EFFECTS OF COGNITIVE RESTRUCTURING AND GRADED EXPOSURE COUNSELLING TECHNIQUES ON SCHOOL PHOBIA AMONG SECONDARY SCHOOL STUDENTS IN KADUNA METROPOLIS, NIGERIA

BY

AHMED, Mustapha Shina
Ph.D/EDUC/5201/2009-2010

DEPARTMENT OF EDUCATIONAL PSYCHOLOGY AND COUNSELLING,
FACULTY OF EDUCATION,
AHMADU BELLO UNIVERSITY,
ZARIA, NIGERIA

APRIL, 2016

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BY

AHMED, Mustapha Shina
N.C.E, B.Ed. (1995), M. Ed. (2006) (Unilorin)

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

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF DOCTOR OF PHILOSOPHY IN EDUCATIONAL GUIDANCE AND COUNSELLING IN THE DEPARTMENT OF EDUCATIONAL PSYCHOLOGY AND COUNSELLING, FACULTY OF EDUCATION, AHMADU BELLO UNIVERSITY, ZARIA

APRIL, 2016

DECLARATION

I declare that the work in the thesis entitled "Effects of Cognitive Restructuring and Graded Exposure Counselling Techniques on School Phobia among Secondary School Students in Kaduna Metropolis, Nigeria" has been written by me in the Department of Educational Psychology and Counselling under the supervision of Dr. Mustapha I. Abdullahi, Prof. Raliya M. Bello, and Dr. Yunusa Umaru. The information derived for the literature has been duly acknowledged in the text and a list of references provided. No part of this thesis was previously presented for another degree or diploma at this University or any other Institution.

_____ _____

AHMED, Mustapha Shina **Date**
Ph.D/EDUC/5201/2009-10

CERTIFICATION

This thesis entitled **"**EFFECTS OF COGNITIVE RESTRUCTURING AND GRADED EXPOSURE COUNSELLING TECHNIQUES ON SCHOOL PHOBIA AMONG SECONDARY SCHOOL STUDENTS IN KADUNA METROPOLIS, NIGERIA" by AHMED Mustapha Shina meets the regulations governing the award of PhD in Educational Guidance and Counselling of Ahmadu Bello University, Zaria, and is approved for its contribution to knowledge and literary presentation.

_____ _____

Dr. Mustapha I. Abdullahi **Date**
Chairman, Supervisory Committee

_____ _____

Prof. Raliya M. Bello **Date**
Member, Supervisory Committee

_____ _____

Dr. Yunusa Umaru **Date**
Member, Supervisory Committee

_____ _____

Dr. Aisha Muhammed **Date**
Head, Department of Educational
Psychology and Counselling

_____ _____

Prof. Kabir Bala **Date**
Dean, Postgraduate School

DEDICATION

This thesis is dedicated to my late Parents in persons of Hajiya Fatima Ahmad Pass and my late Father, Alhaji Ahmadu Pass Mustapha. Their invaluable contributions to my success will remain in my mind forever. May Allah grant them Aljanatul Firdausi (Amen).

ACKNOWLEDGEMENTS

The researcher's foremost gratitude goes to Allah (SWT) for His grace, wisdom, guidance and mercy that facilitated the completion of this study, and for keeping him alive and in good health to witness the completion of this work. This thesis contains the result of a research conducted with the help and guidance of several people without whom the work would not have been completed. Naturally, not all of them can be mentioned individually, so to those in the group of unmentioned, the researcher owes a world of debt and appreciate their willing help and devotion.

The researcher wishes to acknowledge the contributions of the Thesis Supervisors. He is most grateful to Dr. Mustapha I. Abdullahi, Professor Raliya M. Bello, and Dr. Yunusa Umaru, for not only helping him to conceptualise, implement and successfully complete this thesis but helping him whenever he needed help, guiding him at the appropriate times and having confidence in him. Indeed they are truly great teachers, and the researcher will forever remain grateful to them.

The researcher's sincere gratitude also goes to the Head of Department of Educational Psychology and Counselling, Dr. Aisha Muhammed for her co-operation, support and timely advice. Besides, the researcher wishes to express his deepest appreciation to members of the department in ABU particularly Prof. Musa Balarabe, Prof. Khadija Mahmoud, Dr. Hadiza Tukur, Dr. U. Abdulwahid, Dr. (Mrs) Bawa, and Prof. D.A. Oliagba for their significant contributions. The researcher wishes to express a very special gratitude to the internal supervisors in persons of Professors M. Balarabe, C.E. Dikki, and M. A. Suleiman. Their constructive criticism have added colour to this work.

Moreover, members of the administrative staff in the department were very helpful to the researcher in a diverse way particularly Malam Muazu and Mr Bashir. Researcher wishes

to express his appreciation to Dr. Salman Adisa of Ahmadu Bello University, Zaria Counselling Unit and Professor Y.K Kajuru, Director Institute of Education ABU, Zaria for their support and Mr. U. Ojo of Iya Abubakar Computer Centre, who helped to analyse the result.

Furthermore, the researcher's gratitude goes to members of staff of the Kaduna State Ministry of Education, Kaduna and Sabon-Tasha Education Zone Offices, Principals, Teachers and Students of schools used for the study in Kaduna Metropolis. May God help you in all your endeavours. Amen.

Finally, the researcher's special thanks and appreciation goes to the Vice Chancellor and members of staff of the National Open University of Nigeria for all the support the researcher have received so far especially on the pursuit of the Ph.D programme. He also appreciates the tremendous support of Dr. Nuhu L. Garba, the Study Centre Director and his fellow colleagues at the Kaduna Study Centre of the National Open University of Nigeria; as well as his family; the wives, Hajiya Safurat Onaolapo Shehu Oniyangi and Hajia Madinat Nma Salati and the children; Abubakar Mustapha, Abdurazaq Mustapha, Ahmed Mustapha, Hikmatullahi Mustapha, Abdullahi Mustapha, Ibrahim Mustapha, and Fatimah Mustapha for their patience, endurance and support during the course of this programme. The researcher wishes them Allah's blessing. Amen.

ABSTRACT

This study investigated the effects of cognitive restructuring and graded exposure counselling technique on school phobia among secondary school students in Kaduna Metropolis, Nigeria. The study was guided by five (5) research questions and five (5) null hypotheses. This study employed a quasi-experimental, non-equivalent control group, pre-test – post-test design. The population of this study was 415 junior secondary school students whereas 36 students were purposively sampled and used for the study. The instrument used for data collection was, Screen for Child Anxiety Related Disorders (SCARED). Data were analyzed using mean, standard deviation, t-test and ANCOVA. Findings revealed that; Male and female students exposed to CRT had a reduced school phobia in favour of female students with ($t = 0.819$, $p = 0.432$), Male and female students exposed to GET had a reduced school phobia in favour of male secondary school students with ($t = 0.948$, $p = 0.366$), Students exposed to CRT such as validity testing, modelling, and systematic positive reinforcement had a reduced school phobia as compared to those in control group ($t = 20.108$, $p = 0.000$), Students exposed to GET such as hierarchy of fears had reduced school phobia than their counterparts in the control group ($t = 18.432$, $p = 0.000$) and Gender was not a significant factor among those exposed to both CRT and GET on reducing school phobia among secondary school students ($f= 0.76$, $p=0.783$). It was therefore recommended that School Principals, Counsellors, Psychologists and form teachers should be exposed to training in CRT and GET in re-addressing students with school phobia among others.

OPERATIONAL DEFINITION OF TERMS

School Phobia: refers to a condition where a child has an excessive fear of attending school which may be partly attributed to being beaten by a class mate, or criticised in front of the class, having to speak in the public, doing examination, and getting undressed to practice sports.

Graded Exposure Technique refers to a technique in which the clients are encouraged by the counsellor to gradually confront their fear-inducing phenomenon in a hierarchical order or sequence of non-phobia conditions.

Cognitive Restructuring Technique: refers to the technique whereby clients are led by the counsellor to learn how to think differently, to change fundamental faulty thinking, and replace it with more rational, realistic and positive thinking of non-phobia conditions.

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CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

School phobia is a challenging problem facing the child and adolescents and has become an important matter to counsellors, teachers, parents, psychologists, psychiatrists, medical doctors, mental health practitioners and educationists especially those who are involved with the education of the children and adolescents. Wiederhold and Wiederhold (2005) indicated that, this behaviour occurs in approximately 2 – 5% of children in school age. Berg, Nicholas, and Pritchard (1969) have noted that school phobia involves difficulties in school attendance, emotional distress at the prospect of going to school but an absence of antisocial characteristics. School phobia has a complex etiology with temperament characteristics, school experience, and family influences contributing to the onset and maintenance of the problems (King, Ollendick, & Tonge, 1995). Also stressful life events at home or school frequently occasion the onset of school attendance difficulties (Blagg, 1987).

Many studies have recorded that the incidence of school phobia is an almost a common occurrence in all schools that students may develop physical symptoms such as headache, dizziness, or stomach ache when they are made to go to school. According to Milman (1961), King, et al. (1999), and Wimmer (2004), prevalence or incidence of school phobia ranges between 2% to 5% of school age children and adolescents. Boys and girls exhibit school phobia at the same rates. School phobia is highest in children ages five to seven and eleven to fourteen. These ages correspond with starting school, and transitioning through middle school or junior high school, both unusually stressful periods.

Many different factors influence the process of school phobia among students and these factors could be the student's temperament, events at school or family situation. School phobia usually develops after a child has been home from school for an illness or injury, death of a relative, or a move to a new school. Usually school phobia develops gradually, with children putting up increasingly intense difficulties in staying in school as time passes. School phobia among secondary school students has forced many schools to introduce various activities to encourage students to make their stay in school a pleasurable event. Many secondary schools in Kaduna metropolis have introduced co-curriculum activities, games and several other social activities. Some schools have organised inter house game activities, cultural festivals, visit to important tourist centres and school or community wide approaches to reduce school phobia, but the behavioural problem still persist.

School counsellors have staged a lot of programme to make students feel happy and find staying in school less difficult. Various socio-personal counselling activities, workshops, and other programmes of assurance have been staged. Counsellors have persuaded and keep records of students who exhibit school phobia. Also, teachers have employed many methods such as being caring and friendly to students. Many teachers act as school guardians or parents to many students, occasionally visit students' home or even invite their parents to schools. Hence, they engage such students in discussion or report them to counsellors, teachers or the school authority. Some parents have taken their children to medical doctors with a view to reducing school phobia.

Despite effort made by the teachers, parents, schools, psychologists and counsellors, government and nongovernmental organisations, the problem still

persist, however, this motivated the researcher to use cognitive restructuring and graded exposure counselling techniques to re-address school phobia among secondary school students in Nigeria. Evidence abound in literature about the role and efficacy of cognitive restructuring technique on various behavioural problems especially those concerning students. Studies like Fremont (2003), Passers and Smith (2004); Dattilio (2004); Dombeck (2006); Carleson (2008); Gladding (2009); Cluxton-keller (2010); Ogugua (2010), Asikha (2014), Cuncic (2014); and Rodriguez (2014) among several others have revealed several roles and efficacies of cognitive restructuring techniques. Cognitive restructuring counselling is widely accepted as an evidence-base technique for many disorders. It has been proved to be effective for treatment of variety of conditions including school and other school phobias, mood, anxiety, personality, eating disorder, substance abuse, tic and psychotic disorders. It is a counselling technique that is popular and widely used and acceptable by guidance counsellors, clinical social workers, medical doctors, psychologists, psychiatrists, and other professional helpers (Rodriguez, 2014). Cognitive restructuring counselling is also one of the most successful techniques suitable for dealing with stress, anxiety, depression social phobia, school phobia, irrational thinking, eating disorder and anger management. If cognition is an important cause of abnormal behaviour, it follows that such behaviour can be treated by changing cognition. Cognitive restructuring counselling technique (CRT) is useful for helping a client to learn the truth and therefore act differently and thus gives himself or herself self treatment whenever he or she has faulty cognition (Boyes, 2013). Apart from this, CRT has also been used as a supporting procedure in the treatment of school refusal, correcting

erroneous thoughts and beliefs in order to obtain or facilitate the behavioural and emotional desired change (King, Ollendick, & Tonge, 1995).

Similarly, graded exposure technique has been reported as useful tool in the treatment of school phobia (Kennedy, 1965). Graded exposure counselling technique has been found to be efficacious in the treatment of social school phobia, anxiety disorder, panic disorder, agoraphobia, school phobia, obsessive-compulsive disorder, post traumatic stress disorder (PSTD), and anger management (Tolin, 2011 & Carbonel, 2014). Also, it has the power of helping the clients to weaken the connections between troublesome thoughts and situations surrounding them. Furthermore, Graded Exposure Technique (GET) has the potential for not just making the clients to gradually face the feared event or object on step by step basis, but also gain control over the situation.

1.2 Statement of the Problem

Students, teachers, parents, educationists and all stakeholders concerned with junior secondary school education have made several attempts in reducing school phobia among secondary school students through advice, organisation of social skills training, and even medication to reduce difficulties in school attendance. But school phobia still persists among students. Although fear and anxiety are adaptive and necessary for survival, such responses become problematic when they are excessive, persist over time, and produce considerable discomfort for the students.

School phobia is characterized by excessive fear to diverse events associated to school such as being beaten by teachers or classmates, bullied or criticized in front of the class, having to speak in public, doing examinations,

getting undressed to practice sports and so on. This may be partly attributed to peers group pressure, bullying by fellow students or adult, delay by parents, hawking, insecurity, and other social economic problems among others. In educational settings, the anxiety related problems of students may act as barriers to optimal academic and or social development. School phobia can be so frustrating to students and parents. When left untreated, it can cause significant stress for students. Potential consequences of prolonged school phobia are severe. The problem can result to lack of academic progress, failure to develop satisfactory social relationships, and significant family conflict to adult emotional disorders. If school phobia is not curtailed, it is capable of derailing students future ambitions, prevents parents from realizing the aim of their kind and monetary effort, and government from its developmental goals.

It was at this background that this study sought to investigate the efficacy of CRT and GET in reducing school phobia among secondary school students in Kaduna metropolis, Nigeria.

1.3 Objectives of the Study

The objectives of this study were:

1. To determine the effect of cognitive restructuring technique (CRT) in reducing school phobia between male and female secondary school students.
2. To determine the effect of graded exposure technique (GET) in reducing school phobia between male and female secondary school students.
3. To determine the effect of CRT on reducing school phobia among the secondary school students in the treatment group and the control group.

4. To determine the effects of GET on reducing school phobia among the secondary school students in the treatment group and the control group.
5. To determine the relative effects of CRT and GET on reducing school phobia among male and female secondary school students

1.4 Research Questions

This study provided answers to the following research questions:

1. What is the effect of cognitive restructuring technique (CRT) in reducing school phobia between male and female secondary school students?
2. What is the effect of graded exposure technique (GET) in reducing school phobia between male and female secondary school students?
3. What is the effect of CRT on reducing school phobia among secondary school students in the treatment group and the control group?
4. What is the effect of GET on reducing school phobia among secondary school students in the treatment group and the control group?
5. What are the relative effects of CRT and GET on reducing school phobia among male and female secondary school students?

1.5 Hypotheses

The following hypotheses guided the study:

1. There is no significant effect of cognitive restructuring technique (CRT) in reducing school phobia between male and female secondary school students.

2. There is no significant effect of graded exposure technique (GET) in reducing school phobia between male and female secondary school students.
3. There is no significant effect of CRT on reducing school phobia among secondary school students in the treatment group and the control group.
4. There is no significant effect of GET on reducing school phobia among secondary school students in the treatment group and the control group.
5. There are no significant relative effects of CRT and GET on reducing school phobia among male and female secondary school students

1.6 Basic Assumptions

The following were the basic assumptions:

1. Significant differences may exist in the effect of cognitive restructuring technique (CRT) in reducing school phobia between male and female secondary school students.
2. Significant differences may exist in the effect of graded exposure technique (GET) in reducing school phobia between male and female secondary school students.
3. Significant differences may exist in the effect of CRT on reducing school phobia among secondary school students in the treatment group and the control group.
4. Significant differences may exist in the effects of GET on reducing school phobia among secondary school students in the treatment group and the control group.

5. Significant relative effects of CRT and GET on reducing school phobia may exist among male and female secondary school students

1.7 Significance of the Study

The findings of this study would add to theory building in cognitive restructuring and graded exposure counselling techniques in addressing school phobia among secondary school students in Nigeria and the rest of the world. Therefore, the work would of immense benefits to the following stakeholders concerned with the affairs of schools in Kaduna metropolis.

The students would be well assured and becoming more independent and cognitively active to schooling: such as attending assembling ground, football competitions, clubs and other daily routines within and outside the school system.

Counsellors especially those in secondary schools would derive a great benefit from the study, in that they would be acquainted with the various issues on school phobia. Through this work, the counsellors would be exposed to theories, causes, processes, and nature and treatment techniques of school phobia. They would also derive empirical data for reducing it among the students. Thus, they would be able to handle and guide the students in such a way that school phobia would be reduced and academic performance could be enhanced. Counsellors would be provided with armful materials concerning the effects of CRT and GET on school phobia. Thus, they can pick from those ideas when dealing with students or advising school authorities and parents on students affairs.

Teachers would also benefit from this study in the sense that they would realize the socio-psychological factors underlying school phobia and how to use the two techniques in helping the affected students. Thus, they would refer

affected students to counsellors and give necessary accurate information to such clients.

School authorities including the principals, vice principals, non-teaching staff, proprietors and the likes would no doubt benefit from this study. The work would inspire them in giving their own support to reduction of school phobia among the students. The study would guide the aforementioned staff in term of staging and approving programmes, materials and necessary funds to help in reduction of school phobia among the students.

Furthermore medical doctors, nurses, psychiatrists, and other professional helpers would derive benefit from this work. The above mentioned professionals would be exposed to armful materials in terms of symptoms, socio-psychological and pathological causes, management and methods of reducing school phobia among secondary school students. Thus, the experts would be able to refer the clients for counselling as at when due.

Moreover, the above mentioned professionals would be exposed to how cognitive restructuring and graded exposure counselling techniques can be used in reducing school phobia. Thus, they would be able to learn how to use the techniques in helping their clients. Of special importance to these professionals is the knowledge of handling and understanding of cognitive distortions, cognitive restructuring, and exposure of the clients to trauma stimuli when they make contact with this work. Such experience would no doubt add to their professional skills and competence.

There is no doubt that parents would benefit from this work. Parents who hitherto this time have been disturbed by their children school phobia would now have a proper understanding of the nature and the causes of the phenomenon. It is

expected that they would take appropriate active steps in preventing school phobia among their wards or children. The parents would also have enough guidance on socio-psychological and pathological factors involved in school phobia and therefore prevents their children from falling into them. Such parents are expected to report to the counsellor and cooperate with him when any of their children suffers school phobia.

Furthermore, this research work would validate theories on school phobia and establish the relationship between cognitive restructuring and graded exposure counselling techniques. This would equip guidance officers in secondary schools in Kaduna metropolis. Thus, they would be able to report any student that exhibit characteristics similar to school phobia to counsellors or the school authority.

This work would be very useful to research community. It would provide instruments, empirical data and several references to interested researchers working on school phobia, cognitive restructuring and graded exposure counselling techniques. They may therefore, comment, adopt, and or modify as deemed fit by their studies.

Stakeholders in secondary schools would definitely benefit from this work in the sense that they may be able to influence decisions concerning the affairs of the schools. They would be able to influence funding, staffing, and provision of necessary materials to counsellors, teachers, and students with a view to reducing school phobia.

1.8 Scope and Delimitation of the Study

The main focus of this study was to assess the effect of cognitive restructuring and graded exposure counselling techniques in reducing school phobia among the secondary school students in Kaduna metropolis. Therefore, the

scope of the work covered junior secondary school students (JSS1). Both male and female students were used for the study. Students at this level experiencing school phobia are in the period when they face more academic works than their primary school counterparts. The study was also delimited to the north and south zones of the metropolis. The study was conducted in public secondary schools; hence private secondary schools and higher institutions of learning were not part of this study. Only junior secondary school students were used, hence students of senior secondary schools were not covered. Two counselling techniques; cognitive restructuring and graded exposure techniques were used hence techniques such as positive reinforcement, aversive technique, and others were not included in this study.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

2.1 Introduction

The review of related studies was done under the following sub – headings;

The Concept of School Phobia

Symptoms of School Phobia

Characteristics of School Phobia

Causes of School Phobia

Effects of School Phobia

The Concept of Cognitive Restructuring

Forms of Cognitive Distortions

Cognitive Restructuring Working Template

The Concept of Graded Exposure

Graded Exposure Working Template

Relationships among the Variables

Theoretical Framework

Pavlovian Conditioning Theory

Operant Conditioning Theory

Albert Bandura's Social Learning Theory

Rachman's Integrative Model for Fear

Aaron Beck Theory of Cognitive Restructuring

The Cognitive Restructuring Model of Depression

Psychoanalytical Theory of Sigmund Freud

Empirical Studies

Summary of Literature Review

2.1.1 Concept of School Phobia

There is no consensus among authors on the term “school phobia” (Paige, 1997; and Davies, 2012). Thus, the term has been used interchangeably with other terms like “school refusal”, “school avoidance”, “fear of school”, “school fear”, “phobia of school”, “scolionophobia”, and or “didaskaleinophobia” to describe the same phenomenon (Paige,1997; Lyton & Cotter, 2007; Davies, 2012; Linden, 2014; and Changethatsrightnow.com, 2014).

Johnson, Falstein, Szurek and Svendsen (1941) described school phobia as the enduring refusal to school attendance observed in children and adolescents who, for irrational reasons, develop active reactions of anxiety or panic in line with fears associated to a school distressing situation. The problem often begins with an undefined complain related to school or poor motivation for school attendance which progresses to a total refusal, in which permanence at school can only be achieved by parental persuasion, begs, or punishment as well as pressure from teachers. Avoiding behaviour can also be accompanied by clear symptoms of anxiety or even generalized panic at the time to go to school. Many children may return home at only half way of the school as others may leave school in an anxious state. Children might insist to express their desire to go to school and may even be ready to do it, however, they cannot overcome the fear they experience at that particular moment. School phobia may appear in the presence of specific stimuli. Monday’s return to school from holidays, first day of classes after recovering from illness, change of classroom or school, can evolve to a definitive refusal to attend school, preceded by anxiety symptoms and even physical symptoms such as nausea, vomits, headaches, diarrhoea, abdominal pain and throat pain, which often disappear when the child is allowed to stay home and

reappear as the possibility of attending school materializes. School phobia has been defined as an anxious fear of school caused by the child and mother's separation anxieties (Johnson et al., 1941).

School phobia behaviour is a psychosocial problem for students characterized by severe emotional distress and anxiety at the prospect of going to school, leading to difficulties in attending school and, in some cases, significant absences from school (Kahn, Nursten, & Carroll, 1981). School phobia, according to Davies (2012) refers to an anxiety disorder in children who have an irrational, persistent fear of going to school. Children who are school phobic want to be in close contact with their parent or caregiver. School phobic children are often insecure, sensitive, and do not know how to cope with their emotions. They appear anxious and may become physically ill at the thought of attending school.

School phobia is a broad term that encompasses a child motivated refusal to attend or remain at school, or a clear and apparent difficulty in doing so (Kearney, 2008). This school phobia often results from anxiety produced either by the separation from a major attachment figure or from fear of an aversive situation at school such as bullying or an oral presentation. School phobia can also result from positive reinforcement, or rewards, such as access to television, video games, or simply attention that is received outside of school.

The main condition of school phobia is severe difficulty attending or remaining in school, resulting in prolonged absences. From this core symptom there can result both internalizing and externalizing behaviours (Kearney & Albano, 2000). Internalizing behaviours include anxiety, depression, fear, fatigue, and somatic complaints. Externalizing behaviours include tantrums, aggression,

clinging, non-compliance, refusing to move and running away. Some situations can preclude the school phobia, such as a legitimate illness or disorder.

Gutiérrez-Maldonado, Magallón-Neri, Rus-Calafell, and Peñaloza-Salazar (2009) defined school phobia as a condition characterized by fear to diverse events associated to school such as being beaten by a classmate, bullied or criticised in front of the class, having to speak in public, doing exams, getting undressed to practice sports and so on.

Alston (2003) also defined school phobia as a condition wherein a child has a fear of attending school. For these students, walking into a school can bring a frightening feeling, and they might be overwhelmed by the school's size, of the number of people in it or of feeling lost. Students with school phobia experience severe emotional distress when they think about attending school. Many of them are simply afraid to be away from home and experience high levels of anxiety when they are away from parents and or home.

Kearney and Bates (2005) and Kearney (2007) have defined school phobia as a denial to attend school or difficulty remaining in the school throughout the day. It is a gamut of behaviour exhibited by youth, or students which includes skipping parts of the school day, displaying extreme resistance to attending school in the morning, and constantly seeking the school nurse in order to be dismissed from school. Changethatsrightnow.com (2014) described school phobia (also, scolionophobia) as a persistent, abnormal, and unwarranted fear of school, despite conscious understanding by the phobic individual and reassurance by others that there is no danger. It is an extreme unwarranted fear and or physical aversion to school.

Kearney and Albano (2000) explained that school phobic students usually refuse or fear school and or tries to: (a) avoid school-related objects or situations that cause distress or negative effect, (b) escape aversive social and or evaluative situations, (c) receive attention from others outside of school, and or (d) pursue reinforcement outside of school.

Two typical cases which can improve our understanding of school phobia were reported in Sertzer and Salzhauer (2001). Rebecca, an eight-year-old girl**,** has always had difficulty attending school. Since she began third grade two months ago, her problems have significantly worsened. She constantly begs to stay home from school, having tantrums that cause delay in dressing and often result in her missing the bus. After arriving at school, Rebecca frequently complains of stomach-aches, headaches and a sore throat to her teacher and asks to visit the school nurse with whom she pleads to call her mother. Her mother typically picks her up early twice a week. When Rebecca gets home she spends the remainder of the afternoon watching TV and playing with her toys. When her mother is unable to pick her up early, Rebecca calls her mother's cell phone periodically throughout the afternoon to "check in" and reassure herself that nothing bad has happened. Rebecca's teacher has expressed concern about her missing so much class time which has resulted in incomplete assignments and difficulty learning.

In another case, Nicholas is a fourteen-year-old boy who has missed forty-three days of school since beginning the eighth grade four months ago. When home from school, Nicholas spends most of the day online or playing video games. On the days he does attend school he is typically late for his first period which enables him to avoid hanging out with other kids before class. He always

goes to the library during lunch. When he does go to class, he sits in the back of the classroom, never raises his hand and has difficulty working on group projects. Nicholas' teachers have noticed that he is always absent on days that tests or book reports are scheduled. His parents have already punished him after his first report card came home since he received D's in Maths and Social Studies and failed Gym for cutting. Nicholas' parents have started to wonder if they should change his school placement and have asked the school to arrange home tutoring while this alternative is explored.

School phobia has not been issued a formal psychiatric diagnosis, however, Fremont (2003, p. 2), has designed criteria for differential diagnosis of suffers which may include the following:

- Severe emotional distress about attending school; may include anxiety, temper tantrums, depression, or somatic symptoms.
- Parents are aware of absence; child often tries to persuade parents to allow him or her to stay home.
- Absence of significant antisocial behaviours such as juvenile delinquency
- During school hours, child usually stays home because it is considered a safe and secure environment.
- Child expresses willingness to do schoolwork and complies with completing work at home.

School phobia has also been categorized under social school phobia. School phobia occurs at all ages and when left untreated, it causes significant stress for parents. Potential consequences of prolonged school phobia are severe, from lack of academic progress, failure to develop satisfactory social

relationships, and significant family conflict to adult emotional disorders (Wimmer, 2004).

2.1.2 Characteristics of Students with School Phobia

Common characteristics and features of school phobic students owing to emotional reasons according to Wimmer (2004) are varied, and include the following:

Separation Anxiety: Students who refuse school because of separation anxiety may be worried about the safety of a caregiver or other loved one and fear something bad will happen to that individual. It is common for these children to complain about going to school and engage in morning battles before school that may involve crying, yelling, kicking, or running away. While many young children experience separation anxiety in preschool or before going to kindergarten, the behaviour is more serious when separation anxiety is so extreme that it results in refusal to attend school.

Performance Anxiety: Some students have extreme anxiety about taking tests, giving speeches, or athletic competition in physical education class. Those who have anxiety about these types of performance situations worry about being embarrassed or humiliated in front of their peers.

Social Anxiety: Some students may feel social anxiety or worry about social interactions with peers and or teachers. They are uncomfortable in social situations and may dread socializing with classmates.

Generalized Anxiety: Some students have a tendency to perceive the world as threatening and have general worries about something bad happening. These children may also have specific fears of disastrous events like tornadoes or war.

Depression: Some students experience depression or both anxiety and depression, and the symptoms include sadness, lack of interest in activities, failure to make expected weight gains, sleep difficulties, feeling tired, feeling worthless, feelings of guilt, and irritability. A very serious symptom of depression is suicidal ideation. A child who is talking about harming himself or herself should be referred to a counsellor in order to ensure his or her safety.

Bullying: Some students fear being bullied. These children want to avoid school because of very real situations in which they are physically threatened, teased, or left out by other children.

Health-related Concerns: Some students tend to have high rates of physical complaints. Physicians and the school nurse can assist parents and school staff in determining whether a child has a legitimate physical problem or if physical complaints are related to anxiety. School phobia may also develop after a student has been home sick with an actual illness. In these situations the child refuses to go to school even after recovering physically. The child's physician can communicate with school counsellors regarding when the child who has been ill can return to school or whether there are any restrictions for the child at school. If there is no medical reason for staying home, the child should be at school.

2.1.3 Signs and Symptoms of School Phobia

According to Wimmer (2004) and Davies (2012, p. 1), the signs and symptoms of school phobia can include any of the following; therefore counsellors need to recognize them:

- Frequent complaints about attending school
- Frequent tardiness or unexcused absences
- Absences on significant days (tests, speeches, physical education class)

- Frequent requests to call or go home
- Excessive worrying about a parent when in school
- Frequent requests to go to the nurse's office because of physical complaints
- Crying about wanting to go home
- Frequent stomach-aches and other physical complaints such as nausea, vomiting, diarrhoea, exhaustion, or headaches that cannot be attributed to a physical ailment.
- Clinginess, tantrums, and or panic when required to separate from a parent or caregiver.
- Fear of the dark or being in a room alone.
- Trouble going to sleep and or having nightmares.
- Exaggerated fears of animals, monsters, school, etc.
- Constant thoughts concerning the safety of self or others.

Genuine physical symptoms are common and include dizziness, headaches, nausea, vomiting, diarrhoea, shaking or trembling, fast heart rate, chest pains, and back, joint or stomach pains. These symptoms usually improve once the child is allowed to stay home or out of school. Behavioural symptoms include temper tantrums, crying, angry outbursts, and threats to hurt themselves (self-mutilation).

When a counsellor sees any of these signs it may be a good idea to speak to the child, teacher and the child's parents. It is important to develop an intervention plan as quickly as possible when these warning signs occur, because a quick response has been found to increase the probability of successful outcomes.

2.1.4 Assessment, Diagnosis and Treatment of School Phobia

Because school phobia may be the result of many factors, assessment should involve a variety of methods and sources and should include information gathered across more than one setting, such as interviews, observation of the child, and a review of academic records and attendance history (Wimmer, 2004). Questionnaires completed by teachers, parents, and the student can provide additional information about the child's developmental, social, and emotional status. Academic achievement testing may be needed, particularly if there are academic difficulties contributing to the school phobia. An assessment of the reasons for the school phobia behaviour also involves determining the antecedents and consequences of the child's behaviour. Frequent reasons or causes include escape from anxiety-provoking situations or to gain attention from a parent or other caregiver. Alternately, some students may avoid school in order to engage in a payoff for school phobia which can help in determining the source of the problem.

Wimmer (2004) and Davies (2012, p. 2) have suggested that both home and school issues need to be considered when assessing the reasons that contribute to school phobia.

Home Issues may include any of the following:

- Be experiencing a family change like a move, illness, separation, divorce, death, depression, or financial problems.
- Have been absent from school due to a long illness.
- Enjoy a parent's undivided attention when not in school.

- Be allowed to watch television, play video games or with toys rather than complete schoolwork.
- Have an overprotective parent who reinforces the idea that being away from him or her could be harmful.
- Be apprehensive of an impending tragedy at home.
- Fear an adult at home might hurt a family member while the child is at school.
- Be afraid of neighbourhood violence, storms, floods, fires, etc.

School Issues: A child may…

- Fear criticism, ridicule, confrontation or punishment by a teacher or other school personnel.
- Have learning difficulties -- for example, afraid to read aloud, take tests, receive poor grades, be called on to answer questions or perform on a stage.
- Be afraid of not making perfect test scores.
- Be sensitive to a school activity such as singing a certain song, playing a specific game, attending a school assembly, eating in a lunchroom, or changing clothes for physical education in front of peers.
- Exhibit poor athletic ability, being chosen last for a team or being ridiculed for not performing well.
- Fear teasing due to appearance, clothes, weight, height, etc.
- Feel socially inadequate due to poor social interaction skills.
- Be a victim of peer bullying during school, walking to or from school, or on the school bus.
- Receive threats of physical harm.

- Have difficulty adjusting to a new school
- Have toileting issues concerning the use of a school restroom.
- Be environmentally sensitive to new carpet, fragrant cleaning supplies and/or poorly ventilated classrooms.

The primary treatment goal for children with school phobia is early return to school (Fremont, 2003; and Davidson, 2014). Treatment also should address comorbid psychiatric problems, family dysfunction, and other contributing problems. Because children who are school phobic often present physical symptoms, counsellor may need to explain that the problem is a manifestation of psychological distress rather than a sign of biological illness. A multimodal, collaborative team approach should include the counsellor, physician, child, parents, and school staff that may be useful in the treatment of the school phobic.

Treatment options include behaviour strategies, family interventions, education and consultation and possibly pharmacotherapy. Factors that have been proved effective for treatment improvement are parental involvement and exposure to school (Blagg & Yule, 1984; and Heyne et al., 2002). Treatment strategies must take into account the severity of symptoms, comorbid diagnosis, family dysfunction, and parental psychopathology.

Davidson (2014) has stated that the combination of cognitive and behavioural therapy appears to produce the most successful treatment results. Davidson cited a study where more than 80 percent of children receiving this combination of therapies were attending school normally one year after treatment. Fremont (2003) also opined that there are ranges of empirically supported exposure-based treatment options that are available in the management of school phobia. When a child is younger and displays minimal symptoms of fear, anxiety,

and depression, working directly with parents and school personnel without direct intervention with the child may be sufficient treatment. If the child's difficulties include prolonged school absence, comorbid psychiatric diagnosis, and deficits in social skills, child counselling with parental and school staff involvement is indicated (Fremont, 2003; and Davidson, 2014).

2.1.5 Model for Acquisition of School Phobia

Gonzalez-Prendes and Resko (1999), and Reuterskiold (2009), have stated that the model for acquisition of school phobia could be biological and or psychological. He therefore opined that several psychological theories have been put forward as important in the acquisition and maintenance of fear and specific school phobia. For example, two factor theory, by Mowrer (1939-1956), and the integrative model on the three pathways to fear acquisition proposed by Rachman (1977) seems to date to be the most influential and robust at present (Beidel & Turner, 2005; and Silverman & Moreno, 2005). The major pathways to fear acquisition are direct conditioning experiences, indirect vicarious exposure (observational learning) and transmission of information and instruction. Rachman (1977) suggests that the latter two fear acquisitions can take place even without prior direct contact with the fear stimuli.

In a pathway on fear acquisition, Rachman (1977) proposed that transmission of information and or instruction is significant, for example, information given by parents, peers or significant others. The evidence for this type of learning is more based on common sense than data (Rachman, 1977). However, subsequent studies have emerged that lend support to this mechanism of learning. For example, in a study by Barrett, Rapee, Dadds, and Ryan (1996), children with anxiety disorders were presented with stories about ambiguous

situations. Interestingly, when the children were asked what they would do, they generally answered in terms of approach behaviours to the various situations. However, when the same stories were presented in the presence of the parents and discussed with them, the children, after parental instruction statements, generally changed to an avoidance behaviour style (Barrett et al., 1996).

Conditioning models, as well as Rachman's integrative model, have in turn been criticized for failing to provide a comprehensive account of the onset of fears and school phobias, with the argument that reported experimental and clinical findings are more adequately accounted for by a nonassociative model, thus suggesting a fourth pathway (Menzies & Clarke, 1995; and Poulton & Menzies, 2002). Briefly, the non-associative model suggests that some fears (for example, heights, water, spiders, strangers and separation) are biologically determined, and as such are passed down from our ancestors to increase our chances of survival. Accordingly, these types of fears emerge spontaneously without prior associative learning experiences, whether direct or indirect (Poulton & Menzies, 2002). Along similar lines, Ohman and Mineka (2001) proposed a fear module, representing an evolved adaption, based on four principles: 1. In all primates, the fear module is activated by specific fear relevant stimuli, which are likely to have an evolutionary origin (for example, spiders, snakes); 2. The fear module automatically elicits a response in the above situation; 3. Once the fear module is effectively activated, the fear is hard to control by cognitive means; 4. The fear module is interconnected to the neural circuitry of the amygdala. The main point is that evolutionary fear-relevant stimuli are thought to trigger the fear module and that the situation need only be mildly aversive. Several theorists have in turn criticised the non-associative account. The main criticism put forward is that the

theory is based on negative observational findings (that is, a lack of a learning history in the acquisition of child school phobia) and that it does not take into account children's developmental level or the situation at hand; for example., novelty, aversiveness and unpredictability (Muris, et al., 2002).

Gonzalez-Prendes and Resko (1999), have identified models of acquisition of school phobia to include the learning theories which are most often associated with behavioural approaches that focus on modifying behaviour by manipulating environmental cues (that is, antecedents or reinforcers). Learning theories have focused on explaining how the mechanisms of fear and avoidance of the traumatic memory associated with school phobia are conditioned, activated, and reinforced. From this perspective, unhealthy fears may develop from a single traumatic episode or from exposure to a series of unpleasant events (Wolpe, 1990). School phobia can be acquired on the basis of association through classical conditioning, or they can be learned vicariously through the process of observation (Bandura, 1977, 1986). That is, a person may learn to react with fear by observing others' fearful reactions to specific objects or events.

2.1.6 Causes of School Phobia

Davidson (2014) opined that anxiety disorders including school phobia may have genetic component. Children whose parents have anxiety disorders may have symptoms than children whose parents do not have these disorders. School phobia is often associated with other anxiety disorders such as agora school phobia or other mental health disorders such as depression.

Some experts theorized that another possible cause of school phobia is traumatic and prolonged separation from the primary caregiver in early childhood.

For instance, a child who for one reason or the other had to lose the care of his or her biological mother to someone else may exhibit school phobia.

Family functioning affects school phobia. Stressful events or a dysfunctional family can cause children to feel compelled to stay home. For instance, a child whose mother had just been brutally battered by someone may fear going to school for fear of likely terrible thing that might happen to her. Young children are more likely to refuse to separate from their parent or caregiver because they fear something catastrophic will happen to the adult while they are at school (Davidson, 2014). According to Martin, et al. (1999), problems with family functioning contribute to school refusal in children; however, few studies have systematically evaluated and measured these problems. Parents of children with school avoidance and separation anxiety have an increased rate of panic disorder and agoraphobia. Older children may refuse to leave a parent who is ill or who has a substance abuse problem, in effect trying to cope for the parent. They may also be afraid of some specific aspect of school, such as riding the bus or eating in the cafeteria.

It is not uncommon for middle and high school students to become school phobic because they are afraid of violence either at school or on the way to school, are afraid of failing academically, have been repeatedly bullied or humiliated at school, feel they have no friends at school, or are excluded.

School phobic children who have school phobia usually try to win a parent's permission to stay home, (although some simply refuse to leave the house) or stay out of school. Dysfunctional family interactions that correlate with school refusal include over dependency, detachment with little interaction among

family members, isolation with little interaction outside the family unit, and a high degree of conflict (Kearney & Silverman, 1995).

Apart from that, communication problems within families, problems in role performance (especially in single-parent families), and problems with family members' rigidity and cohesiveness also have been identified (Bernstein & Borchardt, 1996; and Bernstein, et al., 1999). Several studies have emphasised the relationship between parental behaviours and the development of childhood anxiety (Rapee, 1997; Wood, et al., 2003; and Bogels & Brechman-Toussaint, 2006). Such parental behaviours could also influence, either directly or indirectly influence school phobia in secondary school children (Reuterskiold, 2009).

2.1.7 Effects of School Phobia

Frequently fear of school events can cause young children to develop a chronic school phobia leading to significant social and academic difficulties. Fear of school can lead to students' absenteeism. According to Lowry, Sleet, Duncan, Powell and Kolbe (1995), students were reported to have stayed home from school because of fear of violence they experienced or witnessed at schools. The Centres for Disease Control and Prevention (CDC, 1995) further corroborated this position with the report that students stayed away from school when they felt unsafe either at school or travelling to school. The CDC (1995) found that younger female students were more likely to miss school because of fear of school than older female students.

In addition to missing school due to fear of violence; students may begin to perceive certain areas of the school where crime often occurs as unsafe. In an attempt to ensure their own safety, they begin to avoid these places. DeVoe (2004) has reported that, more specifically, the minorities, students in lower grades, in

urban areas, who are attending public schools, were most likely to report avoiding specific places in schools.

Fear of school may lead to psychological and emotional instability at school. In a cross- sectional survey conducted by Bowen, et al. (1998), students' perceptions of danger at school negatively influenced students' sense of psychological engagement in school and confidence in their ability to meet school-related demands and challenges. In addition, students' sense of school coherence decreased as perceptions of school danger increased.

Fear of school is tied to a school's ability to provide an environment conducive to learning, but it may also play a key role in how effective a school is in preventing crime in the first place. As students' fear increase; confidence in school administration, teachers, and other adults within the school diminishes, and informal social controls against evidence weaken.

It has also been noted that when children or students do not feel safe at school, they may adopt a "self – help" approach to settle on their own or with the help of their friends- an undertaking which can have a potentially dangerous outcome (Devine, 1995). This may lead to formation of rival gangs in schools. Lockwood (1997) supported this assertion when he suggested that, when informal social controls weakens, students may resort to bringing weapons to school for protection, or building a reputation for themselves by fighting or exhibiting a tough attitude. One of the roles of the school is to train and develop good characters in children. But when students resort to thuggery and hooliganism, the aim of establishing the schools is defeated.

Baker and Wills (as cited in Phaneuf, 2006) have conducted a study on school phobic children. They have discovered that school phobic children tended

to have more psychiatric problems that needed attention preceding the treatment of their school refusal behaviour. Some school phobic children were also found to have displayed more anxious and withdrawn characteristic too.

Summer and Nagel (as cited in Witts & Houligan, 2007) have discovered that school phobic children are more likely to drop out of school, have lower grade point average (GPA), and have other discipline problems at school. These outcomes are definitely against the school goals. It is a setback to individuals and the national development when students drop out of the school. The dropout may not achieve his or aspirations; yet, the nation's expectation may not be accomplished. For instance, Nigeria's vision 20-20 may suffer a setback.

School phobia may lead to family disintegration or family dysfunction (Linden, 2014). A family whose children are experiencing school phobia may suffer emotional instability. Parents may be sad or even find themselves at logger head due their school phobic child.

2.2.1 Concept of Cognitive Restructuring

Cognitive Restructuring (CR) is conceptualized as a psychotherapeutic process of learning to identify and dispute irrational or maladaptive thoughts known as cognitive distortion, such as splitting, magical thinking, filtering over-generalization, magnification and emotional reasoning, which are commonly associated with many mental health disorders (Gladding, 2009).

Cuncic (2014) defined CR as a cognitive-behavioural technique used to identify and correct negative thinking patterns. The technique involves altering negative automatic thought that occur in anxiety-provoking patterns situations. As thoughts are challenged and disputed, their ability to elicit anxiety is weakened. According to Ford-Martin (2014), cognitive restructuring is a psychosocial

therapy that assumes that faulty cognitive, or thought pattern cause maladaptive behaviour and emotional responses. The treatment focuses on changing thoughts in order to adjust psychological and personality problems.

Connolly as cited in Rodrigues (2014) stated that cognitive restructuring involves learning how to think differently, to change fundamental "faulty thinking", and replace it with more rational, realistic and perhaps positive thinking. When people are involved in events, they tend to develop automatic thoughts (a mental interpretation) of the situation. Sometimes the interpretation may be positive and at other times, the appraisal process may be irrational. If and when the irrational or faulty thinking (also called cognitive distortion) is allowed unchecked, it will generate into dysfunctional emotions and their resultant behaviour problems like anxiety depression, stress and so on and so forth.

Cognitive restructuring was formed on the basis that thinking influences behaviour (Dombeck, 2006). It is assumed that event that happened to a person does not cause stress, anxiety, depression or other disorder, but the way the individual thinks or feels about the event especially, if the individual thinks negatively about the event. Thus, cognitive restructuring is an attempt to help the client to cognitive analysis, or appraisal of his thinking. It is also called a cognitive reframing because therapist helps in teaching the clients to become more conscious of the fact that they are unconsciously appraising and judging all the various stimulus events that come their way, and then teach them to consciously take charge of that appraisal process so as to make sure that their conclusions are accurate and free of biases and mistakes.

Cognitive restructuring involves learning how to think differently to change fundamental "faulty thinking" and replace it with more rational, realistic,

and perhaps positive thinking. Sometimes stress can lead a student to elicit a chain reaction of thoughts that starts with a small, simple problem and leads to a full-blown anxiety and panic over unrealistic fears. The irrational thoughts if left unchecked can cause or lead to undue anxiety or stress. Cognitive restructuring (CR) can help the client in indentifying irrational thought or "faulty thinking" and can also help in disputing irrational or maladaptive thoughts.

Apart from the above, CR also helps in replacing irrational thought with more appropriate thoughts. Yet CR tends to help client in strengthening "self talk" that can influence performance. (Dombeck, 2006).

2.2.2 Forms of Cognitive Distortions

Carleson (2008) opined that everything we think is an automatic thought. A problem arises only when our automatic thoughts manifest as cognitive distortions. Cognitive distortion according to Hope, Burn, Hyes, Herbert and Warner (2010, p. 1) are characterized in six categories. They can be (1) self-evaluated thoughts (2) thoughts about the evaluation of others, (3) evaluative thoughts about the other person with whom we interact (4) thoughts about coping strategies and behavioural plans (5) thoughts of avoidance, and (6) any other group of thoughts.

Gladding (2009) and Scott (2014) have identified various manifestations of cognitive distortion among people. This include all-or-nothing thinking, overgeneralization, mental filter, disqualifying the positive, jumping to conclusion, emotional reasoning, personalization, magical thinking, magnification and so on and so forth.

All-or-nothing thinking

This happens when a person thinks in extremes, with no gray areas or muddle round (Scott, 2014). Such a person use words like “always” and “never” when describing things. This type of thinking can increase stress in one’s life and may make problems seem bigger than they are in reality.

Overgeneralization

Those prone to this tend to take isolated events and assume that all future events will be the same. For example, a student who over generalizes may disrespect any teacher believing that all teachers will always pardon disobedience.

Disqualifying the Positive

Those who disqualify the positive tend to treat positive events like flinches, thereby clinging to a more negative world view and set of low expectations for the future (Scott, 2014). When you try to help such a person solve a problem, he or she is always on the negative side.

Jumping to Conclusions

A lot of people especially students are into this type of cognitive distortion. Rather than letting the evidence bring them to a logical conclusion, they set their sights on a conclusion (often negative), and then look for evidence to back it up, ignoring evidence to the contrary (Scott, 2014). For example, a student who decides that everyone in his new class will hate him, and ‘knows’ that they are only acting nice to him in order to avoid punishment, is jumping to conclusion. Conclusion-jumpers can often fall prey to mind reading (where they behave that they know the true intentions of others without talking to them or verifying such claim) and start predicting how things will turn out in the future and behaving these predictions to be time.

Magical Thinking

This is the attribution of causal relationship between actions and events to superstitious beliefs. Magical thinking can cause a person to experience fear of performing certain acts or having certain thoughts because of an assumed correlation between doing so and threatening calamities (Coleman, 2012).

Emotional Reasoning

It is a cognitive process that occurs when a person believes that what he or she is feeling is true regardless of a presented evidence.. Emotional reasoning can amplify the effects of other cognitive distortions. For example, a student may feel insecure about her understanding of a test material even though she is perfectly capable of answering the questions. If she acts on her insecurity about failing the written test, she might assure that she misunderstands the material and guess at the answers randomly.

2.2.3 Cognitive Restructuring Working Template

The cognitive restructuring template is meant to be used as a guideline to learning the process of CR with students. CR was chosen for this template because it provides a basic framework for most behavioural models. The template provides the beginning counsellor with steps to take and questions to ask that promote collaboration between the counsellor and client. There are suggested questions under each heading to help start the process. After using the initial questions, guide the client through each process, asking questions that occur to you. Although there is no one ‘’script’’ for any counselling session, it is the hope of the researcher that this template will serve as an impetus to learning.

Tools for Change

Cognitive restructuring counsellors shift the focus from the client (or student) with the problematic behaviour to the system (such as fellow students, teachers, family and other significant persons) to help engage in shared responsibility. Cognitive restructuring counsellors use the following specific techniques:

Cognitive Rehearsal: The client recalls a problem from the past, and the counsellor and the client work together to develop strategies to the problem so that if it occurs in future, the client has a plan.

Validity Testing: The counsellor tests the validity of the client's beliefs or thoughts, giving the client time to defend his or her viewpoint. If the client cannot defend the beliefs or thoughts they are said to be invalid.

Writing in a Journal: The client may be asked to journal thoughts and situations that occur daily. The counsellor and the client then review the journal to figure out any maladaptive thought patterns that could affect the client's behaviour.

Guided Discovery: The counsellor guides the client through a scenario; enabling the client to understand any cognitive distortions.

Modelling: This involves role–playing exercises by the counsellor so that the client may learn new ways of responding to certain situation.

Homework: The counsellor commonly gives assignments to clients to help them learn new ways of dealing with current dilemmas.

Systematic Positive Reinforcement: This technique involves the client performing a desirable behaviour and then being provided with a pleasant reinforcement or reward.

Phase 1: Joining and Building Rapport

Cognitive restructuring counsellors should be genuine, empathic, and active listeners and convey understanding by asking clarifying questions and validating all the group members. Assignment begins in the first session and is an ongoing process throughout therapy. To prepare clients for the assessment, Cormier and Cormier (1998) recommended communicating the purpose, such as the following:

Today I would like to focus on the concerns that have been bothering you the most. In order for me to find out exactly what you are concerned about, I will be asking for some specific information. This information will help us identify exactly what you would like to work on in our sessions. How does this sound to you?

After the clients agree, some of the following questions can be used as a guide:

"How did you make the decision to come to therapy?"

"What are your present concerns in your life?"

"What situations are not going as well as you to you would like?"

Phase 2: Understanding the Presenting Issue

The following questions could be asked to identify the presenting issues:

" Which of the problems that you have described are you most consumed with today"

"What feelings are you experiencing when you think of these situations?"

"What do these situations prevent you from doing?"

"What thoughts make you feel worse?"

"How would you feel if you did not have these thoughts?"

"Where is the proof that what you are telling yourself is true?"

Phase 3: Assessment of (students) Group Dynamics

Counsellors identify students' schemata through identifying automatic thoughts and maladaptive assumptions. Counsellors may use a problem analysis, functional analysis, and a behaviour analysis.

"When you have these thoughts and experience those feelings as a result of the concerns, how do you respond to others?"

"How do others respond to you when this happen?"

To the students: "What do each of you think when your (class mate) has these experiences? How do these thoughts affect your interactions?"

"What do you each think about when these experiences happen to one of your class mates when he or she works so hard to help?

Phase 4: Goals

In CRT, the clients decide the counselling goals. The counsellor helps the clients to change problematic thinking so that feelings and behaviour will change.

Here are some comments or questions that a counsellor might use during this phase:

"What would you each like to be that you are doing at the same time in your life?

"Who in your class do you think would be most relieved when (a class mate) is no longer having these problems?"

"If you (or identified person) did not have these problems; how would your relationships be different in your class?"

"What would you like to change in your relationship with your class mates so that the problem is less of a burden?"

"What do you need, want, and expect of each other?"

Phase 5: Amplifying Change

The counsellor continues to assess and evaluate the students' progress throughout treatment. Homework is given to amplify new behaviour that are defined and discussed in session. The counsellor continuously recognizes change when clients first report improvements in functioning. The counsellor notes changes in activities and inquires about the thoughts and belies that contribute to the clients' mood and behaviours.

"I am noticing that you are each getting along better today in our session. Can each of you tell me what you are thinking about and feeling to help this happen?"

"It seems that you have each had a better week. Can you each tell me how your thoughts contributed to what you did that help things to be better?"

"In your opinion, what have other people in your school or family been doing recently that has helped your behaviour to change?"

Phase 6: Termination

Clients terminate when they achieve their therapeutic goals. Most counsellors allow clients to schedule follow –up sessions to aid in maintaining progress.

2.3.1 Concept of Graded Exposure Counselling Technique

Graded exposure counselling technique is based on the principles of respondent conditioning often termed Pavlovian extinction (Mark & Meyer, 1981). The counsellor uses grade exposure counselling techniques to identify the cognitions, emotions and physiological arousal that accompany a fear-inducing stimulus and attempts to break the pattern of escape that strengthens the fear response, through measured to progressively stronger stimuli until habituation is reached (De Silva & Rachman, 1981). The technique involves the creation of a program of steadily escalating steps or challenges (a hierarchy), which can be

explicit ("static") or implicit ("dynamic"), that work towards a final goal representing a "non-phobic" response (Miltenberger, 2008). The client then voluntarily moves through the steps, with a means of terminating each step which is under voluntary control. While counselling exposure has a strong evidence base, some clinicians are uncomfortable using Graded Exposure Counselling, specifically in cases of PTSD, because they do not understand it or are not confident in their own ability to utilize it, or more commonly, see significant contraindications for their client (Becker, Zayfert, & Anderson, 2011; and Jaeger, Echiverri, Zoellner, Post, & Feeny, 2009) Graded exposure and flooding differ in that flooding starts at the most extreme item in a fear hierarchy, while graded exposure does not (De Silva & Rachman, 1983; and Cobb, 1983).

The exposure procedures are divided into three types. The first is in vivo or “real life.” This type of procedure uses a direct approach with activities in different situations. For example, if someone fears public speaking the person may be asked to give a speech to a small group of people just to channel that fear directly. The second type of exposure is imaginal, where clients are asked to imagine a situation that they are afraid of. This procedure is helpful for people who need to confront feared thoughts and memories. The third type of exposure is interceptive, which may be used for more specific disorders such as panic or post-traumatic stress disorder. Clients confront feared bodily symptoms such as increased heart rate and shortness of breath. All of different types of exposure can be used together or they can be used separately

According to Davis and Ollendick (2005), Myers and Davis (2007), and Joseph and Gray (2008); graded exposure is a technique in behaviour treatment intended to treat anxiety disorders. It involves the exposure of the client to the

feared object or context step by step without any danger, in order to overcome their anxiety. Procedurally it is similar to the fear extinction paradigm in rodent work and numerous studies have demonstrated its effectiveness in the treatment of anxiety disorders such as Post Trauma Stress Disorder (PTSD), and specific school phobias. Thus, it is suitable for treating school phobia.

This intervention is a variant of a behavioural treatment known as reinforced practice, dating back to the late 1960s. Theoretically, treatment principles are based on the use of operant procedures, shaping and extinction, used during repeated and controlled graduated exposures, with counsellors providing reinforcement and verbal feed-back for overcoming avoidance behaviour (Davis & Ollendick, 2005).

A good example of in vivo graded exposure is the following hierarchy used by Garvey and Hegrenes (as cited in Gutierrez-Maldonado, Magallon-Neri, Rus-Calafell, & Penaloza- Salazar, 2009) in their study: to sit in the car with the counsellors in front of the school, to get out of the car and to approach to the school wall, to walk near the sidewalk, to reach the beginning of the school front entrance stairs, to reach the end of the school front entrance stairs, to approach the school front door, to enter the school, to approach the classroom when the teacher is there, to enter the classroom, to sit in the school desk when the teacher and one or two classmates are there, to sit in the school desk with a full classroom. The procedure was performed the following 20 days for a period of 20-40 minutes.

Grohol (2009) explained that graded exposure as a specific type of cognitive-behavioural counselling technique that is often used in the treatment of post-traumatic stress disorder (PTSD), and school phobias (including school phobia). In school phobia, graded exposure technique is intended to help the client

face and gain control of the fear and distress that was overwhelming in the trauma, and must be done very carefully step by step (from the lesser to the highest school phobia provoking stimuli) in order not to re-traumatize the client. In some cases, trauma memories or reminders can be confronted all at once (”flooding”), while for other individuals, it is preferable to work gradually up to the most severe trauma by starting with less upsetting life stressors or by taking the trauma one piece at a time. A counsellor works with the client to determine which method is best suited for the particular client and their trauma.

In school phobias, exposure technique is used in conjunction with imagery. In conjunction with learning how to bring about a relaxed state at-will, the counsellor gradually exposes clients to what frightens them and helps them cope with their fears.

Exposing someone to their fears or prior traumas without the client first learning the accompanying coping techniques — imagery exercises and or education — can result in a person simply being re-traumatized by the event or fear. Therefore exposure counselling is typically conducted within a technique with a counsellor trained and experienced with the technique and the related coping exercises.

Graded exposure technique: The counsellor helps the client construct an exposure fear hierarchy, in which feared objects, activities, or situations are ranked according to difficulty. They begin with mildly or moderately difficult exposures, and then progress to harder ones. Hence this is tangential to this study. Systematic desensitization involves three steps. In the first step, the client is given relaxation training. In the second step, counsellor and client construct a hierarchy of fears – that is, a list of anxiety-producing situations in order of their increasing

horror to the client. The following, for example, is the hierarchy of fears (in this case going from most to least frightening) established for a patient who was plagued by fears of dying (Wolpe & Wolpe, 1981, p. 54):

1. Seeing a dead man in a coffin
2. Being at a burial
3. Seeing a burial assemblage from a distance
4. Reading the obituary notice of a young person who died of a heart attack
5. Driving past a cemetery (the nearer, the worse)
6. Seeing a funeral (the nearer, the worse)
7. Passing a funeral home (the nearer, the worse)
8. Reading the obituary notice of an old person
9. Being inside a hospital
10. Seeing a hospital
11. Seeing an ambulance

Exposure is similar to systematic desensitization. Except that the relaxation training is eliminated. Clients are simply confronted with the experiences they fear, but in the absence of reinforcement, so that the maladaptive response (anxiety, avoidance) can extinguish. Today, instead of flooding, most behaviour counsellors use graded exposure. As in systematic desensitization, the client confronts the feared stimulus gradually, in steps. For example, people with dog school phobias first watch videos of dogs, then enter a room where there is a caged dog, then stand in front of the cage, and so on, until, with the extinction of the fear, they are petting the dog.

2.3.2 Principles of Graded Exposure Counselling Technique

According to Shire (2005) the following principles should be followed when using graded exposure:

- Help the individual plan a series of steps for the graded exposure hierarchy. The first step is one that causes little anxiety. While the last step is one that causes maximum anxiety (see sample plan on the following page). The individual can plan these steps at home and bring them in to the next consultation for discussion.
- Help the individual identify any exaggerated fears that occur in each situation (For example, "I will faint") and decide what is more likely to happen (For example, "I am anxious but I am unlikely to faint").
- Encourage the individual to practice the first step of the hierarchy. He or she does not move on to the next step until the previous step has been mastered with minimum anxiety. Continue this process until the person can manage all situations in the hierarchy.
- Indentify a friend or family member who can provide support and encouragement.
- Encourage the individual to avoid using alcohol or drugs to cope with feared situations.
- If fears continue after the above methods have been tried. Seek consultation from someone who has specialized training in the behavioural principles of graded exposure counselling technique.

2.3.3 Model of Graded Exposure Plan

Problem: Panic attacks and fear of leaving the house.

After mastering the education, the individual could embark on the plan below (developed in conjunction with the individual according to his or her specific fears).

The individual is instructed to persevere at each step until the step can be performed with minimum anxiety. Only then does the individual move on the next step.

- Sit on the front veranda for 20 minutes (anxiety rating 3/10).
- Walk to the letterbox to collect the mail then remain in the front garden for 20 minutes (anxiety rating 4/10).
- Walk around the block once (anxiety rating 5/10).
- Walk around the block twice (anxiety rating 6/10).
- Walk up to the post office at 10 am when it is not busy and buy a stamp (bring stamp in for inspection) anxiety rating 7/10).
- Catch a bus to the shopping centre. Get out and wait for the next bus, then return home (bring bus tickets in for inspection) (anxiety rating 8/10).
- Catch a bus to the shopping centre, go to the florist, buy a bunch of flowers as a reward, walk around the centre for another 15 minutes, then return home (anxiety rating 9/10).
- Catch a bus to the shopping centre on a Saturday morning, catch lift up to car park then escalator to come down again, go to supermarket and buy 16 items from shopping list (retain docket). Then return home anxiety rating 10/10).

2.3.4 Overcoming Problems during Graded Exposure

Considered the following questions if problems are encountered during graded exposure therapy:

Is the individual trying to progress too quickly or too slowly?

Tasks that are too easy are not rewarding and tasks that are too difficult are demoralizing. The secret to success is regular and gradual progress.

Has the individual had enough practice at this step?

It is important that the individual masters the present step before moving on to a more difficult step. Some steps are more difficult than others hence the individual may need to progress more slowly at times. Moving on without sufficient practice can lead to loss of self-confidence and motivation if the individual experiences a setback at the next step.

Is the increase in difficulty between steps too great?

If so, intermediate steps may need to be added so that the increase in difficulty is more manageable.

These techniques will help the individual feel calmer and more in control. However, these techniques require practice so it is sensible for the individual to master these techniques before commencing with the exposure exercises.

Is the individual identifying exaggerated fears and replacing these fears with thoughts about more likely outcomes?

Encourage individuals to ask themselves questions such as:

"What EVIDENCE is there that a particular event or response is going to happen?"

"REALISTICALLY, what is the WORST thing that can happen? "What if… DOES happen? Will it really be so bad? What is MORE LIKELY to happen?"

Remember that setbacks do occur.

If a setback occurs it may be helpful for the individual to return to a pervious step at which he or she feels more comfortable. It will also be helpful to encourage the individual to view the setback in a positive light.

2.3.5 Variations of Exposure Technique

According to American Psychological Association (APA, undated), there are several variations of exposure counselling. These include:

- In vivo exposure: Directly facing a feared object, situation, or activity in real life. For example, someone with a fear of snakes might be instructed to handle a snake, or someone with social anxiety might be instructed to give a speech in front of an audience.
- Imaginal exposure: Vividly imagining the feared object, situation, or activity. For example, someone with Posttraumatic Stress Disorder might be asked to recall and describe his or her traumatic experience in order to reduce feelings of fear.
- Virtual reality exposure: In some cases, virtual reality technology can be used when in vivo exposure is not practical. For example, someone with a fear of flying might take a virtual flight in the psychologist's office, using equipment that provides the sights, sounds, and smells of an airplane.
- Interoceptive exposure: Deliberately bringing on physical sensations that are harmless yet feared. For example, someone with Panic Disorder might be instructed to run in place in order to make his or her heart speed up, and therefore learn that this sensation is not dangerous. Exposure therapy can also be paced in different ways. These include:

- Graded Exposure Technique: The counsellor helps the client construct an exposure fear hierarchy, in which feared objects, activities, or situations are ranked according to difficulty. They begin with mildly or moderately difficult exposures, and then progress to harder ones. Hence this is tangential to this study.
- Flooding: Using the exposure fear hierarchy to begin exposure with the most difficult tasks.
- Systematic Desensitization: In some cases, exposure can be combined with relaxation exercises to make them feel more manageable and to associate the feared objects, activities, or situations with relaxation.

Graded exposure treatment is thought to help in several ways (Kaplan & Tolin, 2011), including:

- Habituation: Over time, people find that their reactions to feared objects or situations decrease.
- Extinction: can help weaken previously-learned associations between feared objects, activities, or situations and bad outcomes.
- Self-efficacy: Exposure can help show the client that he/she is capable of confronting his/her fears and can manage the feelings of anxiety.
- Emotional processing: During exposure, the client can learn to attach new, more realistic beliefs about feared objects, activities, or situations; and can become more comfortable with the experience of fear.

2.4 Relationship among the Variables

The focus of this study is directed at investigating the effects of cognitive restructuring and graded exposure counselling techniques on school phobia among

secondary school students in Kaduna metropolis. Therefore this section intends to highlight the relationship that exists among the variables.

First of all school phobias a behavioural problem, has been found to be a cognitively meditated and unwarranted responses to school because school attendance will not ordinarily elicit anxiety provoking stimuli. But when anxiety provoking stimuli have been associated with school attendance, school phobia develops. Therefore, school phobia is a poor response or behaviour learnt from past events. Studies such as Gonzalez- Prendes and Resko (1999), Olatunji, Cisler, and Deacon, (2010), and Mankiewiez and Turner (2014) have emphasized the efficacies of cognitive- behavioural techniques in the treatment of anxiety disorder depression all sorts of school phobia (including school phobia). Cognitive restructuring (CRT) and graded exposure (GET) are counselling techniques derived from the cognitive-behavioural approaches.

The CRT and GET are rooted in the fundamental principles that clients' cognitions play a significant and primary role in the development and maintenance of school phobia. In addition CRT and GET hold the assumption that cognitive processes and contents are accessible and can be known. It is the knowledge and accessibility of the cognitive contents to the counsellor and the client that can facilitate the treatment of school phobia.

Moreover, CRT and GET hold the assumptions that if faulty cognitive are the source of behavioural problems, then a need to unlearn and replace the negative response should be a paramount issue in the treatment. In many instances, unwarranted fear of school may not be in the school phobic's awareness, but with proper training and practice which are embedded in CRT and GET, he or she becomes aware of them. CRT and GET also hold the assumptions

that the way we think about our reality is central to how we react to that reality. Also, the two techniques hold the assumption that cognitions can be intentionally targeted, modified, and changed. Thus school phobia (which is a cognitive behavioural response) can be treated.

Furthermore, CRT and GET usually conduct an assessment of the clients with a view to knowing possible level of the anxiety (or school phobia). The two treatments also use education in guiding the client. For CRT, the education is necessary to enables the client understand the rationale behind the cognitive restructuring technique and procedures for treating the school phobia. While in GET, education is necessary to ensure that the school phobic understands the way of the treatment is done. This is because lack of prior education is capable of escalating client's problem than bringing a relief.

Itemizing various levels of school phobia is ensured by CRT and GET. Each items or anxiety provoking stimuli are technically treated with a view to relieving the student of the school phobia.

Both techniques have a "here and now" approach in the treatment of school phobia. Yet CRT and GET give the client knowledge and capacity for self treatment in the future.

2.5 Theoretical Framework

Ivan Pavlov Classical Conditioning Theory

Give me a dozen healthy infants, well-formed, and my own specified world to bring them up in and I'll guarantee to take any one at random and train him to become any type of specialist I might select - doctor, lawyer, artist, merchant-chief and, yes, even beggar-man and thief, regardless of his talents,

penchants, tendencies, abilities, vocations and the race of his ancestors. (Watson, 1924, p. 104).

Classical conditioning theory involves learning a new behaviour via the process of association. In simple terms two stimuli are linked together to produce a new learned response in a person or animal. There are three stages to classical conditioning. In each stage the stimuli and responses are given special scientific terms:

Stage 1: Before Conditioning:

In this stage, the **unconditioned stimulus (UCS)** produces an **unconditioned response (UCR)** in the organism. In basic terms this means that a stimulus in the environment has produced a behaviour / response which is unlearned (i.e. unconditioned) and therefore is a natural response which has not been taught. In this respect no new behaviour has been learned yet.

For example, a stomach virus (UCS) would produce a response of nausea (UCR). In another example a perfume (UCS) could create a response of happiness or desire (UCR).

This stage also involves another stimulus which has no affect on a person and is called the **neutral stimulus (NS)**. The NS could be a person, object, place etc. The neutral stimulus in classical conditioning does not produce a response until it is paired with the unconditioned stimulus.

Stage 2: During Conditioning:

During this stage a stimulus which produces no response (i.e. neutral) is associated with the unconditioned stimulus at which point it now becomes known as the **conditioned stimulus (CS)**.

For example a stomach virus (UCS) might be **associated** with eating a certain food such as chocolate (CS). Also perfume (UCS) might be **associated** with a specific person (CS).

Often during this stage the UCS must be associated with the CS on a number of occasions, or trials, for learning to take place. However, one trail learning can happen on certain occasions when it is not necessary for an association to be strengthened over time (such as being sick after food poisoning or drinking too much alcohol).

Stage 3: After Conditioning:

Now the conditioned stimulus (CS) has been associated with the unconditioned stimulus (UCS) to create a new conditioned response (CR). For example a person (CS) who has been associated with nice perfume (UCS) is now found attractive (CR). Also chocolate (CS) which was eaten before a person was sick with a virus (UCS) is now produces a response of nausea (CR).

Little Albert Experiment (School phobias)

Ivan Pavlov could only show that classical conditioning applied to animals; but did not show how it also applies to humans (McLeod, 2008). In a famous (though ethically dubious) experiment, Watson and Rayner (1920) showed that it did. Little Albert was a 9-month-old infant who was tested on his reactions to various stimuli. He was shown a white rat, a rabbit, a monkey and various masks. Albert described as "on the whole stolid and unemotional" showed no fear of any of these stimuli. However what did startle him and cause him to be afraid was if a hammer was struck against a steel bar behind his head. The sudden loud noise would cause "little Albert" to burst into tears. When "**Little Albert**" was just over 11 months old the white rat was presented and seconds later the hammer was struck against

the steel bar. This was done 7 times over the next 7 weeks and each time "little Albert" burst into tears. By now "Little Albert only had to see the rat and he immediately showed every sign of fear. He would cry (whether or not the hammer was hit against the steel bar) and he would attempt to crawl away. Watson and Rayner had shown that classical conditioning could be used to create any form of phobia; including school phobia. A school phobia is an irrational fear of school, i.e. a fear of school that is out of proportion (McLeod, 2008).

Application of Classical Conditioning to School Phobia

Passer and Smith (2004), McLeod (2008), and Watt and Difrancescantonioa (2010) have explained various principles derived from Classical Conditioning of Pavlov. According to them, these are acquisition, extinction, spontaneous recovery, stimulus generalization, stimulus discrimination and higher order conditioning among others. Pavlov have noted, that classical conditioning occurs in three phases—acquisition, extinction, and spontaneous recovery.

Acquisition: This refers to the period during which a response is being learned (Passer & Smith, 2004). An individual gradually learns—or acquires—the CR. When the CS (fearful noise) and UCS (a little white rat) are paired over and over again, the CR (fear or school phobia) increases progressively in strength. In general, the closer in time the pairing of CS and UCS, the faster learning occurs, with about a half second delay typically being the optimal pairing for learning. Longer delays usually decrease the speed and strength of the organism's response. A student may acquire school phobia (CR) when while attending school (UCS) one day; he fell into the hands of a bully who beat or scare him (CS). The next thing is that he will start developing fear (CR) to attend school. There is the likelihood that many of the students that survived the school assembly bomb

attack at a secondary school in northern Nigeria in 2014 (which led to the death of more than fifty persons; including staff and students) might have acquired school phobia; that is, fear school for fear of another bomb attack.

Extinction: It is regarded as a procedure whereby the repeated presentation of conditioned stimulus (CS) in the absence of unconditioned stimulus (UCS) with which it was previously paired (Hermans, Craske, Mineka, & Lovibond, 2006). Following a series of CS-only presentations, the conditioned response (CR) that was established during the preceding acquisition phase gradually diminishes. In a process called extinction, the CR decreases in magnitude and eventually disappears when the CS is repeatedly presented alone, that is, without the UCS. After numerous presentations of the tone without meat power, Pavlov's dogs eventually stopped salivating. The CR fades away over repeated trials, just as many memories gradually decay. Yet the truth is more complicated and interesting than that. Extinction is an active, rather than passive, process. During extinction a new response, which in the case of Pavlov's dogs was the absence of salivation, gradually "writes over" or inhibits the CR, namely, salivation. The extinguished CR does not vanish completely; it is merely overshadowed by the new behaviour. The extinction principle can be used to make the client to unlearn undesirable behaviour like school phobia. Counsellors can utilise extinction by exposing the client to the anxiety provoking stimuli (school) without causing the client the previous stress associated with the attending school. Thus the unwarranted response (school phobia) is extinct.

Spontaneous Recovery: In a phenomenon called spontaneous recovery**,** a seemingly extinct CR reappears (often in somewhat weaker form) if the CS is presented again. It's as though the CR were lurking in the background, waiting to

appear following another presentation of the CS. In a classic study, Pavlov presented the CS (tone from a metronome) alone again and again and extinguished the CR (salivation) because there was no UCS (mouth watering meat powder) following it. Two hours later, he presented the CS again, and the CR returned. The animal had not really forgotten the CR, just suppressed it. Spontaneous recovery in terms of reappearance or reoccurrence of school phobia may happen if and when graded exposure is not preceded with education or when it is haphazardly used by counsellors. Therefore, counsellors treating school phobia with GET or CRT are advised to give the client good education before embarking on treatment.

Stimulus Generalization and Discrimination

As much as classical conditioning helps us adapt to and learn new things, it would be virtually useless if we could not apply it to new situations. As Greek philosopher Heraclitus observed, "We never step into the same river twice." No two stimuli are identical; even our friends and family may look a tiny bit different every time we see them. We need to learn to respond to stimuli that differ somewhat from those we originally encountered during conditioning. By the same token, we do not want to go around shouting "Mom!" at every woman who has the same height and hair style as our mothers. Pavlov found that, following classical conditioning, his dogs salivated not merely to the original tone or sound but to sounds similar to it. This phenomenon is **stimulus generalization:** the process by which CSs that are similar, but not identical, to the original CS elicit a CR. Stimulus generalization occurs along a generalization gradient. The more similar to the original CS the new CS is, the stronger the CR will be. Pavlov found that his dogs showed their largest amount of salivation to the original sound, with progressively less salivation to sounds that were less and less similar

to it in pitch. Stimulus generalization allows us to transfer what we have learned to new things. In the same vein, a school phobic who was traumatised by a senior student may develop a school phobia because of fear of all senior students.

Stimulus Discrimination

Stimulus discrimination is the flip side of the coin to stimulus generalization; it occurs when we exhibit a less pronounced CR to CSs that differ from the original CS. Stimulus discrimination helps us understand why we can enjoy scary movies. Although we may hyperventilate a bit while watching sharks circle the divers in the movie Open Water, we would respond much more strongly if a shark chased us around in a tank at the aquarium. We have learned to discriminate between a motion picture stimulus and the real-world version of it and to modify our response as a result. The use of GET by counsellor was to help client to be able to achieve such discrimination.

Higher-order Conditioning

Taking conditioning a step further, organisms learn to develop conditioned associations to CSs that are associated with the original CS. If after we condition a dog to salivate to a tone we pair a picture of a circle with the tone, the dog eventually salivates to the circle as well as to the tone. This finding demonstrates **higher-order conditioning:** the process by which organisms develop classically conditioned responses to CSs associated with the original CS. As we might expect, second-order conditioning—in which a new CS is paired with the original CS—tends to be weaker than garden variety classical conditioning, and third-order conditioning—in which a third CS is paired with the second-order CS—is even weaker. Fourth-order conditioning and beyond is typically difficult or impossible. Higher-order conditioning also helps to explain how some people

develop addictions to cigarettes, heroin, and other drugs. Many addictions are shaped in part by higher-order conditioning, with the context in which people take the drugs serving as a higher-order CS. People who do not generally smoke cigarettes may find themselves craving one at a party because they have smoked occasionally at previous parties with their friends who smoke. Behaviourists refer to these higher-order CSs as occasion setters, because they refer to the setting in which the CS occurs.

Criticisms against Classical Conditioning

Classical conditioning emphasizes the importance of learning from the environment, and supports nurture over nature (McLeod, 2008). However, it is limiting to describe behaviour solely in terms of eithernature or nurture, and attempts to do this underestimate the complexity of human behaviour. It is more likely that behaviour is due to an interaction between nature (biology) and nurture (environment).

Strength of classical conditioning theory is that it is scientific. This is because it's based on empirical evidence carried out by controlled experiments. For example, Pavlov (as cited in McLeod, 2008)) showed how classical conditioning can be used to make dog salivate to the sound of a bell.

Classical conditioning is also a reductionist explanation of behaviour. This is because complex behaviour is broken down into smaller stimulus - response units of behaviour.

Supporters of a reductionist approach say that it is scientific. Breaking complicated behaviours down to small parts means that they can be scientifically tested. However, some would argue that the reductionist view lacks validity. Thus, whilst reductionism is useful, it can lead to incomplete explanations.

Operant Conditioning Theory of B. F Skinner

Another behavioural theory accounting for the development of fears is based on the operant conditioning model (McLeod, 2007). Skinner is regarded as the father of Operant Conditioning. By the 1920s John B. Watson had left academic psychology and other behaviourists were becoming influential, proposing new forms of learning other than classical conditioning (Watson as cited in McLeod, 2007). Perhaps the most important of these was Burrhus Frederic Skinner. Although and for obvious reasons, he is more commonly known as B.F. Skinner. Skinner believed that human beings do have such a thing as a mind, but that it is simply more productive to study observable behaviour rather than internal mental events. He believed that the best way to understand behaviour is to look at the causes of an action and its consequences. He called this approach operant conditioning. Skinner's theory of operant conditioning was based on the work of Thorndike (as cited in McLeod, 2007). Edward Thorndike studied learning in animals using a puzzle box to propose the theory known as the 'Law of Effect'. Skinner introduced a new term into the Law of Effect - Reinforcement. Behaviour which is reinforced tends to be repeated (that is, strengthened); behaviour which is not reinforced tends to die out-or be extinguished (that is, weakened). Skinner studied operant conditioning by conducting experiments using animals which he placed in a **'Skinner Box'** which was similar to Thorndike's puzzle box.

Skinner coined the term operant conditioning. The term refers to a roughly changing of behaviour by the use of reinforcement which is given after the desired response. He identified three types of responses or operant that can follow behaviour.

- **Neutral Operant**: A response from the environment that neither increases nor decreases the probability of a behaviour being repeated.
- **Reinforcer**: A response from the environment that increases the probability of a behaviour being repeated. A reinforcer can be either positive or negative.
- **Punisher:** A response from the environment that decreases the likelihood of a behaviour being repeated. Punishment weakens behaviour.

Experiment

Skinner placed a hungry rat in his Skinner box. The box contained a lever in the side and as the rat moved about the box it would accidentally knock the lever. Immediately it did so a food pellet would drop into a container next to the lever. The rat quickly learned to go straight to the lever after a few times of being put in the box. The consequence of receiving food if it pressed the lever ensured that the rat would repeat the action again and again.

Application of Principles of Operant Conditioning to School Phobia

Reinforcement is something that encourages the repetition of a behaviour. We have positive and negative reinforcement.

Positive reinforcement strengthens a behaviour by providing a consequence an individual finds rewarding. For example, if each time a student finds staying home more pleasant and away from school (as a result of an unpleasant event) he or she is more likely to repeat this behaviour in the future. In a situation whereby parents provide amenities such films, video games and the likes at home, thus they strengthen or help in maintaining the behaviour of school school phobia and staying at home for the child.

Negative Reinforcement

The removal of an unpleasant reinforcer can also strengthen behaviour. This is known as negative reinforcement because it is the removal of an adverse stimulus which is rewarding to the animal or person. Negative reinforcement strengthens behaviour because it stops or removes an unpleasant experience. For example**,** if a child escapes being beaten by someone in the school, he or she may want to continue staying away to escape being beaten; thus strengthening school phobia. Skinner showed how negative reinforcement worked by placing a rat in his Skinner box and then subjecting it to an unpleasant electric current which caused it some discomfort. As the rat moved about the box it would accidentally knock the lever. Immediately it did so the electric current would be switched off. The rats quickly learned to go straight to the lever after a few times of being put in the box. The consequence of escaping the electric current ensured that they would repeat the action again and again. In fact Skinner even taught the rats to avoid the electric current by turning on a light just before the electric current came on. The rats soon learned to press the lever when the light came on because they knew that this would stop the electric current being switched on. Escape Learning and Avoidance Learning are known as leaned responses (McLeod, 2007)

Punishment

Punishment is defined as the opposite of reinforcement since it is designed to weaken or eliminate a response rather than increase it. Like reinforcement, punishment can work either by directly applying an unpleasant stimulus like a shock after a response or by removing a potentially rewarding stimulus, for instance, parents may deny the school phobic some privileges like watching television whenever he stays away from school.

Behaviour Modification

Behaviour modification is a set of therapies / techniques based on operant conditioning (Skinner, as cited in McLeod, 2007). The main principle comprises changing environmental events that are related to a person's behaviour. For example, the reinforcement of desired behaviours and ignoring or punishing undesired ones. Examples of behaviour modification therapy include token economy and behaviour shaping

Token Economy

Token economy is a system in which targeted behaviours are reinforced with tokens (secondary reinforcers) and are later exchanged for rewards (primary reinforcers). Tokens can be in the form of fake money, buttons, poker chips, stickers, and so on. The reward can range from anything from snacks to privileges or activities. Token economy has been found to be very effective in managing psychiatric patients (McLeod, 2007). Perhaps it may work suitably with school phobic too. However, the clients can become over reliant on the tokens, making it difficult for them to adjust to society once they leave caregiver's, office, hospital, and so on. Counsellors also use token economy at secondary school by giving students stickers to reward good behaviour.

Merits of Operant Conditioning

Operant conditioning has been conducted in a scientific manner. Skinner's study of behaviour in rats was conducted under carefully controlled laboratory conditions. It is primarily concerned with observable behaviour, as opposed to internal events like thinking and emotion. The major influence on human behaviour is learning

from our environment. In the Skinner study, because food followed a particular behaviour the rats learned to repeat that behaviour, for example, operant conditioning. There is little difference between the learning that takes place in humans and that in other animals. Therefore research operant conditioning can be carried out on animals as well as on humans. Skinner proposed that the way humans learn behaviour; especially fear and or school phobia is much the same as the way the rats learned to press a lever.

The emphasis laid by Skinner is on how any type of school phobia including school phobia is maintained are in certain ways. The school phobic is constantly learning new behaviours and how to modify such existing behavior is possible through the application of various principles of operant conditioning. Operant conditioning can be used to explain a wide variety of behaviour, from the process of learning, to addiction and acquisitionof school phobia. It also has practical application (such as token economy) which can be applied in schools, classrooms, prisons and psychiatric hospitals.

Criticism against Operant Conditioning

Operant conditioning have been criticized of failing to take into account the role of inherited and cognitive factors in learning, and thus is an incomplete explanation of the learning process in humans and animals. For example, Kohler (as cited in McLeod, 2007) found that primates often seem to solve problems in a flash of insight rather than be trial and error learning. Also social learning theory (Bandura, as cited in McLeod, 2007) suggests that humans can learn automatically through observation rather than through personal experience. The use of animal research in operant conditioning studies also raises the issue of extrapolation. Some *psychologists* argue we cannot generalize from studies on animals to humans as

their anatomy and physiology is different from humans, and they cannot think about their experiences and invoke reason, patience, and memory or self-comfort.

Albert Bandura's Social Learning Theory

The social learning theory was proposed by Albert Bandura. The works of Cherry (2008), and Duncan (2008) have contributed to our understanding of the social learning theory. The social learning theory proposed by Albert Bandura has become perhaps the most influential theory of learning and development (Cherry, 2008). While rooted in many basic concepts of traditional learning theory, Bandura believed that direct reinforcement could not account for all types of learning (Cherry, 2008). Thus, Bandura was quoted to have said that:

"Learning would be exceedingly laborious, not to mention hazardous if people had to rely solely on the effects of their own actions to inform them what to do. Fortunately, most human behaviour is learned observationally through modelling: from observing others, one forms an idea of how new behaviours are performed, and on later occasions, this coded information serves as a guide for action".

Asonibare (2004) has stated that modelling, imitation, observational learning or social learning is used by various experts interchangeably to refer to the same thing. Thus he (Asonibare) stated that modelling at times is referred to as imitative, observational learning or social learning.

Bandura (as cited in Asonibare, 2004) has stressed the importance of social and cognitive factor as well as the role of observational models in determining behaviour as an opposition to Skinner's emphasis on environment as a determinant of organisms (or man's) behaviour. He represents behaviour as a function of the person and the environment called reciprocal determination. This interaction among person, behaviour and environment demonstrates how the

world and the person cause each other. Duncan (2008) thus argued that social learning theory states that people learn by watching others in social setting and modelling behaviour they think will lead to favourable outcomes, while avoiding behaviour they think may lead to punishing consequences. School phobia is an attempt by children to avoid stressful events in the school.

Bobo Doll Experiment

In the famous "Bobo doll experiment in 1961, Bandura demonstrated that children learn and imitate behaviours they have observed in other people (Duncan, 2008; and Cherry 2008). The children in Bandura's study observed an adult acting aggressively toward a Bobo doll. When the children were later allowed to play in a room with the Bobo doll, they began to imitate the aggressive acting they had previously observed.

In the study, Bandura identified three basic models of observational learning which include:

a. A live model, which involves an actual individual demonstrating or acting out behaviour.
b. A verbal instructional model, which involves descriptions and explanations of behaviour.
c. A symbolic model, which involves real or fictional characters displaying behaviours in books, films, television programmes, or online media.

Application of Social Learning Concepts to School Phobia

Cherry (2008) has identified the basic learning concepts as observational learning, intrinsic reinforcement, the modelling process such as attention, retention, reproduction and motivation. However, a revision has been effected on this theory by Bandura in 1986 to include agents of experience (Duncan, 2008).

Observation Learning

Observation learning theory stresses the importance of unique experience in family, school, community and so on and so forth (Cherry, 2008). According to this view point, we learn behaviours through observing and mimicking the behaviours of others. Children who have observed other students being brutalized in school may acquire fear of school at a very trivial provocation.

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All these according to Bandura, connote that people can learn through observation. A student who has escaped or survived a cult attack that led to death of many students, including his close friend may suffer school phobia. Ordinary news broadcast on radio or television can influence school phobia in some students.

Intrinsic Reinforcement

Mental states are important to learning (Cherry, 2008). Bandura had argued that external, environmental reinforcement was not the only factors that influence learning and behaviour (as proposed by Skinner and other operant conditioning psychologists). Bandura described intrinsic reinforcement as a form of internal reward, such as pride, satisfaction, and a sense of accomplishment. For example, a

student who is usually praised by his parents for always staying out of trouble (though an extrinsic reinforcement or the self motivation) may refuse school for fear of bully who may want to attack him; and the consequent self image which may be dented in front of his parents.

The emphasis on internal thoughts and coquitos helps connect learning theory to cognitive developmental theories. While many textbooks place social learning theory with behavioural theories, Bandura himself describes his approach as a 'social cognitive theory' (Cherry, 2008).

The Modelling Process

In a sharp reaction to behaviourists who believed that learning led to a permanent change in behaviour, observational learning demonstrates that people can learn new information without demonstrating new behaviours. It is not all the observed behaviours that are effectively learnt. Factors involving both the model and the learner can play a role in whether social learning is successful. Cherry (2008) argued that certain requirements and steps must be followed.

To corroborate the above assertion, Asonibare (2004) regarded the requirements as characteristics of effective models which include that

a) Similarity of models to observer in age, sex, and attitude will enhance modelling than dissimilarity.
b) Models that have a degree of prestige and status are more likely to be imitated than those of low prestige.
c) Models who are competent in their performance and who exhibit warmth tend to facilitate modelling.
d) The kind of relationship that the model has with the observed will determining enhancement of modelling.

The fact that a person witnesses a stressful event and he has not displayed fear immediately does not mean he cannot still display the fear in future (Ewen as cited in Cherry, 2008). Students who witnessed or heard information about dreadful events in schools are likely to exhibit school phobia.

The counsellor who is to treat school phobic is, by this concept, requires to present a high degree of prestige, competence, warmth, confidence, and positive regard for the clients who may be school phobic.

Bandura has stated that the following steps are involved in social learning and modeling process (Cherry, 2008).

Attention

In order to learn through observation, the learner must direct his or her attention to the model, (that is, to the other person performing an activity). Anything that detracts the learner's attention is going to have a negative effect on observational learning. If the model is interesting or there is a novel aspect to the situation, the learner is far more likely to dedicate his or her full attention to learning. Bakare (1977) has reiterated the importance of attention during learning when he observed that learning involves three distinguishable stages. These are acquisition stage, retention stage and reproduction stage. The acquisition stage is where the attention of the learner is grossly required; otherwise effective learning will not take place. School phobia may not be acquired where children are unable to pay attention to stressful events that led to fear. To be able to generate school phobia, the child must witness the event or get information about it. In the other way, counsellor treating school phobia school emphasise the need for the clients to be very attentive in order to ensure the success of the treatment.

Retention

The ability to store information is also an important part of the learning process. The learner must be able to do what the teacher, the person or model have said or done. Only when the learner can retain some representation of the model's or teacher's action or words in memory can he or she perform similar action at later times or acquire useful information. Retention can be affected by a number of factors, but the ability to pull up information later and act on it is vital to social learning. School phobic might have learnt about events that influenced the fear but may present the unwarranted behaviour at a later time. In another way, counsellor using CRT and GET needs to make his clients to retain the techniques learnt in upsetting school phobia.

Reproduction

Once the learner has paid attention to the model and retained the information, he or she must be able to perform the behaviour he observed. This aspect of social learning is termed a production process which depends on the learner's abilities. If he cannot perform the behaviour in question, have a clear representation of it in his memory, then, the learning is of little use. In addition, the learner's capacity to monitor his own performance and adjust until it matches that of the model (Baron, 2001). Counsellor should treat client with a view to the latter reproducing the techniques overcoming school phobia.

Motivation

Motivation plays a vital role in social learning. Learners often acquire information through observational learning but may not put it into immediate use in their behaviour. In order for observational learning to be successful, learners must be motivated to imitate the behaviour of the model. Learner may have no

need for the someone tie a bow tie but have no plan behaviour may involve high risk of punishment, as when he observed a model cheating during an examination, but do not want to try it himself. In another example, if the learner sees another student with school phobia he (the learner) may not start to show the behaviour until something in the environment urges or motivate him to develop it. Counsellor also needs to motivate clients to seek counselling when they harbour fear of school.

Bandura (2001) refined the social cognitive theory with "agents of experience and features of agency (Duncan, 2008). These are stated below;

Agents of Experience

Bandura asserted that people are agents of experiences rather than simply undergoers of experience (Duncan, 2008). He re-emphasized that people are not machines passively serious as victims of their environment. He laid much emphasis on the role agency plays in learning. Human being have five basic capabilities which distinguished them from dogs, cats, rats, birds or animal in behaviuorists experiment. Human beings can form hypothesis, set goals, make judgment, and regulate the reciprocal interactions among person, behaviour, and environment. Human beings have abilities to symbolize, self-directed forethought, the ability to learn vicariously or through experiences of others, self-regulation, and self-reflection (Goldhaber, 2001). Therefore, counsellors and all stakeholders in secondary school affairs need to reassure students of their safety.

Feature of Agency

Bandura said that the choices people make shape the neuronal functional structure of their brains while referring to emerging research into brain development. By regulating their motivation and activities, people or learners can

produce the experiences that form the functional neurobiological substrate of symbolic, social, psychomotor and other skills (Duncan, 2008). For this to occur, Bandura proposed four core features of personal agency which includes intentionality, forethought, self-reactiveness and self-reflectiveness.

Criticisms against Social Learning Theory

Ewen (as cited in Cherry, 2008) has stated the criticisms levied against the social learning theory. Bandura has been criticised for ignoring such important and complicated aspects of behaviour as conflicts, both conscious and unconscious, and for an excessive bias against psychoanalysis. He all too readily accepts the negative findings of outdated and outmoded laboratory studies of defence mechanisms, and he rejects the value of clinical data without considering the other side of the story. Despite these criticisms,, social learning theory has been accepted and used by many researchers. Among the generally accepted findings is the observation of aggression that tends to increase the likelihood of behaving aggressively (Ewen, 1998). Modelling is more likely to be more effective, if the model is attractive.

Aaron Beck's Cognitive Restructuring Theory

The terms cognitive therapy (CT) and the generic term cognitive-behaviour therapy (CBT) are frequently used as synonyms to describe counselling based on the cognitive model. The term CBT is also used for a group of techniques in which a cognitive approach and a set of behavioural procedures are combined. CBT has been used as an umbrella term to include both standard CT and a theoretical combination of cognitive and behavioural strategies (Beck, 2005).

Since about 45 years ago, when the role of cognition in depression (Beck, 1963) and in therapy (Beck, 1964) was first described in the literature, there has been continuing progress in the development of cognitive theory and counselling. Empirical testing of both has refined the cognitive model throughout the years (Beck, 1967; and Beck, 1976). The essential features of CT, however, have persisted, in particular the emphasis on the influence of distorted thinking and unrealistic cognitive appraisals of events on an individual's feelings and behaviour (Beck, Rush, Shaw, & Emery, 1979). Aaron Beck, the founder of cognitive counselling, formulated a coherent theoretical framework before treatment strategies were developed. The guidelines to develop and evaluate the novel system of psychopathology and counselling, according to Beck (2005) were:

1) To construct a comprehensive theory of psychopathology that articulated well with the counselling approach;
2) To investigate empirical support for the theory; and
3) To conduct empirical studies that tested the efficacy of the therapy.

Research thereafter involved several stages; trying to identify the idiosyncratic cognitive elements derived from clinical data in various disorders; developing and testing measures to systematize these clinical observations; and preparing treatment plans and guidelines for counselling (Beck, 1976).

Research and clinical practice have shown CT to be effective in reducing symptoms and relapse rates, with or without medication, in a wide variety of psychiatric disorders. Beck applied CT's theoretical and counselling set of principles systematically to a sequence of disorders starting with depression(Beck, 1967; and Beck et al., 1979), suicide(Beck, Resni & Lettieri, 1974),anxiety disorders and school phobias (Beck, Emery, & Greenberg, 1985), panic disorder

(Beck, 1985), personality disorders (Beck, Freeman, & Davis, 1990), and substance abuse (Beck, Wright, Newman, & Liese, 1993). Interpersonal problems (Beck, 1988) and anger, hostility, and violence (Beck, 1999) were also studied. In addition, more recent work with this approach has shown an additional effect over medication treatment of severe psychiatric disorders such as schizophrenia (Beck & Rector, 2005; and Rector & Beck 2001) and bipolar disorder (Lam et al., 2003; and Lam, McCrone, Wright & Kerr, 2005). Ongoing adaptations of cognitive-behavioural protocols for an increasingly wider range of psychological and medical disorders (Beck, 1997) have been tested for chronic pain, marital distress, childhood somatic disorders, as well as for bulimia nervosa and overeating problems (Beck, 2007). There are now over 330 outcome studies on cognitive-behavioural interventions, and research production has continued (Butler, Chapman, Foreman, & Beck, 2006). A few neuroimaging outcome studies (Linden, 2014; Liggan& Kay, 1999; and Goldapple, 2004) have recently confirmed what was already thought: CBTs produce physiological and functional changes in many brain sites.

Historical and Philosophical B**ackground to CBTs**

In the early 1960s, a "cognitive revolution" began to emerge (Dobson & Scherrer, 2004) although the first major texts on cognitive modification appeared only in the 1970s. Albert Bandura's (Bandura, 1965) research on information-processing models and vicarious learning together with empirical evidence in the area of language development (Vygotsky, 1962) raised questions about the traditional behavioural model available up to that date, and pointed out the limitations of a non-mediational behavioural approach in explaining human behaviour (Mahoney, 1974). An increasing number of theorists and therapists

started to identify themselves as being "cognitive-behavioural" in orientation; some of the most important early proponents of a cognitive and cognitive-behavioural perspective were Beck (Beck,1963; Beck, 1967; Beck, 1970) Ellis, (Ellis, 1962), Cautela (Cautela, 1967), Meichenbaum (Meichenbaum, 1973) and Mahoney (Mahoney, 1995).

A diversity of CBT approaches have emerged over the decades, reaching varied degrees of application and success (Dobson & Scherrer, 2004). According to Mahoney (1995), CBTs can be organized in three major divisions: 1) coping skills therapies, which stress the development of a repertoire of skills designed to give the patient the instruments to cope with in a variety of problem situations; 2) problem-solving techniques, which emphasize the development of general strategies to deal with a broad range of personal difficulties; and 3) restructuring counselling, 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. A few of these conceptual models of cognitive-behavioural modification, as presented by Dobson and Dozois (Dobson & Scherrer, 2004) are briefly summarized below. Aaron Beck's cognitive counselling will be discussed in a separate section in this article.

Self-instructional training was developed in the 1970s by Donald Meichenbaum (Meichenbaum, 1993), with a particular focus on the relationship between verbal self-instruction and behaviour. Supported by extensive literature, self-instructional training has its emphasis on graded tasks, cognitive modelling, directed mediational training, and self-reinforcement, which clearly reflects Meichenbaum's behavioural background. Stress inoculation training, another CBT with a multi-component coping-skills approach, was also developed by

Meichenbaum (Meichenbaum, 1985) and is based on the theoretical premise that in learning to deal with mild levels of stress, clients essentially become "inoculated" against uncontrollable levels of stress. Problem-solving therapy, conceptualized as self-control training, was proposed in 1971 by D'Zurilla and Goldfried (D'Zurilla & Goldfried, 1971): its purpose is to train in basic problem-solving skills that are subsequently applied to real problem situations and thus promote generalized behaviour change. It has been developed and used in a variety of situations, such as stress prevention and management, anger management, depression, and coping with cancer (Nezu, 1986).

Rational emotive behaviour therapy (REBT), a restructuring therapy developed by Albert Ellis, is regarded by many as one of the first cognitive-behavioural therapies. Over 45 years ago, Ellis, originally a psychoanalyst, developed the so-called ABC model, which posits that any particular experience or event activates (A) individual beliefs (B), which in turn generate emotional, behavioural or physiological consequences (C). Ellis also postulates that 12 basic irrational beliefs, which take the form of unrealistic or absolutistic expectations, underlie emotional disturbance. The goal of therapy is to identify irrational beliefs, and through logical-empirical questioning, challenging, disputing and debating forcefully modify them (Dryden & Ellis, 2001).His 1962 book Reason and Emotion in Psychotherapy remains a primary reference for this approach.

Constructivist counselling has a structural cognitive approach introduced in the early 1980s (Guidano & Liotti, 1983).While there are some parallels between the cognitive-behavioural and the constructivist perspectives, such as the identification and modification of cognitive structures through a variety of behavioural and cognitive techniques, there are important differences between

CBT, termed a “rational” approach, and the constructivist perspective considered as a “post-rational” approach (Meichenbaum, 1993). Guidano (Guidano & Liotti, 1983) expressed increasing concern with the validity value of cognitive structures over the truth value of the content of cognitive structures; rather than dealing with thought content, therapies within constructivism would emphasize the process of thinking and the generation of meaning. As pointed out by Neimeyer (1985), the post-rational approach may be even “radically divergent from a traditional cognitive therapy perspective”.

In recent years, many other cognitive-behavioural approaches have emerged and evolved from the original cognitive and cognitive-behavioural conceptual model. Schema therapy, developed by Jeffrey Young (Young, Klosko, & Weishaar, 2003), and Dialectic behaviour therapy (DBT) developed by Marsha Linehan (Linehan, 1993) are two good examples of CBT approaches being used to treat individuals with more severe psychopathology, particularly borderline personality disorder.

(1) Similarities and differences between CBTs

CBT approaches share common ground, although there are considerable differences in principles and procedures between them for the fact that the pioneers in the development of cognitive-behavioural interventions came from different theoretical backgrounds. For example, while both Aaron Beck & Albert Ellis had psychoanalytic backgrounds, other theorists such as Meichenbaum, Goldfried and Mahoney were originally trained in behaviour modification.

According to Dobson & Dozois (Dobson & Dozois, 2001), current CBT approaches share three fundamental propositions. The first is the mediational role of cognition, which asserts that there is always a cognitive processing and

appraisal of internal and external events that can affect the response to those events; the second one, states that cognitive activity may be monitored, assessed and measured; and the third, that behaviour change may be mediated by these cognitive appraisals, and may be, thus, an indirect sign of cognitive change.

CBT can be contrasted with purely behavioural treatments in which cognition is not an important explanatory variable and is not primarily targeted for intervention. Therefore, approaches aimed strictly at behaviour change, such as the stimulus-response model, are not cognitive-behavioural; similarly, any therapy that focuses solely on cognitive change is not cognitive-behavioural. Any form of therapy that does not include the proposition of the mediational model as an important component of the treatment plan is not under the scope of CBT, and the label "cognitive-behavioural" cannot be applied (Dobson & Dozois, 2001). In sum, a defining feature of cognitive-behavioural counselling is the concept that symptoms and dysfunctional behaviours are cognitively mediated and, hence, improvement can be produced by modifying dysfunctional thinking and beliefs.

In addition, the various cognitive-behavioural therapies share a number of commonalities that are not theoretically central (Dobson & Dozois, 2001). First, in contrast to longer-term psychoanalytic therapy, most CBTs are time-limited in nature, with many treatment manuals recommending 12-16 sessions for uncomplicated depression and anxiety. Personality disorders and other chronic disorders will take longer, maybe more than 1-2 years of treatment. Second, almost all CBTs are applied to specific problems or disorders, a characteristic that reflects their behaviour counselling heritage and in part explains their time-limited nature. Rather than implying a limitation of CBTs, their problem-focused nature reflects a continuing effort to document counselling effects, to establish

therapeutic frontiers, and to identify the most efficacious counselling for a given problem. A third commonality, the assumption of patient control, emphasizes that the client is the active agent in his or her treatment. The assumption of patient control is made possible by the types of problems that classical CBTs typically address, which include discrete disorders and conditions, self-control problems, and general problem-solving abilities. Related to the assumption of patient control is a fourth commonality: many CBTs are explicitly or implicitly educative in nature, as the therapeutic model may be taught and the rationale for intervention communicated to the client, which stands in contrast to other psychotherapeutic approaches. The fifth commonality extends directly from their educative process, as most CBTs set the implicit goal that the patient will learn about the counselling process over the course of therapy. Clients not only overcome the referral problems in therapy, and thus learn to prevent relapses, but also learn counselling skills, which they themselves may apply comprehensively to an array of different problems in their lives. In CBT clients become their own counsellors.

As Dobson and Dozois pointed out, even though therapies identified as cognitive-behavioural share a number of theoretical and practical features, and despite their various procedural overlaps, "it is no more appropriate to state that there is really one cognitive-behavioural as it is to state that there is one psychoanalytic therapy" (Dobson & Dozois, 2001). However, while cognitive-behavioural counselling in general involves a whole variety of approaches, cognitive counselling as developed by Beck, with its own set of principles and very specific methodologies and techniques, is fairly uniform.

Cognitive Theory

(1) Theoretical Foundations

The cognitive model was originally constructed following research studies conducted by Aaron Beck (Beck, 1963; and Beck, 1964) to explain the psychological processes in depression, in an attempt to prove Freudian's theory of depression as repressed retroflexed hostility. Instead of hostility and anger, the research on clients' dreams showed a "sense of defeat, failure and loss" (Beck & Ward, 1963).Depressed clients' themes while dreaming were consistent with their waking themes; dreams could simply be a reflection of the person's thoughts. Based on systematic research and clinical observations, Beck (1976) proposed that the symptoms of depression could be explained in cognitive terms as biased interpretations of events attributed to the activation of negative representations of the self, the personal world, and the future (the cognitive triad).

As a natural consequence, Beck began to increasingly question the psychoanalytic unconscious motivational model and therapeutic method, especially the psychoanalysis' emphasis on motivational-affective conceptualizations of emotional disorders, which largely ignored cognitive factors, as it was substantiated by his research findings on depression (Beck, 1964).Laying the grounds for cognitive theory and technique, Beck started differentiating the cognitive from the psychoanalytic approach, focusing the treatment on present problems, as opposed to uncovering hidden traumas from the past, and on analyzing accessible, rather than unconscious, psychological experiences (Beck, 1976; and Beck, et al., 1979). Nevertheless, the experience with psychoanalysis was important in the initial development of the therapeutic concepts and strategies of CT. An important contribution to the foundations of CT

was given by the Freudian formulation of hierarchical structuring of cognition into a primary process (i.e., out of awareness and based on fantasies and wishes) and a secondary process (i.e., accessible to awareness and based on the principles of objective reality), as well as the concept that symptoms are based on pathogenic ideas (Beck, 1963).Since his psychoanalysis training and along his professional career, Beck identified himself with neo-analysts, such as Alfred Adler, Karen Horney, Otto Rank and Harry Sullivan, who emphasized the importance of understanding and dealing with patients' conscious experiences as well as the need to treat the meanings patients give to events they experience in their lives. Cognitive theory with its focus on intrapsychic processes rather than overt behaviour is more a legacy from psychoanalytic theory, although therapeutic procedures are more similar to behaviour counselling (Beck, 1984).

Furthermore, the theoretical structure of CT was built on contributions from other schools, such as the phenomenological-humanistic approach to psychology. Inspired in part by philosophers such as Kant, Heidegger and Husserl, it adopted the emphasis on conscious subjective experience. Derived from the Greek stoic philosophers came the concept that human beings are disturbed by the meanings they attach to facts, not by the facts per se. Carl Rogers with his client-oriented counselling inspired the therapeutic style of gentle questioning and the unconditional acceptance of the patient. John Bowlby's (Bowlby, 1969) attachment theory was a highly valuable source for the development of cognitive conceptualization.

Influences from cognitive sciences and cognitive psychology also accounted for the foundations of CT. The writings of cognitive psychologist George Kelly had a prominent impact, especially his personal construct theory,

which, along with Piaget's (Piaget, 1954) idea of schemata, evolved into Beck's similar definition of schemas. The cognitive theory of emotions by Richard Lazarus (Lazarus & Alfert, 1964), the problem-solving approach by Goldfried and D'Zurilla (Goldfried, 1971), the self-management models by Albert Bandura (Bandura), and Donald Meichenbaum (Meichenbaum, 1977), along with cognition-oriented writers, such as Arnold Lazarus (Lazarus, Davidson, & Polefka, 1965), also influenced cognitive theory and counselling. CT's emphasis on a problem-solving approach to conscious problems was also adopted by Ellis's rational-emotional-behaviour counselling (Cautela, 1967).

The scientific approach espoused by behaviour counselling contributed to diverse therapeutic procedures and strategies, such as the session structure, the greater activity by the counsellor, the setting of treatment goals for the entire counselling as well as of an agenda for each session, the formulation and test of hypotheses, the elicitation of feedback, the use of problem-solving techniques and social skills training, the assignment of between-sessions homework and experiments, and the measurement of mediational variables and outcomes. However, from a philosophical point of view, CT may be seen as much more humanistic, exploratory, as it works with constructs such as the mind, and deals with feelings and thoughts, whereas many would see behaviour counselling as too mechanistic.

(2) Principles of CT

Again, following the information-processing approach, the major principle of CT is that the way individuals perceive and process reality will influence the way they feel and behave. Thus, the counselling goal of CT, since its very origins, has been to reframe and correct these distorted thoughts, and collaboratively

endeavour pragmatic solutions to engender behavioural change and ameliorate emotional disorders.

Cognitive counselling posits that there are thoughts at the fringe of awareness that occur spontaneously and rapidly, and are an immediate interpretation of any given situation (Beck, 1976).These are called automatic thoughts and are distinguished from the ordinary flow of thoughts observed in reflective thinking or free association. They are generally accepted as plausible, and their accuracy is taken for granted. Most people are not immediately aware of the presence of automatic thoughts, unless they are trained at monitoring and identifying them. According to Beck and Newman (2005), "it is just as possible to perceive a thought, focus on it, and evaluate it as it is to identify and reflect on a sensation as pain". Some of the cognitive distortions found across different emotional disorders are summarized in Table 1.

In the roots of these distorted automatic interpretations are deeper dysfunctional thoughts called schemas (also called core beliefs, and used interchangeably by many authors). As defined by Clark, Beck and Alford (1999), schemas are "relatively enduring internal cognitive structures of stored generic or prototypical features of stimuli, ideas, or experiences that are used to organize new information in a meaningful way thereby determining how phenomena are perceived and conceptualized". Once a particular basic belief is formed it may influence the subsequent formation of new related beliefs, and if they persist, they are incorporated into the enduring cognitive structure or schema (Beck, 1971). Core beliefs embedded in these cognitive structures shape an individual's thinking style and foster the cognitive errors encountered in psychopathology.

Schemas are acquired early in an individual's development, and act as "filters" through which current information and experience is processed. These beliefs are moulded by personal experiences and derived from identification with significant others and from the perception of other people's attitudes toward them. The child's environment either facilitates the emergence of particular types of schemas or tends to inhibit them. The schemas of well-adjusted individuals allow for realistic appraisals, while those of maladjusted individuals lead to distortions of reality, fostering, in turn, psychological disorder (Beck, 1976).

Schemas have a variety of properties, such as permeability, flexibility, breadth, density, and also a degree of emotional charge, which may determine the difficulties or facilities encountered in the treatment process (Beck, 1976). Even though latent or inactive at given times, schemas, for example, "I am unlovable", are activated by particular situations analogous to those early experiences that engendered the development of the schema. Associated with these dysfunctional core beliefs are subjacent individual conditional beliefs that lead to assumptions such as "If I don't have a loving wife, I'm nothing" and rules such as "A man cannot live without a wife". The activation of these schemas interferes with the capacity for objective appraisal of events, and reasoning becomes impaired. Systematic cognitive distortions (For example, catastrophizing, emotional reasoning, and selective abstraction) occur as dysfunctional schemas are activated. As tentative coping strategies to avoid getting in contact with their core and underlying beliefs, patients may engage in compensatory strategies. Although these cognitive and behavioural manoeuvres alleviate their emotional suffering momentarily, in the long run compensatory strategies may reinforce and worsen dysfunctional beliefs.

There is a reciprocal relationship between affect and cognition, as increasing emotional and cognitive impairment may result from one reinforcing the other (Beck, 1971). A crucial hypothesis of the cognitive model has been the notion that certain beliefs constitute a vulnerability to emotional disorders (stress-diathesis model). For example, if an individual holds a cognitive vulnerability to themes of loss and failure, the emotional and behavioural consequences will include sadness, a sense of hopelessness, and social withdrawal, as found in depression. If other individuals hold danger-oriented beliefs, anxiety will prevail and predispose them to narrow their attention to perceived threat, make catastrophic interpretations of ambiguous or even neutral stimuli (Beck, et. al., 1985),and engage in dysfunctional "safety behaviours"; they will be impelled to seek escapes or avoid the risk of perceived rejection, embarrassment or death. The danger-oriented biases – which occur automatically and are not necessarily under conscious control – are found in every phase of information processing (perception, interpretation, and recall) across all anxiety disorders (Beck & Clark, 1997). In clients with vulnerability to themes of humiliation, unfairness or the like, anger will be the tone, and a behavioural response in a retaliatory manner might be justified as self-defence (Beck & Newman, 2005). Each personality disorder is also characterized by a specific personal set of dysfunctional cognitive contents, such as defectiveness, abandonment, dependency, or need for a special status, which constitute the individual's cognitive vulnerability. When activated by external events, drugs, or endocrine factors, these schemas tend to bias the information processing and produce the typical cognitive content of a specific disorder, with its own cognitive constellation and idiosyncratic set of beliefs

(Beck, 2005). A brief summary of cognitive profiles in psychopathology may be seen in Table 2.

Beck's model of vulnerability to depression was refined (Clark, Beck, & Brown, 1992) to suggest that predisposing beliefs could be differentiated according to whether the client's personality was primarily autonomous or sociotropic. Autonomous individuals would more likely become depressed following an autonomous event (For example, a perceived personal failure) than following a sociotropic event (For example, loss of a relationship), and the reverse would be true for sociotropic individuals.

(3) Procedures and Techniques

CT is not a set of techniques applied mechanically as we would think at a first glance. The counsellor's competence in a full range of treatment skills is needed to ensure efficacy to CT procedures. As Beck points out, first and primarily, to fulfil the counselling endeavour, it is important to establish a good working relationship with the client, a counselling procedure called collaborative empiricism. Client and counsellor work as a team of scientists in evaluating the client's beliefs, testing them out to see whether they are accurate or not, and modifying them according to reality. Second, the counsellor uses Socratic questioning as a means to guide the client in a mindful questioning that will enable clients to have insight over their distorted thinking, a procedure called guided discovery.

Throughout the treatment, the collaborative and psycho-educational approach to treatment is used, with specific learning experiences designed to teach clients to:

1) Monitor and identify automatic thoughts;

2) recognize the relationships among cognition, affect, and behaviour;

3) test the validity of automatic thoughts and core beliefs;

4) correct biased conceptualizations by replacing distorted thoughts with more realistic cognitions; and

5) Identify and alter beliefs, assumptions, or schemas that underlie faulty thinking patterns (Beck, 1976).

In contrast to psychoanalytical technique, CT sessions have a structure in which the cognitive counsellor plays an active role in helping the client identify and focus on important areas, proposing and rehearsing specific cognitive and behavioural techniques, and collaboratively planning between-sessions assignments. A treatment plan for the whole treatment and the agenda for each session are discussed with the client, and a feedback of the client's thoughts about the ongoing session and the whole treatment is routinely asked in order to create the opportunity to treat and handle any misconceptions and misunderstandings that might arise over the course of counselling. The cognitive counsellor has to be a good strategist to devise specific treatment procedures that have higher chances of producing specific changes for that particular client.

CT encourages their clients to adopt the empirical problem-solving approach of scientists, and the counsellor serves as a role model for their patients by instilling self-efficacy, enthusiasm and hopefulness about the challenging work of changing maladaptive cognitions. Although school phobia is not encouraged, its manifestation might be a valuable tool in demonstrating to clients their interpersonal distortions. Similarly, any manifestation of school phobia is dealt with and treated as underlying dysfunctional beliefs.

(4) Case Conceptualization

From the very beginning of treatment, the counsellor develops (ideally in a collaborative manner, as always) a cognitive conceptualization for the individual client. Case conceptualization is an ongoing work throughout a treatment course; as new important clinical data are brought into therapy, cognitive conceptualization will be changed and updated as needed while the treatment progresses. To prepare a treatment plan, an individual case conceptualization is strongly needed, as it guides therapeutic interventions.

Case conceptualization holds both a historical and prospective evaluation of thought patterns and thinking styles (Beck & Newman, 2005). By searching and assembling common cognitive denominators across diverse life situations and the patient's evaluation of them, a cognitive pattern can be identified. It will include an understanding of the idiosyncratic set of dysfunctional beliefs, individual specific vulnerabilities, and the behavioural strategies clients use in attempting to cope with their core beliefs. A sample of the Cognitive Conceptualization Diagram, as depicted by Beck (1993) is presented in appendix III.

(5) Cognitive and Behavioural Techniques

The separation of CT interventions into cognitive techniques and behavioural techniques is only for instructive purposes, in that many of the techniques affect both client's thought processes and behavioural patterns. As we know, cognitive change fosters behavioural change, and vice-versa. A number of different techniques may be used depending on the cognitive profile of the disorder, the phase of counselling, and the specific cognitive conceptualization of a given case. Behavioural techniques might be more used in cases of severe

depression in which there is a need to promote the client's behavioural activation. Conversely, when the patient does not primarily need behavioural activation, more purely cognitively oriented procedures may be applied. For patients with anxiety disorders, an understanding of the fundamental principles of the cognitive model will probably be necessary before the introduction of any behavioural experiment.

A variety of cognitive techniques are used in CT, such as the identification, questioning, and correction of automatic thoughts, reattribution and cognitive restructuring, cognitive rehearsal, and other imagery therapeutic procedures. Among the behavioural techniques, there are, for example, activity scheduling, mastery and pleasure ratings, graded-task behavioural assignments, reality testing experiments, role-playing, social skills training, and problem-solving techniques. We will present briefly a small sample of cognitive techniques first.

Initial treatment focuses on the increase of the clients' awareness of automatic thoughts, and further work will focus on core and underlying beliefs. Treatment may start by identifying and questioning automatic thoughts, which can be done in different ways. The counsellor can guide clients to assess their automatic thoughts, especially when there is a perceived emotional arousal during the session, by simply asking: "What is going through your mind?", or any variation of this question. Cognitive distortions may be unveiled by asking, for example, "What are the evidences for your conclusion?", "Are you omitting contradictory evidence?" "Does your conclusion follow logically from the observations you have made?", "Are there alternative explanations that may be more accurate in explaining this particular episode?". When asked to reflect on alternative explanations, clients may realize that their initial explanations evolved

through invalid inferences, which leads them to think of different interpretations of events, thus attaching new attributions and meanings to them (Beck & Newman, 2005).

Most people are unaware that negative automatic thoughts precede unpleasant feelings and behavioural inhibitions, and that the emotions are consistent with the content of the automatic thoughts. To increase their awareness of these thoughts, clients can learn to track them and with systematic training pinpoint what kind of thoughts occurred immediately before an emotion, a behaviour, and a physiologic reaction as consequences of that thought (Ellis' ABC sequence). The Dysfunctional Thought Record (DTR), as depicted by Judith Beck (Beck, 1995) in Appendix IV, may be used to help track the thoughts that were activated by the stimulus situation and that generated the consequent emotion and behaviour. A DTR exercise may enable clients to discover, clarify and change the meanings they have assigned to upsetting events and compose an alternative or rational response. Sometimes, the simple task of identifying cognitive errors (Table 1), alone or in combination with the filling out of a DTR, might be a good exercise to work on at the office or as a homework assignment.

For structural changes to occur, they have to go far beyond changing cognitive errors associated with a specific syndrome. Only through the analysis and correction of the more ingrained beliefs, changing the organization of these beliefs, cognitive restructuring may be accomplished. Treatment has to focus on the client's core beliefs, such as "I'm unlovable", and underlying beliefs, such as "If I don't have a wife, then I'm a failure" which are re-evaluated in the same way as automatic thoughts, that means, looking for evidence that supports them and correcting them with reality testing.

Cognitive rehearsal is an imagery technique devised to help clients experience their feared situations by imagining that it is occurring right at that moment. At the office or as a between-session assignment, patients are asked to "live through" the feared situation in imagery and build up the best coping strategies to overcome it successfully. In the same manner, through imagery, clients can rehearse problem solving and assertiveness training as needed to overcome their problem situations.

Behavioural techniques are integrated into a CT treatment program in many different forms. When chronic and severely depressed clients have their activity level reduced, and are reluctant to commit themselves to any goal because they have low expectations about any achievements, behavioural activation procedures should be promoted. For example, counsellor and client may assign experiments collaboratively to see whether the client's negative expectations are valid or come from wrong inferences about him/herself, other people and the future. For instance, a depressed woman may believe she is no more capable of preparing a Sunday dessert that her grandchildren liked so much; as a matter of fact, she even believes she is unable to stay out of bed long enough to do almost anything, let alone to prepare a dessert. To gather evidence of her expected capacity of mastery on dessert preparation and expected capacity of experiencing pleasure with her cooking skills, she is stimulated to rate her mastery and pleasure expectations before performing the task on Sunday morning and compare them to what her thoughts and feelings actually were after she completed the assigned task. She will probably receive, as usual, many positive feedbacks, which will help her correct inaccurate mastery and pleasure ratings. Frequently depressed people have dysfunctional expectations about their capabilities when feeling

depressed, and are surprised at a much better outcome than they expected. As the client puts them to test, the outcome brings a different perspective. As clients are able to appraise their thoughts more objectively, a whole set of thoughts become hypotheses that have to be submitted to reality testing. Because most clients need to proceed in small steps, a number of graded-task behavioural assignments are tailored for individual clients to progressively promote greater successful experiences without overwhelming them with tasks greater than their present coping capacities.

Much of cognitive counselling is devoted to problem-solving techniques; clients will learn to follow the necessary steps, such as defining the problem, generating alternative ways of solving it and implementing alternative solutions. Social skills training maybe a necessary tool as part of the treatment plan. A client that fears social situations and has poor social performance will benefit from role-playing the feared situation with the counsellor to build up inhibited social skills and overcome the problem. The counsellor acts as a role model so that clients can learn to perform socially. After sufficient role-playing at the office, clients are stimulated to performing real life situations what they have built in the office.

Cognitive counselling has been developed for application in individual group, couples and family formats, for adults, adolescents and children, in a variety of treatment contexts. The indications for cognitive counselling are determined by client and counsellor variables, rather than by the nature of the disorder (Beck & Newman, 2005).

Rachman's Integrated Model of Fear

Rachman (1977) has presented six arguments against acceptance of the conditioning theory of fear acquisition. They are: (1) the failure of people to

acquire fears in what are theoretically, undoubtedly fear-evoking situations (For example. air raids). (2) It is difficult to produce conditioned fear reactions in human subjects, even under controlled laboratory conditions. (3) The conditioning theory rests on the equipotentiality premise (Seligman & Hager, 1972), which is now recognized to be untenable. (4) The distribution of fears in normal and neurotic populations is difficult to reconcile with the conditioning theory. (5) A significant number of phobic patients, psychiatric and military, recount histories that cannot be accommodated by the conditioning theory. (6) Fears can be reduced by vicarious processes and it seems highly likely that they can be acquired by similar processes.

1. Failures to Acquire Fear

On the face of it there can be few experiences more frightening than undergoing an air-raid. However, the well-documented information on the subject (Janis, 1951), shows that during the Second World War the great majority of people endured air-raids extraordinarily well-contrary to the universal expectation of mass panic. Exposure to repeated bombing did not produce increases in psychiatric disorders. Although short-lived fear reactions were common, surprisingly few prolonged phobic reactions emerged. In the course of his official report to the Medical Research Council, Sir Aubrey Lewis said that "the doctors in Liverpool trained 18 volunteers as auxiliary mental-health workers for service in and after raids, but none of the 18 has been required: there was no such work for them to do," (Lewis, 1942, p.178). His summary of his findings ("air-raids have not been responsible for any striking increase in neurotic illness", p. 182) is in keeping with many similar reports from other workers. Wilson (1942, p. 284) noted that "the small number of psychiatric casualties that have followed aerial

bombardment has been a matter for surprise". Although he did obtain some evidence of fear induction and of an exacerbation of neurotic reactions, on the whole Lewis's survey was remarkable in showing how uncommon these reactions were. In Coventry, Manchester, Liverpool and London, psychiatrists and other service-workers agreed that there had not been any significant increase in the number of patients attending psychiatric clinics. There was however evidence of more fear and related disturbances among the children. So for example, 4 per cent of 8000 school-children in Bristol (subjected to severe air-raids) were said to have developed anxiety symptoms attributable to raids. However, this leaves 96 per cent mildly affected or unaffected. The fears were particularly common and noticeable among children who had been subjected to traumatic experiences. It was also observed in Bristol and in Manchester, that "frightened mothers communicated their fears to the children" (Lewis, 1942, p. 181).

This British information is matched by the reports from Japan and Germany collated by Janis (1951). Immediately after an air-raid, many people experienced acute emotional reactions characterised by startle responses, tremor, fatigue and sleep disturbance. However, these acute reactions generally dissipated spontaneously, usually within the course of a day or two. People adapted to air-raids and became more courageous with increasing experience, even when as in London, the raids became progressively heavier.

The observations of comparative fearlessness enduring despite repeated exposures to intense trauma, uncontrollability and uncertainty, run contrary to the conditioning theory of fear acquisition. According to this theory, people subjected to repeated air-raids should acquire multiple conditioned fear reactions and these should be strengthened with repeated exposures.

2. Conditioning Human Fears

Bregman's (1934) thorough attempt to condition fear in 15 normal infants, was a failure. Evidence from a different source and of a different nature is consistent with Bregman's failure and with war-time observations, in showing that people fail to acquire fears in situations where the theory predicts that they should occur. Hallam &Rachman (1976, p. 183) point out that many writers on the subject of electrical aversion therapy, "appeared to assume that the successful administration of treatment would result in the development of a mini school phobia-repeated associations of the conditioned stimulus with an unpleasant electrical shock would result in a situation in which the presentation of the stimulus produces fear reactions". To the contrary, Marks and Gelder (1967) found that most of their clients reported indifference to the conditioned stimuli employed in electrical aversion therapy; it was rare to find someone who complained of fear after undergoing the course of treatment. The same observation was reported by Bancroft (1969) and by Hallam *et al.* (1972).

Because the expected conditioned fear reactions did not emerge, and for some related reasons, Hallam and Rachman (1976) carried out two studies which were intended to provide an analogue for electrical aversion therapy. We were interested in finding out, among other things, whether repeated conditioning trials, carried out over numerous training sessions, and involving an electrical UCS, would result in the development of conditioned fear reactions. This research was carried out on 14 male research workers and postgraduate students, all of whom volunteered for at least one session of conditioning. Five of them also agreed to volunteer for a further nine training sessions. This latter group of subjects received 205 shocked trials over ten sessions. The other volunteer subjects received 20

trials during a single recording session. Cardiac, skin resistance and respiratory measures were recorded in the search for psychophysiological concomitants of what was expected to be a programme of fear conditioning. In the event, the results failed to confirm the hypothesis that conditioned fear reactions would develop. "The 'CR' did not resemble, in either magnitude or direction, the cardiac responses of phobic clients who are presented with their phobic stimulus, nor did subjects report anxiety or discomfort in the presence of the conditioned stimulus" (Hallam and Rachman,1976, p. 192).

We were similarly unsuccessful in our search for evidence of conditioned fear reactions developing in alcoholic patients who underwent aversion therapy. "In effect, the results show that when alcoholics who have undergone aversion therapy are compared with alcoholics treated in other ways, there is no difference in their subjective anxiety responses to alcoholic stimuli or in the peripheral autonomic responses that usually accompany states of fear or anxiety. Subjective distaste for alcohol seems to be the only specific consequence of aversion therapy" (Hallam & Rachman, 1976, p. 194).

3. The Equipotentiality Premise

The conditioning theory of fear acquisition (Eysenck and Rachman, 1965) assumes that any stimulus can be transformed into a fear signal. In addition the theory assumes that, given comparable exposures, all stimuli have roughly an equal chance of being transformed into fear signals. In some versions of the conditioning theory of fear, reservations were noted. For example, Eysenck and Rachman argued that "neutral stimuli which are of relevance in the fear-producing situation and or make an impact on the person in the situation are more likely to develop phobic qualities than weak or irrelevant stimuli". Even when reservations

of this sort were noted however, little attempt was made to specify their nature or implications.

This assumption of equal conditionability, or more properly in the term used by Seligman and Hager (1972), equipotentiality, was incisively criticized by Seligman (1970). His argument was developed by Seligman and Hager (1972) who observed that "general-process learning theorists believe that what an organism learns about is a matter of relative indifference. In classical conditioning the choice of the conditioned stimulus, unconditioned stimulus and response matters little; that is, all conditioned stimuli and unconditioned stimuli can be associated more or less equally well, and general laws exist which describe the acquisition, extinction, inhibition, delay of reinforcement, and spontaneous recovery of all conditioned and unconditioned stimuli" (p. 2). They proposed that the equipotentiality premise be replaced by the concept of preparedness and Seligman (1971) developed this alternative idea with particular reference to school phobias. In brief, he argued that prepared school phobias are of biological significance, are acquired rapidly, generalize broadly and are resistant to extinction.

The preparedness hypothesis has received partial support from the work of Ohman, Erixon, &Lofberg(1975) who found that their normal human subjects acquired conditioned responses to pictures of (phobic) snakes and that these were more resistant to extinction than their conditioned reactions to supposedly neutral stimuli (human faces or houses). Further explorations of this interesting departure are awaited with interest, and it should be noted that they did not find differences in fear acquisition. Such differences are more likely to emerge with more trials and a better dependent variable than the GSR.

With hindsight we can now see that difficulties with the equipotentiality premise, particularly in its application to the acquisition of fear, began accumulating many years ago. For example, English (1929) was only partly successful in his attempt to replicate Watson's demonstration of the acquisition of a fear of white rats in his experimental subject. little Albert. English found that fear reactions could be conditioned only to selected stimuli. Along similar lines, Bregman (1934) failed in her thorough attempts to condition a group of 15 infants (median age 12 months) to fear a range of simple and biologically insignificant objects. The repeated presentation of geometrically shaped wooden objects and of cloth curtains, in association with a disagreeably loud and startling sound of an electric bell, did not produce conditioned fear reactions to the (biologically insignificant) stimuli. Other exceptions were quoted by Valentine (1946), who succeeded in producing in a 2year-old child an unstable fear of a caterpillar, but failed to make her fear a pair of opera glasses. For the present, it is sufficient to notice that the equipotentiality premise cannot be sustained by the conditioning theory of fear acquisition.

4. The Distribution of Fears

Given the equipotentiality premise, the corollary for fear acquisition would be that all stimuli have an equal chance of being transformed into fear signals. However, this is not borne out by surveys of the distribution of fears; either in a general population or in psychiatric samples (Rachman, 1974). For example, in an epidemiological study of common fears carried out in a small Vermont city, Agras, Sylvester, &Oliveau (1969) found that the prevalence of a fear of snakes was 390/1000 while fear of the dentist was only 198/1000 despite the fact that contact with the dentist was almost certainly far more frequent, and indeed, far

more likely to be associated with painful episodes. To take another example from their survey, the prevalence of snake fears in the 30-year-old subjects was over 5 times as great as their fear of injections.

Anthropological observations of an isolated Indian community in Canada, are consistent with the view that the distribution of fears is non-random. Hallowell (1938) pointed out that the Indians were fearless of certain dangerous animals such as wolves and bears, but were considerably frightened by some harmless creatures-notably frogs and toads.

Subject only to their prominence in the environment, many objects and situations should have an equal probability of becoming fear-provoking. What we find instead however, is that some fears are exceedingly common-far too common for the conditioning theory. Other fears are far too rare. Fear of the dark is commonly seen among children, but not pyjama school phobias. In the case of animal school phobias, one might expect that within a city population the prevalence of the fear of lambs should approximate that of the fear of snakes. In practice however, the fear of snakes is common and the fear of lambs is rare. Moreover, a genuine fear of snakes often is reported by people who have had no contact with the reptiles. Consequently one is forced to conclude that a fear of snakes can be acquired even in the absence of direct contact- and this significant concession opens three possibilities. Either the fear of snakes is innate or it can be transmitted indirectly, or the fear of snakes is ‘lurking’ and will appear with only slight provocation. The last of two of these three possibilities are of course compatible.

5. Clients' Reports of Fear Onset

Whatever its value, the conditioning theory is not a satisfactorily comprehensive account of the genesis of fears. It had become apparent that "clinically it is often difficult to determine the origin of a patient's school phobia" (Rachman, 1968, p. 32). In similar vein, Marks (1969, p. 92) described "many school phobias where there was no apparent trauma to initiate the school phobia". It can be extremely difficult to find a convincing precipitant of a school phobia (De Silva, Rachman, & Seligman, 1976). Goorney and O'Connor (1971) encountered this problem in their analysis of the excessive fears of peace-time air-crews. In a study of 97 cases of excessive anxiety encountered in Royal Air Force (RAF) crews, they were able to relate the fears of one quarter of all their cases to specific precipitants such as accidents or frightening incidents. In one third of the cases however, there was no discernible cause and in the remainder, the precipitants were not of a traumatic or conditioning type, For example. a return to flying after a long absence.

6. The Vicarious Transmission of Fear

The significant advances made in our understanding of the processes of observational learning and modelling (Bandura, 1969, 1971) made it plain that we acquire much of our behaviour, including emotional responses, by vicarious learning experiences. It was proposed (Rachman, 1968) that fears can be acquired either directly or vicariously and that stimuli are likely to develop fearful qualities if they are associated, directly or vicariously, with painful or frightening experiences. It has to be conceded however that at this stage, the evidence in support of vicarious acquisition of fear in humans is indirect and largely anecdotal-this is entirely understandable because of the ethical objections to

experiments in which one sets out to induce lasting fears in subjects. As mentioned earlier, it was observed during the war that the fears or lack of fears displayed by mothers during the course of air-raids was an important determinant of whether or not their children developed similar fears. Along the same lines, John (1941) commented on the social facilitation and inhibition of children's' fears during air-raids. She obtained a correlation of 0.59 between the fears of mother and child. In normal conditions there is a good deal of correspondence between the fears of children within the same family, with correlations ranging between 0.65 and 0.74 (May, 1950). Similarly, Hagman (1932) found a correlation of 0.67 between the total number of fears exhibited by children and their mothers. Grinker and Spiegel (1945) provided clear examples of combat airmen who acquired fears after observing a crew mate expressing intense fear. In their survey of 1700 infantry troops in the Italian theatre during the Second World War, Stouffer, et al. (1949) found that 70% of the respondents had a negative reaction to seeing a comrade 'crack up'. Half of the total sample said that it made them feel anxious and/or like cracking up themselves.

It can of course be argued that in most of the examples cited here, a conditioning explanation can suffice. This defence is persuasive insofar as the examples involve the occurrence, in temporal and spatial contiguity, of neutral and frightening stimuli. However, the social transmission of fear opens wide the possibility of the indirect acquisition of fears. That possibility, indeed likelihood, poses serious difficulties for a conditioning theory. If it is confirmed experimentally that fear reactions can be acquired to stimuli which the person has never encountered, then the conditioning theory cannot be adequate.

Incidentally, there are good grounds for believing that fears can be acquired by indirect transmission-not necessarily by vicarious social learning only. This conclusion, that indirect transmission does occur, seems inevitable from a study of the distribution of fears-in that, people report fears of objects or situations which they have never actually encountered.

In sum, these 6 arguments lead to the conclusion that the conditioning theory of fear acquisition is neither comprehensive nor adequate.

Pathways to Fear

In the opinion of Rachman, there are at least three major pathways to the acquisition of fear. We can continue to regard conditioning (and include under this label the taste aversion phenomenon) as an important fear-induction process, but at least two other pathways can be identified. They are distinguished by being indirect processes of acquisition. The first, vicarious acquisition has already been described and it was pointed out that the evidence to support this notion is still flimsy. The conviction that fears can be acquired vicariously is drawn more from the successful demonstrations of vicarious fear-reduction (Bandura, 1969; Rachman, 1972, & 1976) than from the largely indirect and anecdotal evidence referred to earlier. A third pathway of significance, fear acquisition by transmission of information and or instruction, has been strangely overlooked-despite the fact that it is obvious, or perhaps because it is too obvious. Although I am unaware of any conventionally acceptable evidence that fear can be acquired through the transmission of information (and particularly, by instruction), it seems to be undeniable. Information-giving is an inherent part of child-rearing and is carried on by parents and peers in an almost unceasing fashion, particularly in the child's earliest years. It is probable that informational and instructional processes

provide the basis for most of our commonly encountered fears of everyday life. Fears acquired informationally are more likely to be mild than severe. Like the acquisition of fear by vicarious experience, informational and instructional processes have no difficulty in coping with the fact that people display fears of situations and objects which they have never encountered. Acceptance of the notion that fears can be acquired by informational process also enables us to explain some, but by no means, all of the failures to acquire fear in situations where it might, on the conditioning theory, have been expected to arise. Not only do we learn by information and instruction which situations to fear, we also learn to distinguish those situations and objects which are not dangerous and therefore not to be feared. We also learn and are taught to cope with dangers and to endure the accompanying discomfort or pain.

The best explanation offered so far for the non-random quality of fears is the concept of preparedness proposed by Seligman (1971). He hypothesized that "school phobias are highly prepared to be learned by humans and, like other highly prepared relationships they are selective and resistant to extinction, and probably are non-cognitive" (Seligman, 1972, p. 43). He also suggested that most school phobias are of biological significance and that the "great majority of school phobias are about objects of natural importance to the survival of the species" (p. 465). Human school phobias are 'largely restricted' to situations that threaten survival, potential predators, unfamiliar places, the dark, deformities etc. If this theory can be supported by experimental and other evidence, we will then be in the best-ever position to account for the non-random incidence of fears, and perhaps also to deal with the skewed distribution of fears both in the general population and in clinical samples. It may also provide the best basis for an

explanation of why people fail to acquire fears despite exposure to considerable stress. It may not be stretching the point too far to say that civilian populations exposed to air-raids during the war failed to acquire many new fears because the stimuli associated with the trauma and stress of bombing (For example. aircraft, bombs, etc.) are not 'prepared' stimuli. These modern artefacts do not feature in our biological inheritance.

The considerable individual differences in the range and intensity of fears need to be encompassed by any theory for which comprehensiveness is claimed. Just as the conditioning theory of fear acquisition rests on the assumption that most fears are acquired, so the 3 pathways hypothesis outlined here is based on a similar assumption. This is not to deny that there are biological differences in the propensity to develop fears. From everything we know about the biological and genetic bases of personality (Eysenck, 1967) it seems certain that there is a genetic contribution to the general level of human fearfulness. Of greater interest is the question of whether or not the propensity to fearfulness is related to other important aspects of personality, For example. neuroticism. If there is any value in the present tripartite scheme of fear acquisition, it may turn out that some people are particularly prone to develop fears by a process of conditioning (including the taste aversion phenomenon), while others are more susceptible to fears that are socially transmitted by vicarious learning or by information processes.

Whether this speculation is borne out or not, it seems likely that we will uncover a connection between prepared fearful stimuli and acquisition of fears by a conditioning process. Those fears which are transmitted by informational and instructional processes are likely to comprise a large number of non-prepared stimuli.

It can be seen that we are moving towards a position in which it is postulated that there is an ease of connection between certain people and certain stimuli-and contrariwise, that some people are particularly invulnerable to certain fear stimuli. In addition to postulating an appropriate fit between the person and the stimulus, we also have to take into account the occurrence of 'critical moments'. In attempting to explain those fears which have an acute onset, one needs to know why the fear emerges at the particular time that it does. It is plain from clinical experience that certain patients experience critical incidents in which the fear has its onset. What is particularly interesting is the fact that quite frequently these same people have been exposed to the same stimulus repeatedly in the past without acquiring the fear. It seems that for acute onset fears, there are certain psychological states in which the person is vulnerable to the acquisition of fear. To take a clinical example, in those agoraphobic patients who report an acute onset of fear, one needs to know why the fear arose on the day that it did, at the time that it did. And why do they acquire a fear of public transport, crowded or open spaces, or whatever the content of their school phobia is, when on hundreds or thousands of previous exposures to the same set of stimuli, they remained unaffected?

So in framing an explanation for fears of acute onset, we have to try to match the person with the stimulus and the critical moment of onset. (In passing, it might be mentioned that at least as far as acute onset of agoraschool phobias are concerned, it seems likely that the critical incident occurs when the person is in an emotionally upset or apprehensive state before the critical incident occurs. Another predisposing factor seems to be physical illness and associated feelings of weakness, nausea, dizziness etc.)

To sum matters up, it is suggested that the classical conditioning theory of fear acquisition can account for only part of the available information. It is suggested in addition, that fears can be acquired by indirect processes. The two most important of these are the vicarious acquisition of fear and the informational and instructional transmission of fear. It is speculated that intense fears of biological significance (in Seligman's theory) school phobias are more likely to be acquired by a conditioning process. The common everyday fears are probably acquired by the indirect and socially transmitted processes of the information-giving type and by vicarious exposure.

Any of these three pathways to fear, alone or in combination, can be implicated in the acquisition of fear. By appealing to one or more of these pathways, it should be possible to explain most of the common features of human fear including the observed distribution of fears in normal and clinical populations, the non-random incidence of fears, sudden or gradual acquisition of fears, the indirect transmission of fears, and failures of fears to arise under stress conditions.

Thus far we have considered fear solely in terms of the older conception sometimes known as the 'lump theory of fear' (Rachman, 1974). If we adopt the more complex conception proposed by Lang (1970), according to which fear comprises at least three imperfectly related components, and then the three pathways approach will in turn become more complex. Lang has argued that the three major components of fear are subjective report, avoidance behaviour, and psycho physiological disturbance. These three components can co-vary, vary inversely or vary independently (Rachman and Hodgson, 1974; and Hodgson and Rachman, 1976). If this analysis is applied to the three pathways approach to fear

acquisition we can hazard the speculation that fears acquired by a conditioning process (which for present purposes, includes the taste aversion phenomenon), the components which will be most markedly involved are the psycho physiological and behavioural, with the subjective component playing a comparatively minor role. In the case of fears transmitted indirectly (i.e. vicariously or informationally) one might expect the subjective aspect to be predominant and the psycho physiological changes and behavioural effects to be comparatively minor. This line of reasoning appears to be compatible with Seligman's concept of prepared school phobias-which it will be remembered, he described as being non-cognitive and resistant to extinction. By contrast, one might expect non-prepared fears to have a larger cognitive element, i.e. they can be more readily acquired, and indeed reduced, by cognitive manipulations. It has to be admitted however, that so far, the attempts to relate prepared school phobias to therapeutic considerations have yielded unexpected (Rachman & Seligman, 1976) or unrewarding results (De Silva et al., 1976).

In conclusion, are we any closer to understanding the opening question of why people so often fail to acquire fears in dangerous situations? The Seligman hypothesis is of some utility in that biologically non-significant stimuli are said to be 'poorly prepared for fear. Also, people are considerably more resilient than the conditioning theory allows. Not only is the equipotentiality (of stimuli) premise untenable, the comparable premise that all people are equally (and easily) vulnerable to fear, is similarly, hard to sustain. Despite the not inconsiderable casualty rate caused by air-raids on Britain, people developed relatively few fears-by contrast, the air-combat crews had a high incidence of (comparatively transient) fear. The casualty rate for airmen was far greater (it ran as high as 723

per 1000 in the early stages of the Second World War (Flanagan, 1948, p. 207)) and unlike the civilians they were not able to escape to the partial safety of a bomb-shelter at a given signal. When repeatedly subjected to extraordinarily dangerous, virtually inescapable trauma, most people acquire fears. But even under these most extreme circumstances, the large majority contained, and later recovered from their fears.

Biological Explanation of School phobia

Jacofsky, Santos, Khemlani-Patel, and Neziroglu (as cited in Zupanick & Dombeck, 1995) have improved our understanding about the biological explanation of school phobia. They explained that the intricacies of our bodies, especially our brains, are presumed to be involved in the origins and maintenance of anxiety disorders and school phobias. As mentioned, biological factors (or vulnerabilities) usually have to be in place for an anxiety disorder that can lead to school phobias to manifest. Because of advancements in genetic research, we now know that many diseases and disorders have a genetic component. Therefore, it should come as no surprise that psychiatric disorders are believed to have a genetic component as well. The findings of Bernstein and Garfinkel (1988) have given a strong support to genetic and or biological connection to school phobia. In their study, they found that school phobic children had many first and second degree relatives with anxiety, depression, or a combination of anxiety and depression.

At birth, there are observable temperamental differences. These differences appear to be a function of genetics. Some babies are much more sensitive to stimulation and stress than are other babies. These differences remain as the child matures. People born with these extra-sensitive temperaments are

thought to be at greater risk for developing anxiety disorders or school phobia later in life because their nervous system is more easily aroused. You may recall that normal anxiety is distinguished from pathological anxiety by the intensity, frequency, and duration of symptoms. People with these extra-sensitive temperaments are prone to experience greater intensity, frequency, and duration of anxiety symptoms, than people with less-sensitive temperaments. Therefore, they are more likely to experience pathological levels of anxiety and or school phobia at little arousal.

In a related way, certain personality characteristics are thought to have a genetic component. One such characteristic is called neuroticism. Neuroticism refers to a person's emotional stability. Neuroticism is best thought of as a personality characteristic that reflects a tendency toward negatively interpreting environmental cues, and a greater reactivity to those cues. For example, a child with high neuroticism is likely to interpret a small fight between two boys as an indication of a looming and certain threat to his or her life. As a result, he will become highly anxious and unable to concentrate whenever he or she enters school. Contrast this to a person with low neuroticism. Such a person is likely to be disappointed in the fight between the boys who are fighting. Rather than developing fear, the fight stands to motivate them to face their own business in the school. Simply stated, people with high neuroticism appear to be more sensitive to stress, and stress seems to affect them in a greater way. Subsequently, high neuroticism places individuals at greater risk for the development and/or exacerbation of anxiety disorders including school phobia. Moreover, chronic negative reactions to stress may actually lead to further changes in brain

chemistry. These changes further strengthen a person's preexisting biological vulnerability.

Genetics certainly account for some of the biological differences between people, but our biological make-up also accounts for the similarities among people. One such similarity is the human response to fear. This response is known as the fight-or-flight response. This adaptive response serves to protect people from danger.

The human body is thought to consist of ten(10) inter-related systems. More than half of these ten (10) complex systems are involved in the production of anxious and fearful symptoms:

1. The nervous system (which includes the brain);
2. The cardiovascular system;
3. The respiratory system;
4. The digestive system;
5. excretory system;
6. The endocrine system.

These six systems are responsible for the physiological, electrical, and chemical changes that cause and affect the manifestation of anxiety symptoms. Explanations of these various systems can become quite complicated. Our goal is to highlight the areas that are most important for understanding the origins of anxiety symptoms and of course school phobia in students.

Psychoanalytical Theory of Sigmund Freud

Studies like Stevenson (2001), Allpsych and Heffner Media Group (2003), Kalat (2004), Cherry (2014), Hasgerty (2014) and Counselingdirectory.org (2014) have enriched our understanding on psychoanalytic theory of Sigmund Freud.

Psychoanalytic therapy based its assumptions on the premise that psychological problems are rooted in the unconscious, manifest symptoms are caused by hidden or 'latent' disturbances, typical causes for psychological upset include unresolved issues during development or repressed trauma, and treatment looks to bring repressed conflicts to the surface where individuals can deal with it. By working through and understanding the conflicts, the psychoanalysis aims to change the patient (or client) on a deeper level (counselingdirectory.org, 2014). Sigmund Freud (as cited in Allpsych & Helffner media Group, 2003) has presented the structure of human personality to consist of id, ego and superego. While the topographical model of the personality consists of conscious unconscious and subconscious departments.

As human beings, Freud in Cherry (2014) believed that we are born with certain amount of psychological energy that forms the basic structures of our personality. These are the id, ego and superego. The "id" allows us to get our basic needs met. 'Id' is based on pleasure principle. In other words, the id wants to feel good at all times without consideration for the reality of the situation. When a child is hungry, the 'id' wants food, and therefore the child cries. "Id" always seeks for pleasure or satisfaction without care for time, place or pain or discomfort of anyone else. "Id" is usually within the first two years of child's development.

The ego appears within the next three years of the child as a result of continues interaction with the environment. Freud based "ego" on the reality principle. The ego understands that other people have needs and desires and that sometimes being impulsive or selfish can hurt people in the long run. Therefore, it is the ego's jobs to meet the needs of the 'id' while taking into consideration the reality of the situation. The superego develops the time the child attains five years

old. Superego is the moral part of us and it develops due to the moral and ethical restraints placed on us by people closer to us; such as the mother, father, other siblings and neighbours. Many equates superego with conscience as it dictates our belief of right and wrong (Allpsych & Heffner Media Group, 2003).

Freud opined that the interaction of the three departments determine our behaviour or personality. According to Freud "ego" is the strongest (among the three compartments). So that it can satisfy the needs of the "id", not upset the superego, and still take into consideration the reality of every situation. Freud opined that if the "id" gets too strong, impulsive and self gratification takes over the person's life. And if the 'superego' gets too strong the person would be driven by rigid moral principles and would be judgmental too. According to Freud, this is the root cause of other mental illness and or maladaptive behaviours if reality of a person's personal identity, reality about others or objects in relationship is obscured, the individual may suffer maladaptive behaviour; and as such may develop unnecessary anxiety, fear, and or school phobia. According to Cherry (2014), Freud believed that behaviour and personality derives from the constant and unique interaction of conflicting psychological forces that operate at three different levels of awareness: the preconscious, the conscious and unconscious. The conscious mind includes everything that we are aware of. This is the aspect of our mental processing that we can think and talk about rationally. A part of it includes our memory, which is not always part of consciousness but can be retrieved easily at any time and brought into our awareness. Freud called this the preconscious.

The unconscious mind is a reservoir of feelings, thoughts, urges, and memories that are outside of our conscious awareness. Most of the contents of the

unconscious are unacceptable or unpleasant such as feelings of pain, anxiety, or conflict. According to Freud in Cherry (2014), the unconscious continues to influence our behaviour and experience, even though we are unaware of these underlying influences. The interaction of these psychological forces show in our behaviour and therapeutic relationship will not be an exemption. Thus, transference-focused technique will enable the client to examine unresolved conflicts and symptoms that arise from past dysfunctional relationships and manifest in forgetfulness.

Sigmund Freud also developed the psychosexual stages theories of development. According to Stevenson (2001), Freud's psychosexual theory was based on the psyche, and that sexual pleasure drive on the individual psyche, and that human body is sensitive to sexual, erotic stimulation. The erogenous zones, according to Freud are the mouth, the anus and the genital. Hence the child's sexual desire at each of the stages affects his behaviour. At a given stage of development, the child has certain needs and demands to be met (such as the need of the infant baby to a nurse). Frustration occurs when the needs are not met. Over indulgence develops when the needs are met more than enough. Both frustration and overindulgence lock the child libido permanently into the stage in which they occur, which results in fixation. If the child progresses normally through the stages, resolving each conflict and moving on, then little libido remains invested in each stage of development. But if fixation happens at any stage, the mode or method of obtaining satisfaction which characterized the stage will dominate and affect his adult personality (Stevenson, 2001). It is the feelings, attitudes, sensations that were derived at the psychosexual stages that are being displaced or unconsciously brought forward in later relationship, including therapeutic

relationship that is referred to as transference. Such transference is careful observed and interpreted to enable the owner (the client) know the effects it has on his behaviour and problems reported to the counsellor..

The psychosexual stages are the oral stage, the anal stage, the phallic stage, the latency stage and the genital stage. The oral stage usually covers from birth to two years of the infant child. The child seeks sexual pleasure with his mouth through suckling and accepting things into the mouth. If his needs are not met, the child develops frustration. If needs are excessively met, he becomes over-indulged. Whichever of the two, there will be the development of fixation.

The anal state portends the expression of sexual pleasure through the anus zone. The child's does this with the retention or expulsion of faeces and urine. With the advent of toilet training, the child may face some challenges.

The phallic stage is the most sexual conflict period according to Freud (Stevenson, 2001). The child's erogenous zone is the genital region. A conflict tagged Oedipus complex occurs here in which a male child's unconscious desire to possess the opposite sexual parent and to eliminate the same sexual one. Oedipus complex is when a male child unconsciously desires the mother with hatred for the father and Electra complex is the other way round.

The latency stage is a period that the sexual drive lies dormant. This is usually the stage before the adolescent stage. The genital stage is adolescent when the child develops heterosexual development. The less energy the child has left invested in unresolved psychosexual developments, the greater his capacity will be to develop normal relationship with the opposite sex.

Empirical Studies

In Clayton-Australia, King (1998) evaluated the effects of a four-week cognitive-behavioural treatment on school phobia in school-aged children. King's sample consisted of children age 5 to 15 (N= 34). Participants were referred to the treatment by school personnel, professional therapists, and physicians. All participants met Berg's school refusal criteria and were classified as being either fully absent, partially absent, or resistant to attending school altogether, although these categories were not defined. Students were assessed by the research team before and after treatment using the Anxiety Disorders Interview Schedule (ADIS) for children and parents to determine diagnoses. The assessment indicated that most children were displaying some sort of anxiety or phobic disorder in addition to school refusal behaviour. Participants were randomly assigned to either cognitive-behavioural treatment or a wait list control group, for which treatment began following the study period.

The treatment consisted of two components: child therapy and parent/teacher trainings. The child therapy component of the treatment included six 50-minute individual sessions, which consisted of rapport-building, individual goal setting, coping skills (to address bullying), relaxation (relaxation tapes), self-talk, role-playing, gradual exposure to school setting, and review of concepts and skills learned. The parent training component of the treatment included five 50-minute sessions, which consisted of rapport-building, child behaviour management skills, establishing household routines, social reinforcement, troubleshooting problems, and modelling or rehearsal. The teacher training component of the treatment consisted of one training session, which focused on

practical behaviour management strategies, planning of buddy support systems, and regular telephone calls to measure progress in the classrooms.

Results from King's analysis demonstrated a significant 32 percentage point increase in school attendance (percent of days present) from pre-treatment to post-treatment. King's 2001 follow-up evaluation demonstrated a 9.1 percentage point decrease in school attendance from post-treatment to 3-5 year follow-up. Study limitations: The study utilized a small sample (N=34) of students, which makes it difficult to generalize the finding of this study to the population at-large.

Melbourne-Australia, Heyne (2002) investigated the varying effects of child counselling, caregiver training, and the combination of child therapy and caregiver training on school phobia. The study involved children age 7 to 14 who demonstrated anxiety-based school phobia. Students were referred to the program by parents, school personnel, and professional therapists. Referred students were selected into the study based on Berg's school refusal criteria. For example, the child displays severe emotional upset when faced with the prospect of going to school. However, there is an absence of anti-social behaviour.

The study was administered by the School Refusal Clinic, which is housed in the Child and Adolescent Mental Health Service at Monash Medical Centre (Melbourne, Australia). Study participants (N=61) were assessed two weeks before and after exposure to the treatment and at 4.5 month follow-up in order to determine its effect on school phobia. Participants were treated at the clinic and randomly assigned to one of the following three treatments:

Child Counselling: Eight 50-minute sessions, which included relaxation training, social skills training, cognitive therapy, skills implementation, troubleshooting, and relapse prevention? Parent and Teacher Training: Eight 50-

minute sessions, this included parent trainings at the clinic and consultations with school personnel. Psychologists helped to enable parents by providing instructional handouts, strategies for behaviour management, and a cognitive therapy program.

Child Counselling plus Parent and Teacher Training: Sixteen 50-minute sessions, which included child therapy and parent and teacher trainings as described above. Findings indicate that the combination of parent and teacher trainings had the greatest impact on increasing attendance rates. However, all groups made significant improvements in attendance rates. Attendance increased by 67% points for participants that were given the parent and teacher training treatment. The combination of child therapy and parent and teacher trainings demonstrated similar gains (61%). In fact, both interventions that included the parent and teacher component demonstrated significantly larger gains than the intervention that only included the child therapy component (39%). However, the child therapy treatment was the only intervention which demonstrated an improvement in attendance between post-intervention and follow-up.

Three randomized controlled studies have compared the efficacy of graded exposure with verbal coping skills (Sheslow, Bondy, & Nelson, 1983), vicarious exposure (Menzies & Clarke, 1993) or computer-aided vicarious exposure (Dewis et al., 2001) in children with school phobias or assessed as having severe fears.

Sheslow, Bondy, and Nelson (1983), 32 children in private day-care, aged 4 to 5 years, were recruited via a parental survey report on children's fear of the dark. The children who met a criterion of strong fear of the dark from two repeated behavioural avoidance tests (32 of 74 (43%), were matched for gender and duration of dark tolerance and randomized to one of four conditions: 1. A

graduated exposure group, 2. A verbal coping skills group, 3. A combination of both treatments, and 4. A contact-control group. Outcome measures at pre- and post-tests included a behavioural avoidance test, measuring the time the child could tolerate the dark (0–150 seconds), and a child-reported fear rating on a fear thermometer. Two post-tests, differing in instructional demand, were administered to investigate if children's avoidance of the dark could be effectively modified through direct instruction. This was done in a counterbalanced way, where children in the low demand situation were asked to try to stay in the dark as long as they could without feeling afraid, and in the high demand instructions, for the children to try as hard as they could to stay in the dark for as long as possible without feeling afraid.

Children in the exposure group were gradually exposed to nine levels of decreasing illumination, with two exposures at three different and increasing time intervals, of 10, 20 and 30 seconds respectively. In the verbal coping group, treatment consisted of psycho-education about the dark, learning coping phrases, and to practice these phrases during pretend games based on narratives of dark situations. In the combined treatment, children received the verbal coping skills and in the last step exposure (30 seconds for each level), instead of pretend games. The duration of the treatment and contact control group time was three sessions of 20 to 30 minutes, on three consecutive schooldays, and for all three treatment conditions, children could signal anxiety verbally or beep a bicycle horn, whereupon the room was fully lit. Children in the contact control group learned to recite a last line of three nursery rhymes, all interventions were reported as carried out in a positive context with songs, play and cookies.

The main finding was that children in the two treatment conditions that included direct exposure to the dark demonstrated significant increases in ability to tolerate the dark. However, no significant differences were found between the low and high demand instruction conditions to differentially modify children's avoidance of the dark. The strength of this study is the experimental design and the use of behavioural test at pre- and post-assessment. This is especially important when assessing very young children, for whom correctly labelling their subjective fears might be hard. Unfortunately, following a more strict inclusion criterion, these children were not diagnosed, nor were there any clinical severity ratings done before or after treatment. Also, no follow-up was done, so conclusions about treatment effects over time cannot be drawn, and the sample sizes, eight in each group, is small.

In the study of Menzies and Clarke (1993) 48 children, aged 3 to 8 years, with water school phobia were randomized to one of four conditions: 1. In vivo Exposure plus Vicarious Exposure (IVVE); 2.Vicarious Exposure (VE); 3.In vivo Exposure (IVE); and 4. Assessment only control. All children in treatment had individual weekly sessions for three weeks, and children in the control group were offered treatment after a three-week waiting period. Assessment measurements were a Behaviour Rating Scale, consisting of seventeen water-related activities with graded level of difficulty, a seven point scale measuring the children's overall reaction on the water-related activities, and a child and parent report on the Water school phobia survey schedule. Assessments were done at pre- and post-treatment, and at a three-month follow-up. Additionally, a generalization assessment was carried out with the treatment groups, one week after the post-assessment, at a different location and swimming pool. The main findings were

that children in the IVVE and the IVE groups showed significant improvement on all four measures, and were significantly more improved from pre- to post-treatment in comparison with the control group. Interestingly, there were no significant differences between the IVVE and the IVE group. Also, children in the VE group had no significant treatment gains over the control group. When testing for generalization effects in an unfamiliar swimming pool, results indicated reductions in scores across all treatment groups. Contrary to the authors' hypothesis, the vicarious exposure treatment not only failed to produce treatment gains on its own but also failed to enhance the gains from the in-vivo exposure treatment. At the three-month follow-up, however, the IVVE group showed greater maintenance than the IVE group. This study has several strengths in that a standardized behavioural measure was used, complementing parent and child report, as well as independent observer assessment of the children's overall reactions in the behavioural tests. A weakness, also discussed by the authors, is the short follow-up period, which makes it difficult to evaluate the long-term effects of the treatment.

Dewis et al. (2001) carried out the first single blind, randomized, control trial on the efficacy of computer-aided vicarious exposure (CAVE), in the treatment of children diagnosed with spider school phobia. In this study, 28 children and adolescents aged 10–17 years were randomized to a three 45-minute sessions (every three to four days) of either live graded exposure (LGE), CAVE or a wait-list control group. Screening instruments consisted of the CIDI-A, a computerized questionnaire to aid providing diagnoses, and an estimate of intelligence via either the WISC-III or WAIS-III short form. Self-report instruments (Subjective Units of Distress Scale (SUDS), Spider School phobia

Questionnaire for children, School phobia Targets, Adjustment Rating Scales) and Behavioural Approach Test were done at pre- and post-treatment and at a one-month follow-up. The LGE treatment consisted of presentations of increasingly more realistic pictures of spiders, followed by individual live graded exposure tasks, wherein a rating of 20 on the SUDS (range 0–100) was used as a guide to advance to the next exposure level. In the CAVE treatment, a software program instructed the participants to guide on screen a person with spider school phobia through increasingly different spider scenarios. Interestingly, the screen figure's anxiety levels were shown via an anxiety thermometer, and as the participants continued the vicarious exposure, the figure's anxiety levels decreased, thus simulating habituation. Common to both treatments, no relaxation, modelling or self-exposure homework instructions were given. The reported results indicated that the children in the LGE group showed significantly more within-group improvement in symptomatology, on most of the self-report measures, inclusive of the BAT, both from both pre- to post- as well as from pre- to follow-up assessment. Effect sizes measuring the magnitude of treatment change were in the large range for all assessments in the LGE group, both at post-treatment and at follow-up. In contrast, for the CAVE group the effect size was medium to large, in four of the six assessments, at post-treatment, and in five of six assessments at the follow-up. The wait-list group showed small effect sizes on all assessments except for the SUDS, which was large. The authors discussed the weaker results they found for the CAVE in this study in comparison with reported results from studies on adults. Discrepancies might be due to the use of a more compact treatment delivery and a shorter-follow up, wherein children were given less opportunity to try out their new skills; and the CAVE program utilized an adult screen model

which might not produce optimal learning for children. Also, the omission of homework between sessions and a maintenance program after treatment might also be responsible for the small change reported at the follow-up. In summary, graduated in-vivo exposure has been classified in reviews as a well-established treatment for treating the behavioural component of the school phobia, a general criticism though is the lack of measures on physiology and cognition in the studies (Davis & Ollendick, 2005).

Bernstein et al. (2000) investigated the efficacy of 8 weeks of imipramine versus placebo in combination with cognitive-behavioural therapy (CBT) for the treatment of school-refusing adolescents with comorbid anxiety and major depressive disorders. The study used a randomized, double-blind trial with 63 subjects entering the study and 47 completing. Outcome measures were weekly school attendance rates based on percentage of hours attended and anxiety and depression rating scales. Over the course of treatment, school attendance improved significantly for the imipramine group ($z = 4.36$, $p < .001$) but not for the placebo group ($z = 1.26$, not significant). School attendance of the imipramine group improved at a significantly faster rate than did that of the placebo group ($z = 2.39$, $p = .017$). Over the 8 weeks of treatment, there was a significant difference between groups on attendance after controlling for baseline attendance; mean attendance rate in the final week was 70.1% +/- 30.6% for the imipramine group and 27.6% +/- 36.1% for the placebo group ($p < .001$). Defining remission as 75% school attendance, 54.2% of the imipramine group met this criterion after treatment compared with only 16.7% from the placebo group ($p = .007$). Anxiety and depression rating scales decreased significantly across treatment for both groups, with depression on the Children's Depression Rating Scale-Revised

decreasing at a significantly faster rate in the imipramine group compared with the placebo group ($z = 2.08$, $p = .037$). Imipramine plus CBT is significantly more efficacious than placebo plus CBT in improving school attendance and decreasing symptoms of depression in school-refusing adolescents with comorbid anxiety and depression.

Bernstein, Hektner, Borchardt, and Mcmillan (2001) conducted a study on the treatment of school refusal: One-Year follow-up. The study intended to conduct a 1-year follow-up of anxious-depressed school-refusing adolescents who participated in an 8-week study of imipramine versus placebo, each in combination with cognitive-behavioural therapy. Sixty-five percent (41 of 63) of the randomly assigned subjects returned for follow-up evaluation, which consisted of diagnostic interviews, clinician rating scales for anxiety and depression, family functioning measure, and a questionnaire regarding interim treatments and school programs. Results show that from the adolescent and/or parent perspective, 64.1% met criteria for an anxiety disorder and 33.3% met criteria for a depressive disorder. Remission rates and acquisition rates for specific anxiety and depressive disorders were determined. In the follow-up period, 67.5% received at least one psychotropic medication trial and 77.5% had outpatient therapy. Higher level of somatic complaints on the Anxiety Rating for Children-Revised Physiological subscale at baseline predicted more severe depression on the Children's Depression Rating Scale-Revised at follow-up ($p = .029$). In addition, a substantial number of subjects met criteria for anxiety and/or depressive disorders 1 year after treatment. Investigation of duration of acute treatments and evaluation of maintenance treatments for school refusal is needed.

Tyrer and Tyrer (1974) carried out a study on school refusal, truancy, and adult neurotic illness. A survey design method was used for the study. Two hundred and forty adult psychiatric patients, comprising 60 phobic, 60 anxious, and 120 depressed patients, were interviewed about problems of school attendance during their childhood. Using a specially designed questionnaire, non-attendance due to school refusal was separated from that due to truancy. A control population of 120 orthopaedic and dental patients, matched for age and sex with the psychiatric sample, was also interviewed. It was found that school refusal had occurred significantly more often among the psychiatric patients than among the controls ($P < 0{\cdot}05$). The incidence of truancy was similar in both groups. Both school refusal and truancy had occurred more frequently in female than in male patients. The results suggest that, contrary to some studies, there is a link between childhood and adult neurotic disorders and that some children who present with problems of school refusal are at risk in adult life.

Egger, Costello, and Angold (2003) examined the association between anxious school refusal and truancy and psychiatric disorders in a community sample of children and adolescents using a descriptive rather than etiological definition of school refusal. Method used by the study was to collect data from eight annual waves of structured psychiatric interviews with 9- to 16-year-olds and their parents from the Great Smoky Mountains Study were analyzed. The results indicated that pure anxious school refusal was associated with depression (odds ratio [OR] = 13, 95% confidence interval [CI] 3.4, 42) and separation anxiety disorder (OR = 8.7, 95% CI 4.1, 19). Pure truancy was associated with oppositional defiant disorder (OR = 2.2, 95% CI 1.2, 4.2), conduct disorder (OR = 7.4, 95% CI 3.9, 14), and depression (OR = 2.6, 95% CI 1.2, 56). Of mixed school

refusers (children with both anxious school refusal and truancy), 88.2% had a psychiatric disorder. They had increased rates of both emotional and behaviour disorders. Specific fears, sleep difficulties, somatic complaints, difficulties in peer relationships, and adverse psychosocial variables had different associations with the three types of school refusal.

Butler et al. (2006) reviewed the meta-analyses of treatment outcomes of CBT/CT for a wide range of psychiatric disorders and medical conditions. A search in the literature from 1967 to 2003 pooled a total of 16 methodologically rigorous meta-analyses encompassing more than 9000 subjects from 330 studies. The review focused on effect sizes that contrasted outcomes of CBT with the outcomes for control groups for each disorder, providing an overview of the efficacy of CBT/CT. Because the literature reviews generally combine studies labelled CBT and CT under the CBT scope, the findings of these reviews were pooled and, whenever possible, pinpointed the more evident CT studies. Among the limitations of the meta-analytic approach are the assumptions of uniformity across the studies in the samples, in the content of therapy, and in therapists.

Butler et al. findings reveal that large effect sizes (grand mean = 0,90) were found for adult unipolar depression, adolescent unipolar depression, generalized anxiety disorder, panic disorder with or without agora phobia, social school phobia, post-traumatic stress disorder, and childhood depressive and anxiety disorders. The comparison-weighted grand mean effect size for these disorders when compared to no-treatment, waiting list, or placebo controls is 0.95 (SD = 0.08). CBT is associated with large improvements in symptoms for bulimia nervosa, and the associated effect sizes (M = 1,27, SD = 0.11) are significantly larger than those that have been found for pharmacotherapy. Moderate effect sizes

(M = 0.62, SD = 0.11) were obtained when CT was compared to controls for marital distress, anger, childhood somatic disorders, and several chronic pain variables (i.e., pain expression behaviour, activity level, social role functioning, and cognitive coping and appraisal).

CT was found somewhat superior to antidepressants in the treatment of adult unipolar depression (ES = 0.38), and was equally effective as behaviour therapy in the treatment of adult depression (ES = 0.05) as well as in obsessive-compulsive disorder (ES = 0.19). The efficacy of CT for sexual offenders is relatively low (ES = 0.35); however, in combination with hormonal treatments, it is the most effective treatment for reducing recidivism in this population. Finally, the review reported that CT was found to be superior to supportive/nondirective therapy in two comparisons for adolescent depression (ES = 0.84) and two comparisons for generalized anxiety disorder (ES = 0.71).

CBT has also shown promising results as adjunct to pharmacotherapy in the treatment of schizophrenia: the average uncontrolled effect size of 1.23 for CBT compares favourably with uncontrolled effect size of 1.23 for CBT compares favourably with an effect size of 0.17 for schizophrenic patients receiving only routine care. CT/CBT may also have a therapeutic role in the relapse prevention of schizophrenia as reported in a randomized controlled study of CT with very high-risk groups.

Terada et al, (2011) investigated school refusal by patients with gender identity disorder. In its method, the study evaluated a total of 579 consecutive Japanese GID patients at the outpatient GID Clinic of Okayama University Hospital between April 1997 and October 2005. Results show that the prevalence of school refusal was 29.2% of the total sample. School refusal was more frequent

among GID patients with divorced parents than those with intact families. Multiple logistic regression analysis showed that younger age at consultation and divorce of parents were significantly associated with school refusal among the male-to-female GID patients. The rate of school refusal among GID patients is high, and school refusal is closely related with a low level of education and current unemployment.

Park et al, (2015) carried out an investigation on school refusal behaviour in South Korean first graders: A prospective observational community-based study. The study used survey method to: (1) prospectively observe the actual development of school refusal behaviour according to a history of separation anxiety symptoms (SAS) and (2) explore factors for predicting school refusal behaviour in children who were just beginning primary school. The participants were 277 children, aged 6–7 years, who were expected to enter primary school in 2 months. The parents were surveyed about the child's history of SAS and their behaviour. The children were questioned about anxiety symptoms. The children were surveyed about whether school refusal behaviour developed or not after they entered primary school. Of the 248 children who responded to the follow-up survey, 7.66% of children met the criteria for school refusal behaviour during the 3 months after entering school. It was found that there were no significant differences in the occurrence of school refusal behaviour according to the children's SAS history. Familial risk factors for school refusal behaviour included low parental educational level and a working mother.

Gillies, Taylor, Gray, O'Brien, and D'Abrew (2012) conducted a study on psychological therapies for the treatment of post-traumatic stress disorder in children and adolescents. The study searched the Cochrane Depression, Anxiety

and Neurosis Review Group's Specialised Register (CCDANCTR) to December 2011. The CCDANCTR includes relevant randomised controlled trials from the following bibliographic databases: CENTRAL (the Cochrane Central Register of Controlled Trials) (all years), EMBASE (1974 -), MEDLINE (1950 -) and PsycINFO (1967 -). It also checked reference lists of relevant studies and reviews. It applied no date or language restrictions. All randomised controlled trials of psychological therapies compared to a control, pharmacological therapy or other treatments in children or adolescents exposed to a traumatic event or diagnosed with PTSD. Two members of the review group independently extracted data. If differences were identified, they were resolved by consensus, or referral to the review team. It calculated the odds ratio (OR) for binary outcomes, the standardised mean difference (SMD) for continuous outcomes, and 95% confidence intervals (CI) for both, using a fixed-effect model. If heterogeneity was found, it used a random-effects model. Fourteen studies including 758 participants were included in this review.

Findings revealed that the types of trauma participants had been exposed to include sexual abuse, civil violence, natural disaster, domestic violence and motor vehicle accidents. Most participants were clients of a trauma-related support service. The psychological therapies used in these studies were cognitive behavioural therapy (CBT), exposure-based, psychodynamic, narrative, supportive counselling, and eye movement desensitisation and reprocessing (EMDR). Most compared a psychological therapy to a control group. No study compared psychological therapies to pharmacological therapies alone or as an adjunct to a psychological therapy. Across all psychological therapies, improvement was significantly better (three studies, n = 80, OR 4.21, 95% CI 1.12 to 15.85) and

symptoms of PTSD (seven studies, n = 271, SMD -0.90, 95% CI -1.24 to -0.42), anxiety (three studies, n = 91, SMD -0.57, 95% CI -1.00 to -0.13) and depression (five studies, n = 156, SMD -0.74, 95% CI -1.11 to -0.36) were significantly lower within a month of completing psychological therapy compared to a control group. The psychological therapy for which there was the best evidence of effectiveness was CBT. Improvement was significantly better for up to a year following treatment (up to one month: two studies, n = 49, OR 8.64, 95% CI 2.01 to 37.14; up to one year: one study, n = 25, OR 8.00, 95% CI 1.21 to 52.69). PTSD symptom scores were also significantly lower for up to one year (up to one month: three studies, n = 98, SMD -1.34, 95% CI -1.79 to -0.89; up to one year: one study, n = 36, SMD -0.73, 95% CI -1.44 to -0.01), and depression scores were lower for up to a month (three studies, n = 98, SMD -0.80, 95% CI -1.47 to -0.13) in the CBT group compared to a control. No adverse effects were identified. No study was rated as a high risk for selection or detection bias but a few were rated as a high risk for attrition, reporting and other bias. Most included studies were rated as an unclear risk for selection, detection and attrition bias.

Mattick and Peters (1988), investigated the treatment of severe school phobia: Effects of guided exposure with and without cognitive restructuring. The study used fifty one social school phobias with severe scrutiny fears were randomly assigned to treatment in an experiment designed to assess the effectiveness of therapist-guided exposure and to determine the extent to which cognitive restructuring alone increases the effects of this exposure. Additionally, the ability of treatment induced changes in locus of control, of irrational attitudes, and of within session habituation to predict level of functioning at follow-up was assessed. Treatments integrity assessment showed compliance with instructions

that was consistent with the respective treatments. The combined condition proved to be significantly more effective than guided exposure alone in end state functioning, in increasing behavioural approach and in decreasing self-related avoidance. Regression analysis showed that treatment-induced changes in fear of negative evaluation (FNE), irrational beliefs, locus of control, and exposure-practice habituation were significantly predictive of end state functioning at follow-up the change in FNE accounted for virtually all the explained variance.

Goldfried, Linehan, and Smith (1978) investigated the reduction of test anxiety through cognitive restructuring. The study used 36 18-49 yr old Ss compared 2 procedures for reducing test anxiety with a waiting list control. In the first, systematic rational restructuring, the participants were trained to realistically re-evaluate imaginally presented test-taking situations. In the second; a prolonged exposure condition, Ss were presented the same hierarchy items but with no instructions for coping cognitively. Ss were administered the following measures of test anxiety; the S-R Inventory of Anxiousness, Achievement Anxiety Test, Test Anxiety Questionnaire, Fear of Negative Evaluation, Social Avoidance and Distress Scale, and the Trait Scale of the Stait-Trait Anxiety Inventory. Findings show greater anxiety reduction in the systematic rational restructuring condition, followed by the prolonged exposure group, with no changes for the control. Only those in the rational restructuring condition reported a significant decrease in subjective anxiety when placed in an analogue test-taking situation in the restructuring condition also reported greater generalized anxiety reduction in social-evaluative situations. Within the broader context of cognitive behaviour therapy, these results indicate that the cognitive reappraisal of anxiety-provoking situations can offer an effective treatment procedure for the reduction of anxiety.

A pilot study of a cognitive restructuring programme for treating post-traumatic disorders in adolescents was conducted by Rosenberg, Jankowski, Fortuna, Rosenberg, and Mueser (2011). The study explored the feasibility and efficacy of manualized cognitive restructuring program for treating adolescents suffering from posttraumatic stress disorder (PTSD). 9 girls and 3 boys (mean age 16 years; range = 14-18), with PTSD, were recruited from a community mental health centre and a tertiary health care centre and enrolled in a pilot study. The adolescents were seen weekly for 12-16 weeks of individual treatment. Variables assessed included: trauma history, PTSD diagnosis and severity, depression, substance abuse, and client satisfaction. Twelve adolescents consented to treatment; 9 completed the program. The number of types of traumas reported averaged 6.5 (range = 1-13). Paired t-tests were used to test pre-post change for PTSD symptoms and depression, in completers. From baseline to post-treatment, there were statistically significant improvements in PTSD and depression. Treatment gains were maintained at 3 month follow-up. Preliminary results suggest the feasibility of implementing manualized cognitive restructuring program to treat PTSD in adolescents. Completers rated themselves as improved and satisfied at post-treatment and 3-month follow-up. Feedback from referring clinicians also indicated high satisfaction.

Johnco, Wuthrich, and Rapee (2013) investigated the role of cognitive flexibility in cognitive restructuring skill acquisition among older adults. In the study, neuropsychological measures of cognitive flexibility were administered to 40 normal community-dwelling. Results indicated that the majority of participant showed good cognitive restructuring skill acquisition with brief training. The multiple regression analysis suggested that those with poorer cognitive flexibility

on neuropsychological testing demonstrated poorer quality cognitive restructuring. In particular, preservative thinking styles appear to negatively impact the ability to learn cognitive restricting.

Jung and Steil (2013) carried out a randomized controlled trial on cognitive restructuring and imagery modification to reduce the feeling of being contaminated in adult survivors of childhood sexual abuse suffering from posttraumatic stress disorder. The study used thirty-four women with CSA – related PSD (mean age = 37 years) were randomized to either the CRIM group or a waitlist control group. Primary outcomes were intensity, vividness, and uncontrollability of the FBC, associated distress, and PTSD symptoms, which were are assessed using the clinician Administered PTSD Scale and the Posttraumatic Diagnostic Scale. Outcomes were measured pre- and post treatment, and at the 4 – week follow-up. MANOVAs were used to compare improvements across conditions. Findings reveal that all FBC scores yielded a greater reduction in the CRIM group than the waitlist control (WL) group. Between – group effect sizes at follow-up were large and highly significant (intensity: $d = 1.52$, $p < 0.001$; vividness: $d = 1.28$, $p < 0.001$; uncontrollability: $d = 1.77$, $p < 0.001$; distress: $d = 1.80$, $p < 0.001$). PTSD symptoms also yielded a greater reduction in the CRIM group than the WL group, with large between – group effect sizes (clinician – Administered PTSD Scale: $d = 0.93$, $p < 0.001$).

Umar, Abdullahi, Oliagba, Sambo and Abdulwahid (2014) investigated the effect of cognitive restructuring (CR) intervention on tobacco smoking among adolescents in senior secondary schools in Zaria Educational Zone of Kaduna State, Nigeria. The study employs a quasi-experiment non-equivalent control group, pre-test-post-test design in the investigation. 129 (71 male and 58 female)

schooling adolescents were drawn from 4 schools in Zaria Educational Zone. An instruction tagged Cognitive Behaviours Intervention Scale (CBIS) was adopted and used for the study. Data were analysed using means t-test and analysis of covariance (ANCOVA). Findings reveal that cognitive restructuring intervention programme (CRIP) significantly affects tobacco use cessation.

Mankiewicz and Turner (2014) investigated the cognitive restructuring and graded behavioural exposure for delusional appraisals of auditory hallucinations and comorbid anxiety in paranoid schizophrenia. Sixteen sessions were delivered to a 40-year-old male with diagnoses of paranoid schizophrenia and comorbid anxiety, focusing primarily on cognitive restructuring of paranoid appraisals of auditory hallucinations and behavioural experiments employed progressively via graded exposure to anxiety-inducing stimuli. Standardised measurements, behavioural frequency sampling, and subjective data indicated a considerable reduction in both paranoia and anxiety. Also, the client's psychosocial functioning improved substantially. The report indicates that the treatment may help those with experiences of psychosis and comorbid anxiety reach a significant improvement in their quality of life and offers an encouraging and innovative perspective on direct engagement with the content of paranoia and voices at the onset of therapy.

2.6 Summary of Literature Review

This chapter has reviewed related literatures on effects of cognitive restructuring and graded exposure counselling techniques on school phobia among secondary school students in Kaduna metropolis. The concept of school phobia was reviewed vis-à-vis; the meaning, signs, characteristics of students with school phobia, causes, and effects. The chapter also reviewed the concept of cognitive

restructuring with topics such as the meaning, forms of cognitive disorder, and cognitive restructuring working template.

Furthermore, the concept of graded exposure counselling technique, model of graded exposure, plan and steps in overcoming problems during graded exposure. The reviewed literatures show that interesting relationships exist among the variables. Thus, it was reviewed that counsellors can use either or both cognitive restructuring and graded exposure counselling techniques to treat students or children who exhibit school phobia.

The chapter also reviewed classical conditioning theory, operant conditioning theory, Bandura's social learning theory, Rachman's integrative model of fear, and biological model for fear. Furthermore, Aaron Beck theory of cognitive restructuring, the cognitive model of depression, and psychoanalytical theory of Sigmund Freud were used for the review. Related empirical studies were also reviewed in the chapter.

The review shows that there is no study ever carried out on the effect of cognitive restructuring and graded exposure counselling techniques on school phobia among secondary school students in Kaduna metropolis. Most of the available works are studies carried out in foreign countries. Thus, this present study is exploratory in nature for Kaduna, Nigeria and possibly representing the African frontier. Apart from that, most of these studies were not recently conducted. Even Mankiewicz and Turner (2014) which is recent, is a foreign study. It was not from Nigeria or Africa. It is therefore expected that the present study would fill the gap created in literature in terms of time and environment.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter presents the methodology used in carrying out this study. Specifically, it describes the research design, population, sample and sampling technique, instrumentation, pilot study, validity and reliability of the instrument treatment procedure, procedure for data collection and analysis.

3.2 Design of the Study

A quasi-experimental research design involving non-equivalent pre-test-post-test was used for the study. Quasi-experimental design involves administering a treatment. Participants are not randomly assigned to treatment (Trochim, 2006). This is because the study covered fewer participants under control condition. The study included a pre-test post-test control group design with both treatment group and a control group. This was considered appropriate because quasi experimental design involves one treatment and one control group non-equivalent control group design, is the simple experiment without random assignment. The design for the Non-Equivalent Groups Design (NEGD) consists of two groups, a program and comparison group, and that each is measured pre and post test (Trochim, 2006).

The use of intact classes was necessitated by and used by the study. The design is symbolically represented thus:

Table 3.2.1: Quasi- Experimental Design

Group	Pre-test	Treatment	Post-test
Experimental group (CRT)	0_1	X_1	O_2
Control group	0_1	-	O_2
Expt. Group (GET)	0_1	X_1	O_2
Control group II	0_1	-	O_2

Key:

0_1 = Pre-test that was administered to treatment and control group respectively,

X_1 = Treatment was given to CRT experimental group

0_2 = Post-test that was administered to the two groups after treatment

0_1 = Pre-test that will be administered to treatment and control group respectively,

X_1 = Treatment to be given to experimental group

0_2 = Post-test that will be administered to the two groups after treatment

3.3 Population of the Study

The population of the study consisted of all the public junior secondary school students identified with school phobia in Kaduna Metropolis, Nigeria. All together, 415 male and female junior secondary school students were identified from 30 secondary schools. The choice of junior secondary class one students was guided by the assumption that the students have attained the puberty and formal operational stage of physical and cognitive development. At this stage students can be taught new kinds of thinking which are abstract, formal and logical. Thinking symbolically at this stage is necessary if one should be able to deal with behaviour problems at their level of education.

3.4 Sample and Sampling Techniques

The sample of this study consisted of 36 identified school phobia junior secondary class one (JSS1) students, from the sampled four intact classes was drawn from three co-educational junior secondary schools in Kaduna metropolitan, Nigeria. The students selected were those identified by their class teachers and school counsellors with school phobia, separation anxiety and school refusal based on the SCARED administered to them.

To compose this sample, the researcher purposely sampled all the co-educational junior secondary schools identified with high incidence of school phobia through the SCARED. Three schools namely; Government Junior Secondary School, Kakuri, Government Junior Secondary School, Ungwan Sarki, and Government Junior Secondary School, Kawo were purposively selected from those indentified with very high rate of school phobia. The researcher randomly assigned the three co-educational junior secondary schools into the treatment and control group schools.

3.5 Instrumentation

The Instrument tagged SCARED (screen for child anxiety related disorders) developed by Birmaher, Brent, Chiappetta, Bridge, Monga, and Baugher (1999) was adapted and used for this study. The original scale of the instrument ranges from Not true or Hardly ever true (0), Somewhat true or Sometimes true (1) and Very true or Often true (2) respectively was changed by the researcher to ranges from Not true or Hardly ever true (1), Somewhat true or Sometimes true (2) and Very true or Often true (3) respectively.

Scoring:

A total score of ≥**25** may indicate the presence of Scolionophobia **Disorder,** and Scores higher than 30 are more specific

A score of **7** for item 1,6,9,12,15,18,19,22,24,27,30,34,38 may indicate **Panic Disorder or Significant Somatic Symptoms.**

A score of **9** for item 5,7,14,21,23,28,33,35,37 may indicate **Generalized Anxiety Disorder.**

A score of **5** for item 4, 8,13,16,20,25,29,31 may indicate **Separation Anxiety SOC**

A score of **8** for item 3,10,26,32,39,40,41 may indicate **Social Anxiety Disorder**

A score of **3** for item 2, 11, 17, 36, may indicate **Significant School Avoidance**

3.6 Validation of the Instrument

The SCARED was face validated by three lecturers in Educational Psychology, and Guidance and Counselling of Department of Ahmadu Bello University, Zaria after a rigorous criticism and technical inputs relating to the appropriateness of the items and clarity of the language. The inputs of these experts contributed to the final form of the instrument that was used for the study.

The treatment programme was also validated by two lecturers in the department of Guidance and Counselling and Educational Psychology. The objective activities, evaluation techniques, time limits and a number of periods were provided to serve as a guide for their comments. Their comments and suggestions were used in improving the treatment programme

3.7 Pilot Study

The SCARED was trial tested on 10 JSS1 public junior secondary school students in Zaria Local Government Area, Kaduna State, Nigeria. The students completed the items between 15 to 20 minutes. Precisely two weeks later, the SCARED was re-administered on the same set of students. All the questions raised by the students were answered and issues observed served as guidance for the researcher.

3.8 Reliability of the Instrument

The SCARED was trial tested on 10 JSS1 students drawn from a co-educational secondary school in Zaria Local Government Area, Kaduna State, Nigeria. The internal consistency, reliability estimate of the instrument was determined using the Cronbach - Alpha method and the obtained reliability estimate was found to be 0.82. In order to determine the stability of SCARED over time, a test re-test analysis using Pearson correlation method was conducted. This became necessary since the same SCARED, though reshuffled was used both pre-test and post test.

3.9 Treatment Procedure

The basic premise of cognitive-behavioural theory (CBT) is that people can learn new behaviours to use in response to stimuli and that the thought processes that serve as an intermediate step between the stimuli and the behaviour can be altered, thereby, influencing school phobia.

Cognitive-behaviour theory (CBT) was developed from two theoretical streams behaviourism (behavioural theory) and cognitive theory (CT) using a

theoretical model that was adopted and used as a treatment procedure as shown in the figure below

$$S \rightarrow \quad O \rightarrow r \rightarrow R$$

S = Stimuli Control, a method whereby cues (For example, tip sheets/chart showing student in schools) are provided to a person as a reminder of the desired behaviour (For example., not going to school).

O = Organism, which is the person seeking help to quit using school phobia. More specifically, it refers to internal processes such as thoughts and feelings. Influences at this stage include techniques designed to change how a person thinks about his or her school phobia and to train that person to think differently about engaging in this behaviour. This part of the model separates CBT from strictly behavioural approaches.

R = Response. CBT seeks to modify or alter a person's responses. For example, a person can be taught new skills to help him put down a school phobia or find another activity to engage in when craving school phobia

R = Reinforcement, which is necessary to help the person continue performing a new behaviour (such as not fearing school) instead of the old behaviour (school phobia).

The intervention programme was adopted from Beck et al. (1993) and (2005) respectively. Each module lasted for two periods of 40 minutes each. The entire programme was capped up with a 20 minutes drama presentation. The plot of the drama was a student who often have school phobia was liable to remain poor and unemployed in teaching, lecturing, banking, nursing, engineering and so on when student freely choose his or her action, he or she also chose the consequence.

Both the experimental and control group were given a reshuffled version of SCARED as the post-test in the weeks.

Treatment Procedure

Pre-Treatment: before the commencement of the training, the counsellors took time to familiarize themselves with the subjects to ascertain for instance, their competency, interest and the academic problems they encounter in school. This, it was believed will help the counsellors in determining how best to motivate the subjects to acquire the new skills.

Immediately after assigning the classes to treatment and control groups the SCARED was administered to them.

In order not to disrupt the school programme, instructions on CRT and GET were done during free periods. The experiment was designed to last for six weeks.

Treatment Programmes: CRT and GET programme were used in training the treatment schools. Both the treatment and control groups received conventional behaviour management in their normal class setting. Those in the treatment group received instruction in CRT and GET.

Treatment Phases: Pre-treatment phase, treatment phase and post-treatment phase

Treatment 1: CRT

Week 1

Session 1: Establishing the Relationship

Session 2: Nature Purpose and Process of School phobia, CRT and **Cognitive Rehearsal**: The client recalls a problem from the past, and the counsellor and the

client work together to develop strategies to the problem so that if it occurs in future, the client has a treatment plan.

Week 2

Session4: Validity Testing: The counsellor tests the validity of the client's beliefs or thoughts, giving the client time to defend his or her viewpoint. If the client cannot defend the beliefs or thoughts they are said to be invalid.

Session5: Writing in a Journal: The client may be asked to journal thoughts and situations that occur daily. The counsellor and the client then review the journal to figure out any maladaptive thought patterns that could affect the client's behaviour.

Week 3

Session6: Guided Discovery: The counsellor guides the client through a scenario; enabling the client to understand any cognitive distortions.

Session7: Modelling: This involves role-playing exercises by the therapist so that the client may learn new ways of responding to certain situation.

Week 4-5

Session8: Homework: The counsellor commonly gives assignments to clients to help them learn new ways of dealing with current dilemmas.

Session9: Systematic Positive Reinforcement: This technique involves the client performing a desirable behaviour and then being provided with a pleasant reinforcement or reward.

Week 6

Session 10: Revision of the CRT

Session 11: The Re-administration of the study SCARED

Treatments 2: GET

Session 1: Establishing the Relationship

Session 2: Meaning, and nature of school phobia and Procedure involves on GRADED EXPOSURE TECHNIQUE (GET)

Week 1

Session 3: Hierarchy of Fear / School phobia

1. Seeing a school in a calendar/watch a video
2. Seeing a school assemblage from a distance

Week 2

1. Driving past a school (the nearer, the worse)
2. Seeing a school (the nearer, the worse)
3. Passing a school (the nearer, the worse)

Week 3

1. Reading the notice from board
2. Being inside a school

Week 4

1. Seeing a school
2. Attending an assembling ground

Week5

1. Entering a class
2. Sitting in a class
3. Attending a lesson and so on

Week 6

Session 13: Revision of the Sessions

Session 14: The Re-administration of the SCARED

The SCARED were administered to the subjects in the treatment groups and those in the control group immediately after treatment were completed. The researcher re-administered the instrument through the school counsellors who were taught the strategy. The researcher mainly supervised the testing process. The administration of these tests was conducted in such a way that the subjects were exposed to the same testing conditions

3.10 Control of Extraneous Variables

To ensure that only variable observed in the academic achievement of the subject can be attributed to the treatment rather than to some extraneous variables, the researcher controlled the variables in the following ways, in order to neutralize or minimize their influences.

1. Randomization of the subjects into the treatment and control groups was not possible because of the problem of disrupting the normal classes. The researcher randomly assigned the intact classes to the treatment condition through simple balloting techniques.
2. To enable the researcher control the initial group difference among the subjects in each group analyses of covariance (ANCOVA) was utilized using pre-test scores as covariates to the post-test scores.
3. To minimize student's sensitization to the treatment, all the assessment was announced to the students as the normal continuous exercise. The trainers were also introduced to the students as the schools used in the study adopted the following technique.

a. The research assistants used for the study were given intensive orientations on how to implement the training programme.

b. There were trial sessions in which the research assistants used the training programme. At the end of the total sessions, the researcher discussed extensively the observed source of problems and solutions to such problems.

c. The researcher also monitored closely the teaching of CRT and GET to ensure, that the teachers involved in the study adhere strictly to the use of the procedure prepared and given to the subjects.

d. To determine the extent of mastery of the required technique by the research assistants, the researcher used them to train the subjects sampled during the field trial.

3.11 Procedure for Data Administration

The researcher obtained a letter of introduction (shown in Appendix I) from the Department of Educational Psychology and Counselling. The letter was given to the Kaduna State Ministry of Education where an approval (shown in Appendix II) was given to the researcher to conduct research and liaise with Sabon-tasha and Kaduna Zonal Education Offices which supervise public secondary schools in Kaduna metropolis. The two offices granted their approval (through the letters shown in Appendixes III and IV). Copies of these letters were distributed to Principals of secondary schools (15 secondary schools in each of the two zones were randomly selected for identification of cases of school phobia).

After the approval of the secondary school principals, the attendance registers of JSS1 students were checked. The screening of the students' attendance was limited to the last and current term (the term in which the study took place). Apart from that, the JSS1 form teachers completed SCARED (shown in Appendix

V) and also presented names of students who met the school phobia criteria in their classes. This was done for identification purpose.

Schools identified with high cases of school phobia were selected for the treatments (CRT and GET) and control groups. The SCARED was administered to the students. Between 20 to 25 students participated in the pretest from the two treatment groups and the control group.

The counsellor welcomed the students, explained the purpose of the exercise, after establishing rapport with them. The students were told that the instrument has no right or wrong answers. They were asked to feel free and honest in responding to the SCARED. The exercise took an average of 30 minutes to complete. The same procedure was employed during the post-test.

3.12 Procedure for Data Analysis

The data collected after administering the research instrument were collated, organized and analyzed. Mean and standard deviation and t-test were used in answering the five research questions and hypotheses, whereas analysis of covariance (ANCOVA) was used to test hypothesis five at 0.05 level of significance.

CHAPTER FOUR

RESULTS AND DISCUSSION

4.1 Introduction

The focus of this study was directed at investigating the effects of cognitive restructuring and graded exposure counselling technique on school phobia among secondary school students in Kaduna metropolis, Nigeria. Therefore, this chapter presents data analysis, results, and the discussion of the findings.

4.2 Data Presentation

The data collected for the study covered the distribution of the subjects into two groups; distribution of subjects into treatment and control groups and the distribution of subjects by gender.

Table 4.2.1: Frequency Distribution of Respondents into Groups

Groups	Frequency	Percentage
Treatment	24	66.66%
Control	12	33.33%
Total	36	100%

Table 4.2.1 above shows the distribution of respondents into groups. The treatment group consisted of twenty four (24) respondents (students) representing 66.67% and the control group consisted of twelve (12) respondents (students) representing 33.33%.

Table 4.2.2: Distribution of Respondents into Treatment and Control Groups

Treatment Group	Frequency	Percentage
Cognitive Restructuring Counselling Technique (CRT)	12	33.33%
Graded Exposure Counselling Technique (GET)	12	33.33%
Control	12	33.33%
Total	**36**	**100%**

Table 4.2.2 above is the frequency distribution of respondents into treatment and control groups. SCARED was administered to the thirty-six (36) respondents by the researcher. Twelve (12) respondents representing 33.33% were treated using CRT, and another twelve (12) respondents representing 33.33% were also treated using GET; while twelve (12) respondents representing 33.33% were not given treatment and used as the control group.

Table 4.2.3: Frequency Distribution of Respondents on Gender Basis

Gender	Frequency	Percentage
Male	19	52.78%
Female	17	47.22%
Total	**36**	**100%**

Table 4.2.3 above is the frequency distribution of respondents on the basis of gender across treatment and control groups. Nineteen (19) male respondents, representing 52.78% and 17 female respondents representing 47.22% were used for the study.

4.3 Answers to Research Questions and Hypotheses

The research questions were answered with their corresponding hypotheses that guided this study as shown below:

Hypothesis One: "There is no significant effect of CRT on reducing of school phobia between male and female secondary school students".

Table 4.3.1: Independent t-test statistics on the difference in the reduction of school phobia between male and female secondary school students exposed to CRT

Variable	Sex of CRT students	N	Mean	Std.dev	Std. Err	Df	t-cal	t-crit	Sig (p)
Post-test scores	MALE	6	43.0833	10.18537	4.15816	10	0.819	1.96	0.432
	FEMALE	6	38.8333	7.60701	3.10555				

calculated p > 0.05, Calculated t< 1.96, at df 10

Results of the independent t-test statistics above showed that there is no significant difference in the mean reduction of school phobia between male and female secondary school students exposed to CRT.

This is because the calculated p value of 0.432 is higher than the 0.05 alpha level of significance, while the t-calculated value of 0. 819 were found to be lower than the t-critical value of 1.96, at df 10. Their calculated mean school phobia scores were 43.0833 and 38.8333 by male and female students exposed to the CRT treatment respectively. That is no significant differences exist between male and female students exposed to CRT treatment implying that the treatment is effective for both male and female students in school phobia reduction. Consequently, the null hypothesis which states that there is no significant difference in the mean reduction of school phobia between male and female secondary school students exposed to CRT, is hereby accepted and retained.

Hypothesis Two: "There is no significant effect of GET in reducing school phobia between male and female secondary school students."

Table 4.3.2: Independent t-test statistics on the difference in the reduction of school phobia between male and female secondary school students exposed to GET

Variable	Sex of GET students	N	Mean	Std.dev	Std. Err	Df	t-cal	Sig (p)
Post-test scores	MALE	7	49.6429	11.22762	4.24364	10	0.948	0.366
	FEMALE	5	56.1000	12.22395	5.46672			

Calculated p > 0.05, Calculated t< 1.96, at df 10

Results of the independent t-test statistics above showed that there is no significant difference in the mean reduction of school phobia between male and female secondary school students exposed to GET. This is because the calculated p value of 0.366 is higher than the 0.05 alpha level of significance while the t-calculated value of 0.948 was found to be lower than the t-critical value of 1.96, at df 10. Their calculated mean school phobia scores were 49.6429 and 56.1000 by male and female students exposed to the GET treatment respectively. This implies that no significant mean school phobia differences between male and female students exposed to GET treatment implying that the treatment was effective for both male and female students in school phobia reduction. Consequently, the null hypothesis which states that "there is no significant difference in the mean reduction of school phobia between male and female secondary school students exposed to GET, is hereby accepted and retained.

Hypothesis three: "There is no significant effect of CRT on reducing school phobia among secondary school students in the treatment group and the control group."

Table 4.3.3: Independent t test statistics on the difference in the effect of CRT in school phobia reduction of secondary school students

Variable	Groups	N	Mean	Std.dev	Std. Err	Df	t-cal	Sig (p)
Post test scores	CRT (EXP2)	12	8.4167	4.85159	1.40053	22	20.108	0.000
	CONTROL	12	86.7500	12.59239	3.63511			

calculated p < 0.05, Calculated t > 1.96, at df 22

Results of the independent t-test statistics above showed that significant difference was observed in the effect of CRT on school phobia reduction among students. This is because the calculated p value of 0.000 was found to be lower than the 0.05 alpha level of significance while the t-calculated value of 20.108 was found to be higher than the t-critical value of 1.96, at df 22. Their calculated mean school phobia reductions were 8.4167 and 86.7500 by CRT and control group students respectively. This implies that students exposed to the CRT have reduced school phobia than those in control group. Consequently, the null hypothesis which states that there is no significant difference in the effect of CRT in reducing school phobia among students is hereby rejected.

Hypothesis Four: "There is no significant effect of GET on reducing school phobia among secondary school students in the treatment group and the control group."

Table 4.3.4: Independent t-test statistics on the difference in the effect of GET in school phobia reduction of secondary school students

Variable	Groups	N	Mean	Std.dev	Std. Err	Df	t-cal	t-crit	Sig (p)
Post test scores	GET (Exp1)	12	18.7500	2.17945	.62915	22	18.432	1.96	0.000
	Control	12	86.7500	12.59239	3.63511				

Calculated p < 0.05, Calculated t > 1.96, at df 22

Results of the independent t-test statistics above showed that significant difference was observed in the effect of GET on school phobia reduction among students. This is because the calculated p value of 0.000 was found to be lower than the 0.05 alpha level of significance while the t-calculated value of 18.432 was found to be higher than the t-critical value of 1.96, at df 22. Their calculated mean school phobia reduction were 18.7500 and 86.7500 by GET and control group students respectively. This implies that students exposed to the GET have reduced school phobia than those in control group. Consequently, the null hypothesis which states that there is no significant difference in the effect of GET in reducing school phobia among students is hereby rejected.

Hypothesis five: "There are no significant relative effects of CRT and GET on reducing school phobia among male and female secondary school students".

Table 4.3.5: Analysis of Covariance on the difference between male and female secondary school students in the effect of CRT and GET on school phobia

Source	Type III Sum of Squares	Df	Mean Square	F	Sig.
Corrected Model	300.465[a]	3	100.145	.768	.513
Intercept	69152.429	1	6222.419	530.003	.000
Sex	9.912	1	7.912	.076	.783
Group	131.162	1	111.102	1.005	.007
sex * group	25.958	1	25.118	.199	.656
Error	30270.327	232	130.416		
Total	327493.000	236			
Corrected Total	30570.792	235			
a. R Squared = .010 (Adjusted R Squared = -.003)					

Results of the ANCOVA analysis table above revealed that there is no significant difference between male and female students in the reduction of phobia among secondary students exposed to GET and CRT. Reason being that gender was not a significant factor among those exposed to both GET and CRT in reducing school phobia among secondary school students with (f= 0.76, p=0.783). The descriptive statistics showed that male had a mean score of 60.0000 and 34.6643 in their GET and CRT respectively; while their female counterpart had a mean score of 56.0000 and 33.6643 in their GET and CRT respectively.

Therefore the null hypothesis which states that there are no significant relative effects of CRT and GET on reducing school phobia among male and female secondary students is hereby accepted and retained.

4.4 Summary of the Major Findings

The findings of this study, reveals that;

1. Male and female students exposed to CRT had a reduced school phobia in favor of female students with (t = 0.819, p = 0.432). This implies that CRT

treatment is effective in reducing school phobia between male and female students.

2. Male and female students exposed to GET had a reduced school phobia in favor of male secondary school students with (t = 0.948, p = 0. 366). This implies that GET treatment is effective in reducing school phobia between male and female students.

3. Students exposed to CRT such as validity testing, modelling, and systematic positive reinforcement had a reduced school phobia as compared to those in control group (t = 20.108, p = 0. 000). That is, students exposed to CRT have reduced school phobia than those in the control group.

4. Students exposed to GET such as hierarchy of fears had reduced fears than their counterparts in the control group (t = 18.432, p = 0.000). That is, students exposed to GET have reduced school phobia as compared to their counterpart in the control group.

5. Gender was not a significant factor among those exposed to both CRT and GET on reducing school phobia among secondary school students (f= 0.76, p=0.783) This implies shows that there is no significance differences between male and female students exposed to CRT and GET in reducing school phobia among secondary school students.

4.5 Discussion

The findings of the study reveal that significant differences do not exist in reduction of school phobia between male and female students exposed to CRT. This is an indication that the CRT is effective in the reduction of school phobia among male and female students. It is an indication that gender does not add or

reduce the potentiality of CRT in the reduction of school phobia. In other word, male or female students in Kaduna metropolis would benefit from the CRT when use for reduction of school phobia. This finding agrees with the positions of Rosenberg et al, (2011). They found that cognitive restructuring programme show a statistically significant improvement in the PSTD and depression of the affected adolescents. Apart from that, CRT also has the capability of enhancing good cognitive restructuring skill acquisition of male and female students. This is in line with the finding of Johnco et al, (2013). They revealed that the majority of the participants in their study showed good cognitive restructuring skill acquisition with just brief training. This improvement in cognitive restructuring skill acquisition was also expressed by the students (in CRT group) who participated in the study. Moreover, the students who completed the treatment showed great cessation in school phobia. This was demonstrated by their improved school attendance and the testimonies of some form teachers during the brief sent forth programme for the researcher. The cessation of school phobia by CRT agrees with the finding of Umar et al, (2014) They maintained that cognitive restructuring intervention programme (CRIP) significantly affects tobacco use cessation among adolescents in senior secondary schools in Zaria Education Zone of Kaduna States, Nigeria. That is to say, CRT is quite capable and effective in reducing and or eradicating students behavioural problems especially school phobia. Another finding of this study have revealed that significant differences do not exist in the reduction of school phobia between male and female students exposed to GET. This is an indication that the GET is effective on all students irrespective of their gender. GET, according to Kaplan and Tolin (2011) is quite effective in habituation (that is, reducing school phobia), extinction (can help weaken

previously learned associations between fear of school activities, fear of school staff, school situations and bad outcomes), self-efficacy (that is, the treatment has shown the participants that they are capable of facing or confronting and managing their school phobia with or without assistance from anybody), and emotional processing (the GET treatment has refined the feelings and thinking of the GET students to learn to attach new and more realistic beliefs about activities, staff, other students and situations in school, and become more comfortable with school attendance. In addition to the above; the study showed that significant difference exists between male and female students exposed to CRT and GET in the reduction of school phobia. The study reveals that CRT is more effective than GET in the reduction of school phobia between male and female students. This is an indication of the strength of CRT which has been proved. This position on the effectiveness of CRT among other counselling techniques agrees with the findings of Rosenberg et al. (2011) who identified the treatment as very effective in posttraumatic disorders in adolescents. Perhaps, school phobia is another adolescent disorder hence the usual (and of course higher effectiveness) of CRT. Another evidence in support of the higher effectiveness of CRT over GET might be the cognitive restructuring skill acquisition with brief training inherent in the earlier (that is CRT) which is capable of giving the client long lasting improvement.

Furthermore, the study has revealed that significant difference exist between those exposed to CRT and those in the control group. This is an indication of the effectiveness of CRT again. The CRT of course would have reduced the school phobia of the school phobic students. What would have resulted in the differences are the components of the CRT treatment. The CRT

having based its ideology on the extinguishment of behavioural problem would have done this by (according to Aaron Beck) identifying the irrational thought leading to maladaptive behaviour. This of course was carried out during the study by making students mention the causes of their school phobia (writing in journal), validity testing, guided discovery, modelling, homework and systematic positive reinforcement. The students were able to make a self-discovery of how obnoxious their perceptions which resulted into school phobia have been. This position on the effectiveness of CRT in the treatment of school phobia is supported by the findings of Goldfried et al, (1978). They reported that participants in a rational restructuring treatment condition had a significant decrease in subjective anxiety while the control group did not. The result of that finding is an indication of cognitive appraisal of anxiety-provoking situation which can offer an effective treatment procedure for reduction of anxiety. Thus, the CRT did for reducing school phobia among the secondary school students who received the treatment and no improvement was found among the control group. It is impossible to change a person's action until his mind is changed.

Another finding revealed significant differences exist between the students exposed to GET in reduction of school phobia and those in the control group. This is another indication in the effectiveness of GET in the reduction of school phobia. This finding is not different from the position of Menzies and Clarke (1993), who reported children in the exposure treatment condition improved from pre-to-post-treatment in comparison to the control group.

At this junction, it will be appropriate to add that the use of any or both of these treatments (CRT and GET) would help in the reduction of school phobia among students irrespective of their gender. Studies such as that of Sheslow et al

(1983), Benstein et al (2000), Buller et al (2006), Gillies et al (2012), Jung and Steil (2013), and Mankiewicz and Turner (2014) have all reported the effectiveness the usage of conjugal-behavioural counselling (which CRT and GET belong to) on all forms of anxiety-provoking situations, events and so on.

CHAPTER FIVE

SUMMARY, CONCLUSION, AND RECOMMENDATIONS

5.1 Summary of the Study

Students, teachers, parents, educationists and all stakeholders concerned with junior secondary school education have made several attempts in reducing school phobia among secondary school students through advice, organisation of social skills training, and even medication to reduce difficulties in school attendance. But school phobia still persists among students. Although fear and anxiety are adaptive and necessary for survival, such responses become problematic when they are excessive, persist over time, and produce considerable discomfort for the students.

School phobia is characterized by excessive fear to diverse events associated to school such as being beaten by teachers or classmates, bullied or criticized in front of the class, having to speak in public, doing examinations, getting undressed to practice sports and so on. This may be partly attributed to peers group pressure, bullying by fellow students or adult, delay by parents, hawking, insecurity, and other social economic problems among others. In educational settings, the anxiety related problems of students may act as barriers to optimal academic and or social development. School phobia can be so frustrating to students and parents. When left untreated, it can cause significant stress for students. Potential consequences of prolonged school phobia are severe. The problem can result to lack of academic progress, failure to develop satisfactory social relationships, and significant family conflict to adult emotional disorders. If school phobia is not curtailed, it is capable of derailing students

future ambitions, prevents parents from realizing the aim of their kind and monetary effort, and government from its developmental goals.

It was at this background that this study sought to investigate the efficacy of CRT and GET in reducing school phobia among secondary school students in Kaduna metropolis, Nigeria. Five research questions, 5 objectives, and 5 hypotheses were generated for the study.

The study employed quasi experiment design in investigated the effect of CRT and GET on reducing school phobia among secondary school students in Kaduna metropolis. An instrument tagged SCARED was adopted and used for the study. Mean, standard deviation, t-test and (ANCOVA) were used to analyse the data. Findings revealed that.

1. Male and female students exposed to CRT had a reduced school phobia in favor of female students. This implies that CRT treatment is effective in reducing school phobia between male and female students.
2. Male and female students exposed to GET had a reduced school phobia in favor of male secondary school students. This implies that GET treatment is effective in reducing school phobia between male and female students.
3. Students exposed to CRT such as validity testing, modelling, and systematic positive reinforcement had a reduced school phobia as compared to those in control group. That is, students exposed to CRT have reduced school phobia than those in the control group.
4. Students exposed to GET such as hierarchy of fears and gradual confrontation with the school phobia phenomena had reduced fears than their counterparts in the control group. That is, students exposed to GET

have reduced school phobia as compared to their counterparts in the control group.

5. Gender was not a significant factor among those exposed to both CRT and GET on reducing school phobia among secondary school students. This shows that there are no significant differences between male and female students exposed to CRT and GET in reducing school phobia among secondary school students.

5.2 Conclusion

Based on the findings of this study, it was concluded that; Significance differences do not exist in the effect of CRT on reducing school phobia between male and female secondary school students. This implies that CRT treatment is effective in reducing school phobia among male and female student, Significance differences do not exist in the effect of GET on reducing school phobia between male and female secondary school students. This implies that GET treatment is effective in reducing school phobia among male and female students; significant difference exists in the effectiveness of CRT and GET on reducing school phobia among secondary school students. That is, CRT is more effective than GET in reduction of school phobia, significant difference exists between those exposed to CRT and those in control group on reducing of school phobia among secondary school students. That is, students exposed to CRT have reduced school phobia than those in the control group, significant difference exists between those exposed to GET and the control group on reducing of school phobia among secondary school students. That is, students exposed to GET have reduced school phobia as compared to their counterpart in the control group and Gender was not a

significant factor among those exposed to both CRT and GET on reducing school phobia among secondary school students. This implies shows that there is no significance differences between male and female students exposed to CRT and GET in reducing school phobia among secondary school students.

5.3 Recommendations

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

1. School Principals, Counsellors, Psychologists and form teachers should be exposed to training in CRT and GET in re-addressing students with school phobia.
2. Male and female secondary school students who exhibit school phobia should be exposed to CRT and GET.
3. Seminar, workshop and conferences should be organized for teachers, counsellors, psychologists on how to use CRT and GET in reducing school phobia.
4. CRT and GET should be emphasized to replace the outdated methods of handling school phobia for example, punishment, flooding among others

5.4 Suggestions for Further Studies

The focus of this study was directed at investigating the effect of cognitive restructuring and graded exposure counselling techniques in reducing school phobia among the secondary school students in Kaduna metropolis. Therefore, further studies are hereby suggested below:

1. Effects of CRT and GET on School Phobia among secondary school students across other states in Nigeria.

2. Effects of CRT and GET on School Phobia among primary school pupils irrespective of age and school location.
3. Effects of CRT and GET on other behavioural problems such as shyness, gender identity disorder, anxiety, fear of food, fear of sexual abuse, all forms of social phobia, anger, poor eating habit and so on.

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APPENDIX I

LETTER OF INTRODUCTION

Ph.D/EDUC/5201/2009-2010

DEPARTMENT OF EDUCATIONAL PSYCHOLOGY AND COUNSELLING
FACULTY OF EDUCATION,
AHMADU BELLO UNIVERSITY, ZARIA

Our Ref: Ph.D/EDUC/5201/2009-2010 Date: 30/4/2015

HON. COMMISSIONER
MINISTRY OF EDUCATION
KADUNA STATE

Dear Sir,

STUDENTS' FIELD RESEARCH

The Department of Educational Psychology and Counselling, Ahmadu Bello University, Zaria requires each student working for a Degree to complete a research project/ Thesis/Dissertation. They are therefore required to collect data for the research studies.

Most of them will need to be allowed access to certain relevant documents and some valuable information which you may have.

Please accord them all the necessary assistance.

TOPIC OF RESEARCH:

EFFECT OF COGNITIVE RESTRUCTURING AND GRADED EXPOSURE COUNSELLING TECHNIQUES ON SCHOOL PHOBIA AMONG SECONDARY SCHOOL STUDENTS IN KADUNA METROPOLIS.

Thank you for your continued cooperation.

Yours Sincerely,

Research Adviser

APPENDIX II

KADUNA STATE MINISTRY OF EDUCATION'S LETTER OF APPROVAL

MINISTRY OF EDUCATION
KADUNA STATE

)hone; 242222 PBX
missioner: 249721
Sec.: 062-249722
ram: SECEDUCATE
NCE/STAT.3/Vol.II/.....

State Secretariat
Independence Way,
Private Mail Bag No. 2017
Kaduna Nigeria

Date:_____

The Zonal Director
Sabon Tasha Zone.
Kaduna

PERMISSION TO CONDUCT RESEARCH

The bearer Mal/Mr./Mrs./Miss/Messrs: AHMED MUSTAPHA SHUAIBU
is a student from: A.B.U
ZARIA
for conducting a research on: EFFECTIVE OF COGNITIVE RE-STRUCTURING & GRADED EXPOSURE COUNSELLING TECHNIQUE ON SCHOOL PHOBIA AMONG SEC. SCHOOL STUDENTS IN KADUNA METROPOLIS.
for the award of Ph.d IN G.S.C.

I am directed to convey the Ministry of Education's approval for the above research.
Give him/her your maximum co-operation please.

Officer's Name Philip Bahago Signature
Designation AD/PRO/MRE Date 30/4/18

( )
For: Hon. Commissioner

APPENDIX III

KADUNA ZONE EDUCATION OFFICE'S PERMISSION TO CONDUCT RESEARCH

KADUNA STATE
MINISTRY OF EDUCATION
ZONAL EDUCATION OFFICE
KADUNA

062-218499
ail: zonaleduckad@yahoo.com

ADDRESS:
Doka Crescent
Private Mail Bag No. 2169
Kaduna - Nigeria

r Ref: KDZ/GEN/1018/VOL.I/115
r Ref: _____

Date: 12/0515

The Principal

.....

.....

PERMISSION TO CONDUCT RESEARCH
AHMED MUSTAPHA

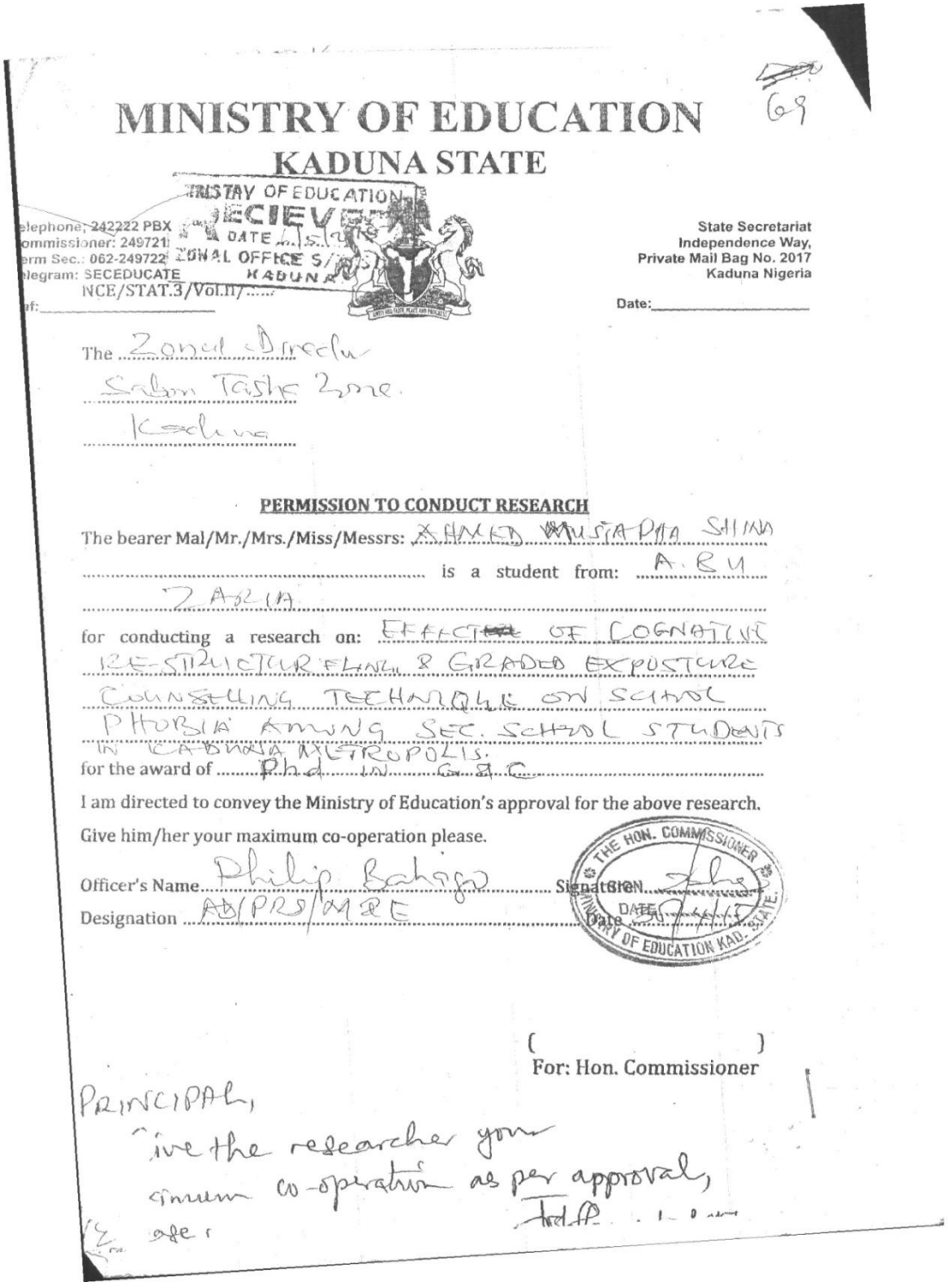
I am directed to inform you that the above bearer name is a student from Ahmadu Bello University Zaria, He wants to conduct a research on Effect on Cognitive Restructuring and Graded Exposure Counseling Techniques on school Phobia among secondary school students in Kaduna State metropolis; for the award of Ph.D in Guidance and Counseling (Education research).

Approval has been granted for him to carry out academic research. You are therefore requested to assist and give him the necessary cooperation to conduct the research in your school please.

Martha James
C.P.O
For: Director

APPENDIX IV

SABON TASSHA ZONE EDUCATION OFFICE'S PERMISSION TO CONDUCT RESEARCH



MINISTRY OF EDUCATION

KADUNA STATE

MINISTRY OF EDUCATION RECIEVED DATE ZONAL OFFICE S/ KADUNA

Telephone: 242222 PBX
Commissioner: 249721
Perm Sec.: 062-249722
Telegram: SECEDUCATE
Ref: NCE/STAT.3/Vol.II/.....

State Secretariat
Independence Way,
Private Mail Bag No. 2017
Kaduna Nigeria

Date:

The Zonal Directo
Sabon Tasha Zone.
Kaduna

PERMISSION TO CONDUCT RESEARCH

The bearer Mal/Mr./Mrs./Miss/Messrs: AHMED MUSTAPHA SHINA

is a student from: A.B.U ZARIA

for conducting a research on: EFFECTIVE OF COGNATIVE RE-STRUCTURING & GRADED EXPOSTURE COUNSELLING TECHNIQUE ON SCHOOL PHOBIA AMONG SEC. SCHOOL STUDENTS IN KADUNA METROPOLIS.

for the award of Phd IN G.S.C.

I am directed to convey the Ministry of Education's approval for the above research.

Give him/her your maximum co-operation please.

Officer's Name Philip Bahago Signature

Designation ADPRS/MRE Date

THE HON. COMMISSIONER MINISTRY OF EDUCATION KAD. STATE. DATE

( )
For: Hon. Commissioner

PRINCIPAL,
Give the researcher your
maximum co-operation as per approval,
Thank
Date:

APPENDIX V

SCREEN FOR CHILD ANXIETY RELATED DISORDERS (SCARED) CHILD VERSION

Name _____

Date:_____

Directions:

Below is a list of sentences that describe how people feel. Read each phrase and decide if it is "Not True OR Hardly Ever True" or somewhat True" or "Very True or Often True" for you. Then, for each sentence, fill in one circle that responds to the response that seems to describe you *for the last 3 months.*

S/No		1 Not True or Hardly Ever True	2 Somewhat True or Sometimes True	3 Very true or Often True	
1.	When I feel frightened, it is hard to breathe	O	O	O	PN
2.	I get headaches when I am at school.	O	O	O	SH
3.	I don't like to be with people I don't know well.	O	O	O	SC
4.	I get scared if I sleep away from home.	O	O	O	SP
5.	I worry about other people liking me	O	O	O	GD
6.	When I get frightened, I feel like passing out	O	O	O	PN
7.	I am nervous	O	O	O	GD
8.	I follow my mother or father wherever they go.	O	O	O	SP
9.	People tell me that I look nervous	O	O	O	PN
10.	I feel nervous with people I don't know well	O	O	O	SC
11.	I get stomach aches at school.	O	O	O	SH
12.	When I get frightened, I feel like I am going crazy	O	O	O	PN
13.	I worry about sleeping alone	O	O	O	SP
14.	I worry about being as good as other kids	O	O	O	GD
15.	When I get frightened I feel like things are not real	O	O	O	PN
16.	I have nightmares about something	O	O	O	SP

	bad happening to my parents				
17.	I worry about going to school	O	O	O	SH
18.	When I get frightened my heart beats fast	O	O	O	PN
19.	I get shaky	O	O	O	PN
20.	I have nightmares about something bad happening to me	O	O	O	SP
		1 Not True or Hardly Ever True	**2 Somewhat True or Sometimes True**	**3 Very true or Often True**	
21.	I worry about things working out for me.	O	O	O	GD
22.	When I get frightened, I sweat a lot.	O	O	O	PN
23.	I am a worrier.	O	O	O	GD
24.	I get really frightened for no reason at all	O	O	O	PN
25.	I am afraid to be alone in the house	O	O	O	SP
26.	It is hard for me to talk with people I don't know well.	O	O	O	SC
27.	When I get frightened, I feel like I am choking	O	O	O	PN
28.	People tell me that I worry too much	O	O	O	GD
29.	I don't like to be away from my family	O	O	O	SP
30.	I am afraid of having anxiety (or panic) attacks	O	O	O	PN
31.	I worry that something bad might happen to my parents	O	O	O	SP
32.	I feel shy with people I don't know well	O	O	O	SC
33.	I worry about what is going to happen in future	O	O	O	GD
34.	When I get frightened, I feel like throwing up	O	O	O	PN
35.	I worry about how well I do things				GD
36.	I am scared to go to school	O	O	O	SH
37.	I worry about things that have already happened	O	O	O	GD
38.	When I get frightened, I feel dizzy	O	O	O	PN
39.	I fell nervous when I am with other children or adults and I have to do something while they watch me (for example: read aloud, speak, play a game, play a sport).	O	O	O	SC
40.	I feel nervous when I am going to parties, dances, or any place where	O	O	O	SC

	there will be people that I don't know well				
41.	I am shy	O	O	O	SC

TOTAL	PN =

Scoring:

A total score of ≥**25** may indicate the presence of **Scolionophobia Disorder,** and Scores higher than 30 are more re specific

A score of **7** for item 1,6,9,12,15,18,19,22,24,27,30,34,38 may indicate **Panic Disorder or Significant Somatic Symptoms.**

A score of **9** for item 5,7,14,21,23,28,33,35,37 may indicate **Generalized Anxiety Disorder.** **GD =**

A score of **5** for item 4, 8,13,16,20,25,29,31 may indicate **Separation Anxiety SOC** **SP =**

A score of **8** for item 3,10,26,32,39,40,41 may indicate **Social Anxiety Disorder** **SC =**

A score of **3** for item 2, 11, 17, 36, may indicate **Significant School Avoidance** **SH =**

For children ages 8 to 11, it is recommended that the clinician explain all questions, or have the child answer the questionnaire sittin with an adult in case they have any questions

APPENDIX VI

EXPERIMENTAL GROUP1: COGNITIVE RESTRUCTURING COUNSELLING SESSIONS

Session one

Objectives i) Introduction of selves by both the counsellor and the students;

ii) Explain the mission of the counsellor to the clients.

iii) Establish a counselling relationship with the clients

Step I: The counsellor introduces self to the clients

Step t II: The counsellor introduces the to the clients what relationship they are both to enter, which is counsellor/clients relationship

Step III: The counsellor explains to the clients the counsellor's responsibilities while the counselling sessions last

Step IV: The counsellor also explains to the clients their own responsibilities

Step V: The counsellor then emphasizes the importance of developing a collaborative relationship for the success of the counselling process.

Step VI: The counsellor then ask the clients to respond to those points by accepting the commencements of the process or otherwise

Step VII: The counsellor then request the clients to ask any questions on what has been in discussed in the session.

Step VIII: The counsellor then informs the clients about coming to the end of the session.

EXPERIMENTAL GROUP 1: COGNITIVE RESTRUCTURING COUNSELLING SCHOOLS
Session Two

Objectives:

1. To properly explain to the clients what school phobia is.
2. To introduce to the clients what counselling treatment can do to change behavior;
3. To introduce cognitive restructuring counselling technique to the client.

Steps I: The counsellor welcomes the students to the second session of the relationship;

II. The counsellor introduces to the students what relationship they are about to enter, which is counsellor/client relationship;

III. The counsellor explains to the students the counsellor's responsibilities while counselling sessions last;

IV. The counsellor also explains to the students their own responsibilities For example. punctuality, follow counsellor's instructions, indicate when an event makes you fear, and indicate when fear reduces or disappears and so on.

V. The counsellor then explains to the students the importance of adopting a collaborative relationship for the success of the sessions.

VI. The counsellor then asks the students to respond to these points by accepting the commencement of the process or otherwise;

VII. The counsellor then explains to the students what cognitive restructuring technique is and how it can be used to reduce or eradicate school phobia.

VIII. The goals to the treatment will then be set collectively between the counsellor and the students.

IX. The counsellor gives the students home work which will form part of the session to come. They are to list ten school phobia.

EXPERIMENTAL GROUP 1: COGNITIVE RESTRUCTURING COUNSELLING SESSIONS

Session Three

Objectives: i. Identify evidences against the negative thoughts mentioned in the previous session

ii. Examine the evidence against the negative thoughts mentioned in the previous session

iii. Identify the unwanted behaviours exhibited by the client, which are mainly caused by the negative thoughts.

Step I: The counsellor warmly welcomes clients into another session, expressing unconditional regards for them. Some complimentary comments would be made by the counsellor on the clients to make them feel at home.

Step II: The counsellor will read out the home works (negative thoughts) about school phobia as forwarded by the clients. This will be done to refresh the minds of both the counsellor and clients.

Step III: Each of the negative thoughts will be viewed in its own merit, looking at its negative effects on the clients and the behaviour that the thoughts precipitate.

Step IV: The clients will be guided to identify how these thoughts affect their fear of school.

Step V: The counsellor will then inform the clients of coming to the end of the session, but will ask if the client has anything to enquire or bring forward.

Step VI: A homework will be given to the students requesting them to come up with at least ten difficulties (school phobia) they have.

EXPERIMENTAL GROUP 1: COGNITIVE RESTRUCTURING COUNSELLING SESSIONS

Session Four

Objectives: i. Challenge the distorted thoughts identified in the previous sessions

ii. Guide the client to positively think of better alternatives to challenge their distorted thoughts.

Step I As usual, the counsellor welcomes the client into another session of the treatment.

Step II The counsellor leads the clients in recapitulating on the previous sessions and the success so far achieved.

Step III Having discussed the negative thoughts in previous sessions, the counsellor now defines what a normal and positive thinking is, as against a distorted thought.

Step IV The counsellor, with the cooperation of the clients, then begins to challenge the distorted thoughts presented by the clients by picking each thought and exposing its faults.

Step V The counsellor then guides the client in selecting substitute positive thoughts. In this sessions, four out of the fifteen negative thoughts will be exposed and substituted with more realistic thoughts.

Step VI The counsellor then clearly offers his support to the clients appreciating the kind of collaborative sessions they have had.

Step VII The clients would then be asked if they have any observation to make on the progress so far made.

Step VIII The session then ends with an assignment for the clients to think deeply on the substitution of the negative thoughts with more realistic ones, and report back in the next session how such substitution has affected her feelings and behaviour towards anything that has to do with attending school.

EXPERIMENTAL GROUP I: COGNITIVE RESTRUCURING COUNSELLING SESSIONS

Session Five

Objectives: i) To continue to challenge the distorted and unrealistic thoughts identified in the previous sessions.

ii) Also continue to guide the client to positively think better alternatives to her challenged distorted thoughts.

Step I: As usual, the counsellor welcomes the clients into another session of the treatment.

Step II: The counsellor leads the clients in recapitulating on the previous sessions and the success so far achieved.

Step III: Having discussed the negative thoughts in previous sessions, the counsellor now defines what a normal and positive thinking is, as against a distorted thought.

Step IV: The counsellor, with the cooperation of the clients, then continues to challenge the distorted thoughts presented by the client, by picking each thought and exposing its faults.

Step V: The counsellor then guides the clients in selecting substitute positive thoughts. In this session four out of the fifteen negative thoughts will be exposed and substituted with more realistic thoughts.

Step VI: The counsellor then clearly offers his support to the clients appreciating the kind of collaborative sessions they have had.

Step VII: The clients would then be asked if they have any observations to make on the progress so far made.

Step VIII: The session then ends with an assignment for the clients to think deeply on the substitution of the negative thoughts with more realistic ones, and report back in the next session how such substitution has affected their feelings and behaviour towards fear of school.

EXPERIMENTAL GROUP I: COGNITIVE RESTRUCTURING COUNSELLING SESSIONS

Session Six

Objectives:

i) To continue to challenge the distorted and unrealistic thoughts identified in the previous session

ii) Also continue to guide the client to positively think better alternatives to her challenged distorted thoughts.

Step I: As usual, the counsellor welcomes the clients into another session of the treatment.

Step II: The counsellor leads the clients in recapitulating on the previous sessions and the success so far achieved.

Step III: Having discussed the negative thoughts in previous sessions, the counsellor now defines what a normal and positive thinking is, as against a distorted thought.

Step IV: The counsellor, with the cooperation of the clients, then continues to challenge the distorted thoughts presented by the client, by picking each thought and exposing its faults.

Step V: The counsellor then guides the clients in selecting substitute positive thoughts. In this session four out of the fifteen negative thoughts will be exposed and substituted with more realistic thoughts.

Step VI: The counsellor then clearly offers his support to the clients appreciating the kind of collaborative sessions they have had.

Step VII: The client would then be asked if they have any observation to make on the progress so far made.

Step VIII: The session then ends with an assignment for the clients to think deeply on the substitution of the negative thoughts with more realistic ones, and report back in the next session how such substitution has affected their feelings and behaviour towards school phobia.

EXPERIMENTAL GROUP I: COGNITIVE RESTRUCTURING COUNSELLING SESSIONS

Session Seven

Objectives:

i) To continue to challenge the distorted and unrealistic thoughts identified in the previous session

ii) Also continue to guide the clients to positively think better alternatives to their challenged distorted thoughts.

Step I: The counsellor welcomes the clients as usual, establishing a close rapport with them.

Step II: The counsellor also reviews the progress so far made and the way forward.

Step III: The counsellor then requests the clients to explain to him how the replacement of the distorted thoughts has affected their feelings and behaviour

Step IV: Continue to challenge the remaining distorted thoughts from where the last session stopped.

Step V: Again, while challenging the negative thoughts, the counsellor guides the clients in substituting the negative thoughts with more realistic ones. The remaining three unrealistic thoughts will be replaced during this session.

Step VI: At this point, the session will be rounded off by informing the clients and giving them the opportunity to make any observation deemed necessary.

EXPERIMENTAL GROUP 1: COGNITIVE RESTRUCTURING COUNSELLING SESSIONS

Session Eight

Objectives: (i) to present the client other possible automatic thoughts which they did not present.

ii) To present to the client possible faulty behaviour that the automatic thought may cause.

Iii) To challenge the automatic thoughts and explain how they can negatively affect the students.

Step I The counsellor welcomes the clients to another session.

II Make reference to the automatic thoughts the clients presented, which have been dealt with.

III List some other faulty thinking or automatic thoughts which were presented by other students.

IV Critically look at the faults in such thoughts by letting the students themselves analyze and criticize them before the counsellor.

V Discuss possible behaviour that the automatic thoughts could cause and their unhelpful nature.

VI Challenge both the automatic thoughts and possible unhelpful behaviour they cause.

VII Lets the students ask questions or make further comments.

VIII Session comes to an end.

EXPERIMENTAL GROUP 1: COGNITIVE RESTRUCTURING COUNSELLING SESSIONS

Session Nine

Objective: I) Replacement negative thought with desirable behaviour.

II) Modelling desirable behaviour

III) Systematic reinforcing desirable behaviour

Step i) The counsellor warmly welcomes the client into another session of the treatment.

ii) The counsellor appreciates the collaborative efforts they had throughout the weeks of the counselling process

iii) The client will be requested to express what resulted from the substitution of her distorted thoughts with more realistic thoughts.

Iv) Counsellor lead students in the performance of desirable behaviour.

v) Modelling of desirable behaviour to clients.

vi) Systematic reinforcement of desirable behaviour to client explanation, demonstration and praises of clients who exhibit such.

vii) Clients are allowed to make comments and ask questions.

viii) Session comes to an end.

EXPERIMENTAL GROUP 1: COGNITIVE RESTRUCTURING COUNSELLIG SESSIONS

Session Ten

Objective: I) Continuation of modelling of desirable behaviour.

II) Systematic positive reinforcement of desirable behaviour continues.

III) Examining the effect of the treatment on the students.

Step i) The counsellor warmly welcomes the clients into another session of the treatment.

ii) The counsellor appreciates the collaborative efforts they had throughout the weeks of the counselling process.

Step ii) Counsellor models desirable behaviour.

Step iii) Counsellor leads students to model desirable behaviour.

Step iv) Systematic positive reinforcement is carried out by counsellor and students of desirable behaviour.

Step v) Counsellor examines the effect of treatment on the clients.

Step vi) Gives clients opportunity to make comments and ask questions

Step vii) Session comes to an end.

EXPERIMENTAL GROUP 1: COGNITIVE RESTRUCTURING COUNSELLIG SESSIONS

Session Eleven

Objective: i) To ascertain the effects of the counselling process carried out in the last ten sessions.

ii) To discuss other relevant issues not discussed in the previous session.

iv) To make students make comment and model desirable behaviour.

Step i) the counsellor warmly welcomes the client into the final session of the treatment.

ii) The counsellor appreciates the collaborative efforts they had throughout the weeks of the counselling process

iii) The client will be requested to express what resulted from the substitution of her distorted thoughts with more realistic thoughts.

iv) Discuss some general aspects of school phobia and the counselling process

v) Counsellor allows students to make comments and ask questions on the treatment made so far.

vii) Session comes to an end.

EXPERIMENTAL GROUP 1: COGNITIVE RESTRUCTURING COUNSELLIG SESSIONS

Session Twelve

Objective: I: To examine the effect of the treatment on the students.

II: To discuss other relevant issue about the treatment and recapitulate previous session.

III) To round off counselling relationship.

VI) To administer the post-test on the students.

Step i) A short drama is staged on modelling desirable behaviour against school phobia

Step ii) Counsellor treats comments and questions of students.

Step iii) Counsellor appreciates the collaborative efforts of the students.

Step iv) Counsellor informs and administers SCARED to the students.

Step v) Counsellor informs the students about the end of the treatment.

APPENDIX VII

EXPERIMENTAL GROUP II: GRADED EXPOSURE COUNSELLING SESSIONS

Session one

Objectives
i) Introduction of selves by both the counsellor and the students;
ii) Explain the mission of the counsellor to the clients.
iii) Establish a counselling relationship with the clients

Step I: The counsellor introduces self to the clients.

Step t II: The counsellor introduces to the clients what relationship they are both to enter, which is counsellor/clients relationship.

Step III: The counsellor explains to the client the counsellor's responsibilities while the counselling sessions last.

Step IV: The counsellor also explains to the clients his own responsibilities.

Step V: The counsellor then emphasizes the importance of developing a collaborative relationship for the success of the counselling process.

Step VI: The counsellor then ask the clients to respond to those points by accepting the commencements of the process or otherwise.

Step VII: The counsellor them request the clients to ask any questions on what has been in discussed in the session.

Step VIII: The counsellor then informs the clients about the coming to the end of the session.

EXPERIMENTAL GROUP II: GRADED EXPOSURE COUNSELLING SESSIONS

Session Two

Objectives:

i) To properly explain to the client what school phobia is all about.

ii) To introduce to the client what counselling treatment can do to change behavior;

iii) To introduce graded exposure counselling technique to the client.

Step I: The counsellor welcomes the students to the second session of the relationship;

II: The counsellor introduces to the students what relationship they are about to enter, which is counsellor/client relationship.

III: The counsellor explains to the students the counsellor's responsibilities while counselling sessions last.

IV: The counsellor also explains to the students their own responsibilities eg follow user instructions, punctuality, regular attendance, saying the truth and so on.

V) The counsellor then explains to the students the importance of adopting a collaborative relationship for the success of the sessions.

VI) The counsellor then asks the students to respond to these points by accepting the

commencement of the process or otherwise;

VII) The counsellor then explains to the students what graded exposure is and how it can be used to minimize the school phobia.

VIII) The goals to the treatment will then be set collectively between the counsellor and the students.

IX) The counsellor gives the students home work which will form part of the session to come. They to list ten school phobias For example. List some reasons why you think students may have school phobia.

X) The counselor informs students that we have come to the end of the session.

EXPERIMENTAL GROUP II: GRADED EXPOSURE COUNSELLING SESSIONS

Session Three(School Phobia Hierarchy)

Objectives

I) Introduce the client to the concept of school phobia hierarchy in graded exposure counselling
II) Identify the events that precipitate school phobia to the client.
III) Guide the clients in arranging the school phobia provoking event according to its intensity (SUD) in the individual.

STEP i: The counsellor will welcome the clients as usual, into another stage of the graded exposure counselling process, called school phobia hierarchy. Details of what it means will be explained to clients after brief discussion on the homework.

ii: The counsellor then explains to the clients what school phobia hierarchy is, and its position in the graded exposure counselling technique.

iii: The clients will be informed that they are most responsible for the success of the stage, because it is what they feel in their minds that must be truthfully told, and it will be the main focus.

iv: The counsellor and students will use the homework submitted for a sample of a school phobia hierarchy .

v: The counsellor presents various school phobia images of events or situations and discuss them with the students.

vi: The clients will then be asked to mention related events or situations that make them sometimes fear or refuse school.

vii: With the identification of the events twelve most prevailing of the events will be shortlisted. The clients will then be taught how to assign **Subjective Unit of Distress (SUD)** to each of the event so on the scale 0-100. These ratings will be collected and organized out of which 10 most school phobia provoking events will be decided. It is anticipated that the list may look like the following:

*Stand with the counsellor in front of the school

*. To approach the school wall

* To walk near the sidewalk

* To reach the beginning of the school front entrance stairs

* To reach the end of the school front entrance stairs

*to approach the school front gate

* To stay at the verandah of the classroom

*To enter an empty classroom

*To enter the classroom when one or two students are there

*To enter the classroom filled up with students few more students

*To sit in the school desk when the teacher and classmates are there

*To sit in the school desk with a full classroom

* And other related school phobia situations as may be mentioned by the students.

Step viii: The counsellor gives clients homework to rate their school phobia according to their intensity.

Step ix: The session comes to an end. The counsellor asks client to make any observations on the process just followed. The counsellor informs of the students to bring their school phobia hierarchies to the next sessions.

EXPERIMENTAL GROUP II: GRADED EXPOSURE COUNSELLING SESSIONS

Session Four (Graded Exposure)

Objective:

i. To review the client's understanding of school phobia hierarchy:

ii. To explain to the client the importance of school phobia hierarchy in graded exposure counselling:

iii. To exemplify the levels of school phobia events;

iv. To introduce to the client, the concept of Subjective Unit of Discomfort (SUD).

Step 1: The counsellor welcomes the clients to another stage in the counselling process

ii: The counsellor asks the clients to explain what they understands by school phobia hierarchy.

iii: The counsellor gives more explanation of school phobia hierarchy with some applicable examples (i.e. the computer images).

iv: The counsellor explains how the hierarchy differs between individuals as some school phobia are more frightening to some people than others.

v. The clients are asked what events, situations, persons, or places of the school that makes them more frightened.

vi. The clients are then given a homework to list the events that makes them fear school. They are to present the list in the next session according to their individual SUD

vii. The clients are given the opportunity to ask any questions relevant to what has been

viii. The clients are introduced to the concept of subjective unit of distress (SUD) , its meaning and rating process

ix. The clients are then requested to give example of events that makes them fear or refuse school

x. Counsellor presents images of school phobia provoking events and asks students to practice imagining them (the events) and arranging them in hierarchy.

xi. The clients are given the opportunity to rate the events creating the SUDs ranging from 0-10.

xii. Students are asked to rate their school phobia according to SUD (as homework and present in the next session).

xiii. Counsellor informs students about the coming to an end of that session.

EXPERIMENTAL GROUP II: GRADED EXPOSURE COUNSELLING SESSIONS

Session Five (Graded Exposure)

Objective:

I) To introduce students to the process in graded exposure counseling technique.

II) To commence the exposure to fear of school provoking events or situations so as to confront them from the students' thoughts.

III) To commence the exposure process of the events according to hierarchy (i.e. from the lowest to the highest school phobia inducing events).

Step: i) The counsellor welcomes students back to another counselling session.

ii) Counsellor reviews the last session with the students with the homework

iv) The students are reminded of the school phobia hierarchy constructed during last session. Counsellor informs the students to signify by raising their left hand up if and when they fear any of the events or situations they are exposed to.

v) The counsellor informs the students of the commencement of the graded exposure treatment.

vi) Graded exposure on the two lower order of school phobia through visit to the end of the school fence and later to the school gate.

vii) Counsellor gives students opportunities to make comments and also answer their questions.

viii) Counsellor informs students about the end of this session.

EXPERIMENTAL GROUP II: GRADED EXPOSURE COUNSELLING SESSIONS

Session Six (Graded Exposure)

Objective:

I) To continue the process in graded exposure counseling technique.

II) To continue the graded exposure to fear of school provoking events or situations so as to confront them from the students' thoughts.

III) To commence the exposure process of the events according to hierarchy (i.e. from the lowest to the highest school phobia inducing events).

Step: i) The counselor welcomes students back to another counselling session.

ii) Counsellor reviews the last session with the students with the homework

iii) The students are reminded of the school phobia hierarchy constructed earlier. Counsellor reminds the students to signify by raising their left hand up if and when they fear any of the events or situations they are exposed to.

iv) The counsellor informs the students of the commencement of the graded exposure treatment.

v) Graded exposure on the four lower order of school phobia.

vi) Counsellor gives students opportunities to make comments and also answer their questions.

vii) Counsellor informs students about the end of this session.

EXPERIMENTAL GROUP II: GRADED EXPOSURE COUNSELLING SESSIONS

Session Seven (Graded Exposure)

Objective

i. to review the achievement recorded in the last session:
ii. to review the effects the client is beginning to feel on his school phobia
iii. to continue with the graded exposure processes on the school phobia provoking events.

Step 1: The counsellor welcomes back the clients to another session of the treatment

Step II: The counsellor will request the clients to individually express their feelings about the effects of the treatment on them.

Step iii: The clients will be requested to go into the next scene, which is client to enter the school. As usual, the clients are to raise their hands when they fear the scene. The counsellor will then ask him to stop the scene and repeat until the feared situation is overcome.

Step iv: The client will then be told to approach an empty classroom when there is nobody there also be told to raise their hands when they are afraid of any situation. The counsellor will then tell him to stop the scene, and repeat until the fear disappears.

Step v: The session will be ended up by asking the client to make his observation.

EXPERIMENTAL GROUP II: GRADED EXPOSURE COUNSELLING SESSIONS

Session Eight (Graded Exposure)

Objective

I) To recapitulate on the achievement made so far

II) To find out about the feelings of the clients

III) To continue the graded exposure process

STEP i) The counsellor welcomes the students back to the counselling session

STEP ii) The counsellor ask students about their feelings on the achievement made so far.

STEP iii) The counsellor listens to students' comments.

STEP iv) The counsellor engages the students on the next two higher stages of the school i.e. The students enter the classroom when one or two students (without a teacher) are there.

STEP v) The Counsellor makes the students enter the classroom when more students (without a teacher) are there

STEP vi) The counselor informs the students about the end of the session.

EXPERIMENTAL GROUP II: GRADED EXPOSURE COUNSELLING SESSIONS

Sessions Nine (Graded Exposure)

Objective:

I) To recapitulating the achievement so far recorded;

II) To assess the feeling of the clients about the session

III) To continue with the treatment procedure.

Step i: The clients will be welcomed back into another session in the treatment

Step ii: The clients will be requested to give account of the effects of the treatment far felt in their school phobia

Step iii: The clients will be guided to enter a full class when a teacher is there. They will be requested to raise their hands when they have fear of the scene. The scene will be stopped and repeated until the fear disappeared.

Step IV: The counsellor asks about the students' feeling and about the effects of the treatment.

Step v: The counsellor informs the students about the end of the session.

EXPERIMENTAL GROUP II: GRADED EXPOSURE COUNSELLING SESSIONS

Sessions Ten (Graded Exposure)

Objective:

I) To review the achievement recorded in the last session.

II) To review the effect the clients is feeling on school phobia.

III) To continue with the next higher level of school phobia hierarchy

STEP i : The counsellor welcomes the clients back to the counselling session.

STEP ii: The counsellor requests the clients to express their feelings about the effects of the treatment.

STEP iii: The counsellor leads the students to the two last stages of the school phobia hierarchy; one after the other. The least fear provoking stage, as usual, must be confronted by the clients before the higher fear provoking one.

STEP iv: The counsellor makes the clients repeat any level or go back from lower to higher level of the hierarchy whenever there is any need for that.

STEP vi: The counsellor asks students to express their feeling on the effect of the treatment on their school phobia.

STEP vii: The counsellor informs the clients about the end of that session.

EXPERIMENTAL GROUP II: GRADED EPAXPOSURE COUNSELLING SESSIONS

Sessions Eleven (Graded Exposure)

Objective:

I) To review the last session

II) To assess the feelings of the clients about the treatment

III) To continue graded exposure

STEP i: The counsellor welcomes the clients back to the session

STEP ii: The clients are made to express their feeling about the effect of the treatment on their feeling.

STEP iii: Students are engaged in more graded exposure

STEP iv: Students are made to make comments about the session

STEP v: The counsellor informs the clients about the end of that session.

EXPERIMENTAL GROUP II: GRADED EXPOSURE COUNSELLING SESSIONS

Sessions Twelve (Graded Exposure)

Objective: I: To examine the effect of the treatment on the students.

II: To discuss other relevant issue about the treatment and recapitulate previous session.

III) To round off counselling relationship.

VI) To administer the post-test on the students.

Step i) A short drama is staged on modelling desirable behavior against school phobia

Step ii) Counsellor treats comments and questions of students.

Step iii) Counsellor appreciates the collaborative efforts of the students.

Step iv) Counsellor informs and administers SCARED to the students.

Step v) Counsellor informs the students about the end of the treatment.