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EFFICACY OF COGNITIVE BEHAVIOURAL THERAPY IN REDUCING DEPRESSION AMONG IDPs IN THE NORTH EAST AND NORTH CENTRAL, NIGERIA

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ABSTRACT

This study found out the efficacy of cognitive behavioural therapy in reducing depression among IDPs in the North east and North central, Nigeria. The study was a quasi-experimental study which adopted pretest/post-test control group design. The population consisted of male and female IDPs with mild and moderate symptoms of depression in Borno and Benue States. The sample size for the study was made up of 60 IDPs. Out of this, 30 were drawn from Agan, Benue State (15 in the treatment group and 15 in the control group) and 30 from Mongonu, Borno State (15 in the treatment group and 15 in the control group). It was hypothesized that there was no significant difference in the pretest and posttest scores of symptoms of depression among the IDPs in Benue and Borno States after the application of cognitive behavioural therapy, and that there was no significant effect of age, gender and marital status on the efficacy of cognitive behavioural therapy in reducing symptoms of depression among IDPs in Benue and Borno States. Independent t-test and ANOVA were used as statistical analysis. Results showed that significant differences existed in the pre-test and post-test mean scores of depression symptoms among the IDPs in the treatment groups in both States. There was no significant effect of age, gender and marital status on the efficacy of cognitive behavioural therapy in reducing symptoms of depression among IDPs in both Benue and Borno States. It was recommended among others that adequate provisions should be made by Benue and Borno State governments and of course the Federal government for urgent and regular application of cognitive behavioural therapy by experienced psychologists in all the IDP camps in order to treat the IDPs with symptoms of depression and that Benue and Borno State governments and all relevant stakeholders should be mindful of possible occurrence of cognitive depression among the IDPs irrespective of their ages, and use cognitive behavioural therapy directed at all age groups to treat them of depression symptoms if they manifest.

INTRODUCTION

Nigeria, like other parts of the world, is confronted with security threats including political upheavals, armed conflicts, trans-national organized crime and terrorism. Many of these threats have had adverse implications on the security and well-being of the people of Nigeria. Such threats have engendered huge humanitarian crisis such as death, hunger, poverty and mass displacement of people from their homes. The forced migration of people from their homes has often resulted in the problem of Internally Displaced Persons (IDPs).

The primary responsibility of protecting and ensuring the survival, livelihood and dignity of Internally Displaced Persons (IDPs) rests with the Federal Government of Nigeria. To achieve this, the government established the National Commission for Refugees, Migrants and Internally Displaced Persons (NCFRMI) to manage IDPs in Nigeria. The management of IDPs in the country has however increasingly become one of the most daunting challenges in recent times (Akume, 2015).

In Nigeria, armed attacks perpetrated by Boko Haram Terrorists (BHT) in the North East (NE) states of Adamawa, Bauchi, Borno, Gombe, Taraba and Yobe have led to over 2,863,436 IDPs as at November, 2021 (Alhassan, 2021). The IDPs spreading across the NE and North Central (NC) zones of Nigeria as well as the Federal Capital Territory (FCT) account for about 88.16 per cent of IDPs in the country. These IDPs suffer emotional problems associated with memory of fearful events, loss of livelihood, frustration, assault and human rights abuse, amongst others which are among the

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causative factors of depression. The activities of Boko Haram Terrorists, unknown gun men and armed bandits have also festered social vices such as crime, assassination and sexual abuse against the IDPs, particularly the children, which represent 62.81 per cent of the IDP population. These problems have subjected the IDPs to depressive state culminating in High blood pressure, paralysis and death in some cases.

Depression, as a mood disorder is characterized by sadness, despair, feelings of worthlessness and low self-esteem. It often leads the depressed individual to be physically, mentally and socially inactive. It is the most common psychological disorder that places people in an emotional trap from which it is increasingly difficult to escape (Ashfield, 2010). As one of the most common mental health problems, an episode of major depression may last from 6 to 12 months or longer. Half the people who recover from an untreated episode of depression will slip back into their former state of depression within two years of their former episode.

Given the prevalence of IDP camps in North central and North eastern parts of the country with a large population of IDPs in such camps, and given the fact that they are still possibly experiencing some stressors causing depression, it is very important that a remedy is provided. How this could be achieved through cognitive behavioural therapy is the thrust of this research.

PROBLEM STATEMENT

Internally Displaced Persons camps were supposed to be alternative temporary homes for the victims where adequate succor is provided. Though home is home, but the IDPs camps were supposed to be managed in such a manner that the victims could heave a sigh of relief. Unfortunately, the management of IDPs camps today are far from ideal. In most of the existing camps, both in the North East and North Central, ugly reports abound about the management of the existing IDPs camps which accommodate victims of series of deadly attacks that have claimed several lives and property and leaving the people homeless. This is a strong causative factor of depression as, in the first place, no amount of provision made in the camps could be like the ancestral home of the victims and secondly, this is worsened by the poor management of the camps. There are repeated reports of sexual harassment, inadequate food, water, public services, healthcare as well as education (Hassan, 2017; Agundor, 2018).

In recent times, the IDPs suffer neglect, with limited government support for their basic needs such as food and clothing thus placing extra burden and stress on the host communities. Consequently, the IDPs are exposed to threats such as disease, hunger, crime, abuse, social conflict and political repression. Having lost their ancestral homes, loved ones and property, the poorly-managed IDPs' camps worsen the physical, psychological and emotional frame of mind of the IDPs to the extent that they become depressed. Once depressed, the IDPs feel worthless, hopeless and guilty. They develop poor self-concept and suicidal thoughts as their cognitions lose complete touch with reality.

Worse still, people who are depressed are disinterested, disenchanted, lack energy and motivation. They are irritated and may not see the point of doing anything worthwhile as depression takes over the whole person's emotions, bodily functions, behaviours and thoughts. They become less physically, mentally and socially active which tends to worsen depression (Ashfield, 2010; Raven, 2013). This is dangerous to a democratic and developing society like Nigeria and Benue State in particular. If the IDPs in Benue State are allowed in their present depressed state of mind, they could become a menace to themselves, their host communities and the State. This calls for an urgent need for a study of this nature to remedy the situation especially as the insecurity situation persists and the IDPs remain in the camps.

RESEARCH HYPOTHESES

The following null hypotheses were generated and tested at 0.05 level of significance:

Ho1: There is no significant difference in the pretest and posttest scores of symptoms of depression among IDPs in Benue and Borno States after the application of cognitive behavioural therapy.

Ho2: There is no significant effect of age on the efficacy of cognitive behavioural therapy in reducing symptoms of depression among IDPs in Benue and Borno States.

Ho3: There is no significant effect of gender on the efficacy of cognitive behavioural therapy in reducing symptoms of depression among IDPs in Benue and Borno States.

Ho4: There is no significant effect of marital status on the efficacy of cognitive behavioural therapy in reducing symptoms of depression among IDPs in Benue and Borno States.

LITERATURE REVIEW

Depression, according to Oltmanns and Emery (2016), can refer either to a mood or to a clinical syndrome or a combination of emotional, cognitive and behavioural symptoms. The feelings associated with a depressed mood often include disappointment and despair. Baron (2018) defined depression as "a mood disorder involving intense sadness, lack of energy, and feelings of worthlessness and despair". To recognize the onset of depression, some of the warning signs according to Baron are feeling down, sad, and blue every day of the week, ongoing lack of interest in all pleasurable activities including ones previously enjoyed, significant weight loss when a person is not dieting, fatigue and loss of energy every day, insomnia or sleeping too much, persistent inability to think or concentrate, or consistent feelings of indecisiveness.

In his explanation, Terry (2010) noted that the causes and risk factors of depression in older adults and the elderly include:

i) Health problems – Illness and disability; chronic or severe pain; cognitive decline; damage to body image due to surgery or disease.

ii) Loneliness and isolation – Living alone; a dwindling social circle due to deaths or

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relocation; decreased mobility due to illness or loss of driving privileges.

iii) Reduced sense of purpose – Feelings of purposelessness or loss of identity due to retirement or physical limitations on activities.

iv) Fears – Fear of death or dying; anxiety over financial problems or health issues.

v) Recent bereavements – The death of friends, family members, and pets; the loss of a spouse or partner.

SYMPTOMS OF DEPRESSION

In analyzing different case studies of episodes of depression, Oltmanns and Emery, (2016) explain that many of the most important symptoms and signs of depression can be divided into four general areas namely; emotional symptoms, cognitive symptoms, somatic symptoms, behavioral symptoms. Episodes of major depression and mania typically involve in all four kinds of symptoms.

Emotional symptoms of depression, according to Oltmanns and Emery, (op.cit.) include such negative emotions as sadness, anxiety, fear and anger. These reactions may last only a few moments at a time. Emotional symptoms also called dysphoric (unpleasant) mood is the most common and obvious symptom of depression. Most people who are depressed described themselves as feeling utterly gloomy, dejected or despondent. Cognitive symptoms of depression involve changes in the thinking of the depressed. Such symptoms, according to psychologist (e.g. Piaget, 1990; Oltmanns and Emery, 2016; DSM-IV-TR, 2000; Owojaye, 2015) include inability to concentrate, pay sustained attention, difficulty in making simple decision, easy distraction, feeling of hopelessness, worthlessness and guilt (self-blame), feelings of low self-esteem, delusions and hallucinations, suicidal thoughts, inability to think and remember constructively (memory impairment) or cognitive slowness. Somatic symptoms or physical symptoms of depression are related to basic physiological or bodily functions. They include fatigue, aches and pains, and serious changes in appetite and sleep patterns.

Oltmanns and Emery (2016) note that most obvious behavioural symptoms of depression is slowed movement. Depressed people may talk and walk as if they are in slow motion. Others become completely immobile and may stop speaking altogether.

TYPES OF DEPRESSION

There are two basic types of depression: bipolar and unipolar. People with bipolar depression experience emotional extreme at both ends of the mood continuum, going through periods of both depression and mania (excitement and elation). The mood swings in bipolar depression can be patterned in many ways. People with unipolar depression experience emotional extremes at just one end of the mood continuum as they are troubled only by periodic bouts of depression.

The Diagnostic and Statistical Manual of Mental Disorders-IV (2000) approach to classifying mood disorders recognizes several subtypes of depression, placing special emphasis on the distinction between unipolar and bipolar depression. Under unipolar, there are two types of depression namely; Major depression and Dysthymia. Under bipolar, there are bipolar I (manic depression), bipolar II (hypomanic depression). Major depressive disorder, according to Kassin (2017) is a disorder where people show persistent feelings of sadness and despair and loss in interest in major sources of pleasure.

Symptoms listed in Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. Text Revision (DSM-IV-TR) for major depressive episode includes:

i) Depressed mood most of the day, nearly every day, as indicated either by subjective report (for example, feels sad or empty) or observation made by others (for example, appear tearful). In children and adolescent, it can be irritable mood.

ii) Markedly diminished interest or pleasure in all or almost all activities of the day, nearly all day.

iii) Significant weight loss when not dieting or weight gain (for example a change of more than 5 percent of body weight in a month), or decrease or increase in appetite nearly every day.

iv) Insomnia or hypersomnia nearly every day.

v) Psychomotor agitation or retardation nearly every day (observable by others).

vi) Fatigue or loss of energy nearly every day.

vii) Feelings of worthlessness or excessive or inappropriate guilt nearly every day (not merely self-reproach or guilt about being sick).

The DSM-IV-TR criteria for bipolar include:

i. Inflated self-esteem and grandiosity

ii. Decreased need for sleep- for example, feels rested after only 3 hours of sleep.

iii. More talkative than usual, or pressure to keep talking.

iv. Fight of ideas or subjective experience that thoughts are racing.

v. Distractibility-that is attention too easily drawn unimportant or irrelevant external stimuli.

vi. Increase in goal directed activity either socially, or at work or school, or sexually or psychomotor agitation.

vii. Excessive engagement in pleasurable activities that have a high potential for painful consequences- for example, the person engages in unrestrained buying sprees, sexual indiscretion, or foolish investments.

Causative Factors of Depression

According to Ashfield, (2010), many factors contribute to depression. These include:

i. Family history of depression

ii. Hormonial changes (in women and men)

iii. Emotional stress (e.g. bereavement, job loss, relationship breakdown).

iv. Medicines (e,g. some cancer and heart medicines).

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v. Personality i.e. the type of person one is and how one responds to life events.
vi. Social support- whether one has sufficient supportive people around one. People isolated on farms or station properties may lack important social support.
vii. Life changes-major life changes such as birth of a baby may increase the risk of developing depression.
viii. Medical conditions such as thyroid and other hormone problems, or battling with a chronic or terminal illness.

Social causes of depression in women, (as with men too) along with lifestyle choices, relationship, and coping skills, according to Baron (2018) include:

i. Marital or relationship problems
ii. Family responsibilities such as caring for children, spouse or ageing parents.
iii. Experiencing discrimination at work or not reaching important goals, losing or changing a job, retirement, or embarking on military service.
iv. Persistent money problems.
v. Death of love one or other stressful life event that leaves the person feeling useless, helpless, alone, or profoundly sad.

THEORETICAL FRAMEWORK

In order to treat and prevent depression, there is the emergence of various theories of depression. However, the most relevant to this research is Beck's Cognitive Theory:

Beck's Cognitive Theory of Depression

In analyzing the intricacies of depression, Beck, (2004) believes that a psychological mechanism that plays a key role in depression is negative views about oneself. According to Becks, individuals suffering from depression often possess negative self-schemas- negative conceptions of their own traits, abilities, and behaviours. They have in habitual thinking errors that underlie their disorder. Depressed people tend to (1) blame their setbacks on personal inadequacies without considering circumstantial explanations, (2) focus selectively on negative events while ignoring positive events, (3) make unduly pessimistic projections about the future and (4) draw negative conclusions about their worth as a person based on insignificant.

Beck notes that the depressed-prone individuals tend to be highly sensitive to criticism from others and are often very concerned about disapproval from them. Because they are more likely to notice and remember negative information, their feelings of worthlessness strengthen, and when they are exposed to various stressors (e.g. the breakup of a romantic relationship, a failure at work), their thinking becomes distorted in important events in a negative light-for instance, they interpret a complement from a friend as insincere, or someone's being late for an appointment as a sign off rejection.

This theory is the basis on which this research is anchored. It explains how the depressed are likely to make negative assertions about themselves in terms of their beliefs, interpretations, and perceptions about the past, the present and the future which results to depression. Besides, Beck the proponent of this theory developed the Cognitive Behavioural Therapy for depression which is being experimented in this research to find out its efficacy in reducing depression symptoms among the IDPs in Benue and Borno States.

Age and Depression

Weissman, (2011) noted that old age is often portrayed as a time of rest, reflection and opportunities to do things that were put off while raising families and pursuing careers. Unfortunately, the aging process is not always so idyllic. Negative life events associated with old age such as chronic and protracted medical disorders, loss of peers and loved ones and the inability to take part in once-cherished activities can take a heavy toll on an aging person's emotional well-being. An older adult may also sense a loss of control over his or her life due to failing eyesight, hearing loss and other physical changes, as well as external pressures such as limited financial resources. These and other issues often give rise to negative emotions such as sadness, anxiety, loneliness and lowered self-esteem, which in turn lead to social withdrawal and apathy (Eegunius, 1992).

Gender Differences and Depression

Depressed men are less likely than women to acknowledge feelings of self-loathing and hopelessness. Instead, they tend to complain about fatigue, irritability, sleep problems, and loss of interest in work and hobbies. Other signs and symptoms of depression in men include anger, aggression, violence, reckless behavior, and substance abuse. Even though depression rates for women are twice or thrice as high as those in men, men are at higher suicide risk, especially older men (Nolen-Hoeksema 2002 in Oltmanns & Emery, 2016). The high rates of depression in women could be due to hormonal factors, particularly when it comes to premenstrual syndrome (PMS), Premenstrual Dysphonic Disorder (PMDD), postpartum depression, and premenopausal depression. Nolen-Hoeksema 2002 cited in Hockenbury and Hockenbury (2010), notes that as for signs and symptoms, women are more likely than men to experience pronounced feelings of guilt, sleep excessively, overeat, and gain weight. Women are also more likely to suffer from seasonal affective disorder. This pattern has been reported in study after study, using samples of treated patients as well as community surveys and regardless of assessment procedure employed.

Marital Status and Depression

According to Gross (2011), it is not so much being married that is the issue but rather, the qualities and pattern of the relationship, characteristics of the partner and the consequences of marriage for the individual's lifestyle that matter. It seems that married young adults (and those who are cohabiting) are happier, healthier, live longer and have lower rates of various psychiatric disorders than those without a partner. Those who seem to benefit most are married men (compared with single, divorced and widowed men and

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women) while unmarried men are the worst off. Gross emphasizes that married women are slightly better off than unmarried women, but unmarried women are considerably healthier and happier than unmarried men.

In contributing to literature with respect to marriage and depression, Bee (1994) cited in Gross (2011) suggests that married adults are less vulnerable to both disease and depression because they are buffered by support from their attachment to their partner. Men seem to benefit most of all from the protective nature of marriage partly because they are less likely to have close confidants outside marriage and because wives (more than husbands) provide emotional warmth/support to their spouse.

METHODOLOGY

The study was a quasi-experimental study which adopted pretest/post-test control group design. In its simplest form, the design consisted of two groups of IDPs – the treatment group and the control group which were equated on all the relevant variables. The participants were pretested using Beck Depression Inventory (BDI) so as to get a baseline data on their levels of symptoms of depression. The Cognitive Behavioral Therapy was then applied on the treatment groups in both States while the control groups were given a placebo in form of mere literacy lessons. Later, the BDI was reapplied to both groups (post-test).

The population for this study consisted of male and female IDPs with mild and moderate symptoms of depression in Borno and Benue States who had been in IDPs camps and exposed to various stressors that could cause depression. Borno represented North East while Benue represented North central. They totaled 1,667 in Borno and 887 in Benue (National Commission for Refugees, Migrants and Internally Displaced Persons NCFRMI, 2021; The State Emergency Management Agency SEMA, 2021).

The sample size for the study was made up of 60 IDPs. Out of this, 30 were drawn from Agan, Benue State (15 in the treatment group and 15 in the control group) and 30 from Mongonu, Borno State (15 in the treatment group and 15 in the control group). Experts (e.g. Gay cited in Olayiwola, (2007); Okoli, (2000) suggest a minimum of 15 participants per group. Besides, psychotherapists (e.g. Rush & Beck, 2000; Beck, 2004), suggest that a typical psychotherapy group comprises of at least 12 to 15 participants.

The treatment procedure was in line with Beck's CBT template cited in Ogbu (2015). It has eight treatment stages which were administered in sessions for eight weeks. The treatment stages were Introductory/preparation stage; Cognitive rehearsal stage; Empirical validity test stage; Writing in a journal; Guided discovery stage; Modeling stage; Systematic positive reinforcement stage and Termination of the CBT. Independent t-test and ANOVA were used to analyze the data.

RESULTS

Participants' Socio Demographic Data.

The personal data of the participants used for the study include age, gender, and marital status.

Table 1: Treatment Group

Group	Frequency	Percentage
Treatment	30	50
Control	30	50
Total	**60**	**100**

As shown in table 1, 60 participants (30 (50%) in the treatment group and 30 (50%) in the control group were involved in the study in both States. Out of the 30 in each state, 15 were in the treatment group and 15 in the control group. Those in the treatment group were those who were exposed to Cognitive Behavioural Therapy, while those in the control group were not exposed to the therapy but were given mere placebo in form of literacy education.

Table 2: Age of the Participants in the Treatment Group

Age Range	Frequency	Percentage
30-40 Yrs.	14	46.6
41-50 Yrs.	8	26.7
51-60 Yrs.	8	26.7
Total	**30**	**100**

Table 2 shows that 14(46.6%) of the participants were between 30-40 years while 8(26.7%) were between 41-50 years and the rest 8(26.7%) were aged between 51-60years.

Table 3 Gender of the Participants in the Treatment Group

Gender	Frequency	Percentage
Male	18	60
Female	12	40
Total	**30**	**100**

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As shown in table 3, there were 18 male participants representing 60% in the treatment group (10 in Borno State and 8 in Benue State), while 12 representing 40% (7 in Benue State and 5 in Benue State) were females.

Table 4: Marital status of the Participants in the Treatment Group

Marital Status	Frequency	Percentage
Married	24	80
Unmarried	6	20
Total	**30**	**100**

According to table 4, 24 (80%) of the participants were married (12 in Borno State and 11 in Benue State) while the remaining 6(20%) were unmarried (3 in Borno State and 3 in Benue State).

HYPOTHESES TESTING

Ho1: There is no significant difference in the pretest and posttest scores of symptoms of depression among IDPs in Benue and Borno States after the application of cognitive behavioural therapy.

To test this hypothesis, the pre-test and post-test mean cognitive symptoms of depression of the IDPs in the treatment groups in both States were computed and comparatively analyzed using the independent t-test analysis to determine the presence or absence of significant difference in the level of their depression symptoms. The result is shown in table 5.

Table 5: Independent-test on the Mean Depression Symptoms of the IDPs in the Treatment Groups.

Variables	**CBT Treatment**	**N**	**Mean Scores**	**Std. dev.**	**Std. err**	**Df**	**T-Value**	**Sig (p)**
Mean depression symptoms	Pre-Treatment	15	20.07	2.87	0.739			
						28		
Scores:	Post-Treatment	15	11.37	2.26	0.582		9.240	0.000

P calculated<0.05, t calculated>1.96 at df 28

The result of the above independent t-test statistics in table 11 shows that there was significant difference in the pre-test and post-test scores of depression symptoms among the IDPs in both Benue and Borno States after the application cognitive behavioural therapy. Reason being the fact that the p value of 9.240 is higher than the critical value of 1.96 ($p<0.05$; $t>1.96$). This means that cognitive behavioural therapy was effective in reducing the cognitive symptoms of depression of the IDPs in the treatment groups in both States. Therefore, the null hypothesis which states that there is no significant difference in the pretest and posttest scores of symptoms of depression among IDPs in Benue and Borno States after the application of cognitive behavioural therapy is hereby rejected.

Ho2: There is no significant effect of age on the efficacy of cognitive behavioural therapy in reducing symptoms of depression among IDPs in Benue and Borno States.

To test this hypothesis, the combined mean cognitive symptoms of depression among the three ages of the IDPs in the treatment groups were computed and compared using the Analysis of Variance Statistics. The result of the test is shown in table 6.

Table 6: Analysis of Variance (ANOVA) Statistics on the Mean Depression Symptoms of the IDPs in the Treatment Groups on the Basis of their Age Groups.

Variation	Sum of Squares	Df	Mean Square	F	F critical	Sig. (P)
Between Groups	5.644	3	2.822	.516	2.60	.609
Within Groups	65.589	12	5.466			
Total	**71.233**	**14**				

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Table: 6 (b) Descriptive Statistics on the Mean Cognitive Depression Symptoms of the IDPs in the Treatment Groups on the basis of their Age Groups.

Age Groups	N	Mean	Std. Dev.
30-40yrs	14	10.9286	2.84939
41-50yrs	8	11.1250	1.93111
51-60yrs	8	12.3750	1.37689
Total	**30**	**11.3667**	**2.25568**

The outcome of the analysis of variance (ANOVA) statistics on table 6 shows that there was no significant effect of age on the effectiveness of cognitive behavioural therapy in reducing symptoms of depression among IDPs in both Benue and Borno States. Reason being the fact that the p value of 0.609 is higher than the 0.05 level of significance while the calculated F ratio value of 0.516 is lower than the 2.60 F critical value (P>0.05;F<2.60) at df 2 for between groups, and 12 for within groups. This implies that age has no effect on the effectiveness of cognitive behavioural therapy in reducing cognitive symptoms of depression among the IDPs. Therefore, the null hypothesis which states that there is no significant effect of age on the efficacy of cognitive behavioural therapy in reducing depression symptoms among IDPs in Benue and Borno States is hereby retained.

Ho3: There is no significant effect of gender on the efficacy of cognitive behavioural therapy in reducing symptoms of depression among IDPs in Benue and Borno States.

To test this hypothesis, the pre-test and the post-test mean depression symptoms among male and female IDPs in the treatment group were computed and comparatively analyzed using the independent t-test analysis. The result of the test is shown in table 7.

Table 7: Independent t-test on the Mean Depression Symptoms of Male and Female IDPs in the Treatment Group.

Variable	Gender	N	Mean	Std. Dev.	Std. Err.	Df	T-Value	Sig (P)
Mean depression	Male	9	7.38	1.80	0.90			
								.288
Symptoms scores	Female	6	11.45	2.80	0.70	13	..107	

P calculated>0.05, t calculated < 1.96 at df 13

The result of the above independent t-test statistics in table 7 shows that there was no significant effect of gender on the effectiveness of cognitive behavioural therapy in reducing depression symptoms among IDPs in Benue and Borno States respectively. The outcome of the t-test shows that the p value of 288 is higher than the 0.05 alpha level of significance and the calculated t-value of 0.107 is lower than the t critical value of 1.96 (p>0.05; t<1.96) at 13 df simplifying that gender has no effect on the effectiveness of cognitive behavioral therapy in reducing depression symptoms among the IDPs. Therefore, the null hypothesis which states that there is no significant effect of gender on the effectiveness of cognitive behavioural therapy in reducing depression symptoms among IDPs in Benue and Borno States is retained.

Ho4: There is no significant effect of marital status on the efficacy of cognitive behavioural therapy in reducing symptoms of depression among IDPs in Benue and Borno States.

To test this hypothesis, the pre-test and post-test mean cognitive depression symptoms among married and unmarried IDPs in both treatment groups were computed and comparatively analyzed using the independent t-test analysis. The result is shown in table 8.

Table 8: Independent t-test on the Mean Depression Symptoms of Married and Unmarried IDPs in the Treatment Group.

Variables	Marital Status	N	Mean	Std. Dev.	Std. Err.	Df	T-Value	Sig (P)
Mean Depression	Married	24	12.57	4.424	1.04			
								.914
Symptoms Scores	Unmarried	6	8.88	2.802	0.70	13	0.110	

P calculated>0.05, t calculated<1.96 at df 13

The result of the above independent t-test in table 8 shows that there was no significant effect of marital status on the effectiveness of cognitive behavioural therapy in reducing depression symptoms among the IDPs in Benue and Borno States. The outcome of the t-test shows that the p value of .914 is higher than the 0.05 alpha level of significance and the

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calculated t value of 0.110 is lower than the t critical value of 1.96 ($p>0.05;t<1.96$) at 13 df implying that marital status has no effect on the effectiveness of cognitive behavioural therapy in reducing depression symptoms among the IDPs. Therefore, the null hypothesis which states that there is no significant effect of marital status on the efficacy of cognitive behavioural therapy in reducing depression symptoms among IDPs in Benue and Borno States is retained.

DISCUSSION

The study found out that significant differences existed in the pre-test and post-test mean scores of depression symptoms among the IDPs in the treatment group. The calculated pre-treatment mean scores of cognitive symptoms of depression dropped significantly among the IDPs in the treatment groups in both Benue and Borno States after the application of cognitive behavioural therapy. At post-treatment stage, there was a mean difference of 8.70 implying that there was a significant reduction of depression symptoms among the IDPs in both States in the treatment groups after the application of cognitive behavioural therapy. Besides, the outcome of hypothesis 1 in this respect shows that significant differences existed in the pre-test and post-test mean scores of depression symptoms among the IDPs in the treatment groups in both States ($t = 9.240$; $p = 0.000$). This result corroborates the observation of Beck (2004) that in his experiment, participants receiving cognitive behavioural therapy experienced a complete and nearly immediate reduction in depression symptoms related to their traumatic memories while those in the control group showed no such change. Beck's (2004) conclusion is upheld by the present findings.

Furthermore, given the outcome of hypothesis 2 ($P>0.05;F<2.60$), results showed that there was no significant effect of age on the effectiveness of cognitive behavioural therapy in reducing cognitive symptoms of depression among IDPs in both Benue and Borno States. This result upholds Beck's findings in his application of cognitive behavioural therapy which he originally developed for depression and was efficacious on all age groups.

Results also showed, by the outcome of hypothesis 3 ($t = 0.107$; $p = .288$) that there was no significant effect of gender on the efficacy of cognitive behavioural therapy in reducing depression symptoms among IDPs in Benue and Borno States. This result lends credence to the theoretical opinion of Beck (2004) that the goal of cognitive behavioural therapy is to help a person, whether male or female learn to recognize negative patterns of thought, evaluate their validity and replace them with healthier ways of thinking. Beck argues that CBT is a practical approach oriented to changing the behavior of the oppressed, irrespective of gender rather than trying to alter the dynamics of personality.

Lastly, results in Hypothesis 4 ($p>0.05;t<1.96$) showed that there was no significant effect of marital status on the effectiveness of cognitive behavioural therapy in reducing depression symptoms among the IDPs in Benue and Borno States. The finding agrees with the conclusion reached by Beck (2004) that the cognitive behavioural therapy proved effective in both married and unmarried depressed individuals who were involved in his experiment.

CONCLUSIONS

Based on the result of the study, it is concluded that the use of cognitive behavioural therapy is effective in reducing symptoms of depression of the IDPs with mild and moderate episodes given the significant drop in the combined mean scores of the symptoms of depression among the IDPs after the treatment. It is also concluded that age, gender and marital status do not affect the efficacy of cognitive behavioural therapy in reducing symptoms of depression.

RECOMMENDATIONS

The following recommendations are made based on the findings of the study:

1) Adequate provisions should be made by Benue and Borno State governments and of course the Federal government for urgent and regular application of cognitive behavioural therapy by experienced psychologists in all the IDP camps in order to treat the IDPs with symptoms of depression.
2) It is also recommended that Benue and Borno State governments and all relevant stakeholders should be mindful of possible occurrence of cognitive depression among the IDPs irrespective of their ages, and use cognitive behavioural therapy directed at all age groups to treat them of depression symptoms if they manifest.
3) It is equally recommended that CBT programmes should be accessible to both male and female IDPs. The State governments and all relevant stakeholders should employ competent psychologists/psychotherapists and provide enabling environment and facilities for regular cognitive behavioural change programme for both young and older IDPs who may be depressed.
4) Lastly, it is recommended that the IDPs, whether single, married, divorced, widow or widower but have symptoms of depression should be exposed to cognitive behavioural therapy to help them reduce their symptoms of depression.

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