# EFFECTS OF COGNITIVE BEHAVIOURAL THERAPY ON OPPOSITIONAL DEFIANT DISORDERS AMONG SECONDARY SCHOOL STUDENTS IN NSUKKA EDUCATION ZONE OF ENUGU STATE

**Ngozi H. Chinweuba**
Department of Counselling and Human Development Studies
Faculty of Education, University of Nigeria, Nsukka

**Abstract**
The study investigated the effects of cognitive behavioural therapy on oppositional defiant disorder among secondary school students in Nsukka Education Zone of Enugu State. The target population of the study consisted of 3357 students in SSSII in the Zone. While the sample for the study was 49 SSII students diagnosed with oppositional defiant disorder from two co-educational senior secondary schools in Nsukka Education Zone. Two research questions and two null hypotheses guided the study. The study adopted pure experimental design, specifically the pretest-posttest control group design. The study adopted an instrument titled Students Oppositional Defiant Disorder Rating Scale (SODDRS). The instrument was validated by three experts, one from the department of Counselling and Human Development Studies. The second from Psychology Unit in the Department of Educational Foundations and the third from the Measurement and Evaluation in the Department of Science Education, all in the Faculty of Education; University of Nigeria, Nsukka. Data collected were analyzed using mean and standard deviations while the null hypotheses were tested using ANCOVA $P<0.05$ level of significance. The finding showed that cognitive behavioural therapy is efficacious in the treatment of oppositional defiant disorder and there is no significant interaction of treatment and gender on the mean of students' oppositional defiant disorder. Recommendations made include the need for counsellors to use CBT to provide treatment and support for both male and female students. The educational implications of these findings were also discussed.

**Keywords:** Cognitive behavioural therapy, oppositional defiant disorders, secondary School students

## Introduction

Students grow and progress through school; some of them constitute a diverse group with special needs. Some of these students may deviate from the norm physically, socially, mentally or emotionally. This necessitates the introduction of such programmes as counselling, cognitive restructuring, and therapy to help them in their adaptation, modification, and adjustment processes as they navigate through secondary education.(Kolo,2015). Secondary School Students are usually between the ages of 12-18 and it is at this stage that the mental curiosity of the child is being developed (Kolo, 2015).

Behaviour is the outward or external expression of the internal or inward processes of the individual. It is an action that can be observed and measured in an objective way (Nwobi & Obiukwu, 2021). Therefore, behaviour is a measurable and observable act, a response to a stimulus. Instances of behaviour include; aggression, gentleness, kindness, temperament, the way one talk, laughs, smile, eat, look and how one interact with others. Sometimes, students display inappropriate behaviour in the classroom which can make it difficult for teachers to teach effectively; students to learn effectively; cause harm to themselves or others and isolate the students from other peers (Yohana, 2018). According to the author, when such behaviour occurs in the classroom settings, often from a student;

it could be termed behaviour problem. Behaviour problem is behaviour that is socially defined as a problem, as a source of concern, or as undesirable by the social and legal norms of conventional society and its institution of authority (Jessor, 2017). In the current society, many secondary school students are suffering from some forms of behaviour problems. These behaviour problems sometimes are manifested in the form of violet activities, students secretly watching sex clips in class, fighting and destruction of property among others (Agwaya, Pamela, Peter, & Ogolla, 2018). According to Kaezkurkin and Fog (2022), behaviour problems are categorized into the following dimensions: conduct disorder (CD), Oppositional Defiant Disorder (ODD), Anxiety or Withdrawal disorders, Socialized aggression, Attention Deficit Hyperactivity Disorder (ADHD), and Childhood Psychosis. This study will concentrate on Oppositional Defiant Disorder (ODD) which mostly beset young people during their developmental years and tend to manifest repeatedly in students of secondary school age, which if left untreated could deteriorate to more complex disorders.

Oppositional Defiant Disorder is conditions which students argue repeatedly with authority figures. It is a condition in which students show resentment, and often throw temper tantrums, and in which physical aggression is limited (Kaczkurkin & Foa, 2022). Oppositional Defiant Disorder according to America Psychiatric Association, (2013) is a form of anger, hot-tempered mood, confrontation or deviant behaviour, or nastiness which last for at least six months as evidenced by at least few symptoms exhibited during interaction with an individual who is not a blood relative. Oppositional Defiant Disorder manifest through loss of temper, disobedience to rules, sluggish, stubbornness, argue extremely, resentful, easily annoyed, ungovernable, unteacheable, desire to harm, vindictive, and disturbing habits in such individuals who are often older than five years (Kyeva, Ireri, & Menecha, 2021).

Oppositional Defiant Disorder is one of the leading contributory causes of indiscipline, disobedience, violence, assault, Vandalism, violating drug and substance abuse in schools, poor student-teacher relations and poor academic performance in schools (Burke, Butler, & Perkins, 2023). Also, Ghosh, Ray and Basuu, (2017), viewed oppositional defiant disorder (ODD) as a mental disorder characterized by disruptive behaviour, a pattern angry and irritable mood, argumentative and vindictive behaviour. Lavigne et al. (2015) suggested that oppositional defiant disorder delineates overt behaviour which contravenes with both informal and formal application in social environmental system. According to Riley, Ahmed and Locke (2016), students with ODD display diverse types of indiscipline and maladjusted behavioural disorders that are not only limited to lying, but includes loss of temper, argumentative, noncompliance with request and rules of grown-ups, deliberate annoyance and blame shifting towards others, violence, dishonesty, alcoholism, disobedience, lesson boycott and pornography practicing. Observably, the secondary school students in Nsukka Education Zone of Enugu State are mostly entangled with ODD problems. Hence, they need to be exposed to Cognitive Behavioural Therapy that would enable them to understand themselves better in order to be able to exhibit acceptable social behaviour.

The term Cognitive Behavioural Therapy (CBT) is a form of Psychotherapy that emphasizes the important role of thinking on how one feels and what one does. It is based on the cognitive model, which is the way we perceive situations that influences how we feel emotionally. Aziz, Seyed, Kianoosh and Mehrangiz (2020), explained that CBT is a form of talking therapy that combines cognitive therapy and behaviour therapy, it focuses on how one thinks about the things going on in one's life, that is, ones thoughts, images,

beliefs and attitudes (ones cognitive processes) and how this impacts on the way one behaves and deal with emotional problems. It then looks at how the person can change any negative pattern of thoughts or behaviour that may be causing such difficulty (Aziz, 2020). CBT is a general classification of Psychotherapy based on social learning theory, which emphasizes how our thinking interacts with how we feel and what we do. It is based on the view that when a person experiences depression, anxiety, or anger that these stresses can be exacerbated (or maintained) by exaggerated or biased ways of thinking and that these patterns can be modified by reducing erroneous and maladaptive beliefs (Berk Leyen, 2017). CBT assumes that changing maladaptive thinking leads to change in emotion and behaviour as observed by Shokri, Alizade and Farrokhi (2018), thus therapist use CBT techniques to help individuals challenge their patterns of thoughts and beliefs and replace 'errors in thinking such as over generalizing, magnifying negatives, minimizing positives and catastrophizing, with more realistic and effective thoughts, thereby decreasing emotional distress and self-defeating behaviour.

Modern forms of CBT include a number of diverse but related techniques such as: exposure therapy, stress inoculation training, cognitive processing therapy, cognitive therapy, relaxation training, dialectical behaviour therapy, and acceptance and commitment therapy (Hayes & Hofmann, 2017). Besides Khakpoor, Saed, and Shahsavar (2019) added that CBT can be organized in three major divisions: coping skills therapies, which stress the development of a repertoire of skills designed to give the patient the instruments to cope with a variety of problem situations; problem solving therapies, which emphasizes the development of general strategies to deal with a broad range of personal difficulties and restructuring therapies, which emphasize the assumption that emotional problems are a consequence of maladaptive thoughts, being the goal of treatment to reframe distorted thinking and to promote adaptive thoughts. Some researchers perceive males as those who exhibit Oppositional Defiant Disorder (ODD) in the classroom more than females, while others perceive females as those who exhibit Oppositional Defiant Disorder (ODD) in the classroom more than males. This to the researcher's mined the issue of gender as a moderating variable of interest.

Gender refers to roles, attributes and values assigned by culture and society to male and female. Gender is culturally constructed distinction between feminist and masculinity (Ajayi, 2020). Gender refers to the widely shared expectations and norms within a society about appropriate male and female behaviours, characteristics and roles (nwobi & Obikwu, 2021). A gender role according to Uwameiye and Isersmeiya (2030), is all the characteristics, expected behaviours and roles of men and women which a particular society has determined and assigned to each sex, and these roles, attributes and values define the behaviour of male and female as well as the relationship between them. They are created and maintained by social institutions such as families, governments, communities, schools, churches and the media (Jessor,2017). Such roles traits, and characteristics as posited by the author, are ascribed distinctively and strictly to male and female. Socialization based on gender even within our schools, assures that females are made aware that they are unequal to males. Examination of the classroom shows that females and males continue to be socialized in ways that work against gender equity. Teachers seem to socialize females towards some feminine ideals. For instance, females are praised for being neat, quite, and calm, whereas males are encouraged to think independently, be active, and speak up. (Jessor, 2017).

Females are socialized in schools to recognize popularity as being important and learn that educational performance and ability are not as important as indicated in a

research conducted by Idigun, (2025), females in grade six and seven were rated on the understanding that for them, being popular and well liked are more important than being perceived as competent or independent. Males, on the other hand, are more likely to rank independence and competence as more important. This feminist socialization of females begins much earlier than the middle grades. At early ages, females begin defining their femaleness in relation to males (Idigun, 2015).

Gender differences in ODD suggest that boys meet criteria more frequently than girls in the ratio of 1:4:1, in preschool and elementary school years (American Psychiatric Association, 2013). However, gender differences appear to disappear in adolescence and beyond (Munkuold, Lundervold & Manger, 2011). Girls, on the other hand, appear to be at a higher risk of developing depression later in life as a result of ODD (Burke, Koyuncu & Fiksenbaum, 2008), boys show a greater tendency in developing ODD (Rowe, Costello, Angold, Copeland & Maughan, 2010). Sasikata and Swarnakumari (2019) carried out a study on parent and teachers' ratings on gender differences in social skills, problem behaviours and academic competence of children with mild intellectual disability in inclusive education. Findings revealed that boys score higher than girls on externalizing and hyperactivity problem behaviours. In all, one does not know whether such differences found in the aforementioned studies could be same in this study. It is based on this premise that the researcher intends to investigate the effect of Cognitive Behavioural Therapy on students with Oppositional Defiant Disorders in Nsukka Education Zone of Enugu State. Two research questions and two hypotheses guided the study.

Purpose of the Study

The general purpose of the study was to the effects of cognitive behavioural therapy on oppositional defiant disorder among secondary school students in Nsukka Education Zone of Enugu State. Specifically, the study sought to:

1. examine the students' mean score on oppositional defiant disorder of those exposed to cognitive behavioural therapy and those in the conventional group?
2. examine the influence of gender on students mean oppositional defiant disorder?

**Research Questions**

The following research questions guided the study;

1. What is students' mean score on oppositional defiant disorder of those exposed to cognitive behavioural therapy and those in the conventional group?
2. What is the influence of gender on students mean oppositional defiant disorder?

**Hypotheses**

**$HO_1$**: There is no significant difference in the mean oppositional defiant disorder scores of students exposed to cognitive behavioural therapy and those in the conventional group.

**$HO_2$**: There is no significant influence of gender on students mean oppositional defiant disorder.

**Methods**

The research adopted pure experimental design specifically; pretest-posttest control groups design. This design is best suited for this study because pure experimental design is one in which subjects is randomly assigned to treatment conditions. The design was in order to find out the effect of the treatment on the participants. The sample of the study was made up of 49 SSII students that were diagnosed and identified with

Oppositional Defiant Disorder (ODD) (21 males and 28 females) from a target population of 3,357 SSII students from the sixty (60) public secondary schools from Nsukka Education Zone of Enugu State. (Source: Post-primary Schools Management Board (PPSMB): Planning and Research Statistics (PRS).

Data for the study were generated using an instrument titled Students Oppositional Defiant Disorder Rating Scale (SODDRS) which was adapted from the Conduct and Oppositional Disorder Scale (CODDS) for Disruptive Behaviour Disorders. The scale was created by Adrian, Shichun, Wesley and J.Anghong (2022). Students Oppositional Defiant Disorder Rating Scale (SODDRS) is a ten-item scale which was used to access for the DSM-IV criteria of oppositional defiant disorders in students. The instrument had two sections. Section 'A' sought respondents' personal data. Section 'B' gave instructions for answering the questionnaire. The instrument was based on a 4-point scale with response options of: Never (1), Sometimes (2), Often (3), or Very often (4). The respondents were required to circle the option that most appeal to them. The reliability coefficient of the instrument yielded a reliability index of 0.95. The instrument was used for both pre-test and post-test data collection. The pretest helped to determine the Students' Oppositional Defiant Disorder (ODD). The experimental group received training using the training manual on the Rational Emotive Behavioural Therapy which was designed to improve the self-control and social skills of students' who are suffering oppositional defiant disorder. The treatment lasted for a period of eight weeks and each session lasted for 45 minutes. While the control group received training using conventional teaching method. Data collected for the study were analyzed using mean, standard deviation and analysis of covariance (ANCOVA) with the help of the Software 'Statistical Package for Social Sciences (SPSS). Mean and Standard deviations were used to answer the research questions while analysis of covariance (ANCOVA) was used to test the hypotheses at 0.05 level of significance.

**Results**

**Table 1**: **Mean and Standard deviation of the oppositional defiant disorder scores of students exposed to cognitive behavioural therapy (CBT) and those in the conventional group**.

| | **Pre-test** | **Post-test** | **Lost Mean** |
|---|---|---|---|
| **N** | Mean Std Deviation | Mean Std Deviation | |
| **Treatment 24** | 34.00 – 3.26 | 17.42 – 1.47 | 17.40 |
| **Control 25** | 34.08 – 3.21 | 30.20 – 1.87 | 30.1 |

Results shows that the students who were exposed to CBT had a mean oppositional defiant disorder score of (M= 34.00, SD= 3.26) at the pretest and a mean oppositional defiant disorder score of (M= 17.42, SD = 1.47) at the posttest. On the other hand, the students in the control group had a mean oppositional defiant disorder scores of (M= 34.08, SD= 3.21) at the pretest and a mean oppositional defiant disorder score of (M=30.20, SD=1.87) at the posttest. The adjusted mean scores of 17.40 and 30.21 for the students of the CBT and control groups respectively, indicates that the students of the CBT group had lesser mean oppositional defiant disorder score than their control group counterparts.

**$H0_1$:** There is no significant difference in the mean oppositional defiant disorder scores of students exposed to cognitive behavioural therapy (CBT) and those in the conventional group.

**Table 2: Analysis of Covariance of the effect of treatment on oppositional defiant scores of students.**

| Source | Type III sum of Square | DF | Mean Square | F - Sig | Partial Square |
|---|---|---|---|---|---|
| **Corrected Model** | 2001.687[a] | 4 | 500.422 | 165.392.000 | 938 |
| **Intercept** | 23.8.711 | 1 | 238.711 | 78.895.000 | 642 |
| **Pre-oppositional Defiant Disorder** | .194 | 1 | .194 | .064.801 | .001 |
| **Treatment** | 1940.397 | 1 | 1940.397 | 641.313.000 | 936 |
| **Error** | 133.129 | 44 | 3.026 | | |
| **Total** | 30215.00 | 49 | 3.026 | | |
| **Corrected Total** | 2134.816 | 48 | | | |

A.R Squared= 938 (Adjusted R Squared= .932)

Result reveals that there is a significant difference in the mean oppositional defiant disorder scores of students exposed to CBT and those in the conventional group in favour of the CBT group, F (1.44) =641.313, P=.000. Thus, the null hypothesis is rejected since the probability value of .000 is less than the 0.05 level of significance. Besides, the effect size of .936 shows that 93.6% reduction in the oppositional defiant disorder is attributed to the effect of CBT.

**Table 3: Mean analysis of the oppositional defiant disorder scores of male and female students**.

| Gender | N | Pretest Mean | STD D | Post-test Mean | STD D | Lost Mean |
|---|---|---|---|---|---|---|
| **Male** | 21 | 33.29 | 3.61 | 24.76 | 6.83 | 23.82 |
| **Female** | 28 | 34.61 | 2.79 | 23.32 | 6.60 | 23.78 |

Result reveals that the male students had a mean oppositional defiant disorder score of (M=33.29, SD=3.61) at the pretest and a mean oppositional defiant disorder score of (M=24.76, SD=6.83) at the post-test, while female students had a mean oppositional defiant disorder score of (F=34.61, SD=2.79) at the pretest and a mean oppositional defiant disorder score of (F=23.32, SD=6.60) at the post-test. The adjusted mean scores of 23.82 and 23.78 for the male and female students respectively, indicates that the female students had lesser mean oppositional defiant disorder score than the male students.

**H0₂**: There is no significant influence of gender on students' mean oppositional defiant disorder.

Table 2 reveals that there is no significant interaction effect of treatment and gender on students' oppositional defiant disorder, $F$ (1, 44) = .005,p = .947. Therefore, the null hypothesis is not rejected (p≥ .05). Hence, gender does not significantly influence the oppositional defiant disorder among students.

**Table 4: Mean analysis of the oppositional defiant disorder scores of male and female students exposed to CBT and those not exposed.**

| Treatment | Gender | N | Pretest Mean | STD D | Post-test Mean | STD D |
|---|---|---|---|---|---|---|
| **CBT** | Male | 9 | 33.67 | 3.57 | 17.33 | 1.50 |
| | Female | 15 | 34.20 | 3.17 | 17.47 | 1.51 |
| **Control** | Male | 12 | 33.00 | 3.77 | 30.33 | 2.06 |
| | Female | 13 | 35.08 | 2.33 | 30.08 | 1.75 |

Result above reveals that the male students who were exposed to CBT had a mean oppositional defiant disorder score of (M=33.67, SD=3.57) at the pretest and a mean oppositional defiant disorder score of (M=17.33, SD=1.50) at the post-test while male students of the control group had a mean oppositional defiant disorder score of (M=33.00, SD=3.77) at the pretest and a mean oppositional defiant disorder score of (M=33.00, SD=2.06) at the post-test. On the other hand, female students who were exposed to CBT had a mean oppositional defiant disorder score of (F=34.20, SD=3.17) at the pretest and a mean oppositional defiant disorder score of (F=17.47, SD=1.51) at the pretest while female students of the control group had a mean oppositional defiant disorder score of (F=35.08, SD=2.33) at the pretest and a mean oppositional defiant disorder score of (F=30.08, SD=1.75) at the pro-test. This means that while the male students of CBT group had lesser mean oppositional defiant disorder than the female students off the CBT, the female students of the control group had lesser mean oppositional defiant disorder than the male students of the control group.

**Discussion**

One of the findings of the study reveals that students in Nsukka Education Zone of Enugu State who were exposed to CBT group had lesser mean opposition defiant disorder score than the control counterparts. Thus, it was further revealed that there is a significant difference in the mean oppositional defiant disorder scores of students exposed to cognitive behavioural therapy (CBT) and those in the conventional group in favour of the CBT group. This is not strange because CBT helps clients understand the thoughts and feelings that influence behaviour. Students exposed to CBT are now more obedient and peaceful, having gained the ability to control their temper, avoid being touchy, refraining from arguments, verbal abuse and their former blame game. They now have positive relationship with their teachers and other students. The findings of this study is consistent with the findings of Susan, Pluterion, Winnie and Alice (2018) whose study investigated the efficacy of cognitive behaviour therapy on oppositional defiant disorder among children in selected primary schools in Niarobi Country, Kenya. The study established that CBT was effective in the reduction of ODD Symptoms in children.

Another findings of the study indicated that, female students had lesser mean oppositional defiant disorder score than the male students. The findings show that female students are less prevalent to ODD than their male counterparts and this is not new because the American Psychiatric Association (2013) states that boys meet the ODD criteria more frequently than the girls in the ratio of 1:4. This is the reason behind male students being angrier, disobedient and fights more frequently than their female counterpart. The findings were in agreement with the findings of Sasikala and Swarnakumari (2019) whose study is on parent and teacher ratings on gender differences in social skills, problem behaviours and academic competence of children with mild intellectual disability in inclusive education. Findings revealed that boys score higher than

girls on externalizing and hyperactivity problem behaviours with no gender differences on internalizing.

**Conclusion**

The present study made it possible to empirically examine the effect of Cognitive Behavioural Therapy (CBT) on Oppositional Defiant Disorder in Secondary Schools in Nsukka Education Zone of Enugu State. It is evident that CBT is highly more efficacious than conventional counselling in eliminating oppositional defiant disorder. Therefore, cognitive behavioural therapy should be used frequently by counsellors in both co-educational and single sex schools in Nsukka Education Zone of Enugu State to bring treatment and support to secondary school students with oppositional defiant disorder.

**Recommendations**

Based on the findings of the study, the following recommendations were proffered:

1. Counsellors should use CBT to bring treatment and support to their students manifesting oppositional defiant disorder. They should stop concentrating on conventional counselling which is less efficacious.
2. Counsellors should devote more efforts on the male students during therapy since they have higher mean oppositional defiant disorders than their female counterparts. Again, the frequency of treatment for male students should be higher than their female counterparts so as to eliminate this observed difference in order for them to profit maximally in their academics.

## REFERENCES


Adrian, R., Shichun, L., Wesley, S., & Jianghong, L. (2022). The conduct and oppositional defiant disorder scales (CODDS) for disruptive behaviour disorders (pp. 20–26). https://www.elsevier.com/open-acess/userliense/1.0/

Agwaya, A. J., Aloka, J. O., Raburu, P. A., & Ogolla, P. O. (2018). Relationship between self-esteem and indulgence in behaviour problems among secondary school students in Kenya. *Mediterranean Journal of Social Sciences, 9*(3), 135–142.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Association.

Aziz, M. O., Seyed, A. M., Kianoosh, H., & Mehrangiz, P. (2020). Interactive therapy (short-term psychodynamic psychotherapy & cognitive behavioural therapy) and cognitive behavioural therapy in the treatment of generalized anxiety disorder: A randomized controlled trial. *Complementary Therapies in Clinical Practice, 39*, Article 101122.

Berkleyen, N. (2017). Understanding the academic procrastination attitude of language learners in Turkish universities. *Educational Research and Review, 12*(3), 108–115.

Burke, J. D., Butler, E. J., & Perkins, A. G. (2023). *Disruptive behaviour disorders in children and adolescents in school psychology*. Oxford University Press.

Burke, R. J., Koyuncu, M., & Fiksenbaum, L. (2008). Gender differences in work experiences, satisfactions and well-being among physicians in Turkey. *Gender in Management: An International Journal, 24*, 70–79.

Ghosh, A., Ray, A., & Basu, A. (2017). Oppositional defiant disorder: Current insight. *Psychology Research and Behaviour Management, 10*, 103–116. https://doi.org/10.2147/PRBM.S120582

Hayes, S. C., & Hofmann, S. G. (2017). The third wave of cognitive behavioural therapy and the rise of process-based care. *World Psychiatry, 16*(3), 245–246. https://doi.org/10.1002/wps.20442

Idigun, O. (2016). Efficacy of cognitive behavioural therapy on enhancing low self-esteem among secondary school students in Ethiope-East local government area. *Academic Journal of Educational Research, 4*(1), 1–7.

Jessor, R. (2017). *Problem behavior theory and adolescent health: The collected works of Richard Jessor (Vol. 2).* https://doi.org/10.1007/978-3-319-51349-2

Kaczkurkin, A. N., & Foa, E. B. (2022). Cognitive-behavioural therapy for anxiety disorders: An update on the empirical evidence. *Dialogues in Clinical Neuroscience.*

Khakpoor, S., Saed, O., & Shahsavar, A. (2019). The concept of anxiety sensitivity in social anxiety disorder presentations, symptomatology, and treatment: A theoretical perspective. *Cogent Psychology, 6*(1), Article 1617658. https://doi.org/10.1080/23311908.2019.1617658

Kolo, I. (2015). Education sector reforms and road map for Buhari government. http://leadership.ng/features/448136/education-sector-reforms-and-road-map-for-buhari-government

Lavigne, J. V., Bryant, F. B., Hopkins, J., & Gouze, K. R. (2015). Dimensions of oppositional defiant disorder in young children: Model comparisons, gender and longitudinal invariance.

Munkvold, L. H., Lundervold, A. J., & Manger, T. (2011). Oppositional defiant disorder: Gender differences in co-occurring symptoms of mental health problems in a general population of children. *Journal of Abnormal Child Psychology, 39*(4), 577–587.

Nwobi, N. L., & Obiukwu, A. C. (2021). Effect of cognitive behaviour therapy on mathematics test anxiety and achievement of secondary school students in Ogidi education zone, Anambra State, *4*(2).

Riley, M., Ahmed, S., & Locke, A. B. (2016). Common questions about oppositional defiant disorder. *American Family Physician, 93*(7), 586–591.

Rowe, R., Costello, E. J., Angold, A., Copeland, W. E., & Maughan, B. (2010). Developmental pathways in oppositional defiant disorder and conduct disorder. *Journal of Abnormal Psychology, 119*, 726–738. https://doi.org/10.1037/a0020798

Sasikala, G., & Swarnakumari, P. (2019). Parent and teacher ratings on gender differences in social skills, problem behaviours and academic competence of children with mild intellectual disability in inclusive education. *Journal of Social Psychology, 25*, 33–41.

Susan, C., Philemon, Y., Winnie, W., & Alice, M. (2018). The efficacy of cognitive behaviour therapy on oppositional defiant disorder among children in selected primary schools in Nairobi County, Kenya. *International Journal of Current Research, 10*(10), 74026–74038.

Uwameiye, B. E., & Iserameiya, F. E. (2013). Gender based violence in Western Nigeria. Retrieved February 15, 2026, from http://ichfik.org/gender-based-violence-in-westernNigeria

Yohana, A. (2018). *Effect of cognitive behaviour therapy on intellectual achievement responsibility among students* (Doctoral dissertation, Ahmadu Bello University, Zaria).