RELATIONSHIP BETWEEN POST-TRAUMATIC STRESS DISORDER AND ACADEMIC PERFORMANCE AMONG SECONDARY SCHOOL STUDENTS IN RIVERS STATE, NIGERIA

BY

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ZARIA, NIGERIA

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A THESIS SUBMITTED TO THE SCHOOL OF POSTGRADUATE STUDIES AHMADU BELLO UNIVERSITY, ZARIA
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DECLARATION

I hereby declare that this thesis entitled: **"Relationship between Post-Traumatic Stress Disorder and Academic Performance among Secondary School Students in Rivers State, Nigeria"** was written by me under the supervision of Prof. Khadija Mahmoud, Prof. Musa Balarabe and Dr. Aisha I. Mohammed of the Department of Educational Psychology and Counselling. The information derived from the literature has been duly acknowledged in the text and list of references provided. No part of this work to the best of my knowledge has been previously presented for another degree or diploma at this or any other institution.

_____ _____

Edebor Florence Date

CERTIFICATION

This thesis entitled: **"Relationship between Post-Traumatic Stress Disorder and Academic Performance Among Secondary School Students in Rivers State, Nigeria"** meets the requirements governing the award of degree of Doctor of Philosophy in Educational Psychology, faculty of education, Ahmadu Bello University, Zaria is approved for its contribution to knowledge and literary presentation.

Prof. K. Mahmoud Chairman, Supervisory Committee	Date
Prof. M. Balarabe Member, Supervisory Committee	Date
Dr. A.I. Mohammed Member, Supervisory Committee	Date
Dr. A.I. Mohammed Head of Department, Educational Psychology and Counselling	Date
Prof. K. Bala Dean, Postgraduate School	Date

DEDICATION

This thesis is dedicated to my family, my husband and children who stood by me in prayers towards the success of this research.

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ABSTRACT

This study employed correlational design to investigate the relationship between post-traumatic stress disorder and academic performance among secondary school students in Rivers State, Nigeria. Some selected behaviour problems` of aggression, anxiety and depression, caused by post-traumatic stress disorder were studied. Based on the focus of the study, four research objectives, and corresponding research questions and hypotheses were formulated which offers the study a direction. A sample of 327 students identified as traumatized from their responses in the instrument were used for the study. The instrument used was the questionnaire which comprised of thirty (30) items. Data collected from the sampled respondents were analyzed using statistical package for social sciences. All the four null hypothesis which guided this work were tested at 0.05 alpha level. The results obtained showed that negative relationship exists between Aggression and Academic Performances of secondary school students of Rivers state (r = 0.767, p = 0.000). Negative relationship exists between anxiety and academic performances of secondary school students of Rivers state (r = -0.802, p = -0.000), negative relationship exists between Depression and Academic Performances of secondary school students of Rivers State (r = 0.830, p = 0.000). There is no significant difference in academic performance of traumatized male and female secondary school students (t = 0.800, p = 0.424). Based on the outcome of the study, it was recommended that Schools should employ psychologists who should provide psychological interventions that could help take care of symptoms of post traumatic stress disorder such as depression, anxiety and aggression so as to pave way for healthy living and improved academic performance, students who experiences post-traumatic stress disorders should be given cognitive behaviour therapy to enable them to know how their thinking affects their mood and to teach them to think in a less negative way about life and themselves, conducive atmosphere should be provided by government to improve security in schools and enhance teaching and learning, this will go along way in reducing post traumatic stress disorder such as depression, anxiety and aggression, male and female student that experience post-traumatic stress disorder should be given orientation periodically by experts/psychologists for re-educating and re-assurance in life.

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LIST OF ABBREVIATIONS

ADCA	-	Anxiety Disorders in Childhood and Adolescence
ADHD	-	Attention Deficit Hyperactivity Disorder
ANOVA	-	Analysis of Variance
CBT	-	Cognitive Behaviour Therapy
CDC	-	Centre for Diseases and Control
CGPA	-	Cumulative Grade Point Average
CNS	-	Central Nervous System
ECA	-	Epidemiologic Catchment Area
GAD	-	Generalized Anxiety Disorder
IPT	-	Interpersonal Therapy
IQ	-	Intelligence Quotient
NECO	-	National Examination Council
PD	-	Phobia Disorder
PPMC(r)	-	Pearson Product Moment Correlation Coefficient
PTSD	-	Post-Traumatic Stress Disorder
SAD	-	Separation Anxiety Disorder
SPSS	-	Statistical Package for Social Sciences

OPERATIONAL DEFINITION OF TERMS

The following terms are operationally defined as follows:

Academic Performance is the student's achievement score in English language, Mathematics and Social Studies in academic work.

Aggression refers to students behaviour whose primary or sole purpose or function is to injure another student or organism, whether physically or psychologically.

Anxiety refers to a state of uneasiness, accompanied by dysphoria and somatic signs and symptoms of tension, focused on apprehension of possible failure, misfortune, or danger.

Behaviour Problems are unwanted behaviour that affects student ability to learn and become emotionally unstable in the classroom. Behavioural problems in this study include aggression, anxiety and depression.

Depression simply means mood of students with post-traumatic stress disorder characterized by a state of sadness and loss of interest or pleasure in a given task, accompanied by severe cases of anorexia and consequent weight loss.

Post-Traumatic Stress Disorder (PTSD) is a psychological experience caused by severe shock, especially when the harmful effect last for long time. The effect may bring about aggressiveness, anxiety and depressive condition in an individual or organism

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

Post-traumatic Stress disorder occurs when people loss their loved ones, may be in motor accident, plane crash, exposure to violence, child abuse in form of physical, sexual and emotional abuse, and weather related disaster like flood in 2013 that happened in many parts of the southern Nigeria, and recent bomb explosion that occurred in many Nigerian societies. There are other major acts of violence such as the crisis in the Niger Delta Area, cultism and killing of innocent students by cult members in our society. Religious crisis, chieftaincy tussle, bullying and public coercion, are source of traumatic events confronting students today, especially at the secondary school level.

Moroz (2005), viewed post-traumatic stress as something that persist after a traumatic incident has ended and continues to affects the student's ability to self-regulation, both physically and emotionally. Post traumatic symptoms in children and adolescent students may encompass one or more of a broad range of behaviours, including terrified responses to sights, sounds or other sensory input that remind the child of the traumatic experience(s). Difficulty in sleeping, and concentrating, aggression, anxiety and depression are all triggered by post-traumatic stress.

Post-traumatic stress among students may also be as a result of violent environment, cultism, death of loved ones, chieftaincy tussle, gun shooting, political issues which brought about the behaviour of anxiety, aggression, depression which may go unnoticed thereby leading to psychological problem among the students. Post-traumatic stress disorder (PTSD)

includes fear, anger, helplessness and so on and the victims may need help from counselors, parents, teachers and the psychologist.

National Institute of Mental Health (2001), showed that trauma has both a medical, and a psychiatric definition. Medically, trauma can be defined as a serious or critical bodily injury, wound or shock. Psychologically, trauma can be defined as an experience that is emotionally painful, distressful or shocking, which often results in lasting mental and physical effects. This study will adopt the National Institute of Mental Health psychological definition of trauma which states that trauma is an experience that is emotionally painful, distressful and shocking which often results in lasting mental and physical effects. Thus in the aftermath of any communal violence, or disaster the affected victims are always left with emotional pain and shock of such large damage and loss of lives. Students in the course of their everyday life are constantly faced with violent exposures.

Shalev (1998), reports that each year many students sustain injuries from violence, death of friends or family members, and various forms of child abuse, community crisis, wars, exposure to automobile accidents where many people are killed including friends and relatives. The problem student face are all indices of trauma in which students may exhibit a wide range of reactions, generally referred to as Post Trauma Stress Disorder (PTSD), which usually comes after the disaster. Davidson and Smith (2011), illustrates a relationship data between several early trauma and broad range of later disorders. The study showed that 22% of adult psychiatric out-patients received a diagnosis of post-traumatic stress disorder (PTSD), with vulnerability to trauma greatest during early childhood and adolescence in a related study. Brooks (2008) found that veterans with combat-related post-traumatic stress disorder

were more likely to have a history of child physical abuse than those without post-traumatic stress disorder.

Perry, (2000), also reports that the survivor while still arousal state finds it difficult to process information because of the alteration in the functioning of the neocortex. These findings showed that students who have been traumatized remain in a state of fear and will be encompassed with difficulty in processing verbal information. In our schools today many students are dying in silence as a result of exposure to various man-made disasters. They are victims of some unwanted behaviours or what is known as "behaviour excesses" which include aggression, anxiety, and depression this may lead to decline in their academic performance.

Aggression refers to a quality of anger and determination that makes one ready to attack other people. It is applicable to male and female. This attacking behaviour may cause feeling of misunderstanding, unlovable, feeling of discomfort with classmates who are always attacked, such aggressive boys and girls becomes angry with every individual around them and may refuse to conform to authority. The emotional difficulties can incapacitate the student and prevent him or her from normal participation in class work. School children who exhibit aggressiveness are easily distracted by irrelevant sights and sounds they are quick to anger, they shift from one activity to another without necessarily finishing the first one, and seem to get bored easily, they may appear forgetful and even spacey or confused as if "in a frog" (Center for Diseases and Control, 2005).

Hutchinson and Renfrew (2002), defined aggressive behaviour as those actions carried out by an individual with the intention to cause injury or anxiety to others or even to oneself.

This means that aggressive behaviour sometimes take the form of over reaction, the person may shout or become very agitated over minor incidents.

Kowalski (2000), describes anxiety as a vague, highly unpleasant felling of fear and apprehension. In the school students are usually found, having unnecessary worries when they are faced with school work or other life challenges.

Depression, is a condition of great general interest, it is relatively simple to describe in clinical term but difficult to measure scientifically. Depression is a lowering of mood beyond the range of ups and downs encountered in normal life and sustained over time and to such a degree that the quality of life of such a person is significantly impaired (Nwankwo, 2006). Defining it scientifically is more difficult and has led to international agreement that it is present only when certain, manifestation of behaviour is exhibited. Depression is an illness that affects the body, mood and thoughts. The risk of developing depression is increasing worldwide particularly among children and adolescent (Barlow and Durand 2005).

Academic performance is the performance level of a student in a test or examination administered in a school setting on a given subject(s). Academic performance is influenced by many psychological factors, such as family, school and social factors (Amalia 2004). The family factors consist of family attitudes and beliefs towards schooling, parental expectations of academic success, parents' supervision and education, family structure, discipline practices and family stressor, such as poverty, homelessness and illness (Amalia, 2004). The most prominent school factors are general school climate, comprehensive curriculum plans, school-wide assessment, specific school base programmes, social skills interventions, school based services, teachers' pedagogical skills and teacher's beliefs/attitude. The type of environment a student passes through in the course of his education will either facilitate or inhibit his ability

at acquiring knowledge. Very many writers have expressed different views on academic performance of students. Some have tried to associate academic performance with environmental factors, health condition as a result of post-traumatic stress. For instance;

Stele (2002 p. 154) pointed out that:

> *From early infancy through adulthood trauma can alter the way we view ourselves, the world around us, and alter how we process information and the way we behave and respond to our environment without intervention, these cognitive process and behavioural responses can lead to learning deficiencies, performance problems, and problematic behaviour.*

It is against this background that this study tries to find out if there is any relationship between aggression, anxiety, depression and academic performance among junior secondary school students with post traumatic stress disorder in Rivers State.

1.2 Statement of the Problem

Students who experience community violence, kidnapping, shooting and cultism may develop feelings of depression, anxiety and aggressive behaviour. As a result of this, students may resort to unwanted behaviour which may be contrary to societal norms and values. Individual students may exhibit different behaviour patterns due to personal experiences, and this may influence their academic performance.

Today, report abound on heart breaking news of students who are victims of cultism, communal violence, kidnapping, which poses insecurity of lives, where students are under perpetual fear and apprehension of plans of cult members who constantly issue threats and try to molest them. The traumatic experience may bring about poor concentration and anxiety among students. Some students become aggressive due to the rate of community violence, kidnapping, gun shooting, anxious as they cannot cope with the violence environment they

find themselves. There are cases of students losing their parents, loved ones and relatives which is another traumatic episode in the victims' life, they may go to school, keep re-experiencing the event even when lessons may be going on, thereby having depressive mood.

Students whose parents, relatives, friends, love ones died as a result of the community violence, gun shooting, kidnapping cultism situation are exposed to aggression, depression, fear, stress because of the killings, gun shooting and wounds. The nature of problem has link to chieftaincy tussle, landmark, oil wells, oil spillage, political violence, this may all affect student's psychological stability and academic performance.

From the foregoing, the study intends to find out how post-traumatic stress disorder influence academic performance among junior secondary school students (JSS III) in Rivers State.

1.3 Objectives of the Study

The main purpose of the study is to investigate the relationship between aggression, anxiety and depression among students with post-traumatic stress disorder and academic performance. Specifically, the study intends to find out;

1. Relationship between aggression and academic performance among Junior Secondary School Students in Rivers State.
2. Relationship between anxiety and academic performance among Junior Secondary School Students in Rivers State
3. Relationship between depression and academic performance among Junior Secondary School Students in Rivers State
4. Difference between male and female on academic performance among students with post-traumatic stress disorder.

1.4 Research Questions

The following research questions will be answered to guide the study.

1. What is the relationship between aggression and academic performance among Junior Secondary School Students in Rivers State?
2. What is the relationship between anxiety and academic performance among Junior Secondary School Students in Rivers State?
3. What is the relationship between depression and academic performance among Junior Secondary School Students in Rivers State?
4. What is the difference between male and female on academic performance among Junior Secondary School Students in Rivers State?

1.5 Hypotheses

The following hypotheses will be tested in the study at 0.05 level of significant.

HO_1: There is no significant relationship between aggression and academic performance among Junior Secondary School Students in Rivers State.

HO_2: There is no significant relationship between anxiety and academic performance among Junior Secondary School Students in Rivers State.

HO_3: There is no significant relationship between depression and academic performance among Junior Secondary School Students in Rivers State.

HO_4: There is no significant difference between male and female on academic performance among Junior Secondary School Students in Rivers State.

1.6 Significance of the Study

The awareness created by the study would be beneficial to students, parents, teachers, psychologist, guidance counsellors', non-governmental organization and curriculum planners. Traumatized students need intervention, care and protection in their increasingly crisis-prone community and society. The study would help guidance counselors and psychologist to understand and assume their responsibility for providing services to emotionally traumatized students in our schools which hitherto were unnoticed. The study would be of immense help to the family, the family will understand the various difficulties and behaviour that adolescents are faced during crisis and understand their roles in helping students during this difficult time, since the family is the first-line resource for helping traumatized students.

Finally, the researcher would endeavour to write articles from this study which will be published in national journals of counseling, educational psychology on relationship of post-traumatic stress disorder among junior secondary school students will be made known in the nation.

1.7 Basic Assumption

For the purpose of this study, it is assumed that:

1. Aggression may affect the academic performance of students in Junior Secondary School in Rivers State.
2. The academic performance of students with post-traumatic stress disorder may be negatively affected by Anxiety.

3. Depression may affect academic performance of students in junior secondary school in Rivers State.

4. That academic performance of students may be affected by their gender.

1.8 Scope and Delimitation of the Study

The study was carried out among secondary school students that experience post traumatic stress disorder and who manifest various psychosocial problem behaviour such as aggression, anxiety and depression involving males and females.

It was delimited to public secondary schools in areas of Rivers State where there had been constant violence.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

2.1 Introduction

This chapter dealt with the review of literature that was related to the research topic. The review covers the conceptual framework, theoretical framework, problems of aggression, anxiety, depression, academic performance and post-traumatic stress disorder, also in this chapter the review of related studies and a summary of the chapter will be discussed.

2.2 Conceptual Frame Work

In this area, three concepts will be discussed on problems of aggression, anxiety and depression as well as academic performance and post-traumatic stress disorder.

2.2.1 Concept of post-traumatic stress disorder

Post-traumatic stress disorder is a severe anxiety disorder that can develop after exposure to any event that results in psychological trauma (American Psychiatric Association 1994; Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, 1994; Saticher, D., et al. 1999). This event may involve the threat of death to oneself or to someone else, one's own or someone else's physical, sexual, or psychological integrity overwhelming the individual's ability to cope (American Psychiatric Association 1994). As an effect of psychological trauma, traumatic stress disorder is less frequent and more enduring than the more commonly seen post-traumatic stress also known as acute stress response (Birmes, 2007). Diagnostic symptoms for post-traumatic stress disorder include re-experiencing the original trauma(s) through flashbacks or nightmares, avoidance of stimuli associated with the trauma, and

increased arousal – such as difficulty falling or staying asleep, anger, and hyper vigilance (American Psychiatric Association, 1994).

Post-traumatic stress disorder is traumatic stress that persists after a traumatic incident has ended and continues to affects a child's capacity to function (Moroz, 2005).

If post-traumatic stress disorder continues and the student's neurophysiologic responses remain chronically aroused, even though the threat has ended and the student has survived, then the term post-traumatic stress disorder is used to describe the student's enduring symptoms (Moroz, 2005). Because trauma affects the student's ability to self-regulatory, both physically and emotionally, post-traumatic symptoms in infants and young students may encompass one or more of a broad range of behaviours, including the following:

- Difficulty in sleeping, eating, digesting, eliminating, breathing and focusing.
- A heightened startle response and hyper alertness
- Agitation and over-arousal or under-arousal, withdrawal or dissociation.
- Avoidance of eye contact and/or physical contact
- Terrified responses to sights, sounds or other sensory input that remind the child of the traumatic experience(s) (for example, a dog, police siren or the smell of alcohol on a persons breathe).
- Preoccupation with or re-enactment of the traumatic experience (for example, a child's play may take on an urgent, rigid quality and be dominated by people shooting each other with police cars and ambulances arriving at the scene).

Much of the literature on post-traumatic stress focuses on children and adolescent that has been exposed to a one-time traumatic event (e.g. school shooting, natural disaster, accidents, neglecting chronic traumatizing that is characterized by exposure to traumatic

stressors within the same overall context over a period of time ranging from months to years children and adolescents the present with traumatic stress disorder symptoms have been exposed to chronic traumas of community violence, physical injury and maltreatment (Physical/Sexual Abuse) Reiss (2002), in Anderson (2005, p. 1).

Post-traumatic stress in an article reported by Smith and Segal (2011), viewed the concept as a disorder that can develop following a traumatic event that threatens one's safety or makes one feel helpless.

Chronic exposure to trauma has implications on the child's global development consisting of cognitive, physiological, social emotional and behavioural areas. In situation of chronic trauma, the environment in which the trauma occurs always contains the implicit risk of danger, even when the actual in Anderson (2005, p. 1). This has additional implications for the growth and development of the child which are as yet not well understood. Further research is needed to examine the impact and complexity of children's responses to ongoing and multiple traumas Nader (2004), in Anderson, (2004 p. 1)

United State National institute of mental Health (2001), showed that trauma has both a medical and a psychiatric definition. Medically, trauma can be defined as serious or critical bodily injury, wound or shock. Psychologically trauma can be defined as an experience that is emotional painful, distressful or shocking which often result in lasting mental and physical effects. This study will adopt the National Institute of mental health psychological definition of trauma which state that trauma is an experience that is emotional painful, distressing and shocking which often result in lasting mental and physical effect. The after effect of any violence or disaster, the affected victims are always left with emotional pain and shock of such large scale damage and loss of lives. The experience may be traumatic, such as cultism,

community violence, public coercion, class repetition which may go unnoticed thereby leading to psychological problems among the students. Each of these events is unique whether it is death of loved ones, plane crash, motor accident, or rape. These events are all indices of trauma in which students may likely exhibit a wide range of reactions generally referred to as post-traumatic stress (PTSD) that comes after the disaster. The post-traumatic stress disorder (PTSD) focus for this study include depression, anxiety, aggression, manifested by the individuals I *the* victims may need help from counselors, teachers, parents and the society.

Students who have experience trauma may have relationship problem with peers and family members, problems with acting out and problems with school work (Amalia 2004). McNally (1991), in his study found out that trauma during childhood and adolescence can lead to future disorder etching on often indelible signature on the individual maturation and development. He further explained that 27% to 100% of youngsters especially those expose to sudden manmade disasters will develop post-traumatic stress disorder (PTDS). These traumatic events have left psychic scar on the inner selves of the victims.

Francis (2008), pointed out that from early infancy through adulthood trauma can alter the way we view ourselves the world around us and alter how do we process information and the way we behave and response to our environment without intervention, these cognitive process and behavioral problems such as aggression, anxiety, depression, among others can lead to learning deficiencies academic performance problem and school adjustment generally.

The students who are victims of traumatic events need to be identified, debrief and offer the necessary help in order to overcome losing one life and elimination of the terrible behaviour patterns. Many students suffer in silence as a result of exposure to various

manmade disasters. They become victims of some behaviour problems like anxiety, aggression, depression, and this may lead to decline in their academic performances.

Fayombo (1998), in her study of 80 Secondary school student education and the effect on the academic performance of some adolescent drug abuses in Ibadan in her with students confirmed that students gave reasons as studying and living under fear and insecurity for taking drugs. The nefarious activity of cultism and cult is a source of threat to the peace loving and responsible students in the school. These cultists may wait for students who they think are becoming more popular for their liking to beat them up after school; they intimidate other students into assisting them.

Harrison (2004), for example outlined possible reaction after trauma in high possible reactions after trauma in high school student's feelings of anxiety, worries, fear about safety of self, and others, changes in behaviour such as decrease attention and concentration, increase in hyperactivity changes in academic performance, irritability with friends, teachers, events and withdrawal. From the discussion above and findings, students who experience psychological trauma in their everyday life may likely alter their behaviour and academic performance.

Sequel to this line of thought some studies have been carried out among survivors of trauma such as veterans, holocaust survivors, children and adolescent who may have been exposed to various community violence. However, this study will try to find out if there is any relationship between behavior problems, academic performance and post- traumatic stress disorder among secondary school students.

According to Caldwell (2005), "children who are affected by trauma may not see school as a safe environment other than the one where they experience trauma". Traumatized

students may experience barriers in several school related areas, including academic performance, classroom behaviour and interpersonal relationship. Examples of academic performance, potential factors of traumatic effects include disruption of language and communication skills, difficulty organizing narrative materials, lack of comprehension of cause and effect relationship, difficulty with taking another person's perspective, trouble with attending to classroom tasks, barrier with self-regulating or modulating emotions and reduced motivation for academic engagement. Students who are victimized or witness some form of abuse may have traumatic conditions manifesting emotionally, behaviorally cognitively, socially and psychological development deficits.

Students with traumatic stress disorder often display, certain form of behaviour problems. Behaviour problem among students who has been described as fearfulness, other outward displays of distress, such as delinquency anxiety, aggression, destruction of property, fighting, truancy, disobedient, the students are reluctant to go to school (Born Stein 2008). Some factors bring about traumatic experiences. Dunn et al. (2004), asserted that "many factors that affect families can disrupt a student's sense of security and worth for a period of time. Changes in the family structure, for example, might leave a student aggressive, angry, insecure, defensive and lonely especially in the case of divorce.

Psychological Trauma

Trauma is defined as a physical, psychological treat, assault to a child's physical integrity, sense of self, survival or to the physical safety of another person significant to the child (Vermont cups Handbook, p. 170). Students may experience trauma as a result of number of different circumstance, such as;

Abuse, including sexual, physical, emotional.

Exposure to domestic violence.

Severe natural disaster, such as a flood, fire,

Earthquake or tornado

War or other military actions

Abandonment

Witness to violence in the neighbourhood or fights, drive by shootings and law enforcement actions

Personal attack by another person or an animal kidnapping

Severe bulling

Medical procedure, surgery, accident or serious illness.

Psychological trauma may occur during a single traumatic event (Acute) or as a result of repented (chronic) exposure to overwhelming stress Terr (1992), in (Moroz, 2005). Children exposed to chronic trauma generally have significantly worse outcomes than those exposed to acute accidental traumas. In addition, the failure of caregivers to sufficiently protect a child may be experienced as betrayal and further contribute to the adversity of the experience and effects of trauma.

Moroz (2005), stated that traumatic stress may be transmitted by parents to their children. Parents who suffer from untreated post-traumatic stress disorder often have difficulty establishing a secure attachment with their children; they may viscerally transmit their own feelings of anxiety, rage and hopelessness, and in so doing colour the child's internal model of self and the world.

When caregivers are threatening, hurtful or frightening, the intentional human – to – human quality of the traumas causes more severe negative consequences for the child than

trauma from accidental causes (for example, a flood, fire engender feelings of victimization loss of control, despair and hopelessness and beliefs that the world is unsafe and life unfair (Moroz, 2005).

Effect of Psychosocial Trauma on aggression, anxiety and depression

Severe psychological trauma causes impairment of the neuroendoerine systems in the body. Extreme stress triggers the fight or flight survival response, which activates the sympathetic and suppresses the parasympathetic nervous system. Fight or flight responses increase cortisol level in the central nervous system, which enables the individual to take action to survive (Either dissociation, hyperaousal or both), but which at extreme levels can cause alterations in brain development and destruction of brain cells. (Vermont Cups Handbook, p. 176) in (Moroz, 2005).

In children, high levels of cortisol can disrupt all differentiation, cell migration and critical aspects of central nervous system integration and functioning trauma affects basic regulatory processes in the brain stem, the limbic brain (emotion, memory, regulation of arousal and affect), the neovortex (perception of self and the world) as well as integrative functioning across various systems is the central nervous system. Traumatic experiences are stored in the child's body/mind, and fear, arousal and dissociation associated with the original trauma may continue after the treat of danger and arousal has subsided (Moroz, 2005).

Development of the capacity to regulate affect may be undermined or disrupted by trauma, and children exposed to acute or chronic trauma may show symptoms of mood swings, impulsivity, emotional irritability, anger and aggression, anxiety, depression and dissociation. Early trauma, particularly trauma at the hands of a caregiver, can markedly alter a child's perception of self, trust in others and perception of the world. Children who

experience seeker early trauma often develop a foreshortened sense of the future. They come to expect that life will be dangerous, that they may not survive, and as a result, they give up hope and expectations for themselves that reach into the future (Terr, 1992).

Among the most devastating effects of early trauma is the disruption of the child's individuation and differentiation of a separate sense of self. Fragmentation of the developing self occurs in response to stress that overwhelms the child's limited capacities for self-regulation. Survival becomes the focus of the child's interactions and activities and adapting to the demands of their environment takes priority. Traumatized children lose themselves in the process of coping with ongoing threats to their survival, they cannot afford to trust, relax or fully explore their own feelings, ideas, or interests. Character logical development is shaped by the child's experiences in early relationship (Johnson (1987). Young trauma victims often come to believe there is something inherently wrong with them, that they are of fault, unlovable, hateful, helpless and unworthy of protection and love. Such feelings lead to poor self-image, self-abandonment, and self-destructiveness. Ultimately those feelings may create a victim state of body-mind-spirit that leaves the child/adult vulnerable to subsequent traumas and re-victimization (Moroz 2005).

Psychological trauma is often followed by many negative sequels. Scaer (2001), and others have reported that childhood trauma is responsible for great losses in human potential and enormous cost to society. These adverse effects are seen in health care (serious adverse effects to the immune system, cardiovascular system, chronic pain, somatization leading to increase use of multiple health care providers, treatments, medication, surgeries, etc and health difficulties over the individual's lifetime (Moroz, 2005).

Adeniyi (2010), also outline the effect of communal conflicts on children and their academic function, conflicts creates complex emotional reactions and psychological responses.

In addition, Moroz (2005), reported that childhood trauma contributes to lost productivity and dependence as well as to the huge and growing costs of antisocial behaviours, violence, victimization, legal and court involvement, incarceration, supervision and rehabilitation.

Childhood trauma is a major public health concern worldwide. Trauma not only harms individual children themselves, it has an adverse effect on the lives of those around them and on the lives of the inborn children (Harris, et al 2004). The costs of childhood trauma, unrecognized and untreated, are actually much greater than the costs of prevention and early intervention to eliminate or reduce the adverse effects of childhood trauma.

2.2.2 Concept of depression

Many people once believed that severe depression did not occur in childhood. Today, experts agree that severe depression can occur at any age. Studies show that two of every 100 children may have major depression, and so many as eight of every 100 adolescents may be affected (National Institutes of Health, 1999). Depression is a mental state, which may keep one sad and feel that nothing can be enjoy because of situation is so difficult and unpleasant. Children depression is frequently related to family problems and conflicts. Children who exposed to stressful life.

Childhood depressions are frequently related to family problems and conflicts. Children who are exposed to stressful life event affecting the family, such as parental conflict or unemployment, stand an increased risk of depression especially younger children Nolen-

(Hoeksema, Girgus & Seligman, 1992; Sternberg, 1993). Traumatic stress disorder may set in as depressive condition may affect their classroom behaviour and academic performance.

According to Sternberg (1993), opined that as children mature and their cognitive abilities develop, cognitive factors, such as negative thinking styles, appear to play a stronger role in the development of depression characterized by negative attitude towards themselves and the future (Sternberg, 1993). They also tend to adopt a more helpless or pessimistic attribution style than their non-depressed peers (Lewin-Sohn et al, 1994).

Each year, 133-275 million children worldwide witness domestic violence (UNICEF, 2006). In the United States, approximately 15.5 million children live in households experiencing intimate partner violence (McDonald, Jouriles, Ramisetty-Mikler, Caetano, & Green, 2006). The effects on children of witnessing violence are profound and may include post-traumatic stress disorder and other anxiety disorders, depression, behavioural problems, and impaired cognitive and social functioning (McCloskey & Lichter, 2003; Osofsky, 1999; Robbie Rossman, 2001). Recent meta-analyses indicate that exposure to domestic violence results in significant additional psychopathology among children and adolescents from a public health perspective (Kitzmann, Gaylord, Holt & Kenny, 2003; Wolfe, Crooks, Lee, McIntyre-Smith, and Jaffe, 2003).

A growing body of research has identified factors that shape the effects of domestic violence on children, and several of these factors have been conceptualized as risk or protective factors for psycho-pathology related to exposure to traumatic events (La Greca, Silverman Vernberg, & Prinstein, 1996).

For instance, severity and frequency of domestic violence (Edleson, 1999; Grych and Fincham, 1993), as well as children's perceived threat to personal safety and perceived

control over the events (Spilsbury et al., in press), have been linked to greater child psychopathology. Greater impairment has been reported in younger compared to older children. Although a "protective" effect of older age is not consistently found (Watson, 2003).

Child gender also seems important, but research findings have been equivocal: one study found boys more likely than girls to exhibit both internalizing and externalizing problems; other research found problems more frequent in girls some studies found girls more likely to exhibit internalizing and boys externalizing (Egeland, 2003), or no gender differences.

Concerning ethnicity, black children exposed to domestic violence may exhibit fewer externalizing behaviours and greater social competence compared to white children (Spilsbury et al., 2008), however, the influence of ethnicity on children's responses to domestic violence's is understudied.

Unfortunately, research on domestic violence's effects on children has been limited by several methodological problems. One issue is that specific adjustment problems (e.g. depression, conduct disorder, anxiety) have usually been investigated independently, without examining the possible multi-occurrence of different types of problems (Norwood, 2001). However, children exposed to domestic violence probably experience behavioural problems in multiple domains, with significant individual variation likely (Edleson, 1999).

Studying patterns or profiles of psychological adjustment is important because:

a) Such research may increase theoretical understanding of how domestic violence shapes children's mental health by providing a more complete picture children's adjustment to this form of violence.

b) The preserve of stable adjustment patterns may have important treatment implications for children exposed to domestic violence.

Spilsbury et al, (2008), investigated profiles of adjustment in an ethnically mixed sample of children generated through a community service program, which is likely more representative of children exposed to domestic violence than previously studied shelter populations. Spilsbury detected three distinct adjustment profiles, and the study's spilt-sample approach provided evidence of the profiles' validity.

He further asserted that two profiles were characterized by symptoms of psychological maladjustment. One group of children had externalizing problems only. These results are somewhat consistent with previous research on shelter-based samples, which found similar maladjustment profiles plus an additional one consisting of children with externalizing symptoms only (Grych et al., 2000). The presence of a large group of children exposed to domestic violence but without clinically significant symptomatology also supports the idea of resilience among children exposed to domestic violence. Study findings are consistent with other research showing that only a relatively small proportion of the many children exposed to potentially traumatic events develop clinical or subclinical traumatic stress disorder Costello, (2007). Resilience has been conceptualized as positive adaptation, adjustment and recovery, or maintenance of positive adjustment in the context of significant adversity (Becker, 2000).

ongoing protective processes may work to maintain psychological health among a substantial number of children- in domestic violence settings (Grych et al, 2000).

From a developmental perspective, the lack of early intervention for youth exhibiting various symptom clusters is troublesome because such symptoms, especially coupled with chronic environmental adversity, may not only cause problems during childhood but may also lead to psychopathology, including traumatic stress disorder, later in life (Caspi, 2007). Other theoretical work has reviewed child – intrinsic factors (e.g., appraisal/response to danger, resistance and vulnerability) and the broader social ecology of the child, which can often mediate the response to traumatic stress emphasis on neurobiological and neuroanatomical processes De Bellis, (2005); Gunnar, Fisher, & the Early Experience stress, and prevention Network, 2006), in youth exposed to traumas and adverse events highlights both protective factors promoting resilience and risk factors for psychopathology that might be modifiable through preventive or intervention strategies.

Types of Depression

Literature has provided for different forms of depression and they are discussed in this section.

Melancholic depression

Non-melancholic depression

Psychotic depression

each with their own features and causes.

A possible fourth type of depression is

Atypical depression.

Why is this important? We believe that, as with any illness, the person suffering from it can't be properly treated unless the specifics of their illness are understood.

We therefore believe that people who are depressed should receive a sophisticated assessment identifying their particular type of depression and its broad causes, whether biological, psychological or other.

Treatments should be selected according to the specific type of depression experienced by an individual, and its causes.

A description of the different types of depression follows.

Melancholic depression

Melancholic depression According to Health Science Alliance is defined based on its different features. Mind health connect (2013), Melancholy depression consists of more severe depression which is a form of classic biological depression, as well as psychomotor disturbance which includes low energy, poor concentration, slowed or agitated movement. They further stated that Melancholic depression is a relatively uncommon type of depression and it affects less than 10 per cent of people who had depression diagnosis. The numbers affected are roughly the same for men and women. It also has a low spontaneous remission rate. This subtype of depression responds best to physical treatments for example antidepressant drugs, sometimes at best to non-physical treatments such as counseling or psychotherapy.

Non melancholic depression

Non melancholic depression essentially means that the depression is not melancholic, or, put simply, not primarily biological. Instead, it has to do with psychological causes, and is very often linked to stressful events in a person's life in conjunction with the individual's

personality style. Non melancholic depression is the most common of the three sub-types of depression. It accounts for up to 90% of cases of depression seen in clinical practice. Non melancholic depression can be hard to accurately diagnose because it lacks the defining characteristics of the other two subtypes such as psychomotor disturbance or psychotic features. People with non-melancholic depression can experience depressed mood, for more than two weeks, social impairment which is difficulty in dealing with work or relationship (Mindhealthconnect, 2013).

In contrast to the other subtypes of depression, non-melancholic depression has a high rate of spontaneous remission. This is because it is often linked to stressful events in a person's life, which, when resolved, tend to assist the depression to lift Non melancholic depression responds well to different sorts of psychological treatments such as psychotherapies and counseling, and the treatment selected should respect the cause and maintenance of that depressive episode like stress, and personality style. Antidepressant medications can also be used to treat non melancholic depression (Mind health connect, 2013).

Psychotic depression

Psychotic depression is a less common type of depression than either melancholic or non-melancholic depression. It was viewed on the bases of its defining features as even as more severely depressed mood more severe psychomotor disturbance than is the case with melancholic depression and psychotic symptoms which is made up of delusions or hallucinations, with delusions being more common and overvalued guilt ruminations. Psychotic depression has a very low spontaneous remission rate and it responds only to physical treatments such as antidepressant drugs.

A typical depression

A typical depression is a name that has been given to expressions of depression that contrast with the usual characteristics of depression. For example, rather than experiencing appetite loss the person instead experiences appetite increase; and sleepiness rather than insomnia. Someone with atypical depression is also likely to have a personality style of interpersonal hypersensitivity such as expecting others not to like or approve of them.

Being able to be cheered up by pleasant events, significant weight gains or increase in appetite specially to comfort foods, excessive sleeping hypersomnia, heaviness in the arms and legs, a long-standing sensitivity to interpersonal rejection the individual is quick to feel that others are rejecting of them.

Depression in adolescence is common in school environment (Lamarine, 1995). A large number of research findings Wagner (1996), reported that major depression is effected in school children due to failure in school performance. Thus poor interpersonal relationships between teachers and the students result in low self-esteem in the adolescent boys and girls. These findings indicate adolescence as the peak age of depression. Both early and middle adolescence is considered as the appropriate age for the development of depression. Before 1970, people thought that adolescent boys and girls should not be considered as candidates for depression. The Freudian notions about the unconscious have stated that depression is effected in adults only. The childhood depression was thought to be masked by other conditions Kahn (1995). But Lamarine (1995), reported that childhood depression is widely recognized by the physicians and psychiatrists. They consider depression as a serious condition affecting both adolescents and young children. Fritz (1995), observed that

depression may be seen in physical ailments such as digestive problem toward sleeps disorders or persistent boredom.

Lamarine (1995), pointed it out that depression in children may be mistaken for other conditions such as attention deficit disorder, aggressiveness, physical illness, sleep and eating disorders and hyperactivity Allen (2003). Burford (1995), has made it clear that depression in children should not be confused with attention deficit hyperactivity disorder which begins before the age of seven. Wanger (1996), study revealed that sexual orientation adjustment problems are associated with depression. He reported that the link between homosexuality and adolescence suicide is evident in communities with strong social pressure. Mcginn (2000), states that the hopelessness theory which was reflected on Weinstein's theory states that when confronted with a negative event, individuals with a negative thinking process are vulnerable to depression, because they will infer that negative thinking process are vulnerable to depression, because they will infer that negative consequences will follow from this negative event and that occurrence of that event that the individuals themselves are worthless or flawed.

Factors contributing to depression

Genetic factors

Genetic studies have shown that environmental factors shared in families do not substantially influence liability to major depression and do not contribute to observed gender differences (McGuffin et al., 1996). Nonetheless, the role of familial environment cannot be totally dismissed, because events occurring within families and not shared by family members remain candidates. Familial factors may contribute to vulnerability to depression in terms of personal attributes modulating the response to life events, with no increased risk of illness in

the absence of such crises. Age and strictness of diagnostic criteria may be critical variables, since depressive illness in children, as well as milder forms of depression, seems to be largely related to unique or shared environmental factors (Silberg et al, 1999).

Marital divorce and separation

Much attention has been devoted to parental separation and divorce which results to lack of child care in early years as well as physical and sexual abuse in childhood as possible risk factors for depression in adult life. Adverse experiences in childhood have been shown to increase the risk of later depression through several pathways. including: biological mechanisms that is, long-term dysregulation of the hypothalamic pituitary adrenal axis; personal vulnerability such as low self-esteem, helplessness, external locus of control, poor coping strategies adverse environmental factors such as lack of social support, low social status, ongoing difficulties like single parenthood or unplanned pregnancy; and a depression episode in teenage years (Kendler et al., 1993).

Family Environmental Factors.

Family environment has been said to be instrumental to the development of depression in adolescents (Allen, 2013). A child that is constantly exposed to family conflict can develop depression. In line with his thought, age and strictness of diagnostic criteria may be considered a critical factor to this effect in children. He further asserts that depressive illness or other forms of depression tends to be related or shard environmental factors.

Social anti cultural factors

The identification of individuals at high risk for developing depression, based on socio-demographic variables and data collected across different countries and cultural groups, indicates that social roles and cultural influences contribute to a female preponderance in

depression rates. Strong effect exerted by social and cultural factors is provided by some studies showing no, or limited, gender differences n depression rates. Certain conditions prevalent in social and cultural environment can be responsible entirely for gender differences in depression within the cultural and environmental setting. For example, there is clear evidence of significant associations between emotional distress and a situation where an individual is not heavily loaded with responsibilities or overload with responsibilities in family setting. In a representative sample of private households in England, Wales and Scotland, gender differences in emotional distress persisted after controlling for socio-economic status, number of social roles and occupancy of traditional female caring and domestic roles (Allen, 2013).

Life events factor

Stressful life events retain a substantial causal relationship with the onset of depressive episodes (Allen, 2013). No clear evidence is available on the differential role of life events in males and females, but the quality of experience associated with life events may contribute to gender differences in depression. The assumption that females might be at higher risk of depression owing to higher rates of adverse life events has received inconsistent support, with some studies showing gender differences in the expected direction and others finding similar levels of life events in males and females. In any case, the excess of life events in females has not been found to account entirely for their higher frequency of affective disorders (Allen, 2013). They further reported that experiences of defeat, humiliation and entrapment were at the heart of depressive episodes in males and females, although females were far more likely to report such experiences, possibly because of their distinctive social circumstances. Allen (2013) reported other studies that did not find no gender differences in frequency of life

events or in anticipated impact of pleasant and unpleasant events, whereas the actual impact of unpleasant events was rated higher by females. An increased risk of the onset of depression may reasonably be expected when severe events occur life domains to which individuals attach a strong sense of value and commitment. Individuals with few overvalued goals and/or lacking an intimate sense of perceived choice are at high risk since they are left with few alternatives for self- definition and self-evaluation when their main goals are threatened and these situations are more common with the females.

Gender and depression

According to Reed's (1994), study, it was found that a large number of women agree that depression is more common in western society. To him, males run a fairly structured and consistent developmental course. Depressed males often appear either frustrated or lacking in social and interpersonal skills. Moderate improvement in male functioning will usually receive positive responses from both peers and adults. Additionally, male social networks tend to be flexible, and based primarily on current functioning. Therefore, gender differences linked with adverse experiences in childhood and adult depression have been poorly investigated. The available evidence suggests that early traumatic experiences may be partly responsible for a female preponderance in depression rates, since females are at greater risk of certain events such as sexual abuse they are therefore considered to be more sensitive to their depressogenic effects (Rodgers, 1994).

Adolescents can improve their social status as their interpersonal functioning improves (Reed, 1994). His conclusion is that because males are developing healthy beliefs, they are able to cope with depressing feelings. They do not generally develop depression due to lack of negative thoughts about the self, because the social structure correctly rewards them for

having positive thoughts, which prevents depression. On the other hand, the female adolescent social structure is much different, and they are more prone to develop irrational and dysfunctional beliefs. Reed further explained that female adolescents run a less structured and more inconsistent developmental course. The responses from peers and adults to the female's incompetence is variable.

Improved behavior of female adolescents also receives inconsistent feedback. Adolescent females in general are expected to be competent interpersonally. Therefore, a Female adolescent who had been depressed, upon achieving appropriate functioning, would receive only minimal attention for her accomplishment (Allen, 2003). Consequently, improved functioning will often not facilitate immediate social acceptance by females Reed, (1994). He explained that females are more likely to form dysfunctional beliefs due to mixed signals from society. This coincides strongly with Beck's model of depression and the large problem of female depression in western society.

Hence according to Allen (2003), gender differences in depression are genuine. Determinants of such differences are far from being established and their combination into integrated aetio-pathogenetic models continues to be lacking. At present, adverse experiences in childhood, depression and anxiety disorders in childhood and adolescence, socio-cultural roles with related adverse experiences, and psychological attributes related to vulnerability to adverse life events and coping skills are likely to be involved. The identification of individuals at high risk for developing depression based on socio-demographic variables and data collected across different countries and cultural groups indicates that social roles and cultural influences contribute to a female preponderance in depression rates.

Detailed reviews of epidemiological findings suggest that marriage have detrimental effects in females, possibly due to gender-specific demands posed by marriage and the resulting limited number of roles available to females. Similar reasons may explain why looking after small children are associated with greater risk of depression in females. Both home-making and child care reduce the likelihood of females being in paid employment or put additional responsibilities on those who are employed. Married females with no paid employment have to rely for identity and self-esteem on the role of housewife, a role that carries many frustrating elements and has been increasingly ender differences in depression devalued in modern societies. On the other hand, females entering the job market face economic discrimination and job inequality along with role overload and role conflict caused by concurrent primary responsibility for household chores and child care. Although employment tends to have beneficial effects on psychological well-being, these effects may be reduced or reversed where there is role conflict and overload.

Age and Depression

A study done by Epkins (2000), looked at clinic-referred children. Two main groups of these children emerged, those whose personality tends to be internalized, and those who were externalized. Epkins' was looking for evidence of Beckian thinking in young children. She explains that specificity would emerge on all cognitive measures, with internalizing children reporting more negative cognition than externalizing children (Epkins 2000). This is so because focusing on yourself would logically lead to a greater increase of negative automatic thoughts on average, her findings consistent with Beck's Theory, the findings suggest that the negative cognitive triad, cognitive processing distortions, and depressive and anxious though content, may be specifically related to internalizing.

Levels of depression among adolescents

Depression has been grouped into different categories although researchers are yet to arrive at a consensus on different categorized of depression (Crum 2000). Studies on the validity of different depressive disorders have shown inconclusive results. Attempts to distinguish different diagnostic categories have been made by examining symptoms, course, or risk factors. Nevertheless, there are categories that are operationally accepted:

Minor depression

Major depression

Subthreshold depression

Double depression.

Minor Depression

The heterogeneity of minor depression and its separate role from major depressive disorder also have drawn increasing research attention. Family studies suggest that there is a higher risk of minor depression among relatives of propend with major depressive disorder. Epidemiologic evidence suggests that major depressive disorder is more often an exacerbation of a chronic mood disturbance with roots in longstanding vulnerability factors, while in later life minor depression is more often a reaction to commonly experienced stresses. Some researchers have suggested that minor depression is a heterogeneous disorder because some cases of minor depression progress into major depressive disorder while others do not. The study of Crum (2000), found that more people are impaired by minor depression than by major depression disorder. The combination of a higher prevalence and associated impairment of sub threshold or sub-syndrome depressive symptoms emphasis it's clinical and public health importance.

Major depression

Studies have shown that initial depression seventy and level of functional status accounted for more of the variance in outcomes than did type of depressive disorder, A Comparison of symptoms among cases of major depressive disorder and dysthymia, disorder revealed that symptom presentation did not distinguish clearly the difference (Crum, 2000). Another study was based on the 1981 psychiatric assessment of the Baltimore epidemiologic Catchment Area (ECA) which suggested that risk factors differed between the subjects with major depressive disorder and those with no major depression. But major depressive and depressive syndrome was associated with family history of depression stressful life events before the onset. Yet, for the subjects with major depressive disorder, family history was stronger risk factor than stressful life events. It has been demonstrated that individuals with major depressive disorder were associated with 51% more disability days in the community persons with major depression (Crum, 2000).

Double depression

The poor prognoses for double depressive disorders and dysthyrnic disorders have been recognized. It is viewed as the combination of all the different subtypes of depression.

Comorbid depression

Comorbid depression group was defined as “meeting criteria for lifetime diagnoses of both major depressive disorder and dysthyma. Li-Shiun Chen, Eaton, Galio, Nestadt, Crum (2000), found that subjects with comorbid depression had significantly higher proportions reporting symptoms of feeling tired, feeling worthless, and Suicidal thought and behavior than those with major depressive disorder. In a study about 17% of the 59 subjects with major depressive disorder developed comorbid and dysthymia. About 10% of the 136 subjects with

depressive syndrome developed major depressive disorder 5% developed dysthymia; and 8% developed comorbid major depressive disorder and dysthymia. About 19% of the 37 dysthymia subjects developed comorbid major depressive disorder.

2.2.3 Concept of Aggression

According to C.D.C (2005), aggressiveness is another significant problem among school children.

> *"Simply put, aggressiveness refers to those individuals who are emotional hurt, those that have difficulty staying focused with regards to attending to mundane tasks. School children who display aggressiveness are easily distracted by irrelevant sights and sounds, they are quick to anger they shift from one activity to another, without necessarily finishing the first one, and seem to get board easily, they may appear forgetful and even spacey or confused as if "in a frog" (CDC, 2005).*

According to American Psychologist Walter B. Cannon (2001), who reported about parasympathetic and sympathetic the autonomic nervous system, parasympathetic handles the mundane functions of ordinary life, the conservation of bodily resources, reproduction, and the disposal of wastes. These reflects in an individual operation during times of peace, a low and steady heart rate, peristaltic movements of stomach and intestines, secretions by digestive glands, and other aspects. The sympathetic reaction has an activating function, these summons the body's resources in times of crisis and gets the individual ready for vigorous actions Cannon (2001). Sympathetic reaction stimulates the inner core of the adrenal medulla to pour epinephrine and norepinephrine into the bloodstream, the sympathetic stimulation accelerates the heart rate, speed up metabolize. Cannon reported that intense sympathetic arousal serves as an emergency reaction that mobilizes the individual for a crisis for "flight or fight", as he described it.

Many students have trouble remembering which is the sympathetic reaction and parasympathetic. Parasympathetic is for peace while sympathetic provides us with the surge of energy. “Fight and flight” is simply because individuals respond to threat in different ways, some individuals stand perfectly immobile when threatened, so that the attackers may not notice them. Situation involving threat requires the individual to be ready for immediate action; the fight with enemies might have biological underpinning.

According to Renfrew (2002), aggression on self-defense behaviour are controlled by the individual brain which is triggered by different situations – violence community, kidnapping, shooting this may lead them to respond to threat easily.

Types of Aggression

Literature has provided three types of aggression in this section;

Physical aggression

Social aggression

Non-universality of human aggression

Physical aggression

It refers to that aspect of aggression that involves physical fight, and is prevalent with men, biological factors are clearly relevant because aggression is partially influenced by hormones, particularly the sex hormones testosterone. High testosterone level in the blood stream are associated with increased physical aggressiveness in many individual, some human aggression bears no relationship to testosterone levels, so it must be shaped by other factors. (Qunisey 2001). They further state that it will be inaccurate to say that individual testosterone causes aggression, because it can be both a cause and an effect.

Social aggression

In males, aggression is often physical (pushing, punching, much more vigorous. In female aggression usually takes a different form. They may attack each other, by spreading gossip, rumours and steps to isolate someone from friends and allies.

Non-universality of human aggression

The individual vary enormously in how aggressive they are. Some like His Holiness, the Dalai Lama develop a capacity for loving compassion that makes aggression almost unthinkable. Others like some gang member are engage in violent aggression in almost every day of their lives.

Factors Contributing to Aggression

Aggression is motivated by complex beliefs such as historical rights, prior injuries. These beliefs, in turn depend on the sophisticated human capacity for symbolism, a capacity that gives rise to our conceptions, rather than palpable threat to our welfare, that give rise to many instance of human aggression (Green, 2002).

Gender and Aggression

In most cases male and more aggressive than female among the vertebrates, the male is by far the more physical aggressive sex. This difference in combativeness is apparent even in childhood play Bushman (2000). Boy worldwide are more aggressive than girls. In adult, male murderers out number females by ratio of 10:1 Bushman (2002). According to them, this gender difference holds for physical aggression. Female are aggressive but their aggression tends to rely on verbal or social assault not physical violence.

Level of Aggression among Adolescent

Aggression has been grouped into three categories.

The male who is continually fighting will always remain aggressive, they roar, they puff themselves up and they offer all sorts of threats all with the aim of appearing as powerful as they possible can. These hostile actions directed against individual intended to do physical harm is always observable in adolescents.

Age and Aggression

Some children who are not respected may likely become aggressive; they are not liked by peers as a result of his or her hostility.

Children who are victims of trauma or traumatic stress disorder may also display another form of school behaviour problem know as hyperactivity. American Psychiatric Association (2000), described individuals who are hyperactive.

> *as those who have excessively high level of activity, which may prevent as physical and or verbal over activity, they may appear to be in constant motion, "the go" as driven by a motor, they have difficulty keeping their body still, moving about excessively, squirming or fidgeting. Individual who is hyperactive often feel restless, may talk excessively, interrupt others, and monopolize conversation, not letting others get in a word".*

Effects of Depression

Depression are the leading cause of disability, Bech, Rasmussen (2001) noted note that depression is the most common psychiatric complaint is being described by physicians. Major depression significantly affects a person's family and personal relationships, work, or school life, sleeping and eating habits and general health. Feeling of depression impact on functioning and well-being of an individual sufferer.

Depression is one of the most common psychological problems. Depression can interfere with normal functioning of an individual; it can cause problems with work, social and family adjustment. It causes pain and suffering not only to the person affected with the disorder but also to those who care about them. Serious depression can destroy family life as well as personality of the depressed person.

Other impact of depression according to Franklin (2005) are that it:

- Cause tremendous emotional pain
- Disrupts the lives of millions of people,
- Adversely affects the lives of families and friends
- Reduces work productivity and absenteeism
- Has significant negative impact on the economy.
- Depression is a psychological condition that changes how individual think and feel, it affects individual social and physical well being.
- Depressed persons are seen as weak or lazy.

2.2.4 Concept of anxiety

Many people believe that anxiety does not occur in childhood or adolescents, but today experts agree that anxiety can occur at any age. Studies has shown that childhood onset anxiety disorder are among the most frequent psychiatric conditions in children and adolescents. The neurobiological models involved in the etiology of anxiety disorder in youngsters are closely related to neuroimaging studies with individuals presenting these pathologies (CDC, 2005).

Onset anxiety disorder is related to parental problems as well as violence condition in an area. Children who exposed to stressful life event affecting the family or poverty, stand the risk of anxiety, especially young children. Traumatic stress disorder may set in as anxiety condition may affect their classroom behaviour and academic performance.

Russo (1990) and Hoeksema (1990), opined that as children mature and their negative abilities develop, cognitive factors such as their negative thinking styles appear to be stronger in the development of anxiety characterized by negative attitude towards self even their future. They also tend to exhibit anger or pessimistic attribution style their non-anxiety peers.

After attention deficit hyperactivity disorder (ADHD) and conduct disorder, anxiety disorders are the most commonly observed psychiatric diseases in children and adolescents. Up to 10% of children and adolescents are affected by some kind of anxiety disorder (excluding obsessive-compulsive disorder which affects up to 2% of children and adolescents, more than 50% of anxious children will have a depressive episode as part of their anxiety disorder.

Except for post traumatic stress disorder (PTSD), where an external traumatic factor is the primary cause, the major risk factor for childhood-onset anxiety disorder is having a parent with anxiety disorder or depression. Therefore, as with most psychiatric diseases, anxiety disorders are associated with brain development, with significant genetic contribution. In children, emotional development influences the causes and they way fear and worries (normal or pathological) become apparent. Differently from adults, children might not recognize their fears as exaggerated or irrational, especially the younger ones.

Both anxiety and fear are regarded as pathological if they are excessive, disproportionate to the stimulus, or qualitatively different from that observed at this age, and

if they interfere with the child's quality of life, emotional comfort or daily performance. Such exaggerated reactions to the anxiogenic stimulus commonly occur in individuals with inherited neurobiological susceptibility.

Although there is one clinical picture for each anxiety syndrome, most children will have more than one anxiety disorder. It is estimated that approximately 50% of children with anxiety disorders also have a comorbid anxiety disorder.

Approximately 10% of all children and adolescents are estimated to meet the diagnostic criteria for at least one anxiety disorder. In children and adolescents, the most frequent conditions are separation anxiety disorder (SAD) with a prevalence around 4%, generalized anxiety disorder (GAD) (GAD; 2.7% to 4.6%) and specific phobias (2.4% to 3.3%). The prevalence of social phobia I around 1% and that of panic disorder (PD) 0.6%.

Gender distribution equivalent, except for specific phobia, Post-traumatic stress disorder (PTSD) and panic disorder (PD), in which there is a female preponderance. SAD and specific phobias are more often diagnosed in children, whereas pain disorder (PD) and social phobias are more common in adolescents.

If left untreated, anxiety disorders in childhood and adolescence (ADCA) have a chronic albeit oscillating and episodic, course.

The various anxiety disorders in childhood and adolescence often develop during specific developmental stages. SAD is more common than GAD in younger children (6-8 years), whereas in adolescents, GAD is more frequent than SAD, being possibly correlated with precede PD and agoraphobia adults. Adolescents with specific phobias are at a greater risk for specific phobias in adulthood, and adolescents with social phobias have a higher risk for social phobias in adulthood. Likewise, adolescents with GAD, PD or major depression are

at a greater risk for developing these disorders, or their combination, in adulthood. Evidence that some forms of childhood anxiety may be related to anxiety disorders in adulthood contributed to the development of specific diagnostic, treatment and prevention strategies for children and adolescents. Although the diagnostic methods for anxiety disorders in children are similar to those used in adults, the assessment and treatment of pathological anxiety in children have peculiar characteristics.

Most children with anxiety disorders are referred for mental health services due to behavioural problems related to their relationships and school environment. Given the major symptoms, clinicians have to understand these behaviours in a context of restrictions on separation anxiety disorder (SAD) is characterized by excess anxiety separation from parents or substitutes, inappropriate to the level of development, persisting for at least four weeks. Symptoms cause intense distress and significantly interfere in different aspects of children's and adolescents' lives.

Children or adolescents, when left alone, fear that something bad might happen to their parents or to themselves, such as diseases, accidents, kidnapping, robbery, which could separate them from their parents for good. Consequently, they get excessively attached to their caregivers, not allowing them to be away. At home, they have problems sleeping, and need constant company. They often have nightmares about their fears of separation. Refusal to go to school is also common among these patients. The child wants to go to school, shows good adaptation, but shows great distress when he/she needs to stay away from home. The symptoms described above are usually accompanied by somatic anxiety symptoms, such as abdominal pain, headache, nausea, and vomiting. Older children may have cardiovascular symptoms such as palpitations, dizziness and fainting sensation. These symptoms hinder the

child's autonomy, may restrict his/her academic, social and family activities, producing significant personal or family stress. They feel humiliated and fearful, which results in low self-esteem.

Types of Anxiety

Literature has provided for different forms of anxiety and they are discussed in this section.

Generalized Anxiety

Panic Disorder

Phobic Disorders

Obsessive-Compulsive Disorder

Agoraphobia

Generalized Anxiety

Persistent anxiety that is not limited to particular situations. Excessive worrying is the key feature associated with heightened state of bodily arousal, tenseness, being "on edge".

Children with GAD have irrational, exaggerated fears and worries about several situations. They are always tense and give the impression that any situation could trigger anxiety. They worry a lot about what other people think or their performance in different areas and they desperately need to be reassured or calmed down. They hardly relax, often have somatic complaints without any apparent cause, signs of autonomic hyperactivity (e.g.: pallor, sweating, tachypnea, tachycardia, muscle tension and hyperarousal).

GAD usually has an insidious onset; parents do not know exactly when it started, they just say it got worse and worse until it became intolerable, and that is when they often seek medical help.

Panic Disorder

Occurrence of repeated panic attacks, which are episodes of sheer terror accompanied by strong physiological symptoms, thoughts of imminent danger or impending doom, and an urge to escape.

Panic disorder is a debilitating anxiety disorder that is very different from GAD. Panic disorder is not about "panicking." It's not about getting very worried because you might lose your job or a lion is about to attack you in the jungle. That type of panic is normal.

Panic disorder is when you experience severe feelings of doom that cause both mental and physical symptoms that can be so intense that some people become hospitalized, worried that something is dangerously wrong with their health.

Panic disorder is characterized by two things:

- Panic attacks.
- Fear of getting panic attacks.

Panic attacks are intense physical and mental sensations that can triggered by stress, anxiety, or by nothing at all. They often involve mental distress, but are most well-known by their physical symptoms, including:

- Rapid heartbeat (heart palpitations or irregular/fast paced heart rhythms).
- Excessive sweating or hot/cold flashes.
- Tingling sensations, numbness, or weakness in the body.
- Depersonalization (feeling like you're outside yourself).
- Trouble breathing or feeling as though you've had a deep breath.
- Lightheadedness or dizziness.
- Chest pain or stomach pain.

- Digestive problems and/or discomfort.

Panic attacks may have some or all of the above physical symptoms, and may also involve unusual symptoms as well, like headaches, ear pressure, and more. All of these symptoms feel very real, which is why those that experience panic attacks often seek medical attention for their health.

Panic attacks are also known for their mental "symptoms" which peak about 10 minutes into a panic attack. These include:

- Feeling of doom, or the feeling as though you're about to die.
- Severe anxiety, especially health anxiety.
- Feeling of helplessness, or feeling like you're no longer yourself.

Contrary to popular belief, it's possible for the physical symptoms of panic attacks to come both before and after anxiety, meaning that you can experience physical symptoms first before experiencing the fear of death. That is why many people feel as though something is very wrong with their health.

Panic attacks can be triggered by an over-sensitivity to body sensations, by stress, or by nothing at all. Panic disorder can be very hard to control without help. Seeking assistance right away for your panic attacks is an important tool for stopping them, so that you can learn the techniques necessary to cure this panic.

You can also have panic disorder without experiencing many panic attacks. If you live in constant fear of a panic attack, you may also qualify for a panic disorder diagnosis. In those cases, your anxiety may resemble generalized anxiety disorder, but the fear in this case is known.

Phobic Disorders

Excessive fears of particular objects or situations

Many people suffer from what's known as "social phobia," or an irrational fear of social situations. Some degree of social phobia is normal. Small degrees of shyness in public places, or discomfort while public speaking, are natural in most people, and do not imply an anxiety problem.

But when that fear disrupts your life, you may be suffering from social phobia. Social phobia is when the shyness is intense and the idea of socializing or speaking with the public, strangers, authority figures, or possibly even your friends causes you noticeable anxiety and fear.

People with social phobia view public situations as being potentially painful and distressing, living with a constant fear of being judged, observed, remarked upon, or avoided. Those with social phobia also often have an irrational fear of doing something stupid or embarrassing.

What makes this more than just shyness is when those fears cause you to avoid healthy socializing situations altogether. Those with social phobia often live with two or more of the following issues:

- Feeling hopeless or fearful within unfamiliar people or in unfamiliar situations.
- Obsession over being watched, observed, or judged by strangers.
- Experiencing overwhelming anxiety in any social situation with difficulty coping.
- Severe fear of public speaking - beyond what one would consider "normal"
- Anxiousness about the idea of social situations, even when not in one.
- Intense issues meeting new people or voicing up when you need to speak.

Many people with social phobia display avoidance behaviors. They avoid any and all social situations as best they can so as to avoid further fear.

Agoraphobia

Agoraphobia is the fear of going out in public, either the fear of open spaces or the fear of being in unfamiliar places. Many people with agoraphobia either never leave their home, or do anything they can to avoid traveling anywhere other than their home and office. Some people can go to the grocery store or other familiar places, but otherwise experience intense, nearly debilitating fear anywhere else.

Many people (although not all) that have agoraphobia also have panic disorder. That's because for many, agoraphobia is often caused by panic attacks. People experience panic attacks in public places, so they start to avoid more and more places in order to avoid panic attacks until they are afraid to go outside. Some people experience agoraphobia after traumatic events as well.

Agoraphobia is more common for adults. Many also fear losing control (both psychologically and physically), causing them to avoid social situations. Not everyone living with agoraphobia spends all their time in their home. In fact, some of the more common symptoms include:

- Obsessive fear of socializing with groups of people, regardless of whether or not you know them.
- Severe stress or anxiety whenever you're in an environment other than your home, or an environment where you're not in control.
- Feelings of tension and stress even during regular activities, such as going to the store, talking with strangers, or even just stepping outdoors.

- Preoccupation with how to protect yourself or find safety in the event that some type of trouble occurs, even with little reason to believe trouble will occur.
- Finding that your own fears are keeping you prisoner, preventing you from going out and living life because of that fear.

Many people experience moments where they feel vulnerable outdoors and prefer to stay safe in their homes. But when the fear seems to persist for a long time, or is holding you back from living an enjoyable life, you may have agoraphobia.

Obsessive-Compulsive Disorder

Recurrent obsessions (recurrent, intrusive thoughts) and/or compulsions (repetitive behaviors that the person feels compelled to perform). Two major types of compulsions; checking rituals and cleaning rituals. Obsessions generate anxiety that may be at least partially relieved by performance of the compulsive rituals.

Factors Contributing to Anxiety

Biological Factors

Social-Environmental Factors

Emotional and Cognitive Factors

Biological Factors

- Genetic predispositions
- Irregularities in neurotransmitter functioning
- Abnormalities in brain pathways signaling danger or inhibiting repetitive behaviors
- Prepared conditioning

According to a National Health Interview Survey of Child Health taken in 1993, children from disrupted marriages are over 70% more

likely than those living with both biological parents to have been expelled or suspended thereby leading to low academic achievement or total drop out from school. Nicholas (1987), in his studies showed that children whose parents have divorced are more likely to have behaviour problems Children whose parents reconciled or married again actually had more behaviour problems at age six (6) than did those remaining in stable single-parent families Fergusson (2000), followed the lives of almost 1,000 children from birth until they were six years old, periodically interviewing the children's mothers at home, collecting questionnaires about the children's behaviour from mothers and teachers and examining hospital records He confirmed previous findings that compared with children of stable two-parent families, children whose parents divorced show more aggressive, anti-social and anxiety behaviour.

Researchers from Auburn University in Alabama and Brown University in Providence, R.I., assessed children's sleep in 54 healthy 8- and 9- year-old children, along with parental conflict from both the child and parental viewpoint. None of the children had any previously diagnosed sleep disorders, and their parents experienced conflict levels the normal range. The researchers measured parental conflict and assessed the children's sleep through parental and child reports. They also had the children wear an Actigraph, a watch-like device that records movement, for seven nights while in bed. Data from the Actigraph helped researchers determine when children went to sleep and woke up, how often they woke up during the night and how well they slept.

Researchers found that even though children in higher conflict homes went to sleep about the same time as children in lower conflict homes, they slept less and didn't sleep as well. In families where parents had more conflict, children slept less, spent less time in bed actually sleeping, and moved around - fidgeted or tossed and turned more. Children in higher

conflict homes also reported they were sleepier during the day. The associations between conflict and sleep were especially strong when the researchers looked at child-reports of parental conflict (rather than parental reports) and the Actigraph measures of sleep. Those children who perceived their parents' conflict as frequent, intense and unresolved had more disrupted sleep. Elsheikh (2006), concluded that the data obtained from the research suggest that even in families with normal levels of conflict, parental arguments and anger can disrupt children's sleep, this is significant because even mild loss of sleep can disrupt attention, alter information processing, weaken motivation, increase irritability and diminish emotion control. In a related study Elliot & Richards (1991), in a study of British Youngsters found that 7-year olds whose parents eventually divorced had more educational problems than did 7-year olds whose parents did not divorce.

Social-Environmental Factors

- Exposure to threatening
- Observing fear responses
- Lack of social support

Emotional and Cognitive Factors

- Unresolved psychological conflicts (Freudian or psychodynamic theory)
- Cognitive factors, such as over prediction of fear, self-defeating or irrational beliefs, over sensitivity to threat, anxiety sensitivity, mis-attribution of bodily cues, and self-doubts or low self-efficacy

Age and Anxiety

The perceptions of the person are revealed through their perceptions of the object drawn (Gould, 1987). For example, a 16-year-old boy with a violent home life takes the draw-

a-person-in-the-rain test during psychological testing. He draws the person with a broken umbrella- a person without adequate protection from the elements. He draws a house in the distance, safety from the rain but he can't get there. Another evaluation is taken for a 12-year-old girl who lived with her aunt after witnessing her mother's murder. She did not adjust well to her situation. When asked to draw a house, she portrayed her unstable home life in it. "The long walkway attached to the lower left base of the paper seemed to indicate her need for structure in her environment and at least her ambivalence towards emotional accessibility. The bare windows appeared to point to her direct and blunt interpersonal approach. Also, the single line stemming from the chimney possibly suggested the lack of emotional nurturance which she perceived existed in the household".

Unguided drawings can also be the outcome of post-traumatic stress disorder in children. An example of this is the art produced at the Terezin Concentration Camp between 1942 and 1944, where "15,000 children left 4000 pictures" Betensky (1995). In this case, the artwork is a means to personally cope (intentionally or not) with the distress. Sometimes the drawings illustrate realistic settings while others may portray memories of happier times. Regardless of the subject matter, the construction of the picture often follows the same basic format. Dark lines, heavy clouds, and the use of a lot of grays, black, blue, and yellow make the pictures look ominous but without the violent undertones that anger produce. While the previous examples are instances of post traumatic disorder motivated art, the children probably did not consciously choose to have the drawings represent those exposing aspects. Sometimes though, art is used for this actual purpose. During and after the Chechen War, the people were left with their lives drastically altered. Volunteers provided art therapy sessions at a refugee camp to help the children work through their traumatic experience (Weir, 2000).

The drawings depict scenes that many of the children have experienced, such as their homes destroyed and families killed. These brutal images demonstrate fear, anger, and depression. Some of the pictures showed the volunteers that hatred for the Russians was growing and a topic that needed to be handled. There was certainly progress in the therapy; some of the children began to draw images of hope, like a family safe in a bomb shelter. Refugee students that have been displaced to the United States use art as a means of coping with their upsetting past and unfamiliar present (Brunick 1999). Not only do the children have deal with the horrors of the past, but the life they are thrown into is harsh as well. Often families are separated, and new responsibilities are expected in the new culture. Sometimes these children have scholastic, social, and behavioral problems and there may or may not be medical or school records to help understand them from the previous country. Art class is a logical place to deal with these issues due to the often constricting, language barriers. It is considered a no-threatening environment and the open-ended nature of assignments relieves the tension that other classes might have. The children feel capable of expressing themselves more freely in this visual medium. Teachers should be prepared for graphic images and offer support when needed (Brunick 1999).

Art can be used in several therapeutic ways. Group drawings help children that have experienced the same post traumatic stress disorder incident to help revive their memories and encourage discussion about the incident (Ennis 1999). Art can be used as a means to increase feelings of control in both motor and cognitive skills (Pili 2000). There is valuable for children that might suffer from development and other problems due to stress in their lives. A good example of this is Frieda Kahlo. As a teenager, she was hit by a bus. The accident left life-long debilitating injuries that required constant attention.

She used her art as a means of expressing the physical and emotional damage caused by the post traumatic stress disorder life-changing event (Stokstad 1995). Lesser known artist, Jane Orleman, also uses art as a means of muddling through her sexual, physical, and emotional abuse as a child. Not only does she experience in art, but also she assists organization to help abused children with her art (Orleman 1988).

Levels of Anxiety among Adolescent

Perry (1988), in his findings discovered that a growing body of evidence suggests that the developing brain organizes in response to the pattern, intensity and nature of sensory perceptual and affective experience of events during childhood and adolescence to produce a unique person. Mediated by neurotransmitters and hormones, a stressor can affect the differentiation of the brain. Weinstock, Fride and Hertzberg (1988), reported that the developing CNS is exquisitely sensitive to anxiety. For example, rats exposed to pre-natal handling anxiety show major alterations in their anxiety response later in life. Such studies suggest that early exposure to consistent daily stress can result in more adaptive later behaviour and resiliency, while exposure to unpredictable anxiety can result in deficits. Predictability and control can make events more or less destructive. The above research suggests that its plasticity makes the developing brain more susceptible to formation of malignant memories that affect not only the anxiety response system but also the emerging organizations of neural networks regulating other basic states and characteristics of the individual. A child, who has reasonable frustration gratification, and control during rapprochement in regulating tension anxiety by returning to a welcoming mother for comfort, may be establishing an appropriate neurochemical milieu for the development of a flexible, maximally-adaptive physiological apparatus for responding to future stressors, as well as

other neuropsychological structures that mediate object relations, affect regulation, and adaptive personality characteristics For traumatized children, however, the template for organization of their developing systems includes powerful experiences of fear, threat, unpredictability, frustration, anger, helplessness, hunger, and pain. Perry (1988), found that altered cardiovascular regulation, affective liability, behavioural impulsivity, increased anxiety and startles response, and sleep abnormalities in such children such youngsters are at risk to develop "post traumatized stress disorder" brains characterized by deregulated systems that would serve them poorly when exposed to psycho-social anxiety later in life.

Brown, Harris and Copeland (1977), in their studies provide correlative data suggesting that severe early trauma can be a major expresser of underlying constitutional or genetic vulnerability and may be a primary etiological factor in the development of a broad range of later disorders. Davidson and Smith (1990), showed that 22% of adult psychiatric out-patients received a diagnosis of Post-Traumatic Stress Disorder, with vulnerability of trauma greatest during early childhood and adolescence. Moreover, Bremmer, Southwick and John (1993), reported that veterans with combat-related Post Traumatic Stress Disorder were more likely to have a history of childhood physical abuse than those without Post Traumatic Stress Disorder. Brier and Kirwin (1988), concluded that early parental loss accompanied by absence of a lye relationship is associated with adult psychopathology. Herman and Vanderfolk (1989), in their study documented associations between developmental trauma and the creative output of adult artists and borderline personality

2.2.5 Concept of academic performance

Academic performances among students have been observed to be on the increase in our environment despite efforts at improving the school curriculum and quality of teaching Moja (2000). This has been a source of concern to some authors in the West African sub region Etsey, (2005). Studies done on academic performance of school students in our environment were on children with chronic disease (epilepsy and sickle cell anaemia) Ibekwe et al (2007).

The quality of academic performance of students in our secondary schools in Rivers State is a prevalent threat to the nation. Researchers have observed that the quality of academic performance among students in our secondary schools remain relatively poor. Various research has been conducted to determine the causes and method to curb the students' poor academic performance in our schools. Nwankwo (2005), in his study poor academic performance of students is attributed to hereditary and environmental factors. He still went further to explain that environmental factors can be subdivided into students, homes, teachers and school environmental factors.

Though school behavioural problem was reported not to have any influence on the overall academic performance of these students, significantly larger proportion of poor achievers than age – and sex – matched healthy classmates were documented in both groups (Ekanem 2012).

Studies from the West countries have reported poor academic performance in the developed countries (Abolfotouh 1997). They noted that these children had serious problems of social adjustment, were disruptive at home as well as in school and failed to make friends (Schacher 1986). They also had difficulties keeping notes to learn (Taylor, et al., 1986).

Salvin (2004), reported that children with emotional problem quite frequently, are other disabilities or mental retardation, all this result into diminishing academic performance (P. 374). In other words, a child who experiences traumatic stress disorder may likely affect his/her behaviour and academic performance. In looking at student's behavioural problems, students may have school behaviour problems, if their behaviour is unacceptable within a defined societal context. Behaviour is defined as the totality of the individual disposition in different aspects. In education, it embraces the totality of an individual behaviour, interest, value, academic achievement and attributes. These can influence the student's perception and ability to learn (Amelia 2004).

Brooks (2008), reported that students who are victim of traumatic stress show a wide range of reactions. Some suffer worries, and bad memories of the experience, others bare more affected and experience long term difficulties, some of these difficulties may include emotional depression, irritability, outburst of anger, or feelings of guilt, or continuous episodes called "flashback: which include fearful feelings of experiencing the trauma again, such students often tend to be emotionally withdrawn from friends, family and teachers, such behaviour having negative effect on their academic performance.

Certain characteristics features which children's display after post traumatic stress disorder are as follows. Students who are less interested in exploring new things, neither are they excited by new things, such students are more likely to be scared; they are shy around stranger, and may not speak well to people outside the family. These students do have poor social skills, less involvement in and after school activities, (Brooks, 2008).

Slade and Wissow (2000), reported that individual who had experience post traumatic stress disorder, in experience, as students had lower high school grade point, have problem

with teachers in the area of completion of homework or with school absence, the report add that traumatic experience in childhood has statistically significant effects on the victims psychological well-being such as anti-social behaviour, depression and low self-esteem. People who suffer from post-traumatic stress disorder sometimes following a traumatic event, particularly an event that involves actual or threatened death or serious bodily injury to oneself or others that creates intense feelings of fear, helplessness or horror. The symptom of post traumatic stress disorder includes re-experiencing of the trauma either thoughts or memories or in extreme cases, through a flashback in which the trauma relieved at full emotional intensity (Chandler, 2000).

Davidson and Smith (1990), in their study provided a correlative data between severe early trauma and broad range of later disorder. The study shows that 22% of adult psychiatric out-patients received a diagnosis of post-traumatic stress disorder (PTSD), with vulnerability to trauma greatest during early childhood and adolescence. In related study, Bremmer, et al (1993), found that veterans with combat-related post-traumatic stress disorder are more likely to have a history of childhood physical abuse than those without post-traumatic stress disorder. According to Kenny (2003), concluded that early parental loss accompanied by absence of a supportive relationship is associated with adult-psychopathology. Many incidents of early sexual or physical abuse, expulsion, public coercion in the school assembly, community violence may affect a large number of children and adolescents. Perry (2002), also found out that the survivor while still in arousal state finds it difficult to process information because of the alteration in the functioning of the neocortex.

Hennessey and Mahoney (2004), described post trauma stress disorder as a type of mental illness that some people develop after experiencing traumatic or the threatening

events, such as rape, warfare or other forms of disorders, natural disasters such as earth quakes, floods, automobile or air plane crashes.

Post-traumatic stress disorder is an extreme reaction to extreme stress, post traumatic stress disorder can severely disrupt one's life, besides the emotional pain of relieving the trauma, and the symptoms of the disorder may cause a person to think that he/she is going crazy.

Freyd (2002), reported that there are several behavioural responses common towards stressors, including the proactive, reactive and passive responses, Proactive responses include attempts to address and correct a stressor before it has a noticeable effect on life style. Reactive responses occur after the stress and possible trauma has occurred, and is aimed at correcting or minimizing the damage of a stressful event. A passive response is often characterized by an emotional numbness or ignorance of a stressor.

McNally, at el (2003), reported that those who are proactive can often overcome stressor and are more likely to be able to cope well with unexpected situations, while those who are more reactive will often experience more noticeable effects from an unexpected stressor. However, in the case of those who are often enact no intentional coping actions, especially among school age children. These groups of individual usually lack necessary ability to cope and they may have problem coping with academic life.

Post traumatic stress disorder is often associated with behaviour problems among students in our secondary schools today, behaviour problems like anxiety, depression, and aggression.

2.2.6 Relationship between Post-Traumatic Stress Disorder and Academic Performance

The quality of academic achievement of students in our secondary schools in Nigeria is a prevalent threat to the nation. Researchers have observed that the quality of academic achievements among students in our secondary remain relatively poor. Various researches have been conducted to determine the causes of and methods to curb the students' poor academic achievements in our schools especially secondary school students who are the focus of this study. Nwankwo, (2005) attributed students' poor academic achievement to hereditary and environmental factors. He still went further to explain that environmental factors can be subdivided into students, home, teachers and school factors.

Delaney – Black, (2002) in her findings reported that children exposed to high levels of community violence and trauma-related distress, have lower 1Q scores and lower academic events. In her research on violence exposure linked to 1Q in children New York, she found out that 85% of 6-7 year olds said they had heard guns being shot at least once in their lives. Nearly 80% said they had seen somebody get stabbed. Furthermore, the research revealed that almost 4 out of every 10 children said they worry in class sometimes about people being shot.

In her findings, she reported that violence exposure might be associated with negative academic achievement. Furthermore, her findings suggested that violence exposure may be associated with the actual impairments in academic ability and learning potentials, even in absence of distress. According to Madison, (2006) a 2002 USA study on the effect of parental divorce has on children's academic achievement. The effect of divorce on children shows that psychological damage builds up on children in the home before divorce and

subsides after it, but academic progress of these affected children continues to weaken throughout the students' educational career. Madison, (2006) further pointed out that Ohio State University researchers speculate that during or after divorce, children may initially fall behind academically and have trouble catching up in class and worse, they lose their motivation.

According to a National Health Interview Survey of Chld Health taken in 1993, children from disrupted marriages are over 70% more likely than those living with both biological parents to have been expelled or suspended thereby leading to low academic achievement or total drop out from school. Nicholas (1987) in his studies showed that children whose parents have divorced are more likely to have behaviour problems. Children whose parents reconciled or married again actually had more behaviour problems at age six (6) than did those remaining in stable single-parent families. Fergusion (2000) followed the lives of almost 1,000 children from birth until they were six years old, periodically interviewing the children's behaviour from mothers and teachers and examining hospital records. He confirmed previous things that compared with children of stable two-parent families, children whose parents divorced show more aggressive, anti-social and withdrawn behaviour.

Researchers from Aubum University in Alabama and Brown University in Providence, R.I., assessed children's sleep in 54 healthy 8- and 9- year-old children, along with parental conflict from both the child and parental viewpoint. None of the children had any previously diagnosed sleep disorders, and their parents experienced conflict levels in the normal range. The researchers measured parental conflict and assessed the children's sleep through parental and child reports. They also had the children wear an Actigraph, a watch-like device that

records movement, for seven nights while in bed. Data from the Actigraph helped researchers determine when children went to sleep and woke up, how often they woke up during the night and how well they slept.

Researchers found that even though children in higher conflict homes went to sleep about the same time as children in lower conflict homes, they slept less and don't sleep as well. In families where parents had more conflict, children slept less, spent less time in bed actually sleeping, and more around – fidgeted or tossed and turned more. Children in higher conflict homes also reported they were sleepier during the day. The associations between conflict and sleep were especially strong when the researchers looked at child-reports of parental conflict (rather than parental reports) and the Actigraph measures of sleep. Those children who perceived their parents' conflict as frequent, intense and unresolved had more disrupted sleep.

Elshekh, (2006) concluded that the data obtained from the research suggest that even in families with normal levels of conflict, parental arguments and anger can disrupt children's sleep. This is significant because even mild loss of sleep can disrupt attention, alter information processing, weaken motivation, increase irritability and demise emotion control. In a related study Elliot & Richards (1991) in a study of British Youngsters found that 7-year olds whose parents eventually divorced had more educational problems than did 7-year olds those parents did not divorce.

Ryan (1994) in a study of 51 adults with learning disability showed that people with learning disability developed post traumatic stress disorder at a rate comparable to the stable population when exposed to trauma. He concluded that each of the adults studied had experienced at least two types of trauma and the most frequently experienced were sexually

abused, physically abused and few cases of non-abuse such as sibling dying in a fire, seeing a close friend die in a seizure or an accident. He reported that almost all had violent and disruptive behaviour.

Bremner, Randall, Scot, Bronen, Seibyl, Southwick, Delanay Mcarthy et al, (1995) in their research have shown that Post-traumatic stress disorder (PTSD) clearly alters a number of fundamental brain mechanisms. Abnormal levels of brain chemicals that affect coping behaviour, learning and memory have been detected among people with the disorder.

The recent revision for post-traumatic stress disorder (PTSD) according to American Psychiatric Association (1980, 1987) is the first formal diagnostic attempt to spell out the nature of those events, which are likely to produce stress disorders. These events include the threat of injury or loss of life to one self or loved ones, destruction of one's community, hearing about the kidnap or torture of loved ones and witnessing mutilation or violent death. According to Smith, North and Spitznagel, (1993) rates of Post-traumatic stress disorder (PTSD) identified in child and adult survivors of violence and disasters vary widely. For example, estimates range from 2% after a natural disaster (tornado), 28% after an episode of terrorism (mass shooting), and 29% after a plane crash.

Culross, (1991) is also of the opinion that post-traumatic stress disorder can take time to manifest and its effect can differ from person to person. Researches findings in PTSD vary, but indicate that 50 – 59% of people experience it in some form after an incident. He also stated that the first reaction to traumatic event is usually intense anger, combined with an over-riding fear for some victims that having survived the danger once the likelihood was that one may be confronted with it again. Gradually after a period of time euphoria and optimism set in during which the individual's psychological defense begins to crumble leaving the

individual with post-traumatic stress disorder such as grief, poor concentration and other overwhelming feelings which bring about psychological disorder and low academic achievement on concerned students. Secondly, a post-traumatic self disorder (PTSFD) may develop response to the failure of the environment to empathically respond to the stressed individual.

2.2.7 Relationship between anxiety and students' academic performance

Academic performance, the type of environment a student passes through in a course of his/her education will either facilitate or inhibit his/her ability at acquiring knowledge. Very many writers have expresses different views on academic performance of students. Some have tried to associate academic performance with various factors within the home, the school, the learner himself or herself and is environment.

In children, high levels of cortisol can disrupt all differentiation, cell migration and critical aspects of central nervous system integration and functioning anxiety affects basic regulatory processes in the brain stem, the limbic brain (emotion, memory, regulation of arousal and affect), the neovortex (perception of self and the world) as well as integrative functioning across various systems is the central nervous system. Anxiety disorder are stored in the child's body/mind, and fear, arousal and dissociation associated with the original worries trauma may continue after the treat of danger and arousal, which affects the academic performance of the child drastically (Nwankwo, 2005).

Note that exposure of the individual to the feared social situation almost invariably provokes anxiety, which may take form of panic, crying, tantrums, freezing or shrinking, from social anxiety disorder is a combination of two things, genetic and environment which may likely be traumatic experience in the home environment. Learning disability is another

problem to behaviour among school children. Bender, (2004) sees learning disabilities as "a general term for a diverse group of disorders characterized by significant difficulties in the acquisition and use of listening, speaking, reading, writing, reasoning, or computing. These disorders stem from the individual and may occur across the lifespan. It also includes problems in self-regulatory behaviours, social perception, and social interaction may exist with learning disabilities".

Students, who experience excessive worries, uneasiness may have problem with their studying habit. Anxiety disorders are among the most common in childhood and adolescent. According to one study of 9-10 to 17-years-olds, as many as 13 of every 100 young people have an anxiety disorder U.S. Department of Health and Human Services, (1999). Anxiety disorders include:

- Panic disorder, which causes terrifying "panic attacks" that include physical symptoms, each as a rapid heartbeat and dizziness.
- Obsessive-compulsive disorder, which causes children to become "trapped" in pattern of repeated thoughts and behaviours, such as counting or hand washing.
- Phobias, which are unrealistic and overwhelming fears of objects or situations.
- Excessive trembling and sweating.
- Chest pain and headaches.

Base on the above discussion, anxiety disorder may have a relationship on the students' academic performance. Individual experiencing emotional crisis due to communal problems, family dispute, loneliness, fear and trouble of relationship may benefit from this study.

2.2.8 Relationship between aggression and students' academic performance

Trauma is defined as a physical, psychological treat, assault to a child's physical integrity, sense of self, survival or to the physical safety of another person significant to the child (Vermont cups Handbook, p. 170). Students may experience trauma as a result of number of different circumstance, such as;

Abuse, including sexual, physical, emotional.

Exposure to domestic violence.

Severe natural disaster, such as a flood, fire,

Earthquake or tornado

War or other military actions

Abandonment

Witness to violence in the neighborhood or fights, drive by shootings and law enforcement actions

Personal attack by another person or an individual kidnapping,

Severe bulling

Medical procedure, surgery, accident or serious illness.

Psychological trauma may occur during a single traumatic event (Acute) or as a result of repeated (chronic) exposure to overwhelming stress Terr (1992), in (Moroz 2005). Children exposed to chronic trauma generally have significantly worse outcomes than those exposed to acute accidental traumas. In addition, the failure of caregivers to sufficiently protect a child may be experienced as betrayal and further contribute to the adversity of the experience and effects of trauma.

Moroz (2005), stated that traumatic stress may be transmitted by parents to their children. Parents who suffer from untreated post-traumatic stress disorder often have difficulty establishing a secure attachment with their children; they may viscerally transmit their own feelings of anxiety, rage and hopelessness, and in so doing colour the child's internal model of self and the world.

When caregivers are threatening, hurtful or frightening, the intentional individual to individual quality of the traumas causes more severe negative consequences for the child than trauma from accidental causes (for example, a flood, fire engender feelings of victimization loss of control, despair and hopelessness and beliefs that the world is unsafe and life unfair (Moroz 2005).

2.2.9 Relationship between depression and students' academic performance

(a) A person has been exposed to a traumatic event.

(b) The traumatic event is persistently re-experienced in one (or more) of the following ways:

Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Recurrent distressing dreams of the event.

Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated) Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event. Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

Efforts to avoid thoughts, feelings, or conversations associated with the trauma. Efforts to avoid activities, places, or people that arouse recollections of the trauma. inability to recall an important aspect of the trauma. Markedly diminished interest or participation in significant activities. Feeling of detachment or estrangement from others.

Restricted range of affect (e.g., unable to have loving feelings).

Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span).

Persistent symptoms of increased arousal (not present before the trauma), a indicated by two (or more) of the following:

Difficulty falling or staying asleep.

Irritability or outbursts of anger.

Difficulty concentrating.

Hypervigilance.

Exaggerated startle response.

Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. Davidson at al (1997).

Van der kolk, et al (1996), described following long-term effects of trauma Generalized hyperarousal and difficulty in modulating arousal.

Aggression against self and others

Inability to modulate sexual impulses

Problems with social attachments-excessive dependence or isolation. Alterations in neurobiological processes involved in stimulus discrimination

Problems with attention and concentration

Dissociation

Somatization

Conditioned fear responses to trauma-related stimuli

Loss of trust, hope and sense of personal agency

Social avoidance and loss of meaningful attachments

Lacks of participation in preparing for the future.

Cole and Putnam (1992), proposed that people's core concepts of themselves are defined to a substantial degree by their capacity to regulates their internal states and by their behavioural responses to external stress.

In children traumatized by abuse, a lack of development, or loss, of self-definition, including:

Disturbances of the sense of self, such as a sense of separateness, loss of autobiographical memories, and disturbances of body image.

Poorly modulated affect and impulses control, including

Insecurity against self and others, and suspiciousness lack of intimacy, aggression and isolation.

The loss of self-regulation is possibly the most far-reaching effect of psychological trauma in both children and adult. Mandel (1999), in Moroz (2005). They asserted that the

younger the age at which people were to have long-term problems with the regulation of anger, anxiety and sexual impulses.

Moroz (2005), reported that children and youth who experience overwhelming psychological stress, particularly those with the greatest number of vulnerabilities and the fewest number of protective factors, are most at risk for alternations in brain neurophysiology, imprinting of trauma-based response pattern (i.e, dissociation, numbing, freezing, hyper, vigilance, hyperarousal); and compromised integration of brain functioning that adversely affects learning, character development, self-esteem and immune system functioning.

While all children have strengths and vulnerabilities, protective factors in a child's tile are undermined by child abuse or neglect Moroz (2005), she buttressed that there is evidence that trauma significantly reduces 10, which may be one of the single most protective factors in a child's life. In addition, childhood trauma is a significant risk factor for a number of major public health problems, including depression, substance abuse, sexually transmitted disease, and increased health. Depression is three times more likely in adults who were abused as children than in the general public, (Moroz 2005).

Emerging evidence has implicated traumatic events in major public health problems such as violence and criminality, substance abuse, academic and vocational dysfunction, and mental and physical illness (Saizingur et al 2005).

2.10 Psychotherapy of Post-traumatic stress disorder

Psychotherapy is "talk" therapy. It involves talking with a mental health professional to treat a mental illness. Psychotherapy can occur one-on-one or in a group. Talk therapy treatment for Post-traumatic stress disorder (PTSD) usually lasts 6 to 12 weeks, but can take

more time. Research shows that support from family and friends can be an important part of therapy (Dennis, Butler and Steven, 1999).

Psychoeducational group treatment programs often contain some components of psychotherapy and/or cognitive-behavioral interventions, but the central focus of the psychoeducational groups is to educate batterers about their violence and to help them understand how it damages interpersonal relationships (Stordeur & Stille, 1989). Psychotherapy The goal of psychodynamic therapy is to change behaviors by expanding the client's capacity for feelings and how he/she responds to these feelings (Lanza, 2002). The psychodynamic view of anger considers the client's anger as part of an aggressive drive.

The emotional expression of anger leads to catharsis, which ultimately reduces the anger (Kahn, 1995). A client's expression of anger may be indicative of a deeper conflict within the unconscious. Therefore, via the direct approach of the therapist and the various techniques of psychodynamic therapy, this underlying conflict can be conjured up to the conscious awareness of the client, allowing her/him to deal with the root of the anger. Lanza (2002) compared psychodynamic treatment with cognitive-behavioral therapy and reported that both groups had improvements in decreasing overtly aggressive behaviors and had significant decreases in trait aggression and the ability to control aggression. There were no differences in state aggression or efforts to control aggression. However, Davidson and Smith (2011) found that the closer emotional engagement and corrective emotional experience of the psychodynamic approach provided the participants an opportunity for characterological change beyond that experienced using the cognitive-behavioral component alone, on which, until these studies, the predominant focus had been. Given that psychodynamic treatment has fared equal to cognitive-behavioral therapy, further testing of the psychodynamic approach to

dealing with anger is needed. Some limitations of the psychodynamic approach suggested so far have been its costs and length of treatment and the lack of quality research to study its effectiveness. In addition, Harris, Putnam, and Fair Bank (2004) noted that stressing an open exchange of feelings among men in a group may cause unease among them the subjects in the study were not comfortable discussing childhood trauma feelings, which increased the attrition rate for the group.

Many types of psychotherapy can help people with Post-traumatic stress disorder (PTSD). Some types target the symptoms of Post-traumatic stress disorder (PTSD) directly. Other therapies focus on social, family, or job-related problems. The doctor or therapist may combine different therapies depending on each person's needs. Congnitive Behaviour Therapy (CBT) seeks to change the way to trauma victom feels and acts by changing the patterns of thinking and/ or behaviour responsible for negative emotions. CBT have been proven to be an effective treatment for Post-traumatic stress disorder (PTSD), and is currently considered the standard of care for Post-traumatic stress disorder (PTSD) by the United States Department of Defense in CBT, individuals learn to identify thoughts that make them feel afraid or upset, and replace them with less distressing thoughts. The goal is to understand how certain thoughts about cause Post-traumatic stress disorder (PTSD) related to aggression, anxiety and depression.

Recent research on contextually based third – generation behaviour therapies suggests that they may produce results comparable to some of the better validated therapies. Many of these therapy methods have a significant element of exposure and have demonstrated success in treating the primary problems of Post-traumatic stress disorder (PTSD) and co-occurring depressive symptoms.

Exposure therapy is a type of cognitive behavioural therapy that involves assisting trauma survivors to re – experience distressing trauma – related memories and reminders in order to facilitate habituation and successful emotional processing of the trauma memory. Most exposure therapy programs include both imaginal confrontation with the traumatic memories and real life exposure to trauma reminders; this therapy modality is well supported by clinical evidence. Indeed, the success of exposure – based therapies has raised the question of whether exposure is a necessary strategy in the treatment of Post-traumatic stress disorder (PTSD). Some organizations have endorsed the need for exposure. The US Department of Veterans Affairs has been actively training mental health treatment staff in prolonged exposure therapy and cognitive processing therapy is an effort to better treat US veterans with Post-traumatic stress disorder (PTSD)

One helpful therapy is called cognitive behavioral therapy, or CBT. There are several parts to CBT, including:

- **Exposure therapy.** This therapy helps people face and control their fear. It exposes them to the trauma they experienced in a safe way. It uses mental imagery, writing, or visits to the place where the event happened. The therapist uses these tools to help people with Post-traumatic stress disorder (PTSD) cope with their feelings.

- **Cognitive restructuring.** This therapy helps people make sense of the bad memories. Sometimes people remember the event differently than how it happened. They may feel guilt or shame about what is not their fault. The therapist helps people with Post-traumatic stress disorder (PTSD) look at what happened in a realistic way.

- **Stress inoculation training.** This therapy tries to reduce Post-traumatic stress disorder (PTSD) symptoms by teaching a person how to reduce anxiety. Like cognitive restructuring, this treatment helps people look at their memories in a healthy way.

2.11 Assessment and Diagnosis of Aggression, Anxiety and Depression

Delgado and Schillerstrom (2009), note that a diagnostic assessment of aggression, anxiety and depression may be conducted by a suitably trained general practitioner, or by a psychiatrist or psychologist or professional guidance – counselor, who records the person's current circumstances, biographical history, current symptoms and family history.

Clinical Diagnosis: The broad clinical aim is to formulate the relevant biological, psychological and social factors that may be impacting on the individual's mood. The assessor may also discuss the person's current ways of regulating their mood be it healthy or otherwise, such as alcohol or drug use. The assessment under clinical diagnosis also includes a mental state examination which involve an assessment of the person's current mood and though content, such as the presence of themes of hopelessness or pessimism, self – harm or (suicidal though), or an absence of positive thought plans. Before diagnosing a major aggression, anxiety and depressive disorder, in clinical term, the doctor generally performs a medical examination and selected investigations to rule out other causes of symptoms. Some of these diagnostic procedures include blood test measuring thyroxine to exclude hypothyroidism; and basic electrolytes: as well as serum calcium to rule out a metabolic disturbance, and a full blood count including other indication of adverse affective reaction to environment testosterone levels may also be evaluated to diagnose hypogonadism, which is a cause of depression in men (Yohannes & Baldwin, 2008).

Psychological Diagnosis

To diagnose aggression, anxiety and depression, psychologists often make use of rating scale. Rating scale provides an indication of the severity of symptoms for a time period, a person's scores above a given cut – off point can be used more thoroughly for evaluating a depressive disorder diagnosis. Several rating scales are used for this purpose. Rating scale help in the screening programs which have been advocated to improve detection aggression, anxiety and depression. Bagby, Ryder and Schuller (2004), write on the use of checklists, such as multiple choice questionnaire that clinicians/ psychologists may use to rate the severity of patient's/ clients major depression, for example use of Beck rating scale for aggression, anxiety and depression, this questionnaire rates the severity of symptoms observed in anxiety, aggression and depression such as low mood, insomnia, agitation anxiety and weight loss.

Beck (2006), notes that rating scale is also useful to psychologist in the assessment/diagnosis of aggression, anxiety and depression. Demand media inc (2011), notes that use of psychological evaluator checklist which are meant to measure specific behaviour or symptoms that may indicate a disorder such as attention deficit in adolescents or school age children. Checklists are questionnaire used by teachers' parents or psychologists to determine if a child or youth need further evaluation for psychological disorder.

General Assessment: Conditions that contribute to aggression, anxiety and depression disorder involve observation of clients behaviour change. This is needed in order to identify and alter dysfunctional cognitions. Some of this method include finding out is the person exhibit any of the following characteristics, overeating, oversleeping, fatigue, extreme sensitivity to rejection, moods that worsen or improve in direct response to events or

delusional thoughts, or other symptoms of psychosis accompany the symptoms of aggression, anxiety and depression.

2.12 Treatment of Aggression, Anxiety and Depression

In order to know how to treat aggression, anxiety and depression in anyone or patient/ client, professionals in the field of psychotherapy or psychologists, guidance counselors, must understand the root causes of it for the particular individual aggression, anxiety and depression symptoms vary greatly from person to person as well as do the cause as a result treatment protocols vary depending on the fundamental or psychological need. Professional treatment of depression need to be based on a sound understanding of all the issue involved in the often times complicated topic of depression. Learning to understand treatment procedure includes learning about its signs, symptoms, causes and level of the stage of individual client.

Psychological Treatment

There are a wide range of psychological treatment for aggression, anxiety and depression, according to Waman (2008), some of the main ones are:

- Cognitive Behaviour Therapy (CBT)
- Interpersonal Therapy (IPT)
- Mindfulness – Based Cognitive Therapy
- Positive Psychology
- Psychotherapies
- Counseling
- Narrative Therapy

Psychological treatments provide either an alternative to medication or work alongside medication. As always, a thorough assessment of the person is needed in order to decide on the best of approaches.

Cognitive Behaviour Therapy (CBT)

Helpguide.org (2010), notes that peoples suffering from aggression, anxiety and depression particularly 'non – melancholic depression' will often have an ongoing negative view about themselves and the world around them. This negative way of thinking is often not confined to aggression, anxiety and depression, but is an ongoing part of how the person thinks about life. Many or all of their experiences are distorted though a negative filter and their thinking patterns become so entrenched that they don't even notice the errors of judgement caused by thinking irrationally. Cognitive behaviour therapy aims to show people how their thinking affects their mood and to teach them to think in a less negative way about life and themselves. It is based on the understanding that thinking negatively is a habit, and like any other bad habit, it can be broken.

CBT is conducted by trained therapists either in one on one therapy sessions or in small groups. People are trained to look logically at the evidence for their negative thoughts, and to adjust the way they view the world around them. The therapist will provide 'homework' for between sessions. Between 6 – 10 sessions can be required but the number will vary from person to person. CBT can be very beneficial for some individuals who have depression but there will be others for whom it is irrelevant.

Interpersonal Therapy (IPT)

Helpguide.org (2010), notes the causes of depression, or our vulnerabilities to developing depression, can often be traced to aspects of social functioning (work, relationships, social rules) and personality.

Therefore, the underlying assumption with interpersonal therapy is that aggression, anxiety, depression and interpersonal problems are interrelated. The goal of interpersonal therapy is to help the person understand how these factors are operating in the person's current life situation to lead them to become depressed and put them at risk to future depression.

The therapy occurs in three main phases:

- An evaluation of the patient's history
- An exploration of the patient's interpersonal problem area and a contract for treatment.
- Recognition and consolidation by the patient of what has been learnt and developing ways of identifying and countering aggressive, anxiety and depressive symptoms in the future. Usually 12 – 16 sessions of IPT will be required.

Mindfulness – Based Cognitive Therapy

Mindfulness – based cognitive therapy is a relatively new form of treatment for depression. According to Helpguide.org (2010) this approach was developed by Segal, Willaims and Teasdale (adapted from the work of Jon Kabat – Zin) in order to prevent relapse for those who had previously experienced an episode of depression.

Mindfulness is a form of self – awareness training that has been taken from mindfulness meditation. Mindfulness is about being aware of what is happening in the present

on a moment by moment basis, while not making judgements about whether we like or like what we find.

Generally, mindfulness – based cognitive Therapy is undertaken in an 8 one – on – one therapy sessions depending on their training and experience.

Other mindfulness – based approaches have also been developed that may be used for depression (e.g. MiCBT) and therapies such as Dialectical Behaviour Therapy and Acceptance and Commitment Therapy also use components of mindfulness in their approach.

Positive Psychology

Positive Psychology is a new and quickly growing area of psychology that is interested in the conditions that contribute to the flourishing or optimal functioning of people, according to Helpguide.org (2010). Positive psychology is founded on the belief that people want more than an end to suffering. People want to lead meaningful and fulfilling lives, to cultivate what is best within themselves, to enhance their experiences of love, work, and play. We have the opportunity to create a science and a profession that not only heals psychological damage but also builds strengths to enable people to achieve the best things in life'. Professor Martin Seligman.

Positive Psychology researchers have identified many everyday activities that improve wellbeing. These include; keeping a gratitude diary, performing small acts of kindness, learning to favour enjoyable moments and varying pleasant experiences to avoid routine.

Psychotherapies

Psychotherapy is an extended treatment (month to years) in which a relationship is built up between the therapist and the patient. The relationship is then used to explore aspects of the person's past in great depth and to show how these have led to the current depression.

Understanding this link between past and present – insight – is thought to solve the depression and make the person less vulnerable to becoming depressed again (Helpguide.org 2010).

Counseling

Counseling encompasses a broad set of approaches and goals that are essentially aimed at helping an individual with problem solving – solving long standing in the family or at work; or solving sudden major problems (crisis counselling). Depressed persons are counsel to reflect upon and challenge their thinking patterns, so as to improve their mood, fear and anger. Behavioural intervention counseling such as interpersonal therapy are effective at preventing new onset depression, because such interventions appear to be most effective when delivered to individuals or small groups (Beck, 2006).

Narrative Therapy

Narrative Therapy is a form of counselling based on understanding the 'stories' that people use to describe their lives (Helpguide.org, 2010). The therapist listens to how people describe their problems as stories and helps the person to consider how the stories may restrict them form overcoming their present difficulties. It sees problems as being separate from people and assists the individual to recognize the range of skills, beliefs and abilities that they already have (but may not recognize) and that they can apply to the problems in their lives.

Narrative Therapy differs from many therapies in that it puts a major emphasis on identifying people's strengths, particularly as they have mastered situations in the past and therefore seeks to build on their resilience rather than focus on their negatives.

2.3 Theoretical Framework

2.3.1 Beck's Cognitive Theory of Depression

Underlying Dysfunctional Beliefs

Beck's in his theory of depression, believed that the cognitive symptoms of depression actually precede the affective and mood symptoms of depression, rather than vice versa. According to him, the issue central to depression are the negative thoughts, instead of hormonal changes or low rates of reinforcement as postulated by other theorists. It is a cognitive theory that strongly deal with the cognitive perceptions of the brain. He argued that negative automatic thoughts, generated by dysfunctional beliefs, were the cause of depressive symptoms.

Beck's main argument was that depression was instituted by one's view of oneself, instead of one having a negative view of oneself due to depression. This has large social implications on how we perceive each other and thereby relate our dissatisfactions with one another. Abela and D'Alessandro's (2002), study on college admissions is a good example of this phenomenon. Their study revealed that the student's negative views about their future strongly controlled the interaction between dysfunctional attitudes and the increase in depressed mood. The research clearly backed up Beck's claim that those at risk for depression due to dysfunctional attitudes who did not get into their college of choice then doubted their futures, and these thoughts lead to symptoms of depression.

Therefore, the students' self-perceptions became negative after failing to get into college, showed signs of depression due to their thinking, although other aspects of their study did not agree properly with Beck's views in his theory. Therefore, one possible explanation of

discrepancies between these studies is that immediately following the occurrence of a negative event, cognitively vulnerable individuals show marked increases in depressed mood Allen (2003). In essence, vulnerable individuals may exhibit depressed mood which may be accompanied by a host of other depressive symptoms. Their level of depressed mood, however, was simply not more severe than individuals who did not possess dysfunctional attitudes" (D'Allesandro, 2002).

Another study, carried out based on Beck's Theory of cognitive depression, by Sato and McCann's (2000), where Beck's sociotropy authonomy scale was used. The scale was originally meant to identify self feelings that would lead to depression, mainly solitude and interpersonal insensitivity, independence, and individualistic achievement. However, the results of the study showed that the independence did not correlate with depression, and the sociotropy, not autonomy was a precursor of depression. As they described, sociotropy can be characterized by an individual's emphasis on interpersonal interactions involving intimacy, sharing, empathy, understanding, approval, affection, protection, guidance, and help tend to place importance on seeking approval from others and on trying to avoid disapproval from others as much as possible Sato, & McCann (2000). Therefore, it was found that a strong correlation with sociotropy and depression exists, which is a trait that is strong when relating to underlying thoughts and emotions.

Moilanen's (1995), study, a strong support for Beck's theory was found. The study revealed that student's depression was often associated with dysfunctional beliefs and negative future attitudes. She suggests that the cognitive theory has reasonable validity for describing the symptoms of depression for no referred adolescents, and that the subject's depression is closely correlated with his or her ability to deal with dysfunctional attitudes and

beliefs, as well as doubt towards the future. However, the results of this study were not entirely consistent with Beck's theory, particularly the proposition that a predominantly negative self-schema underlies the information processing of depressed individuals. We see how perhaps, at least in adolescents, the idea of the negative self-schema is not a clear as Beck wishes it to be.

Molianen (1993), earlier study showed that stronger results in support of Beck's cognitive theory of depression. The study revealed that the student's current depressive states were consistently found to be related to their negative processing of personal information. The students' cognitive thoughts were shown to be affecting them, and as a result they developed symptoms of depression. As a result of impressive outcome of then study, as it tends to suggest that Beck's theory should be used in further research in the college student population and how depressed students are treated. As therapists, we should make strong effort to closely look at a student's cognitive thoughts as a way of assisting the student to recover.

Furthermore, Beck's Cognitive model of depression shows how early experiences can lead to the formation of dysfunctional beliefs, which in turn lead to negative self views, depression. One interesting study on this aspect is Reed's (1994), study on reducing depression in adolescents. Many studies have ascertained that depression is more common in women in western society. Reed's study amazingly shows a large number of female whose cognitive thinking prevented them from recovering from depression, while the males adjusted much better. He comments that this emanates from the difference between early experiences of males and females.

Gonca and Savasir (2001), opined that based on Beck's theory it shows that individuals prone to depression, posses negative self believes and views about themselves,

thereby sing themselves as worthless, unlovable, deficient, filled with obstacles and failure, negative future, believe that no effort can change the situation or circumstances they found themselves, hence, all these converge together to give rise to depression.

2.3.2 Rogers theory of Self worth

The central concept in Rogers' theory is the self, an organized, consistent set of perceptions of and beliefs about oneself. Once formed, plays a powerful role in guiding our behaviours is not a reaction to unconscious conflicts, but a response to our immediate conscious experience of self and environment.

Rogers believed that, without undue pressure from other, individuals naturally move toward personal growth, self-acceptance and self-actualization, which is the fulfillment of their potential for love, creativity and meaning.

Rogers began his inquiring about human nature with people who were troubled. Rogers examined the conditioned, controlling world that kept them from having positive self-concept and reaching their full potential as human being. Under the stress of pressure from society and family, however, people can develop rigid and distorted perspectives of self and can lose touch with their own values and needs. This can lead to behaviour disorder and even loss of touch with reality.

Rogers theorized on the need for positive regard. He believed that we are born with an innate need for positive regard – that is, for acceptance, sympathy, and love from others. Rogers viewed positive regard as essential for healthy development. Ideally, positive regard received from parents is unconditional – that is independent of how the child behaves. Unconditional positive regard communicates that the child is inherently worthy of love. Rogers stressed that we can help a persons develop a more positive self-concept through

unconditional positive regard, empathy and geniuses. He said that we need to be accepted by others, regardless of what we do.

Furthermore, unconditional positive regard is Rogers' term for accepting, valuing, and being positive toward another person regardless of the person's behaviour. Rogers recognized that when a person's behaviour is below acceptable standards, inappropriate, or even obnoxious, the persons still needs the respect, comfort, and love of others. Rogers strongly believed that unconditional positive regards elevate the person's self-worth (Smith, et al, 2001).

2.3.3 Bandura social learning theory

Albert Bandura believes that behaviour is caused by an interaction between inner processes and environmental influence. He posits that the internal processes that influence are based principally on previous experiences of the individual and can be manipulated and also measured as covert events he places a central emphasis on the role of the cognitive determinants of behaviour.

Bandura believe in human cognitive ability to determine action and to perform "both insightful and Bandura stresses that social learning experience play a crucial role in the development and modification of the individual's behaviour imitation of other people's behaviour tends to influence and at times enrich an individual's personality. He relates the question of personality development to cultural or social expectation. In societies were rewards and for certain activities individual may specially develop themselves to achieve those ideals. Bandura relies on experimental methods to assess personality. His primary interest is in conversations between manipulatable, antecedent event and consequent response variable. He orients seriously towards correlational statistics. Man is a social learning

variables can help us to treat learning disabilities that have roots in social development, disorders like excessive academic anxieties, nightmares, insomnia, alcoholism, phobia among others have roots, and learning how to treat or at least cope with them will improve behaviour and learning.

2.3.4 Sigmund Freud psychoanalytic theory of anxiety

Dr. Sigmund Freud developed Psycho-analysis in the early 1890's. psycho-analysis means the analysis of the mind, but it is used to describe the specific method of analyzing the mind as developed by Freud. Prior to this development, Dr. Freud was a neurologist who 1eved that psycho-analysis is much more than a method of treating mental disorder.

Although Freud gives merit of his work to Viennese physician Dr Josef Bremer who made use of psycho-analysis procedure in the treatment of his patient, a girl suffering from hysteria for over two years. The twenty-one-year-old girl as a result of the hysteria developed a series of physical and psychological disturbances such as loss of sensation and power of vision, disturbed severe nervous cough and rigid paralysis. For several weeks the patient was unable to drink in spite of a tormenting thirst, her power of speech was reduced, unable to speak or understand her native language. Finally, the girl was subject to condition of absence of confusion, of delirium, these symptoms posed concern to and sundry.

From the study of psycho-analysis the doctor found that her case was not of organic brain disease but symptoms of residues of emotional experiences which he later called psychical trauma. After much study, Freud came to the conclusion that the patient's symptoms were the result of emotional (psychological) disturbances. Since the patient was not consciously aware of what was troubling her, Freud postulated the existence of the

unconscious mind. Freud learned from his work on that past emotional traumas had befallen his patient.

Thus, according to his psycho-analysis theory, he postulated that painful memories and feelings associated with these traumas had been expressed into the unconscious mind and were making their effects known in the patient's physical symptoms. Freud initially used hypnosis to attempt to help the patient recall these traumas. While confirming some of his theories about the current effects of past traumas, hypnosis did not yield lasting results. Consequently, Dr. Freud began developing the "talking cure" that is, attempting to help his patients, while in a conscious state, to remember and deal with their emotional trauma.

Freud's theoretical analysis affords us the opportunity to understand the influence which the unconscious mind can exercise over the conscious mind and the account of hysteria, a state of extreme excitement, fear or anger which forces the individual concerned to lose control of self.

Sigmund Freud worked primarily with adult, but paid considerable attention to the recall of childhood experiences and gave emphasis to the important of development history in the child. His theory stressed the vital role of early patterns of behaviour. It maintains that unless the basic drive (instincts) are gratified during early interaction, the child will leave infancy with some degree of fixation (defensive attachment to an earlier state of psychosexual development that inhibits the learning of new behaviours and acquisition of new relationship) and will be somewhat impaired in his ability to adapt and adjust to life situations. When gratification during succeeding stages of development is insufficient, the child will fall back on earlier patters of behaviour. These concepts of fixation and regression are related to a sequence of personality development.

The experiences that occur in each period are believed to affect the character traits manifested throughout life. The psychoanalytic has three is based on a personality structure made up of three parts – the id, ego and superego. Fraud posited that id consists primarily of unconscious aggressive instincts. The aggressive instinct was associated with death instincts or khanates. The Ego, comes in between the internal needs, manifested by the id, and external demand represents the reality principle as it limits the pleasure principle of the id. The forces of the id, however, lure and individual to destroy society and the go part of personality needs to moderate and control the id imputes.

2.3.5 John Dollard and Neal E. Miller Theories

Dollard and Miller are ardent disciples of conditioning. They have advanced a succinct summary of the basic pillars of learning that are related to learning these include:

- Dives which constitute force or motivation to learn.
- Cues that elicit appropriate responses.
- The responses which must be made before it can be rewarded.
- Reinforcement or reward which follows a correct response.

The above fundamentals of learning are related to conditioning. Teachers can employ them in their teaching, and reward the correct responses to repeat themselves. The necessary cues must be provided to elicit the desirable response whether in the classroom or other setting. It has been devoted to the stimulus response (S-R) school of psychology. Theories of learning here embrace the gestalt, psychology, the molar emphasis and the insight or perceptual process of learning. The theories were formulated as a reaction against the stimulus response theories which were considered to have reduced behaviour to stimulus and response. Gestalt psychologist, the atomistic, fragmented and molecular view of behaviour as posited by

the stimulus response theories loses touch with the fact that man's capacity to perceive the total situation and figure out the solution to his problems cannot be approach, therefore destroys the forces that bind learning experiences into meaningful wholes. The whole learning situation including the environment needs to be perceived as a whole unit or pattern, rather than a series of district parts. Gestalt argues that learning does not necessarily depend on the connection between stimulus and response. He belief on "Patter", 'form', 'configuration' or 'shape'. A person perceive object as unified whole not as a cluster of individual sensation. Reorganization and restructuring of the psychological environment is more important for a total understanding of the problem than the reductionist and atomistic tendencies of behaviorism (Denga, 1983). A total pattern of stimuli should be viewed while considering the significance of a learning situation.

Behaviour in school is a concept in which student's behaviour conforms to the demands of their capacity to fulfill the school requirement. The psychoanalytic theory by Sigmund Freud 1938 is used in this study. Freud viewed man as a pleasure seeking animals by nature. Man wants to seek pleasure and avoid pain. The social restriction imposed by the society and his own moral standards dictated by his super ego come in conflict with the undesignated desires of his basic pleasure seeking nature. An individual drift towards malfunctioning of behaviour and maladjustment in case, such satisfaction is threatened or denied (Brophy et al, 1975).

Freud postulated the imaginary concepts of "id", "ego" and "superego" for the adjustive and non-adjustive behaviour patterns and formulated that a person's behaviour remains normal or in harmony with his self and his environment to the extent that his ego is able to maintain a balance between the evil desire of his id and the moral ethical standard

dictated by his superego. In the case where ego is not enough to exercise proper causal over one's id and superego, malfunction of behaviour would result. The ego saves as a mediator between the id and reality, is largely concerned with personal safety. Two different situations could arise. If the superego dominates then there is no acceptable outlet expression of the repressed wishes, impulses; without care for moral norms and adjusted within the harmful experience. Students within the violent areas who dominate by ego may tend to use defense mechanism in their behaviour process.

Student in violence areas are faced with different challenges including school behaviour. The environment plays a role in influencing the individual experiences. However, students who aspire for self actualization will be able to acquire the knowledge to do what is appropriate in a given situation and that will enhance their adjustment to school easily than those who dwell on their past experience and do not aspire for self actualization as inappropriate resulting behaviour problem in school.

2.4 Review of Empirical Studies

This section reviewed empirical findings reported by different researchers which are relevant to the topic.

The empirical studies of Post Traumatic Stress Disorder (PTSD) believe that when one experience traumatic event it may result to health condition and behaviour problem.

This has been reported by Slade and Wissow (2000), the effect of post traumatic stress disorder on behaviour and symptoms in relationship between traumatic event and re-experience of the memories causing an emotional problem to the individual. The study noted that these children, who had serious problems of social adjustment, were disruptive at home

as, well as in school and fail to make friends. (Taylor, et al 1986).

Brooks (2008), reported that students who are victim of traumatic stress show a wide range of reactions. Some suffer worries, and bad memories of the experience others bare more affected and experiencing long term difficulties, some of these difficulties may include emotional depression, outburst of anger, irritability or continuous episode call "flashback" which include fearful feelings of experiencing the trauma again. Such students often tend to be emotionally withdrawn from friends, family and teachers such negative behaviour affects the students' academic performance.

Terr (1992), proposed that development of the capacity to regulate affect may be undermined or disputed by trauma, and students exposed to acute trauma may show symptoms of anger, aggression, anxiety, depression and disassociation Terr (1992), in Moroz (2005). Children exposed to chronic trauma generally gave significant worse outcomes than those exposed to acute accidental traumas. In addition to increase risk for post traumatic stress disorder, many children who experience severe trauma, also experience symptoms of attention deficit hyperactivity disorder (ADHD), which mark extreme inattention, fear, irritability and foreshortened sense of future.

Children exposed to early trauma due to abuse or neglect lag behind in school readiness and academic performance, they have diminished cognitive abilities wear and tear on immune system and decreased occupational attainment Harris et al (2004), in Moroz, (2005).

Above all, the educational psychologist plays a major role in all behaviour problems of the students, he is to see that a positive behaviour for the students is effected, and those who are traumatized are guided properly.

2.5 Summary

This chapter reviewed the related literatures for the study. Concept of post traumatic stress. The concept of academic performance and some school behaviour problems of junior

secondary school in Rivers State such as; anxiety, aggression and depression are documented in this chapter.

Some authors were considered under conceptual frame work view as in post traumatic stress disorder (PTSD). Post traumatic stress disorder varies in various ways depending on the individual perception, gender, cognitive or personality trait and how they see the situation on ground, level of post traumatic stress disorder and influence on gender. The characteristics of aggression, anxiety and depression among students, the relationship between post traumatic stress and behaviour problems. Effect of post traumatic stress on students as reported by McNally et al (2003), that those who are proactive can often overcome stressor and are likely to be able to cope well with unexpected situations, while those who are more reactive will often experience more noticeable effects from an unexpected stressor. In the case of those who are often enact no intentional coping action, especially among school age children. These groups of individual usually lack necessary ability to cope and they may have problem coping with academic life. Kessler et al (2005), characterizes the symptoms of post traumatic stress disorder, symptom like irritability, difficulty concentrating, sleep disturbance and causing significant stress and functional impairment in important areas of functioning.

The theory suggested for post traumatic stress in that of Albert Bandura social learning theory and Beck's theory of depression. The psychoanalytic theory be Sigmund

Freud and John Dollard and Neal E. Miller theory. Another empirical study to cite is the study of students under the influence of post traumatic stress disorder on anxiety, aggression and depression, the relationship between post traumatic stress disorder on male and female experiences and their academic performance, the environment where they dwell is also to be considered.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter discussed the research method used in this study. These include research design, population, sampling technique, instrument for data collection, validity and reliability of instrument, pilot study, and procedure for data collection, procedure or data analysis technique.

3.2 Research Design

This is a correlation survey design. This is because the design can provide all the safeguard prerequisite for confirming or rejecting hypothesis. Correlation design refers to studies in which the purpose is to discover relationship between variables through the use of correlation statistics (Belue, 2005). Therefore, since this research seeks to find out the relationship between trauma and some psycho-social behaviours and academic achievement, it is an appropriate design to use.

3.3 Population of the Study

The population of the study consisted of 2,200 junior secondary school students' male and female in five public secondary schools, one from each of the five local government area of Rivers State selected for the study. According to Rivers State Local Government Education Board (2013), the population of students in those areas are as follows;

Table 3.1 Distribution of Population by Local Government Area and Schools

S/N	*LOCAL GOVERNMENT AREA IN RIVERS STATE*	*NAMES OF SCHOOLS*	*TOTAL NUMBER OF STUDENT IN JSS III*
1.	Obio/Akpor LGA	Comprehensive Secondary School Oginigba	500
2	Emohua LGA	Community Secondary School, Rumuekpe	400
3	Ikwerre LGA	Comprehensive Secondary School Isiokpo	300
4	Ahoada LGA	County Grammar School Ahoada	500
5	Khana LGA	Community Secondary School, Yege	500
Total		5	2,200

Source: Local Government Education Board Rivers State (2013)

3.4 Sample and Sampling Technique

Three hundred and twenty-seven (327) respondents, made up of all JSS III students were randomly sampled from the population of the study which comprised of two thousand two hundred (2,200) students that was drawn from the affected local government areas. The population of JSS III students was sampled using simple random sampling techniques to select three hundred and twenty-seven (327) respondents as suggested by Krejiece & Morgan (1970), who recommended a sample size of at least three hundred and twenty-seven (327) for a population for two thousand and two hundred.

The selection of the school was purposively done, based on areas where violence erupts frequently. Five schools (5) were selected. They are; Comprehensive Secondary School Oginigba, Community Secondary School, Rumuekpe, Comprehensive Secondary

School Isiokpo, County Grammar School Ahoada and County Grammar School Ahoada. Three hundred and twenty-seven (327) students were selected after the administration of the questionnaire, students who indicate that they still reflect the feelings of the traumatic events they experienced at some point in time were selected for the study. They were selected because after they experienced trauma, the feelings of the trauma still lingered on them and possibly soon pre-occupy and influenced their behaviours. Those students who experienced any type of trauma but had forgotten it, and were no more pre-occupied with the aggressive, anxiety, depressive feelings of the event from their responses in the questionnaires were not selected for the study. Only students who earned high scores of 45 and above were used in the study (Gillihan et al, 2012).

The academic performance of junior secondary school students was obtained from National Examination Council (NECO). The mean ($\bar{x}$) scores in English language, mathematics and social studies will be used to determine their academic performance.

Table 3.2 Distribution of sampled JSS III respondents by Gender

	Name of School	*Boys*	*Girls*	*Total*
1	Comprehensive Secondary School Oginigba	38	32	70
2	Community Secondary School, Rumuekpe	40	30	70
3	Comprehensive Secondary School Isiokpo	35	25	60
4	County Grammar School Ahoada	47	13	67
5	Community Secondary School, Yege	40	20	60
	Total	207	120	327

The table above showed that from the total of 327 subjects there are 207 boys and 120 girls in the study.

3.5 Instruments for Data Collection

Four (4) instruments used are: aggression scale; anxiety scale, depression scale and academic performance test scale was adopted and used for this study. Questions on post stress disorder scale and aggression; anxiety, depression are scales on a four-point Likert scale rating. Strongly Agree (SA) = 4, Agree (A) = 3, Disagree (D) = 2, and Strongly Disagreed (SD) = 1.

The intruments are divided into six sections, section 1, 2, 3, 4, and 5.

A. Personal data of the respondents: It contains the sex of the student and the school

B. **Anxiety scale:** Clinical Anxiety Scale, was adopted from Snaith, Baugh, Clayden, Husain and Sipplo (2014) and it contains 12 items

C. **Aggression scale:** the scale was adopted from Ladd and profiled Snaith, Baugh, Clayden, Husain and Sipplo (2014), it contains 17

items

D. **Depression scale**: The scale was adopted from BECKS inventory Snaith, Baugh, Clayden, Husain and Sipplo (2014).

E. **Academic performance Test:** includes the cumulative grade point average (CGPA) of each student on the three subjects, mathematics, English and social studies.

The Post Traumatic Stress Disorder instrument consists of Anxiety Scale (AS) 12 items, Depression Scale (DS) 20 items and Aggression Scale (E) 17 items.

3.6 Validity of the Instrument

Contents and face validity of the instruments; aggression, anxiety, depression, and academic performance test were determined. Content and face validity of the instrument was done by lecturers in the department of Educational, Psychology and Counselling in Ahmadu Bello University, Zaria, who have made their contribution, after their contribution, the researcher went for pilot study.

The pilot study was carried out in Community Secondary School, Agban-Ndele, Rivers State. Fifty (50) questionnaires were distributed to the respondents for the pilot study. Cronbach alpha coefficient statistical method was used to test the internal consistency of the instrument.

According to Kerlinger (1977), the use of pilot study was the best way to validate an instrument before collecting data. Also, test-retest statistical method was carried out to determine the reliability of the instrument.

3.7 Reliability of the Instrument

Pilot study was carried out using traumatized students who report aggression, anxiety, depression. The reliability of the 30 item trauma event questionnaire (TEQ) for identifying

traumatized students was determined using Conbach's alpha using test-re-test method for post traumatic events. The instruments were administered to a group of 50 students in junior secondary school in the five local government areas in Rivers State. The reliability coefficient scores on the table below:

Table 3.7.1 Reliability Test Result

s/n	*Variables*	*Cronbach's Alpha*	*Test-Retest*
1	Aggression	.967	.987
2	Anxiety	.860	.870
3	Depression	.906	.888
4	Post Traumatic Stress Disorder (PTSD)	.760	.766

3.8 Procedure for Data Collection

The researcher collected the introductory letter from the department of educational psychology and counseling, Ahmadu Bello University, Zaria. The Introductory letter served a researcher's permit for conducting the study. The researcher presented the letter of introduction to the principal of schools; Comprehensive Secondary School Oginigba, Government Secondary School Emohua, Bierabi Memorial Grammar School Bori, Community Secondary School Isiokpo, and County Grammar School Ahoada. The principal introduced the researcher who administered the instruments through face to face procedure to the respondents. The administration and retrieval of the instrument was done with the help of the class teacher. Completed instruments were subjected to further statistical analysis and presented in chapter four (4).

3.9 Procedure for Data Analysis

The data collected was analyzed using Statistical Package for Social Sciences (SPSS 17.0 version) computer software, to obtain mean (X) and Standard deviation (SD) for research questions while, Pearson Product-Moment correlation coefficient (r) was used to address the hypothesis. The number of students who had experienced a particular traumatic event were expressed in percentage. The package also provided the significant value (sig. 2- tailed) for each of (r) calculated. while the P value enabled the researcher to reject or retain the formulated.

However, the interpretation of the significant value (sig 2-tailed) for each of (r) calculated given by SPSS was done by comparing the value with alpha level (0.05) at which each of the hypotheses was tested

CHAPTER FOUR

RESULTS AND DISCUSSIONS

4.1 Introduction

This research work is aimed at investigating the influence of Post-Traumatic Stress disorder on academic performance of students in Rivers state. A total of 320 out of the sampled 327 respondents representing 98.3% were used in this analysis. The Statistical package IBM version 20 was used in the analysis of the data. The descriptive statistics involving frequency and percentages were used to present the bio data variables of sex and locations. The second part answers the research questions using item means, standard deviations and frequency and comparing the overall cumulative mean with the standard decision mean in order to determine overall answers to each question. The third part test the four research hypotheses by means of Pearson Product Moment Correlation statistics and t-test. The conclusion and recommendations was also provided in line with the four research questions.

4.2 Presentation of Bio Data Variables

Table 4.1.1: Classification of students by their Local Government Area

Locations	*Frequency*	*Percent*
Obio Akpor	27	8.4
Emohua LGA	108	33.8
Ikwere LGA	27	8.4
Ahoda LGA	59	18.4
Khana LGA	99	30.9
Total	320	100.0

The table above revealed the distribution of respondents according to their locations within the state. Obio Akpor LGA had 27 (8.4%) respondents while, Emohua LGA had

108 (33.8%) as against Ikwere LGA that has 27 (8.4%) respondents while Ahoada LGA had the representation of 9 (18.4%) respondents and the rest 99 or 30.9% of the respondents were from Khana LGA.

Table 4.1.2: Distribution of respondents according to their Sex status

Gender	*Frequency*	*Percent*
Male	156	48.8
Female	164	51.3
Total	320	100.0

The respondents according to their gender status as shown in the above table revealed that 156 representing 48.8% are males while the remaining 164 representing 51.3% are females.

4.3 Answering the Research Questions

A total of four research questions are to be answered in the course of this study. They are presented in the following tables.

Research Question One:

What is the relationship between aggression and academic performance among Junior Secondary School students in Rivers State?

Table 4.2.1: Distribution of responses on aggression and academic performance among Junior Secondary School students in Rivers State

Variables	*N*	*Mean*	*S.D*
Aggression	320	55.2903	5.569
Academic Performance	320	179.267	10.848

From the table (4.21) above, negative relationship may exist between aggression and academic performance among junior secondary school students in Rivers State.

Research Question Two:

What is the relationship between anxiety and academic performance among Junior Secondary School students in Rivers State?

Table 4.2.2: Distribution of responses on anxiety and academic performance among Junior Secondary School Students in Rivers State

Variables	***N***	***Mean***	***S.D***
Anxiety	320	51.9000	5.8713
academic performance	320	179.2677	10.8485

From the table above (4.2.2) the result revealed that negative relationship may exist between anxiety and academic performance among junior secondary school students in Rivers State.

Research Question Three

What is the relationship between Depression and academic performance among Junior Secondary School students in Rivers State?

Table 4.2.3: Distribution of responses depression and academic performance among Junior Secondary School Students in Rivers State

Variables	***N***	***Mean***	***S.D***
Depression	320	58.183	5.698
Academic Performance	320	179.267	10.848

From the table above (4.3.2) the result revealed that a negative relationship may exist between depression and academic performance among Junior Secondary School students in Rivers State.

Research Question Four:

What is the difference between male and female on academic performance among junior secondary school?

Table 4.2.4: Descriptive Statistics showing the difference between male and female on Academic Performance among junior secondary School.

Variable	*Gender*	*N*	*Mean*	*Std. Deviation*
Academic Performance	Male	164	182.4423	10.91329
	Female	156	181.4268	11.75677

The descriptive statistics above showed that the mean academic performance of male and female students of junior secondary schools in Rivers State. Their academic performances were 182.4423 and 181.4268 with an insignificant mean difference of 0.0921. This shows that there may be no significant difference between male and female on academic performance among junior secondary school students of Rivers State.

4.4 Testing of Research Hypotheses

Research Hypothesis One

This null hypothesis stated that there is no significant relationship between Aggression and Academic performance among secondary school students in Rivers State

Table 4.3:1 Pearson Product Moment Correlation (r) statistics on the relationship between Aggression and Academic performance among secondary school students in Rivers State.

Variables	*N*	*Mean*	*S.D*	*r*	*df*	*Sig (p)*
Aggression	320	54.5750	5.67075	-0.767	318	0.000
Academic Performances	320	181.9219	11.34705			

. Correlation is significant at the 0.05 level (2-tailed).

An understanding of the above Pearson Product Moment Correlation statistics revealed that there is significant but negative relationship exist between Aggression and Academic performance among secondary school students in Rivers state.

This is because the calculated significant (p) value of 0.000 is lower than the 0.05 alpha level of significance at a correlation index r level of -0.767 at df of 318. The inverse relationship shows that academic motivation is negatively affected by aggression. Hence, the null hypothesis which state that there is no significant relationship between Aggression and Academic performance among secondary school students in Rivers state, hereby rejected.

Research Hypothesis Two:

This null hypothesis stated that there is no significant relationship between anxiety and Academic performance among secondary school students in Rivers State.

Table 4.3:2 Pearson Product Moment Correlation (r) statistics on the relationship between Anxiety and Academic performance among secondary school students in Rivers State.

Variables	***N***	***Mean***	***S.D***	***r***	***df***	***Sig (p)***
Anxiety	320	51.7781	5.81837	-0.802	318	0.000
Academic Performances	320	181.9219	11.34705			

*****. Correlation is significant at the 0.05 level (2-tailed).***

An understanding of the above Pearson Product Moment Correlation statistics revealed that there is significant inverse relationship between Anxiety and Academic performance among secondary school students in Rivers metropolis.

This is because the calculated significant (p) value of 0.000 is lower than the 0.05 alpha level of significance at a correlation index r level of -0.802 at df of 318. The relationship between the two is inversely proportional. This shows that the Academic motivation is significantly inversely affected by anxiety. Hence, the null hypothesis which state that there is no significant relationship between Anxiety and Academic performance among secondary school students in Rivers metropolis, hereby rejected.

Research Hypothesis Three

This null hypothesis stated that there is no significant relationship between Depression and Academic performance among secondary school students in Rivers State

Table 4.3:3 Pearson Product Moment Correlation (r) statistics on the relationship between Depression and Academic performance among secondary school students in Rivers State.

Variables	***N***	***Mean***	***S.D***	***r***	***df***	***Sig (p)***
Depression	320	58.0531	5.65577	-0.830	318	0.000
Academic Performances	320	181.9219	11.34705			

*****. Correlation is significant at the 0.05 level (2-tailed).***

An understanding of the above Pearson Product Moment Correlation statistics revealed that there is significant inverse relationship between Depression and Academic performance among junior secondary school students in Rivers metropolis.

This is because the calculated significant (p) value of 0.000 is lower than the 0.05 alpha level of significance at a correlation index r level of -0.830 at df of 318. The relationship between the two is inversely proportional. This shows that the Academic motivation is significantly inversely affected by presence of anxiety among students. Hence, the null hypothesis which state that there is no significant relationship between Depression and Academic performance among secondary school students in Rivers State, hereby rejected.

Hypothesis Four

This null hypothesis stated that there is no significant difference between male and female on academic performance among junior secondary school students in Rivers State.

Table 4.3.4: Independent t-test Hypothesis on Male and Female Students on Academic Performance among Junior Secondary Schools Students in Rivers State

Variable	*Gender*	*N*	*Mean*	*SD*	*df*	*t*	*Sig (p)*
Academic Performance	Male	164	182.4423	10.91329	318	0.800	0. .424
	Female	156	181.4268	11.75677			

Calculated t< 1.96, calculated p>0.05

Results of the independent t-test statistic showed that there were no significant differences between male and female students academic performance in Rivers State. This was because the calculated p value of 0.424 is higher than the 0.05 alpha level of significance, while the calculated t value of 0.800 is lower than the 1.96 t critical at df 318. Their mean academic performances are 182.4423 and 181.4268 for male and female students respectively. This showed that the gender status of the students did not reveal any difference in the students' academic performance. Therefore, the null hypothesis which state that there was no significant difference between male and female on academic performance among junior secondary school students in Rivers State, thus the null hypothesis was retained.

4.5 Summary of the Major Findings

The following are the major findings of the study

1 Significant negative relationship existed between aggression and academic performances of junior secondary school students of Rivers State (r = -0.767, P = 0.000). This implies that, the aggression students' face is significantly related and also affected their academic performance.

2 Significant negative relationship existed between anxiety and academic performances of junior secondary school students of Rivers State (r =-0.802, P = 0.000). This implies that, the level of anxiety students' face is significantly related and also affected their academic performance.

3 Significant negative relationship existed between depression and academic performances of junior secondary school students of Rivers State (r = -0.830, P = 0.000). This implies that, the level of depression students face is significantly related and also affect their academic performance.

4 There are no significant differences in the academic performance of male and female students in junior secondary schools in Rivers State (calculated t value of 0.800 is lower than the 1.96 t critical at df 318). Thus there was no significant difference between male and female on academic performance among junior secondary school students in Rivers State, thus the null hypothesis was retained.

4.6 Discussions of Findings

In this section the outcome of the research hypotheses is discussed with their corresponding research questions to determine how they are in agreement or disagreement

with quoted literatures.

The result of hypothesis one showed that there was significant inverse relationship between aggression and academic performance among secondary school students in Rivers State. At a correlation level of -0.767 the calculated significant (p) value of 0.000 is lower than the 0.05 alpha level of significance, which explains why the null hypothesis was rejected. This implies that the higher the aggression behaviour, the lower the academic performance and vice versa. The answer to the research question one showed that students are mostly faced traumatic disorders of nervousness when a gun is shot and they are so afraid and become easily get confused. This is in line with Renfrew (2002) that aggression on self defence behaviour are controlled by the individual brain which is triggered by different situations – violence community, kidnapping, shooting this may lead them to respond to threat easily. These reflects in an individual operation during times of peace, a low and steady heart rate, peristaltic movements of stomach and intestines, secretions by digestive glands, and other aspects. The sympathetic reaction has an activating function, these summons the body's resources in times of crisis and gets the individual ready for vigorous actions Cannon (2001).

The result of hypothesis two showed that there was significant inverse relationship between anxiety and academic performance among secondary school students in Rivers State. At a correlation level of -0. 802. The calculated significant (p) value of 0.000 is lower than the

0.05 alpha level of significance, which explains why the null hypothesis was rejected. This implies that the higher the anxiety behaviour, the lower the academic performance and vice versa. The answer to the research question two revealed the respondents show mostly anxiety signs of safety and fear to talk to people most times may affect their academic performance.

This is in line with Russo (1990) and Hoeksema (1990), opined that as children mature and their negative abilities develop, cognitive factors such as their negative thinking styles appear to be stronger in the development of anxiety characterized by negative attitude towards self even their future. They also tend to exhibit anger or pessimistic attribution style their non-anxiety peers.

The result of hypothesis three showed that there is significant inverse relationship between depression and Academic performance among secondary school students in Rivers State. At a correlation level of -0. 830. The calculated significant (p) value of 0.000 is lower than the 0.05 alpha level of significance, which explains why the null hypothesis was rejected. This implies that the higher the depression behaviour, the lower the academic performance and vice versa. The answer to the research question three revealed that in conclusion the depression traits most faced by the respondents include experiencing mood swing, showing irritation when frustrated and lack of sleep. This is in line with Lamarine (1995) that childhood depression is widely recognized by the physicians and psychiatrists. They consider depression as a serious condition affecting both adolescents and young children. Fritz (1995), observed that depression may be seen in physical ailments such as digestive problem toward sleeps disorders or persistent boredom. Also Lamarine (1995), pointed it out that depression in children may be mistaken for other conditions such as attention deficit disorder, aggressiveness, physical illness, sleep and eating disorders and hyperactivity Allen (2003). Burford (1995), has made it clear that depression in children should not be confused with attention deficit hyperactivity disorder which begins before the age of seven. Wanger (1996), study revealed that sexual orientation adjustment problems are

associated with depression. He reported that the link between homosexuality and adolescence suicide is evident in communities with strong social pressure.

The result of hypothesis four showed that there are no significant differences in the academic performance of male and female students in junior secondary schools in Rivers State. Their mean academic performance is 182.4423 and 181.4268 for male and female r students respectively. This showed that the gender status of the students does not have any relationship with the students' academic performance. This necessitated why the null hypothesis was retained. Hence their mean academic performances are almost the same. Hence one can implied that there is no difference between male and female students and their academic performance. Furthermore, Relationship between gender and academic performance, the result of this hypothesis showed that there is no significant difference between male and female academic performance among junior secondary school students in Rivers State, which explains why the null hypothesis was retained. This suggests that there are significant differences between male and female on academic performances among junior secondary school students of Rivers State. This is in line with Salvin (2004) that reported that children with emotional problem quite frequently, are other disabilities or mental retardation, all this result into diminishing academic performance. Also Brooks (2008) reported that students who are victim of traumatic stress show a wide range of reactions. Some suffer worries, and bad memories of the experience, others bare more affected and experience long term difficulties, some of these difficulties may include emotional depression, irritability, outburst of anger, or feelings of guilt, or continuous episodes called "flashback: which include fearful feelings of experiencing the trauma again, such students often tend to be emotionally withdrawn from friends, family and teachers, such behaviour having negative effect on their

academic performance.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter presents the summary, conclusion and recommendations on the investigation aimed at examining the influence of post-traumatic stress disorder on academic performance of students in Rivers State.

5.2 Summary

This study was structured into five chapters in order to effectively carry out this research. Chapter one presented the background and purpose of the study, the statement of problem and four research questions, including the hypotheses formulated for the study, scope and limitations. In line with the research objectives, four research questions were stated as well as four null hypotheses. The study is significant as it will provide the Rivers State Ministry of Education adequate information on expert views how students post-traumatic stress disorder can influence students' academic motivation and consequently their academic performance, as well as provide quality service delivery to the students for better performance in their general assessment. Chapter two presented the literature review that are related to this study under the concept of post traumatic behaviour, aggression, anxiety and depression behaviour as they can affect the students' academic performance. In chapter three the research methodology used and adopted were discussed. The correlational design was used. The population of this study comprised of all the junior secondary school students from Rivers state who are traumatic. A total of five local government areas were purposively selected and a total of 320 students were used for this study. The sampling technique adopted was the

random sampling technique using the Krejcie and Morgan table for selecting sample from a known population. The reliability test was also carried out in this chapter to determine the reliability of the instrument used for gathering the data. In chapter four, the analysis, presentation and discussion of the results was carried out. The SPSS version 20 statistical package was used to carry out the entire data analysis. It was discovered that significant negative relationship exists between aggression, anxiety and depression. No significant difference between male and female in academic performance. Chapter five presents the study's summary of the five chapters, conclusion and recommendations.

5.3 Conclusion

The study investigates the relationship of post-traumatic stress disorder on academic performance of students of Rivers State. Therefore, from the findings the following conclusions were made.

The study confirmed that: negative relationship exists between aggression and academic performances of junior secondary school students of Rivers State. This implies that, the aggression students' face, negatively affect their academic performance.

Negative relationship exists between Anxiety and academic performances of junior secondary school students of Rivers State. This implies that, the anxiety students' face, negatively affect their academic performance.

Negative relationship exists between depression and academic performances of junior secondary school students of Rivers State. This implies that, the depression students face, negatively affect their academic performance.

There is no significant differences in the academic performance of male and female students in junior secondary schools in Rivers State. Implying that male and female

students do not differ in their academic performances.

5.4 Recommendations

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

1. Schools should employ psychologists who should provide psychological interventions that could help take care of symptoms of post traumatic stress disorder such as depression, anxiety and aggression so as to pave way for healthy living and improved academic performance.
2. Students who experiences post-traumatic stress disorders should be given cognitive behaviour therapy to enable them to know how their thinking affects their mood and to teach them to think in a less negative way about life and themselves.
3. Conducive atmosphere should be provided by government to improve security in schools and enhance teaching and learning, this will go along way in reducing post traumatic stress disorder such as depression, anxiety and aggression.
4. Male and female student that experience post-traumatic stress disorder should be given orientation periodically by experts/psychologists for re-educating and re-assurance in life.

5.5 Suggestions for further studies

The study is by no means exhaustible, further studies are therefore suggested in the following areas:

1. Relationship between traumatic behaviour, parental upbringing and academic performance of adolescents in secondary schools in Rivers State.
2. Effect of Socio-cultural background and traumatic behaviours on the academic performance of students in South – South States of Nigeria.

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APPENDICES

EDUCATIONAL PSYCHOLOGY SECTION DEPARTMENT OF EDUCATIONAL PSYCHOLOGY AND GUIDANCE COUNSELING, AHMADU BELLO UNIVERSITY, ZARIA

Date _____

QUESTIONNAIRE ON RELATIONSHIP OF POST TRAUMATIC STRESS DISORDER ON ACADEMIC PERFORMANCE AMONG JUNIOR SECONDARY SCHOOL STUDENTS IN RIVERS STATE

QUESTIONNAIRE

THE QUESTIONNAIRE BEING DESIGNED ON RELATIONSHIP OF POST TRAUMATIC STRESS DISORDER ON ACADEMIC PERFORMANCE AMONG JUNIOR SECONDARY SCHOOL STUDENTS IN RIVERS STATE

Dear Respondent,

The purpose of this questionnaire is to investigate the relationship of post-traumatic stress disorder on academic performance among junior secondary school students in Rivers State Whatever information given will be treated as confidential and will be used for research purpose only.

Sign_____

EDEBOR FLORENCE

Ph.D./EDUC/0664/2009-2010

SECTION A: BIODATA

Instruction:

Please tick (√) the responses that best described your opinions (your name need not to appear in any part of the questionnaire)

1. L.G.A:

   Obio/Akpor LGA ☐

   Emohua LGA ☐

   Ikwerre LGA ☐

   Ahoada LGA ☐

   Khana LGA ☐

2. Gender:

   Male ☐

   Female ☐

   School ☐

S/No	My experience on traumatic events have kept me in this condition:	SA	A	SD	D
1	I have trouble in concentrating				
2	I am always nervous when I here a gun short				
3	I fear the absence of my parents				
4	I don't feel safe at all time				
5	I am afraid of going to school alone				
6	I feel I am a total failure as a student				
7	I cry easily				
8	I like fighting other students				
9	I feel insecure within the school				
10	I am full of anger				
11	I am so afraid that I become easily confuse				
12	I feel my future is hopeless				
13	I look at people around me with fear				
14	It is hard to get interest in anything				
15	I am scared of sleeping alone because of the nightmares that come with it				
16	I am always aggressive				
17	I feel terrorized when it is dark				
18	I feel so lonely without a friend				
19	I feel my response to others now should be aggression				

20	I am scared of sleeping because of the nightmares that come with it				
21	I feel as if no one likes me				
22	It is not easy for me to get the basic needs				
23	Where possible I try to avoid sound as it makes me want to scream aloud				
24	I am always nervous now				
25	I cannot help worrying				
26	I am sad all the time				
27	It is hard to get interested in anything				
28	I am not giving good food and so not fed well at home				
29	I don't feel safe anywhere				
30	I like shouting at other students				

Source: The Scale of items of civilian version

Adopted from Snaith, Baugh, Clayden, Husain and Sipplo (2014)

ANXIETY SCALE

S/No	**This is my recent situation**	**SA**	**A**	**D**	**SD**
1	I fear the absence of my parents				
2	I don't feel safe at all time				
3	I am afraid of going to school alone				
4	I look at people around me with fear				
5	I always have restless feelings when I see people around me.				
6	I am afraid to talk to people				
7	I stay always from anything that reminds me of past event				
8	I had bad dreams about my past experience				
9	I am sad all the time				
10	I feel terrorized when it is dark				
11	I have trouble falling asleep because of the picture of the past events				
12	I loss interest in every pleasurable things				

Source: The clinical Anxiety Scale (2014)

Adopted from Snaith, Baugh, Clayden, Husain and Sipplo (2014)

DEPRESSION SCALE

S/No	**I have been boarded by the following problems for so long.**	**SA**	**A**	**D**	**SD**
1	I feel, I am a total failure as a student				
2	I feel my future is hopeless				
3	I am so sad and unhappy that I cannot understand it				
4	I feel that life has no meaning				
5	I feel I am a complete failure as a person				
6	I can't concentrate on things such as reading newspapers or watching television				
7	I have been moving around a lot more than usual				
8	I hate myself				
9	I cannot get along with other people				
10	I cannot think of no good reason for ever hunting a person				
11	I threaten people I know				
12	I have become mad that I have broken things				
13	When frustrated I let my irritation show.				
14	I am always in mode swing				
15	I can't take care of things at home				
16	I cannot make decisions at all anymore				
17	I wake up several hours earlier than I used to and cannot get back to sleep				
18	I blame myself for everything bad that happens				
19	I have no appetite at all anymore				
20	I have lost all of my interest in other people				

Source: Beck's Depression Inventory (BDI)

Adopted from Snaith, Baugh, Clayden, Husain and Sipplo (2014)

AGGRESSION SCALE

S/No	**This is my recent reactions.**	**SA**	**A**	**D**	**SD**
1	I hit someone back as soon as he or she hits me				
2	I cannot control the urge to strike on other person				
3	I get into fight more than the average person				
4	I always resort to violent to protect my right				
5	I have enough provocation, that makes me go into querying				
6	I like fighting junior students, to check their misbehaviour.				
7	I like being forceful in getting my way through in life.				
8	I do retaliate when others hurt me				
9	I feel it is good to break things when I am angry				
10	For me, fighting is good if it will help teach a stupid person a lesson				
11	I am always looking out for stubborn people to punish				
12	I like encouraging students to fight during inter-house sports				
13	I react to blows as people push me				
14	I like breaking things around me when am agree				
15	I don't like keeping quiet when people annoy me				
16	I always disrupts other students activities in the class				
17	I always argue with other students in the class				

Source: Aggression Scale
Adopted from Ladd, G.W., & Profilet, S.M. (1996).

SECTION C: ACADEMIC PERFORMANCE SCALE

A. MATHEMATICS TEST

INSTRUCTION: Answer all questions in this section

1) Which of the following is Pythagorean theory?

(a) (10, 24,26)(b) (12, 29, 31) (c) (14, 49, 50) (d) (18, 30, 34)

2) Simplify 1 ½ + ¾

(a) 2 ½ (b) 1 ¼ (c) 3 ¼ (d) ¼ (e) 2 ½

3) The volume of a cone of height, hand base radius, r is given by

(a) 1/3 Πh (b) 1/3 $\Pi^2 h$ (c) Πrh(d) $\Pi r^2 h$ (e) $2\Pi rh$

4) What is the value of $2^2 + 3^3 + 1^8$

a) 12 b) 15 c) 14 d) 16 e) 17

5) A cone 8cm high and has a base diameter wof 12cm. its slant height is

a) 6cm b) 8cm c) 10cm d)12cm e) 020cm

6) Write down the value of 3.142×10^2

(a) 30142 (b) 314.2 (c) 3.1420 (d) 3142.0 (e) 300142

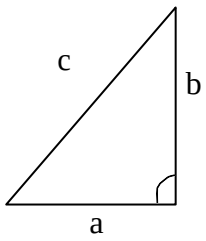
7) The bearing of p from Q is 063. The bearing of Q from P is (a) 027^0 (b) 063^0

(c) 117^0 (d) 153^0 (e) 243^0

8) Simplify $\frac{1}{3} + \frac{1}{4} - \frac{1}{12}$

(a) $\frac{3}{12}$ (b) $\frac{7}{12}$ (c) $\frac{7}{3}$ (d) $\frac{3}{4}$ (e) $\frac{1}{2}$

9) Which one of the following equations gives the value of a^2?



(a) $A^2 = b^2 - c^2$ (b) $a^2 = (b-c)^2$ (c) $a^2 = b^2$ (d) $a^2 = c^2 - b^2$ (e) $a^2 = (c-b)^2$

10) A right angle is equal to_____

(a) 100^0 (b) 180^0 (c) 90^0 (d) 60^0 (e) 80^0

source: *Junior School Certificate Examination Result, 2010*

D. ENGLISH LANGUAGE TEST

Instruction: Fill in each blank with the correct word from the list below, (match, filter discovered, paralyzed, complicated, astonished).

1. The news that he had won the first price of one million naira in the national lottery was the most_____news that Ake had heard in a long time.
2. Many people boil and_____water before drinking it.
3. The sight of the gun man_____the old woman and she was easily robbed.
4. The teacher had to explain the story to the children because they found it very_____

5) The small, gentle boy often went home in tears for he was no_____for the big bully at school.

6) The boy's mother_____that he had been stealing when she found some bags of sweets hidden in his suitcase.

Write Yes or No

7) These words: might, sum, simmer are the /m/ consonants.

8) Night, sinner, sun are /n/ consonants sound.

9) Sand, rice, garri are countable noun.

10) Water and milk are uncountable noun

E. SOCIAL STUDIES TEST

Instruction: Answer all questions in this section

1) Socialization is the training of the child in the _____

(a) In the culture of the society

(b) In the culture of the family

(c) In the culture of the village

(d) In the culture of the home

2) A child learns how to do things like the following except_____

(a)) Socialization (b) Understanding (c) Examination

(d) Culture

3) Agents of socialization includes the following except_____

(a)) School (b) Playmates (c) Religious (d) Training

4) Socialization of the child starts within_____

(a) Family (b) Mass media (c) Citizens (d) Brother

5) Human right includes the following except_____

(a)) Right to state some of the human right

(b) Right to human dignity

(c)) Right to private and family life

(d) Right to personal liberty and lawful detention

6) _____and_____are the rules of the nation

(a) Obeying the national anthem and obeying the national pledge

(b) Obeying the authority and obeying punctuality

(c) Obeying the self-control and obeying the love of nation

7) Social instability is a state of_____and _____

(a)) Restlessness and confusion

(b) Break down the law and crime

(c)) Co-operation and happiness

8) _____is an offence against the law of the land

(a)) Crime (b) Selfishness (c) Inefficiency (d) Favoritism

9) _____are those things that makes life easy and enjoying

(a) Amalgamation (b) Social amenities

(c) The study of physical environment (d) The study of children

10) Nigeria was made a republic in the year_____

(a) 1960 (b) 1967 (c) 1963 (d) 1969

APPENDIX II

QUESTIONNAIRE

Dear respondent,

This is an academic survey, kindly respond as honestly as possible. All information provided you will be treated with utmost confidentiality.

Your should not write your name – just tick (√) the appropriate options you feel corresponds to the statements.

SECTION A BIO DATA

- Name of School …….
- Local Government Area: …….
- Class: ……..
- Gender /Sex: Male [ ] Female [ ]

APPENDIX III

Department of Educational Psychology and Counselling,

Faculty of Education

Ahmadu Bello University, Zaria

Nigeria

Our Ref De/S.25

_____

_____

_____

Dear Sir,

STUDENT FIELD RESEARCH

The department of Educational Psychology and Counselling Ahmadu Bello University, Zaria required each student working for degree to complete a research thesis/project. Our students entering the final year of their studies will be collecting data during the year.

Most of them will need to be allowed access to certain relevant documents and some valuable information which you have. Please give assistance as much as possible.

_____

_____

_____

Thank you for your cooperation

Yours Sincerely
Research
Advisor

APPENDIX IV

RIVERS STATE UNIVERSAL BASIC EDUCATION BOARD

EMOHUA LOCAL GOVERNMENT EDUCATION AUTHORITY

Our Ref ……. Your Ref……. Date 21/7/2014

The Principals'

Emohua, Local Government Education Authority.

RE – FLORENCE EDEBOR

The above bearer is a student of Ahmadu Bello University presently carrying out research in schools. Please do not hesitate to give her all the necessary assistance she may require

Thanks

HOD (SS)