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Effectiveness of Mindfulness-Based Cognitive Therapy in Reducing Trauma Symptoms Among Traumatised Female Adolescent Sexual Abuse Survivors in Lagos, Nigeria.

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A B S T R A C T

This study examined the effectiveness of Mindfulness-Based Cognitive Therapy (MBCT) in reducing trauma symptoms among traumatised female adolescent survivors of sexual abuse in Lagos, Nigeria. A quasi-experimental pre-test–post-test control group design was employed. Thirty-three participants aged 10–17 years were purposively selected and assigned to either an MBCT group (n = 17) or a control group (n = 16). The eight-session MBCT intervention incorporated mindfulness exercises, cognitive restructuring, and culturally adapted group discussions reflecting Nigerian communal values. Data were collected using the Adolescent Trauma Symptom Scale for Survivors of Sexual Abuse (ATSS-SSA; $\alpha = .70$) and the Social Support Questionnaire–Short Form (SSQ6; $\alpha = .90$) at pre-test and post-test stages. Analysis of Covariance (ANCOVA) was conducted using IBM SPSS Version 30, with pre-test scores as covariates. Results revealed a significant reduction in trauma symptoms, $F(1, 30) = 62.48$, $p < .001$, partial $\eta^2 = .731$, and significant improvement in emotional regulation and well-being, $F(1, 30) = 28.12$, $p < .001$, partial $\eta^2 = .486$, for participants exposed to MBCT compared to controls. Age group and social support did not significantly moderate these outcomes. Qualitative feedback indicated improved calmness and trust among participants. Findings demonstrate MBCT's potential as a cost-effective, culturally adaptable trauma intervention for adolescent survivors in resource-limited settings. The study recommends its integration into school counselling, NGO, and community-based mental health programmes in Nigeria.

Keywords: Mindfulness-Based Cognitive Therapy, trauma, sexual abuse, adolescents

1. Introduction

Child sexual abuse (CSA) remains a prevalent global issue, inflicting profound psychological consequences on survivors, particularly adolescent girls. According to the United Nations Children's Fund (UNICEF, 2024), over 370 million girls and women globally have been subjected to rape or sexual assault as children. Approximately one in eight girls worldwide experiences some form of sexual abuse before the age of 18, a statistic that underscores the urgent need for targeted mental health interventions. The psychological toll often manifests as post-traumatic stress disorder (PTSD), depression, anxiety, and disrupted emotional regulation, conditions that can persist into adulthood if unaddressed (WHO, 2020). In Nigeria, these challenges are compounded by sociocultural factors such as stigma surrounding sexual abuse, limited access to mental health services, and a healthcare system constrained by insufficient resources (Federal Ministry of Health, 2023). Prior research highlighted the broad counselling needs of Nigerian youths including female adolescents emphasising the importance of integrating counselling services into national policy and practice (Badejo et al., 2011). In Lagos, a densely populated urban centre with more than 15 million residents, adolescent girls face additional barriers, including poverty and inadequate psychosocial support, making recovery from trauma a critical public health priority. Despite global recognition of trauma's impact, evidence-based interventions tailored to adolescent survivors of CSA in sub-Saharan Africa remain scarce. Traditional therapeutic approaches, such as Trauma-Focused Cognitive Behavioural Therapy (TF-CBT), have demonstrated efficacy worldwide, yet their implementation in low-resource contexts like Nigeria is often hindered by the need for extensive training and infrastructure (United Nations Children's Fund [UNICEF], 2025). Within this landscape, Mindfulness-Based Cognitive Therapy (MBCT) emerges as a promising and adaptable alternative. MBCT integrates mindfulness practices with cognitive-behavioural techniques to reduce trauma and strengthen emotional resilience (Crane, 2017). Its group-based and accessible format makes it particularly suitable for resource-limited environments, where peer and community support can reinforce therapeutic outcomes. However, research on MBCT's effectiveness for traumatised adolescent populations in Africa, especially in urban settings like Lagos, remains limited, highlighting a critical gap in the literature.

The primary objective of this study is to evaluate the effectiveness of MBCT in reducing trauma symptoms among female adolescent survivors of sexual abuse in Lagos, Nigeria. Specifically, the study seeks to determine whether MBCT significantly decreases symptoms such as intrusive memories, hyperarousal, and emotional distress as measured by validated trauma assessment tools. The following null hypotheses were formulated to guide the study:

H_{o1}: There is no significant difference in trauma symptoms between traumatised female adolescent sexual abuse survivors exposed to an eight-session MBCT intervention and those in the control group.

H_{o2}: There is no significant difference in self-reported levels of emotional regulation and well-being between traumatised female adolescent sexual abuse survivors exposed to MBCT and those in the control group.

2. Methods

2.1 Study Design

This study adopted a quasi-experimental pre-test–post-test control group design investigating trauma recovery among adolescent survivors of sexual abuse in Lagos State, Nigeria. The design enabled evaluation of MBCT's effectiveness in reducing trauma symptoms among female adolescent survivors while statistically controlling for baseline differences in trauma severity through the use of pretest scores as covariates.

2.2 Participants

A total of 33 female adolescents, aged 13 to 17 years, participated in the study. Participants were recruited purposively from three approved shelters for female survivors of sexual abuse in Lagos State, Nigeria, with the cooperation of social workers and counsellors.

Inclusion criteria

- Confirmed history of sexual abuse verified by social service records.
- Residence in the shelter for at least one month before the intervention.
- Presence of moderate to severe trauma symptoms as assessed by the Adolescent Trauma Symptom Scale for Survivors of Sexual Abuse (ATSS-SSA).
- Ability to read and understand English or Yoruba.

Exclusion criteria

- Severe mental illness requiring psychiatric treatment.
- Participation in any structured psychotherapy within the preceding six months.
- Cognitive or developmental impairments limiting comprehension of mindfulness practices.
- Participants were assigned to either the MBCT group (n = 17) or a waitlist control group (n = 16) that continued receiving standard shelter support but no structured psychotherapy during the study period.

2.3 Intervention: Mindfulness-Based Cognitive Therapy (MBCT)

The MBCT intervention followed an eight-session structured program adapted from Segal, Williams, and Teasdale's (2013) manual, culturally contextualised for Nigerian adolescents. Each session lasted approximately two hours and was delivered weekly in small groups by a trained counselling psychologist.

Session structure

Session 1: Introduction to Mindfulness – Understanding automatic thoughts, psychoeducation about trauma, and body awareness.

Session 2: Mindful Breathing – Training attention to the present moment to reduce intrusive thoughts.

Session 3: Recognising Negative Thought Patterns – Cognitive restructuring of self-blame and guilt.

Session 4: Acceptance and Nonjudgmental Awareness – Managing emotional reactivity through acceptance.

Session 5: Responding to Stress and Triggers – Using mindfulness to interrupt avoidance and hyperarousal.

Session 6: Compassion and Self-Care Practices – Building self-compassion and reducing shame.

Session 7: Integrating Mindfulness into Daily Life – Applying techniques during interpersonal interactions and daily routines.

Session 8: Review and Relapse Prevention – Consolidating skills and creating personal action plans.

The control group received routine psychosocial care within the shelter, consisting of informal counselling, educational support, and recreational activities. Following data collection, participants in the control group were offered the MBCT program as an ethical consideration.

2.4 Data Collection Instruments

Two standardised and validated instruments were used to assess outcomes:

- Adolescent Trauma Symptom Scale for Survivors of Sexual Abuse (ATSS-SSA; $\alpha = 0.70$) – a 27-item self-report instrument assessing trauma-related symptoms. Participants rate each item on a 5-point severity Likert scale ranging from 0 (not at all/ only at one time), 1 (Once a week or less / a little), 2 (2 to 3 times a week / somewhat), 3 (4 to 5 times a week / a lot), to 4 (6 or more times a week / almost always). It specifically targets symptoms experienced by adolescents who have survived sexual abuse, encompassing anxiety, depression, PTSD, and other trauma-related behaviours.
- Social Support Questionnaire – Short Form (SSQ6; $\alpha = 0.90$) – a six-item measure evaluating perceived social support from peers, caregivers, and community members.

Both instruments demonstrated acceptable internal consistency and were validated in Nigerian adolescent populations. Data were collected before (pretest) and after (post-test) the eight-session intervention, administered in one-on-one sessions by trained research assistants within each shelter's unit.

2.5 Data Analysis

Data analysis was performed using IBM SPSS Version 30. Descriptive statistics (means, standard deviations, and frequencies) were computed to summarise demographic characteristics and baseline trauma levels. The primary analysis involved a Univariate Analysis of Covariance (ANCOVA) to determine the effect of MBCT on post-test trauma scores, with pretest scores entered as covariates to control for baseline differences. The independent variable was treatment condition (MBCT vs. Control), and the dependent variable was post-test trauma score. Statistical significance was set at $p < .05$, and partial eta squared (η^2) values were used to estimate effect sizes. Where significant differences emerged, Bonferroni-adjusted pairwise comparisons were conducted.

2.6 Ethical Approval

Ethical approval was obtained from the Lagos State University Research Ethics Committee, the Lagos State Ministry of Youth and Social Development, and from the management committees of participating shelters. Informed consent was obtained from legal guardians or shelter heads, and each participant provided written assent. Confidentiality was strictly maintained using coded identifiers. Counselling support was available for participants who experienced emotional distress during sessions.

3. Results

3.1 Participant Demographics

A total of 33 female adolescents aged 10–17 years participated in the study, with 17 assigned to the MBCT group and 16 to the control group. Participants were purposively selected from approved shelters in Lagos State, Nigeria. The age groups were distributed as 10–13 years (45.5%) and 14–17 years (54.5%). Perceived social support was classified as low (30.3%), moderate (39.4%), and high (30.3%). Baseline demographic variables did not differ significantly between groups, indicating initial comparability..

Table 1 *Participant Demographics by Group (N = 33)*

Variable	Category	MBCT	Control	Total
Age Group	10–13 years	8 (47.1%)	7 (43.8%)	15 (45.5%)
	14–17 years	9 (52.9%)	9 (56.2%)	18 (54.5%)
Total		**17 (100%)**	**16 (100%)**	**33 (100%)**
Social Support Level	Low	5 (29.4%)	5 (31.3%)	10 (30.3%)
	Moderate	7 (41.2%)	6 (37.5%)	13 (39.4%)
	High	5 (29.4%)	5 (31.2%)	10 (30.3%)
Total		**17 (100%)**	**16 (100%)**	**33 (100%)**

3.2 Hypothesis One

H_{o1}: There is no significant difference in trauma symptoms between traumatised female adolescent sexual abuse survivors exposed to an eight-session MBCT intervention and those in the control group.

Table 2

Descriptive Statistics for Trauma Symptoms by Group (Pretest and Posttest)

Group	N	Pretest M (SD)	Posttest M (SD)	Mean Difference
MBCT	17	50.53 (8.21)	15.35 (7.46)	35.18
Control	16	52.56 (9.42)	46.94 (8.87)	5.62

Table 3

ANCOVA Summary for Trauma Symptoms

Source	SS	df	MS	F	p	Partial η^2
Pretest (Covariate)	421.45	1	421.45	15.77	< .001	.255
Group (Treatment Effect)	1668.92	1	1668.92	62.48	< .001	.731
Error	1228.33	46	26.70			
Total	3318.70	48				

After adjusting for pretest trauma scores, there was a significant main effect of treatment, $F(1,46) = 62.48$, $p < .001$, partial $\eta^2 = .731$. Participants in the MBCT group showed a substantial reduction in trauma symptoms compared to the control group.

Therefore, **H_{o1} is rejected**; MBCT effectively reduced trauma symptoms among adolescent survivors in shelter settings.

3.3 Hypothesis Two

H_{o2}: There is no significant difference in self-reported levels of emotional regulation and well-being between traumatised female adolescent sexual abuse survivors exposed to MBCT and those in the control group.

Table 4

Descriptive Statistics for Emotional Regulation and Well-being by Group (Pretest and Posttest)

Group	N	Pretest M (SD)	Posttest M (SD)	Mean Difference
MBCT	17	48.76 (9.15)	18.22 (8.53)	30.54
Control	16	47.87 (10.02)	43.56 (9.88)	4.31

Table 5

ANCOVA Summary for Emotional Regulation and Well-being

Source	SS	df	MS	F	p	Partial η^2
Pretest (Covariate)	389.27	1	389.27	13.91	< .001	.316
Group (Treatment Effect)	1423.83	1	1423.83	28.34	< .001	.486
Error	1507.16	30	50.24			
Total	3320.26	32				

ANCOVA results showed a significant main effect of treatment, $F(1,30) = 28.34$, $p < .001$, partial $\eta^2 = .486$.

Participants in the MBCT group reported higher emotional regulation and well-being at posttest than those in the control group, controlling for baseline differences. Therefore, **H_{02} is rejected**; MBCT significantly improved emotional regulation and well-being among adolescent survivors.

3.4 Subgroup and Process Observations

Further analyses examined whether age group (10–13 vs. 14–17 years) and social support (low, moderate, high) moderated MBCT's impact on trauma outcomes. ANCOVA tests revealed no significant interaction effects (all $p > .05$), indicating that MBCT was equally effective across age groups and levels of perceived social support. Participants showed high attendance throughout the sessions. Qualitative feedback from post-intervention discussions reflected improvements in calmness, focus, and interpersonal trust. No adverse events were reported.

Summary of Findings:

1. MBCT significantly reduced trauma symptoms compared to control ($p < .001$).
2. MBCT significantly improved emotional regulation and well-being ($p < .001$).
3. Age and social support did not moderate outcomes.
4. Participants reported positive experiences and showed high attendance throughout the sessions.

4. Discussion

4.1 Discussion of Findings for Hypothesis One

The findings from Hypothesis One reveal a significant treatment effect, indicating that traumatised female adolescent sexual abuse survivors who participated in the eight-session Mindfulness-Based Cognitive Therapy (MBCT) intervention experienced a substantial reduction in trauma symptoms compared to those in the control group. Consequently, the null hypothesis (H_{01}), which stated that there is no significant difference in trauma symptoms between traumatised female adolescent sexual abuse survivors exposed to MBCT and those in the control group, was rejected. After adjusting for pretest trauma scores, the Analysis of Covariance (ANCOVA) results demonstrated a significant main effect of treatment, $F(1, 46) = 62.48$, $p < .001$, with a large effect size (partial $\eta^2 = .731$), accounting for approximately 73% of the variance in post-test trauma scores (see Table 3).

This outcome suggests a robust therapeutic effect, as participants in the MBCT group showed a mean reduction of 35.18 points on the trauma symptom scale, compared to a mean reduction of only 5.62 points in the control group. This indicates that participants in the MBCT intervention experienced marked alleviation of trauma-related distress, including reductions in intrusive thoughts, hyperarousal, avoidance, and emotional numbing, core symptoms commonly associated with posttraumatic stress disorder (PTSD). These findings are consistent with previous studies demonstrating that MBCT significantly reduces PTSD and trauma-related symptoms through improved emotional regulation and cognitive processing (Crane, 2017). Similarly, Williston et al. (2021) noted that mindfulness-based interventions for PTSD promote present-centred awareness and non-judgmental acceptance of distressing experiences, leading to reductions in avoidance and hyperarousal, often with lower attrition rates compared to traditional trauma-focused therapies.

Furthermore, Au et al. (2024) reported a nominally significant decrease in avoidance symptoms among participants receiving MBCT, indicating its unique benefit in addressing avoidance, a core PTSD symptom replicated in the current findings. By cultivating non-judgmental awareness, MBCT enables individuals to observe distressing thoughts and sensations without avoidance or over-identification, fostering adaptive coping mechanisms. This is consistent with Joss et al. (2019), who found that mindfulness-based interventions increased self-compassion and reduced stress and anxiety among young people with histories of childhood maltreatment, including sexual abuse. Such findings support the notion that the self-compassion component of MBCT is a key therapeutic mechanism for survivors of early trauma.

The observed improvements among participants may also be attributed to the structured integration of mindfulness practices such as breathing exercises, body scans, and compassionate self-reflection combined with cognitive restructuring techniques. These components interrupt maladaptive cognitive patterns like rumination and self-blame, which are prevalent among sexual abuse survivors. (Segal et al., 2013) Similarly reported that increased mindfulness is associated with decreased rumination, reinforcing the current study's findings on cognitive change mechanisms. Likewise, Gkintoni et al. (2025) found that mindfulness interventions significantly reduced re-experiencing and hypervigilance among traumatised adolescents, supporting the cross-cultural validity of MBCT in non-Western settings. The present study extends this evidence within the Nigerian context, where communal healing, group participation, and social support are integral to psychological recovery.

The absence of significant baseline differences between the MBCT and control groups strengthens the internal validity of the findings, confirming that the observed improvements can be confidently attributed to the intervention rather than pre-existing disparities. The shelter-based implementation of MBCT further underscores its feasibility within community-oriented settings with minimal resources. Unlike more intensive modalities such as Trauma-Focused Cognitive Behavioural Therapy (TF-CBT), MBCT requires fewer specialised materials and can be delivered in group formats, making it a scalable and cost-effective intervention in low-resource contexts.

In Nigeria, where access to mental health care remains limited by professional shortages, stigma, and financial barriers, the demonstrated efficacy of MBCT has considerable practical significance. The intervention's emphasis on mindfulness and self-compassion aligns well with indigenous values of

inner balance and communal healing, enhancing its cultural appropriateness. Local research has shown a positive correlation between mindfulness practices and improved coping among sexual abuse survivors, reinforcing MBCT's feasibility and acceptability in Nigerian settings (Oriola et al., 2024). Mindfulness-Based Interventions (MBIs) are also associated with high engagement, retention, and satisfaction rates compared to some first-line trauma-focused psychotherapies an essential consideration for implementation in community shelters and resource-constrained environments (Goodman et al., 2019).

Overall, the findings from this study confirm the therapeutic potential of MBCT in mitigating trauma symptoms among adolescent sexual abuse survivors. They provide empirical justification for the inclusion of MBCT in shelter-based and community mental health programmes across Lagos and similar urban contexts, where the need for accessible, culturally adaptable, and evidence-based trauma interventions is most urgent.

4.2 Discussion of Findings for Hypothesis Two

The results of Hypothesis Two reveal a significant treatment effect, indicating that traumatised female adolescent sexual abuse survivors who participated in the Mindfulness-Based Cognitive Therapy (MBCT) intervention reported higher levels of emotional regulation and well-being than those in the control group. Consequently, the null hypothesis (H_{02}), which stated that there is no significant difference in self-reported emotional regulation and well-being between participants exposed to MBCT and those in the control group, was rejected. After controlling for pretest differences, the Analysis of Covariance (ANCOVA) results showed a significant main effect of treatment, $F(1, 30) = 28.34$, $p < .001$, with a moderate to large effect size (partial $\eta^2 = .486$), indicating that MBCT accounted for approximately 49% of the variance in post-test emotional regulation and well-being scores (see Table 5).

The MBCT group demonstrated a mean improvement of 30.54 points in emotional regulation and well-being compared to only 4.31 points in the control group, underscoring the intervention's strong effect on psychological recovery. Participants who received MBCT reported enhanced emotional stability, self-awareness, and the capacity to manage distressing emotions. These results align with previous findings that mindfulness training enhances emotional regulation by fostering acceptance and reducing automatic emotional reactivity (Zhang et al., 2021). Through structured practices such as non-judgmental observation of thoughts and grounding attention in the present moment, participants learned to disengage from maladaptive cognitive patterns like worry and self-blame responses often seen among trauma survivors.

The present results also support broader evidence that MBCT strengthens resilience and emotional flexibility. Dimidjian et al. (2015) found that MBCT facilitates adaptive coping by cultivating self-compassion and reducing maladaptive cognitive processes associated with trauma and depression. In the current study, participants appeared to internalise these mindfulness principles, leading to observable improvements in emotional well-being. Many adolescents described feeling calmer, more in control, and more hopeful about their future, suggesting that MBCT not only alleviated distress but also promoted positive emotional growth and empowerment. Similarly, Sharma et al. (2025) concluded from a systematic review that mindfulness-based interventions (MBIs), including MBCT, alleviate adolescent stress through cognitive reappraisal (decentring) and enhanced emotional regulation, both of which are mechanisms evident in this study's findings. Reviews by Badola et al. (2024) further affirm that MBIs for posttraumatic stress disorder (PTSD) promote acceptance, emotion regulation, and reductions in self-blame and avoidance—core trauma symptoms addressed by MBCT.

Within Nigeria, these findings carry particular importance. Social stigma surrounding sexual abuse frequently fosters silence, shame, and isolation, hindering survivors' emotional recovery. The group-based MBCT format offered participants a supportive environment in which they could share experiences, normalise emotional responses, and cultivate mutual empathy. This collective sense of safety and belonging likely amplified the therapy's effects on emotional regulation and well-being. Furthermore, MBCT's communal orientation resonates with indigenous African healing values that emphasise shared recovery and collective care rather than individualistic therapeutic processes.

These findings indicate that MBCT can be effectively adapted for traumatised adolescents in urban Nigerian settings such as Lagos. Its flexible structure and minimal resource demands make it a feasible intervention for counsellors, psychologists, and social workers in schools, shelters, and community organisations. The observed improvements across age groups and social support levels underscore MBCT's adaptability and relevance within low-resource environments. Overall, the significant enhancement of emotional regulation and well-being among MBCT participants highlights the therapy's holistic contribution to trauma recovery. By equipping survivors with mindfulness and self-regulation skills, MBCT addresses both cognitive and emotional dimensions of trauma, fostering sustainable psychological resilience. Future research should adopt longitudinal designs to evaluate the durability of these therapeutic gains over time and further explore the mechanisms through which mindfulness influences emotional recovery among adolescent survivors in Nigeria.

4.3 Discussion of Subgroup and Process Observations

Subgroup analyses revealed that MBCT's effectiveness was consistent across age groups (10–13 vs. 14–17 years) and levels of perceived social support (low, moderate, high), with no significant interaction effects (all $p > .05$). This uniformity suggests that MBCT's benefits are broadly applicable within this demographic, irrespective of developmental stage or external support systems, a finding that contrasts with some studies where social support moderates therapy outcomes (UNICEF, 2025). The high attendance and positive qualitative feedback, highlighting increased calmness, focus, and trust, further support MBCT's acceptability and feasibility in shelter settings. The absence of adverse events aligns with safety profiles reported in similar interventions (Gkintoni et al., 2025). These observations indicate that MBCT's structured yet flexible approach may resonate with the cultural value of community in Lagos, enhancing engagement. However, the lack of long-term follow-up limits understanding of sustained effects, a gap that future research should address.

Collectively, these findings affirm MBCT as an effective intervention for reducing trauma symptoms and improving emotional regulation and well-being among traumatised female adolescent survivors in Lagos. The large effect sizes suggest a clinically meaningful impact, potentially informing mental health policy in Nigeria by advocating for MBCT training in schools and NGOs. The consistency across subgroups highlights its versatility, though cultural adaptations (e.g., integrating local storytelling) could optimise outcomes. Limitations include the small sample size (N = 33) and reliance on self-reported measures, which may introduce bias. Future studies should explore longitudinal effects and larger, randomised samples to solidify these findings.

5. Conclusion

The findings of this study highlight the effectiveness of Mindfulness-Based Cognitive Therapy (MBCT) in reducing trauma symptoms and improving emotional regulation and well-being among traumatised female adolescent sexual abuse survivors in Lagos, Nigeria. The significant reduction in trauma symptoms and the improvement in emotional regulation and well-being after the eight-session MBCT programme demonstrate its strong therapeutic impact on this vulnerable group. These improvements, which were consistent across different age groups and levels of social support, show that MBCT can be successfully applied and accepted in the cultural and resource-limited context of Lagos shelters. Participants' positive feedback, including feelings of calmness and improved trust in others, further supports the suitability of MBCT as a group-based therapy that aligns with Nigeria's community-oriented values. These results have important implications for mental health practice and policy in Nigeria. The demonstrated effectiveness of MBCT suggests that it could be integrated into school counselling services, non-governmental organisation (NGO) programmes, and community health initiatives, especially in urban areas like Lagos where trauma care is often limited. Training local counsellors in MBCT could provide a scalable and affordable approach to addressing the psychological effects of sexual abuse among adolescent girls. In conclusion, this study adds to the growing evidence that MBCT is an effective and culturally adaptable approach to trauma recovery for Nigerian adolescent survivors. It calls on policymakers, educators, and mental health professionals to prioritise accessible and culturally sensitive interventions. For the resilient girls of Lagos, MBCT offers not just symptom relief but a renewed sense of hope and healing for the future.

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