



## Effects of Stress Inoculation Training and Cognitive Behaviour Therapy in Enhancing Conjugal Bliss of Women with Childhood Trauma in Lagos, Nigeria

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**Abstract.** In Nigeria, reports have linked past trauma with low levels of conjugal bliss in women. Previous studies on conjugal bliss focused more on family and environmental factors than on interventions such as Cognitive Behavioural Therapy (CBT) and Stress Inoculation Training (SIT). This study, using a quasi-experimental design, therefore, was designed to determine the effects of CBT and SIT on the conjugal bliss of women with past trauma in Lagos State, Nigeria, while also examining the moderating effect of partner support. The research was conducted using the Vulnerability Stress Adaptation Model of Marriage Theory. The study employed a four-stage sampling technique, selecting two local government areas (LGAs), Agege and Ajeromi Ifelodun, based on the availability of Primary Healthcare Centres (PHCs). PHCs were purposively selected based on the number of eligible women and the conduciveness of the locations for intervention. A screening test was administered to 205 married women in the selected LGAs using the Childhood Trauma Questionnaire-Short Form (CTQ-SF/MEQ) to identify those with past trauma. Respondents who scored 50.0% and above were included in the study, resulting in a final sample of 81 married women (married for 1–10 years) receiving medical services at the PHCs. Participants were randomly assigned to either the CBT or SIT intervention groups. Findings revealed that both CBT and SIT significantly improved conjugal bliss among women with past trauma, with SIT demonstrating the highest levels of improvement. Additionally, partner support played a crucial role in enhancing conjugal bliss. The study suggests that marriage and family health practitioners, as well as women's affairs bodies, should incorporate these therapeutic interventions to improve conjugal well-being among women with past trauma.

**Keywords:** Married women with past trauma, Cognitive behaviour therapy, Stress inoculation training, Conjugal bliss

### 1. Introduction

Trauma in the past is said to greatly affect the marital lives, as far as women are concerned, which provokes serious exploration. A person may have been past trauma from an adverse childhood experience, for example, neglect, physical, emotional, and sexual abuse, where it has lifelong effects of such experiences in a person's life (Redd, 2017). These experiences often lead to many social, emotional, mental, and cognitive impairments, resulting in the high risk of unhealthy behaviour, chronic health issues, and mental health problems like post-traumatic stress disorder (PTSD), depression, and addictive behaviours (Morin, 2019; Dye, 2018). According to Offor, Ogunbowale, and Omopo (2025), the psychological and socio-economic factors will inform an individual who would eventually become involved in sexual offence acts; indeed, their effects on later behavioural outcomes could be much more comprehensive given the scale of how childhood trauma affects a later individual's state. Such a trauma could affect adult relationships, including marriage, with a visible impact on intimacy, trust, and satisfaction in marriage (Nguyen, Karney, & Bradbury, 2017; Bigras et al., 2015).

The most recent Nigeria Demographic and Health Surveys (NDHS) (2018) further expose the disturbing picture of the sad stories of young women in terms of engaging in sexual violence, with more than half experiencing engagement in sexual activities before the age of eighteen and many reporting incidences of violence (Ekine, 2020). Such early trauma can have far-reaching consequences as it affects the survivor socially, educationally as well as emotionally. Bakare, Asuquo and Agomoh (2010) point out the disinterest

around the abuse of women and girls even as a very large fraction of the population. Most survivors develop fear, anxiety, and lack of trust, which extraordinarily affect their marital relationships. It has also been proved through research that childhood trauma influences patterns of behaviour and emotional reactions that can be carried into adulthood (Omopo, Offor, & Ogunbowale, 2024).

Research describes how early adversities predict marriage dissatisfaction where avoidance of intimacy and fear of abuse contribute to decreased couple satisfaction (Nguyen et al., 2017; Bigras et al., 2015). Past trauma-related biological stress responses disrupt regulatory processes of the limbic-hypothalamic-pituitary-adrenal (L-HPA) axis to mental and physical health (Cherry, 2019). Omopo (2024) delved into the PTSD symptomatology and diagnostic criteria, largely focusing on how unprocessed trauma is portrayed in relational spheres, particularly marriage. Marriage is, in fact, part of the socio-cultural endeavors that provide a platform or ground for family life; when interference of such past trauma takes place, challenges to its practice are serious and significant (Jain, 2019; Tavakol et al., 2016). Factors of marital bliss include sex, income, communication, and common ground (Korporaal, Groenou, & Van-Tilburg, 2013; Buss, 2003). Although there have been different studies addressing various aspects of conjugal bliss like economic conditions, social security, etc., the effect of therapeutic interventions such as Cognitive Behavioural Therapy (CBT) and Stress inoculation training (SIT) on women with histories of abuse has hardly been explored (Taghani et al., 2019).

Cognitive behavioural therapy (CBT) is an evidence-based treatment that has a highly structured approach to helping the client identify maladaptive thoughts and beliefs connected with traumatic experiences (Resick & Schnicke, 1993). The therapy works by processing traumatic memories and constructing coping strategies that reinterpret the trauma, thus minimising its aversive effects on the person's life (Schulz et al., 2006). Therefore, CBT aims to teach clients about their trauma symptoms, the effect of thoughts and feelings on recovery, and also provides them with skills to counter unhelpful beliefs. Some studies suggested that cognitive reframing techniques may effectively target trauma-related behaviours (Omopo & Odedokun, 2024).

Stress inoculation training (SIT) is more like a "vaccine" against stress, which helps to prepare clients to face future stressors and deal with present stressors. Khorsandi, Vakilian, and Salehi (2016) report that SIT is a form of stress therapy developed by Meichenbaum back in 1976. SIT has three interlocking phases:

conceptual education, skills acquisition, and application, and has been seen to alleviate anxiety and depression among several populations (Aneja et al., 2017). Research on those therapies' impacts on women with past trauma-their abilities to enjoy and stay in conjugal bliss though otherwise-are scanty in Nigeria. Omopo, Offor, and Ilori (2024) studied clinical evaluations of PTSD-related triggering cues to gain further insights into the psychological trauma borne by survivors.

Several studies have already concluded that those who have undergone past trauma tend to show improvement in their relationship satisfaction but there is little information on how CBT and SIT affect the wellbeing of couples. It is also worth putting into consideration the presence of moderator effects of partner support as they may not be alleviative to traumatic impacts in marriage-life. It clearly indicates the necessity of exposure to ongoing research in covering this gap.

It was also apparent that previous trauma strongly influences a woman's married bliss and has an effect on emotional and relational problems. However, using the intervention therapies of CBT and SIT would be very helpful to women who are finding it difficult to cope with the intricacies of their past experiences and would like to work in that regard toward their marital satisfaction. A better understanding of the effects of these therapies on the improvement of conjugal bliss among women with traumatic history must, therefore, be addressed. This is especially important in Nigeria, where this issue is largely prevalent yet understudied.

### 1.1 Statement of the Problem

Conjugal bliss is a genuine feeling of pleasure, contentment, ease, joyfulness, and fulfillment that can be expressed by both husband and wife in their union. Sadly, due to low levels of conjugal bliss, many marriages today are on the brink of collapsing for reasons such as; too many expectations from the partners, poor interpersonal skills, health challenges, in-law interference, peer pressure, and past trauma. A study spearheaded by the United Nations International Children's Emergency Fund (UNICEF, 2015) reports that 6 out of 10 children in Nigeria experience some form of trauma before the age of 18 with girls at a higher risk. This, therefore, portends that a high segment of the married female population can be women with past trauma thus further insinuating that they can carry different mental and emotional encumbrances of varied degrees into their homes and when unexpected pressure sets in, like in-law interference or financial constraints, such stress can

trigger some maladaptive behaviour reducing conjugal bliss. This can further result in outcomes such as domestic violence, separation, and divorce indicating the need for professional psychological intervention.

Furthermore, it has been observed that some couples in Nigeria may find it difficult to experience some level of conjugal bliss as they were raised in emotionally deprived environments. Some of such settings contribute to children being exposed to a wide range of predispositions. Some early inadequate psychological nurturance that such settings can demonstrate include: disregard for their basic intellectual needs, extreme punitive 'disciplinary' measures, insufficient care, inadequate attention, verbal assaults, threats, destructive criticism, exposure to inappropriate sensual activities, rape, molestations and other forms of adverse circumstances eventuating into difficult challenges in adulthood. Although issues on mental health are gaining public attention, there is still a scarcity of studies on women's past trauma and conjugal bliss. This study, therefore, was designed to determine the effects of Stress Inoculation training and Cognitive Behavioural therapy on the conjugal bliss of women with past trauma.

### 1.2 Purpose of the study

The main purpose of the study was to investigate the effects of Stress Inoculation training and Cognitive Behavioural therapy on the conjugal bliss of women with past trauma in Lagos State, Nigeria.

Specifically, the study set out to:

- determine the main effect of treatment (Stress Inoculation training and Cognitive Behavioural therapy) on the conjugal bliss of women with past trauma.
- examine the main effect of partner support (low, moderate, and high) on the conjugal bliss of women with past trauma.
- investigate the interaction effect of treatment and partner support on the conjugal bliss of women with past trauma.

### 1.3 Hypotheses

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

- There is no significant main effect of treatment (Stress Inoculation training and Cognitive Behavioural therapy) on the conjugal bliss of women with past trauma in Lagos State.
- There is no significant effect of partner support (low, moderate, and high) on the

conjugal bliss of women with past trauma in Lagos State.

- There is no significant interaction effect of treatment and partner support on the conjugal bliss of women with past trauma in Lagos State.

## 2. Theoretical Framework

Karney and Bradbury developed the Vulnerability Stress Adaptation (VSA) model of marriage in 1995 (Karney, 2010). In addition to these, findings by Karney and Bradbury (1995) and Karney (2010) reiterate that couples with significant levels of enduring vulnerabilities who pass through stressful circumstances will encounter a hard time maintaining their marriages. According to Karney and Bradbury (2020), the VSA model is a framework for comprehending the active and complex processes of marriage. They posit that the model is divided into three basic elements namely; enduring vulnerabilities, stressful conditions, and adaptive processes. Karney (2010) affirms that spouses' susceptibilities and life stressors either positively or negatively influence these parts. In considering enduring vulnerabilities, Karney and Bradbury (1995) describe them as stable traits which spouses bring into marriage such as irrational beliefs, problematic behavioural qualities, and emotional challenges arising from past trauma (Karney, 2010).

Van Der Troost (2005) explains that Karney and Bradbury (1995) developed longitudinal studies reviewing 115 marriages. They aimed to gain some insight into spouses' conjugal bliss and to also observe how marriages achieve different outcomes over time. This led to their conclusion that an unhappy childhood and maladaptive behaviours could lead to negative marital outcomes; conversely, positively inclined variables like adaptive behaviours would yield promising results in terms of satisfaction and stability (Eysenck, 2000). Furthermore, Van Der Troost (2005) reveals that the VSA model hinges on four foundational postulations (social exchange, behavioural, crisis, and attachment theories) however they are not all applicable to this study. The three relevant theories, namely, social exchange, crisis, and attachment have therefore been retained.

## 3. Methodology

### 3.1 Design

The study adopted a pretest-posttest, control, quasi-experimental design. The design was used to explain, interpret or contextualise quantitative findings and to

describe in detail unexpected results from the quantitative study.

### 3.2 Population

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

### 3.3 Sample and Sampling Techniques

The sample comprised married women in Lagos State who had been exposed to trauma during their childhood. The sampling was done in four stages: local government areas, centre, the participants, and assigning treatment /non-treatment groups. Two Local government areas were selected; Agege and Ajeromi Ifelodun LGAs were purposively selected based on a large number of Primary Healthcare centres available in the local government areas. Similarly, the PHCs were purposively selected based on how large the number of women available for the study was and how conducive the locations were for intervention. A screening test was administered to 205 married women in the two locations using the Past trauma Questionnaire-short form (CTQ-SF/MEQ). The purpose of the screening test was to identify women who had experienced past trauma. The CTQ-SF/MEQ has 28 items with a minimum score of 28 and a maximum of 140. Respondents who scored 50.0% and above of the distribution were used in the study, while those who scored below did not participate. A total of 81 married women (married between 1-10 years) who received medical services at Primary Healthcare Centres of the selected local government areas were eligible for participation in the study. The centres were randomised into CBT and the SIT groups respectively.

### 3.4 Control of Extraneous Variables

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

- appropriate randomisation of the participants into the two treatment groups and the control group.
- adherence to the inclusion criteria.
- effective use of the use of analysis of covariance (ANCOVA) statistical tool.

## 3.5 Instrumentation

### ENRICH Conjugal Bliss (EMS) Scale

The ENRICH (Evaluation and Nurturing Relationship Issues, Communication and Happiness) Conjugal bliss scale is a 15-item instrument adapted from Fowers and Olson (1993). The focal point of the instrument is based on how spouses perceive conjugal bliss in their union. The authors used a Likert scale of 5 points: 5= Strongly agree, 4= Agree, 3= Neutral (Undecided), 2= Disagree and 1 =Strongly disagree. In this study, the instrument was used on married women who have experienced past trauma intending to test the level of satisfaction in their marriages. Some of the items were: *my partner and I understand each other; I have some needs that are not being met by our relationship*. The scale consisted of 5 items described as idealistic distortions which were overly positive evaluations of marriage thus denying the existence of challenges for example; *my partner completely understands and sympathises with my every mood* while the other 10 domains like *I have some needs that are not being met by our relationship* were based on marital quality. Raw scores were calculated by the reverse. Its concurrent validity was .73 with a Locke-Wallace Marital Adjustment test measuring common areas of satisfaction and conflict in marriage. This instrument was revalidated using 31 married women who were not part of the samples of the main study. The Cronbach alpha of .771 (See Appendix) was established indicating that the instrument is valid and reliable because it (Cronbach alpha) showed a measure of construct validity and internal consistency of the rating scale. Three items such as *our relationship is a perfect success; my partner and I understand each other perfectly* which correlated negatively with the scale were removed leaving a total of 12 items.

### Partner Support Scale

Yildirim (2004) developed this instrument, which offers three response options: appropriate for me, exceptionally appropriate, and not appropriate. The instrument assesses the perceived support of spouses. It emphasises that my spouse is involved in my aspirations and aspirations. This study utilised a Likert scale with a score of 5 for "Every time," 4 for "Frequently," 3 for "Sometimes," 2 for "Rarely," and 1 for "Never." Instructed respondents to select the column that most accurately represents their perspective on each subject. Participants were guaranteed the highest level of confidentiality. The instrument assessed instrumental, informational, validation, appraisal, and emotional support. Section A comprised respondents' age, religion, tribe, and

duration of marriage. Section B comprised 27 items. There are concerns regarding my husband's reluctance to share, desire to conceal, and incapacity to comprehend. Percentile ranks categorised responses into three groups. Poor support was defined as individuals scoring between the lowest scores and 33.3%, moderate support as 33.4% to 66.7%, and high support as 66.8% to 100%. A total of 31 married women who were not involved in the primary study completed the instrument in order to validate it. The rating scale is internally consistent and construct valid, with a Cronbach alpha of .959.

### **Past Trauma Questionnaire-Short Form (CTQ-SF)**

Bernstein, Stein, Newcomb, Walker, Pogge, Ahlvia, Stocks, Handelman, Medrano, Desmond, Zule (2003) founded CTQ-SF. It assessed trauma in the study including physical, emotional, sexual, and neglect injuries. The participants were questioned about their 1-17 year-old traumatising experiences. Each question asked respondents to choose the number that best expressed their thoughts. Answers were honest, even if personal. The responses were private. One was never true, two seldom, three occasionally, four often, and five often. Question examples: I knew someone would protect me. Replace "stupid", "lazy", and "ugly" with "some family members called me". The Marriage Enhancement questionnaire (CTQ-SF) has 28 items with a score range of 28-140. A scale identified trauma survivors. This score indicated women who have. This study found that married women with 50.0% or above had past trauma, but those with minimum scores to mean scores did not. In validation, 31 married women outside the main study took the test. Cronbach alpha of .932 indicated the rating scale's validity and reliability.

### **3.6 Procedure for Data Collection**

An introduction letter was obtained from the Lagos State Ministry of Health and submitted to the selected primary healthcare centres. Informed consent forms were given, and the participants were informed about the study's purpose and potential benefits, and assured of confidentiality. The study was conducted in stages, namely: pre-session, pretest, intervention, and post-test. Groups were randomly assigned into treatment and non-treatment groups. During the pretest stage, instruments were administered and participants signed an informed consent form. The intervention stage consisted of eight sessions of treatment packages to that of control group not receiving any treatment.

Participants in all the three groups were post tested with ENRICH and data collected for analysis.

### **3.7 Data Analysis**

For the quantitative aspect of the study, the analysis of covariance (ANCOVA) was the major statistical tool. It was used to partial out the initial differences between the three groups. Since there were differences in the posttest scores, estimated marginal means were used to estimate the strength of the differences, moreover, the direction of differences was determined using Sidak post-hoc pair comparison analysis. In addition, the interaction effects were significant thus requiring a graphical representation to determine the nature of the interaction.

### **3.8 Ethical Consideration**

The Ministry of Health in Lagos State granted ethical approval for a study on Stress Inoculation training and Cognitive Behavioural therapy. The study aimed to understand the decline of marriages and provide solutions for their sustainability. The findings were beneficial to participants, providing enduring coping skills and improving their conjugal bliss. The study was non-maleficent and voluntary, allowing participants to withdraw at any time.

## **4. Results and Discussion**

This section presents the results obtained from the study. This is done based on the analysis of the seven hypotheses formulated for the study. Explanations have been given following the findings of previous empirical studies. In addition, limitations of the study and areas suggesting further research have been highlighted. Furthermore, this research has made recommendations based on the findings and contributions of the investigation to the body of knowledge.

**Hypothesis One:** There is no significant main effect of treatment (Stress Inoculation training and Cognitive Behavioural therapy) on conjugal bliss of women with past trauma in Lagos State.

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

The summary of the analysis is presented in Table 1.

**Table 1:** Summary of Analysis of Covariance (ANCOVA) Post-Test for Conjugal Bliss of Women with Past Trauma in Lagos State

Source	Sum of Squares	Df	Mean Square	F	Sig.	Partial Squared	Eta
Corrected Model	7295.981 <sup>a</sup>	18	405.332	6.430	.000	.544	
Intercept	9424.758	1	9424.758	149.511	.000	.607	
PRE EMS (Covariate)	119.739	1	119.739	1.899	.171	.019	
Treatment	3527.016	2	1763.508	27.976	.000	.366	
Partner support	1451.227	2	725.613	11.511	.000	.192	
Treatment * Partner support	397.846	4	99.461	1.578	.186	.061	
Error	6114.597	52	117.58				
Total	259511.000	80					
Corrected Total	13410.578	81					

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

Key: \*Sig at 0.05

Table 1 revealed that there was a significant main effect of treatment on conjugal bliss of women with past trauma in Lagos State ( $F_{2,81} = 27.98, P < 0.05, \eta^2 = 0.37$ ). This means that there was a significant difference in the mean scores of the conjugal bliss of women with past trauma in Lagos State exposed to cognitive behaviour therapy (CBT) and stress inoculation training (SIT) when compared with the control group. Hence, the null hypothesis stated was rejected. The table also showed a contributing effect size of 37.0%. This implies that 37.0 % of the variance in conjugal bliss of women with past trauma in Lagos State was accounted for by the treatment (CBT, SIT, and control). This also means that cognitive behaviour therapy (CBT) and stress inoculation training (SIT) are both effective forms of intervention in the conjugal bliss of women with past trauma in Lagos State. To further provide some information on conjugal bliss of women with past trauma in Lagos State among participants in the three groups (CBT, SIT, and Control), it was imperative to determine the magnitude of the mean scores of the participants in each of the treatments and the control group. Therefore, the estimated marginal mean score was calculated and presented in Table 2

**Table 2:** Estimated Marginal Mean

Treatment	Mean	Std. Error	95% Confidence Interval	
			Lower Bound	Upper Bound
CBT	49.782	1.357	47.089	52.474
SIT	50.015	1.308	47.420	52.610

The following observations were made from Table 4.2; showing that married women exposed to SIT had the highest conjugal bliss (50.02) followed by CBT (49.78) and control (37.06). To determine the direction of the differences, Fisher's LSD was not suitable for use in this study because the number of participants for the three levels of experimental and control groups was not equal. In addition, even though Bonferroni is widely used, Sidak post-hoc analysis possesses more statistical strength (King and Eckersley, 2019). Sidak also has tighter bounds than Bonferroni (Lee, Nunes Dunis, Lowe and Anders, 2016; Blakesley, Mazumdar, Dew, Houck, Tang, Reynolds and Buffers, 2009) therefore; it was more suitable as presented in Table 3.

Table 3 Sidak Post-Hoc Analysis Showing Differences in the Treatment Groups

Subset for alpha = 0.05			
	N	1	2
CBT	40	49.782	
SIT	41	50.015	

The following observations were made from Table 3:

- (i) There was no statistically significant difference in the post-hoc test mean scores obtained by participants in the CBT and SIT treatment groups on conjugal bliss of women with past trauma in Lagos State. However, the participants in the SIT group (Mean = 50.02) benefited slightly more than those in the CBT group (Mean = 49.78).
- (ii) There was a significant difference in the post-hoc test mean scores obtained by participants exposed to SIT and the control group. The mean scores of participants in SIT (Mean = 50.02) were significantly better than those in the control group (Mean = 37.06) on conjugal bliss of women with past trauma in Lagos State.

(iii) There was a significant difference in the post-hoc test mean scores obtained by participants exposed to CBT and the control group. The mean scores of participants in CBT (Mean = 49.79) were significantly better than those in the control group (Mean = 37.06) on conjugal bliss of women with past trauma in Lagos State.

This showed that there was a significant difference between the mean scores of participants in CBT, SIT and those in the control group. Again, SIT was more effective in the two groups than the control group, thus indicating that the intervention had the greatest potency on the conjugal bliss of women with past trauma in Lagos State than CBT and control groups.

**Hypothesis Three:** There is no significant effect of partner support (low, moderate and high) on conjugal bliss of women with past trauma in Lagos State.

The results from Table 1 showed that there was a significant main effect of partner support on conjugal bliss of women with past trauma in Lagos State ( $F_{2, 97} = 11.51, P < 0.05, \eta^2 = 0.192$ ); meaning that there was a significant effect of partner support (that is; low, moderate and high) on the conjugal bliss of women with past trauma in Lagos State. Hence, the null hypothesis three was rejected. Table 1 also displayed a contributing effect size of 19.2%. This means that 19.2% of the variance in conjugal bliss of women with past trauma in Lagos State was accounted for by partner support.

Furthermore, to provide information on the extent to which partner support on conjugal bliss of women with past trauma in Lagos State among participants at the three levels (low, moderate, and high), the magnitude of the mean scores of the participants in each of the levels was computed as shown in Table 4. Consequently, the estimated marginal mean was calculated and presented in Table 4.

**Table 4:** Estimated Marginal Mean

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

Table 4 confirmed that the mean score of participants with moderate partner support (50.69) was the highest, therefore, showed utmost conjugal bliss. This was followed by those who had high partner support (45.53) and lastly by those with low partner support (40.67).

### 5. Discussion of Findings

The hypothesis was rejected as revealed in Table 1. There was a significant main effect of treatment (Stress Inoculation training and Cognitive Behavioural therapy) on conjugal bliss of women with past trauma in Lagos State. This indicated that both Stress Inoculation training and Cognitive Behavioural therapy were effective means of treatment on conjugal bliss of women with past trauma. This agreed with the findings of Amipour et al. (2017) who reported a significant effectiveness of Cognitive behaviour therapy on conjugal bliss of war veterans with posttraumatic stress disorder. Again, Bashpoor (2012) indicated that CBT has the ability to improve the conjugal bliss of women who survived exposure to infidelity. In the light of this, Murray et al. (2018) explained that CBT's capacity to focus on cognitive

restructuring and reducing avoidance of trauma-related stimuli in individuals who have experienced disturbing events such as past trauma, can demonstrate its usefulness through challenging negative beliefs about self as well as others (Monson, Resick, and Rizvi, 2014).

Before intervention, Iverson et al. (2015) explained that some married women who exhibit certain overgeneralised maladaptive thoughts due to early adverse situations, and who also uttered some core negative beliefs, were found to significantly change after treatment. This was seen in one of the participant's before/after impact statements written by respondent (38) who was sexually molested by a close male friend of the family whom she was very familiar with. She was still a Nursery/Primary school pupil at the time the incident occurred. According to her, "The traumatic experience left me with trust issues from my childhood but now I am working on it. When bad things happen, it can take a while to get over the pain and feel safe again but with self-help methods and other strategies taught during the programme, I have discovered at this time that it is possible to recover. As a wife, I am more welcoming to my husband's jokes and sexual advances, something I used to find difficult

to do. I feel a lot safer because I am able to trust my husband and others better.”

This has indeed buttressed the point that women who had received CBT have reported remarkable improvements in the interpretation of their early traumatic event. This was because the intervention produced more self-compassion and made them more hopeful about their future. As a result of this progress, there would often be reductions in symptoms of anxiety, depression, intrusive thoughts, avoidance and emotional numbing which have been associated with early traumatising experiences (Lenz et al., 2014). Additionally, CBT has been known to significantly decrease hopelessness and records improvement in sleep disturbances (Gutner et al., 2013) which are also linked to early challenges. Similarly, Galovski, Harik, Blain, Elwood, Gloth, Fletcher and Davila (2016) recommended that CBT can also be used to assist distraught women using Socratic questioning techniques while giving precedence to beliefs of assimilation and over-accommodation in order to improve the condition. Based on how important sexual satisfaction is in marriages, CBT has been used as a successful stigma-reduction intervention on women who have survived sexual violence which can particularly induce depression, anxiety, guilt, shame, self-blame and other psychological damages (Murray et al., 2018). Cognitive behaviour therapy has proved to be an effective evidence-based treatment for women who have difficulties navigating marital functioning including those caused by past trauma.

Similarly, from the findings of this study, SIT was found most effective on conjugal bliss of women with past trauma. This aligned with the findings of Akbari and Khodadadi (2013) which reported that the intervention led to decreased levels of marital conflicts thereby increasing conjugal bliss. Furthermore, their study affirmed that living with a spouse who is struggling with the effects of a past trauma can cause increase in marital clashes, stress and decrease in satisfaction. In their conclusion, they recorded that SIT can improve marital relationship by produce significant improvement in marital quality. Rabiee, Zaharakar and Farzad (2019) recommended SIT as a mediation for married women. They affirmed that it is an intervention that can be linked with reducing symptoms of prolonged mental, emotional and physical exhaustion thus increasing marital bliss in married women. This further demonstrated the proficiency which SIT as a psychological intervention possesses in ameliorating and improving conjugal bliss. Hojjat et al. (2016) also observed from the cohorts in their study that the hands-on coping skills designed for use in SIT were found stimulating

because they helped individuals build resilience and boost enough confidence to deal with difficult situations hence enhancing functionality.

Shalkouhi et al. (2015) also Nikrokh and Zaharakar (2015) explained that infertility and pregnancy are part of the complex issues of marital life which can generate some psychological stress resulting in anxiety, depression, feelings of failure with outcomes like marital dissatisfaction. As a result of this, SIT has proven to be effective in alleviating stress in this complex phase because it can build a high level of resilience and tenacity to help couples facing life-stressors. In addition to this, Brannon, Updegrade and Feist (2021) submitted that SIT has the ability to facilitate the learning of adaptive techniques which can boost psychological ‘immunity’ to accelerate healing and increase self-confidence. Shalkouhi et al. (2015) maintained that despite the damaging outcomes of past trauma, the therapy builds a level of determination that can help individuals face marital issues successfully while finding meaning in the disturbing experiences such that they even learn to believe in themselves, their spouses and others. Again, another phase of life which affects many women is having their babies for the first time. This is a major transitional life occurrence which could bring about stress characterised by emotional turmoil affecting conjugal bliss. Odinka et al. (2018) confirm that SIT can help to reduce maternal stress while increasing conjugal bliss (Beigelman and Bacharier, 2013).

There is also a relationship between conjugal bliss and job stress observed in married female bankers and nurses. These women can be exposed to many stressors such as work place complaints, time schedule pressures, and heavy work load resulting in lack of sexual interest, reduction in shared activities, ultimately leading to poor conjugal bliss outcomes (Fawole and Isiaq, 2017; Barzideh et al., 2014). To this end, Spears (2019) identified that married female professionals who are faced with job stressors reporting low conjugal bliss can benefit enormously from SIT thus producing significant changes in the cognitive, motivational and emotional areas of behaviour. A probable reason why SIT could have been more effective than CBT was because it was full of action skills designed with easy to do hands-on methods. It was also less stressful because it did not dwell on the memory of the traumatic event nor did it involve much use of writing like CBT.

Hypothesis two was rejected as there was a significant main effect of partner support (low, moderate and high) on conjugal bliss of women with past trauma (Table 1). However, the participants in the moderate

level of partner support enjoyed conjugal bliss significantly more than those in both low and high levels. Gbiri and Akinpelu (2012) confirmed that partner support positively influenced the wellbeing of stroke survivors as it provided the emotional, financial and motivational assistance needed to improve. Again, women such as those attending the fertility clinic are quite vulnerable to psychological pain thus requiring partner support, therefore, Omoaregba, James, Lawani, Morakinyo and Olotu (2011) clarified that not having partner support predicted high emotional distress leading to marital disharmony.

Supportive spousal behaviour such as affection, attention and material provision when shown can increase conjugal bliss. Again, this was corroborated by Khan and Aftab (2013) as they reiterated that the higher the level of assistance received from spouses the more enhanced the satisfaction. This conflicted with the findings of the present study which revealed that women in the moderate level of partner support experienced more conjugal bliss. Apart from that, it also opposed the findings of Enebuwa-Okoh and Osho (2016) as well as Monin and Clark (2011) who submitted that high spousal assistance can enhance marital fulfilment. In the same vein, the findings of this study did not entirely agree with Arisukwu, Igbolekwu, Oyekola, Oyeyipo, Asamu and Osueke (2021) who reported that though partner support had a substantial effect on conjugal bliss, high levels of support were detected to sustain and promote good quality of marital life. Peter-kilo and Long John (2021) were however consistent with the results of this study as they recorded that there was a significant association between marital harmony and partner support but at a moderate level.

Another investigation, which agreed with this study, was that of Brock and Lawrence (2009). Their work on how levels of partner support can affect conjugal bliss showed that those couples who indicated that they were receiving high or low levels of care experienced a reduction in satisfaction. They stated that the plausible explanation for this was that husbands who are emotionally disconnected from their wives feel a certain level of fear and guilt; implying that these emotions can lead such men to display certain tendencies like an over-generous show of affection through unnecessary gifts. They added that, this type of men can overcompensate to make up for their shortcomings by providing more than their wives need. They concluded that these wives usually perceived that their husbands' support could be deceitful schemes meant to cover up their clandestine affairs. As a result of this, Brock and Lawrence (2009) asserted that receiving elevated levels of partner

support than is necessary is especially disadvantageous to wives' conjugal bliss, similarly declined levels of assistance can produce low marital harmony. Again, past trauma can leave a 'wounded child' within an adult married woman (Teicher, 2000). This could lead to emotional and cognitive encumbrances such as fear of being abandoned, anxiety, low self-esteem, nagging, suspicion, and anger issues (Thatcher, 2018; DeCarvalho et al., 2015; Marshall et al., 2011). Therefore, as past trauma can intensify already existing problems in marriage (Lauders et al., 2019, Marshall et al., 2011) not expecting or anticipating too much from a spouse can serve as a defense mechanism; in this way, moderate levels of partner support can help women with past trauma cope with averting heightened responses to relationship stress.

Hypothesis three was not rejected because there was no interaction effect of treatment and partner support on the conjugal bliss of women with past trauma as shown on Table 1. Partner support is useful in marriage as it indicates the type of sustenance given by couples to maintain their marital relationships. Furthermore, partner support geared towards growth predicts better mental health outcomes for spouses. According to Nguyen, Karney and Bradbury (2017) individuals with a background history of past trauma are linked with difficulties in relationships which is why Cooke, Racine, Plamondon, Tough and Madigan (2019) claimed that compassion can serve as a protective element that can be used to promote resilience in families with people who have experienced past trauma. They reiterated that support from the spouse of a survivor can be a key tool for change and overall wellbeing. Spouses' behaviours are critical in understanding the health outcomes of adverse childhood experience survivors (Evans, Steel, Watkins, and DiLillo, 2014) which can escalate due to spousal abuse but mitigated by sensitive and compassionate ones (Widom, Czaja, Bentley and Johnson, 2012).

Partner support is the demonstration of love, care and affection by one's spouse using marriage maintenance strategies such as emotional, informational, instrumental, appraisal and validative measures, which are necessary for strengthening marital bonds thereby producing satisfaction (Enebuwa-Okoh and Osho, 2016). Therefore, conjugal bliss is a complex crucial feature which couples require in the attainment of marital happiness along with receiving support from one another aimed at thriving in life especially when challenges arise. Apart from partner support, another area of help for couples can be therapy.

John, Adebayo, Boychuk and OlaOlorun (2022) highlighted that intervention can focus on problematic areas in relational strengths and weaknesses with the goal of enhancing marital harmony. However, from the empirical findings of this study, the conjugal bliss of the women with past trauma was unaffected whether or not they received the treatment to enhance partner support. The probable reason for this could be that the women believe in family ties. Family ties are deep bonds embedded in the ethnic context of the rich Nigerian culture. These ties breed a sense of belonging, comfort and stability between spouses generating strong commitment to the marital relationship. This study supported Ogungbola and Akomolafe (2019) who postulated that elements of family ties such as togetherness, forgiveness, patience and understanding are important for conjugal bliss as they can foster peace.

Moreover, the spousal mate retention tactics described by Shackelford and Shackelford (2021) seem like another feasible explanation of the findings of this current study. They stated that women frequently use mate retention strategies which are behavioural methods to reduce relationship problems and increase satisfaction. These strategies can include tolerating the significant other despite his flaws, looking physically attractive to gain and maintain his attention, cooking delicacies to captivate him, also pretending to reach orgasm during intercourse to inflate the man's ego which is a common behaviour that 60% of married women practice (Shackelford and Shackelford, 2021).

### 5.1 Implication of the Study

Past trauma, a series of adverse experiences, can lead to severe psychological effects such as depression, anxiety, eating disorders, and sleep disturbances. These events can also cause stress, which can lead to chronic mental illnesses. Conjugal bliss, a mental state indicating the perceived cost and gains of marriage, can be a risk factor for satisfaction. Stress Inoculation training and Cognitive Behavioural therapy can help individuals become aware of their thoughts, feelings, and behaviour, identify negative core beliefs, and manage stress symptoms using effective coping strategies. This study highlights the importance of recognising children and adolescents who exhibit symptoms of past trauma and provides valuable information for social workers and school counsellors. Mental health workers and policymakers can use this research to develop trauma-informed interventions and plans to make the nation safer and healthier.

### 5.2 Conclusion

This study investigated the effects of Stress Inoculation training and Cognitive Behavioural therapy on conjugal bliss of women with past trauma in Lagos State, Nigeria. Partner support were the moderating variable. Participants were exposed to the treatment packages as interventions, thus relevant data were collected, collated and analysed using appropriate statistical tools. Based on the findings of the study, the following conclusions were reached: Stress Inoculation training and Cognitive Behavioural therapy were effective on conjugal bliss of women with past trauma in Lagos State. Therefore, applying the ethics, components and structured approaches of both interventions could be effective in strengthening conjugal bliss of women with past trauma. Additionally, stress inoculation training was more efficacious in reinforcing marital harmony of women with past trauma. Furthermore, women with moderate levels of partner support had the best conjugal bliss than those in the low and high levels.

### 5.3 Recommendations

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

These interventions (Stress Inoculation training and Cognitive Behavioural therapy) can be used to help women going through traumatic experiences to nurture satisfaction in marriage and harmony in homes.

The knowledge provided in the research on past trauma, conjugal bliss, and partner support can provide guidance for parents, teachers, school management, social workers, psychologists, psychiatrist, legal bodies, policy makers including other organisations involved in mediating on behalf of trauma victims as well as survivors to identify, understand and seek appropriate professional help for them.

Whilst Government empowerment programmes are beneficial for enabling women reach their full potentials, psychological assessments and interventions like Stress Inoculation training and Cognitive Behavioural therapy may be needed to assist those who have experienced past trauma.

The study focused on married women with past trauma; however, its knowledge could be extended to premarital counseling sessions for the singles to create a forum where issues of early trauma, its impact on marital relationships and how to cultivate better relationship outcomes can be discussed.

Through this study, it is obvious that some married women who are traumatised need interventions. This can be encouraged by setting up support groups where interventions can be administered. This can be utilised to help the affected women improve functionality and to correct such anomalies like the erroneous culture of silence.

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