EFFECTS OF SOCIAL SKILLS TRAINING AND TRANSACTIONAL ANALYSIS COUNSELLING TECHNIQUES ON SOCIAL WITHDRAWAL BEHAVIOUR AMONG SECONDARY SCHOOL STUDENTS IN FEDERAL CAPITAL TERRITORY, NIGERIA

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A THESIS SUBMITTED TO THE SCHOOL OF POSTGRADUATE STUDIES, AHMADU BELLO UNIVERSITY, IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF THE DEGREE OF DOCTOR OF PHILOSOPHY IN GUIDANCE AND COUNSELLING

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Declaration

The researcher hereby declare that the work in this thesis entitled **"Effects of Social Skills Training and Transactional Analysis Counselling Techniques on Social Withdrawal behaviour among senior secondary school students in Federal Capital Territory, Nigeria"** has been carried out by her in the Department of Educational Psychology and Counselling, Ahmadu Bello University, Zaria. The information derived from the literature review has been duly acknowledged in the text and lists of references were provided. No part of this Dissertation was previously presented for another degree or diploma at this or any other institution.

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CERTIFICATION

This is to certify that this research work entitled **"Effect Of Social Skills Training And Transactional Analysis Counselling Techniques On Social Withdrawal Behaviour Among Senior Secondary School Students In Federal Capital Territory, Nigeria"** by Josephine Olayinka AKINTUNDE has been read and meet the regulation governing the award of PhD in Guidance and Counselling of the Ahmadu Bello University, Zaria and is approved for its contribution to knowledge and literary presentation.

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DEDICATION

This thesis is dedicated to God Almighty and to the researcher's late Mother Mrs. Victoria Olufemi Awofegha (VOA) – a Mother in a million; she really misses her mother but celebrates the mother even in death (Rest in peace abiyamo tooto)

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ABSTRACT

This study examined the effect of Social Skills Training (SST) and Transactional Analysis (TA) Counselling Techniques on Social Withdrawal Behaviour (SWB) among secondary school students in Federal Capital Territory, Abuja Nigeria. This study adopted quasi experimental design involving pretest - posttest control group. Six (6) objectives with corresponding research questions and hypotheses guided the study. The population of the study consisted of socially withdrawn year 2 students in the Government Secondary Schools in the Federal Capital Territory (FCT); purposive sampling technique was used to select the sample size of sixty (60) students. The 60 participants were assigned into three groups of two experimental groups and control group with 20 in each group. The instrument used for selection was Social Withdrawal Checklist (SWC), while main instrument Social Withdrawal Questionnaire (SWQ) adapted and modified by the researcher was used for data collection. The data collected from the study were analyzed using One-way Analysis of Covariance (ANCOVA) to determine the proportion of the variance of the criterion which exists before treatment and what was obtained after. The findings from result revealed that SSTCT was significantly effective in reducing both moderate and high levels of SWB among Senior Secondary School students; it also revealed that TACT was effective in the reduction of moderate and high levels of SWB among Senior Secondary School students. It also revealed that both SSTCT and TACT are relatively effective in reducing moderate and high levels of SWB among secondary school students. It also revealed that SSTCT was more effective compared to TACT. Based on the findings, it was concluded that both SSTCT and TACT are effective treatment technique in reducing SWB students. The researcher recommended that the school Counsellors, Psychologists and Social Workers should endeavour to make use of both SSTCT and TACT in the treatment of SWB among Secondary school students.

OPERATIONAL DEFINITION OF TERMS

The following terms used in this study was operationally defined as follows:

***Social withdrawal behaviour*:** This is when a student demonstrates typically very low rates of social behaviour in interactions with others such as peers and other people around.

Social Skills Training (SST): This is a type of psychotherapy that is aimed at facilitating, improving and helping the students to improve on their social skills, interact and communicate properly well so they can become socially competent.

Transactional Analysis (TA): This is a technique of personality and communication as well as a talking therapy which involves skillful questioning carried out in the form of one-on-one counselling aimed at helping students to improve their personal and social functioning.

Moderate level of Social Withdrawal Behaviour: This is the used to indicate the students exhibiting Social Withdrawal Behaviour that is yet to get to the extreme but still need to be treated so that the behaviour will not escalate.

High level of Social Withdrawal Behaviour: This has to do with the extreme point of Social Withdrawal Behaviour.

Relative Effect: This is the ratios of outcome measures between treatment comparison group in the study. It expresses the outcome in one group to that in the other.

CHAPTER ONE

INTRODUCTION

1.1 Background to the study

Secondary school students are at their adolescent stage which is an intense time of emotional and physical change in young person's life. Developing appropriate emotions and controlling them is very essential during adolescence, meeting social demands and eliminating the damaging effects of the emotions on attitudes, habits, behaviour and physical well-being is essential. Adolescence is a period when the individual experience a lot of feelings and will want to express their feelings.Some adolescents become very quiet and withdrawn socially while some enjoys being alone, separated from their peers for hours and days; some prefer working, playing and studying alone.

It can be especially challenging for adolescents to establish and maintain competent social interactions because of many developmental changes that occur. The physical and emotional changes associated with puberty and the more advanced cognitive and verbal abilities affect the adolescent's interactions with both peers and adults. Adolescents experience a variety of other changes that affect social relationships, including school and peer group changes, changes in family structure or functioning and alterations in societal and community expectations.Some adolescents either take pleasure in activities that will not make them interact with others but rather interact with equipmentor machines such as computer, automobile, toys, or get involved in designing homes, writing scripts, poems, lyrics, book chapters and so on, hence they have distinct need for solitude. Conversely, there are some other individuals who when they are in the social company of their peers avoid others and actively choose to be alone so as to escape the initiation and maintaining interpersonal relationship. There are others who prefer to live in solitude because of their home background and upbringing while they are much younger. All these cases of adolescents avoiding social company, living in solitude, preferring to be alone even when in the company of confreres and avoidance in initiating and maintaining interpersonal relationship can be construed as Social Withdrawal Behaviour.

Social Withdrawal Behaviour is closely related to shyness, social inhibition and social incompetence as well as social isolation; it is an absolute form of avoidance of social contact and communication. It refers to the consistent (across situations and over time) display of all forms of solitary behaviour when encountering familiar and or unfamiliar peers; simply put social withdrawal is construed as isolating oneself from the peer group, (Rubin&Asendorpf, 1993).Socially withdrawn, in the views of Ogunbawo (1988), is a person who demonstrates typically very low rates of social behaviour in interactions with others such as peers or mates. In affirmation, Nnodum (2001) advanced that socially, an isolate could be described as an individual who is unwilling or is finding it difficult to interact or associate with others such as peers or classmates. Being an isolate is a manifestation of extreme or high level of social

withdrawal. It is a type of social seclusion and the individuals are often seen as being socially awkward. Socially withdrawn students lack the necessary social skills that enhance social interaction and this could be responsible for withdrawing from or keeping away from social interaction, scenes or contacts with others. Nnodum (2001) remarks that isolates are unable to solicit for assistance from people around them; they find it difficult to ask for clarifications or questions on confusing or unclear issues, initiate, participate in and terminate conversations or discussions.The experience of social isolation among pupils in schools is a phenomenon that is presently taking a devastating dimension in the school environment in Nigeria. (Nlemadim, Falaye & Okoiye, 2013).

The lack of social interaction in childhood may result from a variety of causes, including social fear and anxiety or a preference for solitude. From early childhood through to adolescence, socially withdrawn children are concurrently and predictively at risk for a wide range of negative adjustment outcomes, including socio-emotional difficulties (for example, anxiety, low self-esteem, depressive symptoms, and internalizing problems), peer difficulties (for example, rejection, victimization, poor friendship quality), and school difficulties (for example, poor-quality teacher-child relationships, academic difficulties, school avoidance). But the tendency to withdraw from others appears to be moderately stable over time from childhood to adolescence and across diverse social situations(Rubin,Coplan, &Bowker, 2009). Social Withdrawal behaviour in adolescents has been associated with such constructs as shyness, behaviour inhibition, isolation and rejection, social reticence, passivity and peer neglect. Social Withdrawal behaviour is viewed as emanating from such constructs as internal factors as anxiety, negative self-esteem and self-perceived difficulties in social skills and social relationship, (Rubin &Asendorpf, 1993).

Some studies in the past have found that social withdrawal predicts depression symptoms for children who had insecure attachment relationship with their parents (Gullone, King, &Ollendick, 2006). Social Withdrawal is listed as a symptom or maker of anxiety or phobic disorder and major depression. Most socially withdrawn youth tend to experience significant anxiety regarding their social experience (Ginsburg & Grover, 2005). They may feel a great deal of fear in tackling common school situations such as answering the teacher's questions in front of the whole class, speaking in public, asking question of the teacher and other students or initiating conversation with the peers. They are less likely than their peers to engage in social problem solving after they have experience a failure in trying to deal with a social situation. They are likely to give up and withdraw from social situations rather than experiencing the discomfort and embarrassment they perceive will occur if they fail in this situation, (Marshall 2001). In addition to exhibiting shyness, withdrawal and not interacting with peers, socially withdrawn or anxious youth often have poor problem solving skills. (Velting& Albano, 2001).In any classroom, there may be some children who are more quiet, shy or submissive than others and spend an obviously little amount of time interacting with others; these children are referred to as socially withdrawn (Rubin, Stewart& Coplan, 1995). Since social interaction is crucial to the normal

development of a child, the issue of social withdrawal has received prolonged attention from researchers, educators and parents (Rubin & Asendorpf , 1993b).

Socially Withdrawn children and young adolescents often experience peer rejection and victimization, they feel and think poorly of themselves. One of the most important skill parents, teachers and social network of the child accomplish is to teach children how to get along with others. No matter how gifted a child is physically or mentally, his happiness and success in life will also depend on his ability to get along with people. Consequently, compliance in social skills will help children to develop a satisfactory life.

At every level of human development and progress, interpersonal relationship, interdependent and interaction are essential elements. And, socially withdrawn Students (adolescents) are faced with diverse internalizing challenges such as loneliness, anxiety, inability to express self in public, low self-esteem, low self-confidence, low self-concept and depression. They also tend to lack some social skills such as interactional skills, communication skills and so on, which in turn have effect on their academic performance and achievement.This means, to be able to cope with challenges of their developmental process, the students must be empowered with various coping techniques that will make them relevant among their peers. In the light of these effects; this study used Social Skills Training (SST) and Transactional Analysis (TA) Counselling Techniques as the intervention (coping) treatment strategies in reducing social withdrawal behaviour among secondary school students.

Social Skills Training (SST)Counselling Technique has its basis derived from Social Learning Theory (Bandura, 1969) and Operant Condition techniques that have been tried and tested effective for the full range of human learning and behaviour therapy. Social Skills Training is a fundamental factor for the formation of relationships. These include the building and maintenance of relationship, the ability to handle the unreasonable behaviour of others and be able to get along with peers and other adult authority figure. SST is a technique that is used to harmonize or develop interpersonal relationship among individuals, it is a constructive process that involves assertiveness, communication and listening skills, modeling and management of feeling It also involves setting clear expectations with specific instruction, coaching the individual through the use of frequent prompt, using modeling, engaging the individual in role-playing and offering abundant positive feedbacks or reinforcement for small improvement in Social behaviour. Social Skills Training has been found to be useful and highly effective in helping individuals improve their interpersonal relationships. It targets social skills performance deficiencies such as abilities to correctly seek entry into a peer group. Hence, this study is using social skills training technique to help Socially Withdrawn students learn skills for developing gratifying relationship with others.

Transactional Analysis (TA) Counselling Technique was originally developed and defined by Eric Berne (1961), it is a theory of personality and communication as well as social action; it is used where there is need to understand the people and their interpersonal relationships and a clinical method of psychotherapy based on the analysis of all possible transactions between two

or more people on the basis of specially defined ego state, it provides a rational method of analyzing and helping the individual to understand his/her behaviour, acquire knowledge and responsibility. The analysis is accomplished in the four domains of personality, interaction, games and plays and aims at the relationship between adults. It is being used in this study to help the socially withdrawn students develop or improve on their self-esteem and self-concept as well as establish strong and effective interpersonal relationships with people around them. Transaction Analysis (TA) is a widely recognized form of modern psychology that involves a set of practical conceptual tools designed to promote personal growth and changes.It is considered a fundamental therapy for well-being and for helping individual to reach their full potential in all aspects of life. In counselling, Transactional Analysis therapy is very versatile, for it can be used in wide range of areas and incorporates key themes of humanistic, integrative, psychoanalytical and psychodynamic therapies. Hence it is considered as the second treatment technique for this research study.

1.2 Statement of the problem

Many students in secondary Schools in the Federal Capital Territory have been observed experiencing life situations arising from their inability to interact appropriately, build and maintain interpersonal relationship with their peers and other adults in the school and around them. Most of them are found to be keeping to themselves all the time, when they are in the midst of their peers they prefer being quiet, keep to themselves or doing thing on their own. They rarely interact, ask or answer questions in the class or outside the class and most time they look lonely, isolated and sad; at time, some of them become aggressive when forced by their peers to interact. These students, at different times are likely to fall victim of bullying, victimization and neglect by their peers, noticing and uncaring teachers and other adult. The lack of interpersonal relationship skills has really denied them of the care and support, love, trust and encouragement they deserve from both within and outside the school. These students are discovered at various levels of the secondary schools in FCT and are considered to be socially withdrawn.

Student's participation and social interaction are viewed to be very important contribution to the attainment of their learning objectives however when a student is not interacting or is having problem communicating with peers, teachers and people around, he or she is socially withdrawn and it becomes an issue. Social Withdrawal behaviour among students jeopardize their chances of achieving their educational goals and they may likelyexperience wide range of negative adjustment outcomes such as anxiety, low self-esteem, low self-confidence and low self-concept, depression and internalization problems. The students are also exposed to peer-difficulties such as peer rejection, victimization, bullying and poor friendship. Certainly, students who are socially withdrawn are faced with avoidance behaviour which interferes with their normal development of social skills and this in turn affects their concentration in class, brings about poor academic performance and may eventually result into school avoidance.

In addition, Social Withdrawal behaviour can bring about anxiety, self-consciousness and worries about being called upon by the teacher. This contributes to a lack of academic confidence, which is evidence in withdrawn student's tendency to rate themselves more poorly on self-report measure of scholastic, academic and social competence. Social Withdrawal behaviour among students (Adolescents in particular) if left unaddressed will contribute to a myriad of problems for these young people during their school years and into adulthood.

Various Behaviour modification and Counselling techniques like assertive training, Cognitive problem solving skill, self-management, self-efficacy skills training, Contingency Management, symbolic Modelling and so on have been used by various researchers to treat Social Withdrawal behaviour, Social incompetence, Social inhibition and Social Isolation. Considering the importance of social interaction, interpersonal relationship and need for communication in the progress development of the student, this study examined the effects of Social Skills Training (SST) and Transactional Analysis (TA) Counselling Techniques in the treatment of Social Withdrawal Behaviour among Senior Secondary School students.

1.3 Objectives of the study

The objectives of this research study are:

1. To examine the effect of Social Skills Training Counselling Technique on moderate level of Social Withdrawal Behaviour among senior secondary school students in Federal Capital Territory, Nigeria.
2. To examine the effect of Social Skills Training Counselling Technique on high level of Social Withdrawal Behaviour among senior secondary school students in Federal Capital Territory, Nigeria.
3. To examine the effect of Transactional AnalysisCounselling Technique on moderate level of Social Withdrawal Behaviour among senior secondary school students in Federal Capital Territory, Nigeria
4. To examine the effect of Transactional Analysis Counselling Technique on high level of Social Withdrawal Behaviour among senior secondary school students in Federal Capital Territory, Nigeria.

5. To examine the relative effect of Social Skills Training and Transactional Analysis CounsellingTechniques on moderate level of Social Withdrawal Behaviour among senior secondary school students in Federal Capital Territory, Nigeria.
6. To examine the relative effect of Social Skills Training and Transactional Analysis CounsellingTechniques on high level of Social Withdrawal Behaviour among secondary school students in Federal Capital Territory, Nigeria.

1.3 Research questions

This research study provided answers to the following research questions:

1. What is the effect of Social Skills TrainingCounselling Technique intervention on moderate level of Social Withdrawal Behaviour among students in Federal Capital Territory Schools?
2. What is the effect of Social Skills Training Counselling Technique intervention on high level of Social Withdrawal Behaviour among students in Federal Capital Territory Schools?
3. What is the effect of Transactional Analysis Counselling technique on moderate level of Social Withdrawal Behaviour among students in Federal Capital Territory Schools?
4. What is the effect of Transactional Analysis Counselling technique on high level of Social Withdrawal Behaviour among students in Federal Capital Territory Schools?
5. What are the relative effects of Social Skills Training and Transactional Analysis Counselling techniques on moderate level of Social Withdrawal Behaviour among students in Federal Capital Territory Schools?
6. What are the relative effects of Social Skills Training and Transactional Analysis Counselling techniques on high level of Social Withdrawal Behaviour among students in Federal Capital Territory School

1.4 **Hypotheses**

The research hypotheses stated in null form tested (at 0.5 level of significance) in this study are:

1. There is no significant effect of Social Skills Training Counselling technique on moderate level of Social Withdrawal behaviour among secondary school students in F.C.T. Abuja.
2. There is no significant effect of Social Skills Training Counselling technique on high level of Social Withdrawal behaviour among secondary school students in F.C.T. Abuja.
3. There is no significant effect of Transactional Analysis Counselling technique on moderate level of Social Withdrawal behaviour among secondary school students in F.C.T. Abuja.
4. There is no significant effect of Transactional Analysis Counselling technique on high level of Social Withdrawal behaviour among secondary school students in F.C.T. Abuja.
5. There is no significant relative effectof Social Skills Training and Transactional Analysis Counselling techniques on moderate level of Social Withdrawal behaviour among secondary school students in F.C.T. Abuja.
6. There is no significant relative effectof Social Skills Training and Transactional Analysis Counselling techniques on high level of Social Withdrawal behaviour among secondary school students in F.C.T. Abuja.

1.6 Basic assumptions

This research study was conducted based on the following assumptions:

1. Social Skills Training Counselling Technique wouldhelp reduce moderate level of social withdrawal behaviour among secondary school students in F.C.T. Abuja
2. Social Skills Training Counselling Technique wouldhelp reduce high level of social withdrawal behaviour among secondary school students in F.C.T. Abuja.

3. Transactional Analysis Counselling Technique would help reduce moderate level of social withdrawal behaviour among secondary school students in F.C.T. Abuja.
4. Transactional Analysis Counselling Technique would help reduce high level of social withdrawal behaviour among secondary school students in F.C.T. Abuja.
5. The Social Skills Training and Transactional Analysis Counselling techniques would likely have relative effect on the moderate level of Social Withdrawal behaviour existing among senior secondary school students in F.C.T. Abuja.
6. The Social Skills Training and Transactional Analysis Counselling techniques would likely have relative effect on the highlevel of Social Withdrawal behaviour existing among senior secondary school students in F.C.T. Abuja.

1.7 Significance of the study

The findings of this study would benefit practicing and upcoming counsellors by enlightening them on how to identify, understand and assist the socially withdrawn student using the appropriate counselling techniques; they would also gain more knowledge on Social Skills Training and Transactional Analysis Counselling technique and the treatment procedure. Findings of this study would also enable the counsellors to know how to help students build up their self-esteem; teach them new and healthy skills of interacting with peers and people around them.

Teachers in various educational levels would also benefit from the findings of this study in such a way that it would enhance their understanding of Social Withdrawal Behaviour, howto identify and help them to manage socially withdrawn students in their class; it would help the teachers in identifying and considering the skill deficit of the students and refer appropriately.Social workers would also use the knowledge gained from the findings of the study to offer qualitative help to individuals and parents that come for assistance.

The Parent, Government and Society at largewould also benefit from the findings of this study by having more awareness about Social Withdrawal behaviour, its causes and effect on the students and have information on how to handle them. Some parents who are overly protective and directive would be exposed to better ways to handle their children such that the children would l not develop Social Withdrawal behaviour and would be able to develop necessary coping and problem solving strategies in their interpersonal relationship with others.

Thefindings of this study would be of great significant to the school at all levels by give them a better idea of how to identify and help thestudents that are exhibiting social withdrawal

behaviour and refer them to the counsellor for help at the appropriate time.The study would assist the participants (students) to understand their behavioural disorders and consciously reconstruct their thinking pattern and take greater responsibility for their own behaviour

This study would serve as a valuable source of information to various personnel in different institutions that are dealing with children and adolescents. A reduction if not total eradication of Social Withdrawal behaviour among children, adolescents and youths would lead to interpersonal relationship, improved academic performance and relatively restore peace and orderliness. Finally, the findings of this study is in no way an exhaustive on Social Withdrawal behaviour, hence it is hoped that it would be an eye opener and open to further studies with the use of other psychological and counselling techniques.

1.8 Scope and Delimitation

This research work focused on the effect of Social Skills Training and Transactional Analysis Techniques on the Social Withdrawal behaviour among secondary school students in Federal Capital Territory. The study is delimited to senior secondary school year two (SSS2) with the application of Social Withdrawal Questionnaire as well as administration of treatment procedure to the participants. The effect of Social Skills Training and Transactional Analysis Counselling Techniques on other variables such as conduct disorder, ADHD, School adjustment problem, Gender difference in social interaction problem and so on could have been used. But for meaningful and effective work, this study was limited to Social Withdrawal Behaviour and covered three (3) selected schools in three Area Councils out of the Six Area Councils that makes up the Federal Capital Territory, Abuja, Nigeria.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

2.1 Introduction

This chapter involves a wide range of review of relevant literature under these broad headings: Conceptual framework, Theoretical framework and Empirical framework. The areas of discussion were: concept, assessment, developmental origin, correlates and consequences, of Social Withdrawal behaviour as well as academic and school adjustment. Adolescents with

Social Withdrawal, gender differences and Social Withdrawal, family structure and Social Withdrawal, Social Skills Training and Transactional Analysis techniques.

2.2 Comceptual Framework

2.2.1 Concept of Social Withdrawal Behaviour

Social Withdrawal has been a topic of great interest to different Counsellors, Psychologist, Professional and Researchers in the area of Social development and learning who have explained the term using different words such as Social Isolation, Social incompetence, Shyness, Social inhibition and Social reticence. Children and adolescents withdrawal behaviour can be associated with such constructs as shyness, behaviour inhibition, isolation and rejection, social reticence, passivity or peer neglect, and social incompetence. Ogunbawo as cited in Nnodum, 2001) view the socially withdrawn individual a person who demonstrates typically very low rates of social behaviour in interactions with others such as peers or mates. Nnodum (2001) in affirmation also advanced that the socially withdrawn (isolate) could be described as an individual who is unwilling or is finding it difficult to interact or associate with others such as peers or classmates. Being an isolate is a manifestation of extreme or high level of social withdrawal. It is a type of social seclusion and the individuals are often seen as being socially awkward. Coplan and Rubin (2010) define 2 subtypes of social withdrawal in children and adolescents, determined by motivation for the withdrawal; according to them, if the motivation is fear or wariness, the term 'Shy' is used but if the motivation is a preference for solitude the term 'Social disinterest' or unsociability is used (a non-fearful preference for solitude). Of these two subtypes of social withdrawal, shyness is better understood. They further describe social withdrawal as a consequence of behaviourally inhibited temperament, rejection by the peer group or a lack of social motivation, emphasizing the possible role of the peer group in maintaining existing socially withdrawn behaviour and so giving a possible external reason for the behaviour.

According Rubin, Hymel, and Mills, (1989), social withdrawal has referred to a heterogeneous group of behaviour, including social inhibition, social isolation, socio-metric neglect, and socio-metric rejection; solitary – passive behaviour. Coplan and Rubin (1998) reported that solitary – passive behaviour manifest when children who engage when the child explores objects of participate in constructive activity while playing alone. Asendorpf (1991) also explain further that children who engage in frequent solitude – passive behaviour are thought to have low avoidance motivations. Coplan, Rose-Kranor, Weeks, and Kingsbury (2012) in their study on alone in the crowd; social motivations, social withdrawal, and socio-emotional, functioning in later childhood found out that different subtypes of socially withdrawn children evident markedly different patterns of socio-emotional functioning in later childhood. Their findings revealed that older children can provide valid self-report of the social motivations

Social withdrawal refers to the process whereby children remove themselves from opportunities for social interactions with peers (Rubin, Coplan, & Bowker, 2009). However, in more recent years, researchers have shifted from a broader unidimensional approach to a consideration of different motivational and emotional substrates that may underlie children's

social withdrawal (Coplan & Armer, 2007). Social Withdrawal behaviour is such a broad construct that its use can be confusing, the main presenting behaviour of social withdrawal is a contact with peers at less than a normal rate or time alone at more than a normal rate, with likelihood of withdrawing from familiar peers as well as unfamiliar peers. This withdrawal from familiar and unfamiliar peers has been especially with low/negative self-esteem, loneliness, anxiety and depression (Rubin, Roots and Bowker, 2010). Previous research has consistently identified different withdrawn behaviours for unsociable, passive anxious and active isolates. Unsociable children have a strong tendency to explore objects or perform constructive activities while playing along (Hart, Yang, Nelson, Robinson, Olsen, Nelson, Porter, Jin, Olsen,&Wu, 2000).

Patternson, Reid and Dishon, (1992) reported that those students who are socially withdrawn usually have difficulty learning appropriate social conduct which place them at risk for difficulties later in life. Also Fujiki, Brinton, Isaacson and Summer (2001) reported in their study on the relationship between withdrawn behaviour and communication ability that increased their level of social withdrawal behaviour in children with specific language impairment (SLI) which is a disorder where children have delayed language acquisition but do not demonstrate delay in other development areas.

Forms of Social Withdrawal Behaviour

Shyness

Shyness is a temperamental trait characterized by excessive wariness and feelings of unease in the face of social novelty and perceived social-evaluation (Rubin et al., 2009). Shy children appear to experience an approach-avoidance conflict, whereby their desire to interact with peers (that is, high social approach motivation) is simultaneously inhibited by social fear and anxiety (high social avoidance motivation); (Asendorpf, 1993; Coplan,Prakash, O'Neil, & Armer, 2004). Shyness shares considerableconceptual overlap with a number of related terms (see Coplan and Rubin, 2010, for a recent review), including *behavioural inhibition*—which is a biologically based disposition toward heightenedreactivity and negative effect in the face of novelty (Kagan,1997)—and *anxious solitude*—which refers to social warinessdisplayed specifically in familiar peer contexts (Gazelle & Ladd,2003).

Unsociability

The non-fearful preference for solitude (also referred to as a*solitropic orientation*, (Leary, Herbst, & McCrary, 2003) has beenexplored extensively in the adult personality literature for quite some time (Bruch, Gorsky, Collins, & Berger, 1989; Cheek &Buss, 1981). Much less is known about unsociable (or *sociallydisinterested*) children, who are characterized as expressing anonfearful preference for solitary activities and having low socialapproach and low social avoidance motivations (Asendorpf, 1993;Coplan et al., 2004).There have been a few studies in which researchers have specificallyattempted to assess unsociability (typically using parentor teacher ratings) in younger children.

Overall, results from thesestudies indicate that in early childhood, unsociability appears to bea comparatively benign form of social withdrawal (Coplan &Weeks, 2010a). For example, unsociability has been associatedwith observed and teacher-rated social withdrawal (although notnecessarily with a *specific* subtype of nonsocial play) in preschool(Coplan et al., 2004), kindergarten (Harrist, Zaia, Bates, Dodge,&Pettit, 1997) and Grade 3 (Spangler & Gazelle, 2009). However, itappears that unsociable children do not avoid peers per se but aresimply less interested in *initiating* peer interaction and are capableof engaging in competent social interactions when called on to doso (Asendorpf & Meier, 1993). Moreover, this form of socialwithdrawal has not been found to be related to anxiety, loneliness or other indices of internalizing problems in early childhood (Coplanet al., 2004; Coplan, Closson, &Arbeau, 2007; Harrist et al.,1997).

Social Avoidance

Asendorpf (1990), Coplan and Arner (2007), consider social avoidance as the third subtype of social withdrawal which is characterized by the combination of low social approach and high social avoidance motivation. Coplan and Arner (2007) stated that one possible way of understanding social avoidance in children is that it may be a precursor to child depression.Asendorpf (1993) used the term *avoidant* to describe another group of socially withdrawn children who were characterized by the combination of low social approach and high social avoidance motivations. In this regard, avoidant children were portrayed as both desiring solitude and actively seeking to avoid social interaction.

Although Asendorpf (1990) speculated that these children would be particularly at risk for social and emotional maladjustment, relatively little is known about the meaning and implications of this particular combination of social motivations. It has been suggested that social avoidance in childhood might represent a manifestation of extreme shyness, whereby avoidant children are overcome with fear and anxiety during social situations to the extent that their desires to approach others are “extinguished” over time (Asendorpf, 1990; Schmidt&Fox, 1999).

According to Hinde (1987), Social Withdrawal behaviour is an individual characteristic that influence the quality of a person’s social relationship and the individual’s reputation and standing in the group, example peer rejection. Hinde’s conceptual model of Social Withdrawal serves as a useful heuristic to present central line of inquiry and major research findings regarding children who avoid or withdraw from their peer group. Vasa and Pine (2006) believed that Social Withdrawal is linked to psychological maladaptation as it represents a behavioural expression ofinternalized thoughts and feelings of social anxiety or depression. Rubin and Asendorpf (1993) viewed Social Withdrawal emanating from such internal factors as anxiety, negative self-esteem and self-perceived difficulties in social skills and social relationships. According to Rubin and Coplan(2004), Social Withdrawal may be best construed as an “Umbrella term” describing a given behavioural prototype (solitude in one form or another) derived from

the variety of focused fear wariness and anxiety as underlying effective contributor to children's withdrawal from their peer.

Fox, Henderson, Marshall, Nichols and Ghera (2005) and Kagan, Snidman, Kahn and Towsley (2007) used the term behaviour inhibition (BI) to describe biologically based wariness during exposure to noble people, things and places. In addition, Asendorpf (1991) uses shyness in conceptualizing wariness in the face of social novelty and /or self-conscious behaviour in situation of perceived social elevation. Coplan, Gavinski-Molina, Lagace-Seguin and Wichman, (2001) viewed Social Withdrawal as social reticence which represents a behavioural construct comprising the watching of others from afar, remaining unoccupied in social company and hovering near but not engaging others in interaction. This behaviour construct putatively reflects internalized feeling of social anxiety as well as conflict motivation of approach and avoidance.

Gazelle and Ladd (2003) used anxious solitude to denote Social Withdrawal wariness in familiar peer context. These term share implication that solitude may result from conflicting emotions and motivations, some individuals may be moved or motivated to approach others and interact socially with them but their social approach and anxiety, and eventually result to avoiding others and become socially withdrawn. Hence, there is a conceptual similarity here with social phobia, an internalizing disorder characterized by a marked and persistent fear of embarrassment that may occur,(American Psychiatric Association, 1994, pg. 411). Ogunbawo (1988) viewed social isolate as a person who demonstrates typically very low rate of social behaviour in interactions with others such as peers and mates. Nnodum (2001) advanced that socially, an isolate could be described as an individual who is unwilling or is finding it difficult to interact or associate with others such as peers or classmates. Being an isolate is a manifestation of extreme level of social withdrawal, a type of social seclusion and the individuals are often seen as being socially awkward. Denollet (2013) refer to behaviour inhibition or social inhibition as a conscious or subconscious avoidance of a subject matter for discussion. Gable, Reis and Elliot (2000) explain that social inhibition can range from normal reaction to social situations to a pathological level, associated with psychological disorders like social anxiety or social phobia.

According to Eisenburg, Fabes and Murphy (1995) shyness is another factor that is a part of social inhibition or social withdrawal. It is associated with low emotional regulation and high negative emotion. In many cases, shy individual have a greater chance of social inhibition. Rubin, Coplan and Bowker (2009) explained that the term Social Withdrawal is used to denote a child isolating him/herself from the peers through consistent display of solitary behaviour in the presence of peers. In this regard, Social Withdrawal is seen to arisefrom internal factors with the child opting for some reason or another not to interact with peers. They went further to explain that Social Withdrawal is an "Umbrella term" encompassing at least two different "reasons" why children might choose to play alone,in addition, that most research focused on children who refrain from social interaction because of their wariness and social fear. Hymel and Rubin (1995) advanced that people become socially withdrawn because they think they have defect, which make them feel self-conscious, unattractive, different and inferior. These makes the socially withdrawn to often have poor evaluation of themselves and engage in self-defeating and negative talks. It can therefore be deduced that there are cultural, cognitive, environmental,

educational, psychological, personality trait and pee rejection effect in the causation of Social Withdrawal behaviour. Rubin and Coplan (2004) defined Social Withdrawal as a behavioural tendency to isolate oneself from peers, this tendency to withdraw from others appears to be moderately stable over time (from childhood to adolescent and across diverse situations).

In clinical perspective, according to American Psychiatric Association (1994), DSM IV and I CD-10 classification of mental and behavioural disorder, Social Withdrawal is viewed as a symptom rather than as a syndrome with its own etiology and prognosis, as such, it has been associated with such clinical disorder of childhood and adolescent as autism, anxiety and phobia disorders, major depression, personality disorder and schizophrenia. While according to Coplan, Rubin, Fox, Calkins and Stewart (1994) Social reticence represent a behavioural construct comprising the watching of others from afar, remaining unoccupied in social construct and hovering near not being engaging others in interaction. This behaviour construct putatively reflects internalized feelings of social anxiety as well as conflicting motivations of approach and avoidance.

Studies also show that depression has a part to contribute to social withdrawal behaviour in adolescents and children and this may have different consequences. Whereas social withdrawal induces by anxiety may yield sympathy, interest and social overtures from others; depressed withdrawn individual may attempt to elicit support in a way that actually causes others to withdrawal from them or even ignore or reject them (Millins, Peterson, Wonderlich&Reaven, 1986). Social Withdrawal behaviour appears to be not only concomitant but also a predator of depression (Bell-Dolan, Reaven& Peterson 1993). Social Withdrawal can often be triggered by negative thoughts that are because self-esteem plays a tremendous role in the development of anxiety.Moreover, the social initiation of socially withdrawn children often result in peer non-compliance despite the fact that these initiation and requests are less likely than are those of non-withdrawn children to require carrying out action that involves both effort and mobility (Rubin &Krasnor, 1986; Stewart & Rubin, 1995).

Causes of Social Withdrawal behaviour

Schmidt and Bass (2010) revealed that the causes of Social Withdrawal behaviour including the shy type are generally understood from an interactional perspective including gene, biological and environmental interactions. It is increasingly understood that biological factors may predispose some children to behavioural inhibition; this is thought to relate to a reduced threshold for stimulation in the amygdala, which regulates emotional experience, (Fox, Henderson, Mershall, Nicholes & Ghera, 2005). Rubin and Root et.al. (2010), also reported that parent-child interactions have often been blamed for the development of social withdrawal behaviour and that the pattern of parent-child interactions in the early years do suggest that parents have an important role to exacerbating existing tendencies. Their research strongly suggests that there is a bidirectional model of effects once parent begin to view their child as behaviourally inhibited. Parents who believe their toddlers are more socially wary, are less likely to encourage exploration and independence and behave in a more nurturing and protective

way. A contradictory view suggests that parent-child interactions may not be as important as many researchers states.

McLeod, Wood and Weisz (2007), in a meta-analysis of 47 studies, expressed that the association between parenting and child anxiety was tested, finding that parenting account for only $47^{0}/_{0}$ of the variance in child anxiety and indicating that other variables are more important. Pattern of parent-child interactions have been researched extensively through early childhood but with little understanding of how parent – child relationship continue to reinforce and affect behaviour beyond primary school and into adolescence. According to Coplan and Armer (2007), causes of unsociability are less well understood, they linked unsociability to a high temperamental attention span, something that seems to predict greater object orientation or a preference for 'things' rather than people. It has also been suggested by Prakash and Coplan (2007) that children who display less social interest than their peers may also do so because a lack of emphasis on developing positive peer relationships is modeled by their parents. This appears to indicate that the interactions of genes, biological and environmental interactions may be as relevant to this type of social withdrawal.

Assessment of Social Withdrawal Behaviour

In the process of at attempting to assess Social Withdrawal behaviour and its construes in children and adolescents, a wide variety of measures has been used by various researchers, these includes behavioural observations, parent's and teacher's rating and peers and self-report. The extant battery of measurecaptures the various forms and meaning of Social Withdrawal behaviour. Rubin, CoplanandBowker (2009) reported that some of the early assessment of the construct of Social Withdrawal – for example, the revised Class Play (RCP) by Masten, Morrison andPellegrini (1998) which is a widely used peer rating procedure wherein classmates nominates peers which fits in various behaviour descriptions. Rubin and Mill (1988) suggested separating the items that is loaded on the original RCP sensitivity/isolation factor to create two conceptually distinct construct- shyness/social wariness- items such as ("someone who is shy", "someone whose feeling gets hurt easily")and social isolation/exclusion ("a person who is often left out, a person who can't get others to listen"). These two construct have been found to be differentially correlated with such construct as aggressive and disruptive behaviour result of Zeller, Vannatta, Schafer and Noll (2003) which demonstrate that children can distinguish between their shy/withdrawn and rejected/isolated peers, at least during last childhood and early adolescence when peer nomination are most commonly used.

Rubin, Wojslawowicz, Rose-Krasnor, Booth-Laforceand Burgees (2006)added item to the above measure to create an extended class play, this misuse further distinguishes between peer rejection/isolation/victimization and shyness/Social Withdrawal (for example someone who gets nervous about participating in class discussion) . Achenbach

andRescorla (2001) also used items from Child Behaviour Checklist and Teacher report form to obtain parent's and teacher's perception of Social Withdrawal. The items from this provide a broader-based assessment of several aspects of children's social withdrawal behaviour. Rubin (2001) employed behaviour modification scale such as Play Observation Scale to assess different forms of solitude in the presence of peers and classmates at school. Other additional measure developed to assess such related construct as behavioural inhibition, shyness and anxiety solitude. Rubin, Hastings, Stewart and Henderson (1997) developed a procedure to assess behaviour inhibition in the company of unfamiliar toddler peers, the measure included toddle's maintenance of contact with his/her mother and frequency of anxious behaviour; there was a little overlap between inhibition as assessed by adult and peer paradigms.

Bishop, Spencerand McDonald (2003) recently developed Parent and Teacher rating scale (Behaviour inhibition questionnaire)designed to access behaviour inhibition in peer situation and in response to behavioural challenges, separation, performance situation, unfamiliar adult and other novel situations. They reported that both maternal and teacher report of behaviour inhibition were strongly associated with observed behaviour inhibition in Kagan paradigms. According to Bishop et. al (2003), Coplan, ArbeauandArmer (2008), Ladd andProfilet (1996), there is moderate to high agreement between sources of assessment with regards to measures of behaviour inhibition, shyness and Social Withdrawal. Some researchers have suggested that discrepancies between such ratings may be meaningful. Spooner, Evans and Santos reported that a group of self-report shy children whose shyness was undetected at school has low self-esteem.

Developmental Origin of Social Withdrawal Behaviour

Biological Foundation: Searching through where Social Withdrawal Behaviour originated from, some may believe that it derives from biological disposition to be emotionally primed to react to novelty and wariness and fear. Several studies have shown that it started from infancy and generally graduate in the advanced stage of adolescence and adulthood. Kagan, SnidmanandArcus (1998) reported that about 15 percent of infants display a high degree of negative effect and distress when presented with novel stimuli. These infants, at toddlerhood, often display fearful, cautious and wary behaviour when presented with novel situation and adult stranger. Kagan (1997) suggested that this early appearance of shyness (also called behaviour inhibition) is a temperamental trait that emanates from a psychological "hard wring" that evolves cautions, wariness and timidity in unfamiliar social situations and non-social situation. In support of these, McMaris, Kagan, Snidmanand Woodward (2002), reported that children who were emotionally reactivated at 4month and who displayed high level of behaviour inhibition at age 14-21months were likely to demonstrate right frontal Electron Encephalogram (EEG) asymmetries in childhood. Henderson, Mashall, Fox and Rubin (2004) found that two types of solitude – social reticence and Solitary – constructive and exploratory behaviour – were associated with a pattern of greater relative right frontal EEG asymmetry. However reticent children were rated by their parent to be more socially fearful and display low cardiac vagal tone than those children who were observed to spend time exploring and constructing on their own whilst in social company. Rubin, CoplanandBowker(2009) in their perspective reported that the ontogeny of a socially withdrawn profile begins with newborn who are biologically predisposed to have a low threshold for arousal when confronted with social or non-social stimulation and novelty.

This hyper arousal, they say, may make the babies extremely difficult for their parent to soothe and comfort. They proposed that some parent might find the dispositional characteristics aversive and difficult.

Hastings, Rubin andDerose (2005) reported that observed behaviour inhibition, maternal report of social fearfulness and cardiac vagal tone loaded on a single factor (with cardiac vagal tone loading negatively) at two years of age while Spangler andSchieche (1998) in their research demonstrated that elevated cortisol (a stress hormone) is associated with demonstration of behaviour inhibition. Rubin, CoplanandBowker (2009) further reported thatthe relationship between biology and behaviour in the study of social withdrawal may be best thought of as transactional in nature. They contend that biological factors may underlie the display of behaviour inhibition and reticence and that behavioural indicator of the underlying biologically-based fearfulness and anxiety may evoke social responses from parent and peers.

Researchers have shown that such factors as parenting style, the quality of parenting child relationship and quality of adolescents' peer relationship affects the development, maintenance and moderation of socially withdrawn behaviour pattern. For instance, attachment theorists have long maintained that the primary attachment relationship develops during the first year of life, especially between the mother and the infant could lead to social withdrawal in future life of the individual.

Consequences of Social Withdrawal Behaviour

From early childhood through to adolescence, Social Withdrawal behaviour is concurrently and predictively associated with a wide range of socio-emotional difficulties (Rubin et. al., 2009). Some of the correlates and consequences of Social Withdrawal

behaviour will be discussed in the study.Being Socially Withdrawn has numerous negative effects on the individual. It is highly handicapping and creates maladjustment in most aspects of the individual's life such as his social, intellectual, personality, language development and academic achievement. It's negative effect on mental development and lowering of academic performance in the individual. (Nnodum, 2002).

Social Cognition and Social Competence: Socially withdrawn children have deficit in social competence; when compared with their sociable age mates. The goals of socially withdrawn children's request appeared less 'costly' for example were more likely to attempt to request attention from their play mates than attempt to obtain an objective and elicit active behaviours from their playmates.The strategies used by withdrawn children were less assertive and direct; their requests were not usually spoken in the imperative.

The outcome of withdrawn children's request was more likely to result in failure despite the use of less costly and direct overtones. These experiences of social failure may give already fearful and insecure children good reason to further withdraw from their peers. For example, according to Wichmann, Coplanand Daniels (2004), as a result of frequent interpersonal rejection by peers, withdrawn children may rather attribute their social failure to internal causes (example something is wrong with me) rather than attributing their social failure to other people and situations.Rubin and Stewart (1996) further explained that the combination of peer rejection and internal dispositional attributions for peer non-compliance could be construe as creating a negative feedback loop whereby an initial fearful, withdrawn children begins to believe their failures are personality based and then this believes are reinforced by increase failure of social initiatives or interactions.

Self-perception and internalization problem: The way an individual perceives him/herself has been explained by researchers as a consequence of Social Withdrawal. CoplanandArbeau (2008) cited that the presence of a large group (initial unfamiliar) of peers, increased demand for verbal participation and a high child-to-staff ratio as factor that may exacerbate withdrawn children's feeling of social fear and self-consciousness. Perhaps as a result, even in the early childhood, as compared to others, withdrawn children report feeling less positively about themselves, are lonelier and display more sighs of anxiety and other internalized problems. Nelson, Rubin and Fox (2005) further reported that in middle of late childhood; socially withdrawn children continue to develop negative self-perceptions their social competence and interpersonal relationships, and unfortunately, this pattern appear to worsen with age even up to adolescence and adulthood. Findlay, CoplanandBowker(2009) reported that during this age period, shyness and social Withdrawal becomes increasingly associated with such internalized problems as anxiety, loneliness and depression.

*Rejection, acceptance, exclusion and victimization:*From early childhood through to adolescence, peer respond to social withdrawal behaviours with exclusion, rejection and victimization, as shown by researchers. Oh, Rubin, Bowker, Booth-Laforce, Rose-Krasnorand Lauren (2008) poised that increased age, socially withdrawn becomes increasingly concurrently and predictively associated with peer exclusion ad rejection. Rubin, Wojslawowicz et al (2006) reported that children begin to view social withdrawal and solitude as behaviour that contrast sharply with age –specified norms and expectations for social interactions and peer relationship involvement during early to middle childhood. Thus, withdrawn children/adolescents become more increasingly rejected and excluded during this age period because their behaviour are viewed by peers as increasingly typical and deviant.

Rubin, Boukwoski, et al (2006) also found that the increasing emphasis on peer interaction and relationshipduring childhood and early adolescence may help to explain why the association between withdrawal and rejection becomes stronger during this development period. Of course, relatively poorer social skills undoubtedly, also contribute to the lower likability rating of some withdrawn children. Biovin, Hymeland Hodges (2001) reported that although, peer attitude and treatment are meaningfully correlated and evident suggested that attitude contribute to exclusion and victimization; careful analysis revealed that these construct play distinct role in peer relation process. HoglungandLeadbetter (2007) reported that regular exposure to bullying may lead to increasedfear of classmates and further withdrawal from peers. Deater-Deckard (2001) opines that Social Withdrawal is one of the correlates and consequences of peer rejection during middle childhood and adolescence. Ladd (2001) also expressed that a typical behaviour becomes more salient to thepeer group with increased age; this may explain why the association between social withdrawal and peer rejection steadily increased with age.

Importantly, studies by Gazelle and Ladd (2003) using growth curve modeling found that the experience of both peer exclusion and victimization accounted for significantly greater stability or increase in the behavioural expression and anxious withdrawal from childhood through early adolescence. Gazelle and Rudolph (2004) have also shown that over the course of fifth and sixth grade, high exclusion by peers led to anxious solitary youth to maintain of exacerbate the extent of their Social avoidance and depression whereas the experience of low exclusion predicted increased social approach and less depression. Numerous studies have indicated that many socially withdrawn children experience repeated and consistent victimization by peers during early and late childhood. In addition, children who are victimize experience physical and verbal abuse from their peers and classmates. Given that the reserved and quiescent demeanour of many socially withdrawn children and given that they often attempt to avoid social company, one might expect that they would be protected from a bullying experience. Yet, researchers have consistently reported that this group of children and adolescents are at high risk of peer victimization. Rubin, Wojslawowicz et al (2006)also reported that withdrawn children may experience victimization because they exude an “anxious vulnerability” and thus are viewed as “easy marks” that are likely to fight back or retaliate.

Gazelle (2008) found that socially withdrawn children who also display attention-seeking and/or aggressive behaviour were at greater risk (relative to withdrawn children who do not display such behaviours) for such peer difficulties at rejection, exclusion and victimization. It was hypothesized that such subtype social withdrawal children may experience greater problems with their peers because they do not only fail to display socially desired behaviour but also because they exhibit socially undesired behaviour. Research on the peer relationship of withdrawn children has examined peer rejection, acceptance, exclusion and victimization, peer-reported acceptance (being well liked by peers)and rejection (being widely disliked by peers) indicates peers' preference for the child as a playmates or social partner, but they do not indicate how peers actually treat or behave towards the child. In contrast, peer exclusion (being left out of peers' activities by being passively ignored or actively refused entry) and victimization (being mistreated by peers, including teasing, verbal put-down and physical harms) describe how a child is actually treated by peers.

Friendship is a significant source of social support in individual growth and development; in childhood and adolescence, friendship is best thought of as a reciprocal dyadic relationship mostly between same age and same sex individual. The reciprocal characteristics mean that both individuals must view each other as a friend. Friendship involvement is positively associated with social competence, it may therefore be expected that many socially withdrawn children are unable to form friendship, though it is common that most children and adolescents have at least one mutual good or best friend. Rubin et al (2006) reported that the majority of socially withdrawn children have at least one stable mutual friend.

Pedersen Vitaro, Barker andBorge (2007) opines that although socially withdrawn children may have difficulties forming large number of friendship, it is nevertheless the case that the withdrawn children and adolescents are as likely as their typical age mates to have at least one mutual and stable friend. Rubin and Wojslawowicz et al (2006) found that approximately 65% of socially withdrawn 10year olds had a mutual best friend and approximately 70% of these bets friendships were maintained across the academic year. These friendship involvement and stability percentage were nearly identical to those of non-withdrawn 10year olds. Thus, despite their difficulties in the large group, withdrawn children and adolescents do appear able to form and maintain close dyadic relationship within the school milieus. They stressed further that the best friend of extremely withdrawn children and adolescents are more likely to be socially withdrawn and victimizedthan the mutual best friend of non-withdrawn children. It then appears as if many social withdrawn children and adolescents are involved in friendship with other children who are experiencing similar psychosocial difficulty; the friendships of socially withdrawn children and adolescents can then be said to be relatively poor in relationship quality.

Rubin andWojslawowicz et al (2006) further found that withdrawn adolescents rated their best friendship as lacking helpfulness, guidance and intimate disclosure; the best friends of these withdrawn adolescents rated their friendship as involving less fun, help and guidance than did the best friends of non-withdrawn adolescents. Oh et al (2006) examined the extent of

which group and dyadic relationship factors conspire to maintain or alter development trajectories of social withdrawal in early adolescence, and they found three distinct growth trajectory classes of social withdrawal from the final year of elementary school, across the transition to middle school and then to the final year of middle school:

A low stable
An increasing and
A decreasing class.

Friendshipness, friendship instability, exclusion and victimization by peers were significant predators of trajectory of increased social withdrawal over four years period. Gazelle andRudolph (2004) found that decrease in social withdrawal were evident for those young adolescents and who experience decrease in rejection and victimization as they made the transition from elementary to middle school, hence they report that when anxious-solitary youth experience less peer exclusion they display an increase in social approach.

Long term Consequences of Social Withdrawal Behaviour: Students exhibiting social withdrawal behaviour are identified with a range of academic and social consequences which are long term; some of such consequences are loneliness, low self-esteem, substance abuse and peer relationship problems (Marchant, Solano, Fisher, Caldarella, Young & Renshaw, 2007). Nnodum (2001) remarked that isolates (Socially Withdrawn individual) are unable to solicit for assistance from people around them; they find it difficult to ask for clarification or questions on confusing and unclear issue, initiate, participate in and terminate conversation or discussions. They find it difficult to express feelings easily, join groups or engage in group work. They are shy and experience fear and anxiety when asked to execute a social task. They often engage in negative talks or self-defeating statements.

Evans (2001) expressed that academically, socially withdrawn children have been found to perform more poorly than their IQs predict, they have less developed language skills and are likely to perform lower on measure of language performance than confident classmates. Rubin, Root, et.al. (2010) proved that early behavioural types remain static throughout childhood and early adulthood and longitudinal studies have shown that early social withdrawal predicts negative peer and self-regard, loneliness and depression in adolescence. There are also some consequences of social withdrawal behaviour which studies have shown to be long term, these consequences are revealed in childhood and run through to adolescence. Rubin, Chen, McDougall, Bowkerand McKinnon (1995) in the Waterloo Longitudinal Project reported that social withdrawal at seven years of age predicted negative self-regard and loneliness at nine and ten years of age, as well as loneliness, depression and negative self-regard at 14years of age.

In addition, Proir, Smart, SansonandOberklaid(2000) found that children rated as chronically shy from early childhood onward were at high risk for the development of anxiety. Relatively, Schwartz,SnidmannandKagan (1999) reported that there is increasing evidence linking extreme shyness in early childhood to clinical anxiety disorders (particularly social phobia) during shyness

in early childhood and late adolescence. Asendorpf, DenissenandvanAken (2008) reportedthat shy/withdrawn children are viewed by teachers and parents as having an overcontrolledpersonality.In their longitudinal follow-ups of such children they found that, over a 19-year period, overcontrolled children remained consistently shyer and withdrawn through to adolescence and young adults than resilient-competent/ non-withdrawn children. Asendorpf and colleagues also found an association with the perceived lack of support from peer, they reported that over the long run, shy/withdrawn male children entered romantic relationship later than non-withdrawn male, this finding agrees with that of Caspi, Elder andBem (1988). The finding also suggested that the implication of shyness and withdrawal may vary for boys and girls hence the role of gender difference is explored.

Social Withdrawal and academic and School Adjustment: Every child need to go to school, however, going to school may also be a difficult issue for socially withdrawn due to the presence of a large group of unfamiliar peers, increased demand of verbal participation, a high child-to-staff ratio, which are factors that can exacerbate withdrawn feeling of social fear and self-consciousness. According to Coplan et al (2008), there is increasingly empirical support for the notion that the transition to school is particularly problematic for withdrawn children and adolescents.

Some of the skills lacked by socially withdrawn children are communication and language skills and these can make transition to and adjustment in school a problem for them. Evans (2001) and Rimm-Kaufman and Meier (2005) reported that withdrawn children speak less frequently than their peers do to both children and adult in the classroom environment. Crozier and Perkins (2002) reported that withdrawn children tend to perform more poorly than non-withdrawn children standardized test of expressive language do. CoplanandArmer (2005) found that the relationship between withdrawal and indices of school adjustment were significantly reduced at higher levels of expressive language. According to Buhsand Ladd (2001), the inability of withdrawn children to be verbally expressive in the classroom may be considered a typical and unacceptable to classmates. This may result into rejection by peers and peer rejection is known to predict for school performance even in the early school years.

There have been evident studies linking social withdrawal in children and adolescent with lack of display of academic competence in school. According to Daly and Korinek (1980), student participation and social interactions were viewed as important contributor to attainment of learning objectives. Crozier and Perkins (2002) reported further that withdrawn children's quietness might be perceived by teacher as a lack of interest or understanding of a topic. Indeed, teachers and peers perceive "quiet" children as being less intelligent. In addition, Evans (2001) expressed that anxiety, self-consciousness and worries about being called upon may interfere with withdrawal children classroom earning. Crozier (1995) opines that this may contribute to lack of academic confidence which evidenced in withdrawn children's tendency to rate themselves more poorly on self-report measures of scholastic and academic competence. When given the opportunity to demonstrate their competence, withdrawn children may evidence performance deficits because stress associated with test performance.

Crozier and Hostettler (2003) explore the academic achievement (vocabulary and maths) of withdrawn children in three different testing environments:
Individual administered assessment
Individual administered written assessment and
Group administered assessment.
The result indicated that the withdrawn children scored significantly lower than non-withdrawn children in both individually administered condition but therewere no significant differences between groups in the group administered condition.Hence, they suggested that in a group setting withdrawn children did not feel the same performance pressure that is experienced in individual administered settings. Considering teacher-student relationships and classroom climate, some researchers have suggested that withdrawn children may either go unnoticed by the teacher or that teachers may encourage shy behaviour because reserved, quiescent, complaint behaviour helps to maintain classroom order (Keogh, 2003 and Rimm-Kaufmann et al, 2002).

CoplanandPrakash (2003) and Ruasill, Rimm-Kaufmann, Justiceand Pence (2006) reported that socially withdrawn children require more attention from teachers and develop less close and more highly dependent relationships with them. HemreandPanta (2002) reported that children whose relationships with teacher are characterized by closeness and greater dependency are at increased concurrent and predictive risk for a number of school adjustment difficulties, importantly, moderately effect may derive from classroom climate. Gazelle (2006) found that anxious-withdrawn first grader were more rejected boys and victimized girls by peers and demonstrated more depressive symptoms in classroom with negative emotional behaviours, conflictual relationship between students and teachers, influence prosocial peer interaction. Coplanand Prakash (2003), Gazelle and Ladd (2003) also reported that socially withdrawn children are more likely to experience other problems related to early school adjustment, including peer rejection, social isolation, increased teacher attention, academic difficulties and school refusal.

In contrast to all above, social withdrawal can have potential benefit in adolescent if the solitude is used positively to achieve some goals. According Hills and Argyle (2000), solitary may also offer practical benefits if socially withdrawn adolescent or adult spent their solitary time constructively, developing independent thinking, reading, writing and other skills. Indeed, adults who express a non-fearful preference for solitude can be as happy as their more extroverted counterparts can.

2.2.2 Concept of Social Skills Training Counselling Technique

The basis of social skills training is derived from social learning theory Bandura, (1969) and operant conditioning, techniques that have been tried and tested effective for the full range of human learning and behaviour therapy. In particular, the principles underlying social skills training emphasize the importance of setting clear expectations with specific instructions, coaching the individual through the use of frequent prompts, using modeling of vicarious

identification, engaging individuals in role playing or behavioural rehearsal, and offering abundant positive feedback or reinforcement for small improvement in social behaviour.
Canney and Byrne (2006) categorized Social Skills according to the level of complexity and interaction as:

i. Foundation skills for basic social interaction: for example- ability to maintain eye contact, maintain appropriate personal space, understand gestures and facial expressions.
ii. Interaction skills for interaction with others: examples – resolving conflicts, taking turns, learning how to begin and end conversations, determine appropriate topics for conversation and interacting with authority figures.
iii. Affective skills for understanding oneself and others: examples – identifying one's feelings, recognizing the feelings of others, demonstrating empathy, encoding body language and facial expressions, determining whether someone is trustworthy.
iv. Cognitive skills in order to maintain more complex social interactions examples – social perception, making choice, self-monitoring, understanding community norms, determining appropriate behaviour for different social situations.

Susan (2013) viewed SST as a form of behaviour therapy used by teachers, therapists and trainers to help persons who have difficulties relating to other people. A major goal of SST is teaching persons who may not have emotional problems about the verbal as well as non-verbal behaviours involved in social interactions. It helps the clients to learn to interpret nonverbal and other signals, so that they can determine how to act appropriately in the company of other people in a variety of situations. SST proceeds on the assumptions that when people improve their social skills or change selected behaviour, they will raise their self-esteem and increase the likelihood that others will respond favourably to them. Susan (2013) explained further that trainees learn to change their social behaviour patterns by practicing selected behaviour in individual or group therapy sessions. Another goal of SST is to improve the patient's ability to function in everyday social situations. SST can help the client/patient to work on specific issues such as improving one's telephone manners that interfere with their job or daily lives.

Mazur (2009) also explained SST as a method of helping people who have problem interacting with others. That client learn basic social skills such as initialing conversations, making eye contact, standing at the appropriate distance, controlling voice volume and pitch, and responding to questions. The therapist first describes and model the behaviour, then the patient or client practice the behaviour in skit or role-play exercises. The therapist watches the

exercise and provides constructive criticism and further modeling. Therapists often conduct this kind of training with groups of people with similar problems. SST technique teachers people, especially those who are shy and socially withdrawn; to make appropriate response when someone does something to them that seems inappropriate or offensive or violates their rights. For example, if a woman has trouble saying no to a coworker who inappropriately asks her to handle some of his job responsibilities, she may benefit from learning how to become more assertive. In this example, the therapist would model assertive behaviour for the client, who would then role-play and rehearse appropriate responses to her coworker.

Social skills, in the view of MastropieriandScuggs (1987), are a collection of behaviours in learner's repertoire of skills that enables him or her to interact successfully in the environment. They are behavioural skills which an individual exhibits in the process of interacting with people in order to belong, become accepted and got along with them (Nnodum, 2001). Some of these skills, as highlighted by MastropieriandScuggs (1987), and Masters, Burish, HoolnandRimm (1987), include conversation skills; assertiveness skills, play interaction skills; self-relate behaviour, interview skills and self-help skills. Others are greeting or salutation skills, being courteous and caring, ability to smile and laugh when appropriate, ability to show sympathy and be sorry to the offended, ability to be cooperative, accommodation and understanding and to engage or participation group work, ability to be appreciative, reciprocate good gestures and commend good acts among others social skills.

Social Skills Training as a primary therapy for psychological problems or as an adjunct to other technique has a long history with an efficacious track record, for instance Kopelowicz, Lieberman and Zarate (2006) as one of the meta-analytic reviews; showed that social skills training is as effective in treating psychological problems as most other therapeutic techniques that are in vogue. According to Glynn, Marder, Lieberman, Blair,Wirshing, Ross andMintz (2002) and Lieberman, Glynn, Blair, Ross andMarder (2002), Social skills training has been well documented as the technique of choice for helping individuals with serious and persistent mental disorders to acquire skills, durably maintain the skills and successfully transfer the skills to everyday life. In recent years, the generalization of skills from the training environment to the person's natural living environment has been particularly emphasized (Heinssen, Lieberma&Kopelowcz, 2000; Lieberman & Fuller, 2000). Kopelowiczand Lieberman, (1998) reported that evidence for the efficacy of social skills training has accumulated for the following outcomedimensions, acquisition, durability and utilization of the skill in real life; improvements in social functioning; reductions in relapse rates and hospitalization; and enhanced quality of life.

Social skills training programs typically include a comprehensive assortment of skills that cover areas such as social problem solving, friendship, conversation, planning, and dealing with feelings (Kavale & Mostert, 2004). The following training procedures may include different forms and combinations. Coaching focuses on direct instruction, and the practice of specific skills, which may be inhibited or lacking. Modeling emphasizes learning from the observation of a live or filmed model, and cognitive problem solving training which teaches adaptive ways of thinking about social situations (Erwin, 1994). Cognitive problem solving training may include rehearsal,

shaping, prompting, and reinforcement (Telzrow & Bonar, 2002). Telzrow and Bonar identified three types of intervention: remedial, compensatory, and instructional/therapeutic.

SST helps people learn how to voice their feelings in a non-threatening manner as well as also learn how to stand up for their own rights. SST teaches people to focus on what is happening in the social environment rather than their internal physiology and teaches how to actively listen to others(Hofmann, 2005). Social Skills Training is based on social learning techniques and emphasizes the role of behavioural rehearsal in skill development rather than discussion. The primary modality of training is role play of simulated conversations, typically conducted in small groups (6-8 Veterans), and performed twice a week in 60-minute sessions. This training opportunity provides a hands-on learning approach to delivering SST from experienced clinicians.

A common focus of SST programs is communication skills. A program designed to improve people's skills in this area might include helping them with nonverbal and assertive communication and with making conversation. It might also include conversational skills that are needed in different specific situations, for example job interviews, informal parties, and dating. Social skills training may be given as an individual or as a group treatment once or twice a week or more often depending upon the severity of a patient's disorder and the level of his or her social skills. Heinssen, Robert, Lieberman, and Kopelowicz. (2000). Social skills training has been implemented to provide aggressive children with a foundation in the prosocial behaviours and social-cognitive skills in which they are deficient and that are necessary for successful peer interaction. School-based programs are ideal for this type of intervention because school is a primary context in which children interact with peers, providing a natural opportunity to assess and train their peer relational skill.

Susan (2013) suggested some disorders that can be treated by a social skills trainer which include: shyness, social isolation, ***social withdrawal***, depression, schizophrenia, social phobia, avoidance personality disorder, alcohol dependence, obsessive-compulsive disorder and development disability. People who suffer from social phobia or shyness are not ignorant of the social cues but they usually avoid specific situations in which their limitation might cause them embarrassment. Social Skills training therefore can be applied to treat the social phobia or shyness, it can help them improve their communication and social skills so that they will be able to mingle with others around them with ease and become self-confidence.

Carter (1998), describe the specific techniques used in SST as follows:

- Instruction
- Modeling
- Role-playing
- Shaping
- Feedback and

- Reinforcement

For instance, instruction can be used to pass across the differences among assertive, passive and aggressive style of communication. The technique of modeling may be used to help the client to increase their eye contact and listening ability during conversation. In role-playing the members of the group have the opportunity to offer feedback to one another about their performance in stimulated situations.

Studies indicate that SST has moderate short-term effects, but limited long-term effect. SST program that includes social perspective- taking may have greater long-term effect than the traditional SST program based on cognitive-behavioural models. Generally SST tends to generalize to similar context rather than to context that are not similar to the training. One approach to improving generalization is to situate the training exercises within the patient's work, living, or social environment (Carter, 1998).

Content of social skills training

SST may be used to teach people specific sets of social competencies. A common focus of SST programs is communication skills. A program designed to improve people's skills in this area might include helping them with nonverbal and assertive communication and with making conversation. It might also include conversational skills that are needed in different specific situations, for example job interviews, informal parties, and dating. The skills might be divided further into such subjects as beginning, holding, and ending conversations, or expressing feelings in appropriate ways.

Another common focus of SST programs involves improving a patient's ability to perceive and act on social cues. Many people have problems communicating with others because they fail to notice or do not understand other people's cues, whether verbal or nonverbal. For example, some children become unpopular with their peers because they force their way into small play groups, when a child who has learned to read social signals would know that the children in the small group do not want someone else to join them, at least not at that moment. Learning to understand another person's spoken or unspoken messages is as important as learning conversational skills. A social skills program may include skills related to the perceptual processing of the conversation of other individuals.

Scheduling

Social skills training may be given as an individual or as a group treatment once or twice a week or more often depending upon the severity of a patient's disorder and the level of his or her social skills. Generally speaking, children appear to gain more from SST in a peer group setting than in individual therapy. Social skill training groups usually consist of approximately 10 patients, a therapist, and a co-therapist.

Culture and gender issues

Social skills training programs may be modified somewhat to allow for cultural and gender differences. For example, eye contact is a frequently targeted behaviour to be taught during social skills training. In some cultures, however, downcast eyes are a sign of respect rather than an indication of social anxiety or shyness. In addition, girls or women in some cultures may be considered immodest if they look at others, particularly adult males, too directly. These modifications can usually be made without changing the basic format of the SST program.

Generalization or transfer of skills

Current trends in social skills training are aimed at developing training programs that meet the demands of specific roles or situations. This need developed from studies that found that social skills acquired in one setting or situation are not easily generalized or transferred to another setting or situation. To assist patients in using their new skills in real-life situations, trainers use role-playing, teaching, modeling, and practice. (Grizenko, Zappitelli,Langevin,Hrychko,El-Messidi,Kaminester,Pawliuk, &Marina, 2000)

Social skills training in combination with other therapies

Social Skills Training (SST) can be very effective when in combination with other psychotherapy programs (example Transactional, self-management training) for treating the underlying anxiety causing the fear.There are many reasons a person could have developed social phobias or social anxiety.For instance, Ayodele, (2011) in his study combined Social Skills Training (SST) with Enhanced Thinking Skills (ETS) and the result of his findings showed that SST is very effective in fostering interpersonal behaviour. Egbochukwu, Oizimende and Oliha (2015), also combined SST with Self- Management Skills (SMS) and the result of their study revealed that both treatment techniques are effective in reducing aggressive, destructive; stealing and

rules violation behaviours among secondary school students. Their findings also revealed that SST when combined with SMS is significantly effective in reducing conduct disorder among secondary school students.

Ayodele (2015) also combined SST with two othertherapeutic packages – ETS and Rational Emotive Behaviour Therapy (REBT) andfound that they are all effective in fostering intrapersonal relationship among Nigerian adolescents. Also, in the treatment of individuals with alcohol dependence, SST has been used together with cognitive restructuring and coping skills training. Social Skills Training has also been integrated with exposure therapy, cognitive restructuring, and medication in the treatment of social phobia. Social Skills Training has been used within family therapyitself in the treatment of marital and family conflicts.

Moreover, SST works well together with medication for the treatment of depression. For the treatment of schizophrenia, social skills training have often been combined with pharmacotherapy, family therapy, and assertive case management. Social skills training should rest on an objective assessment of the patient's actual problems in relating to other people. (Heinssen et.al., 2000).The benefits of social skills training programs include flexibility. The treatment can take place either as individual or group therapy, and new trainers can learn the techniques of SST fairly quickly. An additional advantage of SST is that it focuses on teaching skills that can be learned rather than emphasizing the internal or biological determinants of social adequacy.

2.2.3 Concept of Transactional Analysis Counseling Technique

Transactional Analysis is basically a description of what people do and say of themselves and to each other. Whatever happens between people involves a transaction between their ego states; when messages are sent, a response is expected. There are three types of transactions: complementary, crossed and ulterior. Complementary transactions occur when a message sent

from a specificego state gets the predicted response from a specific ego state of the other person. Crossed transactions occur when an unexpected response is made to a message that a person sends out. Ulterior transactions are complex.Transactional analysis is a talking therapy and sessions are designed to explore an individual's personality and how this has been shaped by experience - particularly those stemming from childhood. This is achieved through skillful questioning and the utilization of various models, techniques and tools. Sessions can be carried out in the form of one-on-one counselling, or with families, couples or groups. The atmosphere that supports transactional analysis is non-judgmental, secure and respectful, ensuring that a positive relationship is forged between the therapist and client(s) in order to provide a model for subsequent relationships and communication that are developed outside of therapy. In this setting the therapist works collaboratively with the individual to identify what has gone wrong in their communication and provide opportunities for them to change repetitive patterns that limit their potential. TA therapists recognize that we all have the potential to live the life we want, rather than the life we are programmed to live. Sometimes however this potential is hindered by repetitive patterns or 'unconscious scripts' that stem from childhood decisions and teachings.

A psychotherapy system used in both individual and group treatment, involving a systematic understanding of the qualities of interpersonal interactions in the treatment sessions; includes four components:

1. Structural analysis of intrapsychic phenomena.
2. Transactional analysis proper, determination of the currently dominant ego state (parent, child or adult) of each participant.
3. Game analysis, identification of the games played in the patients' interactions and of gratifications provided
4. Script analysis, uncovering of the causes of the patient's emotional problems. (Farlex Partner Medical Dictionary, 2012).

Transactional Analysis Psychotherapy is an integrative, relational, psychodynamic therapy grounded in humanistic psychology. It is a widely recognized form of modern psychology that involves a set of practical conceptual tools designed to promote personal growth and change. It is considered a fundamental therapy for well-being and for helping individuals to reach their full potential in all aspects of life. In counselling,Transactional Analysis (TA) therapy is very versatile, for it can be used in a wide range of areas and incorporates key themes from humanistic, integrative, psychoanalytical, psychodynamic therapies. Though it is commonly recognized as a brief and solution-focused approach, transactional analysis can also be applied as an effective long-term, in-depth therapy. Transactional analysis can help with a wide range of problems,

including personality difficulties, stress, depression, anxiety, anger, relationship problems, self-esteem issues, loss and grief.

The key concepts of transactional analysis are:

Ego-states: Ego-states refer to the three major parts of an individual's personality, and they each reflect an entire system of thought, feeling and behaviour. These determine how individuals express themselves, interact with each other and form relationships.

These are:

Parent ego-state - A set of thoughts, feelings and behaviours learnt from our parents and other important people. This part of our personality can be supportive or critical.

Adult ego-state - Relates to direct responses in the 'here and now' that are not influenced by our past. This tends to be the most rational part of our personality.

Child ego-state - A set of thoughts, feelings and behaviours learnt from our childhood. These can be free and natural or strongly adapted to parental influences.

Unconscious scripts: These will be analyzed using the ego-state model, and their identification is crucial to helping clients realize how certain permissions and prohibitions they received as a child are impacting their lives and how they communicate.

These unconscious scripts often exist as repetitive patterns of behaviour, thoughts and feelings - characteristics that suggest the child ego-state is overbearing and tainting other parts of a person's personality.

Transactions: When individuals communicate, their ego-states interact to create transactions. If the ego-states interact and blend in a healthy way, transactions tend to be healthier, but sometimes ego-states can contaminate each other to create a distorted view of the world. Transactions may be classified as straightforward, crossed-up, or ulterior, and understanding these is key to conflict resolution.

Strokes: Strokes refer to compliments, acceptance and recognition, which are influential in how people lead their lives. TA therapy recognizes that we are greatly motivated by the reinforcement we get as children, and if this was dysfunctional, we are likely to adopt dysfunctional patterns of living as we get older.

Intimacy: Another motivation recognized in transactional analysis is intimacy. Similarly to strokes, if the intimacy a child experiences is dysfunctional, then they will learn that this type of intimacy is the best he or she can do to meet basic needs and communicate with others. This can lead to the development of repetitive patterns of behaviour that can hinder a person's potential.

Redecision: This refers to an individual's capacity to redecide and make changes to certain decisions made as a child that stem from unconscious scripts. Redecision reflects the assumption of TA therapy that individuals have the potential to lead their lives as they choose. This power is released after a redecision is made while a client is in their child-ego state.

2.3 Theoretical Framework

Various theoretical foundations will assist in giving in-depth explanation to this study. Some of such theories that will be discussed in this study includeFreudian Psychoanalytic theory, Eric Erikson Psychosocial theory, Attachment theory, Eric Berne Transactional Analysis theory, Social Learning theory and Cognitive Behaviour theory. Each of these theories reveals adequate insight into different aspects of this study; for instance, Psychoanalytic theory provides explanations to the origin of adolescent behaviour and problems and/or the causes for their behaviour while psychosocial theory provides detailed information on the identity of crisis in the stages of development of children through to adolescence. Attachment theory explains the effect of parental attitude toward their children behaviour as well as parental relationship with their children. Eric Berne Transactional Analysis theory sheds more light on how the individual's thought and feelings have effect on the adolescents' social behaviour and the effectiveness of Transactional Analysis technique on Social withdrawal behaviour. The Social Learning theory is to assist in explaining the essence of Social Skills Training technique in this study while Cognitive Behaviour Therapy is to buttress the effectiveness of Transactional Analysis technique.

2.3.1 Freudian Psychoanalytic Theory

Sigmund Freud is the founder of this theory in the late 19th century. Psychoanalytic theory is the theory of personality organization and the dynamics of personality development; it is a clinical method of treating psychopathology. Psychoanalytic theory came to full prominence in the third of the twentieth century as part of the flow of critical discourse regarding psychological treatment after the 1960s long after Freud's death in 1939. Freud's psychoanalytic theory of personality argued that human behaviour was the result of the interaction of three components parts of the mind – the Id, Ego and Super Ego. His structural theory placed great importance on the role of unconscious psychological conflicts in shaping behaviour and personality.

According Heffner (2014), Feud believed that the majority of what an individual experience in life, the underlying emotion, believe, feeling and impulses are not available to them at a conscious level but rather most of what drives the individual is buried in the unconscious. Dynamic interactions among these basic parts of the mind were thought to carry human being through five psychosocial stages of development: oral, anal, phallic, latency and genital. According to Freud, there is crisis which must be worked through at each stage. If the crisis is not properly worked out, the individual could become fixated at that stage of development (Woolfolk, 2010). The genital stage is achieved if the person has met all of his/her needs throughout the other stages with enough available energy. Fixations are seen in adulthood as child-like approach to gratifying the basic impulse of the Id.

The oral stage is from birth to age 2 years and the major pleasure centers on the oral cavity, this involves developing the proper amount of sucking, eating, biting and talking which aids in early development steps such as breast feeding and speaking. Fixation at this stage might lead to drinking, smoking and nail biting or other mouth based behaviour.

Anal stage is between age 2-3years of age, the major pleasure centers here is the anal cavity that is the child's impulse is on how to control his/her excretory system. The goal at this stage is mastery of this system, which usually culminates improper toilet training. Children who do not adequately master this stage or who were harshly punished during toilet training process develop anal fixation. This might lead to anal-retentive personality – obsessively organized or excessively neat (overly tidy) or anal expulsive personality – reckless, careless, defiant, disorganize and socially withdrawn (overly messy), in which one is overly tidy and the other is overly messy.

Phallic stage comes between 3to 5years of age; the major pleasure center is the main genital organ in either boys or girls. The child is thought to develop his/her first sexual desire which is directed towards the opposite sex parent – the boys becomes very close and attached to the mother while the girls to the father. Children at this stage develop phallic fixation, which affect their relationships with their parents adversely, they also have interpersonal relationship problem with opposite sex among their peers.

Latency stage is between ages 5 to 12 years, the major pleasure centers are dormant sexual feelings for the opposite sex. At this stage, the child consolidates character habits developed in the previous three stages. If the child does not learn to derive pleasure from external source such as schooling and friendship, he/she may develop fixation, which makes the individual to be socially unacceptable, or rejected and in turn lead to social withdrawal.

Genital stage is between ages 12years and adulthood, invariably this is the adolescent stage and the pleasure center here is the surge of sexual hormones in the body during puberty. Adolescents are supposed to establish relationship and interaction with their peers in order to master this stage, however, if they do not transit well at this stage they become fixated and become socially withdrawn having unsuccessful relationship and interaction problem with their peers. Social Withdrawal in adolescents can evolve from fixation at any of the Freudian psychosexual stages of development.

As earlier mention Freud's psychoanalytic theory of personality argued that human behaviour was the result of the interaction of three components parts of the mind – the Id, Ego and Super Ego – and he believed that these three personality components are needed to be well-balanced to produce reasonable mental health and stability in an individual. The Id functioning as the irrational and emotional part of the mind, the Ego functioning as the rational part while the Superego as the moral part of the mind, a manifestation of the society or parental values. Berne took inspiration from Freud's theories of personality, combining them with his own observations of human interaction inorder to develop Transactional Analysis (TA) wherein

social transactions are analyzed to determine the ego state of the individual (whether parent-like, child-like or adult-like), like Freud, Berne postulated that each individual possess three "ego states" - the parent, the child and the adult states - which were largely shaped through childhood experience, although these three are all part of Freud's ego none represent the Id or the Superego. They represent an individual's internal model of parents, adults and children and an individual may assume any of these roles in transaction with another person or in internal conversation. Hence Freudian Psychoanalytic theory can be linked with the use of Transactional Analysis in treating Social Withdrawal behaviour and other interpersonal relationship issues.

2.3.2 Erik Erikson Psychosocial Theory

Erik Erikson developed this theory from Freud's psychosexual stages of human development. Erikson, like Freud was largely concerned with how personality and behaviour is influenced after birth – not before birth – and especially during childhood. Erikson's Psychosocial terms is derived from two source words – namely psychological – relating to the mind, brain, personality, behaviour, attitude and social which is external relationship and the environment, both words at the heart of Erikson's theory. Erick Erickson, argued that each age has its own special social and emotional conflicts (Kalat, 1996). Progression from the "infant" stage through the "older adult" stage seems logical and seamless. For an average person, the journey through social and emotional development often presents challenges.

Erikson's psychosocial theory asserted that people experience eight psychosocial crisis stages, which significantly affects each person's development and personality. Each of the eight psychosocial crisis stage asserted by Erikson involves a crisis of two opposing emotional forces, these he called "contrary dispositions". Each crisis of two opposing corresponding life stage and its inherent challenges. Successful passing through each crisis stage involve achieving a healthy ratio or balance between the two opposing dispositions that represents each crisis. In each stage, the person confronts and hopefully master new challenges. The theory postulates must build on the successful completion of the earlier stages, the challenges of stages that are not successfully completed may be expected to reappear as a problem in the future.

Erik Erikson's eight psychosocial stages of life are as follows:

No	Psychosocial crisis stages	Life stage/Age range	Other description	Virtue outcome
1.	Trust vs. Mistrust	Infancy/ 0-5years	Birth to baby walking	Hope &Drive
2.	Autonomy vs. Shame and Doubt	Early childhood/1-3years	Toddler, toilet training	Will power &self-control
3.	Initiative vs. Guilt	Play age/3-6years	Preschool, Nursery	Purpose & Direction
4.	Industry vs. Inferiority	School age / 7-12years	Early school	Competence

				& method
5.	Identity vs. Role confusion	Adolescence / 13-19years	Puberty and teenage	Fidelity, confusion & Devotion
6.	Intimacy vs. Isolation	Young adult / 20-34years	Counting early parent	Love & Affiliation
7.	Generality vs. Stagnation	Adulthood 35-65year	Middle age, parenting	Care & production
8.	Integrity vs. Despair	Mature age 65-old age	Grand parent	Wisdom & remuneration

In all these psychosocial stages of development, stage five – Identity vs. Role confusion – whose virtue is fidelity is very relevant to this study, this stage of development signifies the adolescent stage. Identity means essentially, how a personsees his/herself in relation to the world around. It is a sense of individuality in the context of life and what lies ahead. Role confusion is the negative perspective – an absence of identity – meaning that the person cannot see clearly or at all who they are and how they can relate positively with their environment. Relating this to the adolescent stage, as adolescents make transition from childhood to adulthood, they struggle to belong and to be accepted and affirmed and yet also to become individuals this in itself is a big dilemma aside from all the other distractions and confusions experienced at this life staged.

According Bee (1992), what should happen at the end of this stage is a reintegrated sense of self, of what one wants to do, and of one's appropriate sex role. Success in this stage will lead to virtue of fidelity which involves being able to commit oneself to others on the basis of accepting others even when there may be ideological differences. During this period, the adolescents explore possibilities and begin to form their own identity based on the outcome of their explorations. Failure to establish a sense of identity with society, in response to role confusion, the adolescent may begin to experiment with different lifestyle and become socially withdrawn.

In addition, pressurizing an individual into identity can result in rebellion in form of establishing negative identity and feeling of unhappiness. Stevens as cited in Adeusi, 2013) reported that adolescent are confronted with the need to reestablish boundaries for themselves for themselves and to do this in the face of an often potentially hostile world is often challenging since commitment is requested before particular identity roles are formed. At this point, one is in a state of identity confusion, but the society normally makes allowance for the youth to find themselves and this state is called "The moratorium" (when a person can freely experienceand explore what may emerge as a firm sense of identity, an emotional anddeep awareness of who he or she is). Dependent on this stage is the quality of fidelity, this is the ability to sustain loyalties freely inspite of the inevitable contradictions and confusions of value system. The inability of an adolescent to resolve the crisis at this stage will result to infidelity,

which is a pointer to the onset of behaviour problem such as **social withdrawal**, isolation, aggression and so on.

2.3.3 John Bowlby's Attachment Theory

Attachment theory is one of the most studied aspects of psychology today, it is believed that attachment behaviours formed in infancy will help shape the attachment relationship people have as an adult, some psychologists such as Harris and Field, disagree with the idea. Elliot and Reis (2003) reported that the first and most well-known view on attachment theory is that of John Bowlby, who is known as thefather of attachment theory. He believed that attachment begins at infancy and continues through life and there are several innate behavioural control systems that are the need for survival and procreation. The attachment and exploration systems are central in Bowlby's attachment theory. Bowlby's ethological attachment theory (1969, 1982) provides an essential framework for understanding the impact of early social/emotional relationship on cognition – effective structure used by the child to construct views of the world, self and others. Attachment theory addresses socio-emotional development from the perspective of both process and outcome, and has identified a variety of markers predictive of later academic performance, social competence and psychopathology. Attachment theory provides an awareness of and new history and the subtleties of observed child, parent and teacher's behaviour in the current context.

Bowlby established the foundation for Ainsworth's attachment theory, which also believed in the control system but went further with the strange situation, which splits attachment up, into three types: Secure, Avoidant and Resistant.The Secured type is when an infant seeks protection or comfort from their mother and receives care consistently. Here, the mother is usually rated as a loving and affectionate.

The Avoidant type is when the infant tends to pull away from their mother or ignore her. The mother is usually rated a rejecting of the child attachment behaviour.

The Resistant type is when the infant tends to stay close to their mother. The mother is usually rated as being inconsistent in their case. (Fraley &Spreker, 2003).

In the work of Main and Solomon (1990) a forth category was devised (disorganized-disoriented) in which there is no predictable or effective pattern if eliciting care-giving behaviours by infants when stressed. Each of these attachment classifications, across the lifespan, may be considered on a continuum of emotional regulation for managing affect, events and relation (Dozier, Strovall&Albus, 1999). Those with disorganized-disoriented attachment classifications may present range of behaviour involving under-controlled emotional reaction such as impulsive verbal and/or physical aggression or over-controlled responses in which emotions are difficult to express and behaviour may reflect withdrawal and difficult handling of conflict, (Jacobite&Hazen, 1999). Their emotional reactions are unpredictable and typically maladaptive.

Klaus, Kennelland Klaus (1995) reported that the primary care giver is usually the mother and strong bonds are formed within minutes of giving birth. It is important for new parent and baby to be alone together right from birth to establish a strong bond. If there are too many individuals in the room right after birth, the natural process of attachment can be disrupted and this can have long-term effect on the relationship between children and parent. They show that the children whose mothers are given an extra five hours of contact a day for the first three days of life have significantly higher IQ scores. These children scores higher on language and comprehension tests by five, than children whose mothers are not even given extra time.

According to Allen and Ladd (1999), as a child reaches adolescence, they tend to depart from the attachment relationship with parental type figure. Attachment bonds between parents and adolescents are treated by many adolescent more like ties that restrain that anchor and secure and a key task of adolescence is to develop autonomy so that they no longer need to rely much on parental support when making their way through the world. The adolescents form a new way of attachment and this new form of attachment is predictive attachment behaviour such as with their own kids or in marital relationships. Although the parent and child attachment does not become less important at adolescence, still, the adolescents just become less dependent on the parents. Hence, they try to reach autonomy, exploring the ideas of being independent, but when the independency becomes too overwhelming, they can turn to their parents, the secure base for help. A way of seeking independence from parent is to rely more on peers as attachment figures. Adolescents will form long-term relationship with their peers that may become full attachment.

Friendship attachment are more important during adolescence because they are sources or emotional security and support; contexts for growth in social competence and prototypes of later relationship (Seiffge-Krenke, 1993). However, if adolescent could not adequately form this friendship attachment with the peers or rejected by the peers and their parental attachment is the insecure type, such adolescent may not be able to grow in social competence and such become socially withdrawn. Insecure attachment system have been linked to psychiatric disorder, to which a child is especially susceptible after the loss of an attachment and reacts in a hostile, rejecting manner with their environment (Pickover, 2002).

Harris (1998) said that peers have more to do with a child's personality than the parents do. Krukar also agree with this but only to a certain extent, she is of the opinion that the parents have sort of an obligation to the child to show who "good" person is and who is a bad person. From that, the child should be able to put the two apart, if the parent shows consistent behaviour with the child. If the attachment bond between parent and child is good, then the child should follow along in the path with whom to be friends. From the point of choosing friends, weight is put unto children and their peers. If the peers are "good" friends, they will respect the child's decision and opinions, if they are "bad" friends then they will place a lot of disrespects on the child and therefore the avoidance, withdrawal and resistant personality will come forth. At this point, the secure personality may get pushed back and the child's self-

esteem becomes low, if this continues to happen, then the child's self-esteem will become consistently lower than when he or she bonded with the parent.

Insecure attachment, especially when combined with other developmental risk factors such as low socio-economic status (SES), chaotic home environment and inconsistent hostile rejecting material behaviour, is associated with higher risk for both internalizing and externalizing behaviour problem presumably, via the internal working model (IWM). Although insecure attachments are not pathological state in themselves, current research does suggest a strong relation between one's early attachment classification and later social, emotional, behavioural and academic outcomes, (Goldberg, 1997; Jacobsen & Hofmenn, 1997). Jacobsen andHofmenn, (1997) also reported that children with secure attachment are more likely to develop internal representations of others as supportive, helpful and positive and to view themselves as competent and worthy of respect. They relate more positively to both peers and adults, demonstrate great ego-resiliency, engage in more complex play and receive higher socio-metric rating than children classified as insecure.

Cassidy (1994) also found them to exhibit more flexible and socially appropriate emotional expression and control; they show more focused attention and participation in class, and earn higher grades (Jacobsen &Hofmenn, 1997). Securely attached children also demonstrate better functioning goal-corrected partnership, characterized by more mature perspective-taking mutual communication of effect and joint planning than insecure, disorganized-disoriented peers. They also exhibit a more positive, integrated view of self, are more prone to positive disclosure and cope more adaptively with stressful situation than the insecure adolescents, while Dozier, Lomax, Tyyrelland Lee (2001) reported that adolescent with an anxious-avoidant attachment style also demonstrate distancing strategies to minimize emotional stress. In clinical setting, their distrust of others, lack of comfort with interpersonal issues and tendency towards non-disclosure contribute to their being less responsive to therapy.

Cassidy (1994), Rosenstein andHorowitz (1996) reported that adolescents with anxious-resist attachment demonstrate a greater frequency of anxiety disorder, dysthymic traits and borderline personality disorder than secure and other insecure categories. Carson (1998) expressed that the problems of disorganized attachment orient primarily around aggressive and disruptive behaviour and social isolation. Jacobiteand Hazen (1999) suggested that under stress the disorganized sees others as potential threats and might shift between social withdrawal and defensively aggressive behaviour, thus exhibiting difficulties in responding appropriately and contingently to others. This theory reveals the reason why children develop and exhibit Social Withdrawal behaviour due to their attachment to their parent as they are growing.

2.3.4 Eric Berne Transactional Analysis Theory

Transactional Analysis theory was originally developed by Eric Berne (1961) who was trained as a Freudian Psychoanalyst and Psychiatrist. It evolved out of Berne's dissatisfaction with slowness of psychoanalysis in curing people of their problems. Transactional Analysis therapy is

a Humanistic, Existential, dynamic theory of personality and a therapeutic modality whose practitioners believes human are born in an “OK” state, which each person is unique, and that people ultimately are responsible for their own behaviour and destiny. The theory includes theories of child development and psychotherapy, which form the basis of a theory of psychotherapy and also theory of communication for understanding groups and organizations.

It is used primarily as a therapeutic tool and has its root in behaviourist and humanist tradition, essentially combining some tenets of cognitive behaviourism and psychoanalytic insight. It is based on the assumption that every individual make current decision based on past premises (that is premises that were at one time appropriate for survival needs but may no longer be valid). The Transactional Analysis therapist work with Ego state which is a set of related thoughts; feelings and behaviour in which part of an individual’s personality is manifested at a given time (Stewart & Joines, 1987). Each person have basic trio of Parent, Adult and child (P-A-C) Ego state and the individual constantly shift from one ego state to another, manifesting behaviour congruent with the ego state of the moment (Dusay, 1986).

The parent ego state contains the values, morals, core beliefs and behaviour incorporated from significant authority figures, primarily one’s parent. These can be “Critical Parent” or “Nurturing Parent” which the individual expresses outwardly. When the individual is at the parent ego state, he/she reacts to situation as imagined the parent might have reacted, or in the way his/her parent acted towards them. The Parent ego statecontains all the “shoulds” and “oughts” and other rules for living. When an individual is in that ego state, he/she may act in ways that are strikingly similar to those of his/her parents or other significant people in the early life. The individual may use some of their very phrases, and his/her posture, gestures, voice, and mannerisms may replicate those that he/she experienced in the parents.

The Adult ego state is the processor of data. It is the objective part of the person, which gathers information about what is going on. It is not emotional or judgmental but works with the facts and with external reality. The Adult is without passionate convictions, but many problems also require empathy and intuition to be resolved. The Child ego state is the original part of us and is most naturally who we are. It consists of feelings, impulses, and spontaneous actions and includes “recordings” of early experiences. The Child ego state is divided into Natural Child (NC) and Adapted Child (AC), both of which have positive and negative aspects. The positive aspects of the Natural Child are the spontaneous, ever so lovable, loving and charming parts of all of us. The negative aspect of the Natural Child is to be impulsive to the degree our safety is compromised. The positive aspect of the Adapted Child is that we respond appropriately in social situations. The negative aspect of the Adapted Child involves over adapting wherein we give up our power and discount our value, worth, and dignity. Clients in TA therapy are first taught how to recognize in which of the ego states they are functioning at any given time: Nurturing Parent, Critical Parent, Adult, Nurturing Child, or Adapted Child. The aim is to enable them to decide consciously whether that state or another state is most appropriate or useful.

Transactional analysis emphasizes our ability to become aware of decisions that govern our behaviour and the capacity to make new decisions that will beneficially alter the course of our life. It is an extension of psychoanalysis with the concepts and techniques especially designed for group treatment. It is rooted in an anti deterministic philosophy, placing emphasis on the ability of an individual to rise above habit pattern and to select new goals and behaviours even with the influences of social forces. The main goal of T.A is to gain awareness spontaneity and the capacity for intimacy that is to achieve autonomy. In achieving autonomy, the individual have the capacity to make new decision (redecide), thereby empowering themselves and altering the course of their lives.

As a part of the process of TA therapy, clients learn how to recognize the three ego states—Parent, Adult, and Child—in which they function. Clients also learn how their current behaviour is being affected by the rules they received and incorporated as children and how they can identify the "life-script" that is determining their actions. This approach focuses on early decisions that each person has made, and it stresses the capacity of clients to make new decisions to change aspects of their lives that are no longer working.

The basic goal of transactional analysis is to help clients make new decisions about their current behaviour and the direction of their lives. Individuals learn alternatives to sterile and deterministic ways of living. The essence of therapy is to substitute an autonomous lifestyle characterized by awareness, spontaneity, and intimacy for a lifestyle characterized by manipulative game playing and a self-defeating life-script. Individuals learn to "write their own script" instead of being passively "scripted." Since TA is a contractual therapy, the therapist and the client collaboratively establish the specific goals that guide the therapy sessions.

Various other views of TA goals have been expressed, a few of which are:

• Being a catalyst to enable clients to mobilize their efforts (Dusay&Dusay, 1989).

• Helping clients obtain a friendly "divorce" from their parents (Berne, 1964).

• Helping clients break through a series of impasses that stem from injunctions and early decisions (Goulding & Goulding, 1979).

Transactional analysis identifies four basic life positions, all of which are based on decisions made as a result of childhood experiences, and all of which determine how people feel about themselves and how they relate to others:

1. I'm OK—You're OK.

2. I'm OK—You're not OK.

3. I'm not OK—You're OK.

4. I'm not OK—You're not OK.

The I'm OK—You're OK position is generally game-free. It is the belief that people have basic value, worth, and dignity as human beings. That people are OK is a statement of their essence, not necessarily their behaviour. This position is characterized by an attitude of trust and openness, willingness to give and take, and an acceptance of others as they are. People are close to themselves and to others. There are no losers, only winners.

I'm OK—You're not OK is the position of people who project their problems onto others and blame them, put them down, and criticize them. The games that reinforce this position involve a self-styled superior (the "I'm OK") who projects anger, disgust, and scorn onto a designated inferior, or scapegoat (the "You're not OK"). This position is that of the person who needs an underdog to maintain his or her sense of "OKness."

I'm not OK—You're OK is known as the depressive position and is characterized by feeling powerless in comparison with others. Typically such people serve others' needs instead of their own and generally feel victimized. Games supporting this position include "Kick me" and "Martyr"—games that support the power of others and deny one's own.

The I'm not OK—You're not OK quadrant is known as the position of futility and frustration. Operating from this place, people have lost interest in life and may see life as totally without promise. This self-destructive stance is characteristic of people who are unable to cope in the real world, and it may lead to extreme withdrawal, a return to infantile behaviour, or violent behaviour resulting in injury or death of themselves or others.

The issue of Social Withdrawal behaviour in adolescent can then be seen as product of the inability of the adolescents to be congruence and inability to socialize properly with the peer as a result of not being able to identify his/her ego state hence the need for transactional Analysis therapy. The counsellor assists clients in discovering the disadvantageous conditions of the past under which they made certain early decisions, adopted life plans, and developed strategies in dealing with people that they might now wish to reconsider. From the perspective of redecision therapy, the counselor's function is to create a climate in which people can discover for themselves how the games they play support chronic bad feelings and how they hold onto these feelings to support their life script and early decisions.

Another function of the TA therapist is to challenge clients to discover and experiment with more effective ways of being. The role of the therapist is to help individuals acquire the tools necessary to effect change.TA concepts and techniques can be usefully applied in guidance classes in schools with children ages 5 to 17 (Thompson & Henderson, 2007). A main goal of a transactional analysis with students is to facilitate insight so that they are able to assume increased control of their thoughts, feelings, and actions. As children and adolescents develop this self-understanding, they also acquire the ability to make changes both within themselves and in their transactions with others.

Widdowson (2013) expressed that in theoretical terms, TA holds that this can be understood as enabling clients to either stay or return to their Adult ego state. From a more general

psychotherapeutic perspective, it might be thought that this process enables clients to develop a systematic approach to self-reflection that was then used to self-generate options in how to respond- both internally and externally- to different situations. The use of TA theory also gave the clients a way to make sense of frightening or distressing experiences by helping them to gain insight into their reactions and increase their sense of self-efficacy.

2.3.5 Albert Bandura's Social Learning Theory

Social Learning Theory was proposed by Albert Bandura (1969) who believed that direct reinforcement could not account for learning. He posits that learning is a cognitive process that takes place in a social context and can occur purely through observation or direct instruction, even in the absence of motor reproduction or direct reinforcement. Hence, the theory disagrees with psychoanalytic theory, which believes that humans are innately aggressive and tat frustration automatically leads to social withdrawal or aggression. The theory is of the opinion that people can learn new information and behaviour by watching other people, which is known as an observational learning and or modeling (Ormod, 1999). Another concept of social learning theory is the notion that internal mental states are an essential part of the process of observation and modeling.

The theory also recognizes that just because something has been learned does not mean it will bring about behaviour change. Social learning theories focus on the effect of thought on action and action on thought.Social learning theory is a perspective that states that social behaviour (any type of behaviour that are displayed socially) is learned primarily by observing and imitating the actions of others. The social behaviour is also influenced by being rewarded or punished for these actions.

Bandura's social cognitive theory has expanded the horizon of behaviourism and increased its relevance to the study of personality by increasing psychology's awareness of how situational factors shape behaviour. Social learning theory is a learning theory based on the ideas that people learn by watching what others do, and that human thought processes are central to understanding personality. The theory provides a framework for understanding, predicting and changing human behaviour.

Bandura proposes that people are neither driven by inner forces nor automatically shaped and controlled by external stimuli; rather, human functioning is explained in terms of a model of triadic reciprocal determinism. In this model, which can be visualized as an equilateral triangle, behaviour, cognitive and other personal factors and environmental events all operate as interacting determinant of each other. The nature of persons is then defined within this triadic perspective. Therefore the nature of a person who emerges is unique even though all people are defined within the triad. Because people possess self directive capabilities they are able to exercise significant control over their thoughts, feelings and actions. This self-regulatory function forms an important part of the social cognitive theories. There is a continuous interplay between the self-generated and the external sources of influence. People create guides for their

behaviour, self-motivators for courses of action and then respond to their behaviour in a self-evaluation way.

Social Learning theory has also stimulated current research on social withdrawal. It was suggested and it is now known that children learn about their worlds and how to behave within them, through direct peer tutelage as well as by observing each other. In this regard, children punish or ignore non-normative social behaviour and reward or reinforce positively those behaviours viewed as culturally appropriate and competent. In ethological theory, it is argued that there is relationship between biological and the ability to initiate, maintain or disassemble social relationship. It is a central tenet of ethological theory that social behaviour and organizational structure are limited by biological constrains and that they serve an adaptive evolutionary function (Hawley, 2003).Anderson (2004), Robert, Nyla and Donn (2009, page 213-235) reporting Albert Bandura's social learning theory which proposed that observational learning can occur in relation to three models:

i. Lives Model– in which an actual person is demonstrating the desire behaviour.

ii. Verbal instruction - in which an individual describes in detail, and instruct the participants on how to engage the behaviour.

iii. Symbolic – in which modeling occurs by means of the media, including movies, television, internet, literation and radio. This type of character demonstrating the behaviour.

In correlating the same wrong behaviour and consequences of wrong modeling in individual, social learning theory put up some techniques such as behaviour rehearsal, social skills training and so on, whereby the individual with wrong behaviour patterns will be exposed to new behaviour patterns and skills which will be aided by demonstration and training of skills by the therapy, (Davidson & John, 1994).

According to social learning theory, observational learning is comprised of four component processes: (a) attention, (b) retention, (c) motor reproduction, and (d) motivational:

1. Attention – “People cannot learn much by observation unless they attend to, and perceive accurately, the significant features of the modeled behavior.” (Bandura, 1977b, p. 24).
2. Retention – “People cannot be much influenced by observation of modeled behavior if they do not remember it.” (Bandura, 1977b, p. 25)
3. Motor reproduction – “The third component of modeling involves converting symbolic representations into appropriate actions…by organizing one’s responses spatially and temporally in accordance with the modeled patterns.” (Bandura, 1977b, p. 27)
4. Motivational process – “People do not enact everything they learn. They are more likely to adopt modeled behavior if it results in outcomes they value than if it has unrewarding or punishing effects…those behaviors that seem to be effective for others are favored over behaviors that are seen to have negative consequences.” (Bandura, 1977b, p. 28).

The above four component processes is been employed in using SST which is an independent variable of this research study. The research upon which this theory rests contains many facets that help to explain how people acquire knowledge about human social behaviour that is needed in order to function well; and one of the important facets of human social learning is modeling. Social Skills Training is one of the techniques derived from social learning theory which is based on the principle of setting clear expectations with specific instructions, coaching the individual through the use of frequent prompt, using modeling or vicarious identification, engaging individual in role

playing behavioural rehearsal and offering abundant positive feedback or reinforcement for small improvement in social behaviour.

2.3.6 Cognitive Behavioural Therapy (CBT)

Cognitive Behavioural Therapy (CBT) combines basic theories about how people learn (behaviourism) with theories about the way people think about and interprets events in their lives (cognitive) (Patterson, 2009). CBT was pioneer by psychologists Aaron Beck and Albert Ellis in the 1960s (Gale Encyclopaedia of medicine, 2008). It is one of the major orientation of psychotherapy and represents a unique category of psychological intervention because it is derived from cognitive and behavioural psychological model of human behaviour that includes for instance theories of normal and abnormal development and theories of emotional and psychopathology (Roth &Fonagy, 2005).

CBT is generally short termed and focused on helping client deal with specific problems. It helps clients understand the thoughts and feeling that influence behaviours. It is commonly used to treat a wide range of disorder including phobias, addictions, depression, anxiety and social withdrawal. It is a form of psychotherapy that helps persons to change unhelpful and unhealthy thinking habit, feelings and behaviour. It is a therapy that treats problems and boosts happiness by modifying dysfunctional emotion, behaviour and thoughts; it focuses on solutions, encouraging patient to challenge distorted cognition and change destructive patterns of behaviour.

Grohol, (2011) maintained that CBT combines two very effective kinds of psychotherapy: cognitive therapy and behavioural therapy. Behaviour therapy helps to weaken one connection between stimuli (people, situation or events) and their habitual, undesirable reactions to them. These undesirable reactions may include anger, fear, sadness, self-defeating or self-damaging behaviour, worry panic, social withdrawal and so on. Behaviour therapy also teaches relaxation strategies to calm the mind and the body so that the on can feel better and think clearly. Cognitive therapy on the other hand, emphasizes the role of thinking in how we feel and what we do. Cognitive therapist instructs the clients to identify unhealthy thoughts that can lead to unwanted feelings and behaviour. The clients are taught how to replace unhealthy thoughts with healthier thoughts that can lead to more desirable reaction. When cognitive therapy combined with behaviour therapy into CBT, they both provide very powerful tools for stopping symptoms of worry, fear, shyness, social withdrawal, social isolation, anger, and depression, sensitive to rejection, low self-esteem and anxiety.

Cognitive Behaviour Therapy focuses on the ‘here and now’ instead of focusing on the cause of the issue, and breaks overwhelming problems into these smaller parts to make them easier to

deal with these parts can be described as thoughts emotions, physical feeling as well as the actions. Each of these has the ability to affect the other, for instance the way an individual think about himself/herself and about 7 things can affect the other the emotional and physical feeling as well as the way the individual behaves. Evidence has shown that CBT is not only effective in helping people to get better but it is also effective in minimizing relapses or helping people stay better. It emphasizes the process of learning in improving and maintaining behaviour. CBT place emphasis on certain cognitive techniques that are designed to produce changes in thinking and therefore changes behaviour or mood. It also emphasizes the learning process and ways in which external environment can change both cognition and behaviour.

CBT for children and adolescents usually includes a range of behaviour performance–based procedure and often involves the family or school in therapy, BusariandUwakwe(2001). Cognitive Behaviour therapy has been shown to be beneficial when a student has adequate verbal and intellectual abilities, when cognitions are thought to be problematic in anxiety inducing situations like social withdrawal and where compliance is good with respect to self-monitoring. Neil and Christensen (2009) in a review of the effectiveness of school-based prevention of early intervention program for anxiety, reported that most universal, selective and indicated prevention programmes effectively reduce symptoms of anxiety in children and adolescents with effect size ranging from 0.11 to 1,37.

CBT is a short-term, goal-oriented psychotherapy treatment that takes a hand-on, practical approach to problem-solving, its goal is to change pattern of thinking or behaviour that are behind people's difficulties, and so change the way they feel. It is used to help treat a wide range of issues in an individual's life, from sleeping difficulties, avoidance behaviour or relationship problems, to drug and alcohol abuse. It works by changing the individual's attitude and behaviour by focusing on the thoughts, images, beliefs and cognitive process and how this relates to the way the individual behave, as a way of dealing with emotional issues. The important advantage of CBT it tends to be short, taking four to seven months for most emotional problem. The client attends one session per week, each session lasting for 50minutes approximately. During this period, the client and the therapist work together to understand what the problems are and to develop new strategy for tackling the problems. Cognitive behaviour therapy (CBT) styles include cognitive restructuring, rational-emotive and behaviour therapy, systematic desensitization, **Social Skills Training** and rational-emotive therapy.

2.4 Empirical Studies

This section of this chapter discusses some empirical studies related to Social Withdrawal behaviour in adolescents. These studies include those carried out in developed countries and developing countries. Although, studies on social withdrawal is scarce rather it is seen as social isolation, social incompetence or social inhibition, which are the subtypes of social withdrawal. Building upon the extant theoretical work, strong empirical support has developed for the

notion that peer interaction (and lack thereof) and the relationship that derive from children's interaction of solitude can serve to promote both adaptive and maladaptive social, emotional, and social-cognitive functioning (Rubin et al, 2006). These studies are summarily cited as follows:

Social Withdrawal: Nnodum (2001) in his research also remark that isolates are unable to solicit for assistance from people around them; they find it difficult ask for classification or questions on confusing or unclear issues, initiate, participate in and terminate conversation or discussion. They find it difficult to express their feelings easily, joins groups or engage in group work. They are shy and often engage in negative talk or self-defeating statements. Ogunbawo (1988) also supports this in his study of isolates where he finds that social isolates exhibits low self-concept and find it difficult to show appreciation and comment good acts or gestures among others. With all these features of social isolates, social isolation can then be related to social withdrawal hence being an isolate is a manifestation of extreme or high level of social withdrawal. Coplan, Rose-Krasnor, Weeks, Kingsbury, Kingsbury and Bullock (2012), in their study on social motivational, Social Withdrawal and socio-emotional functioning of later childhood discovered that older children provide valid self-report of their social motivations and suggested that regardless of their differences in their underlying motivational substrates, *all* forms of social withdrawal appear to be poorly received by peers in late childhood. Overall, social withdrawal (both in the schoolyard and outside of school) was associated with self-reported negative peer relations. Accordingly, socially withdrawn behaviours appear to remain a marker for difficulties in the peer group, and thus, these behaviours must be considered as a potential risk factor for socio-emotional difficulties during this age period. Their study also revealed that different subtypes of socially withdrawn children evidence markedly different patterns of socio-emotional functioning in their later childhood.

Nnodum (2002) in his study on the effect of Assertive Training technique in reducing Social Withdrawal tendencies in students reported that socially withdrawn students has numerous negative effects on the individual. It is highly handicapping and creates maladjustment in most aspects of the individual's life such as his social, intellectual, personality, language development and academic achievement. It's negative effect on mental development and lowering of academic performance in the individual. This is to confirm the past findings of Ezewu (1978), Ogunbawo (1988) and Ladele (1981).

Using a person-centered approach, Coplan and Weeks (2010b) used maternal ratings to identify groups of unsociable, shy, and nonwithdrawn-comparison children aged 6–8 years. Results indicated that shy children reported the most loneliness and least school liking, and they were rated by parents and teachers as having the highest levels of internalizing difficulties and peer problems. In contrast, unsociable children did not differ from comparison children on any of the indices of socio-emotional functioning. Ladd and colleagues (Ladd et al., 2011) used peer-nominations to identify groups of unsociable, anxious-solitary (shy) and nonwithdrawn children in Grade 5 (aged 10–11 years). Among their results, anxious-solitary children were more

excluded by peers than were unsociable children, who in turn were more excluded than the nonwithdrawn comparison group.

Bowker and Raja (2011) explored the correlates of unsociability in a sample of adolescents in India. Their findings indicated that after controlling for other forms of social withdrawal, a newly developed self-report assessment of unsociability was not significantly associated with peer-rated social difficulties tha is, exclusion, rejection, victimization) or self-reported loneliness. In a sample of children aged 6–14 years, Coplan, Wilson, Frohlick, and Zelenski (2006) used more general assessments of approach to reward (behavioural activation system or BAS) and high avoidance of punishment (behavioural inhibition system or BIS) to identify a group of children who were both low-BAS and high-BIS. Compared with other groups of children, these "avoidant" children reported the highest levels of negative effect, depressive symptoms, and social anxiety and the lowest levels ofpositive affect and overall well-being. The authors speculated that children characterized by the combination of both a low approach to reward and a high avoidance of punishment may share some conceptual similarity with the socially avoidant children described by Asendorpf (1993). In their study of adolescents in India, Bowker and Raja (2011) developed a new self-report assessment of social avoidance. Avoidance was found to be significantly and positively correlated with both sad and nervous affect. As well, in regression analyses controlling for shyness and social disinterest, avoidance was found to be a significant predictor of peer-exclusion and loneliness.

Wichmann, Coplanand Daniels (2004) reported that when 9 -13 years old withdrawn children were presented with hypothetical social situations in which ambiguously negative events happened to them, they attribute the events to internal and stable "self-defeating" causes. Their findings also revealed that withdrawn children more than non-withdrawn children when faced with such negative situations, they were more with failure experiences and withdrawn children reported that a preferred strategy would be to withdraw and escape. According to Rubin et al (2009), taken together these theories and data supportive of them have led psychologist to conclude that peer interaction and relationship are important force in the development of normal social relationship. They speak to the development of competent behaviour styles and adaptive extra-familiar relationship. The theories offer little with regard to establishing how insufficient or deficit interaction and relationship can lead to maladaptive behaviour style or to non-existent or dysfunctional extra-familiar relationship.

Rubin,Bowkerand Kennedy, (2009) in their study discovered that a "negative feedback loop" may evolve, wherein the initially fearful and withdrawn child comes to believe that his or her social failures are internally based and these self-blamingbeliefs are reinforced by not only the expectation of peer rejection but also the experience of failed initiatives and peer non-compliance.Biovinand Hymel, (1997) and Biovin, HymelandBukowski, (1995) in their similar research found that when a socially withdrawn child is confronted by "real-life" social world, the withdrawn children may be less able than their non-withdrawn peers to meet their social due to their self-blaming and negative social-cognitive tendencies. The "negative feedback loop" may account for the consistent finding that in the middle and later years of childhood, socially

withdrawn children develop negative self-perception, poor self-esteem and feelings of loneliness.

Lemerise and Arsenio (2000) integrated emotional experience into Crick and Dodge's social information-processing model. The inclusion of emotion into this model is important to the study of socially withdrawn children, because it is likely that many withdrawn children react to negative social situations with fear and anxiety. These emotions, in turn may influence the information that is attended to and the information that is recalled. And this mood-congruent information processing might reinforce withdrawn children's social schemas or "working models" that the social world is fear-inducing. Indeed, these emotional responses may explain in part why some children withdraw in social company.

From a theoretical perspective, one may surmise that it is the lack of peer interaction that leads to such deficits in thinking about solving social problems and about others' thoughts, feelings and perspectives. However, neither longitudinal nor experimental studies exist to address this issue of causality. And by mid and late childhood, many socially withdrawn children do not have difficulty in proactively generating solutions to meet some social goals (e.g. objective acquisition; making a new friend; seeking help from a peer) presented to them in hypothetical interpersonal dilemmas (Rubin 1985). These findings may suggest that only minimal experiences in peer interaction or simply observing others solving their interpersonal dilemmas over time is required for the development of some adaptive ways of thinking about solution to interpersonal problems. Rubin, Hastings, Henderson and Chen (1997) regards social withdrawal behaviour or social inhibition as a pattern of responding or behaving, possibly biologically based, such that when unfamiliar or challenging situation were encountered, the individual showed signs of anxiety, distress or disorganization. Asendorpf (1990, 1991) has reported that some children have a low social approach motive without a high avoidance motive. These children demonstrate more objects- than person-oriented activity and prefer quiescent, exploratory or constructive solitude to social activity (referred to as "solitude-passive play").

Adolescents with Social Withdrawal: Adolescence is a unique developmental period, a time of confusion and turbulence. It is a period characterized by strong desire for freedom and independence combined with an increased need for social support from peers. It is also a period of demand for sense of belonging from peers and family members especially parents. As adolescents navigate their world, close peer relationship offers many protective benefits. Adolescents formulate group alliance to provide them with the needed psychological support and sense of belonging. An increased need emerges for social support and emotional connection with the peer group. They desire confidence with who to talk to about their peers, personal lives and challenges. The deeper quality of friendship such as similarities in personality and emotional intimacy becomes essential component of adolescent relationship, (Pollack & Shuster, 2000).

According to Qualterand Munn (2002), one of the strongest indicators of psychological health in adolescents is a sense of meaningful connection with peers. As such, adolescence can be time when an individual is psychologically vulnerable to the risk associated with feelings of social withdrawal from peers, this feeling of social withdrawal contributes to the occurrence of poor psychological health during adolescence. Hansen, GiacolettiandNangle (1995) revealed that children and adolescents with close and supportive friendship report a high level of peer acceptance, increased social competence, and highlevel of motivation as well as increased levels of self-worth, leadership skills and improved school performance. Rubin, Bukowskiand Parker (1998) further expressed that the quality of peer relationship in childhood and adolescencemay be one of the most important indicators of future psychological health. Berndt, Hawkins and Jiao (1999) reported that adolescents who do not report having close friendship consistently have lower level of self-esteem and more psychological symptoms of maladjustment, all these are signs of social withdrawal behaviour.

Social Withdrawal during adolescence is usually a very painful emotional experience, particularly when adolescent's perception of quality and closeness of peer relationship are consistently associated with issues of self-esteem, perceptions of social competence and internalizing problems such as depression (Weinberg, 2001). Previous research reveals that suicidal behaviour among adolescents is associated with low level of close friendship support (Prinstein, Boerger, Spirito, Little &Grapentine, 2000). Further, Harter, Marold, WhitesellandCobbs (1996) reveals that adolescents who report strong social support demonstrate increased level of resilience and decreased level of suicidal risk. Perception of positive relationship with family and friends are associated with lower level of suicidal ideation and suicidal attempt. While DeWilde, Kienhorst; Diekstraand Wolter (1993) reveals that adolescents who report feelings of support by school staff, family or peers display more effective coping mechanism and communicate more positive attitude about their future. In contrast, adolescents who report lack of social support and feeling of isolation may behave in self-harming ways such as suicidal ideation and suicidal attempt (Spruijt&deGoode, 1997).

The school setting is another important social context for adolescent development and academic achievement is a prominent indicator of their ability to adapt to expectations of school environment; hence, their ability to cope also depends on their level of socialization. Christenson, Sinclair, Lehr and Hurley (2000). Masten, Hubbard, Gest, Tellengen, Garmezyand Ramirez (1999); Sinclair, Christenson andThurlow (2005) associates educational goals and active engagement in academics with resilience and positive outcomes such as school completion. As a result, academic achievement may represent a potential protective factor for socially withdrawn/isolated adolescents. According to Eisenberg, Neumark-Szsainerand Perry (2003), students with higher level of school connectedness report significant lower level of psychological problems, suicidal attempt; violence behaviour and peer harassment. Strong connections to school exert powerful influence in the lives of students. For some, relationships with educators are among the most meaningful in their lives (Anderson, Christenson, Sinclair & Lehr, 2004; Garbarino, 1999; Hawkins, Catalano &Kosterman, 1999).

Strong connection to school are associated with safe behaviour, improved health outcomes for adolescents, better academic performance and more extra-curricular involvement Bonny, Britto, Klostermann, Hornungand Slap (2000). Roeser, EccesandSameroff (2000) also explain that relationship between students and teachers have positively associated with students' motivation, achievement, feeling of belonging and effect in school. Hall-Lande, Eisenberg, Christenson andNeumark-Sztainer (2007) found in their study that the relationship among social isolation/Social Withdrawal, psychological health and protective factors remains an important issue in the field of adolescent health. Association between social isolation from peer and psychological health remained strong even after adjusting for these protective factors, suggesting the importance of close relationships. They also reported that social isolation is significantly associated with symptoms of depressive and lower level of self-esteem, which in turn may contribute to additional peer relationship problems and increased feeling of social withdrawal.

Gender Difference and Social Withdrawal: Coplanand Rubin (1998) in their research though could find significant gender difference in the frequency of various withdrawal behaviour but they were able to find gender differences in the outcomes associated with the display of these behaviour. While Nelson, Rubin andFox(2005) revealed in their study that withdrawal behaviour have more maladaptive outcomes for boys than girls throughout childhood and adolescence as expressed by Morrison andMastert (1991). Results from Coplan, ClossonandArbeau (2007) suggested that shyness in boys is more strongly associated with socio-emotional difficulties such as loneliness, anxiety, lower self-esteem, than shyness in girls. Henderson, Fox and Rubin (2001) found that negative reactivity at 9 months predicted display of social wariness at age 4years for boys but not for girls. Stevenson-Hindeand Glover (1996) in their research on Shy girls and boys found that mothers interacted more positively with extremely shy boys than they did with extremely shy girls and for moderately shy girl compared to moderately shy boy. Thus the sex differences obtained seemed to depend on the levels of shyness/withdrawal among boys and girls and they also reported that shyness in girls is more likely to be discouraged and result in more negative interaction. Morrison andMastert (1991) in their study of Peer reputation in middle childhood as a predictor of adaptation in adolescence found that the risk ofbeing socially withdrawn (as asserted via peer nominations) might differ depending on the child's sex. For example,withdrawnisolateboys reported lower self-esteem and less perceived athletic ability in adolescence than did girls.

Hall-Lande, Eisenberg, Christenson andNeumark-Sztainer (2007) found in their research that family connectedness was the only protective factor that influence the relationship between social isolation and suicidal attempt, family relationship may fulfill need for intimacy that is important psychological well-being in socially withdrawn/isolated girls may not be achieved in relationships with school staff or by sense of achievement in school. Therefore socially isolated/withdrawn girls may find the most effective elements in relationship with family member, while for boys, academic achievement and school connectedness mediated the

negative influence of social withdrawal in addition to the family connectedness as a significant protective factor in their environment.

Gender difference can also evident in terms peers' reaction to shy/withdrawn children. Gazelle and Ladd (2003) reported that in early childhood shyness and social withdrawal are more strongly associated with peer exclusion and rejection for boys than for girls. This finding sheds more light on the mechanism by which shy boys come to experience more negative outcome later in life as reported by Asendorpf et al (2008). A number of longitudinal and correlational studies have suggested a different risk status for boys and girls who may experience social withdrawal and fearfulness in the company of peers. Caspi, Elder and Ben (1988) reported that men who were shy/withdrawn at 8 to 10 years old boys were delayed, relative to the norms, with regard to the timing of marriage, parenthood and career establishment. These men were also at greater risk for separation and divorce in adulthood. On the other hand, withdrawn females were "on- time" and adjusted with respect to adult-role transition into married and homemaking, and they did not evidence psychological difficulties. Rubin, Chen andHymel (1993) found that relative to socially normal children, extremely withdrawn 11year-old boys, but not girls described themselves as being lonelier and having poor social skills. The different outcome associated with withdrawal in boys may be partly attributed to societal or cultural expectations; in western societies, shyness/withdrawal appears to be less acceptable for boys than for girls.

Past research has emphasized the important role that family-related variables play in the prediction of various adolescent risky behaviours. It also seems likely that the impact of adolescent risk factors on adult outcomes is influenced, for the better or worse, by the adolescent's family unit. Family structure research has shown that divorce can be a major force in shaping children's live. Marital disputation is associated with cognitive, emotional and behavioural problems and lowered academic achievement in children who have undergone the dissolution. Establishing a family structure is the first step in teaching the child norms but when a household goes through a change, the child often loses sense of values and norms. Studies have shown that a single headed parent home deprive the child from learning proper social norms as the child would experience from a two parent household. Every household outcome is different; they vary between the gender of the child, resources, household income, education, parent and child interaction and much more parental discipline.

Rubin et al (2009) in their study reveals that overcoming, intrusive parent and overly protective parenting style is strongly associated with socially withdrawn behaviour. They reported that parents who are overly protective and directive tend to over-manages behaviours, discourage independence and control their children's activities.As a result, it was suggested that dispositionally inhibited children who are overly restrictive, protective and controlling parents may not develop necessary coping and problem-solving strategies in their interpersonal milieus. In transactional models of the development of social withdrawal and anxiety, parenting behaviours are thought to reinforce the child's feeling of insecurity, resulting in the maintenances of cycle of child hopelessness/helplessness and parent overcontrol/overprotection.

Research has found that parental socialization promotes positive moral development and serves as a protective factor against antisocial behaviour during adolescence. In effect, parenting behaviour such as poor supervision, harsh and inconsistent discipline and poor parenting technique may place adolescents at risk of developing social withdrawal behaviour. Some researcher reveals that adolescent are at the risk of engaging in delinquent behaviour when they are exposed to ineffective parenting techniques such as parental rejection, harsh and inconsistent discipline and poor family relationship. According to Williams andChang, (2000), "juveniles will return to future delinquent act if their parents remain unchanged in the areas of consistent limit, settling, rebuilding emotional attachment and imp rode communication" Kochanska et al (2000)in their recent study highlighted the importance of a positive child relationship and suggested that attachment moderated the relation between parental responsiveness and early conscience development, such that responsiveness was only related to positive outcomesfor children who were securely attached.

Coplan, ArbeauandArner (2008) reported that a moderate role of parental characteristics in relations between temperamental shyness and socio-emotional adjustment in Kindergarten. Results indicates that relations between shyness (as assessed at the start of school year) and indices of maladjustment (at the end of the school year) were significantly stronger among children with mothers characterized by higher neuroticism, threat sensitivity and an overprotective parenting style and significantly weaker for children with mother characterized by high agreeableness and an authoritative parenting style.

During the past decade, investigations have consistently reported linkages between maternal control and over-protectiveness alongside children's social withdrawal behaviour, anxiety and shyness (Bayer, Sanson& Hemphill, 2006). Rubin, Hasings, Stewart, Henderson and Chen (1997) found that mothers of temperamentally shy toddler were over-solicitious; that is they were observed to be highly affectionate and shielding of their children when it was neither appropriate nor sensitive to do so. Examining the developmental differences in two dimensions of attachment security (Parental availability and child dependency on parents) in late childhood and early adolescence using Kern's Security Scale and their association with peer relations using Friendship quality scale. Girl's perceptions of mother's availability and boys' perception of father's availability did not differ as a function of age, dependency on parents, however, decreased with age.

Findings highlight the importance of distinguishing between availability and dependency on parental help when measuring attachment developmentally. Children's report of positive friendship qualities and lack of conflict in theirbestfriendship were related to attachment to both mother and father indication that the quality of parent-child attachment generalizes primarily to the quality of children's close peer relations.

Social Skills Training Counselling Technique: Social Skills Training Counselling Technique has been implemented for children and adolescents by different researchers for the treatment of various social, emotional and interactional problems and encouraging results have been reported. For example; Fashina (1990) revealed in his research on relative effectiveness of SST and TA on the improvement of Nurse/patients relationship that SST was able to help in improving interpersonal relationship more effectively when compared with the TA. He also

affirmed that TA helped improve communicative relationship between the Nurses and patients. His findings revealed that SST leads to significant change in the Nurses' social skills such as communication and listening skills.

Quinn et al (1999)were less positive in their conclusions, finds only a small effect (199) in a meta-analysis of SST children with emotional and behavioural problems, despite studies using an average of 2.5hours of SST per week over 12 weeks. Although these findings appear to be discouraging, meta-analytic studies have shown that the impact of SST varies according to the type of intervention, measures used and lengthof follow-up. Schneider (1992) concluded that SST was more effective with withdrawn children (.69) than with unpopular (.37), aggressive (.37), not atypical (.32) or other (.48) children. In congruence, Kvarme (2010) posits that previous studies have shown that socially isolated and withdrawn children are at risk of developing problems at school. They report lower self-efficacy for assertive and non- isolated and withdrawn children need help to improve their social skill (Marchant, Solano,Fisher, Caldarella, Young & Renshaw, 2007).

Bada (2010) in his research work on the effect of moral and social skills training on behaviour maladjusted youth in Nigeria revealed that SST is effective in the treatment of maladjusted behaviour among the youths. Bada (2015) also further investigated the gender influence on SST among socially maladjusted youth in Nigerian secondary school and the findings of his study revealed that SST is effective in correcting the socially maladjusted students and it help more in girls with the mean score of 109.90 than that of the boys of mean score of 79.03, the study also revealed that the social skill of females are influenced by many factors including inter-hemisphere communication, greater verbal ability and differential socialization by parents and peers.

Ayodele (2011) in a similar study, sought to establish the effect of Enhanced thinking Skill (ETS) and social skills training (SST) in fostering interpersonal behaviour among Nigerian adolescents; employed a pretest and post-test experimental control group design with 3x2 factorial matrix and used gender considered at 2 levels along with 2 experimental and one control group as a moderator variable. The study participants were 120 Senior Secondary School 2 and 3 students randomly selected from 3 chosen secondary schools in Sagamu LGA of Ogun state. Their study revealed that both ETS and SST were effective in fostering interpersonal behaviour among the adolescents but ETS was found to be more effective than SST. This study also revealed that both ETS and SST did better with females compared to males. Based on the findings, it was recommended that all caregivers must continuously update their skills on the use of ETS and SST to help adolescents live meaningful and fulfilled live.

Ayodele (2015) conducted a study on the differential effectiveness of three therapeutic packages in the fostering adolescents' intrapersonal relationship and found that SST when combined with other techniques is effective in improving intrapersonal relationship among the adolescents in Nigeria. Egbochukwu et. al. (2015) investigated the effect of self-management skills and Social Skills Training techniques on the reduction of adolescents' conduct disorder and the findings of their study showed that SST when combined with SMS is significantly effective in reducing conduct disorder among secondary school students. Their study also revealed that both treatment techniques are effective in reducing aggressive, destructive; stealing and rules

violation behaviours among secondary school students. Their findings also revealed that SST being a technique involving learning activities was able to reduce conduct disorder among the adolescents

The teacher and school psychologist in this study were provided with one hour training two sessions on how to implement this intervention prior to the actual instruction. This study used two different but comparable first grade classrooms in the Midwest and used a pre-test /post-test design measuring peer ratings of appropriate social behaviour for all students in each of the classrooms. The peer ratings were on a five point Likert-type scale and measured the students on like to work with and like to play with criteria. After the initial ratings by all students, both groups, one led by their teacher in the classroom and the other led by the school psychologist in another classroom, were given 30minutes of social skills training twice a week for four weeks.

The results of this study showed that the students in the teacher-led group showed significant improvement in the like to work with peers ratings, and there was also an improvement in the like to play with peers rating for this group as well as compared to the school psychologist-led group. The success and improvement of peer acceptance of the teacher-led group over the other may have been as a result of the fact that it was easier for the students to practice and receive reinforcement for their use of appropriate social skills in their classrooms. It seems that it may be helpful for teachers to directly instruct their students in social skills to improve deficits, however many teachers do not lead them to push the intervention to the side in lieu of their many other responsibilities throughout the school days.

Kopelowicz, Lieberman and Zarate (2006) reported in their study of effect of Social Skills Training on Schizophrenia patients that social skills training if carried out with structure designed intensity, culture specific module, patiently and adequately timed, will improve the personal competences among individual with schizophrenia, thereby soothing their pre morbid lack of social skills. Kopelowiczand Lieberman, (1998) reported that evidence for the efficacy of social skills training has accumulated for the following outcomedimensions, acquisition, durability and utilization of the skill in real life; improvements in social functioning; reductions in relapse rates and hospitalization; and enhanced quality of life.

Schneider and Byrne,(1985) who conducted a large meta-analysis of social skills training studies, indicated that social skills interventions were more effective for pre-schoolers and adolescents than elementary children. No gender differences in the effect sizes were noted (although few studies have treated gender as an independent variable). In addition, social skills training; was found to be more effective for withdrawn and learning disabled students than for aggressive students. Converse to what often is expected; the duration of interventions was related negatively to the outcome.According to Glynn, Marder, Lieberman, Blair, Wirshing, Ross andMintz (2002) and Lieberman, Glynn, Blair, Ross and Marder (2002), Social skills training has been well documented as the technique of choice for helping individuals with serious and persistent mental disorders to acquire skills, durably maintain the skills and successfully transfer the skills to everyday life.

In a social skills training research, Segrin (2001), sought and documented a variety of strategies that hold benefit in teaching students with interpersonal difficulties and came out with the following strategies: Personal coping skills such as anger management, are abilities to

focus on problems and what triggers the problem. They established that adolescents who are hungry, anxious, of lower intelligence, tends to show less ability to control their anger. Teaching positive self-talk, problem-solving techniques and relaxation to aid in recognition and reduction of stress and anger is critical. Skills essential for anger management include – non-antagonistic response skills, personal or self-awareness, personal arousal signals as cues to use non-antagonistic strategies, perception of self-control over situation and self-instruction techniques to deal with each of provocation, and maintaining high self-esteem. Direct instruction with social reinforcement to encourage individuals has also been continually used to help students manage anger.

Self-control strategies: self-control is a powerful generalization tool and is not dependent on a special education teacher or being in a special environment. Generalization of self-control strategies that are strengthened by self-monitoring, self-evaluation and self –reinforcement can be used as a complement to teacher-mediated behaviour management approaches in the classroom. Segrin therefore postulated that three steps are involved; self-monitoring which should occur after target behaviour is clearly defined (e.g. self-monitoring for increasing on-task behaviour during independent seatwork). Self-evaluation: in which student can compare their behaviours to externally determined standards and render a judgment of quality and acceptability. Self-reinforcement in which guidelines for using self-control strategies including defining target behaviour, providing direct instruction, monitor accuracy, fading overt procedures, provide programme for generalization and valuation considerations.

Social Skills Training is therefore typically used in association with interpersonal problem solving skills training, cognitive restructuring, training in social perception and social perspective, self-regulation skill training, modification of environmental contingencies, and affect regulation methods (such as relaxation training). As therapists and researchers came to realize that interpersonal problems such as social withdrawal occurs in association with many forms of psychopathology and require remediation, they also recognized the inadequacy of SST as a sole intervention for adolescent emotional and behavioural difficulties. Interventions such as contingency management, parenting skill training and behaviour self-regulation, self-management methods and assertive training were best recognized as being psychological best-practices.

Transactional Analysis Counselling Technique: Nlemadim, FalayeandOkoiye (2013) in their study on the effect of self-efficacy and transactional analysis techniques in enhancing social competence among socially isolated pupils; using pre-test/post-test, control group experimental design with a 3x2x2 factorial matrix. Multi-stage sampling technique was used to select three local governments and 60 participants from three private primary schools in Ibadan. Participants in the two treatment groups were exposed to eight weeks of self-efficacy and transactional analysis techniques training. Their study revealed that there was a significant main effect of treatment on social competence score of socially isolated pupils. Also, there was significant main effect of friendship ability making skills on social competence of participants.

However, there was no significant main effect of gender on the social competence of male and female participants. It also revealed that transactional analysis technique is effective in enhancing social competence among socially isolated pupils in private primary schools which

implies that the challenges of social incompetence can be managed using Transactional Analysis. And that the skills learned would enable socially isolated primary school pupils develop the required confidence that would enable them succeed in developing good interpersonal relationship with their peers in school. They therefore recommend that teachers should endeavour to create interactive environment that would enable pupils relate with each other during and after classroom teaching learning situation. This would motivate pupils to overcome their social incompetence and be socially competent.

Afolayan and Falaye (2010) in their study on use of Self-Management Techniques (SMT) and Transactional Analysis (TA) to enhance self-disclosure of HIV positive status, used introverts and extroverts male and female participant, revealed that the exposure of the participants to the treatments (SMT and TA) encouraged their self-disclosure as well as strengthen their interpersonal communication skills. In a similar study on titled Psychotherapy and disclosure of sero status, Falaye and Afolayan (2015) found out how Transactional Analysis can be used to enhance Self- disclosure of HIV+ status and their findings showed that the 30 participants exposed to TA received awareness and develop self-confidence. The result also revealed that TA is effective in enhancing self-disclosure of positive sero status and in the process of the treatment that participants are able to interact and transact greatly with themselves thereby promoting their interpersonal relationship.

OlusakinandAremu (2010) in their study of socially incompetent reveals that transactional analysis is effective in improving the social competence of adolescents by helping them develop their thinking skills and care that is able to appraise positively stimuli from their social environment and relate in appropriate ways to enhance their social competence.Steiner (2002) noted that transactional analysistherapy creates positive changes in people, relationship and the working environment in relating to self and others while providing coping strategies for understanding the past, managing the present and creating the future. This allows a person to take charge of his life.

Ebrahimisani, Hashemian and Dvkanhan (2012) in their study of the effectiveness of Transactional Analysis group therapy in increasing self-esteem, showed that communication skills of the group exposed to TA were improved and that clients found a new attitude towards their own behaviour and emotion after participating in the group Transactional Analysis therapy and interacting with other members of the group. Their study also revealed that attitude influences the members' conception of the self; the group members become more committed to the accomplishing the group tasks and gained back

their self-esteem and self-confidence. They also express it that TA can be used in any situation where understanding people and interpersonal relationship is needed.

In the studies of Ahmadi (2010), Farhangie, Mohammadian (2007) and Sqty, Abadi and Sudan (2010), it was revealed that TA improves self-esteem and this was supported by Ghi(2007) who showed in the study that psychological therapy and education including TA can help enhance the clients' self-esteem, communication skills and emotional reactions as well as help them stop drug abuse. McCullough, Ashbridge and Pegg (1995) have also reported in their research that TA canbe useful in treating family relationships, parental conflicts with teenagers, group quarrels, behavioural deviations, drug abuse, criminal behaviour and alcoholism.And that Transactional analysis group therapy is not only effective in increasing the self-esteem of soldier-guards serving in prisons but also improves their behaviour and interpersonal relationships.

Emdady and Shafiabadi (2013) in their study of the effect of group counseling with transactional analysis method on university students' general health, The participants were 170 girl university students chosen random stratified sampling and General Health Questionnaire(GHQ) were done on 170 people which among 100 of them had higher than 22 GHQ. In this research which is classified as experimental type, the least 40 people, two groups of 20, one experiment group and the other control, were chosen randomly from two. 10 sessions of TA group counseling method for the experiment group and nothing for the control group were done. Afterwards, the GHQ administered operated for both. The implement was GHQ and statistical data analysis was done by independent T, dependent T and co-variance analysis.

Results showed that TA group counseling method in 10 sessions had significant effect about 'depression', 'anxiety', 'sleep disorder' reduction and 'social performance' improvement and 'general health' increase comparing with the control group. They revealed that group counseling with TA method helps with encouraging adult ego stateand balancing child ego-state, adult ego-state and parental ego-state, developing communication issues and self-leadership and finally general health, reduces anxiety and naughtiness, helps students' physical responses; leads to students' depression reduction. Also group counseling with TA method by self-control and concentration lead to anxiety reduction TA method works on accurate communication skillsand people have better communications by learning TA patterns, because this helps them to understand moods, passion and tendencies better and finally improve their social performance.

Stuart and Alger (2011) in their study on the use of Transactional Analysis in Secondary Educationgave a brief overview of TA and its relevance to secondary education – for pupils, teachers and school improvement. Their study present the findings of the case study on teaching TA to children and young people from 11 – 25 and their teachers. They found that children, young people and teachers with TA skills have better self-awareness, increased understanding of others and as a consequence better relationships and candemonstrate impact on attendance, attainment, personal and professional livesand school climate overall.

Widdowson (2013)researched on the Process and Outcome of Transactional Analysis Psychotherapyfor the treatment of depression: an adjudicated case seriesused systematic case study research which incorporated both quantitative and qualitative methods to investigate the process and outcome of TA psychotherapy for depression. A naturalistic design was used and five cases were examined to explore the application of up to sixteen sessions of TA therapy in community-based routine practice. Four of the cases were analyzed using Elliott's (2001, 2002) Hermeneutic Single-Case Efficacy Design. The findings show that TA therapy can be effective for the treatment of depression. A benchmarking strategy suggests that TA is likely to have comparable effectiveness to other therapies. The clients in this series all reported finding the use of TA theory to understand their own process and take charge of their own change process to be helpful. The use of TA concepts and language provides the therapist and client with a framework for a collaborative approach to therapy. Another similar investigated the effectiveness of TA for treatment of depression: the controlled trial conducted by Fetsch and Sprinkle (1982). Their study found that four weeks of TA group therapy was sufficient to produce reliable improvement in cases of mild depression.

In a study looking at the effectiveness of therapies in routine practice, found that short-term TA therapy had comparable effectiveness to Integrative Counselling Psychology and (using a benchmarking strategy) found that both approaches demonstrated effectiveness equivalent to CBT as delivered within the Improving Access to Psychological Therapies

(IAPT) initiative. Van Rijn *et al.* found that short-term TA therapy had a recovery rate of 57%.

2.5 Summary

The Literatures revealed the view of various researchers about Social Withdrawal behaviour, they viewed is as a broad construct that can be described in different forms such as shyness, unsociability, social avoidance, social inhibition, social isolation; social incompetence and so on. Social Withdrawal was defined as a process whereby an individual (children and adolescents) remove himself or herself from opportunities of social interaction and interpersonal relationship with the peers and other adults around and decides to be alone all the time. It also involves withdrawal from familiar and unfamiliar peers and adults.

The review revealed the causes of social withdrawal behaviour among students and these include environmental causes which are: 1. Home background- separated/broken home and intact home, parenting style, school environment and nature of people to interact with. 2. Biological causes which was as a result of the gene, level of closeness or attachment to the parent and parental neglect and rejection. Literatures also revealed the consequences of Social Withdrawal behaviour on the students, the stress and trauma of being socially withdrawn and how it brings about victimization, bullying, rejection and how it was highly handicapping and creating behaviour in most aspect of the students' life. The feeling of anxiety, low self-esteem, slow self-concept, low self-confidence and low self-perception; the socially withdrawn could end up being depressed. The review showed the effect of Social Withdrawal behaviour on the students' academic performance and achievement, school attendance and adjustment.

The review revealed that socially withdrawn students lack some social skillssuch as communication, listening, language and interpersonal relationship skills; problem solving and decision making skills and as such the need to be taught these skills and Social Skills Training (SST) treatment technique was revealed to be effective therapy for improving the students social skills. In the same vein, Transactional Analysis treatment technique was revealed to to be effective in improving the social competence, self-esteem, self-concept and self-confidence of the socially withdrawn students. Literature reviewed some counseling theories that are linked with the study and these theories include Freudian's Psychoanalytic theory, Erik Erikson's Psychosocial theory, John Bowly's attachment theory; Eric Berne's Transactional Analysis theorySocial learning theory and Cognitive Behaviour therapy.

The empirical studies revealed that students at different level exhibit social withdrawal behaviour and it has really affected their emotional, psychosocial wellbeing, as well as academic performance and achievement. Their interpersonal relationship was also revealed to be gravely affected by the social withdrawal behaviour the exhibited. The review revealed that Social Skills Training (SST) technique was implemented for the children and adolescent exhibition Social Withdrawal and some other related behaviours and they showed that SST was every effecting and brought about positive behaviour changes. The review also showed that SST when combined with other treatment techniques like Self-Management Skills, Problem-solving skill,

Enhanced Thinking Skills, Transactional Analysis and so on was found to be effective in improving interpersonal relationship, interaction, communication and listening skills, reduce aggressive, destructive, stealing and rule violation behaviouramong the students.

Literatures also revealed the effectiveness of TA improving the social competence, self-esteem, self-exposure and self-exposure of the socially withdrawn and social incompetent student. It was also revealed that TA is effective in strengthening the interpersonal communication skill of the participants and that it helped the students bring about new attitude towards their behaviour and emotions. They revealed that TA counseling technique brought about self-awareness, increased understanding of others and positive impact on attendance in school as well as help the students develops their thinking skills. The focus of this study is to find out whether SST and TA Counselling Techniques would reduce the level of social withdrawal behaviour among secondary school students in the Federal Capital Territory. This study revealed that Social Skills Training and Transactional Analysis Counselling Techniques was able to reduce the moderate and high level of Social Withdrawal Behaviour among secondary school students

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter presented detailed and precise description of the methods and procedures adopted for conducting the research which includes the research design, population, sample and sampling techniques, conceptual model, control of intervening and extraneous variables, treatment procedure, instrumentation and procedures for data collection and analysis.

3.2 Research Design

The research design used for this research study was quasi experimental design involving pretest-posttest control group treatment design. This is because it is capable of establishing cause and effect relationship as well as ability to manipulate two or more independent variables at a time without random assignment to condition (Yusuf, 2013). The quasi experimental pretest-posttestcontrol group design can best be diagrammatically illustrated as follows:

O_1 X O_4 ========== Treatment group
O_2 X O_5 ========== Treatment group
O_3 O_6 ==========Control group

Where: O_1, O_2 and O_3 are the pretest for the Social Skills Training (SST) treatment group, Transactional Analysis (TA) treatment group and control group respectively; the X stands for the SST and TA treatments given to the treatment groups and the O_4, O_5 and O_6 represents the posttest for the SST treatment group, TA treatment group and the control group respectively.

This research study was a quasi experimental design because it was conducted in school situation and only the group of students that showed moderate and high symptoms of Social Withdrawal behaviour participated in the research.

3.3 The Population

The population of this study consisted of all senior secondary school year 2 (SSS 2) students of about ten thousand six hundred and fifty (10,650) from the fifty five (55) Co-educational senior secondary schools in Federal Capital Territory (FCT) and the population was made up of 5245 male and 5405 female students.

3.4 Sample and Sampling Technique

The sample size for this study is Sixty (60) Senior Secondary School year 2 students selected from three (3) senior secondary schools out of the entire fifty five (55) schools within FCT. The sample size of sixty (60) was used because the study is an experimental research which does not require large sample size and also to have manageable counselling group in each of the treatment and control groups. The sampling technique used for the selection of the three schools and Sixty (60) participants was purposive sampling technique; this is for easier manageability and to allow the researcher select the participants exhibiting Social Withdrawal behaviour from the larger population of the selected schools in the Area Councils in Federal Capital Territory. Being an experimental research, few participants are required in the counselling group to ensure effectiveness. This according to Patton (2002) is a technique as selecting samples within samples and can lend credibility to a research study. It also illustrates characteristics of subgroup of interest and facilitates comparison.

To identify student exhibiting Social Withdrawal behaviour, a Social Withdrawal Checklist developed from a standardized psychological test Personal Problem Checklist by Adedipe, (1990) (revised in 2008) was administered on all the Senior Secondary School year 2 students in the three selected schools. Therefore the sample size was based on the respondents who had the highest score in the level of social withdrawal issues. The following table is showing the distribution of obtained sample size by the schools:

Table 3.1: The distribution of sample into 3 schools

School	Group	Treatment	No of Participants
School A	Experimental group	Social Skills Training	20
School B	Experimental group	Transactional Analysis	20
School C	Experimental group	No Treatment/Placebo	20
Total			60

3.5 Instrumentation

The instruments used for this research study are two which are:

Social Withdrawal Checklist (SWC)

This instrument was adapted, modifiedand developed by the researcher from a standardized psychological test designed by Adedipe (1990) (revised in 2008).The instrument provided standard scores used in identifying student that are exhibiting social withdrawal behaviour. The instrument is made up of two sections A and B, the section A contained the demographic information such as school, class, name and gender, while the section B comprises of 20 items drawn-out from the interpersonal relationship section of the original psychological test and are structured in 4-point Likert scale form.

Scoring method: The responses categories of the SWC were weighed as follows:

Always true– 4, Often true – 3, Not often true – 2, Never true – 1

The sum of the weight of all the items chosen by the participant represents the individual's total score and the highest score is 60 and above, high score is 30-60 while the lowest score was 0-29. Therefore, any respondent who score 30 and above was identified to be exhibiting social withdrawal behaviour and was selected as part of the participants.

Social Withdrawal Questionnaire (SWQ)

This was used as the major instrument for the datacollection in the pretest and posttest.The Social Withdrawal Questionnaire (SWQ) consist of twenty five (25) items drawn out, adapted and modifiedby the researcher from two existing standardized instruments which are:

- Coping strategies inventory (Social Withdrawal items) by Tobin (2001) and
- Social Phobia Inventory (SPIN) by Davidson (2013).

This instrument consist of two sections A and B, the section A is designed to obtain the participants personal data such as school, class, gender;while the section B consist of twenty five (25) items structured in 4-point Likert scale form

Scoring key of the instrument: All the items in section B of the SWQ were scored on the 4-points Likert scale form to identify the level of Social Withdrawal behaviour exhibited by the participants. The responses categories of the SWQ were weighed as follows:

Always true– 4, Often true – 3, Not often true - 2, Never true – 1

The sum of the weight of all the items chosen by the participant represents the individual's total score. Adopting the SPIN scoring guide method as follows:

Severity	None	Low	Moderate	High
Score	Less than 15	15 - 29	30 - 59	60 and above

Any participant that scores 60 point and above exhibit high social withdrawal behaviour, 30 - 59 points exhibits moderate social withdrawal behaviour, 15-29 points exhibit low social withdrawal behaviour and less than 15 point means none. The score of low and none are negligible and was not considered in this study.

3.5.1 Validity of the Instruments

The content and face validity of the instrument(SWQ) was established by giving copies to three supervisors and three other professional experts in the Department of Educational Psychology and Counselling, Ahmadu Bello University, Zaria. Their suggestions, recommendations (such as the including some items that will make the instrument useful in identifying the students as well as make them express their feelings) and corrections (such as changing some words and phrase of some of the items so that the students will understand them better and they will measure what they are meant to measure)were adequately implemented in order to gain the content and face validity of the instrument.

3.5.2 Reliability of the Instruments

In order to establish the reliability of the instrument, Social Withdrawal Questionnaire (SWQ) , a pilot test was carried out on a sample of fifty (50) Senior Secondary School year 2 (SSS2) students of Government Secondary School, Kwali, Abuja, who were not part of the selected participants meant for the study. A test-retest was employed at interval of two weeks to test reliability co-efficient of the instrument; Pearson's Product moment correlation co-efficient method was used to test the result and the co-efficient obtained was 0.90. Reliability co-efficient of 0.90 showed that the instrument was statistically reliable and considered suitable for the study and subsequently the researcher used the instrument.

3.6 Treatment procedure

The treatment procedure was divided into three phases which are: pre-treatment phase, treatment phase and post-treatment phase. After identifying the students exhibiting social withdrawal behaviour in the school selected, the researcher adequately inform all the participants of the importance of the research and the need for them to be honest, trustworthy and have confidence in the smooth conduct of the research. The participants were also assured of confidentiality concerning the personal information given by them during the research.The researcher with the help and support of the research Assistants (school Counsellors and class teachers) administered the instrument.

3.6.1 Pre-treatment phase:

The researcher visited the selected schools with approval letter obtained from the FCT Secondary School Board (FCT SEB) to the Principals two weeks before the commencement of the treatment phase, this is to seek approval from the Principals; meet and familiarize with the

school Counsellors, the research assistants and the participants. The researcher also administered the Personal Problem Checklist (PPC) to all SS2 students so as to identify the students exhibiting social withdrawal behaviour thereafter; the identified students were grouped into the treatment groups and Control group participants.

The researcher then explained to the participants what the study was all about, how helpful it will be to them and expectations required of them, gave a copy of the PPC and Social Withdrawal Questionnaire (SWQ) to the school counsellor and the class teacher for them to go through. Thereafter the researcher with the support of the counsellor and one of the class teachers administered the Social Withdrawal Scale (SWQ) to the three group members at the appropriate time and venues as the pre-test and baseline data. The time required for them to completely respond to the SWQ is a maximum of thirty (30) minutes. The SWQ was collected at completion, scored and analyzed by the researcher with an estimate of return rate of about 95 to $100^0/_0$ across the schools.

3.6.2 Treatment Phase:

This phase involved exposing the participants to group counselling intervention sessions. The students that participated in this phase were sixty (60); they were selected out of the 300 students that took the Personal Problem Checklist (PPC) in the three selected schools. The sixty (60) students were assigned into three groups with each group comprising 20 participants each. The group and the school were labeled experimental groups 1 and 2, and control group. The experimental group 1 was exposed to Social Skills Training (SST) treatment technique, while the group 2 was exposed to Transactional Analysis (TA) treatment techniques and control group was placed on placebo. The treatment programmes lasted for six (6) consecutive weeks of one session per week. Each session for each group lasted for 50 minutes after school hours at different days of the week and there were also in sessions question and answer, discussion and brainstorming. The researcher used the idea gathered from the discussion, question and answer as value added knowledge. The summary description of the treatment package and sessions activities pf each intervention techniques are stated below while the detailed description of the treatment package are clearly stated in the appendices:

Group one (1) - Social Skill Training (SST) Technique: Treatment package.

WEEK ONE

Session 1: General Introduction,Orientation and Establishment of rapport/talk identity. The researcher welcomed all the participants, introduce self and ask the participants to also introduce themselves one after the other. The researcher then brief the participants of the purpose and nature of the research, assured them of absolute confidentiality. Thereafter, the researcher administered the instrument SWQ for the first time to form the pre-test and baseline data.

WEEK TWO

Session 2: Communication and listening Skills

The researcher welcomed the participants back to the second session and review the homework with them. The researcher then introduced and explained the meaning of communication and communication skills as well as listening skills to them.The researcher and participants explored and discussed the various methods and types of communication and make them understand the importance of effective communication in social interactions. The researcher controls the discussion by giving direct instructions on how they can improve and have effective communication in social relationship.

WEEK THREE

Session 3: Social interaction -Beginning, continuing and ending social conversation and conflict resolution. The researcher took the participants through the steps of beginning and continuing conversation. The researcher also took the participants through conversation talk-time clean-up and explained the three conversation skills which are typically made up of: 1) Identifying and following through on conversation topics, 2) Attentive listening and 3) Gracefully exiting conversation. The researcher as a facilitator models role-play by initiating two conversations-one with familiar person and the other with unfamiliar person.

WEEK FOUR

Session 4: Problem solving and decision-making skills. The researcher welcomes the participants to the fourth session and review the previous session with the participants. The researcher introduced the new skill which is problem solving skill; explain the meaning of problem and problem solving to the participants. The researcher and the participants discussed the causes of problems and the basic steps of solving problems, as well as explore and explains to the participants the way in which their problem solving skills can be enhanced and these way are as follows: focusing on the solution and not the problem, having an open mind, viewing the problems naturally, thinking laterally, using language that creates possibility, simplifying things and so on. The researcher relate problem solving and decision making and discussed with the participants giving them chance to contribute and mention how they can solve problem and make decision about their problems of social inter-relationship..

WEEK FIVE

Session 5: Assertiveness skill – expressing positive feelings and unpleasant feelings.The researcher introduces the participants to the concept of feelings and emotional expressions and self-awareness of feeling. The researcher use a small set of basic feelings to represent all feelings, these basic feelings are: fear, anger, sadness and happiness. The researcher as a facilitator placed the participants into groups to role-playthe basic feelings giving them guidelines. The researcher discuss the component of human right, child's right to the

participants and make them write out some points, then discuss the importance of balancing their assertion (disclosure of what they feel, need and desire) with listening to others (provision of acceptance and understanding) so that they can have healthy relationship. Theresearcher explained the meaning of assertiveness and assertiveness skills to the participants. The researcher also discussed unpleasant feelings and asks the participants to mention sign of disagreement and discuss.

WEEK SIX

Session 6: Review, Recap Feedback and termination. The researcher mentioned and explained the other social skill that could also help reduce the participant's social withdrawal behaviour. Review all that was discussed in the last five sessions; discuss the questions given during the previous session and answer the participants' questions.The researcher discussed the handout issues and rates the participants using Cooperation, Attention and Participation rating scale. The researcher encourage the participants to make what they have learnt part of their lives so as to be able to overcome social withdrawal behaviour totally and live a quality life and have healthy social interaction. The researcher then brought the programme to termination; appreciate the participants for their cooperation, attention and participation. The second half of this session is designated as time to administering the Post-test to the participants with the help of the school counsellor and the class teacher. The researcher then informs the clients of a follow-session two weeks after the sixth session.

Group two - Transactional Analysis (TA) technique Treatment package

WEEK ONE

Session 1: Contracting,general introduction and familiarization.The researcher conduct self introduction and ask the participant to introduce themselves to each other and get familiar with others by interaction and exchange of pleasantries.The researcher then informs and educates the participants about the importance of the programme to them, how much they will benefit from it and the need for their absolute attention, cooperation and participation; and assured of confidentiality.The researcher then explained the meaning, importance and relevance of Transactional Analysis to them and how it would help them in treating the social withdrawal behaviour they are exhibiting. The researcher then administered the SWQ as the pretest andbaseline data.

WEEK TWO

Session 2: Ego States. The researcher welcomes the entire participants back to the second session and explained to them what is at stake for the day. The researcher explained further what T.A is all about, the key concept of the therapy which are the Ego state,- Parent Ego state, Adult ego state and child ego state (simply known as (P-A-C) features and functions and how they affect the individual's personality in the social relationship. The researcher explained each Ego states and how they are related to the study. The researcher observes and exposes the

students to the detailed effect of the ego state making them understand that every person experience and manifest their personality through mixture of behaviours, thoughts and feelings. The researcher also asked the participants if they can identify which ego state they find themselves most of the time as well as make them interact in the group and observe. They are asked to write down their observation about an individual using their participation codes.

WEEK THREE

Session 3: Life positions and frames of reference. Friendship, and peer interaction - The researcher give a brief explanation of the four life-positions using Thomas Harris idea of *staying OK.*The researcher with the participants reviews the previous session's points and discusses the homework. The researcher then explainedthe importance of friendship, role of relationship, and the rules of implementing good relationship. The researcher places the participants into group of four and asks them to role-pay the life-positions using it to develop friendship, display healthy relationship and respect for self and one another. The participants at this point are allowed to interact with one another and try to develop a healthy relationship. Theresearcher then discuss with them the rules of respecting oneself, others, and friends, and counsel them on how to be assertive and self-aware of their feelings. The participants are then allowed to brainstorm on the four life positions and react to the role play as well as allow them to ask question.

WEEK FOUR

Session 4: Strokes and Affirmations. The researcher explained and discussed the importance and roles of communication to the personal and social life using greetings as a typical example,checked the homework of the previous session and discuss briefly with the participants. The researcher explained the meaning of Strokes, Stroke economy, desire for stroke and how stroke can be useful in improving their individual behaviour. The researcher then encouraged the participants to go home and express the various behaviour discussed – communication, greeting and apologizing – withtheir peers, parents, siblings and people around them; record their stoke they get.

WEEK FIVE

Session 5: Cycle of development. The researcher asks the participants to talk briefly about their academic performance, social life and how they feel about their academic performance. The researcher explained the importance and need for absolute obedience and respect for their teachers, school authority, every adults around them aswell as how this could help improve their academic and social life. The researcher also explained the need for them to be compassionate and caring for each other and how they can improve their social behaviour and relationship.The researcher exposed the participants to the meaning of hidden communication and explained double transactional behaviour giving few examples of hidden communication and how it can help reduce the social withdrawal behaviour they are exhibiting.

WEEK SIX

Session 6: Review, Recap Feedback and termination.

The participants provided feedback by presenting some of their change in state of mind and behaviour. The researcher explained the need for them to make decision, and setting of goal for themselves. The researcher and the participants jointly reviewed all the was discussed in the previous sessions, while the researcher further explained the need for them to make decisions and set goals, for themselves and plan properly for their future relationships. The researcher explained the practical application of TA and its ability to help them gain self-leadership improve their self-esteem, self-confidence and get out of their"shell of social withdrawal behaviour and become socially competent. Finally, the researcher evaluated the participants and administered the SWQ with the support of the school counsellor and the class teacher to the participants and then brings the session to a close. After this, the researcher then informs the clients of a follow-session two weeks after the sixth session.

3.6.3 Post-treatment Phase

After the two treatment sessions, the researcher conducted the Post-treatment test for both treatment and control group and correlated the result for the pretest and posttest

3.7 Procedure for data collection

The researcher took the letters of introduction collected from the University to the FCT Secondary Education Board (FCT SEB) to seek approval to conduct research in selected schools. Approval letter given by the Director of Administration of board, and the researcher personally visited all the three (3) schools used for this research with the SEB approval letter to discuss with the school heads, presented the SEB approval letter and the school principals accepted the approvalletter and gave go ahead to the researcher.The researcher also met with the research assistants (school counsellor and SSS 2 class teacher) with the support of the principal, to seek the students' audience and administer the Social Withdrawal Checklist (SWC) which was used to identify students exhibiting Social Withdrawal Behaviour (SWB). The school counsellor and class teacher supported the researcher in administering the instrument for pretest and posttest as well as helped in gathering the participants at every sessions of the treatment period.

3.8 Procedure for Data Analysis

Data collected from this study was analyzed using descriptive and inferential statistical methods. The descriptive statistics of Frequency count and simple Percentage was used for the Demographic data while mean scores and standard deviation were used for answering the research questions. The six research hypotheses were tested with the Analysis of Covariance (ANCOVA)to determine the proportion of the variance of the criterion which exists before treatment and what was obtained after. By using ANCOVA, errors in the variance were substantially minimized in the final scores. All the hypotheses were tested at 0.05 alpha level of significance and F critical value of 2.60.

CHAPTER FOUR

RESULTS AND DISCUSSION

4.1 Introduction

This chapter focuses mainly on the analysis of data collected from the experimental study carried out on the Effect of Social Skills training and Transactional Analysis Counselling Techniques on Social withdrawal behaviour among secondary school students in Federal Capital Territory, Abuja. The students were categorized into three main groups of Social Skills TrainingCounselling Techniques (SSTCT), Transactional Analysis Counselling Techniques (TACT) and Control group. Each group was categorized into moderate and high with their pretest and post test scores. A total of six research questions were answered using the descriptive statistics of Mean and standard deviations, while the six research hypotheses were tested with the one-way Analysis of Covariance (ANCOVA) so as to compare the effectiveness of the treatments with the control group. All the hypotheses were tested at 0.05 alpha level of significance. The presentation of the analysis is done in three sections. The first section presents the demographic distributions of the students. The second section presents the result - answering of research question and testing of research hypotheses while the third the presentation of summary of the major findings.

4.2 Presentation of demographic data in frequencies and percentages

This section presents the description of the participants of the study in frequency counts and percentages.

Table 4.1: Distribution of participants by their groups

Group	Number	Percentage
Social skills training (SST) technique	20	33.33
Transactional Analysis (TA) Technique	20	33.33
Control	20	33.33
Total	60	100.0

The table 4.1 above showed that the respondents were grouped into three basic groups. The first experimental group of social skill training technique comprises of 20 representing 33.33%. The second group comprises of 20 representing 33.33% that were exposed to experimental transactional Analysis technique and the third group is control comprising of 20 also representing 33.33% respondents. The total students that were used in this study are therefore 60.

Table 4.2: Distribution of participants by level of SWB in SSTCT group

Social Skills Training Technique group	Number	Percentage (%)
Moderate	10	50
High	10	50
Total	20	100

Table 4.2 above shows the categories of respondents by their level of Social Withdrawal behaviour in Social Skills Training Counseling Technique (SSTCT) Group. With total of 10 representing 50% are moderate level and 10 representing 50.0% are in the high level.

Table 4.3: Distribution of participants by level of SWB in TACT group

Transactional Analysis Technique group	Number	Percentage (%)
Moderate	10	50
High	10	50
Total	20	100

Table 4.3 above shows the categories of respondents by their level of Social Withdrawal behaviour in Social skills training technique Group. With total of 10 representing 50% are moderate level and 10 representing 50.0% are in the high level.

Table 4.4: Distribution of participants by level of SWB in Control group

Control group	Number	Percentage (%)
Moderate	10	50
High	10	50
Total	20	100

Table 4.4 above shows the categories of respondents by their level of Social Withdrawal behaviour in Social skills training technique Group. With 1 representing 5% of low level and it is negligible. A total of 9 representing 45% are moderate level and 10 representing 50.0% are in the high level.

4.3 Answers to Research Questions

Research Question one: What is the effect of Social Skills Training Counselling Technique on moderate level of Social Withdrawal Behaviour among secondary school students in Federal Capital Territory Schools?

Table 4.5: Mean and Standard Deviation of the effect of SSTCT on moderate level of SWB

Time	*Moderate SWB group*	*N*	*Mean*	*Std. Deviation*
Pretest1	Social Skills Training Technique	10	51.5000	5.35931
	Control group	10	53.5000	5.38000
	Total	20	52.5000	5.32620
Posttest1	Social Skills Training Technique	10	31.7000	3.40098
	Control group	10	46.5000	3.97911
	Total	20	39.1000	8.40363

Table 4.5 shows mean pretest and posttest moderate level of social withdrawal behaviour between group exposed to Social Skills Training Counselling Technique (SSTCT) and a control group. It shows at pretest level that Social Skills Training Technique group had a pretest mean of 51.500 and standard deviation of 5.359 as against a control with a mean of 53.500 and a standard deviation of 5.380. After treatment, group treated with Social Skills Training Counselling Technique had a much lower mean of 31.700 and a standard deviation of 3.400 compared to control group with a mean of 46.500 and standard deviation of 8.403. This outcome suggeststhe treatment has a positive effect on participants exposed to SSTCT.

Research Question Two: What is the effect of Social Skills Training Counselling Technique intervention on high level of Social Withdrawal Behaviour among students in Federal Capital Territory Schools?

Table 4.6: Mean and Standard Deviation of the effect of SSTCT on high level of SWB

Time	*High SW group*	*N*	*Mean*	*Std. Deviation*
Pretest2	Social Skills Training Technique	10	67.6000	7.77746
	Control group	10	71.9000	10.14834
	Total	20	69.7500	9.07208
Posttest2	Social Skills Training Technique	10	34.5000	3.83695
	Control group	10	62.3000	9.47570
	Total	20	48.4000	15.90233

Table 4.6 shows mean pretest and posttest high level of social withdrawal behaviour between group exposed to Social Skills Training Counselling Technique (SSTCT) and an untreated control

group. Descriptive analysis of the outcome shows that at pretest level, students exposed to Social Skills Training Counselling Technique had a mean of 67.600 and standard deviation of 7.777 as against a control with a pretest mean of 71.900 and a standard deviation of 10.148. After treatment, high SWB group treated with Social Skills Training Counselling Technique had a much lower mean SWB of 34.500 and a standard deviation of 3.836 compared to control group with a mean of 62.300 and standard deviation of 9.475. This outcome suggests a positive effectof SSTCT on the treatment group, (that is, those with high level of SWB).

Research Question Three: what is the effect of Transactional Analysis CounsellingTechnique on moderate level of Social Withdrawal Behaviour among secondary school students in FCT?

Table 4.7: Mean and Standard Deviation of the effect of TACT on moderate level of SWB

Time	*Moderate SW group*		*N*	*Mean*	*Std. Deviation*
Pretest1	Transactional Technique	Analysis	10	53.5000	5.38000
	Control group		10	53.5000	5.38000
	Total		20	53.5000	5.23651
Posttest1	Transactional Technique	Analysis	10	35.4000	4.08792
	Control group		10	46.5000	3.97911
	Total		20	40.9500	6.91661

Table 4.7 shows the mean pretest and posttest moderate level of Social Withdrawal Behaviour between group exposed to Transactional Analysis Counselling Technique and an untreated control group. Descriptive analysis of the treatment outcome shows that at pretest level, students who were treated using Transactional Analysis Technique had a mean of 53.500 and standard deviation of 5.380 as against a control with a pretest mean of 53.500 and a standard deviation of 5.380. After treatment, moderate SWB group treated with Transactional Analysis Counselling Technique had a much lower mean SWB of 35.400 and a standard deviation of 4.087 compared to control group with a mean of 46.500 and standard deviation of 3.979. This outcome suggests a positive effect of Transactional Analysis Counselling Technique on those treated for moderate level of SWB.

Research Question Four: What is the effect of Transactional Analysis Counselling technique on high level of Social Withdrawal Behaviour among students in Federal Capital Territory Schools?

Table 4.8: Mean and Standard Deviation of the effect of TACT on high level of SWB

Time	*High SW group*	*N*	*Mean*	*Std. Deviation*
Pretest2	Transactional Analysis Technique	10	71.5000	10.39498

	Control group	10	71.9000	10.14834
	Total	20	71.7000	10.00053
Posttest2	Transactional Analysis Technique	10	43.0000	9.04311
	Control group	10	62.3000	9.47570
	Total	20	52.6500	13.39000

Table 4.8 indicates the mean pretest and posttest high level of social withdrawal behaviour between group exposed to Transactional Analysis Counselling Technique and an untreated control group. Descriptive analysis of the treatment outcome shows that at pretest level, students who were treated using Transactional Analysis Technique had a mean score of 71.500 and standard deviation of 10.394 as against a control with a pretest mean of 71.900 and a standard deviation of 10.148. After treatment, high level SWB group treated with Transactional Analysis Counselling Technique had a much lower mean SWB of 43.000 and a standard deviation of 9.043 compared to control group with a mean of 62.300 and standard deviation of 9.475. This outcome showed that positive effect of Transactional Analysis technique may have taken place on High level of social withdrawal behaviour among senior secondary school students in FCT.

Research Question Five: What are the relative effects of Social Skills Training and Transactional Analysis Counselling Techniques on moderate level of Social Withdrawal Behaviour among students in Federal Capital Territory Schools?

Table 4.9: Mean and Standard Deviation of the relative effects of SSTCT and TACT on moderate level of SWB

Time	*Moderate SW group*	*N*	*Mean*	*Std. Deviation*
Pretest1	SSTCT	10	51.5000	5.35931
	TACT	10	53.5000	5.38000
	Total	20	52.5000	5.32620
Posttest1	SSTCT	10	31.7000	3.40098
	TACT	10	35.4000	4.08792
	Total	20	33.5500	4.12279

Table 4.9 indicates the relative mean pretest and posttest moderate level of social withdrawal behaviour between groups exposed to Social Skills Training Counselling Technique and those treated with Transactional Analysis Counselling Technique. Descriptive analysis of the treatment outcome shows that at pretest level, students who were treated using Social Skills Training Counselling Technique had a mean score of 51.500 and standard deviation of 5.359 as against those treated with Transactional Analysis Counselling Technique with a pretest mean of 53.500 and a standard deviation of 5.380. After treatment, moderate level of SWB of group treated with Social Skills Training Counselling Technique had a lower mean SWB of 31.700 and a

standard deviation of 3.400 compared to Transactional Analysis Technique group with a mean of 35.400 and standard deviation of 4.087. This outcome suggests a better treatment effect for moderate SWB group treated with Social Skills Training Counselling Technique compared to those treated using Transactional AnalysisCounsellingTechnique.

Research Question Six: What are the relative effects of Social Skills Training and Transactional Analysis Counselling techniques on high level of Social Withdrawal Behaviour among students in Federal Capital Territory Schools?

Table 4.10: Mean and Standard Deviation of the relative effects of SSTCT and TACTon high level of SWB

Time	*High SW group*	*N*	*Mean*	*Std. Deviation*
Pretest2	SSTCT	10	67.6000	7.77746
	TACT	10	71.5000	10.39498
	Total	20	69.5500	9.15639
Posttest2	SSTCT	10	34.5000	3.83695
	TACT	10	43.0000	9.04311
	Total	20	38.7500	8.04510

Table 4.10 indicates the relative mean pretest and posttest high level of social withdrawal behaviour between group exposed to Social Skills Training Counselling Technique and those treated with Transactional Analysis Counselling Technique. Descriptive analysis of the intervention outcome shows that at pretest level, students who were treated using Social Skills TrainingCounselling Technique had a mean score of 67.600 and standard deviation of 7.777 as against those treated with Transactional Analysis Technique with a pretest mean of 71.500 and a standard deviation of 10.394. After intervention, high level SWB group treated with Social Skills Training Counselling Technique had a much lower mean SWB of 34.500 and a standard deviation of 3.836 compared to Transactional Analysis Counselling Technique group with a mean of 43.000 and standard deviation of 9.043. This outcome suggests a better treatment effect for group treated with Social Skills TrainingCounselling Technique compared to those treated with Transactional Analysis Technique.

4.4 Testing of Research Hypotheses

In testing the five null hypotheses stated for the study, a one-way analysis of covariance (ANCOVA) was used to control for pretest differences in participants' score on the Social Withdrawal Behaviour (SWB).

Hypothesis one(HO_1): There is no significant effect of Social Skills Training Counselling technique on moderate level of Social Withdrawal behaviour among secondary school students in F.C.T. Abuja

To test the null hypothesis one, one-way analysis of covariance was carried out using pretest scores of participants who received SSTCT and that of Control group as the covariate. The result is presented in table 4.2.

Table 4.11: One-way ANCOVA on effects of SSTCT on moderate level of SWB

Source	*Type III Sum of Squares*	*df*	*Mean Square*	*F*	*Sig.*
Corrected Model	1098.599[a]	2	549.299	38.397	.000
Intercept	350.532	1	350.532	24.503	.000
Pretest1	3.399	1	3.399	.238	.632
Group1	1077.753	1	1077.753	75.336	.000
Error	243.201	17	14.306		
Total	31918.000	20			
Corrected Total	1341.800	19			

a. R Squared = .819 (Adjusted R Squared = .797)

Table 4.11 shows a one-way analysis of covariance conducted to test the effectiveness of SSTCT on moderate level of SWB. Outcome shows that after controlling for covariate, there is a significant effect of Social Skills Training Counselling Technique on moderate level of SWB among secondary school students in FCT, Abuja, *F(1,17)*= 75.336, *p* = .000. It also reveals that 79.7% of variance in post test score can be explained by the treatment. It can therefore be said that to a large extend, SSTCT was effective in improving moderate level of SWB among secondary school students in FCT, Abuja. Therefore, the null hypothesis which states that there is no significant effect of Social Skills Training Counselling Technique on moderate level of Social Withdrawal behaviour among secondary school students in F.C.T. is rejected.

Hypothesis Two (HO2): There is no significant effect of Social Skills Training Counselling technique on high level of Social Withdrawal Behaviour among secondary school students in F.C.T. Abuja

Table 4.12:One-way ANCOVA on effects of Social Skills Training Counselling Technique (SSTCT) on high level of SWB

Source	*Type III Sum of Squares*	*Df*	*Mean Square*	*F*	*Sig.*
Corrected Model	4382.553[a]	2	2191.277	88.223	.000
Intercept	14.595	1	14.595	.588	.454
Pretest2	518.353	1	518.353	20.869	.000

Group2	2998.802	1	2998.802	120.734	.000
Error	422.247	17	24.838		
Total	51656.000	20			
Corrected Total	4804.800	19			

a. R Squared = .912 (Adjusted R Squared = .902)

Table 4.12 shows a one-way analysis of covariance conducted to test the effectiveness of SSTCTon high level of SWB. Result shows that after controlling for covariate (pretest scores for both group), the study finds a significant effect of Social Skills Training Counselling Technique intervention on high level of SWB among secondary school students in FCT, Abuja, *F(1,17)*= 120.734, *p* = .000. It also reveals that 90.2% of variance in the posttest scores between the groups can be explained by the treatment. To a large extend, this implies that SSTCT was effective in improving high level of SWB among secondary school students in FCT, Abuja. Therefore, the null hypothesis which states that there is no significant effect of Social Skills Training Counselling technique on high level of Social Withdrawal Behaviour among secondary school students in F.C.T. is rejected.

Hypothesis Three (HO3): There is no significant effect of Transactional Analysis Counselling technique on moderate level of Social Withdrawal behaviour among secondary school students in F.C.T. Abuja.

Table 4.13:One-way ANCOVA on effects of TACT on moderate level of SWB

Source	*Type III Sum of Squares*	*df*	*Mean Square*	*F*	*Sig.*
Corrected Model	623.789[a]	2	311.895	18.594	.000
Intercept	406.486	1	406.486	24.233	.000
Pretest1	7.739	1	7.739	.461	.506
Group1	616.050	1	616.050	36.726	.000
Error	285.161	17	16.774		
Total	34447.000	20			
Corrected Total	908.950	19			

a. R Squared = .686 (Adjusted R Squared = .649)

Table 4.13 shows a one-way analysis of covariance conducted to test the effect ofTransactional Analysis Counselling Technique (TACT) on moderate level of SWB. After controlling for covariate (pretest scores for both group), the study finds a significant effect of Transactional Analysis Counselling Technique intervention on moderate level of SWB among secondary school students in FCT, Abuja, *F(1,17)* = 36.726, *p* = .000). The R Squared adjusted value suggests that 64.9% of variance in the posttest scores between the groups can be explained by the intervention.This implies that significant effect ofTransactional Analysis technique on moderate Social Withdrawal Behaviouramong Secondary School student has taken place compared with those in control

group. Therefore, the null hypothesis which states that there is no significant effect of Transactional Analysis Counselling technique on moderate level of Social Withdrawal behaviour among secondary school students in F.C.T. is rejected.

Hypothesis Four (HO4): There is no significant effect of Transactional Analysis Counselling technique on high level of Social Withdrawal behaviour among secondary school students in F.C.T. Abuja.

Table 4.14:One-way ANCOVA on effects of TACT onhigh level of SWB

Source	*Type III Sum of Squares*	*df*	*Mean Square*	*F*	*Sig.*
Corrected Model	2163.592[a]	2	1081.796	14.796	.000
Intercept	210.710	1	210.710	2.882	.108
Pretest2	301.142	1	301.142	4.119	.058
Group2	1831.066	1	1831.066	25.044	.000
Error	1242.958	17	73.115		
Total	58847.000	20			
Corrected Total	3406.550	19			

a. R Squared = .635 (Adjusted R Squared = .592)

Table 4.14 shows a one-way analysis of covariance conducted to test the effects of Transactional Analysis Counselling Technique Intervention on high level of SWB. After controlling for covariate (pretest scores for both group), the study finds a significant effect of Transactional Analysis Counselling Technique intervention on high level of SWB among secondary school students in FCT, Abuja, $F(1,17)$ = 25.044, P = .000. The R Squared adjusted value suggests that 59.2% of variance in the posttest scores between the groups can be explained by the treatment.This implies that significant effect ofTransactional Analysis Counselling Technique on high social withdrawal behaviouramong Secondary School students has taken place compared with those in control group. Therefore, the null hypothesis which states that there is no significant effect of Transactional Analysis Counselling technique on high level of Social Withdrawal behaviour among secondary school students in F.C.T. is rejected.

Hypothesis Five (HO5): There is no significant relative effect of Social Skills Training and Transactional Analysis Counselling techniques on moderate level of Social Withdrawal behaviour among secondary school students in F.C.T. Abuja.

Table 4.15:One-way ANCOVA on the tests of relative effects of SSTCT and TACTon moderate level of SWB

Source	*Type III Sum of Squares*	*df*	*Mean Square*	*F*	*Sig.*

Corrected Model	68.855[a]	2	34.428	2.303	.130
Intercept	228.734	1	228.734	15.303	.001
Pretest1	.405	1	.405	.027	.871
Group1	67.916	1	67.916	4.544	.048
Error	254.095	17	14.947		
Total	22835.000	20			
Corrected Total	322.950	19			

a. R Squared = .213 (Adjusted R Squared = .121)

Table 4.15 shows one-way Analysis of Covariance on the testsof relative Effects of Social Skills Training Counselling Technique intervention and Transactional Analysis Counselling technique interventionon moderate level of SWB. Outcome shows that after controlling for covariate which is the pretest score of both group, there is a significant relative effect of Social Skills Training Counselling Technique intervention and Transactional Analysis Counselling techniqueson moderate level of SWB among secondary school students in FCT, Abuja, *F(1,17)* = 4.544, *p* = .048. The R Squared adjusted value suggests that 12.1% of variance in the post test scores can be explained by the group.This implies that there is relative effect of Social Skills training Counselling technique and Transactional Analysis Counselling technique on Moderate social withdrawal behaviour among senior secondary school students in FCT is very close. But there is better effect of SSTCT.Therefore, the null hypothesis which states that there is no significant relative effect of Social Skills Training Counselling Technique and Transactional Analysis Counselling Technique on moderate level of Social Withdrawal Behaviour among secondary school students in F.C.T. is rejected.

Hypothesis Six (HO6): There is no significant relative effect of Social Skills Training and Transactional Analysis Counselling techniques on high level of Social Withdrawal behaviour among secondary school students in F.C.T. Abuja.

Table 4.16: One-way ANCOVA on the tests of relative effects ofSSTCT and TACTon high level of SWB

Source	*Type III Sum of Squares*	*df*	*Mean Square*	*F*	*Sig.*
Corrected Model	366.472[a]	2	183.236	3.608	.049
Intercept	371.105	1	371.105	7.308	.015
Pretest2	5.222	1	5.222	.103	.752
Group2	325.731	1	325.731	6.414	.021

Error	863.278	17	50.781
Total	31261.000	20	
Corrected Total	1229.750	19	

a. R Squared = .298 (Adjusted R Squared = .215)

Table 4.16 shows analysis of covariance tests of relative effects of Social Skills Training Counselling Technique intervention and Transactional Analysis Counselling technique intervention on high level of SWB. Outcome shows that after controlling for covariate which is the pretest score of both group, there is a significant relative effect of Social Skills Training Counselling Technique intervention and Transactional Analysis Counselling techniques on high level of SWB among secondary school students in FCT, Abuja, $F(1,17)$ = 6.414, p = .021. The R Squared adjusted value suggests that 21.5% of variance in the post test scores can be explained by the group. This implies that there is relative effect of both SSTCT and TACT treatments in reducing high level ofSocial Withdrawal Behaviour among senior secondary school students in FCT and that SSTCT is more effective. Therefore, the null hypothesis which states that there is no significant relative effect of Social Skills Training and Transactional Analysis Counselling Techniques on high level of Social Withdrawal Behaviour among secondary school students in F.C.T. is rejected.

Summary of major findings

Based on the findings of this study it was revealed that;

i. There is significant effect of Social Skills Training Counselling Technique on moderate level of Social Withdrawal Behaviour among secondary school students in FCT, Abuja.This implies that SSTCT is effective in reducing moderate level of Social Withdrawal behaviour among secondary school students in FCT.

ii. There is significant effect of Social Skills Training Counselling Technique on high level of Social Withdrawal Behaviour among secondary school students in FCT, Abuja. This implies that SST is effective in reducing high level of Social Withdrawal behaviour among senior secondary school students in FCT.

iii. There is significant effect of Transactional Analysis Counselling Technique on moderate level of Social Withdrawal Behaviour among secondary school students in FCT, Abuja. This implies that TACT is effective in reducing moderate level of social withdrawal behaviour among senior secondary school students in FCT.

iv. There is significant effect of Transactional Analysis Counselling Technique on high level of Social Withdrawal Behaviour among secondary school students in FCT, Abuja. This implies that TACT is significantly effective in reducing highlevel of social withdrawal behaviour among senior secondary school students in FCT.

v. There is significant relative effect of Social Skills Training and Transactional Analysis Counselling Techniques on moderate level Social Withdrawal Behaviour among secondary school students in FCT, Abuja and thatSSTCT is more effective.

vi. There is significant relative effect of Social Skills Training and Transactional Analysis Counselling Techniques on high level Social Withdrawal Behaviour among secondary school students in FCT, Abuja and thatSSTCT is more effective.

4.6 Discussion of Result

The result of this research study found that Social Skills Training and Transactional Analysis Counselling Techniques are effective in the treatment of Social Withdrawal behaviour. This study reported the significant effect of SSTCT on social withdrawal Behaviour among secondary school students in FCT, it implies that for both moderate and high level of social withdrawal behaviour, the significant differences of mean scores obtained is as a result of positive effect of intervention of Social Skill Training Counselling Technique (SSTCT). This is in line with the findings of Fashina (1990) revealed in his research relationship that SST was able to help in improving interpersonal relationship more effectively.

The effectiveness of SST intervention revealed from the findings of this study also consent with the findings of Ayodele (2011) who examine the effectiveness of ETS and SST and found that SST is effective in treating interpersonal behavioural problems among Nigerian adolescents. It also corroborates the findings of Ayodele (2015) in his studyon the differential effectiveness of three therapeutic packages in the fostering adolescents' intrapersonal relationship and found that SST when combined with other techniques is effective in improving intrapersonal relationship among the adolescents in Nigeria.It also agrees with the findings of the study conducted byOyesoji (2006) on the effect of two psychological interventions–SST and Problem-solving skills on Police interpersonal relationship and revealed that SST is effective in improving the Police interpersonal relationship.

This study is also in agreement with Bada (2010) in his research work on the effect of moral and social skills training on behaviour maladjusted youth in Nigeria revealed that SST is effective in the treatment of maladjusted behaviour among the youths and Bada (2015) in further

investigated the gender influence on SST among socially maladjusted youth in Nigerian secondary school and the findings of his study revealed that SST is effective in correcting the socially maladjusted students and it help more in girls with the mean score of 109.90 than that of the boys of mean score of 79.03, the study also revealed that the social skill of females are influenced by many factors including inter-hemisphere communication, greater verbal ability and differential socialization by parents and peers.

Another study which is in line with this study is that of Kopelowicz & Liberman (1998) who reported from their study that SST has accumulated effect on different dimension of social withdrawal behaviour. The effectiveness of SST was also examined by Herbert, Gaudiano, Rheingold, Myers, Dalrymple & Nolan (2005) in their study and showed in their findings that using SST in treating anxiety disorder is very effective whether alone or I combination with other forms of treatment technique.

The effectiveness of SSTCT in reducing SWB and improving interpersonal relationship is as a result of the fact that Social Skills Training focuses on teaching social skills that can be learned rather than emphasizing on the internal or biological determination of social adequacy.This finding isa further confirmation of the fact that positive and mutualbeneficialrelationship requires a set of skills specific toemotional support, assistance and social learning and this inturn is likely to be reflected in their relational self-esteem andcontrol (Adenuga & Ayodele, 2010).

The findings of this study also revealed that Transactional Analysis (TA) technique is significantly effective in the treatment of moderate and high level of social withdrawal behaviour among senior secondary school students in FCT. This finding is in line with research work of Nlemadim, Falaye and Okoiye (2013) on the effect of self-efficacy and Transactional Analysis in enhancing social competence among socially isolated pupils using pretest/posttest and control group and found out that TA has a significant main effect on the socially isolated behaviour of the pupils thereby improving their social competence which implies that the challenge of social incompetence can be managed using TA Counselling Technique. The findings of this study also agrees with the findings of Olusakin and Aremu (2010) which reveals that TA is effective in improving social competence of adolescents by helping them develop thinking skills and care able to appraise positively stimuli from their social environment and interact in an appropriate way.

The result of this study is also in support of Afolayan and Falaye (2010) in their study on use of Self-Management Techniques (SMT) and Transactional Analysis (TA) to enhance self-disclosure of HIV positive status, revealed that the exposure of the participants to the treatments (SMT and TA) encouraged their self-disclosure as well as strengthen their interpersonal communication skills. And Falaye and Afolayan (2015) found out how Transactional Analysis can be used to enhance Self- disclosure of HIV+ status and their findings showed that the 30 participants exposed to TA received awareness and develop self-confidence. The result also revealed that TA is effective in enhancing self-disclosure of positive status and in

the process of the treatment that participants are able to interact and transact greatly with themselves thereby promoting their interpersonal relationship.

Another study which the findings of this study is in line with is the work of Ebrahimisani, Hashemian and Dvkanhan (2012), where they study the effectiveness of TA group therapy in increasing self-esteem and it revealed that the communication skills of group exposed to TA were improved and that their clients found a new attitude towards their own behaviour, emotion and are interacting well with other members of their group. Also StaurtandAlger (2011) in their study on the use of TA in secondary school to improve social interaction of children and young people of age 11-25 years and their teachers, the findings of their study reveals that the children, young people and teacher exposed to TA develop better self awareness, social interaction and increased understanding of others.

The effectiveness of TACT in reducing SWB among Secondary School students who are mostly adolescents could be based on the fact that TA emphasizes a person's ability to become aware of decision that governs the behaviour and capacity to make decision in that will beneficially alter the person's course of life in terms of communication, interaction and interpersonal relationship.

It also agrees with Ahmadu (2010) and Sqty, Abadi and Sudan (2010) that revealed in their findings that TA improves self-esteem, communication skill and emotional reactions as well as being helpful in treating family relationship, parental conflicts with teenagers, group quarrels and behaviour deviations. Another study that this study goes in line with the study of Emdady & Shafiabadi (2013) that revealed in their study of the effect of group counselling with TA technique on university students' general health that TA method helps with encouraging adult ego-state and balancing child ego-state, adult ego-state and parent ego-state, developing communication issues and self-leadership and finally general health, it also help reduce anxiety and naughtiness, helps students' physical responses and reduction in students' depression.

Further findings of the analysis of this research work reveals that there is relative significant effect of the two counselling technique SSTCT and TACT on students exposed to these treatments, the two treatments were found to show positive effect. It was revealed that the effect of both treatment techniques are closely related, hence the effect of SST and TA counselling techniques on moderate and high level of social withdrawal behaviour among senior secondary school students in FCT. This result finding is in agreement with Egbochukwu et. al. (2015) investigated the effect of self-management skills and Social Skills Training techniques on the reduction of adolescents' conduct disorder and the findings of their study showed that SST when combined with SMS is significantly effective in reducing conduct disorder among secondary school students.

The result also revealed that, though both SSTCT and TACT are relatively effective, SSTCT was found to be more effective than TACTgiving that the meanand standard deviation of SSTCT in the null hypothesis five and six are higher compare to that of TACT; this finding is in agreement with Fashina (1990) who revealed that SST was able to help in improving interpersonal relationship more effectively when compared with the TA.Another discovery from

this study is that the significant effect of SST counselling technique in reducing social withdrawal behaviour was established by comparing those exposed to SST treatment to those in the control group. This is in line with Segrin (2001)'s explanation in the study that SST holds great benefit to students with interpersonal difficulties and can help them in personal coping skills such as anger management, problem-solving and critical thinking skills, as well as help students faced with low self-esteem, perception of self-concept to improve and maintain positive self-talk, high self-esteem and good communication skills. This finding is also in line with the study of Ayodele (2011) that used SST and ETS to foster interpersonal relationship and revealed that the combination of SST with other technique was effective in helping adolescents live meaningful and fulfilled lives.

The major goal of both techniques is to encourage the students to think more accurately, improve their communication and listening skills, develop better self-esteem, self-confidence and improve their adaptive ways, all of which facilitate effective problem solving and decision making ability as well as enhance living a more satisfied life and enables the individual to interact with others and develop good interpersonal relationship. Elliot & Busse (1991) approves of this and explained that social skills training can equip individuals are: cooperation, assertiveness, responsibility, empathy and self-control.

CHAPTER FIVE

SUMMARY, CONCLUSIONAND RECOMMENDATIONS

5.1 Introduction

This chapter contains the concise summary of the findings of the study and the contributions of the study to knowledge. It also includes conclusions drawn from the results and findings of the study, recommendations given by the researcher based on the findings of the studyas well as limitations of the study and general suggestions for further research studies based on thefindings of the study.

5.2 Summary

This study was carried out to determine the effect of Social Skills Training Counselling technique and Transactional Analysis Counselling Technique on Social Withdrawal behaviour among secondary school students in the Federal Capital Territory, Abuja, Nigeria. The study was borne out of the realization that secondary school students who are mostly adolescents areexperiencing variety of changes that affects their social relationship and interactions and this in turn are affecting their academic performance, self-esteem, communication relationship, problem solving and decision making abilities.

The population of the study comprised of senior secondary school year 2 students in Federal Capital Territory and purposive sampling technique was used to draw out 60 SSS 2 students in three schools of three Area Councils of FCT; 20 students per school and participants were grouped into the two treatment groups and a control group. The instrument (SWQ) was content and face validated by six professional experts in the field of Educational Psychology and Counselling. A test-retest was employed at interval of two weeks to test reliability co-efficient of the instrument; Pearson's Product moment correlation co-efficient method was used to test the result and the co-efficient obtained was 0.90.

The participants received Social Skills Training Counselling Technique and Transactional Analysis Counselling Techniques treatments for six (6) weeks of one session per week. Each session lasted for 50minutes after school hours at different days of the week. The result of the analysis of this study showed that the six hypotheses formulated in relation to the variables of the study were rejected and the summary of the findings of the study are as follows:

Students exhibiting moderate Social Withdrawal behaviour exposed to SSTCTtreatmenthad a reduction of the behaviour. This implies that SSTCT is effective in reducing moderate level of Social Withdrawal behaviour among secondary school students in FCT.

Students exhibiting high Social Withdrawal behaviour exposed to SSTCT treatmenthad a reduction of the behaviour. This implies that SST is effective in reducing high level of Social Withdrawal behaviour among senior secondary school students in FCT.

Students exposed to TACT treatmenthad a reduction in the moderate social withdrawal behaviour. This implies that TACT is effective in reducing moderate level of social withdrawal behaviour among senior secondary school students in FCT.

Students exposed to TACT treatmenthad a reduction in the high social withdrawal behaviour. This implies that TACT is significantly effective in reducing highlevel of social withdrawal behaviour among senior secondary school students in FCT.

Students exposed to both SSTCT and TACT treatmenthad a reduction in the moderate social withdrawal behaviour in favour of SSTCT. This implies that both SSTCT and TACT are relatively effective, in reducing moderate level of social withdrawal behaviour among senior secondary school students in FCTand thatSSTCT is more effective.

Students exposed to both SSTCT and TACT treatmentshad a reduction in the high social withdrawal behaviour in favour of SSTCT. This implies that there is relative effect of both SSTCT and TACT treatments in reducing high level of social withdrawal behaviour among senior secondary school students in FCT and that SSTCT is more effective.

5.3 Contribution to Knowledge

The outcome of this study based on the result obtained has confirmed the effectiveness of Social Skills Training Counselling Technique SSTCT and Transactional Anaysis Counselling

Technique (TACT) in reducing Social Withdrawal Behaviour (SWB) among Secondary School Students and has contributed to the body of existing knowledge.

Fromthe result of the statistical analysis, it was revealed that SSTCT has yielded significant positive effect on the level of Social Withdrawal Behaviour among secondary school students exposed to treatment package compared to those in the control groupwho had no treatment at all. The positive effect can be attributed to the social skills acquired by the students during the training exercise.

The study also revealed that participants exhibiting moderate and high level of SWB that were exposed to TACT exhibited a reduction in their levelof SWB than their counterparts in the control group who received no treatment hence the effectiveness of TACT treatment package is a favourable development for counselling and other helping profession.

The study also revealed that no matter the level of Social Withdrawal Behaviour (moderate or high) exhibited by the students, Social Skills Training Counselling Technique (SSTCT) and Transactional Analysis Counselling Technique (TACT) are effective in treating and reducing it to the lowest level if not eradicate it. The result of the findings of the study also revealed that the participants exposed to SSTCT treatment package showed higher reduction in their social withdrawal Behaviour after the treatment compared to those exposed to TACT. This indicates that the application of this counseling technique in schools for the treatment of SWBcan further help to reduce interactional and interpersonal relationship behavioural problems among secondary school students and adolescents in general.

The findings have effectively demonstrated that the treatment packages could be used as veritable tools in equipping secondary school students and adolescents at all academic levels with necessary skills that can foster good interpersonal relationship with selves and others. Hence this will make it easy for some other counsellors and teachers on what treatment technique to use in treating social withdrawal behaviour and how the technique can be implemented.

5.4 Conclusion

This research study investigated the effect of Social Skills Training (SST) and Transactional Analysis (TA) Counseling Technique on Social Withdrawal Behaviour among senior secondary school students in Federal Capital Territory. Based on the result and outcome of the findings of the study, it was concluded that both SSTCT and TACT are effective in reducing and treating social withdrawal behaviour. Although SSTCTwas seen to be more effective when compared with TACT on those with high level of social withdrawal behaviour and that the study revealed the in-depth of the effectiveness of SST and TA Counseling Technique from the result of the findings on the moderate and high level of social withdrawal behaviour among the adolescents.

Based on the outcome of this study, it has been concluded that SST is effective in treating both moderate and high social withdrawal behaviour at all stages of growth. The result also

brings about the conclusion that whatever be the level of social withdrawal behaviour in an individual, TA Conselling Technique is effective in treating and reducing it.In comparison between the treatment groups and the control group,it has been concluded that there was behaviour change in the student in the treatment group while those in the control group continues with the same behaviour.

5.5 Recommendations

Based on the findings the following recommendations are proffered.

1. That the School Counsellors, Psychologist and Social Workers should endeavour to make use of Social Skills Training Counselling Technique (SSTCT) adequately and correctly to help in reducing moderate and high level of Social Withdrawal behaviour among secondary school students.
2. That Transactional Analysis Counselling Technique (TACT) should be employed in the treatment of moderate and high level of Social withdrawal behaviour among secondary school students so that the student will be able to relate, communicate well in class and outside class with their peers, teachers and other adults.
3. That SSTCT andTACT should be used in combination for the treatment and reduction of moderate and high level of Social Withdrawal Behaviour and other related interactional behaviour problems among secondary school students.
4. That SSTCT andTACT should be included in the secondary school counselling curriculum and these techniques should be well handled and applied to the students by the school counsellor in helping the students exhibiting social withdrawal behaviour and other related behaviour.
5. That the school counsellors should be give periods on the school Time-table so as to have enough opportunity to identify the students experiencing social

withdrawal behaviour, meet with them in groups and individually and use SSTCT andTACT to them reduce and treat the behaviour problem they are exhibiting.

6. That the teachers, parents and care givers should be encouraged, through the PTA, voluntary organization and versatile guidance counseling unit of the school, to attend programmes, workshops and seminars on SSTCT, TACT and other counselling techniques that will expose to the techniques that help them discover and handle their children that may be exhibiting social withdrawal behaviour and other related behaviour.

5.6 Limitation of the study

In the course of this research study, certain challenges were encountered and these serves as limitations to the study, first of these challenges was the unavailability of adequate literature on social withdrawal behaviour among adolescents in Nigeria. The few works done was on the other forms of social withdrawal such as social incompetence, social inhibition and social isolation. This makes it difficult to get adequate information on social withdrawal exactly, and not all constructs of social withdrawal behaviour were researched on.

Secondly, the issue of limited time was another limitation encountered in the course of this study. The researcher could not meet the participants at a good time, the period was only granted after school and towards closure of the school, because the school authority do not want the normal school period to be encroached into and at the given period, the students were always well composed, they are always eager and in a hurry to go home hence their attention was not fully given as expected most of the time.

Furthermore, the study was limited because only three schools in FCT were used for the study and there are adolescents exhibiting social withdrawal behaviour in others schools (both public and private, especially those in the private schools where there children of rich people most of who are having family problems and the children are at the receiving end) and in other states of the country. Another limitation encountered includes the inability to effect post-treatment evaluation and follow-up which should be about six months after the administration of the posttest and conclusion of the field work. This could not take place due to the nature of the study and the students needing time to concentrate on the academic works and preparation for examination. This study was limited to adolescents (senior secondary school students) and foreign studies reviews from the literature reviewed revealed that social withdrawal behaviour can ensue at infancy and extend to adolescent and adulthood.

5.7 Suggestion for further studies

Further studies on a number of areas related to the general nature of social Withdrawal behaviour among secondary school students will provide a rewarding research experience. For example there is need for further investigation of Social Withdrawal behaviour in all the schools in the Federal Capital Territory and other states of the country.

1. This study was limited to only senior secondary school students year 2 in few schools in FCT, thus it is important to extent further study to a larger population and sample that will cover all the students in the schools, as well as include private schools, other institutions such as correctional institutions, rehabilitation centers, orphanage homes, tertiary institutions and other non-formal educational institutions.
2. Further studies should incorporate post-treatment evaluation and follow-up by engaging the participants for post treatment evaluation and follow-up at least six months after the treatment; this is to ascertain the continuity of the new good behaviour.
3. This study focused on the in-depth effect of the treatment techniques, further studies should consider other variables such as gender, family background, parental type, home nature (intact home and broken/separated home), parents socio-economic status, peer pressure nature of parents' job (self-employed, private or public employed), state of origin and ethnicity, among other as intervening variables to social withdrawal behaviour among adolescents.
4. These Counselling Techniques (SST and TA) should be used to treat other behaviour challenges among adolescents, such behaviour as avoidance personality disorder, disruptive behaviour, Attention Deficit Hyperactivity Disorder (ADHD), oppositional defiant disorder (ODD), depression, drug and substance abuse among others.

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APPENDIX 1

RESEARCH INSTRUMENTS

Social Withdrawal Checklist

Dear Respondent,

This questionnaire is to obtain information from you only for the purpose of research. The scale is a personal problem scale. You are kindly requested to respond as honest as possible. There is no right or wrong answers, any information supplied by you would be treated as confidential. Thank you for your cooperation.

Section A: Demographic Information Please tick (√) where applicable.

1. School:

2. Gender: (a). Male ( ) (b). Female ( )

3. Name:

Section B1: Behavioural interest

Please indicate how often you engage in the behaviour described below by using the scale below

	Items	1 Never True	2 Not Often True	3 Often True	4 Always True
1	I think I do not have self-confidence				
2	I feel I am left out of things.				
3	I am not quick in making friends				
4	I avoid social contact with people				
5	It seems no one understands me				

6	I am never chosen as a leader				
7	I feel treated like an outsider by people				
8	I finds it difficult to keep conversation going				
9	Cannot speak up in class				
10	Failure to take things serious				
11	I easily get worried about things				
12	Not have as much fun as others have.				
13	I feel awkward meeting with people				
14	I think I am careless.				
15	I feel I lack self-control				
16	I feel nervous and anxious most times.				
17	I am afraid of making mistakes.				
18	I am not good and quick in making friends				
19	I find it difficult to talk about my problems.				
20	Not familiar with social etiquette.				

SOCIAL WITHDRAWAL QUESTIONNAIRE

Dear Respondent,

This questionnaire is to obtain information from you only for the purpose of research. The questionnaire is on Social Withdrawal. You are kindly requested to respond as honest as possible. There is no right or wrong answers, any information supplied by you would be treated as confidential. Thank you for your cooperation.

Section A: Demographic Information Please tick (√) where applicable.

1. School:

2. Gender: (a). Male ( ) (b). Female ( )

Section B1: Behavioural interest

Please indicate how often you engage in the behaviour described by using the scale below

	Items	1 Never True	2 Not Often True	3 Often True	4 Always True
1	I always feel like isolating myself from others				

2	I feel alone and apart when I am with my friends and do not let them know how I am feeling.				
3	I am unable to reach out and communicate with those around me because I don't want to be criticized.				
4	I avoid social contact with people.				
5	I do not like sharing my interest, feeling and idea with people around me				
6	I spend more time being on my own				
7	I avoid taking the lead or being the centre of attraction while in a group or among people				
8	I do not feel like talking about myself to anybody around me most of the time				
9	I avoid people around and will not interact with my family and friends.				
10	I do not want to be with people at all.				
11	I easily get irritated by people around me for no reason so I spend most of my time by myself.				
12	I avoid having to talk or give speech first so I find myself waiting for other people to act or talk first.				
13	I always feel awkward and avoid meeting with familiar and unfamiliar people				
14	Although I have the desire to interact with others but I am always anxious about interacting with people.				
15	I rarely initiate relationship with my peers and other people				
16	I want to play with my peers but am nervous and scared of being criticized.				
17	I always turn down social initiation from others because am bothered by blushing in front of people.				
18	I am not good and quick in making friends				
19	I try not to be alone and stand out when playing with my peers				
20	I rarely express myself and feeling in my peer group.				
21	I usually watch my peers interacting without approaching them because I do not want to be embarrassed or look stupid.				
22	I usually feel am an outcast and nobody wants to interact with me because I feel shaky in front of others.				
23	I do not talk or interact when am with my peer.				
24	I hesitate to join other children in play because I				

	worry that they will not include me				
25	I turn down social event by my peers because I am scared and prefer playing alone.				

SOURCES:
David L. Tobin (2001), Coping Strategies Inventory (CSI) – *Social Withdrawal item.*
Jonathan Davidson (2013), Social Phobia Inventory (SPIN)

APPENDIX 2

Social Skill Training (SST) Technique: Treatment package.

WEEK ONE

Session 1: General Orientation, Introduction and Establishment of rapport/talk identity

The objectives of the counseling session: It is to familiarize participants to the group context and group members. To an enabling environment for the participants and the programme to take place, as well as help them to participate well in the treatment programme. To facilitate and direct the clients' motivation to change in behaviour. To provide the participants with general overview of social skills training as a therapeutic approach and give them a general course of structure.

Counselling/Intervention process: The researcher/counsellor welcomes all the participants, introduce self and ask the participants to also introduce themselves using warm-up exercise which will assist in decreasing the anticipated anxiety so as to establish rapport and allow them to engage in brief, light and non-threatening interaction. The researcher then assures the participants of absolute confidentiality and encourages them to keep every information give by individual during the treatment programme confidential. The researcher then go ahead to educate the participants about the importance of the counseling/ intervention programme and the role of the researcher as a counselor and a facilitator. Both the counselor and the participants set out the guiding rule of the programme. The participants are allowed to brainstorm on ideas relevant to issues of social withdrawal, write their responses in a sticky paper and stick it on the white board. They are also allowed to ask questions on the some of the items in the Social Withdrawal Scale give to them previously before the commencement of the programme. The counsellor brings the session to an end by appreciating the participants for their cooperation, commitment and patience during the session and encourages them to attend the next session. Thereafter gives them home assignment.

Home Assignment: The researcher asks the participants to write a page about themselves in the areas of interpersonal relationship, listening to others, making request and so on.

WEEK TWO

Session 2: Communication and listening Skills

Objective of the Counselling session: It is to expose the clients to the various communication skills, methods of communication and types of communication. To give them better understanding on the need for effective communication in social interaction. It is also to expose the participants to listening skills as well as help them improve on their listening abilities. To introduce them to role-play on listening to other people in social situation so as to learn more.

Counselling process: Direct instruction

The researcher welcomes the participants back to the second session and review the homework with them. The researcher then introduce and explain tge meaning of communication and communication skills to them and make them understand the importance of effective communication in social interactions. The counselor and the participants explore and discuss the various methods and types of communication, which include verbal and non-verbal communication, eye contact, facial expression, body gesture/language tone and volume of voice. The researcher controls the discussion by giving direct instructions on how they can improve and have effective communication in social relationship.

The researcher explains how important it is to attend and listen to others in social interaction so as to have functional social awareness. The counsellor asks the participants to answer some questions and write on a paper which they will stick to the white board:

Why is it important to listen to another person?
What are some of the ways you are able to show someone you are listening to them?
What are the differences in someone's body position when they are interested and when they are not interested in what is being discussed?
How do you feel when someone you are talking to does not listen to you
How do you feel when others interrupt you while discussing with another person.

The researcher mentions and discusses the steps of listening skill to the participants, and asks the participants to role-play some listening skills and the scene used includes:

Listening to someone who is talking about a favourite hobby
Listening to someone who is talking about favourite TV show
Listening to a friend talking about a recent outing
Listening to a participant talking about favourite subject
Listening to a participant talking about a teacher.

Collaborative assigned homework: The counsellor shares the participants into groups and gives the first group assignment to discuss and write two pages on the effective communication while the second group is asked to discuss and write on listening to another person.

The counsellor then rate the participant using the Cooperation, Attention and Participation (CAP) rating scale to rate their performance and participation.

WEEK THREE

Session 3: Social interaction -Beginning, continuing and ending social conversation and conflict resolution.

Objection of counseling session: It is to demonstrate effective way of beginning conversation in social interaction. To help the participants learn how to retain conversation and end the conversation positively using by way of role-play. To expose the participants to various conflict resolution skills in social life.

Counselling Process: Role play– The counsellor explain the three conversation skills which are typically made up of 1) Identifying and following through on conversation topics, 2) Attentive listening and 3) Gracefully exiting conversation. And reminding them of the listening skills which have been discussed in the previous session. The counselllor as a facilitator will models role-play by initiating two conversations- one with familiar person and the other with unfamiliar person. Thereafter the counsellor ask the participants what they notice with regards to differences between the opening exchange

The counsellor then takes the participants through the steps of beginning and continuing conversation which are:

Choose time and place.
Look at the person (make eye contact).
Self introduction and greetings exchange.
Making a 'small talk' or 'chitchat'
Determine if the other person in listening and want to talk.

The counsellor explained the meaning of conflict and conflict resolution to the participants. The participants are to mention if they have had conflict with their peers and people around them and try to explain how they handle the conflict and what it resulted into. They are to also say how it affects their personality and social interactions. The counsellor then discusses the steps used in resolving conflict with the students.

The researcher takes the participants through conversation talk time clean-up so as to be able to know when to bring a conversation to an end successfully. All these are to help the participants get out of their withdrawn mood.

The counsellor then rate the participants using the Cooperation, Attention and Participation (CAP) rating scale to rate their performance and participation.

WEEK FOUR

Session 4: Problem solving and decision making skills

Objectives of the counseling session: To enhance the clients' problem solving skills and expose them to the basic steps solving problems so as to help them improve on their social relationship

among their peers. To demonstrate the steps to effective way of solving problem in the society through modeling and role-play.

Counselling process: The counsellor welcomes the participants to the fourth session and review the previous session with the participants. The counsellor then introduces the new skill which is problem solving skill; explain the meaning of problem and problem solving to the participants. The counsellor and the participants discusses the causes problems and the basic steps of solving problems, these include: defining the problem, generating alternatives, evaluating and selecting alternatives and implementing solutions. The counsellor explore and explains to the participants the way in which their problem solving skills can be enhanced and these way are as follows: focusing on the solution and not the problem, having an open mind, viewing the problems naturally, thinking laterally, using language that creates possibility, simplifying things and so on.

The counsellor relate problem solving and decision making and discusses with the students giving them chance to contribute and mention how they can solve problem and make decision about their problems of social inter-relationship. The counsellor gives examples of some individuals models who had personality problems but were able to overcome and solve their problems by make a decision. The participants are also asked to mention some models that they know of and who their role models are and why they made such individual their model, what they know about such person and how that their model solve their problems.

The counsellor then rate the participant using the Cooperation, Attention and Participation (CAP) rating scale to rate their performance and participation.

WEEK FIVE

Session 5: Assertiveness skill – expressing positive feelings and unpleasant feelings.

Objective of the counseling session: to expose the participants to the assertiveness skills that will help them express their feelings of positively as well as express their feelings of unpleasantness without it affecting the interaction and interpersonal behaviour. To provide the participant with an increased awareness of unpleasant emotion and the expression of the emotions.

Counselling process: The counsellor introduces the participants to the concept of feelings and emotional expressions as well as an introduction to self-awareness of feeling. The researcher use a small set of basic feelings to represent all feelings, these basic feelings are: fear, anger, sadness and happiness, which is believed will bring about increase in self-awareness. The counsellor explains briefly the four basic feelings and asks the participants some questions which they answer on a paper and stick to the white board. The questions include:

What are positive and negative feelings?
Could you please give some examples of both feelings?
How do you express your feelings of fear?

When happy, how do you express it?

The researcher as a facilitator placed the participants into groups to role-playthe basic feelings giving them guidelines. The steps to the assertiveness skill are as follows:

Look at the person
Tell them exactly what it was that pleased that pleased you.
Tell them how you feel at moment about what they did or say.

The counsellor discussed the component of human right, child's right to the participants and make them write out some points, then discuss the importance of balancing their assertion (disclosure of what they feel, need and desire) with listening to others (provision of acceptance and understanding) so that they can have healthy relationship. The counsellor asks the participants the following questions:

What are unpleasant feelings?
What are the advantages of expressing your unpleasant feelings?

The counsellor then introduces and discusses steps to this aspect of the skills which are:

Look at the person.
Tell them exactly what it was that displease you politely and reasonably.Tell the person you feel at that moment.
Tell the person why their behaviour affects you.

The counsellor asks the participants to mention the signs of disagreement and they all discuss them together, these signs include crisis, tensions, misunderstanding, incidents, discomfort, denial, avoidance and conflicts. The researcher then explains the importance of reaching solution together using the following steps:

Tell other person your needs briefly.
Listen to the other person's need say other person's needs and your needs in a one-sentence summary of the problem.
Brainstorm all possible solution together.
Together choose the solution

The counsellor then rated the participant using the Cooperation, Attention and Participation (CAP) rating scale to rate their performance and participation.

Assignments: The counsellor the gives the participants take home assignment.

WEEK SIX

Session 6: Review, Recap Feedback and termination.

Objective of the session: To mention the social skills that could not be discussed in detailed. To review and recap all the social skills that has been discussed. To evaluated and get feedback from the participants.

Counselling process: the counsellor mention the other social skill that could also help reduce the participant's social withdrawal behaviour. Review all that was discussed in the last five sessions; discuss the questions given during the previous session. Discuss the handout issues and bring the programme to termination, appreciate the participants for their cooperation, attention and participation. The counsellor encourage the participants to make what they have learnt part of their lives so as to be able to overcome social withdrawal behaviour totally and live a quality life and have healthy social interaction.

The second half of this session is designated as time to administering the Post-test to the participants with the help of the school counsellor and the class teacher. The researcher then informs the clients of a follow-session two weeks after the sixth session.

APPENDIX 3
Transactional Analysis (TA) technique Treatment package

WEEK ONE

Session 1: Contracting

Objectives of the session: To get the participants well informed about the procedure of the whole treatment/intervention session. To create an enabling environment to help the students improve in their interpersonal relationship. To establish transactional contract with the students. It is also to ensure that this therapy is appropriate for the group of students exhibiting social withdrawal behaviour.

Counselling Process: General introduction and familiarization.

The researcher conduct self introduction and ask the participant to introduce themselves to each other and get familiar with others by interaction and exchange of pleasantries. The counsellor then informs and educates the participants about the importance of the programme to them, how much they will benefit from it and the need for their absolute attention, cooperation and participation. The participants are assured of confidentiality and encouraged to keep every information details and important issues discussed in their group during the programme confidential. The researcher as a counsellor and facilitator, facilitate the process of selecting a group leader and secretary and set out guiding rules for the programme. The researcher familiarized the participants with process of the whole programme and informed them of the duration of the whole programme.

The researcher then goes further to expose the students to the meaning, importance and relevance of Transactional Analysis to them and their present situation. The counsellor explains to them that they will need to complete a rating scale (CAP) at the end of every session. The counsellor then brings the session to an end by giving them the participants homework.

WEEK TWO

Session 2: Ego States

Objective of the session: To exposed the participants to the key concept of TA and the way the concept affects to their interpersonal relationship and personality. To help the participants understand the need for them to communicate effectively with their peers and people around them.

Counselling Session: the researcher welcomed the entire participant back to the second session and explained to them what is at stake for the day. The researcher explained what T.A is all about and exposed them to the key concept of the therapy which are the Ego state,- Parent Ego state, Adult ego state and child ego state (simply known as (P-A-C) features and functions and how they affect the individual's personality in the social relationship. After the explanation of each of the Ego states, the researcher asked the students if they can identify which ego state the find themselves most of the time as well as make them interact in the group and observe. They are asked to write down their observation about an individual using their participation codes. The researcher also observed and exposed the students to the detailed effect of the ego state making them understand that every person experience and manifest their personality through mixture of behaviours, thoughts and feelings. Each of the participants read out a conversation on the relationship depict in the conversation.

Homework: the participants are asked to write briefly on their past and present situation including their interpersonal relationship.

WEEK THREE

Session 3: Life positions and frames of reference

Objectives of the session: To expose the participant to the four life position and how it is related to the feelings and relationship of the individual. To make the participants realize the importance of friendship and peer interaction.

Counselling session: Friendship, and peer interaction

The researcher with the participants reviewed the previous session's points and discusses the homework. The counsellor gave a brief explanation of the four life-positions using Thomas Harris idea of *staying OK.* The researcher then explained the importance of friendship and role of relationship, as well as the rules of implementing good relationship. The participants at this point are allowed to interact with one another and try to develop a healthy relationship. The

counsellor then discussed with them the rules of respecting oneself, others, and friends, and counsel them on how to be assertive and self-aware of their feelings. The researcher placed the participants into group of four and asks them to role-pay the life-positions using it to develop friendship, display healthy relationship and respect for self and one another. The participants are then allowed to brainstorm on the four life positions and react to the role play as well as allow them to ask question.

Collaborative assign homework: Each group of the participants is to draw an ecogram based on complex of Transactional Analysis and explain all in one page.

WEEK FOUR

Session 4: Strokes and Affirmations

Objectives of the counseling session: To expose the students to the importance of communication, greetings and apologizing in social interaction. It is also to make the students develop good self-confidence, self-control and self-esteem as well as to expose them to stroking, types of strokes, ways of receiving strokes and its effect on their feelings.

Counselling Process: the researcher checked the homework of the previous session and discuss briefly with the participants. The researcher familiarized the participants with the importance and roles of communication to the personal and social life using greetings as a typical example. The researcher exposed the students to another person stressing the advantages and disadvantages and its effect to interpersonal relationship. The participants are asked to role-play communication and apologizing and asked them how they feel about the whole process. The researcher then went ahead to explain strokes, stroke economy, type of strokes, desire for stokes and how stroke can be useful in improving individual's behaviour.

Homework: The participants are asked to home and express the various behaviour that was discussed – communication, greeting, apologizing – with their parents, siblings and people around them and record the reactions and type of strokes they get as well as how they feel about it.

WEEK FIVE

Session 5: Cycle of development

Objectives of the counseling session: To make the participants identify the effect of disobedience, respect and good feeling on their academic performance and social life. To expose the participants to the need to be compassionate and cares for themselves in their social relationship.

Counselling process: the previous session was reviewed by the counsellor and the participants. The counsellor discusses and relate to the individual life of the clients. The researcher ask the participants to talk briefly about their academic performance and social life in school in the past,

they are also to say what their feelings has been about their school performance. The researcher explain the importance and need for absolute obedience and respect for their teachers, school authority, every adults they meet and make them understand the consequences of their behaviour to their academics and social life.

The counsellor also explained the need for them to be compassionate and caring to each other and how they can help themselves develop and improve on their social behaviour and relationships. The researcher exposed the participants to hidden communication and explains double transactional behaviour giving few examples of hidden communication and how it can help reduce the social withdrawal behaviour they are exhibiting.

Homework: the students are asked to look around them and write out some of their actions that have brought down their self-concept.

WEEK SIX

Session 6

Objectives of the counseling: it is to help the students set goals, make decision and begin to exhibit positive behaviour as well as interact very well.

Counselling process: The previous homework checked. The participants provide feedback by presenting some of their change in state of mind and behaviour. The researcher explained the need for them to make decision, and setting of goal for themselves. The counsellor and the participants jointly reviewed all the previous sessions, the plans, goals, rules and regulations as well as looking at the role of feedback in the progress of the therapy. The practical application of TA and its ability to help the participants gain self-leadership and get out of the 'shell' of social withdrawal to become socially competent.

Final assessment and evaluation is done and the post-test instrument is administered by the researcher with the support of the school counsellor and the class teacher. After this, the researcher then informs the clients of a follow-session two weeks after the sixth session.

APPENDIX 4

Descriptive Statistics

	Moderate SW group	Mean	Std. Deviation	N
Pretest1	Social Skills Training Technique	51.5000	5.35931	10
	Control group	53.5000	5.38000	10
	Total	52.5000	5.32620	20

Posttest1	Social Skills Training Technique	31.7000	3.40098	10
	Control group	46.5000	3.97911	10
	Total	39.1000	8.40363	20

Descriptive Statistics

	High SW group	Mean	Std. Deviation	N
Pretest2	Social Skills Training Technique	67.6000	7.77746	10
	Control group	71.9000	10.14834	10
	Total	69.7500	9.07208	20
Posttest2	Social Skills Training Technique	34.5000	3.83695	10
	Control group	62.3000	9.47570	10
	Total	48.4000	15.90233	20

Descriptive Statistics

	Moderate SW group	Mean	Std. Deviation	N
Pretest1	Transactional Analysis Technique	53.5000	5.38000	10
	Control group	53.5000	5.38000	10
	Total	53.5000	5.23651	20
Posttest1	Transactional Analysis Technique	35.4000	4.08792	10
	Control group	46.5000	3.97911	10
	Total	40.9500	6.91661	20

Descriptive Statistics

	High SW group	Mean	Std. Deviation	N
Pretest2	Transactional Analysis Technique	71.5000	10.39498	10
	Control group	71.9000	10.14834	10
	Total	71.7000	10.00053	20

Posttest2	Transactional Analysis Technique	43.0000	9.04311	10
	Control group	62.3000	9.47570	10
	Total	52.6500	13.39000	20

Descriptive Statistics

	Moderate SW group	Mean	Std. Deviation	N
Pretest1	Social Skills Training Technique	51.5000	5.35931	10
	Transactional Analysis Technique	53.5000	5.38000	10
	Total	52.5000	5.32620	20
Posttest1	Social Skills Training Technique	31.7000	3.40098	10
	Transactional Analysis Technique	35.4000	4.08792	10
	Total	33.5500	4.12279	20

Descriptive Statistics

	High SW group	Mean	Std. Deviation	N
Pretest2	Social Skills Training Technique	67.6000	7.77746	10
	Transactional Analysis Technique	71.5000	10.39498	10
	Total	69.5500	9.15639	20
Posttest2	Social Skills Training Technique	34.5000	3.83695	10
	Transactional Analysis Technique	43.0000	9.04311	10
	Total	38.7500	8.04510	20

```
UNIANOVA Posttest1 BY Group1 WITH Pretest1
  /METHOD=SSTYPE(3)
  /INTERCEPT=INCLUDE
  /EMMEANS=TABLES(OVERALL) WITH(Pretest1=MEAN)
  /EMMEANS=TABLES(Group1) WITH(Pretest1=MEAN) COMPARE ADJ(LSD)
  /PRINT=HOMOGENEITY DESCRIPTIVE
  /CRITERIA=ALPHA(.05)
  /DESIGN=Pretest1 Group1.
```

Univariate Analysis of Variance

Between-Subjects Factors

		Value Label	N
Moderate SW group	1.00	Social Skills Training Technique	10
	2.00	Control group	10

Descriptive Statistics

Dependent Variable: Posttest1

Moderate SW group	Mean	Std. Deviation	N
Social Skills Training Technique	31.7000	3.40098	10
Control group	46.5000	3.97911	10
Total	39.1000	8.40363	20

Levene's Test of Equality of Error Variances[a]

Dependent Variable: Posttest1

F	df1	df2	Sig.
.334	1	18	.571

Tests the null hypothesis that the error variance of the dependent variable is equal across groups.[a]

a. Design: Intercept + Pretest1 + Group1

Tests of Between-Subjects Effects

Dependent Variable: Posttest1

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	1098.599[a]	2	549.299	38.397	.000
Intercept	350.532	1	350.532	24.503	.000
Pretest1	3.399	1	3.399	.238	.632

Group1	1077.753	1	1077.753	75.336	.000
Error	243.201	17	14.306		
Total	31918.000	20			
Corrected Total	1341.800	19			

a. R Squared = .819 (Adjusted R Squared = .797)

Estimated Marginal Means

1. Grand Mean

Dependent Variable: Posttest1

Mean	Std. Error	95% Confidence Interval	
		Lower Bound	Upper Bound
39.100[a]	.846	37.316	40.884

a. Covariates appearing in the model are evaluated at the following values: Pretest1 = 52.5000.

2. Moderate SW group

Estimates

Dependent Variable: Posttest1

Moderate SW group	Mean	Std. Error	95% Confidence Interval	
			Lower Bound	Upper Bound
Social Skills Training Technique	31.619[a]	1.208	29.071	34.167
Control group	46.581[a]	1.208	44.033	49.129

a. Covariates appearing in the model are evaluated at the following values: Pretest1 = 52.5000.

Pairwise Comparisons

Dependent Variable: Posttest1

(I) Moderate SW group	(J) Moderate SW group	Mean Difference (I-J)	Std. Error	Sig.[b]
Social Skills Training Technique	Control group	-14.962*	1.724	.000

Control group	Social Skills Training Technique	14.962*	1.724	.000

Pairwise Comparisons

Dependent Variable: Posttest1

		95% Confidence Interval for Difference[b]	
(I) Moderate SW group	(J) Moderate SW group	Lower Bound	Upper Bound
Social Skills Training Technique	Control group	-18.599	-11.325
Control group	Social Skills Training Technique	11.325	18.599

Based on estimated marginal means

*. The mean difference is significant at the .05 level.

b. Adjustment for multiple comparisons: Least Significant Difference (equivalent to no adjustments).

Univariate Tests

Dependent Variable: Posttest1

	Sum of Squares	df	Mean Square	F	Sig.
Contrast	1077.753	1	1077.753	75.336	.000
Error	243.201	17	14.306		

The F tests the effect of Moderate SW group. This test is based on the linearly independent pairwise comparisons among the estimated marginal means.

```
UNIANOVA Posttest2 BY Group2 WITH Pretest2
  /METHOD=SSTYPE(3)
  /INTERCEPT=INCLUDE
  /EMMEANS=TABLES(OVERALL) WITH(Pretest2=MEAN)
  /PRINT=HOMOGENEITY DESCRIPTIVE
  /CRITERIA=ALPHA(.05)
  /DESIGN=Pretest2 Group2.
```

Univariate Analysis of Variance

Between-Subjects Factors

		Value Label	N
High SW group	1.00	Social Skills Training Technique	10
	2.00	Control group	10

Descriptive Statistics

Dependent Variable: Posttest2

High SW group	Mean	Std. Deviation	N
Social Skills Training Technique	34.5000	3.83695	10
Control group	62.3000	9.47570	10
Total	48.4000	15.90233	20

Levene's Test of Equality of Error Variances[a]

Dependent Variable: Posttest2

F	df1	df2	Sig.
.157	1	18	.697

Tests the null hypothesis that the error variance of the dependent variable is equal across groups.[a]

a. Design: Intercept + Pretest2 + Group2

Tests of Between-Subjects Effects

Dependent Variable: Posttest2

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	4382.553[a]	2	2191.277	88.223	.000
Intercept	14.595	1	14.595	.588	.454
Pretest2	518.353	1	518.353	20.869	.000
Group2	2998.802	1	2998.802	120.734	.000
Error	422.247	17	24.838		
Total	51656.000	20			
Corrected Total	4804.800	19			

a. R Squared = .912 (Adjusted R Squared = .902)

Estimated Marginal Means

Grand Mean

Dependent Variable: Posttest2

Mean	Std. Error	95% Confidence Interval	
		Lower Bound	Upper Bound
48.400[a]	1.114	46.049	50.751

a. Covariates appearing in the model are evaluated at the following values: Pretest2 = 69.7500.

```
DATASET ACTIVATE DataSet1.
UNIANOVA Posttest1 BY Group1 WITH Pretest1
  /METHOD=SSTYPE(3)
  /INTERCEPT=INCLUDE
  /EMMEANS=TABLES(OVERALL) WITH(Pretest1=MEAN)
  /EMMEANS=TABLES(Group1) WITH(Pretest1=MEAN) COMPARE ADJ(LSD)
  /PRINT=HOMOGENEITY DESCRIPTIVE
  /CRITERIA=ALPHA(.05)
  /DESIGN=Pretest1 Group1.
```

Univariate Analysis of Variance

Between-Subjects Factors

		Value Label	N
Moderate SW group	1.00	Transactional Analysis Technique	10
	2.00	Control group	10

Descriptive Statistics

Dependent Variable: Posttest1

Moderate SW group	Mean	Std. Deviation	N
Transactional Analysis Technique	35.4000	4.08792	10
Control group	46.5000	3.97911	10
Total	40.9500	6.91661	20

Levene's Test of Equality of Error Variances[a]

Dependent Variable: Posttest1

F	df1	df2	Sig.
.011	1	18	.919

Tests the null hypothesis that the error variance of the dependent variable is equal across groups.[a]

a. Design: Intercept + Pretest1 + Group1

Tests of Between-Subjects Effects

Dependent Variable: Posttest1

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	623.789[a]	2	311.895	18.594	.000
Intercept	406.486	1	406.486	24.233	.000
Pretest1	7.739	1	7.739	.461	.506
Group1	616.050	1	616.050	36.726	.000
Error	285.161	17	16.774		

Total	34447.000	20			
Corrected Total	908.950	19			

a. R Squared = .686 (Adjusted R Squared = .649)

Estimated Marginal Means

1. Grand Mean

Dependent Variable: Posttest1

		95% Confidence Interval	
Mean	Std. Error	Lower Bound	Upper Bound
40.950[a]	.916	39.018	42.882

a. Covariates appearing in the model are evaluated at the following values: Pretest1 = 53.5000.

2. Moderate SW group

Estimates

Dependent Variable: Posttest1

			95% Confidence Interval	
Moderate SW group	Mean	Std. Error	Lower Bound	Upper Bound
Transactional Analysis Technique	35.400[a]	1.295	32.667	38.133
Control group	46.500[a]	1.295	43.767	49.233

a. Covariates appearing in the model are evaluated at the following values: Pretest1 = 53.5000.

Pairwise Comparisons

Dependent Variable: Posttest1

(I) Moderate SW group	(J) Moderate SW group	Mean Difference (I-J)	Std. Error	Sig.[b]
Transactional Analysis Technique	Control group	-11.100[*]	1.832	.000

Control group	Transactional Analysis Technique	11.100*	1.832	.000

Pairwise Comparisons

Dependent Variable: Posttest1

		95% Confidence Interval for Difference[b]	
(I) Moderate SW group	(J) Moderate SW group	Lower Bound	Upper Bound
Transactional Analysis Technique	Control group	-14.964	-7.236
Control group	Transactional Analysis Technique	7.236	14.964

Based on estimated marginal means

*. The mean difference is significant at the .05 level.

b. Adjustment for multiple comparisons: Least Significant Difference (equivalent to no adjustments).

Univariate Tests

Dependent Variable: Posttest1

	Sum of Squares	df	Mean Square	F	Sig.
Contrast	616.050	1	616.050	36.726	.000
Error	285.161	17	16.774		

The F tests the effect of Moderate SW group. This test is based on the linearly independent pairwise comparisons among the estimated marginal means.

```
UNIANOVA Posttest2 BY Group2 WITH Pretest2
  /METHOD=SSTYPE(3)
  /INTERCEPT=INCLUDE
  /EMMEANS=TABLES(OVERALL) WITH(Pretest2=MEAN)
  /EMMEANS=TABLES(Group2) WITH(Pretest2=MEAN) COMPARE ADJ(LSD)
  /PRINT=HOMOGENEITY DESCRIPTIVE
  /CRITERIA=ALPHA(.05)
  /DESIGN=Pretest2 Group2.
```

Univariate Analysis of Variance

Between-Subjects Factors

		Value Label	N
High SW group	1.00	Transactional Analysis Technique	10
	2.00	Control group	10

Descriptive Statistics

Dependent Variable: Posttest2

High SW group	Mean	Std. Deviation	N
Transactional Analysis Technique	43.0000	9.04311	10
Control group	62.3000	9.47570	10
Total	52.6500	13.39000	20

Levene's Test of Equality of Error Variances[a]

Dependent Variable: Posttest2

F	df1	df2	Sig.
2.410	1	18	.138

Tests the null hypothesis that the error variance of the dependent variable is equal across groups.[a]

b. Design: Intercept + Pretest2 + Group2

Tests of Between-Subjects Effects

Dependent Variable: Posttest2

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	2163.592[a]	2	1081.796	14.796	.000
Intercept	210.710	1	210.710	2.882	.108
Pretest2	301.142	1	301.142	4.119	.058
Group2	1831.066	1	1831.066	25.044	.000
Error	1242.958	17	73.115		
Total	58847.000	20			
Corrected Total	3406.550	19			

a. R Squared = .635 (Adjusted R Squared = .592)

Estimated Marginal Means

1. Grand Mean

Dependent Variable: Posttest2

Mean	Std. Error	95% Confidence Interval	
		Lower Bound	Upper Bound
52.650[a]	1.912	48.616	56.684

a. Covariates appearing in the model are evaluated at the following values: Pretest2 = 71.7000.

2. High SW group

Estimates

Dependent Variable: Posttest2

High SW group	Mean	Std. Error	95% Confidence Interval	
			Lower Bound	Upper Bound
Transactional Analysis Technique	43.080[a]	2.704	37.374	48.785
Control group	62.220[a]	2.704	56.515	67.926

a. Covariates appearing in the model are evaluated at the following values: Pretest2 = 71.7000.

Pairwise Comparisons

Dependent Variable: Posttest2

(I) High SW group	(J) High SW group	Mean Difference (I-J)	Std. Error	Sig.[b]
Transactional Analysis Technique	Control group	-19.141*	3.825	.000
Control group	Transactional Analysis Technique	19.141*	3.825	.000

Pairwise Comparisons

Dependent Variable: Posttest2

(I) High SW group	(J) High SW group	95% Confidence Interval for Difference[b]	
		Lower Bound	Upper Bound
Transactional Analysis Technique	Control group	-27.210	-11.071
Control group	Transactional Analysis Technique	11.071	27.210

Based on estimated marginal means

*. The mean difference is significant at the .05 level.

b. Adjustment for multiple comparisons: Least Significant Difference (equivalent to no adjustments).

Univariate Tests

Dependent Variable: Posttest2

	Sum of Squares	df	Mean Square	F	Sig.
Contrast	1831.066	1	1831.066	25.044	.000
Error	1242.958	17	73.115		

The F tests the effect of High SW group. This test is based on the linearly independent pairwise comparisons among the estimated marginal means.

```
DATASET ACTIVATE DataSet3.
UNIANOVA Posttest1 BY Group1 WITH Pretest1
  /METHOD=SSTYPE(3)
  /INTERCEPT=INCLUDE
  /EMMEANS=TABLES(OVERALL) WITH(Pretest1=MEAN)
  /EMMEANS=TABLES(Group1) WITH(Pretest1=MEAN) COMPARE ADJ(LSD)
  /PRINT=HOMOGENEITY DESCRIPTIVE
  /CRITERIA=ALPHA(.05)
  /DESIGN=Pretest1 Group1.
```

Univariate Analysis of Variance

Between-Subjects Factors

		Value Label	N
Moderate SW group	1.00	Social Skills Training Technique	10
	2.00	Transactional Analysis Technique	10

Descriptive Statistics

Dependent Variable: Posttest1

Moderate SW group	Mean	Std. Deviation	N
Social Skills Training Technique	31.7000	3.40098	10
Transactional Analysis Technique	35.4000	4.08792	10
Total	33.5500	4.12279	20

Levene's Test of Equality of Error Variances[a]

Dependent Variable: Posttest1

F	df1	df2	Sig.
.235	1	18	.633

Tests the null hypothesis that the error variance of the dependent variable is equal across groups.[a]

a. Design: Intercept + Pretest1 + Group1

Tests of Between-Subjects Effects

Dependent Variable: Posttest1

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	68.855[a]	2	34.428	2.303	.130
Intercept	228.734	1	228.734	15.303	.001
Pretest1	.405	1	.405	.027	.871
Group1	67.916	1	67.916	4.544	.048
Error	254.095	17	14.947		
Total	22835.000	20			
Corrected Total	322.950	19			

a. R Squared = .213 (Adjusted R Squared = .121)

Estimated Marginal Means

1. Grand Mean

Dependent Variable: Posttest1

Mean	Std. Error	95% Confidence Interval	
		Lower Bound	Upper Bound
33.550[a]	.864	31.726	35.374

a. Covariates appearing in the model are evaluated at the following values: Pretest1 = 52.5000.

2. Moderate SW group

Estimates

Dependent Variable: Posttest1

Moderate SW group	Mean	Std. Error	95% Confidence Interval	
			Lower Bound	Upper Bound
Social Skills Training Technique	31.672[a]	1.234	29.068	34.276
Transactional Analysis Technique	35.428[a]	1.234	32.824	38.032

a. Covariates appearing in the model are evaluated at the following values: Pretest1 = 52.5000.

Pairwise Comparisons

Dependent Variable: Posttest1

(I) Moderate SW group	(J) Moderate SW group	Mean Difference (I-J)	Std. Error	Sig.[b]

Social Skills Training Technique	Transactional Analysis Technique	-3.756*	1.762	.048
Transactional Analysis Technique	Social Skills Training Technique	3.756*	1.762	.048

Pairwise Comparisons

Dependent Variable: Posttest1

		95% Confidence Interval for Difference[b]	
(I) Moderate SW group	(J) Moderate SW group	Lower Bound	Upper Bound
Social Skills Training Technique	Transactional Analysis Technique	-7.473	-.038
Transactional Analysis Technique	Social Skills Training Technique	.038	7.473

Based on estimated marginal means

*. The mean difference is significant at the .05 level.

b. Adjustment for multiple comparisons: Least Significant Difference (equivalent to no adjustments).

Univariate Tests

Dependent Variable: Posttest1

	Sum of Squares	Df	Mean Square	F	Sig.
Contrast	67.916	1	67.916	4.544	.048
Error	254.095	17	14.947		

The F tests the effect of Moderate SW group. This test is based on the linearly independent pairwise comparisons among the estimated marginal means.

```
UNIANOVA Posttest2 BY Group2 WITH Pretest2
  /METHOD=SSTYPE(3)
  /INTERCEPT=INCLUDE
  /EMMEANS=TABLES(OVERALL) WITH(Pretest2=MEAN)
  /EMMEANS=TABLES(Group2) WITH(Pretest2=MEAN) COMPARE ADJ(LSD)
  /PRINT=HOMOGENEITY DESCRIPTIVE
  /CRITERIA=ALPHA(.05)
  /DESIGN=Pretest2 Group2.
```

Univariate Analysis of Variance

Between-Subjects Factors

	Value Label	N

High SW group	1.00	Social Skills Training Technique	10
	2.00	Transactional Analysis Technique	10

Descriptive Statistics

Dependent Variable: Posttest2

High SW group	Mean	Std. Deviation	N
Social Skills Training Technique	34.5000	3.83695	10
Transactional Analysis Technique	43.0000	9.04311	10
Total	38.7500	8.04510	20

Levene's Test of Equality of Error Variances[a]

Dependent Variable: Posttest2

F	df1	df2	Sig.
8.630	1	18	.009

Tests the null hypothesis that the error variance of the dependent variable is equal across groups.[a]

a. Design: Intercept + Pretest2 + Group2

Tests of Between-Subjects Effects

Dependent Variable: Posttest2

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	366.472[a]	2	183.236	3.608	.049
Intercept	371.105	1	371.105	7.308	.015
Pretest2	5.222	1	5.222	.103	.752
Group2	325.731	1	325.731	6.414	.021
Error	863.278	17	50.781		
Total	31261.000	20			
Corrected Total	1229.750	19			

a. R Squared = .298 (Adjusted R Squared = .215)

Estimated Marginal Means

1. Grand Mean

Dependent Variable: Posttest2

Mean	Std. Error	95% Confidence Interval	
		Lower Bound	Upper Bound
38.750[a]	1.593	35.388	42.112

a. Covariates appearing in the model are evaluated at the following values: Pretest2 = 69.5500.

2. High SW group

Estimates

Dependent Variable: Posttest2

High SW group	Mean	Std. Error	95% Confidence Interval	
			Lower Bound	Upper Bound
Social Skills Training Technique	34.614[a]	2.282	29.801	39.428
Transactional Analysis Technique	42.886[a]	2.282	38.072	47.699

a. Covariates appearing in the model are evaluated at the following values: Pretest2 = 69.5500.

Pairwise Comparisons

Dependent Variable: Posttest2

(I) High SW group	(J) High SW group	Mean Difference (I-J)	Std. Error	Sig.[b]
Social Skills Training Technique	Transactional Analysis Technique	-8.271*	3.266	.021
Transactional Analysis Technique	Social Skills Training Technique	8.271*	3.266	.021

Pairwise Comparisons

Dependent Variable: Posttest2

(I) High SW group	(J) High SW group	95% Confidence Interval for Difference[b]	
		Lower Bound	Upper Bound
Social Skills Training Technique	Transactional Analysis Technique	-15.161	-1.381
Transactional Analysis Technique	Social Skills Training Technique	1.381	15.161

Based on estimated marginal means

*. The mean difference is significant at the .05 level.

b. Adjustment for multiple comparisons: Least Significant Difference (equivalent to no adjustments).

Univariate Tests

Dependent Variable: Posttest2

	Sum of Squares	Df	Mean Square	F	Sig.
Contrast	325.731	1	325.731	6.414	.021
Error	863.278	17	50.781		

The F tests the effect of High SW group. This test is based on the linearly independent pairwise comparisons among the estimated marginal means.

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

Our Ref: _____ Date: 23/02/2016

THE DIRECTOR
FCT SECONDARY
EDUCATION BOARD (SEB)
AREA 3 GARKI ABUJA

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:

EFFECTS OF SOCIAL SKILLS TRAINING AND TRANSACTIONAL ANALYSIS TECHNIQUES ON SOCIAL WITHDRAWAL BEHAVIOUR AMONG SECONDARY SCHOOL STUDENTS IN FEDERAL CAPITAL TERRITORY, ABUJA NIGERIA

Thank you for your continued cooperation.

Yours Sincerely,

DEPARTMENT OF EDUCATIONAL PSYCHOLOGY AND COUNSELLING A.B.U. ZARIA

Research Adviser

FCT - SECONDARY EDUCATION BOARD
EDUCATION SECRETARIAT

P.M.B. 151, Garki, Abuja. Tel: 09-2341148

Block 3, Area 3,
Garki, Abuja.

Our Ref: FCT/EDU/SCH/MT/811/T

Your Ref:.....

Date: 26th MAY, 2016

Mrs. Akintunde J. O.
Department of Educational Psychology &
Counseling, Faculty of Education,
Ahmadu Bello University, Zaria.

RE: APPLICATION FOR APPROVAL

The subject matter above refers please. I am directed to inform you that approval has been granted for you to present your Questionnaires in the following FCT-Secondary Schools:- GSS Lugbe, GSS Kuje and GDSS Gwagwalada.

2. You would liaise with the Principals of the above mentioned Schools for further discussions.

3. Thank you.

NANRE EMEJE (MRS)
Deputy Director (Administration) SEB
For: Ag. Director (SEB)

ABUJA
The Heart of Nigeria

FCT - SECONDARY EDUCATION BOARD
EDUCATION SECRETARIAT

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Block 3, Area 3,
Garki, Abuja.

Our Ref: FCT/EDU/SCH/MT/8117/T

Your Ref: .....

Date: 26th MAY, 2016

The Principal
GSS Lugbe
Abuja

28 MAY 2016

LETTER OF INTRODUCTION

I am directed to introduce to you **Mrs. Akintunde J. O.**, a final year student from Department of Educational Psychology & Counseling, Ahmadu Bello University, Zaria has requested to collect data for the research studies from your school to enable her conduct a project work.

2. Please kindly accord her the necessary audience as she administers the questionnaire items to Teachers and Students in your School.

3. Thank you.

NANRE EMEJE (MRS)
Deputy Director (Administration) SEB
For: Ag. Director (SEB)

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Block 3, Area 3,
Garki, Abuja.

Our Ref: FCT/EDU/SCH/MT/8111/T

Your Ref: .....

Date: 26th MAY, 2016

28 MAY 2016

The Principal
GSS Kuje
Abuja

LETTER OF INTRODUCTION

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2. Please kindly accord her the necessary audience as she administers the questionnaire items to Teachers and Students in your School.

3. Thank you.

NANRE EMEJE (MRS)
Deputy Director (Administration) SEB
For: Ag. Director (SEB)

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EDUCATION SECRETARIAT

P.M.B. 151, Garki, Abuja. Tel: 09-2341148.
Block 3, Area 3,
Garki, Abuja.

Our Ref: FCT/EDU/SCH/MT/811/T

Your Ref: .....

Date: 26th MAY, 2016

The Principal
GDSS Gwagwalada
Abuja

28 MAY

LETTER OF INTRODUCTION

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NANRE EMEJE (MRS)
Deputy Director (Administration) SEB
For: Ag. Director (SEB)