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Applying Cognitive Processing Therapy to Posttraumatic Stress Disorders Syndrome among Internally Displaced Youth Victims of Terrorism in Nigeria

Fidel O Okopi [α], Joshua Pindar [σ], Naomi Adamu [ρ] & Amos Williams [ω]

Abstract- The main concern of this research was to identify those who were experiencing Posttraumatic Stress Disorder Syndrome after Boko Haran terror attacks and to employ Cognitive Processing Therapy strategy in minimising or preventing probable long-term psychological distress. Four (4) practicing counselling psychologists were involved. Traumatic Screening Questionnaire (TSQ) and Checklist- Civilian Version (PCT-C) were pilot-tested and used for the research. Descriptive survey design was used. Purposive and Stratified random samplings were used to select the youths. Cognitive Process Therapy treatment model - Civilian Version (PCL-C) was applied. Total sample population was 76. Findings showed that, after undergone Cognitive Processing Therapy, a total population of 57 (75%) of the respondents experienced little to no severity PTSD while 19 (25%) of respondents experienced moderate to moderately of PTSD. There was no gender significant difference when comparing both sexes at pre-and post-tests results of PTSD Checklist – Civilian Version (PCL-C) In conclusion, Cognitive Processing therapy is one of the efficacious therapy in the treatment of PTSD.

Keywords: posttraumatic stress disorders syndrome; internally displaced youth victims of boko haran terrorism; cognitive processing therapy.

I. Introduction

Terrorism, according to the United Nations report in November 20014, is any act intended to cause death or serious bodily harm to civilians or non-combatants with the purpose of intimidating a population or compelling a government or an international organization to do or abstain from doing any act. Terrorism is, in the broadest sense, the use of intentionally indiscriminate violence as a means to create terror among masses of people; or fear to achieve a financial, political, religious or ideological aim. In this research. the above definitions of terrorism serves as the conceptual definition of Boko Haram terrorism in Nigeria.

a) *Boko Haran Terrorism in Nigeria*

Boko Haram, an Islamic extremist group ("Group of the People of Sunnah for Preaching and Jihad") based in North Eastern Nigeria. Boko Haram is also active in other countries of Chad, Niger and northern Cameroon (U.S. *Department of State 2014)*. Boko Haram Sect was founded in 2002 by Mohammed Yusuf in Maiduguri, the capital of the North-Eastern state of Borno, (IRIN, 2015). The Sect has the political goal of creating an Islamic State and it has become a recruiting ground for jihadis, (Cook 2011). The name "Boko Haram" is usually translated as "Western education is forbidden" which is used to refer to secular Western education (Newman, 2013). Boko Haram has also been translated as "Western influence is a sin" and "Westernization is sacrilege (Newman, 2013; Nigerian Independent Newspaper 17 August 2014*)*. After its founding in 2002, Boko Haram's increasing radicalization led to a violent uprising in July 2009 in which its leader was summarily executed in a controversial circumstance. He was succeeded by Abubakar Shekau, formerly his second-in-command. Boko Haram has maintained a steady rate of attacks since 2011, striking a wide range of politicians, religious leaders, security forces and civilian as targets. The group continued to capture territory in north-eastern and eastern areas of Borno, as well as in Adamawa and Yobe states. These attacks extended across the Nigeria's borders leading to many people being killed and millions displaced from their homes. Global Terrorism Index in 2015 indicated that, terrorism in Nigeria ranked as one of the world's deadliest terror group and estimated above 13,000 Nigerians have been killed in Boko Haram violence between 2009 and 2014; countless more have been wounded (Nigerian Emergency Management Agency Report, NEMA 2015). Amnesty International (AI-2017) has revealed that at least 967 people were reportedly killed by Boko Haram attacks in the four countries as from January to November 2017. In Nigeria alone, the insurgents increased their suicide attacks from 19 in 2016 to 38 in 2017. According to the report, 83 children have been used as human bombs this year. Of this number, 55 were girls, most often under 15 years old; 27 were boys, and one was a baby strapped to a girl. There were 1.7 million people displaced by the insurgency in the north-east, 85 per cent of them in Borno State, where most of

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these attacks took place. (World Report 2017: Nigeria | Human Rights Watch)

b) Internally Displaced Persons in Nigeria

According to a survey conducted by the National Emergency Management Agency, NEMA, in collaboration with International Organisation for Migration, IOM, identified 1,822,541 internally displaced persons, IDPs, in Adamawa, Bauchi, Borno, Gombe, Taraba, Yobe, Nasarawa states and Abuja through Displacement Tracking Matrix, DTM, as of October 2016 . Nigeria's eight-year conflict with Boko Haram has resulted in the deaths of over 20,000 civilians and a large-scale humanitarian crisis (UN, 2017); approximately 2.1 million people have been displaced by the conflict while 7 million need humanitarian assistance;. In June 2017, According to UN Office for the Coordination of Humanitarian Affairs (2017) the number of internally displaced persons (IDPs) currently stands at 1.7 million in Borno, Adamawa and Yobe states, in addition to over 200,000 Nigerian refugees in neighbouring countries. In August 2017 alone, 4,509 new arrivals were recorded in Gwoza and 2,411 in Ngala, and many more in Dikwa, Kukawa, Damboa and Barna.

c) Conditions of Living in IDP Camps in North-east Nigeria

Many internally displaced persons in camps across Borno, Yola, and Yobe states are currently facing traumatic experiences due to the pitiable conditions of living in these camps, while some young girls have become victims of lascivious men and have contracted HIV (Bwala 2015, Sunday Tribune 15th February 2015). According to Bwala (2015), many of the internally displaced persons find it very difficult to adapt to the reality of life; to many of them, life has lost its meaning and the world has come to an end, judging by their attitude and resignation to fate. While physically injuries would have healed, the invisible scars left by those experiences would take far long (Saturday, Tribune 28th Feb; 2015). He further explained that, many of them in IDP camps complained of high rate of criminality; cases of rape have been on the increase while prostitution has been the only way out for most of the young girls there, most of whom are poor. He explained that, to make the matter worse, many of them were orphans whom have nobody to take care of them. 2.5 million IDP population, comprises children under the age of five, pregnant women and nursing mothers. The camps were overcrowded and lacking space due to continuous insecurity, precipitating food insecurity which remains a major concern with 5.2 million people in need of life-saving food assistance. In August 2017, attacks against civilians, including suicide bombings in IDP camps, remains a major concern with over 10 person-borne explosive device attacks took place during the reporting period in Borno alone.(UN Office for the Coordination of Humanitarian Affairs: 2017). In realisation of then egative effects of Posttraumatic Stress Disorder on internally displaced persons, the Federal Government of Nigeria through the Office of the National Security Adviser (NSA), in collaboration with Murtala Muhammed Foundation established Crisis and Trauma a Counselling Centre in Kano in 2014 (IRIN 2015). IRIN report further explained that, also a new Crisis and Trauma Counselling centre has been opened in Maiduguri, the Borno state capital and the stronghold of Boko Haram. According to (IRIN, 2014), In collaboration with Programme Coordinator for the Murtala Muhammed Foundation, the CTCC was part of a strategy by the Federal Government to build capacity within Nigerians national mental health framework to treat PTSD among civilians and military personnel

II. What is Posttraumatic Stress Disorder (PTSD)?

Posttraumatic stress disorder (PTSD) is a clinical syndrome characterised by intrusive memories, emotional avoidance, and heightened physiological arousal following exposure to a traumatic event (American Psychiatric Association [APA], (2013). Post-traumatic stress disorder (PTSD) can occur after an individual has gone through a life-threatening event. During this type of event, the victim may think that, his or her life or others' lives are in danger. The victim may feel afraid or feel that he or she has no control over what is happening. Among co-occurring psychiatric disorders, some mental health professionals have suggested, depression may be most prevalent--and most lethal (Palgi, Ben-Ezra, Langer, &Essar, 2009; Pinna et al, 2013). Such life-threatening events include: combat, military sexual trauma, terrorist attacks, physical violence, sexual violence, such as rape, serious accidents, such as a car wreck and natural disasters, such as a fire, tornado, flood, or earthquake. After any of these events, the victims might be thinking a lot about what happened, avoiding reminders about the events, and thinking negative thoughts about themselves and the world.

According to American Psychiatric Association [APA], (2013)identifies four types of PTSD symptoms

Reliving the event (also called re-experiencing symptoms): Memories of the traumatic event can come back at any time. The victim may feel the same fear and horror she or he did when the event took place. For example the victim may have nightmares such as a flashback feeling as if he or she is going through the event again or seeing or hearing, or smelling something that triggers the relive of the event. Examples of these could, news reports, seeing an accident, or hearing a car backfire

A victim avoiding situations that is a reminder of the event: The victim may try to avoid situations or people

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that trigger memories of the traumatic event. She or he may even avoid talking or thinking about the event. For example the she or he may avoid crowds, because he or she may feel they are dangerous or keep very busy or avoid seeking help because she or he believes such action keeps he or her from having to think or talk about the event

Negative changes in beliefs and feelings: The way the victim thinks about himself or herself and others changes because of the trauma. This symptom has many aspects, including the following: the victim may not have positive or loving feelings toward other people by staying away from relationships or may think the world is completely dangerous, and no one can be trusted.

Feeling keyed up (also called hyper-arousal): The victim may be jittery, or always alert and on the lookout for danger. She or he might suddenly become angry or irritable. For example: she or he may have a hard time sleeping or .may has trouble concentrating or may be startled by a loud noise or surprise.

In summary, PTSD symptoms can change the victim's behaviour and how he or she lives his or her life. The victim may pull away from other people, work all the time, or use drugs or alcohol. The victim may find it hard to be in relationships, and you may have problems with your spouse and family. The victim may become depressed. Some people with PTSD also have panic attacks which are sudden feelings of fear or worry that something bad is about to happens

The main concern of this research was to identify those who were experiencing Posttraumatic Stress Disorder Syndrome after Boko Haran terror attacks and employ Cognitive Processing Therapy strategy to minimise or prevents probable long-term psychological distress. In other words, adaptation of Cognitive processing therapy is to treat acute stress disorder and prevent it from degenerate into chronic Post Traumatic Stress Disorder among the victims of Boko Haram in Nigeria terrorism.

III. Theoretical Frame Work: Cognitive Processing Therapy for PTSD

According to *Field, Beeson, & Jones (2015)*, Cognitive Processing therapy is an aspect of Cognitive Behavioural Therapy. Cognitive Behaviour Therapy combines a cognitive approach (examining thoughts) with a behavioural approach (the things the individual does). The goal is to help the individual learn new positive behaviours which will minimise or eliminate the issue. They further explained that, it seeks to help the client to manage problems by enabling him or her to recognise how his or her thoughts can affect his or her feelings and behaviour. It aims to break overwhelming problems down into smaller parts, making them easier to manage (*Field, Beeson &Jones 2015)*. While working with individuals diagnosed with PTSD, counsellors often expected to target decreasing the severity of (a) recurrent and intrusive distressing memories of the traumatic event, (b) emotional avoidance, and (c) heightened physiological arousal (Makinson & Young, 2012). Outcomes may include decreasing aggressive outbursts, hyper-vigilance, and sleep disturbance that appeared or increased in intensity after exposure to the traumatic event (APA, 2013; Seligman &Reichenberg, 2012).

The objectives of Cognitive Processing Therapy are; to educate the client about the specific post-traumatic stress disorder (PTSD) symptoms and the way the treatment will help him/her overcome it; inform the client about his/her thoughts and feelings; helps the client develops skills of questioning his/her own thoughts; helps the client to recognise changes in his/her beliefs about what happened after going through the traumatic event. Theory behind CPT conceptualizes PTSD as a disorder of non-recovery, in which a sufferer's beliefs about the causes and consequences of traumatic events produce strong negative emotions, which prevent accurate processing of the traumatic memory and the emotions resulting from the events (Resick., & Schnicke, 1993, Monson. Schnurr., Resick, Friedman., Young-Xu., & Stevens., 2006). Because the emotions are often overwhelmingly negative and difficult to cope with, PTSD sufferers can block the natural recovery process by using avoidance of traumatic triggers as a strategy to function in day-to-day living. Unfortunately, this limits their opportunities to process the traumatic experience and gain a more adaptive understanding of it. CPT incorporates trauma-specific cognitive techniques to help individuals with PTSD more accurately appraise these "stuck points" and progress toward recovery *(National Centre for PTSD*, (2016). A type of counselling called cognitive-behavioural therapy has been shown to be the most effective form of counselling for PTSD (Resick, &Schnick, 1993, Monson, Schnurr, Resick, Friedman, Young-Xu, & Stevens, 2006).)

a) Efficacies of Cognitive Behavioural Therapy

According to Nilamadhab Kar (2011), the current literature reveals robust evidence that Cognitive Behaviour Therapy (CBT) is a safe and effective intervention for both acute and chronic Post-Traumatic Stress Disorders following a range of traumatic experiences in adults, children, and adolescents. CBT has been found to be effective for PTSD following terrorist attacks, e.g., in the survivors of the 9/11 terrorist attack on the World Trade Centre (Levitt, Malta, Martin, Davis, & Cloitre, 2007), the 2005 London bombings (Brewin, Fuchkan & Huntley, et al ,2010) and the 1998 bomb explosion in Omagh, Northern Ireland (Gillespie, Duffy , Hackmann & Clark, 2002) CBT for the victims of the World Trade Centre attack was neutralized, applied

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flexibly, in 12–25 sessions, by therapists with no prior training through to extensive training in Cognitive Behavioural Therapy. There were significant pre-post reductions in symptoms of PTSD and depression (Levitt, Malta, Martin, Davis, Cloitre M.).The improvement in PTSD in victims of the 2005 London bombings was well maintained at an average of one year later (Brewin, Fuchkan & Huntley, et al, 2010). Patients with PTSD secondary to the bomb explosion in Omagh received an average of eight treatment sessions by staff with modest prior training in CBT for PTSD. However, the degree of improvement was comparable with that in reported research trials, in spite of the fact that almost half of the patients (53%) had psychiatric co morbidity (Gillespie, Duffy, Hackmann &, Clark, 2002). For the purpose of this study, the researchers used Cognitive Processing Therapy.

Cognitive Processing Therapy: According to Schulz, Resick, Huber, Griffin, (2006), CPT teaches the client how to evaluate and change the upsetting thoughts she or he has had since his or her trauma. Cognitive Processing Therapy is 12-session psychotherapy for PTSD. CPT is based on information processing therapy of PTSD and includes education, exposure and cognitive processing (Resick & Schmicke (1992), Cognitive Processing Therapy (CPT) have been identified by Practice guidelines as one of the best and most evidence for treating PTSD. A typical 12-session run of CPT has proven effective in treating PTSD across a variety of populations, including combat veterans, (Monnson, Price, & Ranslow 2005, Chard, Schumm Owen & Cottingham 2010., Resick, Galovski, Uhlmansick, Scher, Clum& Young 2008) sexual assault victims,(Resick, Nishith, ,Weaver, Astin,, &Feuer, 2002. Chard, 2005) and The CPT used a manualised, empirically supported treatment, Cognitive Processing Therapy, to address symptoms of PTSD in the refugees population (Schulz, Resick, Huber, Griffin, 2006). CPT can be provided in individual and group treatment formats

IV. Research Questions

Questions

1. What percentages of internally displaced youth victims of Boko Haran terrorism in Borno, Yobe and Yola states' IDP camps fell within the following ranges of PCL-C scores at pre- and post-cognitive processing therapy
   a) 17-29 PCL-C scores
   b) 17-29 PCL-C scores Little to no severity
   c) 30-44 PCL-C scores Moderate to moderately High severity of PTSD symptoms
   d) 45-85 PCL-C scores High Severity of PTSD symptoms?
2. What percentage of respondents scored above 17-29 in PTSD Checklist – Civilian Version (PCL-C which is the cut-off point showing little to no severity after undergoing Cognitive Processing Therapy?
3. What percentage of respondents scored below 17-29 in PTSD Checklist – Civilian Version (PCL-C which is the cut-off point showing little to no severity after undergoing Cognitive Processing Therapy?

Hypothesis

There was no significant gender difference between scores of respondents in PTSD Checklist – Civilian Version (PCL-C) at pre and post test results inPTSD Checklist – Civilian Version (PCL-C)

V. Research Methodology

a) Research design

A descriptive survey method was used.

Eligibility

- Ages Eligible for study 15 years to 30 years of age
- Sexes Eligible for study; All sexes
- Volunteers Acceptance All the sample

Administration of Research Instruments

1. The four (4) researchers were practicing counselling psychologists and psychotherapists
2. A letter of introduction obtained from the University Management introducing the each researcher to the Camp Leader and seeking permission to carry out research in the Camp.
3. TSQ and PTSD checklist- Civilian Version (PCT-C) were pilot-tested for reliability using Jabi Abuja IDP camp and Cronbach alpha obtained were .74 and .85 respectively
4. The researchers, first of all, administered the Traumatic Screening Question to identify those who were experienced Post-traumatic Stress Disorder within the first week of April 2017
5. After the identification of patients, the counsellors then administered PTSD Checklist – Civilian Version (PCL-C) as pre-treatment measure in second week of April 2017
6. The researchers applied Cognitive Process Therapy treatment model - Civilian Version (PCL-C) within six weeks as from the second week of April to first week of June 2017, then, administered post treatment, PTSD Checklist – Civilian Version (PCL-C)

Inclusion Criteria

- Male and female youths in the Shuwari II IDP Camp in Maiduguri, Pompomari IDP Camp and Malkohi IDP Camp
- Diagnosed symptoms of PTSD screened via Trauma Screen Questionnaire (TSQ) and only samples who experienced PTSD were selected
- The participants must have experienced a specific insurgent -related event or suffered the death of a close relation or friend or witnessed the gruesome killing of their relations, or suffered the loss of

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properties and their homes a result of attacks on their communities by the Boko Haram insurgents.

- Choice to participate in a study is an important personal decision
- Speaks Hausa Language fluently

b) Sample and Sample techniques

Purposive and Stratified random samplings were used to select youths who developed PTSD and were within the age range of 15 to 30 years from three (3) Internally Displaced People's camps of Shuwari II camp in Borno, Malkohi IDPs camp in Adamawa and Pompomari IDP camp (Damaturu, Yobe States of Nigeria with total sample population of 76. The choice of research locations for the study was premised on the profound and continuous Boko Haram terrorist activities in the North East of Nigeria since 2009 till date. First of all, random selections were done and Trauma Screening Questionnaire was used to screen and select participants who were found to be experiencing PTSD

Shuwari camp: Borno state: Total population was 850;Total number of sampled youths was 28 (13 male and 15 female) after screening using TSQ; Attrition rate was 6

Pompomari Camp: Yobe State; Total camp population was 200; Total number of sampled youths was 22 (10 male and 12 female) after screening using TSQ;Attrition rate was 0

Malkoli Adamawa State; Total population was 1325; Total number of sampled youth was 26 (14 male and 12 female) after screening using TSQ; Attrition rate was 2

Duration of Cognitive Processing Therapy in all the camps was six (6) weeks (2 sessions per a week cumulating into 12 sessions; The total sample population was 76

c) Instruments for the Research

Trauma Screening Questionnaire (TSQ) was used to identify Internally Displaced youths who experienced PTSD. Trauma Screening Questionnaire after initial pilot testing at Abuja Camp and Cronbach alpha was .74 was obtained; PTSD Checklist – Civilian Version (PCL-C) was used for pre-and post-treatment of PTSD. Pre and post-PTSD Checklist – Civilian Version (PCL-C) was administered within the interval of six weeks. Clients were assisted in filling both the Trauma Screening Questionnaire (TSQ) and PTSD Checklist – Civilian Version (PCL-C) through Research Assistants using Hausa Language, which is widely spoken in the Northern Nigeria. The therapists were all Hausa speaking Counselling psychologists and psychotherapists.

d) Cognitive Processing Therapy-Cognitive-only version (CPT-C

The purpose of this study was to determine the efficacy of Cognitive Processing Therapy-Cognitive-only version (CPT-C) on Boko Haran terrorism victims against the benchmark of 17-29 scores (cut off point} which shows little to no severity among post-treatment group results of PTSD Checklist – Civilian Version (PCL-C). The percentages of respondents who scored in various ranges were also determined. Also determined in this study were gender differences in the pre and post treatment results.

Treatment

- Posttraumatic Stress Disorder Checklist-Stressor-specific Version (PCL-C)
- Twelve 90-120 minute structured group sessions
- Essentially conducted by one counsellor and his or her assistance
- 6-8 victims of insurgency per group (2 weeks pre-test and post of Trauma Screening Questionnaire (TSQ) and PTSD Checklist – Civilian Version (PCL-C) and Six weeks for Cognitive Processing Therapy treatment
- Victims completed out-of-session practice assignments

Formats

- CPT includes a brief recorded oral narrated trauma account component in Hausa language, along with on-going practice of cognitive processing intervention techniques.
- The details of the recorded oral narrated trauma account were only shared by the group during sessions, while the emotional and cognitive reactions were identified while oral narrations were processed by the group.
- CPT- C was used for both individual and group sessions
- The groups combined practice assignments and the recorded oral trauma account, which were processed in additional individual therapy sessions
- Time Frame: Baseline, 2 sessions weekly during treatment,
- Benchmark of 17-29 scores in PTSD Checklist Version (PCL-C as cut off point showing little to no severity

e) Data Analysis

Descriptive statistic and t-test analyses were used to determine those who experienced PTSD before and after the treatment of cognitive processing therapy and to establish if there is gende difference between male and female samples. is significant or not

Research Question 1; What percentages of internally displaced youth victims of Boko Haran terrorism in Borno, Yobe and Yola states' IDP camps fell within the following ranges of PTSD Checklist – Civilian Version (PCL-C scores at post-cognitive processing therapy

a) 17-29 PCL-C scores
b) 17-29 PCL-C scores Little to no severity

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c) 30-44 PCL-C scores Moderate to moderately High severity of PTSD symptoms

d) 45-85 PCL-C scores High Severity of PTSD symptoms?

Table 1: Total Percentage of Respondents in Each Level of Severity; Little to no Severity; Moderate to Moderately Severity and High Severity

PTSD Checklist – Civilian Version (PCL-C scores	Level of Severity	Shuwari			Popomari			Malkoli			Percentage	
		M	F	Total	`M	F	Total	M	F	Total		
17-29	Little to no severity	10	12	22	07	09	16	09	10	19	57 (75%)	Cut off Point
30-44	Moderate to Moderately severity	03	03	06	03	03	06	05	02	07	19 (25%)	
45-85	High Severity	00			00			00			00	
Total				28			22			26		

In in Shuwari IDP camp in Borno State, PTSD Checklist – Civilian Version (PCL-C) was administered to 28 respondents out of which thirteen (13) were male and fifteen (15) were female. All the respondents showed PTSD before undergone Cognitive Processing Therapy. After undergone Cognitive Processing therapy, 10 male respondents showed little to no severity while 3 male respondents showed moderate to moderately severity of PTSD while twelve (12) out of fifteen (15) female respondents showed little to no severity and three (3) of them showed moderate to moderately severity of PTSD.

In Popomari IDP camp in Yobe State, PTSD Checklist – Civilian Version (PCL-C) was administered to 22 respondents out of which ten (10) were male and twelve (12) were female. All the respondents showed PTSD before undergone Cognitive Processing Therapy. But after undergone Cognitive Processing therapy, seven (7) of the male respondents showed little to no severity while three (3) of them showed moderate to moderately severity. For female respondents, nine (9) out of twelve (12) of female respondents showed little to no severity while three (3) of them showed moderate to moderately severity after undergone Cognitive Processing Therapy.

In Malkohi IDP camp in Adamawa state, PTSD Checklist – Civilian Version (PCL-C) was administered to 26 respondents out of which fourteen (14) were male and twelve (12) were female. All the respondents showed PTSD before undergone Cognitive Processing Therapy but after undergone Cognitive Processing therapy, nine (9) of the male respondents showed little to no severity while five (5) of them showed moderate to moderately severity. For female respondents, ten (10) out of twelve (12) showed little to no severity while two (2) of the female respondent showed moderate to moderately severity after undergone Cognitive Processing Therapy. From the above analyses, 75% of the respondents indicated little to no severity after undergone the Cognitive Processing Therapy while 25% of them showed moderate to moderately severity of PSTD. None of the respondents scored within the range of 45 -85 points which indicated high severity. Tables below, indicate Male and female Mean and Standard Deviation at pre and post Checklist – Civilian Version (PCL-C and T-Test Results of Pre and Post Tests Results of Male and Female Respondents.

Table 2: Male and female Mean and Standard Deviation at pre and post Checklist – Civilian Version (PCL-C

	Gender	N	Mean	Std. Deviation	Std. Error Mean
pre	1.00	37	58.1081	6.30601	1.03670
	2.00	39	59.7436	7.59057	1.21546
post	1.00	37	24.5135	2.91187	.47871
	2.00	39	25.0256	2.68021	.42918

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Table 3: T-Test Results of Pre and Post Tests Results of Male and Female Respondents

		Levene's Test for Equality of Variances						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference
pre	Equal variances assumed	.949	.333	-1.0215	74	.312	-1.63548	1.60536
	Equal variances not assumed				72.756	.309	-1.63548	1.59753
post	Equal variances assumed	.059	.809	-.7975	74	.427	-.51213	.64151
	Equal variances not assumed				72.659	.428	-.51213	.64293

The T-test result obtained at pre-test was -1.0215
The T-test result obtained at post-test was -.7975
Level of significance was .005 alpha level

VI. Conclusion: Not Significant

The total male sample of 37 in all the sampled IDP camps put together has the mean score of 24.5135 with 2.911 standards Deviation in PTSD Checklist – Civilian Version (PCL-C) after undergoing six Cognitive Processing Therapy while the female counteract sampled population of 39 with mean score of 25.025 and 2.680 in Checklist – Civilian Version (PCL-C)

Using SPSS (Version 20), the T-test result of -1.0215 was obtained when comparing male and female respondents' pre-test mean scores results in PTSD Checklist – Civilian Version (PCL-C) while the t- test at the post in PTSD Checklist – Civilian Version (PCL-C) for both sexes was -.7975 and at .005 level of significance. The T-test results of both male and female respondents at pre-and post-tests of PTSD Checklist – Civilian Version (PCL-C) showed no significant differences

VII. Discussion of Results

Research Question: What percentage of respondents' scores fall between seventeen and twenty-nine (17 to 29) in PTSD Checklist – Civilian Version (PCL-C) an indication of the cut-off point for severity of PTSD?

On table 1 above, 75% of the respondents indicated little to no severity of PTSD after undergone the Cognitive Processing Therapy while 25% of the respondents indicated moderate to moderately severity of PSTD. None of the respondent indicated high severity after undergone Cognitive Processing Therapy.. Though 25% of the respondents scored above the cut-off points, the efficacy of Cognitive Processing Therapy on the treatment of terrorism victims is not in doubt as evidenced above. The 25% of the respondents which indicated moderate to moderately severity PTSD could be attributed to anxiety created by continuous bombings (suicide bombing), and other criminal activities such as rapes, trading sex for food reportedly perpetuated by security agencies and state of insecurity in IDP camps across North-east of Nigeria The researchers therefore are suggesting eight weeks with two sessions per week of Cognitive Processing therapy for terrorism victims, improvement of security in IDP camps and four (4) weeks follow up therapy for more effective treatment.

These findings are in line with Blankenship's (2014) observation that, comparison studies of modalities, limitations, and training requirements of PTSD, identified five treatment modalities which are consistently recommended in the literature as most efficacious current treatments endorsed for PTSD prolonged exposure therapy: These are cognitive processing therapy, trauma-focused cognitive behavioural therapy, stress inoculation training, and eye movement desensitization and reprocessing therapy. He further explained that, research overall shows no significant differences in rates of efficacy between these treatments and therefore recommended for mental health counsellors to select any of the approach that best fits the client population and professional goals based on identified strengths and limitations of each therapy. Alvrez, Mclean and Harris (2011) state that, however, CPT appears to produce significantly more symptom improvement than treatment conducted before the implementation of CPT. They further observed that, there is still room for improvement, as substantial numbers of veterans continue to experience significant symptoms even after treatment with CPT in a residential program. Sur´ıs, Link-Malcolm, Chard, Chul and North (2013) explain that, established literature that has demonstrated the effectiveness of CPT in treating PTSD related to sexual assault in civilian populations. The T-test results of both male and female respondents at pre-and post-tests of PTSD Checklist – Civilian Version (PCL-C) showed no significant differences. Birkeland, Blix, Solberg and Heir (2015) report that, among individuals with considerable levels of posttraumatic stress symptoms, women reported higher levels of physiological cue activity and exaggerated startle response but no significant gender differences in the networks of posttraumatic stress were found. In order to determine if this finding can be applied to other

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participants and circumstances, future studies should be conducted in various IDP camps in Nigeria.

VIII. Conclusion

In conclusion, as indicated above by the findings of this study, Cognitive Processing Therapy has a significant impact in the reduction of PTSD among youth victims of Boko Haran in the North-east part of Nigeria. Also there was no significant difference in the efficacy of Cognitive Processing Therapy among the sexes (gender).

IX. Recommendations

1. In every IDP camp in Nigeria should have a counselling centre man by qualified counselling psychologists or psychotherapist
2. Effective Security should be provided in all the IDP camps so as to forestall further attacks
3. Every camp should be provided with basic needs of life such as food, shelter, water etc.
4. There should be follow-up treatment even when the victims of terrorism have left their camps and settled in their communities
5. Federal Government of Nigeria must be proactive enough to nip on bud situations that will potentially degenerate into terrorism or insurgency
6. The state government of Northern Nigeria should critically look at Almajiri System of education which has served as a breeding ground for the dire terrorism of the Boko Haram with the view of regulating, supervising and modernising its curricula, in order to mitigating against Almajiri scourge.

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