shown difficulties navigating marital activities as a result of thoughts, feelings and behavoiurs prompted by childhood trauma.

Stress inoculation therapy was found most effective on the marital satisfaction of women with childhood trauma based on the findings of this study. This aligned with the

investigations of Akbari and Khodadadi (2013) who reported that the intervention led to decreased levels of marital conflicts, thereby increasing marital satisfaction. Furthermore, their study acknowledged that living with a spouse who is struggling with the effects of childhood trauma can cause an increase in marital clashes, stress and a decrease in satisfaction. In their conclusion, they recorded that SIT can account for significant benefits and improvements in marital quality. This study reinforced the work of Rabiee, Zahrakar and Farzad (2019) which recommended SIT as mediation for married women declaring that it is an intervention that can be linked with reducing symptoms of prolonged mental, emotional and physical exhaustion thereby increasing women's marital bliss. Hojjat et al (2016) also observed in their study that the hands-on coping skills designed for use in SIT were found stimulating because they helped individuals build resilience and boost enough confidence to deal with difficult situations, thus enhancing functionality.

Shalkouhi et al (2015) also Nikrokh and Zahrakar (2015) explained that infertility and pregnancy are part of the complex issues of marital life which can generate some psychological stress leading to apprehension, despair, and feelings of failure with outcomes like marital dissatisfaction. As a result of this, SIT has proven to be effective in alleviating stress in such complex circumstances as it can build a high level of resilience and tenacity to help couples face life stressors. In addition to this, Brannon, Updegrade and Feist (2021) submitted that SIT can facilitate the learning of adaptive techniques that can boost psychological *immunity* to accelerate healing and increase self-confidence. Shalkouhi et al (2015) maintained that despite the damaging outcomes of childhood trauma, the therapy builds a level of determination that can help individuals face marital issues successfully, while finding meaning in the disturbing experiences such that they even learn to believe in themselves, their spouses and others. Again, another phase of life which affects many women is having their babies for the first time. This is a major transitional life occurrence which could bring about stress characterised by emotional disturbances, affecting marital satisfaction. Odinka et al (2018) confirm that SIT can help to reduce maternal stress while increasing marital satisfaction.

There is a relationship between marital satisfaction and stress. Stress can be encountered in the workplace, as observed in married female bankers and nurses. These

women can be exposed to many stressors such as workplace complaints, schedule pressures, and heavy workloads causing a lack of sexual interest, and a reduction in shared activities, ultimately leading to poor marital satisfaction outcomes (Fawole and Isiaq, 2017; Barzideh et al, 2014). To this end, Spears (2019) identified that married female professionals who are faced with job stressors, reporting low marital satisfaction can benefit enormously from SIT thereby producing significant changes in the cognitive, motivational and emotional areas of behaviour. Stress inoculation therapy has therefore proven to be an effective form of treatment, possessing the ability to ameliorate and improve issues of marital satisfaction. Furthermore, a probable reason why SIT seemed to be a more proficient psychological intervention than CPT was that it was designed with action skills (Uzoechina, 2016) which were easy-to-do hands-on methods as they boosted resilience, distress tolerance, and enhanced confidence (Hojjat et al, 2016; Parker et al, 2012). It was also less stressful because it did not dwell on the memory of the traumatic event, nor did it involve much use of writing like CPT.

Hypothesis Two: There is no significant main effect of personality types (extrovert and introvert) on marital satisfaction of women with childhood trauma.

This hypothesis was not rejected as Table 4.1 showed that there was no significant main effect of personality types (extrovert and introvert) on marital satisfaction of women with childhood trauma in Ibadan. This implied that although marriage is a bond between individuals of different kinds of character, there was no significant correlation between personality types and marital satisfaction. Similarly, this current finding was consistent with the investigations of Webbo (2017) which determined that the effect of personality on marital satisfaction had no link. The findings of this study also aligned with those of Fattahi and Homabadi (2017) who observed no significant relationship between personality types and marital satisfaction. However, investigations like Chehreh, Ozgo, Aboiaali and Nasiri (2018) argued that personality can become a major source of stress producing dissatisfaction because certain beliefs and attitudes can considerably destroy marital relationships. Brudek, Steuden and Jasik (2018) and Amiri, Farhoodi, Abdolvand and Bidakhavidi (2011) agreed with this, maintaining that personality remained statistically relevant to marital satisfaction. Similarly, Myers (1992) found that there are four different categories of cognitive functions embedded in the two personality types,

however, reiterating that there is a difference between extroverts and introverts. Myers (1992) also explicated that while extroverts can be gregarious and outgoing individuals who may appear friendly, introverts may conversely seem secretive, unpredictable and difficult to relate with. Furthermore, extroverts also tend to have high levels of positivity, esteem and vitality while introverts may be perceived as boring, intelligent, and uninteresting, yet gifted (Ghaderi, Boraji, Bahrami, and Sohrabi, 2011).

According to Myers and Briggs (1995), there are four main areas that conflicts can arise between individuals of different personality types in marriage. Again, the first is in the difference in personality types, that is, extrovert versus introvert. Based on this difference, they explained that conflicts can arise when the 'outward' extrovert and the 'inward' introvert cannot support their disparate characteristics in marriage. Secondly, their ability to either sense or discern can produce conflict. The couples' ability to either use the 'sensing versus discerning' can reveal a sharp contrast of their different sides because the one who 'discerns' can feel more spiritual, intuitive, reflective and insightful while the one who senses perceives through the five senses. This process reveals that while the sensing individual concentrates on details using biological senses, the discerning significant other prefers to deliberate on the overall situation through intuition and what might also be considered as being instinctive. This can cause clashes if the couple cannot accept, integrate and appreciate their different functions. Thirdly, in considering the 'thinking' as opposed to 'feeling' couples; they state that the feeling individual usually desires helpfulness while the thinking person would rather be given suggestions and ideas to proffer solutions for themselves. A lack of understanding of these differences could result in marital distress. Fourthly, they also explain that; 'judging versus perceiving' indicates that the judging spouse likes using structures like facts and details to evaluate circumstances, while the perceiving one would rather make decisions based on being open and flexible. Again, they concluded that this too can be a source of misunderstanding among couples. However, despite their differences, couples tend to have higher marital outcomes when they understand how they function psychologically.

Older studies like Lester, Haig, and Monello (1989) associated extroversion with reduced marital satisfaction while recent researchers like Nweke, Dile-Aghana, Umeaku and Ofoma (2021) agreed with them since they also observed a significant negative

correlation between extroversion and marital satisfaction. However, studies like Barelds (2005) opposed this as positive correlations were attributed to extroversion and marital satisfaction. Interestingly, Gattis, Berns, Simpson and Christensen (2004) reported no link between extroversion and marital satisfaction. Additionally, the current study supported the findings of Sayehmiri et al (2020) and Kilman and Vendemia (2013) which concluded that the success of marriages would require that spouses have to accept, forgive, tolerate and sustain one another, so that they can mutually benefit from their relationship no matter their personality types. This was further justified in the present study by the results obtained from the focus group discussions. Most respondents in both CPT and SIT groups stated that despite their different inclinations towards being extroversive or introversive, their spouses had accepted them the way they are. This act of acceptance, tolerance and understanding can create a common purpose producing unity in joint decision-making, planning, respect for one another, compassion and trust hence enhancing satisfaction in marriage (Strelnick, 2019).

Hypothesis Three: There is no significant main effect of spousal support (low, moderate and high) on marital satisfaction of women with childhood trauma in Ibadan.

This hypothesis was rejected as there was a significant main effect of spousal support (low, moderate and high) on marital satisfaction of women with childhood trauma (Table 4.1). However, the participants in the moderate level of spousal support enjoyed marital satisfaction significantly more than those in both low and high levels. Spousal support is a way that couples show care, respect, sympathy, interest, and concern for one another (Ebenuwa-Okoh and Osho, 2016). In light of this, Gbiri and Akinpelu (2012) confirmed that spousal support positively influenced the well-being of stroke survivors as it provided the emotional, financial and motivational assistance needed to improve. Again, women such as those attending the fertility clinic are quite vulnerable to psychological pain requiring spousal support, therefore, Omoaregba, James, Lawani, Morakinyo and Olotu (2011) clarified that not having spousal support predicted high emotional distress, leading to marital disharmony. Supportive spousal behaviour such as affection, attention and material provision can increase marital satisfaction. Again, this was corroborated by Khan and Aftab (2013) as they reiterated that the higher the level of

assistance received from spouses, the more enhanced the satisfaction. This conflicted with the findings of the present study which revealed that women with moderate levels of spousal support experienced more marital satisfaction. It equally opposed the findings of Enebuwa-Okoh and Osho (2016), as well as Monin and Clark (2011) who submitted that high spousal assistance can enhance marital fulfilment. In the same vein, the findings of this study did not entirely agree with Arisukwu, Igbolekwu, Oyekola, Oyeyipo, Asamu and Osueke (2021) who reported that though spousal support had a substantial effect on marital satisfaction, high levels of support were detected to sustain and promote good quality of marital life. Peter-kilo and Long John (2021) were however consistent with the results of this study as they affirmed that there was a significant association between marital harmony and spousal support, but at a moderate level.

Another investigation which agreed with this study was that of Brock and Lawrence (2009). Their work on how levels of spousal support can affect marital satisfaction showed that those couples who indicated that they were receiving high or low levels of support experienced a reduction in satisfaction. They stated that the plausible explanation for this was that husbands who are emotionally disconnected from their wives feel a certain level of fear and guilt; implying that these emotions can lead such men to display certain tendencies like an over-generous show of affection through unnecessary gifts. They added that this type of husbands can overcompensate to make up for their shortcomings by providing more than their wives need. They concluded that these wives usually perceive that their husbands' support could be deceitful schemes meant to cover up their clandestine affairs. Again, the FGD presented some justification for this result in a respondent's statement (**PHC Ojoo SIT session, Respondent 4; 24 years**) revealing that her marital satisfaction is not yet *100%*, nor is her dissatisfaction *100%* however *it is on a middle level.* She further explained that endurance, contentment and not comparing herself with others have helped her maintain satisfaction in marriage. She added that *if my husband gives me or not, I am okay.* In addition, she concluded that *expecting too much and not accepting reality can breed problems in marriage.* This reaffirmed the fact that the preferred level of spousal support for married women who have experienced childhood trauma might be moderate levels, therefore, not expecting or anticipating too much from a spouse can serve as a defence mechanism. Childhood

trauma can leave a 'wounded child' within an adult married woman (Teicher, 2000) leading to emotional and cognitive encumbrances which can intensify already existing problems in marriage (Lauders et al, 2019, Marshall et al, 2011) causing disatisfaction. Consequently, moderate levels of spousal support can help women with childhood trauma cope with preventing heightened responses such as fear of abandonment, anxiety, low self-esteem, nagging, suspicion, and anger (Thatcher, 2018; DeCaralho et al, 2015; Marshall et al, 2011) to relationship stress. As a result of this, Brock and Lawrence (2009) asserted that receiving elevated levels of spousal support than is necessary is especially disadvantageous to wives' marital satisfaction, the same way declined levels of assistance can produce low marital harmony. Furthermore, many of the FGD respondents agreed women should understand that money is not everything. Moreover, the respondents viewed contentment as an important component of marital satisfaction. They added that a well-adjusted attitude of respect, acceptance and motivation could make their marriages more satisfactory.

Hypothesis Four: There is no significant interaction effect of treatment and personality types on marital satisfaction of women with childhood trauma in Ibadan.

Results reveal that there was a significant interaction effect of treatment and personality types (extrovert and introvert) on marital satisfaction of women with childhood trauma. This implied that the combination between the therapies (cognitive processing and stress inoculation) and personality types on marital satisfaction of women with childhood trauma had a significant interaction effect, thus, the null hypothesis was rejected.

McLeod (2017) submitted that a person's personality can include moods, attitudes, interests and opinions expressed in his/her social interactions. In this sense, personality can be described as consisting of overt or covert cognitive processes, emotional structures and behavioural patterns combined with other psychological mechanisms to form the characteristics of an individual.

The individuals whose personality type benefitted more from the psychological interventions in this current study were the introverts. The introverts have a tendency to experience more negative emotions like worry, fear, sadness and loneliness which are

linked to poor psychological and physiological health outcomes, whereas the extroverts are associated with a zest for life and happiness (Roberts, Luo, Briley, Chow, Su, and Hill, 2017). Incidentally, Raypole (2021) noted that introversion can play an active role in the development of depression and anxiety because of certain risk factors like susceptibility to stress from life situations, and a high sensitivity toward emotional issues. This is because their reflective nature could induce feelings of sadness, low self-esteem and worry (Wei, 2020). This present research supported the systematic review of Roberts et al (2017) who tracked 207 studies that documented that those notable positive changes particularly in those with low extroversion measures occurred as a result of therapy. Similarly, the study supported the findings of Resick, Monson, and Chard (2014) which explained that there are pre and post trauma thoughts, feelings that can generate stuck points but improve with psychological intervention.

Again, studies like Nguyen, Kim, Romain, Tabani, and Chaplin (2020) confirmed that people's personalities may alter as a result of life events. The current study agreed with their work which reaffirmed that therapies can offer positive changes, especially when strongly linked with areas targeted for intervention. According to Cherry (2021), the implication for this is that therapies which are designed using CBT approaches, especially for individuals who have experienced childhood trauma, concentrate on helping them identify negative thought patterns, cognitive distortions, irrational beliefs and dysfunctional assumptions such that a decline in emotional distress is recorded, while positive changes are observed.

An explanation that can be given for the outcome of this current study is that CPT, being a trauma-focused treatment is designed to ameliorate the psychological conflict that stems from pre-trauma versus post-trauma experiences (Resick, Monson and Chard, 2014). Stuck points formed from strong negative emotions can prevent the healthy processing of adverse situations (American Psychological Association, 2017) but could be addressed in the course of treatment. For this reason, the client becomes aware of the relationship between their thoughts, feelings and the influence on their behaviour. Through methods like Socratic questioning, and well-structured worksheets, the individual can reprocess the traumatic event, thus reappraising the thoughts and feelings that are problematic. Consequently, this could lead to an improvement in their overall

well-being. Another important tool is the impact statement which participants were required to write at the beginning (second session) and the end (seventh session) of the intervention. In the written statements, the participants were encouraged to relive the childhood traumatic event by answering the following questions; *what happened to you?* (that is, the childhood traumatic event), *what effect does the event have on you? How do you think it changed the way you see yourself, others and the world?* From the explanations given by Respondent 41 (36 years), her pre-trauma behaviour was similar to an extrovert, as she demonstrated a love for social interaction, and carefreeness, nevertheless, after the traumatic incident, she viewed herself, others and life differently (see Appendix 11; CPT, impact statement 2). She disclosed that she felt abused, based on her interpretation of the incident. This appraisal affected her feelings which were obviously tainted with self-blame, shame, guilt, anger, bitterness and fear. The incident also altered her personality, making her seem introverted; more self-conscious, reserved, quiet and withdrawn. However, after the intervention, she claimed that she was able to stop judging herself and her mother harshly. Similarly, she was ready to accept her husband's affections and socialize with others again. In addition to this, the study agreed with the investigations of Murray et al (2018) and Lenz et al (2014) which acknowledged that women who have received CPT exhibited great improvements in their views about self, others and life. This pattern can also be observed from the reports (see Appendix 11; CPT, impact statements 1 and 3) of Respondent 38 (25 years) and Respondent 51(29 years).

Stress inoculation therapy, like CPT, is a type of cognitive behavioural therapy. It has three sequential phases, which are: firstly, conceptualisation involves assessment and education. In this phase, a therapeutic alliance can also be developed between the client and therapist. An assessment is carried out to identify the individual's problem. The client is then educated about childhood trauma, the effects of traumatic stress and how effective SIT can be in reducing symptoms. Secondly, the skills acquisition and rehearsal stage target the development of a repertoire of coping skills. Thirdly, the application of skills acquired are demonstrated through role play. In addition to this, identifying poor coping mechanisms, learning to recognize that there is a connection between thoughts, feelings and behaviour can help to reduce catastrophic beliefs (Busari,

2014). Kashani, Kashani, Moghimian, and Shakour (2015) concluded that the techniques of SIT were designed to manage negative emotions such as shame, guilt, fear and anger through the following: deep breathing exercises/affirmations, positive self-talk, muscle relaxation training, cognitive restructuring, and role play.

Similarly, this study supported that of Uzoechina (2016) who discovered that SIT techniques can be characterized as both emotion-focused and problem-solution focused, possessing the ability to help clients to self-manage by regulating their behaviours, feelings and thoughts as they encounter life challenges. Similarly, this work corroborated the findings of Bahodoni and Zandekarim (2018) which emphasised that SIT was effective in the treatment of cognitive-emotional dysregulations in vulnerable married female adolescents as it taught them how to utilize relaxation techniques, identify automatic negative thoughts, and recognise cognitive distortions. Through these new skills, clients would further learn how to replace their undesirable thoughts with healthy alternative ones while practicing problem-solving skills. Again, the findings of this current work agreed with those of Spears (2019) and Jackson et al (2019) who observed that SIT can improve daily functioning, increase self-confidence, reduce stress symptoms and enhance the use of effective coping skills. Stress inoculation therapy is therefore helpful for relapse prevention, self-monitoring and can be used to encourage an optimistic yet realistic attitude to life.

Furthermore, Figure 4.1. showed the interaction effect of treatment (CPT, SIT and Control) and personality types (extroversion and introversion) on marital satisfaction of women with childhood trauma, indicating that introverted participants benefitted more from CPT and SIT as it helped to improve their marital satisfaction. A possible reason for this is that introverts tend to ruminate (the act of overthinking about negative situations), brood and internalise often about life experiences, especially over situations like childhood trauma. These can further keep them stuck in excessive negative thoughts and feelings (Holland and Raypole, 2021), developing into psychopathological challenges, thereby requiring professional therapeutic support. Therefore, CPT and SIT treatment packages were able to assist introverted participants by reducing negative thought patterns, hence helping them to create more productive views and feelings (Dembling, 2013) about themselves, others and the world through journaling, relaxation techniques,

positive self-talk, Socratic questioning, along with other cognitive restructuring techniques.

Hypothesis Five: There is no significant interaction effect of treatment and spousal support on marital satisfaction of women with childhood trauma in Ibadan.

The hypothesis was not rejected because there was no interaction effect of treatment and spousal support on marital satisfaction of women with childhood trauma as shown in Table 4.1.

Spousal support is useful in marriage as it indicates the type of sustenance given by couples to maintain their marital relationships. Furthermore, partner support geared towards growth predicts better mental health outcomes for spouses. According to Nguyen, Karney and Bradbury (2017), individuals with a background history of childhood trauma are linked with relationship difficulties, for this reason, Cooke, Racine, Plamondon, Tough and Madigan (2019) have claimed that the compassion derived from spousal support can serve as a protective element, promoting resilience in families with people who have experienced childhood trauma. They restated that support from the spouse of a survivor can be a key tool for change and overall well-being. Spouses' behaviours are critical in determining the health outcomes of childhood trauma survivors since they can deteriorate due to spousal abuse or can be alleviated by compassionate significant others (Widom, Czaja, Bentley and Johnson, 2012), especially when professional help is sought. Treatment can be effective when spouses recognize a need for improvement in certain areas of their union and not wait until the problem becomes complicated (Doherty, Harris, Hall, and Hubbard, 2021).

John, Adebayo, Boychuk and OlaOlorun (2022) highlighted that therapeutic intervention can focus on problematic areas of relational weaknesses to enhance marital harmony. However, from the empirical findings of this study, the marital satisfaction of the women with childhood trauma was unaffected whether or not they received the treatment to enhance spousal support. The probable reason for this could be that some married women may not feel they need therapy for issues of spousal support as they may believe in family ties. Family ties are deep bonds embedded in the ethnic context of the rich Nigerian culture. These ties breed a sense of belonging, comfort and stability between spouses, generating strong commitments to the marital relationship, irrespective

of the level of the treatment. This study supported Ogungbola and Akomolafe (2019) who expounded those elements of family ties such as togetherness, forgiveness, patience and understanding as important components for marital satisfaction (Sayehmiri er al. 2020). In the focus group discussion, participants recapitulated these instances when they asserted that understanding their spouses, showing them respect, forgiveness, perseverance, having a non-materialistic mindset and keeping intimate issues of their marriages confidential can produce harmony in marital settings.

Additionally, the spousal mate retention tactics described by Shackelford and Shackelford (2021) seem like another feasible explanation that the findings of this current study corroborated. They stated that women frequently use mate retention strategies to reduce relationship problems and increase satisfaction. These strategies can include tolerating the significant other despite his flaws, looking physically attractive to gain and maintain his attention, cooking delicacies to captivate him, also pretending to reach orgasm during intercourse to inflate the man's ego, which is a common behaviour that 60% of married women practice (Shackelford and Shackelford, 2021). Participants in the focus group discussion listed strategies that can be used to improve marital satisfaction as: good physical appearance (dressing well), having a source of livelihood to support the household, living peacefully with others especially in-laws, adhering to whatever one's spouse expects, shunning negative attitudes like stubbornness, taking up jobs which can ensure that a woman has time for the home, contentment, facing reality, not having high expectations from one's partner, endurance and fulfiling one's marital obligations.

Hypothesis Six: There is no significant interaction effect of personality types and spousal support on marital satisfaction of women with childhood trauma in Ibadan.

The hypothesis was not rejected. There was no significant interaction effect of personality types (extroversion and introversion) and spousal support (low, moderate and high) on marital satisfaction of women with childhood trauma in Ibadan.

This implied that personality types were not sensitive to spousal support. It does not matter the type of personality the women have, when they interact with the type of support they receive from their husbands, their marital satisfaction would not be affected or influenced. This finding confirmed that of Yedirir and Hamarta (2015) who observed

that there was no relationship between personality types, spousal support and marital satisfaction. Nevertheless, it did not agree with the findings of Sadeghi, Mootabi and Dehghani (2016) whose investigation explained that personality can act as a stressor, subsequently affecting spouses' ability to bond with each other. This current study also confirmed that of Ghorbani, Watson, Farhadi and Chen (2014) which implied that women with different personality types, whether extroverts or introverts, can possess strong obligations towards making their marriages succeed. From the results of the FGD, some of the participants explained that anytime they encountered challenges in their marital relationships, they felt better after expressing their feelings. This result also validated the work of Yediri and Harmata (2015) which disclosed that personality may not necessarily influence the way couples express their emotions. Other women acknowledged that though they are quiet, they had ways of coping with issues arising in their homes, therefore, whether their spousal support was low, moderate or high, their marital satisfaction remained unaffected. Again, from the FGD, while responding to the question *what areas of spousal support can bring you marital satisfaction?* some respondents declared that patience, displaying affection, giving financial support and acceptance can enhance satisfaction in marriage. Additionally, some of the FGD respondents concluded that marital satisfaction for a woman would entail that she should be assisted in every possible way; however, expecting too much and not accepting reality can breed problems in marriage. This showed that a married woman's personality type may not dictate the level of spousal support she can receive.

Hypothesis Seven: There is no significant interaction effect of treatment, personality types and spousal support on marital satisfaction of women with childhood trauma in Ibadan.

Table 4.1 revealed that there was no significant interaction effect of treatment, personality types and spousal support on marital satisfaction of women with childhood trauma. Therefore, the hypothesis was not rejected. This implied that the combination of treatment, personality types and spousal support had no interaction effect on marital satisfaction. This also demonstrated that the treatment was not sensitive to personality types and spousal support when combined.

4.11 Summary of findings

1. There was a significant main effect of treatment (cognitive processing and stress inoculation therapies) on marital satisfaction of women with childhood trauma in Ibadan. This was because cognitive processing and stress inoculation therapies helped to boost the marital satisfaction of women with childhood trauma. Again, stress inoculation therapy, being a non-trauma-focused approach was found to be more beneficial than cognitive processing therapy.
2. There was no significant main effect of personality types (extrovert and introvert) on marital satisfaction of women with childhood trauma in Ibadan.
3. There was a significant main effect of spousal support (low, moderate and high) on marital satisfaction of women with childhood trauma in Ibadan. Moderate levels of spousal support can influence the marital satisfaction of women with childhood trauma rather than low and high levels.
4. There was a significant interaction effect of treatment and personality types on marital satisfaction of women with childhood trauma in Ibadan, as introverts benefitted more from the interventions than extroverts.
5. There was no significant interaction effect of treatment and spousal support on marital satisfaction of women with childhood trauma in Ibadan.
6. There was no significant interaction effect of personality types and spousal support on marital satisfaction of women with childhood trauma in Ibadan.
7. There was no significant interaction effect of treatment, personality types and spousal support on marital satisfaction of women with childhood trauma in Ibadan.

CHAPTER FIVE
SUMMARY, CONCLUSION AND RECOMMENDATIONS

This chapter presents the summary of the study's findings regarding the generated and tested seven null hypotheses. Furthermore, the conclusion, implications and limitations of the study were stated. In addition, this research has made recommendations based on the findings, contributions of the investigation to the body of knowledge and areas suggesting further research.

5.1 Summary

The study investigated the effect of Cognitive Processing and Stress Inoculation therapies on marital satisfaction of women with childhood trauma in Ibadan, Nigeria. The study explained that marriage is a sociocultural union between a man and a woman who have decided to raise a family. To facilitate the process, marital relationships should be stable and couples remain satisfied. However, many individuals may carry different psychological impediments of varying degrees into their marriages to the extent that coping with marital problems like the absence or presence of children, financial constraints and in-law interference could trigger some maladaptive processes, thus reducing satisfaction. Following this, many studies have attempted to proffer solutions to marital dissatisfaction, yet the problems have persisted. It is the belief of the researcher, however, that Cognitive Processing and Stress Inoculation therapies can promote marital satisfaction of women with childhood trauma. An extensive review of literature covered the theories used which included the Vulnerability Stress Adaptation Model of Marriage by Karney and Bradbury (1995) and the theory of Personality Development by Freud (1923).

The vulnerability stress adaptation model had its foundational perspectives based on theories like; social exchange; crisis and attachment while the theory of personality development stated that from an individual's early stages of life, personality is shaped by three elements; id, ego and super ego. Any imbalance in these three domains

can lead to a damaged personality. Again, Freud (1923) explained that the mind can function on three levels of consciousness namely: the conscious, preconscious and unconscious state. The unconscious state of the mind consists of repressed painful childhood memories, feelings and reactions that the individual is not consciously aware of yet they can cause undesirable feelings. Freud further clarified that these curbed unresolved feelings are often the foundation of psychological problems. The reviewed concepts were marital satisfaction: cognitive processing therapy, stress inoculation therapy, childhood trauma, personality types, and spousal support.

The study adopted the mixed methods of sequential explanatory design (collection of quantitative and qualitative data). The quantitative was a pretest-posttest, control, quasi-experiment with a 3 x 2 x 3 factorial matrix. There were three levels of treatment and non-treatment: cognitive processing therapy, stress inoculation therapy and control. The two moderating variables were personality types examined at two levels (extroversion and introversion) while spousal support was examined at three levels (low, moderate and high). The population for the study comprised married women with childhood trauma in Ibadan. This included women who have been married between 1-10 years and who had encountered traumatic childhood experiences such as neglect, physical, emotional and sexual abuse. They also included women who could interact in English and/or Yoruba languages that attended Primary Health Care Centres in three of the eleven urban local government areas in Ibadan. The actual samples were those who scored 50.0% or more in the screening test (Childhood trauma questionnaire-short form; MEQ). The three treatments took place in three centres (Iwo Road, Ojoo and Agbowo) using the women that were qualified to participate.

The synopsis of the Cognitive Processing therapy included a general introduction, orientation and pre-test administration followed up with: psycho-education on childhood trauma, introduction to CPT and its 3R goals (recognize, reinterpret and recover), recognition of problematic thoughts, feelings and behaviour, and identification of stuck points and how to challenge them. Writing the first impact statement; considering how thoughts and feelings play out after a traumatic incident, learning how to challenge negative beliefs about safety, trust, power/control and esteem issues with self, spouse and others; writing the second impact statement and post-test administration. The synopsis of

the stress inoculation therapy included: a general introduction, orientation and pre-test administration: followed up with psycho-education describing what childhood trauma is and how it could affect the thoughts, feelings and behaviour of an individual. Introduction to SIT and the purpose of intervention, identification of triggers, how to minimize the effects of stress symptoms through the use of effective coping skills such as deep breathing exercise (Fowler, 2022), progressive muscle relaxation (Cohen, 2018), positive self-talk (Damirchi, Mojarrad, Pireinaladin and Grjibovski, 2020) and thought-stopping strategies (Legg, 2020; Susman, 2022) were examined. Role plays (1 and 2) with topics on real-life situations were simulated to aid comprehension and post-test was administered. Focus group discussions were held with ten participants from each of the two treatment centres (CPT and SIT). Four themes on marital satisfaction, personality types, spousal support and marital coping strategies were discussed. Quantitative data were analysed using the analysis of covariance (ANCOVA), estimated marginal means and Sidak post-hoc pair comparison analysis while qualitative data were content analysed.

5.2 Conclusion

This study investigated the effects of Cognitive Processing and Stress Inoculation therapies on marital satisfaction of women with childhood trauma in Ibadan, Nigeria. Personality types (extroversion and introversion) and spousal support were the moderating variables. Participants were exposed to the treatment packages as interventions, thus relevant data were collected, collated and analysed using appropriate statistical tools. Based on the findings of the study, the following conclusions were reached: cognitive processing and stress inoculation therapies were effective on marital satisfaction of women with childhood trauma in Ibadan. Therefore, applying the ethics, components and structured approaches of both interventions could be effective in strengthening marital satisfaction of women with childhood trauma. Additionally, stress inoculation therapy was more efficacious in reinforcing marital harmony of women with childhood trauma. Personality types did not affect marital satisfaction. However, the combination of personality types and treatment demonstrated that introverts benefitted more from both interventions, as their marital satisfaction improved better than the extroverts. Furthermore, women with moderate levels of spousal support had the best marital satisfaction than those with low and high levels.

5.3 Implication of the study

The result of this study has shown that cognitive processing and stress inoculation therapies were effective and beneficial for marital satisfaction of women with childhood trauma. This has implications for children, adolescents, parents, spouses, social workers, family health practitioners, teachers, school counsellors, marriage counsellors, policymakers, (developmental and clinical) psychologists, psychiatrists, other professionals working with trauma victims and survivors will also be enriched with insights from this study.

Childhood trauma can be described as a singular or series of early adverse experiences which can include neglect, sexual, emotional and physical abuse. These events have weighty negative consequences which often lead to dire psychological effects, such as posttraumatic stress disorder, depression, anxiety, and eating disorders. Furthermore, trauma in childhood can cause stress which is often linked to devastating health challenges like asthma, hypertension, stroke and diabetes. It can also intensify the impairment of certain functions, eventuating into chronic and debilitating mental illnesses demonstrating that there is a correlation between the effects of early traumatizing situations and high risk for psychopathology. Survivors of childhood trauma can become adults who manifest negative emotions such as anxiety, fear, anger, bitterness, hopelessness, intense sadness, shame and guilt, making relating with others difficult. Consequently, childhood trauma can affect their marital relationships as it takes its toll on the union by decreasing satisfaction.

Marital satisfaction is a mental state which shows the perceived cost and gains of marriage to a person. It is a subjective and multidimensional phenomenon which can reveal the attitude of couples towards each other. Based on the result of this study, it was therefore demonstrated that participants became aware of the relationship between their thoughts, feelings and behaviours through the use of cognitive processing and stress inoculation therapies. They were also taught to identify their negative core beliefs and thought patterns. The participants were also trained on how to manage their thoughts, feelings and stress symptoms using effective coping strategies from the treatment packages.

Parents, teachers and management of schools could also be orientated through the study that childhood trauma can be a source of serious challenges often accompanied by learning disabilities, poor academic performances and behavioural issues which can be mediated through psychological treatment. Identifying children and adolescents who exhibit various symptoms of childhood trauma can be helped, rather than maintaining a culture of silence. Furthermore, social workers and school counsellors will find the information in this study an effective toolkit to support both pupils and students exposed to any form of early adversity.

Marriage/family therapists, psychologists, psychiatrists and other mental health workers will find this study beneficial in handling psychological challenges of childhood trauma present in marriages, families and society. Similarly, policymakers, with the knowledge from this research about the prevalence and negative impact of trauma, will become more aware of its ravaging effects so that trauma-informed interventions, plans and schemes on how to make the nation safer and healthier will be adopted. Again, the adoption of the theoretical, and procedural components like CPT and SIT can be adopted by stakeholders to improve the functionality of both victims and survivors.

5.4 Limitation of the study

The following were the challenges the researcher encountered in the course of the study.

Many women were reluctant to participate in the study after a while because of the duration of the intervention. This was overcome with some words of encouragement motivating them to commit to the research.

More women would have participated, however, due to family, economic, and social reasons, they declined. Some of the women found the impact statements and filling the worksheets quite difficult to use. Based on this, more time had to be devouted to the writing and explanations the procedure. This study did not focus on the spouses of the female participants, however, gleaning information from them on the level of satisfaction of their wives would have enriched the work.

5.5 Recommendations

Based on the findings of this study, the following recommendations were made:

1) These interventions (cognitive processing and stress inoculation therapies) can be used to help women going through traumatic experiences to nurture satisfaction in marriage and harmony in their homes.
2) The knowledge provided in the research on childhood trauma, marital satisfaction, personality types and spousal support can guide parents, teachers, school management, social workers, psychologists, psychiatrist, legal bodies, policymakers including other organizations involved in mediating on behalf of trauma victims as well as survivors to identify, understand and seek appropriate professional help for them.
3) Whilst Government empowerment programmes are beneficial for enabling women to reach their full potential, psychological assessments and interventions like cognitive processing and stress inoculation therapies may be needed to assist those who have experienced childhood trauma.
4) The study focused on married women with childhood trauma; however, its knowledge could be extended to premarital counselling sessions for singles to create a forum where issues of early trauma, its impact on marital relationships and how to cultivate better relationship outcomes can be discussed.
5) Through this study, it is obvious that some married women who are traumatised need interventions. This can be encouraged by setting up support groups where interventions can be administered. This can help the affected women improve functionality, enhance integration and correct such anomalies as the erroneous culture of silence.

5.6 Contributions to the body of knowledge

The study has contributed to knowledge in the following ways:

1) The study has shown that cognitive processing and stress inoculation therapies are both beneficial in improving marital satisfaction of women with childhood trauma.
2) Besides that, it has added theoretically, empirically and procedurally to the understanding of CPT and SIT.

3) The study established that stress inoculation therapy is highly potent in ameliorating matters of marital satisfaction in women with childhood traumatic experiences.
4) This study has also shown that women can attain satisfaction in their marriages regardless of their personality types.
5) The study disclosed that moderate levels of spousal support can influence the marital satisfaction of women with childhood trauma rather than high levels.

5.7 Suggestions for further studies

This study investigated the effects of cognitive processing and stress inoculation therapies on marital satisfaction of women with childhood trauma. However, further studies can be replicated in different centres with less stringent inclusion criteria so that more women can be qualified to be part of the study.

Furthermore, this study can be carried out in different centres with less restricted time frames to encourage more women to participate in the study.

In addition, this study can be replicated in different centres with less cumbersome impact statements and worksheets. Again, it is suggested that this type of study should be carried out in different centres to include the spouses of the female participants to retrieve information from them on the level of satisfaction of their wives.

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APPENDICES

APPENDIX 1 (A)

UNIVERSITY OF IBADAN

FACULTY OF EDUCATION

DEPARTMENT OF COUNSELLING AND HUMAN DEVELOPMENT STUDIES

ENRICH -MARITAL SATISFACTION SCALE (EMS)

Please, tick (√) the appropriate column that best describes your opinion on each of the items in Section B. Your responses will be treated with utmost confidentiality.

Thank you.

Section A: Background Information

1. Age: ……..
2. Religion: Christianity [ ] Islamic [ ] Traditional [ ]
   Others……
3. Tribe: Hausa [ ] Igbo [ ] Yoruba [ ]
   Others……
4. Years in Marriage: ……
5. Occupation……
6. Qualification……..

Section B: evaluates the degree of satisfaction in marriage.

S/N		Strongly Disagree	Moderately Disagree	Neither Agree nor Disagree	Moderately Agree	Strongly Agree
1.	I am not pleased with the personality characteristics and personal habits of my partner					
2.	I am very happy with how we handle role responsibilities in our marriage.					
3.	My partner completely understands and sympathizes with my every mood.					

4.	I am not happy about our communication and feel my partner does not understand me.					
5.	I am very happy about how we make decisions and resolve conflicts.					
6.	I am unhappy about our financial position and the way we make financial decisions.					
7.	I have some needs that are not being met by our relationship.					
8.	I am very happy with how we manage our leisure activities and the time we spend together.					
9.	I am very pleased about how we express affection and relate sexually.					
10.	I am not satisfied with the way we each handle our responsibilities as parents.					
11.	I have never regretted my relationship with my partner, not even for a moment.					
12.	I am dissatisfied about our relationship with my parents, in-laws, and/or friends.					

ÀFIKÚN KÌN ÍN-NÍ (B)
YUNIFÁSÍTÌ TI ÌBÀDÀN
ÀGBÁRÍJỌ-ẸKA TI ÌMỌ̀ ẸKỌ́
ẸKA TI ÌGBANINÍMỌ̀RÀN ÀTI ÌKẸ́KỌ ÌDÀGBÀSÓKÈ ẸDÁ ÈNÌYÀN
BÙKÚN-ÌGBÉLÉWỌ̀N ÌTẸ́LỌ́RÙN LỌ́KỌLÁYA

Jọ̀wọ́, fi àmi (√) sí orígun tí o bámú tí ó ṣe àpèjúwe tí ó dára jùlọ nípa èro-ọkàn rẹ lórí ọ̀kọ̀ọ̀kan àwọn àlàyé tí ó wà ní Abala B. Àwọn ìdáhùn rẹ yóò ní ìtójú pẹ̀lú bíbò l'àṣírí tí ó péye jùlọ.

A dúpé.

Abala A: Àlàyé Ìpilẹ̀

1. Ọjọ́ orí: ……..
2. Ẹ̀sìn: Kìrìsìtẹ́nì [ ] Ísílàmù [ ] Ìbílẹ̀ [ ]

Àwọn mìíràn …….

3. Ẹ̀yà: Haúsá [ ] Ígbò [ ] Yorùbá [ ]

Àwọn mìíràn……

4. Iye ọdún nínú ìgbeyàwó: ……..
5. Iṣẹ́: ……..
6. Kíkájú ìgbéléwọ̀n: ……

Abala B: Ṣe àgbéyẹ̀wò ìwọ̀n/dìgírì ti ìtẹ́lọ́rùn nínú ìgbeyàwó

Òǹkà		Mi ò gbà rárá	Mi ò gbà níwọ̀ntúnwọ̀nsì	Bóyá gbà tàbí ṣaláìgbà	Gbà níwọ̀ntúnwọ̀nsì	Gbà gidigidi
1	Alábaṣepọ̀ mi àti èmi ní àgbóyé ara wa					

	dáradára					
2	Èmi kò ní inú dídùn pẹ̀lú ìrínisí àwọn àbùdá àti àwọn ìṣesí/ihùwàsí araẹni ti alábaṣepọ̀ mi					
3	Inú mi dun púpọ̀ pẹ̀lú bí a ti ń ṣe àmójútó ipa àwọn ojúṣe wa nínú ìgbéyàwó					
4.	Alábaṣepọ̀ mi ní òye kíkún àti pé ó ní ìkẹ́dùn pẹ̀lú gbogbo àwọn ìṣesí mi					
5.	Inú mi kò dùn nípa ìbánisọ̀rọ̀pọ̀ wa àti pé mo lérò pé alábàgbépọ̀ mi kò ní àgbọ́yé mi					
6.	Ìbáṣepọ̀ wa jẹ́ èyí tí ó ní àṣeyorí tó dára					
7.	Inú mi dun púpọ̀ nípa bí a ti ṣe ń ṣe àwọn ìpinnu àti bí a ti ń yanjú àwọn ìjà.					
8.	Inú mi kòdùn nípa ipò ìṣúná-owó wa àti ọ̀nà tí a fi ń ṣe àwọn ìpinnu àkóso ìṣúná-owó					
9.	Mo ní díè nínú àwọn àìní tí ìbáṣepọ̀ wa kò tíì le ṣàmójútó.					
10.	Inú mi kòdùn pẹ̀lú bí a ti ṣe ń ṣàkóso iṣé ìsinmi àti àwọn àkókò tí à ń lò papọ̀					
11.	Inú mi dun púpọ̀ nípa bí a ti ń ṣe àfihàn ìfẹ́ sí ara wa àti ní ìbáṣepọ̀ ìbálòpọ̀					

12.	Èmi kò ní inú dídùn pẹ̀lú ọ̀nà tí ọ̀kọ̀ọ̀kan wa ṣe mú àwọn ojúṣe gẹ́gẹ́ bí òbí					
13.	Èmi kò ní àbámọ̀ rárá nípa ìbáṣepọ̀ pẹ̀lú alábaṣepọ̀ mi páàpáà fún àkókò kankan.					
14.	Kò tẹ́milọ́rùn nípa ìbáṣepọ̀ wa pẹ̀lú àwọn òbí, àwọn àna àti/ tàbí àwọn ọ̀rẹ́.					
15.	Ó bámilarámu nípa bí ọ̀kọ̀ọ̀kan wa ṣe ń ṣe àwọn iṣẹ́ wa nínú àwọn ẹ̀sìn tí a Gbàgbọ́ àti àwọn iyi rẹ̀					

APPENDIX 2 (A)

UNIVERSITY OF IBADAN

FACULTY OF EDUCATION

DEPARTMENT OF COUNSELLING AND HUMAN DEVELOPMENT STUDIES

MYERS-BRIGGS TYPE INDICATOR SHORT VERSION (MBTI-SV)

Please, tick (√) the appropriate letter that best describes the description of your personality on each of the items. Your responses will be treated with utmost confidentiality.

Thank you.

Section A: Background Information

1. Age: ……..
2. Religion: Christianity [ ] Islamic [ ] Traditional [ ] Others……
3. Tribe: Hausa [ ] Igbo [ ] Yoruba [ ] Others……
4. Years in Marriage: ……
5. Occupation……
6. Qualification……..

Section B: identifies personality type

1.	a. you like to use up energy so you enjoy groups	b. you like to conserve energy so you enjoy one-on-one
2.	a. you interpret life events factually	b. you look for meaning and possibilities in life events
3.	a. you are logical; you are the thinking, questioning, analytic kind of person	b. you are empathetic; you are the feeling, accommodating, compassionate kind of person
4.	a. you are organised, orderly	b. you are flexible, easygoing

5.	a. you are more outgoing, think out loud	b. you are more reserved, think to yourself
6.	a. you are practical, rational, experiential, realistic	b. you are imaginative, innovative, creative, theoretical
7.	a. you are candid, straight forward, frank, upfront	b. you are tactful, kind, encouraging, thoughtful
8.	a. you like to plan, schedule	b. you like unplanned, spontaneous
9.	a. you seek many tasks, public activities, interaction with others	b. you seek private, solitary activities with quiet to concentrate
10.	a. you like the standard, usual, conventional, traditional	b. you like the different, novel, unique; like to try out new things
11.	a. you are firm, tend to criticize, maintain your stand	b. you are gentle, tend to appreciate, resolve conflicts
12.	a. you are insistent, regulated, structured, resolute	b. you are relaxed, tolerant, "live" and "let live," open-minded
13.	a. you are external, communicative, express yourself	b. you are internal, quiet, keep to yourself
14.	a. you focus on 'here-and-now,' in the present	b. you look to the future, "see the big picture"
15.	a. you are tough-minded, fair, unbiased	b. you are tender-hearted, merciful, kind
16.	a. you like preparation, you plan ahead	b. you go with the flow, adapt as you go
17.	a. you are active, initiate	b. you are reflective, deliberate
18.	a. you deal with facts, the "what is," realistic, you are down to earth,	b. you are idealistic, you like to dream, the "what could be," you are inventive, ingenious
19.	a. you are issue-oriented, concerned with solving specific matters	b. you are people-oriented, compassionate, friendly, concerned about others
20.	a. you like control, you supervise; you like constant, hard to change routine	b. you like freedom, lack of restrictions, not bound to routine; you are free as a bird

ÀFIKÚN KEJÌ (B)
YUNIFÁSÍTÌ TI ÌBÀDÀN
ÀGBÁRÍJỌ-ẸKA TI ÌMỌ̀ ẸKỌ́
ẸKA TI ÌGBANINÍMỌ̀RÀN ÀTI ÌKẸ́KỌ ÌDÀGBÀSÓKÈ ẸDÁ ÈNÌYÀN
IRÚ TI MYERS-BRGGS ÌFIHÀN ẸYÀ KÚKURÚ (MBTI-SV)

Jọ̀wọ́, fi àmi (√) sí orígun tí o bámú tí ó ṣe àpèjúwe tí ó dára jùlọ nípa èro-ọkàn rẹ lórí ọ̀kọ̀ọ̀kan àwọn àlàyé tí ó wà ní Abala B. Àwọn ìdáhùn rẹ yóò ní ìtọ́jú pẹ̀lú bíbò l'àṣírí tí ó péye jùlọ.

A dúpé.

Abala A: Àlàyé Ìpilẹ̀

1. **Ọjọ́ orí: ……..**
2. **Ẹ̀sìn: Kìrìsìtẹ́nì [ ] Ísílàmù [ ] Ìbílẹ̀ [ ]**

Àwọn mìíràn …….

3. **Ẹ̀yà: Haúsá [ ] Ígbò [ ] Yorùbá [ ]**

Àwọn mìíràn……

4. **Iye ọdún nínú ìgbeyàwó: ……..**
5. **Iṣẹ́: ……..**
6. **Kíkájú ìgbéléwọ̀n: ……**

Abala B: Ṣe ìdánimọ̀ irúfẹ́ èníyàn

S/N	a. O fẹ́ràn láti lo agbára tán kí o sì jẹ̀gbádùn àwọn ẹgbẹ́	b. O fẹ́ràn láti tọ́jú agbára kí o jẹ̀gbádùn ẹnìkan sí ẹnìkan
2	**a.** O túmọ̀ àwọn ìṣẹ̀lẹ̀ ilé aiyé lódodo	**b.** O wá ìtumọ̀ àti àwọn ọ̀nà àbáyọ tí ó ṣeéṣe nínú àwọn ìṣẹ̀lẹ̀ ilé aiyé
3	a. O jẹ́ ọlọgbọ́n, ìwọ́ jẹ́ ẹnití ó ní ìrònú, tó ń bèèrè, èníyàn tó ń ṣe àtúpalẹ̀	b. O jẹ́ ẹnití ó ní ojú àánú, ẹnití ó ní ìtara, tí ó kónimọ́ra, èníyàn tí ó lójú àánú
4	a. O jẹ́ ẹnití ó létò, tó ń ṣe ǹ kan létòlétò	b. O jẹ́ ẹnití kò ní agídí, oníwàpẹ̀lẹ́/onísùúrù
5	a. O jẹ́ jádejáde dáradára, ẹnití ó ń ṣọ èro-inú rẹ síta	b. Ẹnití kòní agbaja/tí kìí sábà sòrò, dídáronú fúnrara rẹ

6	a. O jẹ ẹnití ó ń ṣe iṣẹ́ láfihàn, tí ó mọ ipin, ṣàgbéyẹ̀wò,	b. O jẹ ẹnití ó ní ojú inú, tí ó ń ṣàwárí ìmọ̀tuntun, ọlọgbọ́n àtinúdá, tí ó ń fi ìdí ìmọ̀ àwárí tí ó ṣeéṣe síta.
7	a. O jẹ ẹnití ó ní òtítọ́, tí yóò sọ̀rọ̀ síta gẹ́gẹ́bí ó ti rí, olódodo, alásọtẹ́lẹ̀	b. O jẹ ọlọgbọ́n, olójú-àánú, oniwuri, tí ó ń ronújinlẹ̀
8	a. O fẹ́ràn láti máa ṣètò, ṣàgbékalẹ̀ ìṣètò	b. O fẹ́ràn àìṣàgbékalẹ̀ ètò, ṣíṣe ǹ kan gìrìgìrì
9	a. O fẹ́ràn ọ̀pọ̀lọpọ̀ iṣé ṣíṣe, àwọn iṣẹ́ ìlú ṣíṣe, ìbáṣepọ̀ pẹ̀lú àwọn mìíràn	b. O fẹ́ràn òmìnira, àwọn iṣẹ́ àdánìkànṣe pẹ̀lú ìdákẹ́jẹ́ẹ́ fún ìfọkànsí.
10.	a. O fẹ́ràn ojúlówó, tí ó ń ṣábà ṣẹlẹ̀, ohun tuntun, ìbílẹ̀	b. O fẹ́ràn oríṣiríṣi, ohun àràmàdà ohun aláìlẹ́gbẹ́; o fẹ́ràn láti gbìyànjú àwọn ohun tuntun.
11.	a. O dúró ṣinṣin pẹ̀lú ìpinnu, fẹ́ràn láti ṣàtakò/ṣòfintótó, dúró pẹ̀lú ìpinnu rẹ	c. O jẹ oníwà ìrẹ̀lẹ̀, ẹnití ó mọ rírì, o jẹ olùlàjà
12.	a. Ẹnití kì í yí ìpinnu rẹ̀ padà, tí ó ń tẹ̀lé òfin/ìlànà, tí ó ní ètò, pinnu	b. O fára nísimi, O láfaradà, "O fi àyè gba ẹlòmìíràn'' ní àkóyawọ́
13.	a. O fẹ́ràn láti ṣe síta , ìbáraẹnisọ̀rọ̀ dára, ṣàfihàn ara rẹ	b. O jẹ ẹnití kìí jáde, tó ń dákẹ́ jẹ́jẹ́, tí ó ń dá dúró
14.	a. Ojú rẹ kìí gbé ibìkan/oníwòyíwòyí, "ní àkokò yìí	b. O má ń wo ọjọ́ iwájú, "rí àwòrán ọjọ́ iwájú tó dára"
15.	a. O jẹ ẹnití ó ní ọkàn líle, olódodo, tíkò fi sí ibìkan	b. O jẹ onínú tútù , aláàánú, onínúrere
16.	a. O fẹ́ràn ìgbáradì, o má ń ṣètò síwájú	b. Ẹnití ó ń bá ìgbà yí, o ní ìbánidọ́gba pẹ̀lú bí ǹ kan ṣe ń lọ
17.	a. Ò ń ṣiṣẹ́ dáradára, o ní ọgbọ́n àtinúdá	b. O jẹ afihàn àpẹẹrẹ, o mọ̀ọ́mọ̀
18.	a. O ṣiṣé pẹ̀lú ìfidímúlẹ̀ àwọn òtítọ́, "kíni ohun tí ó bójúmu,'' onínúrere	b. O jẹ àpẹẹrẹ, o fẹ́ràn láti má lá àlá, ''kíni ó leè jẹ́'' o fẹ́ràn láti ṣàwárí, O ní ọpọlọ/òòye
19.	a. Ẹnití ó dúró ti ìṣàlàyé ọ̀rọ̀, tí ó ní ìfiyèsí sí wíwá ojútùú sí àwọn ìṣòro kan pàtó	c. O jẹ olùfẹ́ àwọn ènìyàn, aláàánú, ore, ẹnití ó ní ìfiyèsí nípa àwọn ẹlòmíràn
20.	a. O fẹ́ràn ìṣàkóso, ìṣàmójútó, o fẹ́ràn déédé, o ní ìbárakú láti ṣe ìyípadà	b. O fẹ́ràn òmìnira, àìsí àwọn gbèdéke, kìí sọ ǹkan di bárakú, o ní òmìnira bí ẹyẹ.

APPENDIX 3 (A)

UNIVERSITY OF IBADAN

FACULTY OF EDUCATION

DEPARTMENT OF COUNSELING AND HUMAN DEVELOPMENT STUDIES

SPOUSAL SUPPORT SCALE (SSS)

Please, tick (√) the appropriate column that best describes your opinion on each of the items in Section B. Your responses will be treated with utmost confidentiality.

Thank you.

Section A: Background Information

1. Age: ……..
2. Religion: Christianity [ ] Islamic [ ] Traditional [ ] Others……
3. Tribe: Hausa [ ] Igbo [ ] Yoruba [ ] Others……
4. Years in Marriage: ……
5. Occupation…….
6. Qualification……..

Section B: Degree of Spousal Support in a Marital Relationship

Keys: Never = NV; Rarely = R; Occasionally = OC; Frequently = FQ; Very Frequently = VFQ

S/N	**Items**	**NV**	**R**	**OC**	**FQ**	**VFQ**
1.	My husband supports me financially when I am in need.					
2.	I feel my husband is kind					
3.	I don't trust my husband					

4.	I feel my spouse is understanding					
5.	My husband does not give me a helping hand with house chores					
6.	My spouse does not enjoy spending time with me					
7.	I feel my husband is kind					
8.	I feel my husband does not love me					
9.	When I am hurt, my spouse does not show concern					
10.	My husband always tries to understand my point of view					
11.	I think my husband is selfish					
12.	I feel my husband is secretive					
13.	My spouse is special to me					
14.	My husband shares ideas with me that can help me move forward					
15.	My husband keeps away from me vital information that can improve my career					
16.	My husband shouts instructions at me like a slave					
17.	My husband appreciates all I do					
18.	I think my husband is rude and disrespectful to me.					
19.	My spouse's advices have helped me in life					
20.	My husband is not there for me					
21.	My spouse gives me suggestions in a harsh manner.					
22.	My husband gives his honest review of my actions in a caring way					
23.	I feel my husband's criticisms are destructive					
24.	My husband corrects my errors in a loving way					
25.	I think my spouse judges me					
26.	My husband expresses his concern over issues that are important to me					
27.	I don't feel safe with my husband					

28.	My husband takes time to pray for/with me					
29.	My spouse does not enquire about my well being					
30.	My spouse comforts me whenever I am sad					
31.	My spouse does not find me physically attractive					
32.	My spouse does not pay attention to my needs					
33.	My spouse calls me endearing names					
34.	My husband and I have no common areas of interest					
35.	My spouse makes me feel important					
36.	My spouse accepts me as I am					
37.	My husband reassures me of his love whenever I have doubts and fears					
38.	My spouse complains about our sex life					
39.	I enjoy hugs and kisses from my husband					
40.	I regret marrying my husband					
41.	I cry a lot over my marriage					
42.	I can confide in my spouse					
43.	My spouse and I do not argue over monetary issues					
44.	My husband and I do not laugh together					
45.	I am pleased with my marital relationship					
46.	I cannot imagine life without my husband					
47.	I think my husband is fun					
48.	My husband has my best interest at heart					
49.	My spouse and I do not discuss issues together before making decisions					
50.	I prefer keeping my personal information to myself					
51.	My spouse is insensitive to my feelings					
52.	My spouse shames me in front of others					
53.	I am overwhelmed by marital responsibilities					

54.	I hate the manner in which my spouse raises important issues					
55.	My spouse recognizes my potentials and encourages me to develop them					
56.	My spouse respects my privacy					
57.	My husband is stingy					
58.	My husband compliments my good looks					
59.	My spouse impresses me with beautiful gifts					
60.	My husband does not show willingness to help me with any task					
61.	My husband enquires about my job					
62.	My husband encourages me to reach my personal goals.					

ÀFIKÚN KẸTA (B)
YUNIFÁSÍTÌ TI ÌBÀDÀN
ÀGBÁRÍJỌ-ẸKA TI ÌMỌ̀ ẸKỌ́
ẸKA TI ÌGBANINÍMỌ̀RÀN ÀTI ÌKẸ́KỌ ÌDÀGBÀSÓKÈ ẸDÁ ÈNÌYÀN
ÌGBÉLÉWỌ̀N ÀTÌLẸYÌN LỌ́KỌ́LÁYA (SSS)

Jọ̀wọ́, fi àmi (√) sí orígun tí o bámú tí ó ṣe àpèjúwe tí ó dára jùlọ nípa èro-ọkàn rẹ lórí ọ̀kọ̀ọ̀kan àwọn àlàyé tí ó wà ní Abala B. Àwọn ìdáhùn rẹ yóò ní ìtọ́jú pẹ̀lú bíbò l'àṣírí tí ó péye jùlọ.

A dúpé.

Abala A: Àlàyé Ìpilẹ̀

1. Ọjọ́ orí: ……..
2. Ẹ̀sìn: Kìrìsìtẹ́nì [ ] Ísílàmù [ ] Ìbílẹ̀ [ ]

Àwọn mìíràn …….

3. Ẹ̀yà: Haúsá [ ] Ígbò [ ] Yorùbá [ ]

Àwọn mìíràn……

4. Iye ọdún nínú ìgbeyàwó: ……..
5. Iṣẹ́: ……..
6. Kíkájú ìgbéléwọ̀n: ……

Abala B: Iyì /dìgírì ti àtìlẹyìn lọ́kọ́láya nínú ìbáṣepọ̀ ìgbeyàwó

Àwọn kókó: Láìláí = LL Ó ṣọ̀wọ́n =S Lẹ́ẹ̀kọ̀ọ̀kan =LK Nígbàgbogbo= NGB

Sábà ṣẹlẹ̀ nígbàgbogbo= SNGB

Òǹkà	Àwọn àlàyé	LL	S	LK	NGB	SNGB
1.	Ọkọ mi ń ṣe àtìlẹyìn owó fún mi nígbàtí mo bá nílo rẹ̀					
2	Mo lérò pé ọkọ mi ní ojú-àánú					
3	Mi ò ní ìgbẹ̀kẹ̀lé nínú ọkọ mi					
4	Mo lérò pé ọkọ mi ní àgbọ́yé					
5	Ọkọ mi kìí ránmílọ́wọ́ nínú iṣẹ́ ilé ṣíṣe					
6	Ọkọ mi kò gbádùn kí ó lo àkókò papọ̀ pẹ̀lú mi					

7	Mo lérò pé ọkọ mi dára					
8	Mo lérò pé ọkọ mi kò fẹ́ràn mi					
9	Nígbàtí mo bá ní ìpalára, ìyàwó mi kò fi ìbánikẹ́dùn hàn					
10.	Ọkọ mi ma ń gbìyànjú nígbàgbogbo láti ní òye ohun tí mo fẹ́					
11.	Mo rò pé ọkọ mi jẹ́ amọtaraẹninìkan					
12.	Mo lérò pé ọkọ mi ń fi àṣírí pamọ́					
13.	Ìyàwó mi jẹ́ pàtàkì fún mi					
14.	Ọkọ mi pín àwọn ìmọ̀ràn pẹ̀lú mi tí ó leè ṣe ìrànlọ́wọ́ fún mi láti ní ìlọsíwájú					
15.	Ọkọ mi maa ń fi àwọn àlàyé pàtàkì pamọ́ fún ìlọsíwájú mi					
16.	Ọkọ mi ma ń pariwo mọ́ mi bí ẹrú					
17.	Ọkọ mi mo iyì gbogbo ohun tí mò ń ṣe					
18.	Mo rò pé ọkọ mi jẹ́ aláìgbọ́ràn àti ẹnití kìí bọ̀wọ̀ fún mi					
19.	Àwọn ìmọ̀ran ìyàwó mi ti ṣe ìrànlọ́wọ́ fún mi ní ìgbésí aiyé					
20.	Ọkọ mi kòsí fún mi					
21.	Ọkọ mi ma ń gbà mí ní ìmọ̀ràn ní ọ̀nà líle					
22.	Ọkọ mi ma ń fún mi ní àgbéyẹ̀wò òdodo nípa àwọn ìṣesí mi pẹ̀lú ìfẹ́					
23.	Mo lérò pé àwọn ìwà àtakò ọkọ mi jẹ́ ìparun					
24.	Ọkọ mi ṣe àwọn àtúnṣe àwọn àṣìṣe mi pẹ̀lú ìfẹ́					
25.	Mo rò pé ọkọ tàbí ìyàwó mi máa ń ṣe ìdájọ́ mi					
26.	Ọkọ mi ṣàlàyé ìbákẹ́dùn rẹ lórí àwọn ọ̀rọ̀ tí ó ṣe pàtàkì sí mi					
27.	Èmi kò ní ààbò pẹ̀lú ọkọ mi					
28.	Ọkọ mi máa ń fi àkókò sílẹ̀ láti gbàdúrà fún mi/pẹ̀lú mi					
29.	Ìyàwó/ọkọ mi kò béèrè nípa ìlera mi					
30.	Ìyàwó/ọkọ mi ń tù mí nínú nígbàkugbà tí mo bá ní ìbánújẹ́					
31.	Ìyàwó/ọkọ mi kò ní ìfanimọ́ra/ìdùnnú pẹ̀lú ẹwà ara mi					
32.	Ìyàwó/ọkọ mi kò ṣe àkíyèsí àwọn àìní mi					
33.	Ìyàwó/ọkọ mi máa ń pè mí ní àwọn orúkọ ìfẹ́					
34.	Ìyàwó/ọkọ mi àti èmi kò ní ohun tí a jìjọ nífẹ̀sí papọ̀					
35.	Ìyàwó/ọkọ mi jẹ́ kí n lérò pé mo pàtàkì					
36.	Ìyàwó/ọkọ mi tẹ́wọ́gbàmí bí mo ṣe rí					
37.	Ọkọ mi máa ń fún mi ní ìdánilójú ìfẹ rẹ̀ sí mi nígbàkugbà tí mo bá ní iyèméjì àti ìbèrù					
38.	Ìyàwó mi máa ń kérora tí a bá ń ní ìbálòpọ̀					
39.	Mò ń gbádùn ìfanimọ́ra àti ìfẹnukonu láti ọ̀dọ̀					

	ọkọ mi					
40.	Mo k'àbámọ̀ pé mo fẹ́ ọkọ mi					
41.	Mo sunkún púpò lórí ìgbéyàwó mi					
42.	Mo le finú han ọkọ mi					
43.	Ìyàwó/ọkọ mi àti èmi kìí ní àríyànjiyàn lórí àwọn ọ̀rọ̀ owo					
44.	Èmi àti ọkọ mi kò rẹ̀rín papọ̀					
45.	Inú mi dùn sí àjọ̀sepọ̀ inú ìgbéyàwó mi					
46.	Mi ò le sọ bí ìgbésí aiyé ṣe máa rí láìsí ọkọ mi					
47.	Mo rò pé ọkọ mi jẹ́ aláwàdà					
48.	Ọkọ mi nifẹ mi púpọ̀ ní ọkàn					
49.	Èmi àti ọkọ mi kìí jíròrò àwọn ọ̀rọ̀ papọ̀ ṣíwájú kí á tó ṣe àwọn ìpinnu					
50.	Mo fẹ́ràn fífi àlàyé ọ̀rọ̀ nípa ara mi sínù mi					
51.	Ìyàwó/ọkọ mi kò kobiara sí àwọn ìmòlára mi					
52.	Ìyàwó/ọkọ mi máa ń dójútìmí ní iwájú àwọn Ẹlòmíràn					
53.	Àwọn ojúṣe ìgbeyàwó pọ̀ lápọ̀jù fún mi					
54.	Mo kórira ọ̀nà èyí tí ọkọ/ìyàwó mi fi máa ń ṣe àgbékalẹ̀ àwọn ọ̀rọ̀ pàtàkì					
55.	Ìyàwó/ọkọ mi mọ àwọn agbára mi àti pé ó ń ṣe ìwúrí fún ìdàgbàsókè wọn					
56.	Ìyàwó/ọkọ mi máa ń ṣe ìbọ̀wọ̀ fún àṣírí mi					
57.	Ìyàwó/ọkọ mi ní ahun					
58.	Ọkọ mi ń ṣe ìgbéláruge fún ẹ̀wà mi					
59.	Ìyàwó/ọkọ mi máa ń ṣe ìwúrí fún mi pẹ̀lú àwọn ẹ̀bùn tí ó lẹ́wà					
60.	Ọkọ mi kìí fi ìfẹ́ hàn láti ṣe ìrànlọ́wọ́ fún mi pẹ̀lú èyíkèyí iṣẹ́-ṣíṣe					
61.	Ọkọ mi máa ń béèrè nípa iṣẹ́ mi					
62.	Ọkọ mi gbàmí níyànjú / ṣe ìwúrí fún mi láti dé ibi àfojúsùn mi					

APPENDIX 4 (A)

UNIVERSITY OF IBADAN

FACULTY OF EDUCATION

DEPARTMENT OF COUNSELING AND HUMAN BEHAVIOUR STUDIES

CHILDHOOD TRAUMA QUESTIONNAIRE SHORT FORM (M E Q)

Please, tick (√) the appropriate column that best describes your opinion on each of the items. Your responses will be treated with utmost confidentiality.

Thank you.

Section A: Background Information

1. Age: ……..
2. Religion: Christianity [ ] Islamic [ ] Traditional [ ] Others……
3. Tribe: Hausa [ ] Igbo [ ] Yoruba [ ] Others……
4. Years in Marriage: ……
5. Occupation…….
6. Qualification……..

Section B

Directions: These questions ask about some of your experiences growing up as a child and a teenager (1-17 years). For each question, circle the number that best describes how you feel. Although some of these questions are of a personal nature, please try to answer as honestly as you can. Your answers will be kept confidential.

S/N	When I was growing up…	never true	rarely true	sometimes true	often true	very often true
1.	I didn't have enough to eat					
2.	I knew there was someone to take care of me and protect me					
3.	People in my family called me things like 'stupid', 'lazy' or 'ugly'					
4.	My parents were too busy or drunk to take care of the family					

5.	There was someone in my family who made me feel that I was important or special					
6.	I had to wear dirty clothes					
7.	I felt loved					
8.	I thought that my parents wished that I had never been born					
9.	I got hit so hard by someone in my family that I had to see a doctor or go to the hospital					
10.	There was nothing I wanted to change about my family					
11.	People in my family hit me so hard that it left me with bruises or marks					
12.	I was punished with a belt, a board, a cord, or some other hard object					
13.	People in my family looked out for each other					
14.	People in my family said hurtful or insulting things to me					
15.	I believe that I was physically abused					
16.	I had the perfect childhood					
17.	I got hit or beaten so badly that it was noticed by someone like a teacher, neighbor, or doctor					
18.	I felt that someone in my family hated me					
19.	People in my family felt close to each other					
20.	Someone tried to touch me in a seal way or tried to make me touch them					
21.	Someone threatened to hurt me or tell lies about me unless I did something sexual for them					
22.	I had the best friend in the world					
23.	Someone tried to make me do sexual things or watch sexual things					
24.	Someone molested me					
25.	I believe that I was emotionally abused					
26.	There was someone to take me to the doctor if I needed it					
27.	I believe that I was sexually abused					
28.	My family was a source of strength and support					

AFIKUN KERIN (B)
YUNIFÁSÍTÌ TI ÌBÀDÀN
ÀGBÁRÍJỌ-ẸKA TI ÌMỌ̀ ẸKỌ́
ẸKA TI ÌGBANINÍMỌ̀RÀN ÀTI ÌKẸ́KỌ ÌDÀGBÀSÓKÈ ẸDÁ ÈNÌYÀN
M E Q

Jọ̀wọ́, fi àmi (√) sí orígun tí o bámú tí ó ṣe àpèjúwe tí ó dára jùlọ nípa èro-ọkàn rẹ lórí ọ̀kọ̀ọ̀kan àwọn àlàyé tí ó wà ní Abala B. Àwọn ìdáhùn rẹ yóò ní ìtọ́jú pẹ̀lú bíbò l'àṣírí tí ó péye jùlọ.

A dúpé.

Abala A: Àlàyé Ìpilẹ̀

1. **Ọjọ́ orí: ……..**
2. **Ẹ̀sìn: Kìrìsìtẹ́nì [ ] Ísílàmù [ ] Ìbílẹ̀ [ ]**

Àwọn mìíràn …….

3. **Ẹ̀yà: Haúsá [ ] Ígbò [ ] Yorùbá [ ]**

Àwọn mìíràn……

4. **Iye ọdún nínú ìgbeyàwó: ……..**
5. **Iṣẹ́: ……..**
6. **Àfijẹ́ri ẹ̀kọ́: ……**

Abala B

Àwọn ìtọ́nisọ́nà: Àwọn ìbéèrè wọ̀nyí béèrè nípa díẹ̀ nínú àwọn ìrírí rẹ nípa bí o ṣe dàgbà bí ọmọdé àti gẹ́gẹ́ bí ọ̀dọ́ (ọmọ ọdún kan sí mẹ́tàdínlógún). Fún ìbéèrè kọ̀ọ̀kan, fa ìlà yíká nọ́mbà tí o ṣe àpéjúwe dára jùlọ bí o ṣe lérò. Bótilẹ̀jẹ́pé díè nínú àwọn ìbéèrè wọ̀nyìí jẹ́ ti ara ẹni, jọ̀wọ́ gbìyànjú láti dáhùn l'ódodo/l'òtítọ́ bí o ṣe le ṣe. Àṣírí bíbò yóò wà fún àwọn ìdáhùn rẹ.

Òǹkà	Nígbàtí mò ń dàgbà…	Kìí ṣe òtít	Kò fẹ́ è jẹ́	Òtítọ́ ni Nígbàmírà n	Ó ṣábà	Òtítọ́ ni ní

		ọ́ rárá	òtítọ́		jẹ́ òtító	ọ̀pọ̀lọpọ̀ ìgbà
1.	Mi ò ní ànító láti jeun					
2.	Mo mọ̀ pé ẹnìkan wa láti gbọ́ bùkátà mi àti dáàbò bò mí					
3.	Àwọn ènìyàn inú ẹbí mi pè mí ní àwọn orúkọ bíi “dìdìrìn”, “ọ̀lẹ/alápámáṣiṣẹ́”, “aláìlẹ́wà”					
4.	Àwọn òbí mi máa ń fi gbogbo àsìkò wọn ṣiṣẹ́ púpọ̀ tàbí mu ọtí ní èyí tí ó jẹ́ àìrójú fún wọn láti ṣe ìtọ́jú fún mi					
5.	Ẹnìkan wa nínú ẹbí mi tí ó jẹ́ kí n lérò pé mo ṣe pàtàkì tàbí jẹ́ ẹni àpọ́nlé					
6.	Mo máa ń wọ àwọn aṣọ dídòtí					
7.	Mo ní àfihàn ìfẹ́					
8.	Mo rò pé àwọn òbí mi kò gbèrò láti bí mi					
9.	Enìkan lu mí ní ìlùkulù nínú ẹbí mi débi wípé mo ní láti rí dókítà tàbí lo sí ilé-ìwòsàn					
10.	Kò sí ǹ kankan tí mo fẹ́ yípadà nípa ẹbí mi					
11.	Àwọn ènìyàn nínú ìdílé mi lù mí ní ìlùkulù débi wípé mo fi ní àwọn ojú-ọgbẹ́ tàbí àwọn àmì/àpá lára					
12.	Wọ́n jẹ mí níyà pẹ̀lú bélìtì, pátákó pẹlẹbẹ, okùn, tàbí àwọn ohun mìíràn tí ó nira					
13.	Àwọn ènìyàn nínú ẹbí mi máa ń wá ìjà láàrin ara wọn					
14.	Àwọn ẹbí mi máa ń sọ ọ̀rọ̀ búburú tàbí ọ̀rọ̀ ìbánújẹ́ sí mi					
15.	Mo gbàgbọ́ pé wọ́n fi ìyà jẹ mí nípa ti ara/ìlòkúlò ara					
16.	Mo lo ìgbésíayé ọmọdé tó dára					
17.	Wọ́n fi ǹ kan gbámi tàbí lù mí lápọ̀jù débi wípé ẹlòmíràn bíi olùkọ́, alábàágbé tàbí dókítà fi mò					
18.	Mo lérò pé ẹnìkan nínú ẹbí mi kò fẹ́ràn Mi					
19.	Àwọn ènìyàn nínú ẹbí mi ní ìṣòkan láàrín ara wọn					
20.	Enìkan gbìyànjú láti fi ọwọ́ kànmí ní ọ̀nà ìbálòpọ̀ tíkò lẹ̀tó tàbí gbìyànjú láti jẹ kí n fí ọwọ́ kàn-án					
21.	Enìkan halẹ̀/dẹ́rùbàmí pé yóò pamílára					

	tàbí kí ó parọ́ nípa mi àyàfi tí mo bá ṣe ohun ìbálòpọ̀ fún wọn					
22.	Mo ní òré tí ó dára jùlọ ní àgbáyé					
23.	Ẹnìkan gbìyànjú láti jẹ́ kí n ṣe àwọn ǹkan tó jẹmọ́ ìbálòpọ̀ tàbí wo àwọn àwòrán ìbálòpọ̀					
24.	Ẹnìkan bàmí jẹ́					
25.	Mo gbàgbó pé wọ́n fi ìyà jẹ mí nípa ìlòkulò ara					
26.	Ẹnìkan wá láti mú mi lo sí ọ̀dọ dókítà tí mo bá nílo rẹ̀					
27.	Mo gbàgbọ́ pé wọ́n fi ipá bámi ṣe ìṣekúṣe/ ní ìbálòpọ̀					
28.	Ìdílé mi jẹ orísun agbára àti àtìlẹyìn					

APPENDIX 5 (A)

UNIVERSITY OF IBADAN

FACULTY OF EDUCATION

DEPARTMENT OF COUNSELLING AND HUMAN DEVELOPMENT STUDIES

Focus Group Discussion Questions

- Session one

  Question 1: What precipitates marital satisfaction?

  Question 2: What precipitates marital dissatisfaction?

- How has it affected someone you know?
- How has this affected you?

- Session two

  Question 3: How does childhood trauma affect marital satisfaction?

- How has it affected someone you know?
- How has it affected you?

- Session three

  Question 4: What strategies are being used to facilitate satisfaction in marriages?

  Question 5: What is your personality type?

  Question 6: With your personality type, which strategies work for you?

  Question 7: What areas of spousal support can bring you marital satisfaction?

ÀFIKÚN KARÙN-ÚN (B)

YUNIFÁSÍTÌ TI ÌBÀDÀN

ÀGBÁRÍJỌ-ẸỊKA TI ÌMỌ̀ ẸỊKỌ́

ẸỊKA TI ÌGBANINÍMỌ̀RÀN ÀTI ÌKẸ́KỌ ÌDÀGBÀSÓKÈ ẸỊDÁ ÈNÌYÀN

Ìfojúsùn Àpéjọpọ̀ Ìjòkó fún Ìjíròrò

Ìgbà Àkọ́kọ́

1) Kí ló máa ń mú kéèyàn ní ìtẹ́lọ́rùn nínú ìgbéyàwó?
2) Kí ló máa ń mú kéèyàn ṣe àìní-ìtẹ́lọ́rùn nínú ìgbéyàwó?
   - Báwo ló ṣe kan ẹnìkan tó o mọ̀?
   - Báwo ni ó ṣe kàn ọ́?

Ìgbà Kejì

3) Báwo ni ìbànújẹ́ ìgbà ọmọdé ṣe ń nípa lórí àwọn obìnrin tó ti ṣe ìgbéyàwó?
   - Báwo ló ṣe kan ẹnìkan tó o mọ̀?
   - Báwo ni ó ṣe kàn ọ́?

Ìgbà Kẹta

4) Àwọn ìlànà ọgbọ́n wo ni wọ́n ń lò láti mú ìtẹ́lọ́rùn bá àwọn ìgbéyàwó?
5) Irú ènìyàn wo lo jẹ́?
6) Pẹ̀lú irú ènìyàn tí o jẹ́, èwo nínú àwọn ọgbọ́n wọ̀nyí ni ó ṣiṣẹ́ fún ọ?
7) Àwọn apá àtìlẹ́yìn ọkọ/aya wo ló leè fún ẹ ní ìtẹ́lọ́rùn nínú ìgbéyàwó?

APPENDIX 6 (A)

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DEPARTMENT OF COUNSELLING AND HUMAN DEVELOPMENT STUDIES

A-B-C Worksheet **Date:_____** **Participant:**

_____

ACTIVATING EVENT **BELIEF/STUCK POINT**

CONSEQUENCE

A **B**

C

"Something happens." "I tell myself something."

"I Feel something."

Are my thoughts above in "B" *realistic?*

_____

_____

What can you tell yourself on such occasions in the future?

_____

_____

_____

ÀFIKÚN KẸFÀ (B)

YUNIFÁSÍTÌ TI ÌLU ÌBÀDÀN

ÀGBÁRÍJỌ-ẸKA TI ÌMỌ̀ ẸKỌ́

ẸKA TI ÌGBANINÍMỌ̀RÀN ÀTI ÌKẸ́KỌ ÌDÀGBÀSÓKÈ ẸDÁ ÈNÌYÀN

A-B-D Ìwé iṣẹ́ **Déètì :_____** **Alábaṣe _____**

GBÍGBÉRÓ ÌṢẸ̀LẸ̀ **ÌGBÀGBỌ́**

ÀTÚBỌ̀TÁN

A **B**

D

“ohun kan ṣẹlẹ̀ “Mo bá ara mi sọ ọ̀rọ̀ kan.”

“mo ní ìmọ̀lára kan”

Ǹjẹ́ àwọn èrò mi ní abala “B” jẹ òtítọ́ bí?

Kíni àwọn ǹkan tí o le bá ara rẹ sọ ní irú àwọn ìṣẹ̀lẹ̀ yìí lọ́jọ́ iwájú?

APPENDIX 7(A)

UNIVERSITY OF IBADAN
FACULTY OF EDUCATION
DEPARTMENT OF COUNSELLING AND HUMAN DEVELOPMENT STUDIES

Challenging Questions Worksheet (CQW)

Below is a list of questions to be used in helping you challenge your problematic beliefs/stuck points. Answer as many questions as you can for the belief/stuck point you have chosen to challenge below.

Belief/Stuckpoint: -

_____

1. What is the evidence for and against this stuck point?

   FOR:

   AGAINST:

2. Is your stuck point a habit or based on facts?

3. In what way is your stuck point not including all of the information?

4. Does your stuck point include all-or-nothing terms?

5. Does the stuck point include words or phrases that are extreme or exaggerated (i.e., always, forever, never, need, should, must, can't, and every time)?

6. In what way is your stuck point focused on just one part of the situation?

7. Where did this stuck point come from? Is this a dependable source of information on this stuck point?

8. How is your stuck point confusing something that is possible with something that is likely?

9. In what way is your stuck point based on feeling rather than facts?

10. In what way is your stuck point focused on unrelated parts of the situation?

ÀFIKÚN KEJE (B)

YUNIFÁSÍTÌ TI ÌLU ÌBÀDÀN

ÀGBÁRÍJỌ-ẸKA TI ÌMỌ̀ ẸKỌ́

ẸKA TI ÌGBANINÍMỌ̀RÀN ÀTI ÌKẸ́KỌ ÌDÀGBÀSÓKÈ ẸDÁ ÈNÌYÀN

ABALA ÌWÉ IṢẸ́ FÚN ÌBÉÈRÈ ÌPÈNÍJÀ

Àwọn ìbéèrè tí ó wà ní ìsàlẹ̀ yìí ni o le lò láti ràn ẹ lọ́wọ́ lati kojú àwọn ìwà kò - tọ́ rẹ. Kìí ṣe gbogbo ìbéèrè ni ó le ṣe rẹ́gí pèlú àwọn ìgbàgbọ́ rẹ tàbí ìṣòro àìletẹ̀síwájú tí ó ń pè ọ́ níjà. Dáhùn iye àwọn ìbéèrè tí o bá lágbára láti fún ìgbàgbọ́ rẹ lórí ìṣòro tí o yàn fún ìpènijà ní ìsàlẹ̀

ÌGBÀGBỌ́ /Kókó ÀÌLETẸ̀SÍWÁJÚ_____

1. Kíni ẹ̀rí sí àti ohun tí ó ni tako àìle-tẹ̀síwájú yìí

   FARAMỌ́ :

   TAKÒ :

2. Ǹjẹ́ àìle-tèsíwájú rẹ jẹ́ bárakú tàbí ó dá lórí òkodoro kan pàtó ?

3. Ọ̀nà wo ni ìṣòro àìle-tẹ̀síwájú rẹ kò ṣe sí lára àwọn ìfitónilétí wọ̀nyìí?

4. Ṣé gbogbo àwọn ìbéèrè wọ̀nyìí ló wà nínú ìṣòro àìle-tẹ̀síwájú rẹ àbí kò sí ọ̀kankan níbẹ̀?
5. Ǹjẹ́ àwọn ìṣòro àìle-tẹ̀síwájú rẹ jẹ ọ̀rọ̀ tàbí àpólà tí ó pọ̀ rékọjá ohun tí a lè fẹnu sọ (bíi àpẹẹrẹ: lóòrè kóòrè, ìgbà, láílái, rárá, nílò, gbọ́dọ̀, rárá, ní gbogbo ìgbà

6. Ọ̀nà wo ni àwọn àìle- tẹ̀síwájú rẹ dá lé orí ìtàn kan pàtó?

7. Níbo ni àwọn ọ̀nà àìletẹ̀síwájú yìí tí wa?

8. Báwo ni kókó àìletẹ̀síwájú rẹ ṣe ń rújú fún ǹkan tí ó ṣeé ṣe pẹ̀lú ǹkan tí ó le ṣeé ṣe?

9. Báwo ni ìṣòro àìletẹ̀síwájú rẹ ṣe dá lé èrò ọkàn rẹ dípò òdodo?

10. Ọ̀nà wo ni ìṣòro àìletẹ̀síwájú rẹ ṣe dá lé ìtàn tí kò ní àṣepọ̀ pẹ̀lú ìtàn náà?

APPENDIX 8 (A)

UNIVERSITY OF IBADAN
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DEPARTMENT OF COUNSELLING AND HUMAN DEVELOPMENT STUDIES

Pattern of Problematic Thinking Worksheet (PPTW)

Listed below are several types of patterns of problematic thinking that people use in different life situations. These patterns often become automatic, habitual thoughts that cause us to engage in self-defeating ways. Considering your own stuck points, find examples for each of these patterns. Write the stuck point under the appropriate problematic pattern. Think about how that pattern affects you.

1. **Jumping to conclusions** or predicting the future (fortune telling):

2. **Exaggerating or minimizing** a situation (blowing things way out of proportion or shrinking their importance inappropriately):

3. **Ignoring important parts** of a situation (mental filtering):

4. **Oversimplifying** things as good/bad or right/wrong (polarized thinking):

5. **Over-generalizing** from a single incident (a negative event is seen as a never-ending pattern):

6. **Minding reading** (you assume people are thinking negatively of you when there is no definite evidence of this):

7. **Emotional reasoning** (using your emotion as proof, e.g. “I feel fear so I must be in danger”):

ÀFIKÚN KẸJỌ (B)

YUNIFÁSÍTÌ TI ÌLU ÌBÀDÀN
ÀGBÁRÍJỌ-ẸKA TI ÌMỌ̀ ẸKỌ́
ẸKA TI ÌGBANINÍMỌ̀RÀN ÀTI ÌKẸ́KỌ ÌDÀGBÀSÓKÈ ẸDÁ ÈNÌYÀN

Ìwé Ṣíṣe Ìrònú Lórí Ìsòro

Àwọn àpẹẹrẹ atọ́ka ìsàlẹ̀ yìí ni ọ̀nà ìrònú orísìírísìí ìṣòro tí ó ń dojú kọ àwọn ènìyàn ní ilé ayé. Àwọn àpẹẹrẹ wọ̀nyìí lópọ̀ ìgbà máa ń di àfọwọ́yí tí ó sì máa ń fa kí ènìyàn já ara rẹ̀ kúlẹ̀. Ronú sì ìṣòro àìletẹ̀síwájú tìrẹ kí ó sì wá àpẹẹrẹ fún ọ̀kọ̀ọ̀kan àwọn ìlànà wònyìí
Kọ ìṣòro àìletẹ̀síwájú náà lábẹ́ bátáàni tí ó bá a mu. Ronú nípa bí àpẹẹrẹ náà ṣe kàn ọ́

1. Fifò sí ìparí tàbí àsọtẹ́lẹ̀ ọjọ́ iwájú?

2. Sísọ àsọjù tàbí díndín ǹkan kù (ṣíṣe àṣejù tàbí díndín pàtàkì ǹkan kù lọ́nà tí kò bójúmu).

3. Àìbìkítà fún àwọn abala tí ó yẹ nínú ìṣẹ̀lẹ̀ kan

4. Ṣíṣe àpọjù ǹkan bí ó ti dára/burú tàbí ẹ̀tọ́/àṣìṣe

5. Àsọjù púpò lórí ìṣẹ̀lẹ̀ kan (ìṣẹ̀lẹ̀ kan tí kò dára gẹ́gẹ́bíi eléyìí tí kò ní ní òpin).

6. Kíka ọkàn ènìyàn (O lérò pé àwọn ènìyàn ń ronú òdì nípa rẹ nígbà tí kò sí ẹ̀rí fún èyí).

7. Ìfarahàn ẹdùn ọkàn (lílo àwọn ẹ̀dùn ọkàn rẹ bíi, “Mo ní ìmọ̀lára ìbẹ̀rù nítorí náà mo gbọ́dọ̀ wọ inú ewu”).

APPENDIX 9A

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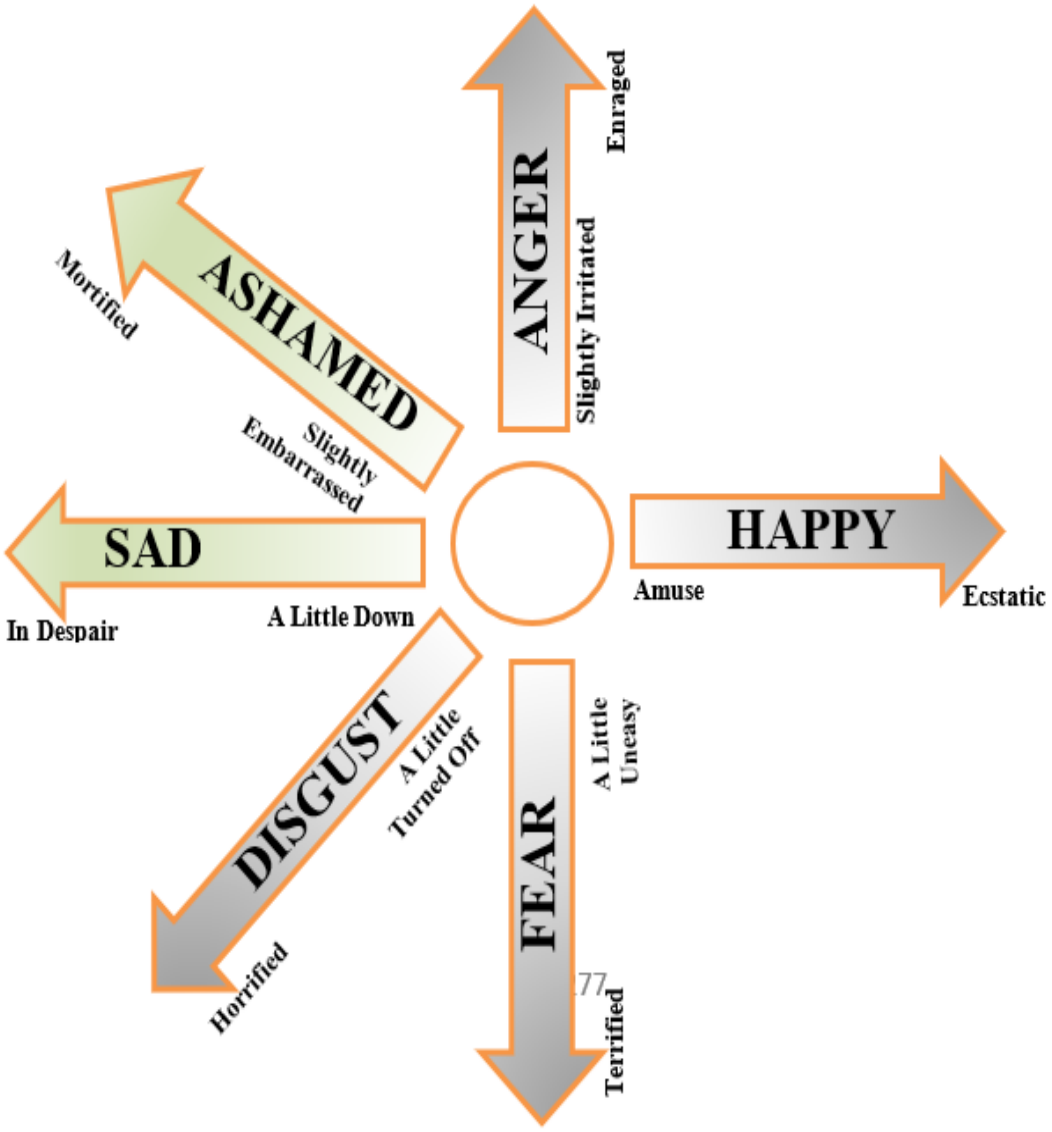
FACULTY OF EDUCATION

DEPARTMENT OF COUNSELLING AND HUMAN DEVELOPMENT STUDIES



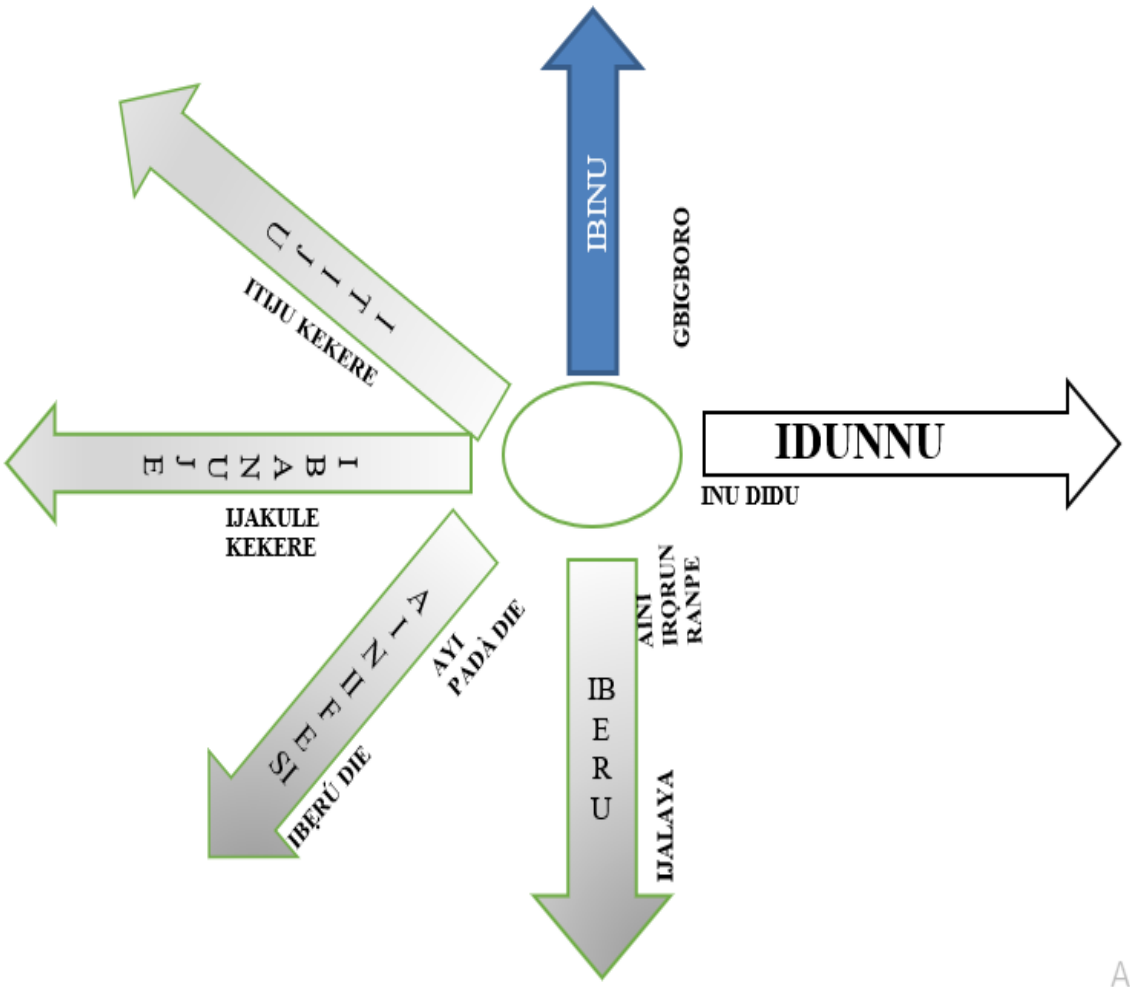
ÀFIKÚN KẸSÀN-ÁN(B)

YUNIFÁSÍTÌ TI ÌLU ÌBÀDÀN

ÀGBÁRÍJỌ-ẸKA TI ÌMỌ̀ ẸKỌ́

ẸKA TI ÌGBANINÍMỌ̀RÀN ÀTI ÌKẸ́KỌ ÌDÀGBÀSÓKÈ ẸDÁ ÈNÌYÀN

ṢÍṢE ÀFIHÀN ÌWÉ ÀFỌWỌ́KỌ FÚN ẸDUN ỌKÀN



APPENDIX 10 (A)

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DEPARTMENT OF COUNSELLING AND HUMAN DEVELOPMENT STUDIES

Challenging Beliefs Worksheet (CBW)

A. Situation	**B. Thought/Stuck Point**	**D. Challenging Thoughts**	**E. Problematic Patterns**	**F. Alternative Thought(s)**
Describe the event, thought or belief leading to the unpleasant emotion(s).	Write thought/stuck point related to Column A. Rate belief in each thought/stuck point below from 0-100% (how much do you believe this thought?)	Use **challenging Questions** to examine your automatic thought from Column B. Consider if the thought is balanced and factual or extreme.	Use the **Patterns of Problematic Thinking Worksheet** to decide if this is one of your problematic patterns of thinking.	What else can I say instead of Column B? How else can I interpret the event instead of Column B? Rate belief in alternative thought (s) from 0-100%
	C. Emotion(s) Specify sad, angry, e.tc., and rate how strongly you fell each	Evidence For? Evidence Against? Habit or Fact? Not including all information? All or none? Extreme or Exaggerated? Focused on just one piece?	Jumping to conclusions: Exaggerating or minimizing: Ignoring important parts: Oversimplifying:	**G. Re-rate Old Thought/Stuck Point** Re-rate how much you now believe the

	emotion from 0-100%	Source dependable? Confusing possible with likely? Based on feeling or facts? Focused on unrelated parts?	Over-generalizing: Mind reading: Emotional reasoning:	though/stuck point in column B from 0-100% **H. Emotion(s)** Now what do you feel? 0-100%

ÀFIKÚN KẸWÀÁ (B)

YUNIFÁSÍTÌ TI ÌLU ÌBÀDÀN

ÀGBÁRÍJỌ-ỆKA TI ÌMỌ̀ ỆKỌ́

ỆKA TI ÌGBANINÍMỌ̀RÀN ÀTI ÌKẸ́KỌ ÌDÀGBÀSÓKÈ ỆDÁ ÈNÌYÀN

Ìwé fún àwọn ìpènijà ohun tí a gbàgbọ́

A. ÌṢỆLẸ	B. ÈRÒ/ÀÌNÍ ÌTẸ̀SÍWÁJÚ	E. ÈRÒ ÌPÈNIJÀ	E. ÌLÀNÀ FÚN ÌṢÒRO	F. ÈRÒ ÌDÀKEJÌ
Ṣe àpèjúwe ìṣẹ̀lẹ̀ , ìrònú tàbí ìgbàgbọ́ tó yọrí sí ẹ̀dùn ọkàn	Kọ ìṣòro àìletẹ̀síwájú tó jẹ mọ́ abala A A. Lo òṣùwọ̀n yìí(0-100%) láti pín ìṣòro àìletẹ̀síwájú yìí Kíni èrò rẹ nípa rẹ̀?	Lo àwọn ìbéèrè ìtaláyà láti dáhùn àwọn èrò tàárà ṣòòsé ní abala B Ronú bí èrò náà bá ṣe rẹ́gí, òdodo tàbí ó pọ̀ jù	**Lo ìlànà ìwé ìṣẹ́ ṣíṣe àṣàrò lórí ìsòro láti wò bóyá èyí jẹ ọ̀kan lára** àwọn ìṣòro rẹ	Kíni ohun tí mo tún lè ṣọ yàtọ̀ sí abala B? Báwo ni mo tún ṣe lè ṣe atúmọ̀ ìṣẹ̀lẹ̀ náà yàtọ̀ sí abala B Ṣe òṣùwọ̀n àwọn èrò rẹ láti 0-100%

	D. ẸDUN ỌKÀN Sọ ní pàtó nípa: ìbánújẹ́, ìbínú, abbl láti 0-100%	Ẹ̀rí fún? Ẹ̀rí lòdì si? Ìṣesí tàbí òkodoro? Kò pẹ̀lú gbogbo àwọn àlàyé yìí? Gbogbo tàbí rárá? Àṣejù tàbí àṣọdùn Dídá lé orí ẹyọkan péré ? Orísun ṣe é gbékẹ̀lé? Dí dojú rú pẹ̀lú ó ṣeé ṣe? Ṣé ó dá lórí èrò rírò tàbí òdodo? Fífi ojú sí bátánì tí kò báramu	Fífò sí ìparí lójijì : Ṣíṣe àfikún púpọ̀ jù tàbí díndínkù Àì bìkítà fún àwọn abala tó ṣe kókó: Ṣíṣe àpọ̀jù ǹkan ju bí ó ṣe yẹ lọ Aṣojú lórí ohun kan Kíka ọkàn Ìfarahàn ẹ̀dun ọkàn	**G.** ṢÍṢE ÒDINWỌ̀N ÈRÒ ÀTIJỌ́ Tún òdinwọ̀n rẹ dà láti 0-100% **GB. Ẹ̀dun ọkàn** Kíni èrò rẹ báyìí ? 0-100%

APPENDIX 11

IMPACT STATEMENTS

Written at the onset of the intervention (1)

Can I feel safe again?

I had an experience some years back during my childhood days which left me traumatized and still affects me till date. My mum used to have a nursery/primary and secondary school behind the main building of our house. Our house and the school were in the same premises. As at then, I was still attending the nursery school myself.

On this particular day, a family friend came looking for us at school. When he got to the nursery school quarters to make some inquiries about my mum's where abouts, he was informed that my mum had gone out and that he could wait for her in the main building of the house. I was therefore called upon and asked to lead him into the house which I gladly did since I was very familiar with him. I led him in as I was instructed. As soon as we got in, he sat in a chair and requested that I sit on his laps. I gladly complied after all he was a close friend of the family. This man then started touching me inappropriately. I stood up immediately and left him. When my mum and sisters came back, I told them about the incident and they set a trap for him which he fell for. Consequently, he was handed over to the authorities. After that, I started having trust issues around guys I see. As a mother now, it has made me over-protective of my children. I cannot leave my children with anybody, not even family members. I often get worried that they could molest them. This is one event that I have found difficult to let go off. Sexual activities have been a struggle for me. Initially. My husband complained bitterly but now he is learning to cope.

Written at the end of the intervention

The traumatic experience left me with trust issues from my childhood but I am working on it. When bad things happen, it can take a while to get over the pain and feel safe again but with self-help methods and other strategies taught during the programme, I have discovered at this time that it is possible to recover. As a wife, I am now more

welcoming to my husband's jokes and sexual advances; something I used to find difficult to do. I feel a lot safer because I am able to trust my husband and others better.

(**Respondent 38, 25 years old, impact statement CPT, PHC Iwo Road).**

Written at the onset of the intervention (2)

Can I be free and happy again?

At the age of 9, I lived in a neighbourhood where we followed a woman to the market place. We enjoyed doing this because she usually bought things for us. My mum never liked the idea of me following that woman so she warned me several times not to do so again. On a particular day, my mother made an eye signal to me, meaning that I should not follow the woman to the market. However, because I enjoyed the goodies the woman bought for me, I ignored her warnings. Unknown to me, thinking back now, she had made a decision to deal with my stubbornness and disobedience once and for all. While we were returning from the market, I spotted her across the road holding a long cane waiting for me. Out of fear, I immediately threw all the snacks I was holding into the bush and intentionally flung myself in front of a moving vehicle. Thank God that I was not killed but only bruised.

My mother did not move an inch from where she was, even as the crowd was trying to get me to safety. Unfortunately, immediately the crowd dispersed, my mother came and flogged me without mercy. It is indeed a day I have never forgotten. After the painful event, I wondered if my mother even loved me. I felt so humiliated. I even blamed myself for all my misfortune. Indeed, I felt both physically and emotionally abused. From that time on, I hardly got out of my home to even attend parties, ceremonies or functions. I would rather stay in my house. For this reason, my husband complains that I behave like a recluse who needs *deliverance.* Often times, he goes out for ceremonies on his own which makes me feel sad and unwanted. Since the incident I find it difficult to accept gifts from people wholeheartedly without feeling ashamed or embarrassed especially when I reflect on how I was badly flogged and injured.

Written at the end of the intervention

The older I grow, the more I learn and understand somethings. Formerly, I would blame my mother for being poor and for living in a suburb area, which encouraged me to accompany people I see anywhere they go, just because I liked the treats, they would give me. Now, I can say that it was not her fault neither was it mine. Now that I think about it, she reacted that way because she was only trying to teach me how to be content though in the process, she hurt me severely leaving me embittered. During the programme, the researcher helped me see that I should let go of any hurtful feelings of the past. I had to forgive my mother. I also had to stop judging my past actions harshly. Staying away from valuable relationships only made me lonely. I have even made up my mind to start going out with my husband now. I am grateful that I participated in the programme as I can now relate freely with my husband and others without having to remember my experience.

(**Respondent 41, 36 years old, impact statement CPT, PHC Iwo Road).**

Written at the onset of the intervention (3)

Who am I?

When I was a young girl, I was left with my paternal grandparents to take care of me while my parents travelled abroad. At a stage, my school fees were not paid, even when my parents sent funds. My grandfather was using the money to pay for the school fees of his second wife's children. This made me sad. I was so happy when my parents returned, however, after a while, the joy of staying with them turned sour as I was treated like a second-class citizen in my own home. I was not allowed to play with my siblings who had been staying with them in the United Kingdom. I would be yelled at, even when I did nothing wrong. There was a day my mother accused me of stealing her money, consequently, I was forced to sleep outside the house.

This really traumatized me. Based on this, I hardly mix with people. I have lost confidence in myself because I feel I do not know how to do anything right. I prefer staying alone. Even when I have challenges, I do not discuss them with anyone. I find it hard to talk with my husband or enjoy any romantic times with him. I also find it difficult to feel safe around my spouse and others around me, though I still thank God that I did not lose my faith in Him.

Written at the end of the intervention

I am happy that this programme came up at this period. Thank God that I was able to open up because I hardly share my experiences with people. Just remembering it brings back memories of shame, hopelessness and worthlessness. I am so happy that during the programme I was told that the situation was not my fault. I do not have control over everything that happens to me. The researcher made me realise that my husband also deserves my trust and affection. My fear of rejection and abandonment made me push him away. Now I can see that I don't need to be ashamed of myself. I can also see that I am surrounded by people who love me and want to be with me. Although, it was an awful experience, I am getting over it. I learnt that I have to forgive those who hurt me, so I can find some form of closure. The wound is healing and with time I believe it will disappear. I have discovered that there is no difficult situation that cannot change for good. This has helped me view many other situations in positive ways.

(Respondent 51, 29 years old, impact statement CPT, PHC Iwo Road)

APPENDIX 12

UNIVERSITY OF IBADAN

FACULTY OF EDUCATION

DEPARTMENT OF COUNSELLING AND HUMAN DEVELOPMENT STUDIES

INFORMED CONSENT FORM

IRB Research approval number: UI/SSHREC/2021/0022

Title of the Research: Effects of Cognitive processing and Stress inoculation therapies on marital satisfaction of women with childhood trauma in Ibadan.

Name of Researcher and department: Grace Gbenga Adewale. Department of Counselling and Human Development Studies, University of Ibadan, Nigeria.

Purpose of Research: The purpose is to investigate the effects of Cognitive Processing and Stress Inoculation therapies on marital satisfaction of women with childhood trauma in Ibadan.

Procedure of Research:

Participants who are available and willing to take part in the study will be selected based on their performances in the screening exercise. All the selected participants will meet at the Primary Health Care centre every week for one hour. Home work will be given at the end of each training session. Each participant would be expected to attempt the home work and give some feedback at subsequent sessions. Overall, a total of 90 participants will be selected for the study.

Expected duration of research and of participant(s) involvement: Participants are expected to be involved in this research for a period of 8 weeks; having sessions every week. They are to spend an hour at each session.

Risks: The study involves no form of risk whatsoever to the participants. The therapies are 'talking' forms of treatment. They are not invasive. They do not involve any form of drug prescriptions or administration.

Costs to the participants of joining the research: Participation of the study will be at no cost for the participants.

Benefit(s): The goal of this research is to find ways of improving quality of life by enhancing marital satisfaction through the interventions.

Confidentiality: Code numbers will be written on all the information to be received in this study, so that names and other forms of identity will not be included. The information can therefore not be linked to any of the participants in any way; no names or forms of identification of the participants will be revealed for public consumption.

Voluntary: Participation in this research is entirely voluntary.

Alternative to participation: the decision not to take part or the withdrawal of participation in this research will not affect participants' treatment in any of the primary healthcare centres in any way.

Due inducement(s): Participants will be given snacks at the end of each session of the intervention; however, they will not be paid any fees for participating in the study.

Consequences of Participants' decision to withdraw from research and procedure for orderly termination of participation: any participant may choose to withdraw from the research at any time they desire. It is worthy of note that some of the information that has previously been obtained about such participants before choosing to withdraw may not be retrievable.

Statement of Researcher:

I have fully explained this research to_____
and have given sufficient information to her to make an informed decision.

Date: _____ Signature: _____

Name: _____

Statement of Participant: Terms of the research have been explained to me. I understand that my participation is voluntary. I know enough about the purpose, methods, benefits and objectives of the research study to judge that I want to take part in it. I understand that I may freely stop being part of this study any time I choose.

I have received a copy of this consent form.

Date: _____ Signature: _____

Name: _____

Detailed contact information including name, telephone, and e-mail of researcher:

E-Mail: ggadewale@gmail.com. In addition, if you have any questions about your participation in this research, contact the Principal Investigator: Grace G. Adewale (+2348095073211).

Department: Counselling and human development studies, University of Ibadan, Oyo State.

ÀFIKÚN KEJÌLÁ (B)

YUNIFÁSÍTÌ TI ÌLU ÌBÀDÀN

ÀGBÁRÍJỌ-ẸKA TI ÌMỌ̀ ẸKỌ́

ẸKA TI ÌGBANINÍMỌ̀RÀN ÀTI ÌKẸ́KỌ ÌDÀGBÀSÓKÈ ẸDÁ ÈNÌYÀN

FỌ̀ỌMÙ ÌFITÓNILÉTÍ FÚN GBÍGBA ÌYỌ̀NDA LÁTỌKÀNWÁ

Nọ́mbà Ìfọwọ́sí ìwádìí (IRB): UI/SSHREC/2021/0022

Àkolé ti ìwádìí náà: Ipa tí ṣíṣe aáyan ìmọ̀-ìjìnlẹ̀ àti àwọn ìtọ́jú aranilọ́wọ́ ìṣàdínkù agbára ìnira/ìṣòro lórí ìtẹ́lọ́rùn ìgbéyàwó ti àwọn obìnrin pẹ̀lú wàhálà ọmọdé ní Ìbàdàn.

Orúkọ ti Olùwádìí àti èka-ìkékọ̀ọ́: Grace Gbénga Adéwálé: Ẹ̀ka-ìkẹ́kọ ti ìgbaninímọ̀ràn àti Àwọn Ẹ̀kọ́ Ìdàgbàsókè Ènìyàn, Yunifásítì ti Ìbàdàn, Nàìjíríà.

Ìdí ti Ìwádìí: Ìdí ìwádìí ni láti ṣe ìwádìí àwọn ipa tí ṣíṣe aáyan ìmọ̀ àti àwọn ìtọ́jú arannilọ́wọ́ ìṣádínkù agbára ìnira/ìṣòro lórí ìtẹ́lọ́rùn àwọn obìnrin pẹ̀lú wàhálà ọmọdé ní Ìbàdàn.

Ìlàna ti Ìwádìí:

Àwọn Olùkópa tí ó wà àti tí ó sì nífẹ́ láti kópa nínú ìwádìí ni a ó yàn lórí bí wọ́n bá ti ṣe dáradára nínú àyẹ̀wò. Gbogbo àwọn olùkópa tí a yàn yóó pàdé ní ibùdó Ilé Ìṣe Ìtọ́jú Ìlera ní gbogbo ọ̀sẹ̀ fún wákàtí kan. A ó fun yín ní iṣẹ́ àdánìkànṣe ní ilé ní ìparí ìdánilẹ́kọ̀ọ́ kọ̀ọ̀kan. Olùkópa kọ̀ọ̀kan ni a nírètí pé yoó gbìyànjú iṣẹ́ àdánìkànṣe ní ilé àti pé yóò dá èsì padà ní àtẹ̀lé ìkẹ́kọ̀ọ́ kọ̀ọ̀kan. Ìwòye, àádọ́rún àpapọ̀ àwọn olùkópa ni a ó yàn fún ìwádìí náà.

Iye àkókò tí a rọ̀ wípé ìwádìí yóò gbà àti ti ìlọ́wọ́sí (àwọn) olùkópa: Àwọn olùkópa ni a nírètí láti ní ipa nínú ìwádìí fún àkókò ọ̀sẹ̀ méjọ; ìdánilẹ́kọ̀ọ́ ọ̀sọ̀ọ̀sẹ̀. Wọ́n ní láti lo wákàtí kan ní ìdánilẹ́kọ̀ọ́ kọ̀ọ̀kan.

Àwọn Ewu: Ìwádìí náà kòní ewu èyíkèyí fún àwọn olùkópa. Àwọn ìtọ́jú arannilọ́wọ́ ìlera bíi "ọ̀rọ̀ sísọ" àwọn ìlànà ìtọ́jú. A kò leè ṣe aláìṣe wọ́n. Wọn kò ní àjọṣepọ̀ pẹ̀lú èyíkèyí ìlànà ìjúwe/ìfọwọ́sí òògùn/egbòogi tàbí ìṣàkóso.

(Àwọn) Àǹfààní: Àwọn àfojúsùn ìwádìí yìí ni láti ṣe àwárí àwọn ọ̀nà ìlọsíwájú dídárasí ìgbésí ayé nípasè àwọn ìgbéláruge ìtẹ́lọ́rùn ìgbéyàwó nípasẹ̀ àwọn ìlọ́wọ́sí/ìdásí.

Àṣírí: Àwọn kóòdù nọ́mbà yóò wà lórí gbogbo àwọn àlàyé tí wà á gbà nínú ìwádìí yìí, nítorínà àwọn orúkọ àti àwọn ọ̀nà ìdánimọ̀ miíràn kò ní wà níbẹ̀. Nítorínà àwọn àlàyé kò

le sopọ̀ pẹ̀lú èyíkèyí àwọn olùkópa ní èyíkèyí ọ̀nà; kò sí àwọn orúkọ tàbí èyíkèyí ìlànà ìdánimò ti àwọn olùkópa tí á fi síta/ṣàfihàn fún lílò àwùjọ.

Ìfinúfídọ̀: Ìkópa nínú ìwádìí yìí jẹ́ àtọkànwá pọ́nńbélé.

Ọ̀na mìíràn láti kópa: Ìpinnu láti má kópa tàbí jáde kúrò nínú ìkópa nínú ìwádìí kò ní ìpalára kankan sí ìtọ́jú ìlera àwọn olùkópa ní àwọn Ilé-ìwòsàn Alábọ́dé ní èyíkèyí ọ̀nà.

Àwọn ohun ìfanimọ́ra tí ó wà: Àwọn olùkópa yóò gba ouńjẹ ìpápánu ní ìparí ìdánilẹ́kọ̀ọ́ kọ̀ọ̀kan ṣùgbọ́n ṣá a kò ní fún wọn ní owó kankan fún ìkópa wọn nínú ìwádìí yìí.

Àpèyìndà ìpinnu ti àwọn olùkópa láti jáde kúrò nínú ìwádìí àti àwọn ìlànà létòlétò fún ìfòpinsí ìkópa: Èyíkèyí olùkópa le pinnu láti jáde kúrò nínú ìwádìí nígbàkugbà tí ó bá fẹ́. Ó yẹ láti ṣe àkíyèsí pé díè nínú àwọn àlàyé tí a ti gbàsílẹ̀ nípa irú olùkópa bẹ́ẹ̀ ṣáájú yíyàn láti jáde kúrò nínú ìwádìí leè má ṣe e gbà padà.

Àlàyé ti Olùwádìí:

Mo ti sàlàyé ìwádìí yìí lẹ́kúnrẹ́rẹ́ fún ……. àti pé mo ti fún un ní àlàyé kíkún láti leè ṣe ìpinnu tó dára.

Òǹkà ọjọ́/Déètì: …… Ìbuwọ́lù: ……

Orúkọ: ……

Gbólóhùn ti olùkópa: Àwọn òfin ti ìwádìí ni wọ́n ti sàlàyé fún mi. Mo ní àgbọ́yé pé ìkópa mi nínú ìwádìí yìí jẹ́ àtọkànwá/ìfinúfídò. Mo ní ìmọ̀ tó nípa ìdí, àwọn ìlànà, àwọn ànfààní àti àwọn àfojúsùn ìwádìí yìí láti ṣe ìdájọ́ pé mo fẹ́ kópa nínu rẹ̀. Mo lóye pé mo ní òmìnira jíjáde kúrò nínú ìwádìí yìí nígbàkugbà tímo bá yàn/fẹ́. Mo ti gba ẹ̀da ti fọ́ọ̀mù ìfinúfídọ̀/gbígbà látọkànwá.

Ọ̀ǹkà ọjọ́/Déètì: ……..

Ìbuwọ́lù: ……..

Orúkọ: ……

Àlàyé kíkún fún ìkànsíni/ìbáraẹnisọ̀rọ̀ tó ní bíi orúkọ, tẹlifóònù, àti e-mail ti olùwádìí nínú:

E-Mail: ggadewale@gmail.com Ní àfikún, tí o bá ní èyíkèyí ìbéèrè nípa ìkópa rẹ nínú ìwádìí yìí, o lè kànsí Olùwádìí Àgbà: Grace. G. Adewale

Ẹ̀ka-ìkẹ́kọ̀ọ́ ti: Ìgbaninímọ̀ràn àti ẹ̀kọ́ ìdàgbàsókè ènìyàn, Yunifásítì ti Ìbàdàn, Ìpínlẹ̀ Òyọ́. Nọ́mbà whatsapp: +234809507211.

Appendix 13A

Reliability Statistics of Enrich Marital Satisfaction Scale (EMS)

Reliability Statistics

Cronbach's Alpha	N of Items
.757	15

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted	
My partner and I understand each other perfectly	214.70	555305.597	-.259	.761	1
I am not pleased with the personality characteristics and personal habits of my partner	217.17	554589.109	.222	.760	2
I am very happy with how we handle role responsibilities in our marriage	214.77	555010.737	.066	.760	3
My partner completely understands and sympathizes with my every mood	215.33	554811.540	.137	.760	4
I am not happy about our communication and feel my partner does not understand me	217.17	554458.833	.276	.760	5

Our relationship is a perfect success	215.07	555183.375	-.050	.761	6
I am very happy about how we make decisions and resolve conflicts	214.93	554947.099	.072	.760	7
I am unhappy about our financial position and the way will make financial decisions	215.93	554743.651	.157	.760	8
I have some needs that are not being met by our relationship	183.17	325223.937	.949	.646	9
I am very happy with how we manage our leisure activities and then time we spend together	182.40	325431.352	.948	.647	10
I am very pleased about how we Express affection and relate sexually	182.00	325540.345	.948	.647	11
I am not satisfied with the way we each handle our responsibilities.	150.80	299258.579	.693	.720	12
I have never regretted my relationship with my partner not even for a moment	214.77	555005.564	.061	.760	13
I am dissatisfied about our relationship with my parents in-laws and/or friends.	217.43	554570.530	.237	.760	14
I feel very good about how we each practice our religious beliefs and values	215.03	555186.930	-.047	.761	15

Appendix 13B

Reliability Statistics of Enrich Marital Satisfaction Scale (EMS)

Reliability Statistics

Cronbach's Alpha	N of Items
.771	12

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
I am not pleased with the personality characteristics and personal habits of my partner	203.97	554990.723	.223	.777
I am very happy with how we handle role responsibilities in our marriage	201.57	555414.737	.065	.777
My partner completely understands and sympathizes with my every mood	202.13	555215.982	.136	.777
I am not happy about our communication and feel my partner does not understand me	203.97	554859.206	.277	.777
I am very happy about how we make decisions and resove conflicts	201.73	555351.306	.072	.777
I am unhappy about our financial position and the way will make financial decisions	202.73	555146.133	.157	.777
I have some needs that are not being met by our relationship	169.97	325612.102	.948	.661
I am very happy with how we manage our leisure activities and then time we spend together	169.20	325822.717	.948	.661
I am very pleased about how we Express affection and relate sexually	168.80	325931.338	.948	.661
I am not satisfied with the way we each handle our responsibilities.	137.60	299290.731	.695	.736
I have never regretted my relationship with my partner not even for a moment	201.57	555411.771	.059	.777
I am dissatisfied about our relationship with my parent in-laws and/or friends.	204.23	554972.185	.238	.777

Appendix 14

Reliability Statistics of Myers and Briggs Type indicator Short -version MBTISV

Reliability Statistics

Cronbach's Alpha	N of Items
.965	20

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
You like to use up energy so you enjoy groups	24.45	127.723	.653	.964
You interpret live events factually	24.42	124.252	.731	.964
You are logical you are they thinking questioning analytic kind of person.	24.39	127.112	.756	.963
You are organised, orderly	24.42	126.118	.778	.963
You are more outgoing, thinking out loud	24.29	127.813	.695	.964
You are practical, rational, experiential, practical	24.48	127.058	.744	.963
You are candid, straight-forward, frank, upfront	24.35	126.103	.810	.962
You like to plan, schedule	24.77	129.714	.794	.963
you seek many tasks, public activities, interaction with others	24.35	126.703	.773	.963
you like the standard, usual, conventional, traditional	24.39	127.712	.718	.963
you are firm, tend to criticise, maintain your stand	24.19	125.561	.827	.962
you are insistent, regulated, structured, resolute	24.32	126.026	.722	.963
you are external, communicative, express yourself	24.61	127.845	.825	.962
you focus on here-and-here now, in the moment	24.42	125.852	.713	.964
you are tough minded, fair, unbiased	24.23	125.981	.802	.962
you like preparation, you plan ahead	24.65	129.437	.739	.963
you are active, initiate.	24.58	127.652	.706	.964

you deal with facts, the "what is ", realistic, you are down to earth	24.58	127.252	.730	.963
you are issue-oriented, concerned with solving specific matters	24.26	125.931	.806	.962
You like control, oversee, constant, hard to change, routine	24.32	127.292	.731	.963

Appendix 15

Reliability Statistics of Spousal Support Scale

Reliability Statistics: Cronbach's

Alpha	N of Items
.959	62

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
My husband supports me financially when I am in need	145.50	2644.948	.400	.958
I feel my husband is kind	145.63	2683.275	.127	.959
I don't trust my husband	147.87	2678.326	.155	.959
I feel my spouse is understanding	145.93	2623.720	.455	.958
My husband does not give me a helping hand with house chores	147.20	2660.993	.216	.959
My spouse does not enjoy spending time with me	147.37	2634.654	.392	.958
I feel my husband is kind	145.73	2676.616	.165	.959
I feel my husband does not love me	148.20	2669.269	.322	.959
When I am hot my spouse does not show concern	147.63	2657.620	.259	.959
My husband always tries to understand my point of view	145.87	2631.775	.465	.958
I think my husband is selfish	148.33	2651.264	.504	.958
I feel my husband is secretive	147.73	2671.995	.157	.959
My spouse is special to me	145.77	2576.254	.724	.957
My husband shares ideas with me that can help me move forward!	146.03	2598.033	.528	.958
My husband keeps away from me by time formation that can improve my career	147.77	2684.875	.089	.959
My husband shout instructions at me like a slave	148.27	2666.409	.317	.959
My husband appreciates all I do	146.20	2635.131	.368	.959
I think my husband is rude and disrespectful to me	148.03	2677.206	.173	.959
My spouse and biases of help me in life	145.77	2605.564	.578	.958
My husband is not there for me	148.17	2682.075	.143	.959
My spouse gives me suggestions in a harsh manner	148.10	2671.817	.205	.959
My husband gives his honest review of my actions in a caring way	146.23	2607.426	.469	.958
I feel my husband's criticisms are destructive	148.27	2653.306	.427	.958
My husband collects my hair is in a loving way	146.40	2579.903	.635	.957
I think my spouse judges me	147.93	2642.271	.412	.958

My husband expresses his concern over issues that are important to me	145.87	2604.051	.565	.958
I don't feel safe with my husband	148.60	2687.283	.290	.959
My husband takes time to pray for/with me.	145.83	2623.454	.475	.958
My spouse does not enquire about my well-being.	148.30	2640.976	.498	.958
My spouse comforts name whenever I am sad	146.20	2561.338	.744	.957
My spouse does not find me physically attractive	148.33	2642.092	.479	.958
My spouse does not pay attention to my needs	148.33	2647.954	.499	.958
My spouse calls me Indian names	147.53	2639.430	.316	.959
My husband and I have no common areas of interest	148.20	2639.545	.448	.958
My spouse makes me feel important	146.47	2545.913	.765	.957
My spouse accepts me as I am	146.47	2541.292	.761	.957
My husband assures me of His Love wherever I have doubts and fears	146.33	2560.575	.657	.957
My spouse complains about our sex life	148.20	2618.924	.558	.958
I enjoy hugs and kisses from my husband	146.33	2539.885	.760	.957
I regret marrying my husband	148.43	2635.771	.530	.958
I cry a lot over my marriage	148.43	2640.323	.570	.958
I can confide in my spouse	146.30	2544.217	.764	.957
My spouse and I do not argue over money tree in use	147.33	2586.989	.599	.958
My husband and I do not laugh together	148.30	2630.493	.533	.958
I am pleased with my marital relationship	146.40	2542.800	.749	.957
I cannot imagine life without my husband	146.70	2565.597	.672	.957
I think my husband is for his fun	146.40	2540.317	.775	.957
My husband has my best interest at heart	146.60	2549.007	.727	.957
My spouse and I do not discuss issues together before making decisions	148.23	2619.082	.592	.958
I prefer keeping my personal information to myself	147.70	2601.390	.563	.958
My spouse is insensitive to my feelings	148.03	2626.861	.476	.958
My spouse shames me in front of others	148.47	2642.878	.552	.958
I am overwhelmed by marital responsibilities	147.63	2598.240	.604	.958
I hate the Manner in which my spouse raises important issues	148.23	2626.254	.575	.958
My spouse recognises my potentials and encourages me to develop them	146.30	2570.079	.650	.957
My spouse respects my privacy	146.07	2536.823	.862	.957
My husband is stingy	148.33	2649.954	.375	.958
My husband compliments my good looks	146.67	2554.368	.707	.957
My spouse impresses me with beautiful gifts	147.07	2575.582	.664	.957
My husband does not show willingness to help me with my task	148.20	2620.855	.545	.958
My husband in enquire by my job	146.47	2557.706	.697	.957
My husband encourages me to reach my personal goals	146.37	2549.206	.748	.957

Appendix 16

Reliability statistics of Childhood Trauma Questionnaire Short Form

Reliability Statistics

Cronbach's Alpha	N of Items
.932	28

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
I didn't have enough to eat	51.23	543.514	.379	.932
I knew there was someone to take care of me and protect me	49.35	496.170	.756	.927
People in my family called me things like stupid lazy or ugly	51.35	542.170	.401	.932
My parents were too busy or drunk to take care of the family	51.42	544.652	.361	.932
There was someone in my family who made me feel that I was important or special	49.06	503.062	.717	.927
I had to wear dirty clothes	51.55	547.856	.407	.932
I felt loved	49.19	503.161	.653	.929
I thought that my parents wish that I had never been born	51.52	548.591	.400	.932
I got hit so hard by someone in my family that I have to see a doctor or go to the hospital	51.16	546.473	.272	.933
There was nothing I wanted to change about my family	50.39	511.712	.644	.929
People in my family hit me so hard that it left me with bruises or marks	51.42	546.652	.470	.931
I was punished with a belt a board a called or some other hard objects	50.58	523.385	.542	.930
People in my family looked out for each other	49.65	498.037	.703	.928
People in my family said hurtful or insulting things to me	51.45	544.523	.446	.931

I believe that I was physically abused	51.61	548.845	.553	.931
I had a perfect childhood	49.61	498.178	.770	.927
I got hit of beaten so badly that I was noticed by someone like a teacher neighbour or doctor	51.42	544.318	.483	.931
I felt that someone in my family hated me	51.26	542.998	.440	.931
People in my family felt close to each other	49.26	493.198	.812	.926
Someone tried to touch me in a sexual way or tried to make me touch them	51.39	543.778	.436	.931
Someone threaten to hurt me or 10 lines about me unless I did something sexual for them	51.65	542.103	.587	.930
I had the best friend in the world	49.77	501.114	.783	.926
Someone tried to make me do sexual things or what sexual things	51.55	538.456	.611	.930
Someone molested me	51.52	536.325	.604	.930
I believe that I was emotionally abused	51.32	531.359	.558	.930
There was someone to take me to the doctor if I needed it	50.06	513.996	.531	.931
I believe that I was sexually abused	51.58	538.785	.548	.930
My family was a source of strength and support.	49.23	490.514	.763	.927

APPENDIX 17

The Treatment Packages

Cognitive Processing Therapy (CPT)

The CPT is an intervention that combines cognitive restructuring techniques with the emotional processing of trauma-related content. This is to enable clients overcome their maladaptive beliefs often involving the five themes which are; safety, trust, intimacy, power/control and esteem. It can be used in the treatment of trauma based on a history of abuse. It can also reduce negative emotions like grief, shame, anger and guilt stemming from traumatizing experiences. Mental health concerns like anxiety, depression and posttraumatic stress disorder have been reported to reduce with the help of this intervention. The treatment manual, worksheets and handout (Resick, Monson and Chard, 2014) were adapted to suit a non-literate population even while maintaining the principal constructs of the treatment model. The worksheets (A-B-C; challenging questions; patterns of problematic thinking; challenging beliefs) and a handout (Identifying emotions handout) were also translated into the Yoruba language.

The A-B-C worksheet (A-B-C; Appendix 6) explained the link between thoughts, feelings and behaviour in any given situation. Furthermore, it helped the participants to recognize their stuck points. The challenging question worksheet (CQW; Appendix 7) consisted of ten questions which also assisted the participants in examining their stuck points from different perspectives. In addition to this, they were able to evaluate and challenge the context of their belief from a 'for or against' perspective in order to recognize if these beliefs are based on feelings or facts. Similarly, the patterns of problematic thinking worksheet (PPT; Appendix 8) was introduced to the participants. This was to enable them categorize some automatic faulty thoughts that can thrive on a person's illogical beliefs consequently perpetuating his/her challenges. Seven problematic patterns were discussed and appropriate examples were given. In the course of recognizing problematic thinking patterns, feelings (such as anger, sadness and fear) which can arouse maladaptive behaviour were labeled using the identifying emotions handout (IEH; appendix 9). Again, the challenging beliefs worksheet (CBW; Appendix

10) was explained and discussed. It combined all the previous skills deliberated upon in other sessions.

In this study, some adjustments were made in some areas of the treatment manual and worksheets to capture the dependent variable (marital satisfaction). These included:
Session 3: exploring symptoms indicating that a married woman has safety issues and the effects on marital satisfaction (see scheme treatment packages delivery on CPT).
Session 7: a married woman who has low self-esteem will make statements such as: *I am bad, destructive and a failure* (see scheme treatment package delivery).
Again, some changes were made in the CQW. The sixth question was changed from *in what way is your stuck point focused on just one part of the story?* and restated as *in what way is your stuck point focused on just one part of the situation?* This was modified to avoid any form of ambiguity. Again, number 4 on the CQW worksheet was changed from *all or none terms* to *all or nothing terms*. Similarly, in the IEH, the arrow indicating *scared* was changed to *fear* for more clarification. Other cognitive distortions like *personalization, magical thinking* and *over-generalisation* were added to the treatment package to aid comprehension of the concepts of assimilation, accommodation and over-accommodation.

In the second session, the participants were asked to write their impact statements explaining and briefly narrating what happened to them, what it means to them and how the incident has affected their view of self, others and the world. Similarly, in the seventh session, they were told to rewrite same. The new impact statements were compared to the initial ones that had been submitted. This helped the researcher and the participants to clearly observe if there were positive changes in their thoughts, feelings and behaviours during the course of intervention. These evaluations served as sources of encouragement, and motivation to the participants, as well as revealing areas where improvement should be focused on. The purpose was to help them cultivate the routine of challenging their thoughts and replacing them with more realistic alternatives so that a balanced way of life is achieved.

According to Resick, Monson and Chard (2014) the therapy is designed in two forms, namely, cognitive processing therapy with the detailed written account of trauma (CPT) and cognitive processing therapy-cognitive only (CPT-C) without the detailed

written account of trauma. The CPT-C uses more cognitive reframing techniques however must still include the impact statement. Again, the latter (CPT-C) can serve different types of indigenous groups hence was used in this current study. At the end of each session, conclusions were reached and resolutions made to reinforce and strengthen the healing process.

Experimental Group One: Cognitive processing therapy (CPT).

Session 1: General introduction, orientation and pre-test administration.

Session 2: Psycho-education; introduction to CPT 3Rs goals (recognize, reinterpret and recover). Participants were informed about what to expect from the intervention. Discussions on meaning of childhood trauma and its impact were highlighted. Assignment: Writing the impact statement; the participants were encouraged to briefly state what happened to them. Questions like: What are the effects of childhood trauma on you? What is your personality type? Are you an introvert or an extrovert? Did childhood trauma change your personality? How did childhood trauma make you see yourself, others and the world?

Session 3: Identification of stuck points and problematic thoughts, feelings and behaviour that occur after traumatic childhood events were explained to participants. Stuck points were described as negative beliefs which make healing difficult. Again, the relationship between thoughts, feelings and behaviour was reiterated. Based on this, participants were taught how to recognize their stuck points and to develop the ability to challenge cognitive distortions (assimilating and over-accommodating thought processes) using the Socratic style of questioning. Participants were introduced A-B-C worksheets. Some impact statements were read and analysed. Stuck points were observed from the impact statements like; *I feel no one likes me* or *the world is an unsafe place for me*. Safety issues were discussed and negative beliefs and symptoms were explained. Answers to questions like; How would you know that a married woman has safety issues? What are the effects of safety issues on marital satisfaction? Cognitive distortions such as jumping to conclusions and oversimplifying situations as good/bad or right/wrong as regards safety issues were challenged. Assignment: A-B-C worksheet (see appendix 6).

Session 4: The A-B-C worksheet assignment was reviewed. Situations that can produce tension and pressure were mentioned. Participants were taught to challenge negative thoughts and feelings that could occur in the above-mentioned situations by asking whether what they tell themselves (at that time) are realistic? Explanations on beliefs about trust issues with self, spouse and others as a result of childhood trauma were explored. The researcher asked questions to enable participants delve into the source of their pain. Examples of such questions were; how was your belief about trust changed as a result of what you experienced and how do you confront these changes? What is the evidence for or against your thoughts and feelings? Are these thoughts and feelings still relevant today? How have issues with trust affected your marriage? The participants were engaged using the challenging questions worksheet (CQW). Items on the worksheet were explained so that the assignments could be properly understood. The cognitive distortion called personalization was examined. Assignment: The participants were encouraged to use the CQW (see appendix 7) to question irrational beliefs.

Session 5: The assignment on the CQW worksheet was reviewed. Questions like *what is the evidence for/against your stuck point* and *is your stuck point based on your former experience, habit or fact?*" were reiterated. Some stuck points which could conflict with intimacy issues were deliberated on. Clarifications were made on how to challenge problematic beliefs involving intimacy issues with self, spouse and others. Again, answers to questions like *how do you know that a married woman has intimacy issues* and *how can these issues affect satisfaction in marriage?*

Furthermore, the researcher explained that there are various types of problematic thinking patterns (some of which had been examined in sessions 3 and 4) which can become automatic (habitual) thought patterns. These different types of problematic habitual thought patterns are: jumping into conclusions (predicting the future and mind reading), maximizing (exaggerating issues), minimizing (inappropriately making important issues seem insignificant), polarized thinking (oversimplifying issues as good/bad or right/wrong), emotional reasoning (deducing from feelings) and ignoring important areas of a situation while focusing on negative experiences (mental filtering). Assignment: Participants were encouraged to identify their habitual maladaptive forms of thinking using the pattern of problematic thinking (PPT) worksheet (see Appendix 8).

Session 6: The process of challenging negative beliefs involving power/control with self, spouse/others was explained. Responses were sought to questions like: *are your feelings usually beyond your control? Do you feel that your spouse or other people are exerting power or control over you? Do you feel victimized? Are you described by your spouse and others as being controlling? Is this behaviour as a result of childhood trauma? How is this affecting your marriage?* The researcher explained that an individual could assume controlling behaviours due to fear, anger and suspicion. The participants were taught that quantifying their levels of emotions using low, moderate or high could help them manage them. The identifying emotions handout (IEH see Appendix 9) was therefore used to teach participants how to label their emotions, recognize the level at which these feelings are expressed and appreciate the need to manage them properly. They were informed that the IEH was a type of emotion meter which was aimed at enabling the participants to recognize, manage and regulate their emotions. Some cognitive distortions like jumping into conclusions, polarized thinking or oversimplifying, and emotional reasoning were considered in the light of power control issues. Assignment: Challenging beliefs (CBW) worksheet (see appendix 10) was given to the participants to teach them how to journal their thoughts and rate their feelings.

Session 7: Esteem issues with self, spouse and others were considered. Again, the participants were taught how to identify stuck points and problematic thinking patterns which could affect their self-worth. Answers were given to questions like *what happens when a married woman lacks self-worth* and *how does this affect her marriage?* A brief summary of all the sessions was made with the researcher stressing the importance of the skills which the participants had learnt.

Session 8: Review of therapy, post-test administration, appreciation and conclusion. Sessions were terminated.

Stress Inoculation Therapy (SIT)

Stress inoculation provides an approach that can help clients deal with already existing stress from trauma. It also produces a mental preparedness to tackle future stressful situations. One of the strengths of SIT is flexibility since it can be tailor-made to suit the peculiarities of any client's condition. This form of intervention places a lot of

emphasis on skills training and acquisition. Participants in this study were therefore taught through the intervention to be 'inoculated' against stress by focusing on managing their emotions through progressive muscle relaxation, guided therapeutic imagery, deep breathing exercise and thought diverting methods. Other strategies included; positive self-talk (learning self-compassion) along with using affirmations (using positive self-statements), thought-stopping techniques, problem-solving approaches, role play, social skills training using assertiveness to improve interpersonal relationships. Through rehearsals, the participants learnt action and coping skills that would help them face daily challenging situations.

The participants were informed that these skills formed a pivotal point of the SIT because it would boost their overall wellbeing through; managing stressful situations appropriately, dealing with critical moments rationally and encouraging oneself after overcoming the situation. The participants were however encouraged to always remember to apply them to various problem areas they could encounter. The researcher also used Socratic 'unusual' questioning styles to enhance self-guided discovery. Role play sessions were employed to demonstrate some life situations where the skills can be applied and to also to motivate them to practice the skills learnt. The goal of SIT is to build and strengthen psychological resilience to stress by improving the client's intra and interpersonal coping skills alongside fostering self-confidence.

Experimental Group Two; Stress Inoculation Therapy (SIT)

Session 1: General introduction, orientation and pre-test administration.

Session 2: Psychoeducation; the link between thoughts, feelings and their influence on behaviour was explained to the participants. Furthermore, the meaning of childhood trauma was explained, symptoms were deliberated upon and their effects on thoughts, feelings and behaviour.

Session 3: The link between thoughts, feelings and behaviour were reiterated. The participants were also told how childhood trauma can cause various psychological and physiological health conditions. In addition, they were enlightened about the two personality types (extrovert and introvert). The stress inoculation therapy was introduced to them and the purpose of the intervention was reiterated.

Session 4: Clarification on how to identify triggers and reducing their symptoms through action skills were discussed. The action skills were described as emotion-enhancing strategies. They were; guided therapeutic imagery, thought diversion, deep breathing exercises and progressive muscle relaxation skills. These were demonstrated for the participants. They were also trained on how various situations where these skills would be useful. This was in order to prepare them for stressful situations, for instance, going to a place related to the traumatic incident could produce negative emotions from the unpleasant memory, therefore, these skills would help them to manage their feelings. They were also encouraged to practice them daily.

Session 5: A recapitulation on the previously learnt skills was done. Furthermore, a new set of skills which were described as problem and solution-focused coping strategies were introduced to the participants. The skills included; problem-solving approaches, positive self-talk, assertiveness skills and thought-stopping methods (challenging unwanted thought patterns). The session was designed to teach the participants how to; handle stress using the coping skills, reflect on their own actions in non-judgmental ways and to challenge illogical thought patterns and recognizing cognitive distortions (cognitive restructuring techniques for self-defeating thought processes) stemming from various marital challenges affected by childhood trauma (using Socratic-probing or self-guided discovery questions).

Session 6: the session was divided into two. In the first part, discussions on how to identify warning signs (triggers) and different ways to use newly acquired skills were considered. The participants were then asked to describe stressful situations in their lives and the effective ways to cope with them using any of the skills. Some proper exposures to the effective uses of disputing negative beliefs (self-blame and self-defeat) were given. In addition, examples of positive self-talk, social skills/assertiveness training and affirmation statements were reiterated. During the second part, the role play (1) titled *I will focus on the positive* was simulated.

Session 7: The application of action skills to problem-related situations through another role play session titled *I will change my strategy* was demonstrated. This activity was designed to enable the participants have a deeper understanding that irrational thoughts

and feelings can be challenged and also that people's emotions can be enhanced through action skills.

Session 8: Review of therapy, post-test administration, appreciation and conclusion.

Control Group

Session 1: Introduction and pre-test

Session 2: Discussion was given on journalism. Its definition, types, functions and purposes were examined.

Session 3: Post-test and conclusion.

SCHEME TREATMENT PACKAGES DELIVERY

Experimental Group one: Cognitive Processing Therapy (CPT)

The 8 sessions lasted for 8 weeks with each at an average of 60 minutes. 50 minutes were allotted for engaging the participants in the intervention while 10 minutes were used for responding to their comments, suggestions and questions.

MATERIALS:

8. Markers
9. Cardboards
10. CPT worksheets and hand outs (English and Yoruba language versions): A-B-C worksheets (see Appendix 6), challenging questions worksheet (CQW see Appendix 7), patterns of problematic thinking worksheet (PPT see Appendix 8), identifying emotions handouts (IEH see Appendix 9), challenging beliefs worksheet (CBW see Appendix 10).
11. A4 size papers and pens.

SESSION 1

General introduction, orientation and Pre-test administration

Objectives: At the end of this session, the participants were be able to:

i) Be acquainted with the researcher

ii) Understand the purpose and benefits to be derived from participating in the programme
iii) State how long the programme would last
iv) Commit to the completion of the programme
v) Agree to the rules and code of conduct guiding the programme.

Activities:

- Participants were welcomed and warmly appreciated for volunteering to participate in the programme. Introductions were made by the researcher and research assistants. The participants were told that they would have identification numbers to aid individuality.
- Participants were informed that they would be having eight (8) sessions of one hour each for eight (8) weeks.
- Purpose and objectives of the programme were disclosed to the participants.
- Rules and regulations guiding the conduct of the participants were stated.
- Confidentiality was guaranteed. Consent forms were distributed, explained and signed.
- Convenient times and days were agreed on and fixed.

SESSION 2

Psycho-education topic: what is childhood trauma? Why does it make me feel this way?

Objectives: at the end of this session, the participants were:

i) Enlightened about the goals of CPT
ii) Able to describe childhood trauma and understand its symptoms and impact
iii) Able to explain their personality types
iv) Write their impact statements

Activities:

- Participants were warmly received.
- Childhood trauma, its signs and symptoms were described. Explanations on the physical and psychological short/long term effects of childhood trauma on the human system were communicated.
- A description of personality types was provided for discussion.
- The participants were given instructions on how to write their impact statements.
- Questions to consider while writing their impact statements were: what happened to you? What effect does this have on you? How do you think it changed the way you see yourself, your spouse, and others around you?
- Other questions to ponder were: did childhood trauma change your personality (considering your personality pre-trauma and post-trauma)? Are you now an introvert or an extrovert? How does this affect your relationship with your spouse? Does it affect how you see yourself?
- Comments and questions were allowed.
- Assignment: write your impact statement.

SESSION 3

Topic: do I feel safe?

Objectives: at the end of this session, the participants were able to:

i) Understand the impact of childhood trauma on them. How has it affected your marriage?
ii) Describe the relationship between thoughts, feelings and behaviour.
iii) Understand what a stuck point is
iv) Relate their personal interpretation and effects of childhood trauma to their current beliefs (stuck points).
v) Consider issues of safety
vi) Explore reasons why they don't feel safe
vii) Recognize that there are symptoms indicating that a married woman has safety issues and how it can affect marriage

viii) Use Socratic questioning to challenge assimilating and over-accommodating beliefs of the participants (pre-trauma and post-trauma thoughts/beliefs).

ix) Draw conclusions and resolutions from discussions.

Activities:

- Participants were pleasantly received and appreciated for attending the session.
- A review of the last session was done.
- Some participants' impact statements were read and commented upon.
- The comments were used to reiterate the impact of childhood trauma on married women.
- Descriptions and examples of stuck points were highlighted.
- The explanations were linked to why there are stuck points when a person has experienced childhood trauma.
- At this stage, the relationship between thoughts, feelings and behaviour were elaborated. The researcher clarified that there are thought and belief patterns which people have before childhood trauma occurred made their former beliefs about safety, trust, intimacy, power/control and esteem being altered when the childhood adverse situation took place.
- The researcher helped the participants determine what safety issues are. Safety was described as the state of being protected from anything or anyone that can cause danger or harm. The difference between physical safety and psychological safety was explained.
- Cognitive distortions concerning safety issues were challenged (jumping to conclusions and oversimplifying situations as good/bad or right or wrong). The belief that they can have control over events or people was exposed as a dangerous ways of viewing life. They were also told that when people are continually exposed to overwhelming situations, they could develop some negative beliefs that they can never be safe. Furthermore, they were told that people who perceived their early lives as being safe and those whose feelings of safety had been altered by events of childhood trauma could have the tendency to feel that everyone is dangerous and the world is not a safe place.

- Symptoms indicating that a married woman has safety issues were discussed. Some symptoms that were examined were; chronic and intense fear and/or worry, intrusive thoughts about danger, fretfulness, hypervigilance and exaggerated startled responses. Can these symptoms change a person's personality? If someone was once out-going, sociable and expressive, can childhood trauma cause a change of character? Yes. The person, on the one hand, could become reclusive, numb, passive, distant and withdrawn while on the other hand, one could become angry, aggressive, socially intrusive, bumptious and boisterous.
- Questions to ponder on: do I feel afraid? Do my thoughts constantly show that I am worried? Are my thoughts and feelings correct every time? Do they always contain facts, evidences and truths about every situation? Should I believe them all the time? Do I have control over everything that happens to me? How can I take precaution to reduce being in a situation where my control is taken away rendering me helpless? Do I feel safe in my house or other places? Do I feel safe with my husband and others? How has safety issues affected my relationship with my husband? Do I feel safe in my interactions with my spouse? Do I feel safe to express myself without bias? Do I feel safe and secure within myself? Whenever I feel safe what factors are present? What can calm me? What makes me unsafe? Are there triggers? How can safety issues be confronted?
- Conclusions were then drawn from appraisals and deliberations such as; I cannot have control over everything that happens to me but I can take precaution by staying away from harm. Not everyone is out to harm me and not everyone is dangerous.
- Resolutions: there may be some people who will harm others but that does not mean that I have to stop trusting those who support me. It is alright to feel safe.
- Comments and questions were encouraged.
- Assignments: A-B-C worksheets.

SESSION 4

Topic: can I trust myself and others again?

Objectives: at the end of this session, the participants were able to:

i) Recognize and challenge stuck points stemming from blame and guilt.

ii) Learn that there are negative thought patterns like (overgeneralization and personalization) which can explain that thoughts and feelings can have erroneous patterns. Introduce the CQW worksheet to demonstrate that there are ways to challenge such flawed patterns.

iii) Have the ability to list some of the symptoms that show that a married woman has trust issues and how it can affect her marriage.

iv) Draw conclusions and resolutions from the points to be considered.

Activities:

- Participants were met and warmly received by the researcher.
- A review of the last session was assessed for further interactions. Issues from the last assignment (A-B-C worksheets) were also deliberated on.
- Discussions focused on some stuck points that can arise from safety issues such as blame and guilt accompanied by distrust. The researcher reiterated that safety is an important prerequisite for trust. Many people can have the belief that their future is bright but childhood trauma can disrupt this confidence and shatter the assurance of success. How can they trust in themselves and others again?
- Trust was defined as believing in one's integrity as well as others. The researcher explained that when a woman experiences childhood trauma, she can find it difficult to believe others making her seem suspicious, disbelieving and interrogative. This can be described as one having trust issues. Trust issues can affect marriage and other important relationships.
- Participants were asked how their beliefs about trust changed as a result of childhood traumatic situations. They were also asked how such changes can be confronted.
- Clarifications that there are maladaptive or problematic thought patterns that make people have negative beliefs were established. It was stressed that negative beliefs can make individuals attribute situations or events to themselves even when they are not caused by them (personalization). Again, a belief that everyone is out to do them harm and no one can ever be trusted (over-generalization) was described as a cognitive distortion. These beliefs were challenged.

- Similarly, the concerns that some married women who use cognitive distortions like overgeneralization and personalization in their homes particularly because of childhood trauma could feel that there was nothing wrong with it. It was also revealed by the researcher that these distortions can make their marriages difficult and unsatisfactory.
- Other matters in marriage which related to trust issues were discussed. The researcher affirmed that trust issues are sensitive as they can affect one's physical and psychological wellbeing.
- The researcher listed some symptoms that showed that a married woman has trust issues as; feelings of self-betrayal, feelings of being betrayed by others, frequently focusing on the negative or other people's mistakes, feelings of discouragement, confusion, anxiety, being overly cautious, inability to make personal decisions due to self-sabotaging thoughts. She can also have problems forgiving herself and others. she can be highly argumentative and quarrelsome. She may find it difficult to share dreams, plans and desires with her spouse because of trust issues leading to loneliness. She can become her spouse's 'detective' searching for evidence to prove some suspicion because she lives in constant fear of abandonment. She can also have excessive self-criticism, and self-doubt thus find it difficult to complete tasks. The researcher also stated that thinking people are not trustworthy even when they are supportive can be detrimental to good relationships. The researcher added that, individuals who are frequently blamed for negative events or are perpetually seen as untrustworthy can feel that they can no longer trust their sense of judgment. The researcher also pointed out that being suspicious of one's spouse without facts and evidences to indicate dubious activities can show that a woman has trust issues. The researcher pointed out that trust issues can affect intimacy. This is because trust and intimacy require vulnerability and women who have experienced childhood trauma avoid feeling vulnerable. Some women with trust issues may have problems forming new relationships. The cognitive distortions like *personalisation* and *overgeneralisation were* analysed in the light of trust issues.

- Questions to ponder: what is the root of my trust issue? How has this affected my marriage? Can I trust my abilities and intentions? Can my spouse be trusted? Is he honest with me? Do I have confidence in my husband's intentions, purposes and actions? Does he trust me? Am I honest with him? Are there others who genuinely care about me? Can they trust me? Can they also be trusted? Do I honour commitments? What can I do to build, establish and maintain trust in my home?
- Resolutions: I may not be able to trust everyone but that does not mean I have to stop trusting those who support me. Yes, I can trust myself even though I know I can make mistakes.
- Conclusions were drawn based on responses such as; yes, I can trust my abilities even though I am not perfect. I will not stop trusting those who support me especially since I know nobody is perfect. I can have discussions with my spouse to rectify any trust issue we have. I will be open to new possibilities. I am a woman of my word.
- Comments and questions were allowed.
- Assignments: learn to challenge one stuck point per day using Challenging Questions Worksheets (CQW).

SESSION 5

Topic: can I soothe myself?

Objectives: at the end of this session, participants were able to:

i) Restate what they understand by negative thought patterns. They were able to use examples such as personalization and overgeneralization to explain negative cognitive patterns.

ii) Examine other maladaptive thought patterns like minimizing/maximizing, polarized thinking, jumping to conclusions (mind reading and fortune telling), emotional reasoning and ignoring important parts (also called selective abstraction or mental filtering; which is the process of fixating on the negative aspects of a subject matter while ignoring the important details).

iii) Understand intimacy.

iv) Self-soothe through their understanding of intimacy issues.

v) Identify some of the symptoms that can show that a married woman has intimacy issues and how it can affect her marriage.

vi) Draw conclusions and resolutions from deliberations.

Activities:

- Participants were greeted, thanked and appreciated for attending the session.
- A review of the last session was done.
- The participants' concerns from the previous assignment (CQW) were analysed.
- A summary on areas of negative thought patterns with emphasis on over-generalization and personalization were made.
- In addition, the researcher was able to examine other maladaptive thought patterns such as; jumping to conclusions (mind reading, fortune telling), maximizing (exaggerating), minimizing (diminish importance), polarized thinking (black and white or oversimplified), emotional reasoning and ignoring important parts (mental filtering or selective abstraction).
- Cognitive distortions concerning intimacy issues were examined. Intimacy was described as the feeling of comfort a woman can demonstrate towards herself. It also entails care, comfort and affection which spouses can display towards one another without necessarily involving sexual activities. Soothing is an important function for stability as it can enable a woman to comfort herself or be pacified by her spouse (cuddling) in times of distress. Self-soothing was explained as an internal resource which an individual can use to experience relaxation, comfort and ease despite the frustrating circumstance. The researcher informed participants that some individuals grow up feeling that they are unable to cope with life events because they never knew that they had the capacity to soothe, support or comfort themselves in the face of challenges through self-compassion. It was also stressed that some might even possess such capacities but had lost the strength to draw comfort from their internal resources because of childhood trauma. This is because when the ordeal struck, they discovered that they felt overwhelmed by intrusive and disturbing thoughts. A woman who has challenges

with issues of intimacy could have problems with accepting care and affection from her spouse. Conversely, she could display an excessive desire for emotional support or emotional neediness which can be overwhelming for her spouse.

- Some of the symptoms which indicate that a married woman has intimacy issues were described as; self-hatred, inability to calm self, lack of self-compassion, fear of being alone, inner emptiness, avoidance, experiencing periods of great fear and panic especially if reminded of childhood traumatic experience. In addition to these, the researcher expounded upon other symptoms like; seeking comfort from external sources (food, sex, shopping, drugs and alcohol), constant need for reassurance from spouse (emotional neediness), constantly craving for attention (clinginess) and feelings of rejection (being withdrawn). Furthermore, other warning signs such as; fear of abandonment (issues with object constancy – fear of lack of physical involvement in a relationship; and object permanence – fear of lack of emotional involvement in relationship), inability to experience connectedness with people even when they have good intentions and apportioning all the blame on self for poor relationship with spouse and others were also explained.
- Questions to ponder: can I have a satisfying close relationship with myself, my spouse and others? When situations occur even though my feelings are strong and unfriendly, they are not permanent; they will fade away as I self-soothe. How do I calm myself when I am afraid, tensed, worried or angry? Which one do I find as a 'healthful' behaviour? Does my love for my spouse vanish whenever there is a disagreement? Do the angry and hostile feelings I feel towards him eventually disappear? Do I nurse the feelings for days, weeks, months and years? Can I accept and reciprocate my husband's romantic or sexual advances? What are the things I appreciate about myself? What do I appreciate about my husband?
- Resolutions: I will resolve issues with those who have let me down. I believe that I can have satisfying relationships with myself, spouse and others. Staying away from meaningful relationships will only make me feel sad, empty and alone. Staying away from unhealthy relationships can help me make better decisions. I resolve to have a healthier relationship with my spouse. I will love and care for

myself. I will show myself some compassion and patience rather than being harsh or judgmental.

- Conclusions were drawn based on the discussions. Inferences based on conclusions were highlighted as; even though a person's feelings are strong and unpleasant they are temporary, so learning how to self-soothe will enable an individual to control transitory overpowering emotions. Other conclusions were: I can have a satisfying relationship with my spouse; I only have to take one day at a time. I can have a healthy relationship with myself because I am responsible and reliable. I can control my emotions.
- Comments and questions were encouraged and appreciated.
- Assignment: the participants were encouraged to identify maladaptive cognitive patterns using the Patterns of Problematic Thinking (PPT) worksheet.

SESSION 6

Topic: do I have absolute power/control over my life?

Objectives: after this session, participants were able to:

i) Understand the term learned helplessness and how it applies to childhood trauma
ii) Identify and learn how to control emotions that are outcomes of childhood trauma.
iii) State some symptoms showing that a married woman has power/control issues from childhood trauma.
iv) Identify what type of relationship they have; healthy or unhealthy.
v) Recognize that they can have control over their emotions
vi) Be aware that they can assert themselves without being afraid (passive) or rude (aggressive).
vii) Resolutions and conclusions were made.

Activities:

- The participants were warmly greeted by the researcher.
- The last session was reviewed.

- The last assignment from the PPT worksheet was also reviewed.
- The identifying emotions handout (IEH) was used to teach participants how to label and manage their emotions (fear, anger, shame and sadness) that could have projected from childhood traumatic occurrence.
- The researcher described power/control as two sides of a coin. Power/control was explained as the ability an individual has to dominate others and make choices for them.
- Participants were told that some women lose their ability to exercise power and control through childhood trauma.
- The researcher explained what the term learned helplessness means. Learned helplessness can make an individual feel that he/she is powerless over the circumstances of life even when solutions are proffered. The researcher further disclosed that an individual may grow up believing that he/she has control over situations of life until an unfortunate childhood incident occurs which disrupts that belief. The disruption can subsequently result in fear, confusion, disappointment and disillusionment however, the individual must realise that he/she can heal from past events.
- Some of the symptoms to indicate that a married woman has power/control issues are; numbing of feelings, avoidance of emotions, chronic passivity, submissive to a servile degree, fawning (seek favour through flattery), excessive readiness to please others, hopelessness, self-destructive habits (drinking, smoking), outrage (when faced with events beyond one's control), feeling overwhelmed when people do not behave in ways one expects, moodiness, docile, lack of assertiveness, manipulative, inability to maintain a healthy marital relationship because her husband feels controlled (through the use of rage, threats, aggression as her positive reinforcements) and feelings of displeasure. These can cause dissatisfaction in marriage. Based on this, the researcher encouraged that assertiveness is an important way of expressing needs, wants, dreams and plans without fear or a sense of entitlement.
- Questions to consider: do I have control over my behaviour? Do I frequently feel that my spouse leaves me without a choice? Do I frequently feel intimated by

others? Have I lost the need to take personal control over the issues of my life? Do I have control over the reactions of others? Can I have control over events? Is my relationship with my spouse healthy or unhealthy? Do I feel that my spouse or/and others are monitoring me? Has my spouse or/and others ever told me that I am controlling? Was my power/control behaviour affected by an early adverse situation? How so? Do I feel some emotions that make me exhibit some 'out of control' tendencies?

- Resolutions: I may not get everything I want out of my marriage but I am open to making it work. I can express myself courteously even while stating what I want. I cannot control events but I can have control over my reactions. Assertiveness contrasts passivity and aggressiveness. Passivity has no power to say 'no'. Aggressiveness is the abuse of power which says 'no' with threats. Assertiveness says 'no' using care, thoughtfulness, consideration and politeness. I will behave in ways that are worthy of respect. I will respect myself.
- Conclusions were established as thus; toxic relationships can affect an individual's mental wellbeing. Healthy relationships involve sharing power and control. It includes care, understanding, consideration and respect for one another. It also involves creating healthy boundaries. Monopolization deceit and subjection are marks of abuse therefore, manipulation, threats, intimidation and force are signs of an unhealthy relationship. A relationship in which one person has all the power tends to be abusive for both male or female spouses.
- Comments and questions were attended to.
- Assignments: Challenging Beliefs worksheet (CBW) was used to help participants learn how to journal their thoughts and rate their feelings.

SESSION 7

Topic: am I bad?

Objectives: at the end of this session, participants were able to:

i) Understand what self-esteem means.

ii) To balance beliefs about their self-worth.

iii) To identify the problematic thinking pattern called magical thinking. This was explained as a stuck point.

iv) Recognize statements which a married woman with esteem issues can make.

v) State some symptoms that a married woman with low self-esteem has.

vi) Draw conclusions and resolutions from interactions.

Activities:

- Participants were appreciated for attending the session.
- A review of the last session was made by the researcher.
- Assignments were checked and issues arising from them were also discussed.
- Researcher helped the participants understand that self-esteem is the belief in one's worth which is a basic human need. The researcher also explained that being understood, respected and taken seriously by others are basic elements which are linked to the development of any one's self-esteem. In addition, it was stressed that childhood adverse experiences can violate a person's sense of self which could lead to self-depreciation. The researcher explained that such individuals will easily believe other people's negative words and feelings about them whether they are true or false. Similarly, as a growing child, a girl could show signs of self-worth, however, an unfortunate event could disrupt and alter her self-confidence generating negative thoughts and beliefs about herself.
- The researcher was able to make participants see that adjustments must be made in their beliefs about their self-worth so that any time something unexpected happens their sense of worth is not disturbed.
- Researcher explained the problematic thinking pattern called magical thinking which can make an individual feel that because 'I am good therefore no bad thing can happen to me.' When an unpleasant event occurs to such a person, he/she may think 'I am being punished for something I have done or my relatives have done.' The researcher emphasized that difficult challenges in life can occur to anyone whether they are kind or unkind in nature.

- A married woman who has low self-esteem will make statements such as: I am bad, destructive and evil; I am damaged and flawed; I am worthless, deserving unhappiness and pain; I am unworthy of love. The researcher explained to them that these types of thoughts can generate dissatisfaction in marriage.
- Symptoms to show a married woman has negative self-esteem include the following; depression, guilt, shame, chronic anger, contempt, bitterness, cynicism, disbelief even when treated with genuine care and consideration. They can become sensitive making them isolate or withdraw from relationships. Their sense of worthlessness can also make them develop some disturbing opinions about reality which can result in the manifestation of various rebellious and self-destructive behaviours.
- Resolutions: I have decided to stop blaming myself for events that I did not cause especially those beyond my control. I forgive myself for issues I did not handle properly. I need to understand that sometimes unpleasant incidents can happen even to kind people. I can adapt a balanced view of others therefore I need to have ground rules to stabilize my relationships. I want to be proud of myself.

  Again, I have to remember that people sometimes make mistakes because they are fallible. I can also make mistakes. I forgive myself. I forgive those who hurt me. I will not jump into conclusions about other people's character without obtaining valid proof. I have made up my mind to stop unwholesome activities like stealing, lying and slandering others because they are unhealthy behaviours. This cannot help my marriage. I believe that I am good enough. I will care for myself. It is okay to forget the past.
- Conclusions were reached and established that: women are precious treasures who need to care for themselves because they deserve to be happy and fulfilled. Again, a realistic view of others is necessary for a person's psychological wellbeing, so it is important to develop a 'wait and see' attitude and not rush into conclusions over other people's behaviour. The participants were charged not to jump into conclusions without adequate facts and information. They were encouraged to tread carefully.
- Comments and questions were allowed.

- **Assignment:** participants were encouraged to give compliments to their spouses and also to receive compliments from them with an appreciative smile. Secondly, they were motivated to do at least one pleasant thing for themselves (even without having to earn it).

SESSION 8

Topic: Post-test and termination of therapy

Objectives: the researcher administered the post-test instrument and sessions were terminated.

Activities:

- The researcher thanked all the participants for their cooperation, regularity and punctuality. The researcher also reminded the participants to continue to use the skills they had learnt and acquired. The post-test instrument was administered. The sessions were terminated.

Experimental Group two: Stress Inoculation Therapy (SIT)

Each of the 8 sessions (8 weeks) were to last for 50 minutes however, 10 minutes were devouted to questions and answers. A total of 60 minutes were used per session.

MATERIALS:

1. Markers
2. Cardboards
3. A4 papers and pens.

SESSION 1

General Introduction, orientation and pre-test administration

Objectives: At the end of this session, the participants were able to:

i) Establish some affinity with the researcher

ii) Understand how long the programme would last

iii) Understand the purpose and benefits of participating in the research exercise

iv) Commit to completion of the programme

v) Agree to the rules guiding participation in the programme. Emphases were made on voluntariness and active participation.

vi) Participants were assured of confidentiality and discretion.

Activities:

- Participants were warmly welcomed. Introductions were made by researcher and research assistant(s).
- The researcher stated the objectives of the programme and its benefits.
- The researcher explained the rules and regulations guiding the programme and good conduct anticipated from each participant was stated.
- The researcher and the participants agreed on convenient days and times for the programme.
- Thereafter, the researcher gave the participants their identification numbers.
- The consent forms were filled and signed by the participants.
- The researcher administered the pre-test instruments.
- The researcher made evaluations by asking participants to state what the objectives and benefits of the programme were.
- The researcher gave the participants the first homework

Assignment

Define childhood trauma. Mention ways that childhood trauma can cause stress in the life of an adult. The researcher commended the participants for their good conduct. They were also reminded of the time for the next session.

SESSION 2

Topic: how trauma can affect how I think, feel and its effects on my body

Discussions on meaning of childhood trauma, its related symptoms also the effects it can have on the thoughts, feelings and the human body were explained.

Objectives: At the end of this session, the participants would:

i) Describe childhood trauma

ii) Explain its symptoms
iii) Describe the effects on the thoughts, feelings and behaviour
iv) Describe the effects of the stress on the human body

Activities

- Participants were warmly welcomed to the second session.
- The previous assignment was reviewed with the participants and their efforts were praised.
- The researcher explained that childhood trauma is a negative event that can happen to a person as a child (from early years to the age of seventeen) negatively affecting his/her views about self, others and the world even in adulthood. It was added that a person can be directly or indirectly exposed to trauma as a child.
- The researcher highlighted the following examples of childhood trauma as; physical, sexual, emotional abuse and neglect. Again, the researcher gave examples of psychological (feelings and thoughts) and physiological (body) symptoms and effects of childhood trauma on an individual. The researcher described it as a negative process that can cause lack of sleep, prolonged sadness (depression), hyper-vigilance (excessive worry), anxiety and fear; also, negative thoughts demonstrating lack of self-worth like 'I am not good enough', 'I cannot trust anybody.' The participants were also told that it could even cause bad dreams, the inability to concentrate on work, display feelings of guilt and anger. Its effects on the body can include unexplainable fatigue, muscle aches, difficulty in breathing, eating too much or little and avoiding others.
- The researcher concluded that the participants needed to acquire certain skills to challenge some of these negative cognitive and emotional responses. The researcher also allowed participants to make contributions and ask questions.

Evaluation: The researcher evaluated the session by asking participants to:

i) Describe childhood trauma and its symptoms
ii) Mention situations that can lead to childhood trauma
iii) Give examples of some negative thoughts and feelings a person can have from childhood trauma.

iv) Give examples of other effects of childhood trauma on the mind and body

Assignment

Participants were told to explain how childhood trauma can result in negative behaviour. Mention some sicknesses that could affect a person as a result of childhood trauma if left without treatment.

SESSION 3

Topic: There is hope

Linking childhood traumatic stress patterns to negative behaviour; how these can cause various psychological and physiological health conditions and introducing the intervention SIT; its purpose and goals.

Objectives: At the end of the session participants were able to:

i) Link childhood traumatic stress patterns with negative behaviour
ii) Explain what their personality types are
iii) Mention some negative behaviours that can be linked with childhood trauma
iv) Mention some health conditions which childhood trauma can cause
v) Describe what SIT is and state its purpose and goals of the intervention.

Activities:

- The participants were once again appreciated and welcomed to the third session.
- The researcher reviewed the assignment with the participants and also praised their efforts.
- The researcher communicated to the participants that childhood traumatic stress patterns can make people become accustomed to the use of maladaptive behaviour because they are trying on their own to cope with the distress. The researcher gave examples of such negative coping strategies as the use of avoidance through smoking, drinking, drug abuse, compulsive eating (eating much to forget pain), rejecting intimacy with spouse (for example, because of the pain and memory of sexual abuse). The researcher also added lack of impulse

control (which can make individuals exhibit high risk tendencies like wild partying, driving recklessly), aggression (fighting all the time), self-loathe, self-criticism (self-hatred because of feelings of worthlessness), withdrawal from others (because of fear of rejection) and always at the brink of tears (because of feelings of helplessness, nursing thoughts of suicide and hopelessness about the future).

- The researcher disclosed that childhood trauma can change systems in the brain. It was furthermore explained that the brain can become over familiar with a hyper-arousal state such that the individual is always on guard expecting troubling or disturbing situations. This can cause severe disorders like: anxiety, panic, mood and sleep disorders. Other outcomes were mentioned by the researcher as; issues that can lead to hallucinations (seeing/hearing what others are not seeing/hearing), nightmares, muscle tension, exaggerated startle responses and restlessness. The researcher further explained that this can even change an individual's personality. The researcher explained that someone who was out-going can become reclusive, fearful and withdrawn.
- Besides this, the researcher stressed that these reactions can make an individual become vulnerable to certain health conditions such as hypertension, obesity, asthma, cancer, heart disease, chronic pain (which can be chest, abdominal pains or muscle tensions) and stomach ulcer. The researcher added others to include; lack of attention because of intrusive or disturbing thoughts and memories, avoiding places and people that remind the individual of the traumatic event, memory problems, inability to maintain relationships (feelings of low self-esteem, guilt, blame and lack of trust) and pessimism.
- The researcher however told the participants that there is hope. The researcher explained that SIT is a type of treatment that can help survivors of childhood trauma prepare themselves to handle stress with minimum distress. The researcher also clarified that it can also help to handle previous symptoms of stress such as hyperventilation and palpitation. It was stressed that the treatment can be beneficial in 'immunizing' against the instability of future disquieting situations with minimum consequences. Again, the researcher gave a brief explanation on

how to identify one's personality, encouraging them to embrace who they are and not what they feel the childhood trauma has done. The researcher commenced teachings on how an individual can cope with future stressful events through managing their thoughts, feelings and behaviour. Based on this, the researcher mentioned some types of coping strategies to be learned in SIT as deep breathing exercises and progressive muscle relaxation. It was mentioned that these skills could help them cope with their emotions, enhance sleep and improve attention. In addition, the researcher informed the participants that some other skills like thought-stopping techniques could be helpful in blocking unwanted thoughts thereby shielding the individuals from pressure.

The researcher encouraged participants to make contributions and ask questions.

Evaluation: Participants were assessed through the following:

i) How can thoughts and feelings be linked to behaviour?

ii) What are some maladaptive behaviours that can be caused by childhood trauma? What are some health conditions that a person can have because of childhood traumatic stress patterns?

iii) describe SIT and state some of its benefits.

Assignment:

The participants were encouraged to take note of their stressful thoughts and feelings. Find out what led to the stress, giving special attention to their thoughts, feelings and behaviour before, during and after the stressful episode.

SESSION 4

Topic: action skills

Four action (Emotion-enhancing) skills with some practical training.

Objectives: at the end of the session, the participants were able to:

i) Understand that there are action skills that can help them deal with their emotional reactions using the following: guided therapeutic imagery, deep breathing exercises, progressive muscle relaxation and thought-diverting activities.

ii) Understand that guided therapeutic imagery can induce feelings of relaxation through the mind and body.

iii) Recognize that deep breathing exercises can also produce calmness that can soothe low self-esteem feelings such as anger and other overwhelming negative emotions.

iv) Be aware that progressive muscle relaxation is an approach that can relieve muscular aches from stress and tension.

v) Acknowledge that thought-stopping techniques can be helpful in reducing intrusive negative thoughts.

Activities

- The researcher welcomed participants to the fourth session.
- The previous session and assignments were reviewed.
- The researcher introduced the 4 action skills to be taught as; i) guided therapeutic imagery; ii) deep breathing exercises; iii) progressive muscle relaxation and iv) thought-diversion strategies.
- Guided therapeutic imagery: the researcher explained that it is an evidence-based scientific technique which therapists use to arouse feelings of relaxation in the mind and body using mental images or pictures. The researcher used verbal prompts like 'close your eyes and imagine yourself in a happy or peaceful place.' These enabled the participants to focus on images of a 'place of rest' or 'happy, peaceful place.'
- Deep breathing exercises: firstly, the researcher explained to the participants that there are two ways that a person breathes; these are from the chest and the abdomen. The deep breathing exercises were learnt from these two regions. Secondly, the researcher commenced with teaching participants how to breathe on counts. Deep breathing on 5 counts for example will feature a rhythmic way of breathing and counting (simultaneously) up to 4 then holding the breath before exhaling deeply at 5. The researcher enabled participants understand that deep breathing exercises can be used with affirmations. Some words of affirmation (positive declarations to improve self-worth) which the researcher used as

samples were; *I am at peace with myself, I appreciate who I am, I do not have to be perfect to be happy, I accept myself, I love myself, I can achieve great heights and I can take charge*. The researcher clarified that other affirmations coined by the participants would be appreciated. The researcher also expounded that deep breathing exercises can be used alongside other methods like scattered counting (counting from numbers 5-1) or picking figures randomly like 81, 20, 164, 9 and 202. Again, the researcher pointed out that combining deep breathing with guided therapeutic imagery could assist the participants with restoring inner peace and calm.

- The following were the researcher's instructions to the participants for engaging in the exercise: relax in a chair in a comfortable position. Breathe in then out deeply. Breathe in and out again using the five counts. Picture standing before a door with a big sign at the top called *peace*. Reach out to the knob taking deep breaths. As this is being done, picture that the door opens. Breathe out. There's warm, soft welcoming light. This light brings in feelings of relaxation and peace. Again, deep breathes in and out at 5 counts using affirmations was also used. The researcher further encouraged them to notice how this exercise could make them feel relaxed.
- The researcher explained that another way to use deep breathing exercises and guided therapeutic imagery was through the mental body scan. The participants were instructed to: close their eyes. Imagine that their eyes become an X-ray machine to see where the tension is within their bodies. For instance, the researcher asked questions like *is it in the chest or around the shoulders?* This was to help them discover where the tension was located. They were told that when the location is determined, they should then exhale (breath out) the pressure from their system and breathe in their healing. Similarly, they were told that as they did that, they should vocalize affirmations like *safety, peace, calm, love, joy, success* and other words of comfort or encouragement that suited their different situations. The researcher also mentioned that as they breathed in or out during the exercise, they could also state that they inhale *joy and exhale sadness*.

- Progressive muscle relaxation: the researcher explained to the participants that PMR is a scientific-based stress reducing approach aimed at enabling an individual to be relieved of tensed muscles to produce calmness. The researcher once again clarified that it is called *progressive* because it begins from a person's 'head' finishing up at the 'toes' thus focusing on the entire body. The researcher proceeded with the training by beginning from the forehead: squeeze muscles of forehead by raising eyebrows high then hold for five seconds then release. The researcher encouraged them to do same for the muscles around the eyes by squinting with the eyelids tightly shut, the nose (squeeze as if something irritating is smelling), jaws (clenched jaws with a fake wide smile) then release them appreciating the softness of the face. They were instructed to gently push their heads back in a way they could see the ceiling, again hold or pause while releasing the tension.
- Participants were asked to pause so they could breathe in and out on five counts. The researcher asked that they clench their right fists with their arms hanging down while their elbows are stretched. Then release the tension. The same procedure will be done for the left arm. Researcher also instructed them to clench both fists then pull them into their chests both inward and outward releasing the tightness. They were told to lift up their shoulders to touch their ears, hold for five seconds then release. The researcher, at this point stated that the participants should gently arch their lower back and hold the contraction for five seconds and then relax. The participants were instructed to tighten their buttocks by slowly increasing and decreasing the muscles. The researcher told the participants to stretch their legs; curling feet and toes (stretching them inwards and outwards). As the participants practised these, the researcher told them that they should observe the difference between their state of tension and relaxation as their muscles contracted and contrasted. The researcher also mentioned that the participants should observe that as they exhale, the tension leaves their body fully relaxed.
- The researcher introduced the next skill called thought-diversion techniques. The researcher described this as the act of choosing a constructive activity that a

person can engage in to redirect a disturbing train of thoughts or emotions. The participants were told that each time they brooded over their worries, they reinforced its power over their minds but when they refocused on diverting their thoughts into constructive activities, they broke its grip. The researcher mentioned a few of such thoughts, emotions and circumstances that can lead to distress as; thinking of past misunderstandings with their spouses, being preoccupied with past painful experiences, ruminating over an angry situation, pondering over embarrassing occurrences and constantly comparing themselves with others. The researcher thereafter listed examples of some creative activities for refocusing as; taking a shower, singing, dancing, watching a movie, taking a walk to appreciate nature, tidying up the house, jogging, trying a new recipe, learning a new language, learning a new skill like playing a musical instrument or sewing, knitting, volunteer work, gardening and online courses (educational). The slogan 'get up and do something' was used to help participants remember the diversion techniques.

- Questions and contributions were appreciated from the participants.

Evaluation: participants were asked to:

Summarize any of the four action skills stating one function.

Assignment:

The participants were motivated by the researcher to go home and practice at least one of the four action skills noting their thoughts and emotions before and after the stressful situation.

SESSION 5

Topic: coping skills

Four (problem and solution-focused) coping skills.

Objectives: at the end of the session, participants were able to:

i) Explain what coping skills are
ii) Be able to distinguish between healthy and unhealthy coping strategies
iii) Be aware of the harmful habits that unhealthy coping mechanisms can produce

iv) Be able to state some habits that can help establish healthy coping skills
v) Understand why they are called problem and solution-focused coping skills
vi) State the four (problem and solution-focused) coping skills with examples
vii) Understand positive self-talk, assertiveness, thought-stopping technique and problem-solving skills.

Activities:

- The researcher welcomed and appreciated the participants for attending the fifth session.
- The previous session and concerns arising from the assignment was attended to.
- Thereafter, the researcher introduced the new topic. The researcher explained that there were certain habits which could affect a person's behaviour deterring him/her from problem-solving, improving interpersonal skills and facing life stressors in adaptive ways. The researcher reiterated that people commonly use coping strategies but not all approaches are healthy, intentional, goal directed and meaningful. The researcher, therefore, stated that coping strategies can be healthy or unhealthy. Unhealthy coping styles were defined as ineffective strategies used to endure a painful situation while healthy coping skills are a set of evidence-based psychological tools which can improve an individual's functionality and general wellbeing. Examples of some unhealthy coping strategies are; avoidance behaviour (withdrawal and isolation), ruminating (preoccupied with stressful thoughts), self-labeling (self-defeating attitude) and denial (decreasing the presence or extent to which a problem exists). The researcher also disclosed that these unhealthy coping styles can breed harmful habits like; negative self-talk, procrastination, poor sense of self-worth, self-blame, angry outbursts, promiscuity, poor eating habits, drinking, isolation, no plans or expectations about the future and aggression. These can become problems in marital relationships.
- The researcher mentioned the following four coping skills that the participants would learn as: positive self-talk, assertiveness/interpersonal skill, thought-stopping techniques and problem-solving skills.

- The researcher started with the first coping skill which was positive self-talk. It was reiterated that rather than promoting a self-sabotaging viewpoint, a healthy or positive self-talk would yield encouraging benefits. A self-sabotaging attitude includes a harsh inner voice ingrained in painful childhood memories or thoughts that feed off self-blame and self-defeating schemas. A positive encouraging and kind inner voice is the characteristic of a healthy self-talk. Positive self-talk will build up self-assurance and confidence. The researcher asked questions like; do you love yourself? Can you state five things you appreciate about yourself? The researcher also encouraged the participants to keep a gratitude journal explaining its function. A gratitude journal will keep an individual positive thus prompting thankfulness, cheerfulness, improved sleep, better self-esteem and self-care. The researcher emphasized that this can produce better marital outcomes. Again, the researcher asked the participants to state three things they are grateful for. An example was given as; 'I am grateful for the supportive people I have in my life'. Furthermore, the researcher encouraged the participants to make use of their affirmations or positive self-statements. These were described as positive words which a woman can say to herself daily that can inspire her to view life in a more positive way. Examples were once more given as; 'I am open to the good things that are coming my way,' 'I am capable of accomplishing great heights' and 'I permit myself to forget the past'.
- The researcher encouraged the participants to make use of another skill called assertiveness. Using assertiveness to express one's feelings of pain, anger and sadness is better than incorporating them internally. Internalizing, brooding and ruminating over painful, sorrowful or annoying situations can produce negative behaviour. The researcher emphasized that negative behaviour like anger, avoidance, and aggression cannot build good relationships especially marital ones. Furthermore, the participants were motivated to display assertiveness rather than aggressiveness or passivity. Assertiveness was defined as the ability that an individual possesses to communicate his/her thoughts and feelings in a healthy, calm and polite way. The participants were encouraged to adopt the habit of watching their tone and paying attention to their non-verbal communication cues

(body language). Furthermore, it was added that seeking correct information, asking questions, trying to forgive past offences and healing from past negative experiences could help develop healthy coping mechanisms.

- The researcher also explained that getting ready to start life on a new slate can build up healthy relationships especially between spouses however, making such progress does not entail avoidance. The researcher described avoidance as a poor coping strategy which can make a woman withdraw, dismiss and shun her spouse and others. It is a behaviour which women who have been traumatized early in life can exhibit. Becoming avoidant can make a person lose focus, lose out on joyful moments of life, complicate situations especially when the individual is using substances like alcohol and drugs to escape reality. The researcher affirmed that interpersonal skills like assertiveness are necessary for personal growth and social integration. Some other interpersonal skills include the use of 'I' statements. The use of 'I' statements make it easy for an individual to express his/her feelings and thoughts whereas 'you' statements can be perceived by others as accusatory thereby making them defensive. In addition to this, the researcher mentioned the 93% rule (55% - body language; 38% - voice tone and 7% - actual conversation) which implies that one's facial expressions, voice tone and physical appearance can enhance interpersonal skills.
- Another coping tool is the thought-stopping strategy. The researcher enlightened the participants that the thought-stopping technique which is an SIT practice can be used to reduce unwanted negative and intrusive thoughts so as to replace them with positive ones. The researcher added that this was traditionally done by simply saying 'STOP' to self, emphasizing that it is a process known as vocal interruption. Other means can be explored like wearing a rubber band which they can snap gently against their wrists.

  The researcher buttressed the point that for the thought-stopping techniques to be effective, the participants must be conversant with 3Rs of challenging thought patterns, namely; recognize, reality check and replace. The first is to acknowledge that one is indulging in negative thinking (recognize); secondly, one must check the reality of the thought (is there any evidence?); thirdly, one should then replace

the negative thought with a positive one (healthy alternative thought) and focus on it. The researcher encouraged the participants to put their hands in front of their faces and say “stop”. They were also told that they can snap their fingers, sing or playfully clap their hands to try to block off unwanted thoughts. Replacing unpleasant thoughts with positive ones and exchanging unwanted images with more desirable ones can redirect one’s thought patterns. The researcher also informed the participants can use the acronym STOP with S representing slow down and step back; T for take a deep breath; O representing observe the thoughts for cognitive distortions and the body for sensations; P for proceed mindfully by staying calm to make it easy for them to remember the skill. Again, keeping a journal to track the negative thoughts can help identify triggers leading to these unwanted thoughts and images. Some of the questions to guide their journaling activities are: What was the situation? What negative thoughts arose in me during/after the situation occurred? What maladaptive feelings did these thoughts arouse in me? What is a more positive alternative thought for me in this situation? How do I feel with this new alternative thought? Participants were also challenged to discover any other healthy means of interrupting unpleasant thoughts through the use of this technique. The researcher concluded that practicing these skills can help to achieve stabilized moods, enhanced attention, emotion regulation and improved sleep patterns.

- The researcher also emphasized that instead of feeling sad, helpless and hopeless over challenges, they could practice the fourth coping ability; the problem-solving skill. A problem-solving strategy was described as an approach that can assist an individual to define, understand and seek out ways to solve their difficulties. The researcher further clarified that participants should always see problems as tasks that can be broken into attainable goals. The following steps were given as tips to develop the problem-solving skill:
    1. What is the problem? Describe it in a simple way (use one word, then describe it in a sentence).
    2. Understand the problem. Break it into smaller pieces or parts.
    3. Generate solutions. Create as many options and plans.

4. Consider the choices.
5. Choose the best course of action.
6. Set STAR goals (specific, time frame, achievable and reviewable) on how to achieve course of action.
7. Implement the solution.
8. Evaluate the outcomes. You can restrategise if necessary.

The researcher concluded that problems are tests which require taking positive steps to achieve success. The participants were encouraged to ask questions and make contributions.

Evaluation

Participants were asked to:

i) State what a coping skill is
ii) Explain the difference between healthy and unhealthy coping strategies
iii) Mention two unhealthy habits which negative coping strategies can produce
iv) Suggest two healthy habits that can be beneficial to producing adaptive coping skills
v) Explain what assertiveness is. Describe how it is different from aggressiveness and passiveness. Mention what they can do to divert attention from an irritating thought or feeling.
vi) Describe positive self-talk. Mention what they can do to promote positive self-talk. State how a gratitude journal can help them accumulate positive thoughts.
vii) Explain one way they can solve problems in a given situation.

Assignment:

The researcher asked the participants to make use of the following questions to develop an action plan for challenges they are presently experiencing;

- What do I want to achieve?
- Why is it important to me?

- How can I best achieve it?
- What resources do I need?
- Who can be of help?
- How can they be of help?
- How will I know when I have achieved what I want?

SESSION 6

Topic: Knowing your triggers/ role play (1)

This session was divided into 2 parts: Knowing how to identify triggers and practices/rehearsals using role play.

Objectives: at the end of the session participants were:

i) Able to describe triggers
ii) Mention some examples of common triggers
iii) State some trigger warning signs
iv) Explain 4 ways to manage triggers
v) Describe what was learnt from the role play (1)

Activities:

- Researcher welcomed participants to the sixth session.
- The previous session was evaluated through short questions and answers. Assignments were appraised.
- The researcher at this point described triggers as a set of stimulants which a person perceives in a given situation as a threat to his/her wellbeing. The researcher included that triggers can lead to feelings of distress or discomfort through memory, smell, sight or sound. In addition to this, it was explained that apart from feelings of distress, triggers can create discouragement or negative self-talk kindling the use of unhealthy coping skills. Some situations of common triggers are; seeing the picture of a lost loved one, disturbing memory of a robbery incident, a fatal car crash that caused death or injuries, sexual molestation, a relationship that caused heartbreak, fearful news of any kind and physical assault. Furthermore, the researcher stated that when an individual faces

a situation of fear and dread, he/she feels highly distressed therefore memories of such incidents could cause disturbances.

The researcher emphasized that triggers have warning signs which can serve as an alert system to an individual that he or she is uncomfortable. These warnings are bodily sensations like; breathing heavily, sweating, gritting one's teeth, shortness of breath, clenching fists and jaws. The researcher told them that a trigger can also be an alert system indicating that the body is trying to relive and express what it went through during a painful ordeal. The researcher explained that triggers involve an individual's five senses like the sense of sight (eyes), sense of smell (nose), sense of hearing (ears), sense of taste (mouth) and sense of touch (skin). Therefore, what one is exposed to through the five senses can serve as sources of triggers. Similarly, the participants were told that another source can be people, places and objects. The researcher further mentioned 3 things that can be done to manage triggers as; i) identify the trigger; ii) trace the origin of the trigger; iii) restructure the negative thought pattern around the trigger.

- The researcher reminded the participants about the skills acquired in sessions 4 and 5. The importance of the four action skills and four healthy cognitive coping strategies were reiterated. The participants were informed about the second part of the session; role play (1). It was verified that role play in the course of an intervention is a therapeutic exercise designed to portray life situations through short plays to display the skills attained. The researcher restated that role plays can be used to imitate real life situations in order to prepare the participant for future challenges. The researcher used 3 steps to set up the role play sessions; i) identification of the situation to be addressed through the role play; ii) request for a volunteer and iii) assigning those who had volunteered to characters for the role play. The researcher concluded by reiterating that the objective of the first role play was to stress the importance of focusing on the positives and the danger of negative thinking. The researcher further added that, the goal of role play1 and 2 were to enable the participants to see how some of the skills they had learnt could be put to use.

ROLE PLAY 1

Title: **I will focus on the positives**

The scene is in the therapist's office.

MRS R: walks in.

Therapist: good morning MRS R. How are you today? Please sit down. How have you been?

MRS R: thank you. I have not been too happy. I lost my job at the school I told you I was working.

Therapist: so sorry to hear that. How do you feel about this?

MRS R: worried!

Therapist: could you please tell me about the worry?

MRS R: I don't know how I will survive. It's as if things are getting worse.

Therapist: things like what? Could you expand that for me, please?

MRS R: well…things like my children's school fees, our house rent which is due in the next 6 months and what we will feed on to survive.

Therapist: so you are saying that you might have lots of challenges.

MRS R: yes. My children might be sent out of school and stuck at home; the land lord might even send us packing. Ah…where will we go! People will start making fun of us.

Therapist: what has your husband said about this?

MRS R: don't even go there!

Therapist: why not? He is your husband, isn't he?

MRS R: you are right, he is. He has been very quiet of late since I lost that job three weeks ago. We hardly talk any more.

Therapist: why do you think he has been quiet? Is he usually like that?

MRS R: no. He is quiet because he is sad. I feel he blames me for losing that job.

Therapist: isn't that too hasty since he hasn't said so?

MRS R: that's true. It's possible he feels the same way I feel…worried and afraid.

Therapist: why is that?

MRS R: his business is at a standstill because of the Covid-19 situation.

Therapist: sorry to hear that. Many people are going through a lot of challenges presently. So, you feel nothing good can come out of this situation?

MRS R: ah…it seems scary. I cannot say.

Therapist: can you recall that there was a time you had this same feeling of worry and anxiety about the future before you got employed? You felt everything was about to crash. What happened then?

MRS R: yes. I remember vividly. That was in 2018. It was surprising we survived that period. Someone who owed my husband some amount of money just decided to pay him then. What a surprise! We were able to start a small poultry with that money.

Therapist: okay, don't you think you could also survive this? Is this different from then?

MRS R: yes, this is certainly different. My children have never been out of school before, I have never been without a job before, we have never been sent out of our house because of delay in paying rent before, my husband has never been so angry with me before and I am so discouraged.

Therapist: no…Mrs R, you have forgotten. You have been without a job before.

MRS R: oh yes, you are right. I have been without a job. That was in 2017. I stopped working because we relocated from Abeokuta to Ibadan so I had to search for a job.

Therapist: so, what were you doing to ensure that things didn't crash?

MRS R: I had some small businesses I was running. Things were tough but we kept on keeping on.

Therapist: were you able to pay for your necessary amenities then like your house rent, school fees for the children, clothing and feeding?

MRS R: oh yes, we were! But with Covid-19 things have changed. You are talking about 2017/2018? Jobs are scarce now and the cost of living is higher.

Therapist: this is true. But is there a chance that you could run some small businesses again?

MRS R: it is possible but I have to think of what I can do.

Therapist: that would be fantastic bearing in mind that you are quite creative, intelligent and hardworking. You will definitely come up with something great.

MRS R: I hope so.

Therapist: now ma'am…I need to tell you this. You have used so much energy in thinking about the negative side of the matter like your children being sent out of school and stuck at home; your landlord throwing you out to the streets, as well as other fears…but these things have not even taken place. You seem to have forgotten that problems are tests with answers. You need to put in as much energy in thinking about positives so you can be more open to finding solutions.

MRS R: well…I think focusing on the negatives as you call them can help me plan better.

Therapist: didn't you notice that the more you brooded over the negatives, the more difficult it was for you to see anything good coming from the situation? The more you do that, the further you give the negatives the power to expand and become larger than life. It cannot even help bring some peace into the relationship with your husband. What do you think?

MRS R: yes. It does make sense!

Therapist: I think that there are different proposals and ideas you and your husband could explore to prevent the incidents you were ruminating about from actually taking place. For instance, you will need to adapt. Get your husband on the same page. Try having a meaningful conversation with him using the assertiveness skills you learnt during therapy. Cut down on certain areas of your budget; make changes, set STAR goals, implement and review your progress. Reviewing will help you see how far you have gone and what needs to be done next. It will also help you to have the deep understanding you need to re-examine what is no longer working so that you can disregard and replace them with better options. This marital coping strategy will make you and your husband more proactive in the right direction instead of being passive aggressive.

MRS R: oh…this makes a lot of sense.

Therapist: looking back, I can say that you have survived even worse situations of childhood trauma. You are a strong woman. As a strong woman you must

definitely focus on the positives which will increase your likelihood of surviving again. Who knows, you might even get a better job as time goes on.

MRS R: wow! I feel better already. I will certainly make it through. Thank you so much.

Session ends

At the end of the role play session, the researcher asked the participants what MRS R was doing wrong initially and what she could have done differently. The participants were also asked if they had ever been in the kind of situation MRS R experienced and what kind of healthy or unhealthy coping strategies they had used.

Questions and comments were appreciated.

Evaluation:

The researcher asked for lessons learnt based on the role-play with emphasis on focusing on the positives.

Assignment:

The assignment was on practicing how to focus on the positives.

SESSION 7

Topic: Role play (2)

Therapeutic role play session

Objectives: at the end of the session, the participants:

i) Developed a deeper understanding about irrational beliefs, negative thoughts and how to challenge them.

Activities:

- The researcher appreciated the participants' relentless efforts for taking part in the programme. They were welcomed to the seventh session.
- The researcher asked participants to state any progress they had made since the inception of the programme. All comments were appreciated and respected.
- The researcher asked for volunteers to participate in the second role-play.

ROLE PLAY 2

Title: I will change my strategy

Scene begins in the therapist's office.

MRS D walks in.

Therapist: good afternoon MRS D. How are you? You look tensed. What's going on?

MRS D: I'm very well though a bit tired.

Therapist: what do you think is responsible for the tiredness?

MRS D: I feel I am tensed, totally stressed out. My husband and I are at it again. We have been shouting at each other for the past three weeks. I sometimes wonder why I am still in the marriage.

Therapist: what you are saying is that nothing is going on well at home?

MRS D: yes, it's an absolute disaster. It's shameful the way we shout, scream and call each other names before the children, relatives, neighbours and friends. I'm fed up!

Therapist: what can you make out of the whole situation?

MRS D: I just cannot stand the sight of the man whether he is doing anything right or wrong. I'm tired of these feelings.

Therapist: what type of things does he do that triggers off these negative thoughts, feelings and behaviour?

MRS D: you know that I am a banker, right. I come home from work late and tired. First thing I see is I notice my children are running around the neighbourhood rough and dirty. No homework done, no supervision…nothing! Next, he is right in front of the television watching a football match. Sometimes, if he is not watching television, then he is on Facebook or snoring on the couch. This puts me off. Whenever I see him like this, I just get angry. It upsets me. At this point in time, I discover that I start sweating, my heart is pounding and I am breathing fast. My alarm system is off but I don't care. Then I start shouting at him calling him all kinds of names. Many times, I even resort to breaking valuables. I get out of control. He hates that. He shouts back at me, gets his car keys and leaves the house. This has never solved anything.

Therapist: so, anytime you come home tired from work and you see him sitting on the couch, it upsets you and triggers off those responses, such that you break stuff, scream and call him names? He also responds by shouting back and leaving the house. None of

which has helped you both. Are there things he does that are helpful to you and the family?

MRS D: oh yes! He has a good job which keeps us comfortable. He also tries to pick the children from school in the afternoons.

Therapist: if you were to describe your husband using some adjectives, what would you say?

MRS D: I would say… hardworking, intelligent but lazy, stubborn and selfish.

Therapist: is he always like that, or it's once in a while you see him as all the mentioned attributes?

MRS D: all the time. Yes…. though, there are times he can be a little sacrificial, for instance, when I was ill, he was helping with the house chores but as soon as I got better, he abandoned them again because he said it's a woman's job.

Therapist: then, does shouting at him achieve anything?

MRS D: it does not do anything fruitful. As a matter of fact, it is damaging.

Therapist: why is it not productive?

MRS D: the children are unhappy. I am unhappy too. My husband sometimes seems like a stranger.

Therapist: then what exactly triggers these reactions for you? Is it that you see something that upsets you?

MRS D: thank you for that question! It's like this as I am driving in, I just see my children outside playing rough, unsupervised and unchecked. The anger begins to brew. I hate seeing my two boys like that, dirty and disheveled.

Therapist: Madam…do you have people who get you angry at work?

MRS D: yes, but I try to manage it.

Therapist: why is that?

MRS D: I don't want to lose my job.

Therapist: at work you can manage your feelings of anger, but at home, you freely use it. Why is that? What thoughts do you have about home?

MRS D: I feel my husband cannot do anything good for anyone else. He is selfish.

Therapist: okay…but you just said he can be a little sacrificial. Apart from that, you think it's alright not to control your thoughts and emotions at home but you can manage them at work. Isn't it?

MRS D: yes. I think so.

Therapist: you have said, "he cannot do anything good for anyone else, he is selfish" could these actually be the thoughts that make you lash out at him? If that is the case, these thoughts have to be challenged. You said he is a hardworking man and has once even cared for you when you were sick. So, there is something good about him. Based on this discovery, what alternative thought can there be to replace shouting and name calling?

MRS D: that he can be nice and thoughtful. That he cares for me and his children. He pays their fees and tries to be there for us in his own way. I guess I still love him despite our challenges.

Therapist: good. Using some positivity can be effective. It takes a lot of practice and effort especially if you have been used to giving negative responses but with time, you will get better at it. Next, try practicing deep breathing exercises to calm your emotions since you already know what to expect from your husband and children. Remember we once talked about using your affirmation or self- statements as you take deep breathes. Can you remember any of them?

MRS D: yes, I can remember. They are 'I feel safe, I feel secure'. I chose these words of affirmation because of the terrible things I had to go through as a child. I was exposed to so much fear and rage. I guess I am still trying to deal with those responses from long term abuse.

Therapist: I appreciate that MRS D and I salute your courage and willingness to work on yourself.

MRS D: thank you so much. I am also grateful for the range of options that therapy can offer. What else do you recommend?

Therapist: you can also make use of thought diversion techniques.

MRS D: what does that mean?

Therapist: a diversion is an activity that creates a distraction from what a person is concentrating on… so what can you distract yourself with?

MRS D: ehm…like ignoring talking to him and taking a shower first.

Therapist: sure, but don't act as though he doesn't exist. Try to rehearse your positive responses and manage the anger in advance. The initial time you get home, the first ten minutes are very crucial therefore you have to 'inoculate' yourself against the perceived stress. Focus on those minutes. Once the hurdle has been scaled, then you can try responding to his behaviour more constructively. Talking to him patiently could achieve much more than shouting and name calling.

MRS D: I totally agree.

Therapist: when having the conversation with him, remember to use "I" statements. "I" statements can help to nurture positive communication in marital relationships. In addition to this assertiveness skill, be friendly towards him so that it can help you to avoid being aggressive. A bit of humor too wouldn't do any harm and a gentle tone plus a friendly disposition could win anybody's heart.

MRS D: absolutely! I certainly will try to comply. I need some peace and unity in my home.

Therapist: I know you can do it. **Session ends.**

Researcher asked participants what they felt MRS D was doing wrong at first and what she could have done differently. Participants were asked to mention some of the skills MRS D was told to practice. The researcher requested for questions and comments which were appreciated.

Evaluation:

The researcher asked the participants which specific skills they would practice and why.

The participants were encouraged to go home and practice lessons learnt.

SESSION 8

Topic: Post-test and termination of therapy

Objectives: researcher administered the post-test instrument and then sessions were terminated.

Activities:

- Researcher appreciated all the participants for their support, regularity and promptness which were displayed all through the exercise. The researcher also

reminded the participants to continue to use the skills they had learnt and acquired. The post-test instrument was administered. The sessions were terminated.

APPENDIX 18

Participants during intervention (SIT)

Cross-Section of Participants during Role Play (SIT)

Some Participants (CPT/Focus Group Discussion)

Cross-Section of Participants during intervention (CPT)

Cross-Section of Participants (SIT/Focus Group Discussion)

Participants during intervention (SIT)

APPENDIX 19

DEPARTMENT OF COUNSELLING AND HUMAN DEVELOPMENT STUDIES
UNIVERSITY OF IBADAN, IBADAN, NIGERIA

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Prof. R. A. Animashaun
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B.Ed., M.Ed., Ph.D
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Dr. J. O. Fehintola
B.Sc., PGDE, M.Ed., Ph.D
Dr. A. K. Taiwo
B.Sc., M.Ed., Ph.D

Date: ....

LETTER OF INTRODUCTION

This is to certify that ...Grace G. Adewale.....

with Matriculation No.: ...64002... is one of our ~~M.Phil/Ph.D~~./Ph.D. students in the Department of Counselling and Human Development Studies, ~~University of Ibadan~~. ~~He~~/She would like to collect data for ~~his~~/her thesis titled:...Cognitive Processing and Stress Inoculation therapies on Marital Satisfaction of Women with Child Sexual trauma in Ibadan.....

.....

Kindly assist him/her in any way you can.

Thank you.

Chy Asuzu

Prof. Chioma C. Asuzu,
Head of Department.

APPENDIX 20 A

TELEGRAMS..... TELEPHONE.....

MINISTRY OF HEALTH

DEPARTMENT OF PLANNING, RESEARCH & STATISTICS DIVISION

PRIVATE MAIL BAG NO. 5027, OYO STATE OF NIGERIA

Your Ref. No. .....
All communications should be addressed to
the Honorable Commissioner quoting
Our Ref. No. AD 13/479/ 4248

29th June, 2021

The Principal Investigator,
Department of Counselling and Human
Development Studies,
[illegible],
University of Ibadan,
Ibadan, Nigeria.

Attention: Adewale Grace

ETHICS APPROVAL FOR THE IMPLEMENTATION
OF YOUR RESEARCH PROPOSAL IN OYO STATE

This is to acknowledge that your Research Proposal titled: "Cognitive Processing and Stress Inoculation Therapies on Marital Satisfaction of Women with Childhood Trauma in Ibadan." has been reviewed by the Oyo State Ethics Review Committee.

2. The committee has noted your compliance. In the light of this, I am pleased to convey to you the full approval by the committee for the implementation of the Research Proposal in Oyo State, Nigeria.

3. Please note that the National Code for Health Research Ethics requires you to comply with all institutional guidelines, rules and regulations, in line with this, the Committee will monitor closely and follow up the implementation of the research study. However, the Ministry of Health would like to have a copy of the results and conclusions of findings as this will help in policy making in the health sector.

4. Wishing you all the best.

Dr. Abbas Gbolahan
Director, Planning, Research & Statistics
Secretary, Oyo State, Research Ethics Review Committee

APPENDIX 20 B

Social Science and Humanities Research Ethics Committee (SSHREC)
University of Ibadan

Chairman
Prof. Jegede Ayodele Samuel.
B.Sc., M.Sc.(Ife) MHSc (Toronto), Ph.D. (Ibadan)

Email: sshrecuisoc@gmail.com
Mobile: +234-080-5725-0326

NOTICE OF FULL APPROVAL AFTER FULL COMMITTEE REVIEW

Re: Cognitive Processing and Stress Inoculation Therapies on Marital Satisfaction of Women With Childhood trauma in Ibadan, Nigeria

UI/Social Sciences Ethics committee assigned number: **UI/SSHREC/2021/0022**
Name of Principal Investigator: **Grace G. Adewale**
Address of Principal Investigator: Department of Guidance and Counselling
Faculty of Education, University of Ibadan

Date of receipt of valid application: 13/07/2021
Date of meeting when determination on ethical approval was made: **27/07/2021**

This is to inform you that the research described in the submitted protocol, the consent forms, and other participant information materials have been reviewed and given full approval by the SSHREC Committee.
The approval dates from **27/07/2021 to 28/07/2022.** If there is delay in starting the research, please inform the SSHRE Committee so that dates of approval can be adjusted accordingly. Note that no participant accrual or activity related to this research may be conducted outside of these dates. All informed consent forms used in this study must carry the SSHRE Committee assigned number and duration of SSHRE Committee approval of the study. It is expected that you submit your annual request for the project renewal to the SSHRE Committee early in order to obtain renewal of your approval to avoid disruption of your research.

Note: the National code for research ethics requires you to comply with all institutional guidelines, rules and regulations and with the tenets of the Code including ensuring that all adverse events are reported promptly to the SSHREC. No changes are permitted in the research without prior approval by the SSHREC except in circumstances outlined in the Code. The SSHRE reserves the right to conduct compliance visit to your research site without previous notification.

Prof. A. S. Jegede

1

APPENDIX 21 A

DEPARTMENT OF GUIDANCE AND COUNSELLING

UNIVERSITY OF IBADAN, IBADAN, NIGERIA

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Head of Department
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B.Sc., M.Ed., Ph.D. (Ibadan)

E-MAIL:
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counshumandevelopment@gmail.com

Date: 28-04-21

The Director of PHC
Ibadan North East
Local Government

LETTER OF INTRODUCTION

This is to certify that Grace Gbenga ADEWALE with Matriculation No.: 67002 is one of our M.Phil/Ph.D./Ph.D. students in the Department of Guidance and Counselling, University of ~~Ibadan~~. ~~He/She would like to collect~~ data for his/her thesis ~~titled~~: Effectiveness of Cognitive processing and Stress Inoculation therapies on Marital Satisfaction of Women with Childhood trauma in the Ibadan Metropolis.

Kindly assist him/her in any way you can.

Thank you.

Prof. Chioma C. Asuzu,
Head of Department.

HoF Iwo Rd PHC,
Kindly assist the bearer in whatever way required for the research activities

APPENDIX 21 B

AKINYELE LOCAL GOVERNMENT HEALTH AUTHORITY

MONIYA, IBADAN.

MONIYA, OYO ROAD P.M.B. 5182, IBADAN.

Your Ref:..... Our Ref:..... Date:.....1st June, 2021.....

The OIC,

Ojoo PHC,

Ojoo, Ibadan.

Re: Request to Collect Data for Thesis Purpose.

This is to introduce to you **Grace Gbenga Adewale,** with Matric Number 64002 who is one of ~~M.Phil~~/Ph.D. student in Department of Guidance and Counseling, University of Ibadan carrying out a research on "**Effectiveness of Cognitive Processing and Stress Inoculation Therapies on Marital Satisfaction of Woman with Childhood Trauma in the Ibadan Metropolis".**

Kindly accord him/her all necessary assistance and cooperation.

Dr. Mustapha Mukaila Ashir.

MOH

APPENDIX 21 C

IBADAN NORTH LOCAL GOVERNMENT

DEPARTMENT OF PRIMARY HEALTH CARE

Local Government Secretariat

P.M.B. 45, Agodi Gate, Ibadan. Tel: 8106801, 8106802

Your Ref:_____

Our Ref:_____ **Date:** 28-04-2021

The Head of Health Facilities
Ibadan North Local Government Health Authority
Agodi-Gate
Ibadan

Attention Please-: **Principal Investigator (Grace Gbenga Adewale)**
Department of Guidance and Counselling,
University of Ibadan

Dear Head/Matron,

PERMISSION TO CONDUCT RESEARCH WORK BY GRACE GBENGA ADEWALE

Kindly allow the above-named Principal Investigator from the Department of Guidance and Counselling, University of Ibadan, Ibadan to enter your health facility for the purpose of interacting with the clients of interest to her. The title of the work is **"Effectiveness of Coginitive Processing and Stress Processing Inoculation Therapies on Marital Satisfaction of Women with Childhood Trauma in the Ibadan Metropolis"** The research is very important and do believe the outcome will be of immense benefit to the larger community and our entire health system in the fullness of time.

In view of the above, I want you to give her all the necessary support and assistance in order to have a quality result at the end.

Thanks for your usual co-operation

Yours sincerely,

28/04/2021

MEDICAL OFFICER OF HEALTH
Ibadan North Local Government
Agodi, Oyo State.

Dr Famakin M.
CMOH/PHC Director
Ibadan North Local Government
Agodi-Gate
08073271174