EFFECT OF COGNITIVE RESTRUCTURING AND SOCIAL SKILLS TRAINING ON SOCIAL PHOBIA AMONG SECONDARY SCHOOL STUDENTS IN KADUNA METROPOLIS, NIGERIA

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ZARIA, 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 DOCTOR OF PHILOSOPHY IN EDUCATIONAL PSYCHOLOGY IN THE DEPARTMENT OF EDUCATIONAL PSYCHOLOGY AND COUNSELLING,

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ZARIA, NIGERIA

MARCH, 2021

Declaration

I declare that the work in this thesis entitled EFFECT OF COGNITIVE RESTRUCTURING AND SOCIAL SKILLS TRAINING ON SOCIAL PHOBIA AMONG SECONDARY SCHOOL STUDENTS IN KADUNA METROPOLIS, NIGERIA has been written by me in the Department of Educational Psychology and Counselling under the supervision of Prof. A. I. Mohammad, Prof. E. F. Adeniyi, and Dr. H. A. Tukur. The information derived for the literature has been duly acknowledged in the text and a list of references provided. No part of this thesis was previously presented for another degree or diploma at this University or any other Institution.

_____ _____

ABUBAKAR Hassan **Date**
P16EDPC 9005

Certification

This thesis entitled **"**EFFECT OF COGNITIVE RESTRUCTURING AND SOCIAL SKILLS TRAINING ON SOCIAL PHOBIA AMONG SECONDARY SCHOOL STUDENTS IN KADUNA METROPOLIS, NIGERIA by ABUBAKAR Hassan meets the regulations governing the award of PhD in Educational Psychology of 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 my ParentsLate Mallam Abubakar Usman and Khadija Abubakar. Their invaluable contributions to my success will remain in my mind forever. May Allah grant them Aljanatul Firdausi (Amen).

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List of Abbreviations

APA: American Psychological Association

APD: Avoidant Personality Disorder

AT: Automatic Thought

CBT: Cognitive Behavioural Therapy

CR: Cognitive Restructuring

CRIP: Cognitive Restructuring Intervention Programme

DSM: Diagnostic and Statistical Manual of Mental Disorder

JSS: Junior Secondary School

RET: Rational Emotive Therapy

SAD: Social Anxiety Disorder

SP: Social Phobia

SPIN: Social Phobia Inventory

SST: Social Skills Training

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OPERATIONAL DEFINATION OF TERMS

Social Phobia: A sense of being in distress or worry in response to social or evaluative situations that may exhibit emotional symptoms (Excessive Fear), physiological manifestations (sweating, palpitation, headache or nausea), and behavioural symptoms (Avoidance of Social Interactions) exhibited by secondary school students.

Cognitive Restructuring: A psychotherapeutic approach, where clients are taught how to identify their distorted thoughts and challenges so as to reduce their Social Phobia.

Social Skills Training: A technique where the clients/students are given training in social and interpersonal relationship skills to reduce their Social Phobia.

Abstract

This study investigated the Effect of Cognitive Restructuring and Social Skills Training on Social Phobia among Secondary School Students in Kaduna Metropolis, Nigeria. Seven (7) Objectives were set to guide this study,and Seven (7) null hypotheses were formulated and tested. Quasi-experimental design involving pre-test, post-test on two (2) experimental groups was used. The population was made up of 1742 students who exhibited symptoms of social Phobia in Kaduna metropolis, Nigeria. A sample size of 40 students was selected through purposive sampling technique. An instrument tagged Social Phobia Inventory (SPIN) was used for data collection. Mean, standard Deviation and t-test statistics were used to analyze data. Findings reveal that students exposed to Cognitive Restructuring (CR) had a reduced Excessive Fear of Social Interactions (p=0.000), that students exposed to Social Skills Training (SST) had a reduced Excessive Fear of Social Interactions (p=0.000), students exposed to Cognitive Restructuring (CR) had a reduced Physiological Manifestations of Social Phobia (p=0.003), students exposed to Social Skills Training (SST) had a reduced Physiological Manifestations of Social Phobia (p=0.000), students exposed to Cognitive Restructuring (CR) had a reduced Avoidance of Social Interactions (p=0.000), students exposed to Social Skills Training (SST) had a reduced Avoidance of Social Interactions (p=0.000) and that there was a significant differential effect of Cognitive Restructuring and Social Skills Training (p=0.009) on Social Phobia among secondary students. The researcher therefore concluded that Cognitive Restructuring and Social Skills Training are effective in reducing Social Phobia among secondary school students. And that Social Skills Training is more effective than cognitive Restructuring in handling Social Phobia. Based on the findings of this study it was recommended among others that Psychologists and Counsellors should be encouraged to use Cognitive Restructuring (CR) and Social Skills Training (SST) in handling Social Phobia among secondary school students so as to develop their social interactions and competency in learning.

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CHAPTER ONE

INTRODUCTION

1.1 Background to the study

Social Phobiais one of the most prevalent and chronic disorders worldwide and it affects occupational, educational, and social affairs of the individual. It is also known for its association with depression and substance use disorder. Social Phobia, also called social anxiety disorder, is the third most common mental health disorder after depression and substance abuse, affecting many people worldwide. It is a disorder involving intense distress in response to public situations. It is a strong fear of being judged by others and of being embarrassed. This fear can be so strong that it gets in the way of going to work, school or doing other everyday activities. People with Social Phobia are afraid of doing common things in front of other people; for example, they might be afraid to sign a check in front of people, or they might be afraid to eat or drink in front of other people

It is normal to be a little bit nervous, at one time or another, especially when meeting new people or giving a speech, but people with Social Phobia worry about these and other things for weeks before they happen, they end up staying away from places or events where they think they might have to do something that will attract other people's attention to them. This can keep them from doing the everyday tasks of living and from enjoying times with family and friends. With the publication of fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), social phobia is formally diagnosed as Social Anxiety Disorder (SAD). When anxiety is disruptive, it is associated with a host of cognitive, behavioural, physiological and emotional problems.

When the problems are pervasive and severe, they may be diagnosed as anxiety disorders. A diagnosis of Social Phobia is meant to denote a condition that is highly disruptive of the daily functioning and that requires an intervention. The diagnosis is intended for those whom social interactions consistently provoke distress and whose fear or anxiety is out of proportion (in frequency and duration) to the situations they are experiencing. Criteria also include that social interactions are either avoided or painfully and reluctantly endured and that the individual's problems often are specific to social settings where the person feels concern about being noticed, observed, judged or embarrassed. In such settings, the individual fears displaying anxiety and experiencing social rejection. The anxiety and fear usually is accompanied by autonomic arousal, for example, sweating. Trembling, tachycardia, and even nausea. The symptoms may arise in reaction to strangers or acquaintances (Matos, Tome, Borges, Manso, Ferreira, & Ferreira, 2008). Moreover, care must be taken not to see shyness and introversion that are within normal limits as Social Phobia, they further explained.

As noted by the National Institute of Mental Health (2014), occasional anxiety is a normal part of life. A student might feel anxious when faced with a problem at work, like going to another school for a competition, before taking an examination, or making an important decision. But Social Phobia involves more than temporary worry or fear, for a person with this disorder the worry and fear do not go away and can get worse over time. The feelings can interfere with daily activities such as job performance, school work, and relationships.Social phobia (SP) represents a mental health problem withdisabling characteristics. The most common is fear of beinghumiliated or mocked in social situations by having improperattitudes or anxiety symptoms such as tremors,

sweating and inattention. Social interaction becomes more threatening whenassociated with lack of motor control seen in behavior such asdrinking, eating or writing.

Students often feel anxious about some activities at school, they frequently behave in ways that lead others to avoid and even reject them, they also lack interactions with peers and this can negatively lead to social and emotional problems as loneliness and isolation. Sociallyphobic students are trapped in a vicious cycle of anxiety, negative expectations about their social performance, and negative peer responses, it is a complex task to break this vicious cycle. Interventions can be usedto address a variety of factors, notably negative thinking and poor social skills.

Social Phobia is a prevalent problem among young people. Although identification and treatment of the disorder often do not occur until early adulthood, approximatelyhalf of those treated for Social Phobia indicate an earlieronset during childhood or adolescence (APA, 2013). According to the Discovery Education (2015) report, Social Phobia affects between 2% and 4% of the population and it is the most common type of mental disorder in the United States. Erk (2014) estimates the prevalenceof anxiety disorders among children from 5% to 18%.Another study by Emslie (2018) reports higher numbersin the range of 6% to 20% of children and adolescents.Observation shows that social Phobia is not just a problem for adults; it isalso a problemfor young people, often manifesting itself in the schoolsetting. Bella and Omigbodun (2009) revealed that despite the early onset, chronic course and co-mobidity of Social Phobia, there is virtually no information about it in sub-Saharan Africa. However, their study revealed that the prevalence of Social Phobia was 9.4% among University students in Nigeria.

According to Wagner (2015), about half of students diagnosedwith Social Phobiaexperience significant difficulty functioning at school. It lowers academicperformance and productivity, although students withmild levels of Social Phobia can sometimes over-come it and improve usingpersistence and hard work. Tardiness, absenteeism, andperfectionism, common with more severe levels of social phobia,can lead to incomplete work, test failure, or possiblerepetition of a grade. He further stressed out that dropout rates are high among students with high level social phobia, but these figures aresometimes attributed to substance abuse and truancywhich can mask untreated Social Phobia.Students with social phobia are adept at avoidingsituations that may evoke fear or anxiety. In a studyof approach and avoidance goals and plans, MacLeod (2014) found that adolescents with high Social Phobia were more motivated to generate avoidance goals and plans and were less specific in forming approach plans.If socially phobic individuals expect an unpleasant situation or failure,they are more inclined to avoid the situation rather thanapproach the situation and plan how to deal with it. Forexample, a student may anticipate failure on an oral presentation assignment or project and, therefore, choose not to attempt itat all or stay away from the school.

In spite of its prevalence and impairing effects, students with social phobia can benefit from support and treatment from therapistsand other individuals in learning toapproach rather than avoid threatening situations.Therefore it is critical to identify strategies that intervene effectively with youth who have social phobia in schools and that will interrupt the progress to more serious problem. Psychotherapy is considered to be the most effective and more permanent treatment for this condition.

Social Phobia is treated by using many therapeutic approaches like cognitive behavioral therapy, social skills therapy, life skills therapy, differential reinforcement technique, miscellaneous behavior change, self-instructional strategies, assertiveness `training among others which many researches show their effectiveness in the treatments of Social Phobia. Therefore, this work was conducted to find out the effect of two therapeutic techniques on SP; that is Cognitive Restructuring (CR) and Social Skills training (SST)

Cognitive Restructuringinvolves identification of distorted thoughts,conditional beliefs and the patient's core belief, thus allowing thetherapist to gain insight into the patient's cognitive processes and functioning to modify the identified distorted thoughts. It focuses onpractical discussions performed during sessions and homeworkassignments to be conducted by the client. Studies have shown that, for circumscribed Phobia, 12 to16 group or individual sessions are enough to significantlyreduce the symptoms. For generalized Social Phobia, treatment responsedepends on the number of co-morbidities and symptom severity;treatment is usually longer.Cognitive Restructuring is proved to be effective in the treatment ofschool refusal as revealed by King (2014) and many other psychological and behavioural problems like school phobia (Shina2015), avoidant behavior(Lawan2016), school refusal (Bernstein et al, 2014),test anxiety (Goldfried,Linehan, and Smith 1978) and so many other psychological issues.

Social Skills Training is proved to be an effective therapy on social phobia as shown in the work of Beidel, (2014). It is also proved to be effective on other psycho-social problems like Avoidant personality Disorder (Lawan2016), social anxiety

(Bolsoni-Silva, and Loureiro2014)Aggressive behaviour (Alavi, Savoji, Amin 2013) and many other social problems.

1.2 Statement of the problem

Secondary school students who are mostly adolescents spend a great deal of their daily life at school, necessitating a considerable amount of social interaction. For the socially phobicstudents, the school environment presents many potentially stressful situations such as giving an oral presentation, answering questions in the class, making friends, and participating in group activities. The socially phobic student may stop socializing with classmates and friends, may stop attending certain classes, or even refuse to attend school completely, and this may lead to poor academic performance, and eventually drop out of school.

Poor academic achievement is one of the major problems faced by students with the symptoms of Social Phobia because they tend to avoid any academic activities that required group work or expressing their views in public as a result of distress or feeling of inadequacy. It is reported that about 19.5 % of junior secondary students display symptoms of social phobia (Kaduna state school survey report, 2016/17). Social Phobia if left unchecked is a risk factor that leads to a serious delinquency such as truancy, school drop-out, drug addiction, unwanted pregnancy and other psychological problems like stress, depression, anxiety and the likes. It is against this background that this study investigates the effect of Cognitive Restructuring and Social Skills Trainingon social phobia among secondary school students in Kaduna metropolis, Nigeria.

1.3 Objectives of the study

The objectives of the study are:

1 To examine the effect of Cognitive Restructuring on fear of social interactions among secondary school students in Kaduna Metropolis, Nigeria.

2 To examine the effect of Social SkillsTraining on fear of social interactions amongsecondary school studentsin Kaduna Metropolis, Nigeria.

3 To find out the effect of Cognitive Restructuring on Physiological Manifestations of social phobia among secondary school studentsin Kaduna Metropolis, Nigeria.

4 To find out the effect of Social SkillsTraining on Physiological Manifestations of social phobia among secondary school students in Kaduna Metropolis, Nigeria.

5 To determine the effect of Cognitive Restructuring on social interactions avoidance among secondary school studentsin Kaduna Metropolis, Nigeria.

6 To determine the effect of Social SkillsTraining on social interactions avoidanceamongsecondary school studentsin Kaduna Metropolis, Nigeria.

7 Tofind out the differential effect ofCognitive Restructuring and Social SkillsTraining on Social Phobia amongsecondary school studentsin Kaduna Metropolis, Nigeria.

1.4 Research Questions

The study answers the following question:

1. What is the effect of Cognitive Restructuring on fear of social interactions among secondary school studentsin Kaduna Metropolis, Nigeria?
2. What is the effect of Social Skills Training on fear of social interactions among secondary school students in Kaduna Metropolis, Nigeria?
3. What is the effect of Cognitive Restructuring on Physiological Manifestation of social phobia among secondary school students in Kaduna Metropolis, Nigeria?
4. What is the effect of Social Skills Training on Physiological Manifestation of social phobiaamong secondary school students in Kaduna Metropolis, Nigeria?
5. What is the effect of Cognitive Restructuring on social interactions avoidance among secondary school students in Kaduna Metropolis, Nigeria?
6. What is the effect of Social Skills Training on social interactions avoidance among secondary school students in Kaduna Metropolis, Nigeria?
7. What is the differential effect of Cognitive Restructuring and Social Skills Training on Social Phobia among secondary school students in Kaduna Metropolis, Nigeria?

1.5 Hypotheses

The following hypotheses are formulated to guide the study:

1. There is no significantdifference between pre-test and post-test score of students exposed to Cognitive Restructuring on fearof social interactions among secondary school students in Kaduna Metropolis, Nigeria.

2. There is no significantdifference between pre-test and post-test score of students exposed to fear of social interactions among secondary school students in Kaduna Metropolis, Nigeria.
3. There is no significantdifference between pre-test and post-test score of students exposed toCognitiveRestructuring on Physiological Manifestationsof social phobiaamong secondary school students in Kaduna Metropolis, Nigeria.
4. There is no significantdifference between pre-test and post-test score of students exposed to Social Skills Training on Physiological Manifestationsof social phobiaamong secondary school students in Kaduna Metropolis, Nigeria.
5. There is no significantdifference between pre-test and post-test score of students exposed to Cognitive Restructuring on social interactions avoidanceamong secondary school students in Kaduna Metropolis, Nigeria.
6. There is no significantdifference between pre-test and post-test score of students exposed to Social Skills Training on social interactions avoidanceamong secondary school students in Kaduna Metropolis, Nigeria.
7. There is no significantdifferentialeffect of Cognitive Restructuring and Social Skills Training on Social Phobia among secondary school students in Kaduna Metropolis, Nigeria.

1.6 Basic Assumptions

The following are the basic assumptions of the study:

1. Some secondary school students in Kaduna Metropolis, Nigeria experience social phobia.

2. It is possible to reduce/manage social phobia among secondary school students in Kaduna Metropolis, Nigeria.
3. Psychological intervention may assist in reducing/managing social phobia among secondary school students in Kaduna Metropolis, Nigeria.

1.7 Significance of the study

The findings of this study will add to theory building in Cognitive Therapy and Social SkillsTraining in handling social phobia among secondary school students in Kaduna metropolis, Nigeria and other parts of the world. Therefore, the work will be of immense benefits to the following stakeholders concerned with the affairs of student in Kaduna metropolis:

Through this work, psychologists and counsellors will be exposed to theories, causes, and nature and treatment techniques of social phobia. They will also derive empirical data for reducing it among the students. Thus, they will be able to handle and guide the students in such a way that challenges of social phobia will be reduced and performance be enhanced.Psychologists and counsellors especially those in secondary schools will derive a great benefit from the study, in that they will be acquainted with the various issues on social phobia.

The students would be well assured and becoming more independent and cognitively active to learning by freely participating in activities such as attending assembly, quiz competitions, clubs activities, making friends and other

socialactivitieswithin and outside the school system when exposed to cognitive and social skill training techniques.

Teachers will also benefit from this study in the sense that they would realize the socio-psychological factors underlying social phobia and how to use the two techniques in helping the affected students. Thus, they would refer affected students to psychologists or counsellors and give necessary accurate information to such clients.

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

Furthermore, medical doctors, nurses, psychiatrists, and other professional helpers would derive benefit from this work. The above mentioned professionals will be exposed to materials in terms of symptoms, causes, management and methods of reducing Social Phobia among primary school pupils. Thus, the experts will be able to refer the clients for psychological intervention and as at when due.

There is no doubt that parents too will benefit from this work. Parents who have been disturbed by their children'sSocial Phobia will have a proper understanding of the nature, management and methods of reducing the phenomenon. It is expected that they will take appropriate active steps in reducing Social Phobia among their wards or children. Parents will also beexposed to guidance on socio-psychological and

pathological factors involved in Social Phobia and therefore prevent their children from falling into factors that can lead to the development of the problem.

This work will be very useful to the research community. It would provide instruments, empirical data and several references to interested researchers working on Social Phobia, Cognitive therapy and Social Skills Training. They may therefore, comment, adopt, and or modify as deemed fit by their studies.

Stakeholders in school affairs will definitely benefit from this work in the sense that they may understand all issues related to Social Phobia among the students and be able to influence decisions concerning the affairs of the schools. They will be able to influence funding, staffing, and provision of necessary materials to psychologists, counsellors, teachers, and students with a view to reducing Social Phobia

1.8 Scope and Delimitation of the Study

The main focus of this study is to assess the effect of Cognitive Restructuringand Social Skills Training in reducing Social Phobia among secondary school students in Kaduna metropolis. The scope of the work covers Junior Secondary School One (JSS I) students where both male and female studentswereinvolved. The reason for involving JSS I students is thatstudents at this level are newly admitted into secondary school and are likely to face the challenges of beingin a new environment where they meet and interact with new teachers and fellow students. Another reason why JSS I students were used for the study is that many literature reviewed show that Social Phobia emanates in school setting during transition periodand adolescence stage as such treatment at the onset may be more effective. The study was conducted in public secondary schools; hence primary

schools, private secondary schools and higher institutions of learning were not part of this study. Two techniques; Cognitive Restructuringand Social Skills Training wereused in this study to reduce social phobia among secondary school students in Kaduna metropolis, Nigeria.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

2.1 Introduction

The review of related studies is done under the following sub-headings:Conceptual perspectivesunderwhich the Concept of Social Phobia, Symptoms of Social Phobia, Characteristics of Social Phobic, Causes of Social Phobia, Treatment of Social Phobia,The Concept of Cognitive Restructuring, Cognitive Restructuring Working Template, The Concept of Social Skills Training and Social Skills Training Working Template are discussed. While under Theoretical Frameworktheories discussed are: Ivan Pavlov Classical Conditioning Theory,Operant Conditioning Theory of B. F Skinner, Aaron Beck's Theory of Cognitive Therapy,Clarck and Wells' Cognitive Therapy Model of Social PhobiaandAlbert Badura's social learning theory. As well as Empirical Studies,andSummary of the chapter

2.2 Conceptual Perspective

2.2.1 Concept of Social Phobia

Phobias are persistent, irrational fears of certain objects or situations. while Social Phobia is the fear of being judged and evaluated negatively by other people, leading to feelings of inadequacy, inferiority, embarrassment, humiliation, and depression. If a person usually becomes (irrationally) anxious in social situations, but seems better when he is alone, then social phobia may be the problem(Warneret al 2015). They further explain that it is a fear of embarrassment in social situations that is

extremely intrusive and can have debilitating effects on personal and professional relationships.Clarck and Wells (2002), explain that Social phobia is characterised by anxiety and apprehension in social or evaluative situationsin which the individual may be subject to scrutiny by others. Individuals with social phobiaare concerned that they will perform in a way that may be humiliating and/or embarrassing.This often consists of a fear of showing anxiety symptoms such as trembling, sweating,blushing or babbling. However, other types of concerns may also be evident, such asconcerns about being boring, or appearing inadequate or stupid. Two sub-types of social phobia are identified in the diagnostic and statistical manual of mental disorders (DSM-V APA, 2013). A generalised sub-type is characterised by a fear of most social situations,while more specific manifestations of social phobia can be identified in which the individualfears a particular type of situation. For example, fear of public speaking or using publictoilets would constitute a specific social phobia. Exposure to feared social situations almostalways cause distress in social situations, and those with this problem realise that their fearis irrational but are unable to overcome it. The experience of social phobia is often accompanied by physical symptomssuch as sweating, trembling, blushing and other physiological symptoms.

The American psychiatric Association (APA) (2013) in its fifth edition of Diagnostic and Statistical Manual (DSM-V) defines social phobia as marked or intense fear or anxiety of social situations in which the individual may be scrutinized by others and this situation interferes significantly with routines, occupational and academic functioning, social activities, and relationships. While the AmericanNational Institute of Mental Health (2014) defines social phobia as a strong fear of being judged by others and

of being embarrassed. This fear can be so strong that it gets in the way of going to work or school or doing other daily activities. People with social phobia are afraid of doing common things in front of other people; for example, they might be afraid to sign a check in front of a cashier at the grocery store, or they might be afraid to eat or drink in front of other people. The institute further explained that it is normal to be a little bit nervous, at one time or another, about things like meeting new people or giving a speech,but people with social phobia worry about these and other things for weeks before they happen. Sometimes, they end up staying away from places or events where they think they might have to do something that will embarrass them. That can keep them from doing the everyday tasks of living and from enjoying times with family and friends.

Rowaand Antony (2015) are of the view that Social Phobia is characterized by an intense fear of embarrassment,humiliation, or scrutiny by others in social or performance situations. Some situations that persons with Social Phobia often fear attending parties, meeting strangers, speaking at meetings, or interacting with authority figures. The number of situations feared by people with Social Phobia varies among individuals.Some people report concerns about a few situations or even just one particular situation (for example, public speaking), whereas others indicate fear across a broad range of social and performance situations.

For the purpose of this study, Social phobia is defined as a sense of distress or worry in response to social or evaluative situationsthat may exhibit both emotional symptoms (likefear), physiological manifestations (like sweating, palpitation,headaches or nausea), and behavioural symptoms (like avoidance of social situations)by secondary school students.

2.2.2 Fear of social interactions

In cognitive models of social phobia, those with social phobias experience dread and fear over how they will be presented to others. They may feel overly self-conscious, pay high self-attention after the activity, or have high performance standards for themselves. According to the social psychology theory of self-presentation, a sufferer attempts to create a well-mannered impression towards others but believes he or she is unable to do so. Many times, prior to the potentially anxiety-provoking social situation, sufferers may deliberately review what could go wrong and how to deal with each unexpected case. After the event, they may have the perception that they performed unsatisfactorily. Consequently, they will perceive anything that may have possibly been abnormal as embarrassing. Thesethoughts may extend for weeks or longer and are often self-defeating and inaccurate. Those with social phobia tend to interpret neutral or ambiguous conversations with a negative outlook, and many studies suggest that socially anxious individuals remember more negative memories than those less distressed (Schneier, 2016).

Those who suffer from social phobia fear being judged by others in society. In particular, individuals with social anxiety are nervous in the presence of people with authority and feel uncomfortable during physical examinations. People who suffer from this disorder may behave a certain way or say something and then feel embarrassed or humiliated after. As a result, they often choose to isolate themselves from society to avoid such situations. They may also feel uncomfortable meeting people they do not know, and act distant when they are with large groups of people. In some cases, they may

show evidence of this disorder by avoiding eye contact, or blushing when someone is talking to them (Acarturk, De Graaf, Van Straten, Have, Cuijpers, 2018).

2.2.3 Physiological Manifestations

Physiological effects, similar to those in other anxiety disorders, are present in social phobics (Beesdo, et al 2017). In adults, it may be tears as well as sweating, nausea, difficulty in breathing, shaking, and palpitations as a result of the fight-or-flight response. The walk disturbance (where a person is so worried about how they walk that they may lose balance) may appear, especially when passing a group of people. Blushing is commonly exhibited by individuals suffering from social phobia (Schneier, 2016). These visible symptoms further reinforce the fear in the presence of others.

2.2.4 Avoidance Behaviours

In the context of social phobia,there are things that people do to reduce anxiety about being in social situations among which is avoidance behaviours. Avoidance behaviours can take thefollowing forms: avoidance, escape or partial avoidance.

i. Avoidance:-True avoidance behaviours involve the complete avoidance of the feared social situation. For example, someone afraid of public speaking might:

- Drop a class in which he has to give a speech
- Change jobs to avoid giving presentations
- Fail to show up for an event such as a wedding or awards ceremony in which he is expected to speak in presence of others

ii. Escape:-When total avoidance is impossible, escape behaviours may be used as a means of dealing with feared situations. It involves leaving or escaping from a feared situation. Some examples of escape include:

- Leaving gathering early
- Walking out in the middle of a speech
- Hiding in the restroom during an event

When neither avoidance nor escape is possible, partial avoidance may be used to alleviate feeling of phobia during social or performance situation which may include the following:

- avoiding eye contact
- crossing arms to hide shaking
- taking drugs
- daydreaming
- sitting at the back of a classroom

2.2.5 Characteristics of social phobic individual

The U.S National Institute of Mental Health (2014) explains that People with social phobia:

- Are very anxiousabout being with other people.
- Are very self-consciousin front of other people; that is, they are very worried about how they themselves will act.
- Are very afraid of being embarrassedin front of other people.

- Are very afraidthat other people will judge them.
- Worry for days or weeksbefore an event where other people will be.
- Stay away from placeswhere there are other people.
- Have a hard timemaking friends and keeping friends.
- May have body symptomswhen they are with other people, such as:heavy sweating, trembling, nausea, and having a hard time talking.

Someone with social phobia is nervous in the company of other people. Above all, he is scared of what others will think of him. He tries to make a good impression but doubts his capability to do so. For this reason he avoids situations in which others could reject him, or stays in the background in such situations. Sometimes the fear of rejection centers on a specific physical phenomenon (for example: trembling hands, , vomiting, and sweating). In some cases the phobia is confined to one specific situation (for example: meeting strangers, speaking in public, phone calls, going to the toilet away from homeetcetera). More often there is a general fear of rejection by others in various situations. The person is then afraid of all kinds of criticism about his appearance, behaviour or character (Stein, et al 2011).Feelings of shyness or discomfort in certain situations arenot necessarily signs of social anxiety disorder, particularly in children. Comfort levels in social situations vary, depending on personality traits and life experiences. Some people are naturally reserved and others are more outgoing.

In contrast to everyday nervousness, social phobia symptoms include fear, physiological arousal and avoidance that interfere with daily routine, work, school or other activities. Social phobia typically begins in the early to mid-teens, though it can sometimes start in younger children or in adults (Baumeister & Leary, 2015).

Schneier, (2016) is of the view that signs and symptoms of social phobia can include persistent:

- Fear of situations in which the individual may be judged
- Worrying about embarrassing or humiliating yourself
- Intense fear of interacting or talking with strangers
- Fear that others will notice that you look anxious
- Fear of physical symptoms that may cause you embarrassment, such as blushing, sweating, trembling or having a shaky voice
- Avoiding doing things or speaking to people out of fear of embarrassment
- Avoiding situations where you might be the center of attention
- Having anxiety in anticipation of a feared activity or event
- Enduring a social situation with intense fear or anxiety
- Spending time after a social situation analyzing performance and identifying flaws in the interactions
- Expecting the worst possible consequences from a negative experience during a social situation

2.2.6 Symptoms of Social Phobia

Acarturk, De Graaf, VanStraten, Have; and Cuijpers, (2018) are of the view that physical signs and symptoms can sometimes accompany social phobia and may include:

- Fast heartbeat

- Trembling
- Sweating
- Stomach upset or nausea
- Trouble breathing
- Dizziness
- Having blank mind
- Muscle tension

According to Bolsoni-Silver and Loureiro (2014), common, everyday experiences that may be hard to endure by a socially phobic individual include, for example:

- Interacting with unfamiliar people or strangers
- Attending parties or social gatherings
- Going to work or school
- Starting conversations
- Making eye contact
- Dating
- Entering a room in which people are already seated
- Returning items to a store
- Eating in front of others
- Using a public restroom

They further explain that social phobia symptoms can change over time. They may flare up if the patient is facing a lot of stress or demands. Although avoiding situations that

produce phobia may make the patient feel better in the short term, but the phobia is likely to continue over the long term if not treated.

2.2.7 Causes of Social Phobia

Research into the causes of social phobia is wide-ranging, encompassing multiple perspectives from neuroscience to psychology and sociology. Some Studieslike that of Kendler, Karkowski and Prescott (2013)suggest that genetics can play a part in combination with environmental factors. Social phobia is not caused by other mental disorders or by substance abuse (Warren, Huston, Egeland&Sroufe2017). Generally, social phobia begins at a specific point in an individual's life and develop over time as the person struggles to recover. Eventually, mild social awkwardness can develop into symptoms of social phobia.

Inam, Mahjabeen, and Abiodullah (2017) conducted a study Causes of Social phobia among Elementary Grade Children" which was an extension of an earlier study which examined the prevalence of social anxiety among elementary school children. This present study, as a further step of the first study, tried to find out the causes of social anxiety among elementary grade children. The objective of the study was to find out the major causes of social phobia in elementary grade children. Structured interview schedules were used to collect data from 30 boys and 30 girls from Central Model School and Government Girls High School, Samanabad respectively. These boys and girls had already been identified as having social phobia in the previous study. The findings of the present study indicated that the major cause of social phobia among both boys and girls was their personal thinking factor.

Genetics:-It has been shown that there is a great risk of having social phobia if a first-degree relative also has the disorder. This could be due to genetics and/or due to children acquiring social fears and avoidance through processes of observational learning or parental psychosocial education. Studies of identical twins brought up (via adoption) in different families have indicated that, if one twin developed social anxiety disorder, then the other was between 30 percent and 50 percent more likely than average to also develop the disorder. To some extent this 'heritability' may not be specific – for example, studies have found that if a parent has any kind of anxiety disorder or clinical depression, then a child is somewhat more likely to develop an anxiety disorder or social phobia(Kendler, Karkowski& Prescott 2013).

Growing up with overprotective and hypercritical parents has also been associated with social anxiety disorder(Merikangas, Avenevoli, Dierker, &Grillon2014). Adolescents who were rated as having an insecure (anxious-ambivalent) attachment with their mother as infants were twice as likely to develop anxiety disorders by late adolescence, including social phobia. (Rapee& Lim2016).

A related line of research has investigated ' behavioural inhibition ' in infants – early signs of an inhibited and introspective or fearful nature. Studies have shown that around 10–15 percent of individuals show this early temperament, which appears to be partly due to genetics. Some continue to show this trait into adolescence and adulthood, and appear to be more likely to develop social anxiety disorder (Warren, Huston, Egeland,&Sroufe 2017).

Social experiences:-According to Schwartz, Snidman, and Kagan (2012), a previously experienced negative social interaction can be a trigger to social phobia, perhaps particularly for individuals high in interpersonal sensitivity. For some of those diagnosed with social phobia, a specific traumatic or humiliating social event appears to be associated with the onset or worsening of the disorder.Mineka and Zinbarg (2015) are of the view that this kind of event appears to be particularly related to specific social phobia, for example regarding public speaking. As well as direct experiences, observing or hearing about the socially negative experiences of others or verbal warnings of social problems and dangers, may also make the development of a social phobia more likely. Beidel and Turner (2015) mentioned that Social phobia may be caused by the longer-term effects of not fitting in, or being bullied, rejected or ignored. Shy adolescents or avoidant adults have emphasized unpleasant experiences with peersor childhood bullying or harassment. Popularitywas found to be negatively correlated with social anxiety, and children who were neglected by their peers reported higher social anxiety and fear of negative evaluation than other categories of children (La Greca, Dandes, Wick, Shaw & Stone 2013). Socially phobic children appear less likely to receive positive reactions from peers (Spence, Donovan &Brechman-Toussaint 2014) and anxious or inhibited children may isolate themselves(Rubin & Mills 2018).

Cultural influences:-Cultural factors that have been related to social phobia include a society's attitude towards shyness and avoidance, affecting the ability to form relationships or access employment or education, and shame (Okano2014). It was revealed that the effects of parenting are different depending on the culture: American children appear more likely to develop social anxiety disorder if their parents emphasize

the importance of others' opinions and use shame as a disciplinary strategy, but this association was not found for Chinese/Chinese-American children. In China, research has indicated that shy-inhibited children are more accepted than their peers and more likely to be considered for leadership and considered competent, in contrast to the findings in Western countries. (Xinyin, Rubin &Boshu2015). Purely demographic variables may also play a role.

Problems in developing social skills, or ' social fluency ', may be a cause of some social phobia, through either inability or lack of confidence to interact socially and gain positive reactions and acceptance from others. The studies have been mixed, however, with some studies not finding significant problems in social skills (Rapee, &Lim2012). Whileothers have (Stopa& Clark 2013). What does seem clear is that the socially anxious perceive their own social skills to be low(Chris & Terry 2015). It may be that the increasing need for sophisticated social skills in forming relationships or careers, and an emphasis on assertiveness and competitiveness, is making social anxiety problems more common, at least among the 'middle classes'. (Heimberg, Stein, Hiripi&Kessler 2015) An interpersonal or media emphasis on 'normal' or 'attractive' personal characteristics has also been argued to fuel perfectionism and feelings of inferiority or insecurity regarding negative evaluation from others. The need for social acceptance or social standing has been elaborated in other lines of research relating to social anxiety (Baumeister & Leary 2015).

Substance-induced:-While alcohol initially relieves social phobia, alcohol misuse can worsen social phobia symptoms and can cause panic disorder to develop or worsen during alcohol intoxication and especially during alcohol withdrawal syndrome. This

effect is not unique to alcohol but can also occur with long-term use of drugs which have a similar mechanism of action to alcohol such as the benzodiazepines which are sometimes prescribed as tranquillizers.(Terra, Figueira& Barros 2014).

2.2.8 Treatmentof social phobia

According to Baumeister and Leary (2015), research has shown that two forms of treatment may well be of value on social phobia: pharmacotherapy and psycho-social therapy.Psycho-Social Therapy:-psycho-social therapy is a form of treatment that is strongly oriented towards reducing symptoms. Acareful investigation is always made to determine how the symptoms have arisen and what keepsthem going. Treatment is then given according to a structured plan. The behaviour therapist choosesmethods and techniques that studies have shown to be effective in combating such symptoms.Patients are given assignments that must be completed at home. Between sessions the patient records all kinds of information and does practical exercises. Step by step, increasingly moredifficult situations are practiced.

Three aspects must be distinguished in the behaviour therapy of social phobia:

a. Dealing with anxiety-provoking thoughts

b. Acquiring social skills

c. Practicing overcoming avoidance: confronting anxiety-provoking situations. These three approaches have proved effective both separately and in combination.

i. Dealing with anxiety-provoking thoughts:-Dealing with anxiety-provoking thoughts is also known as cognitive therapy (cognition = thought).The first step is to track down negative thoughts (e.g. "1'm sure to get the shakes" or "they're boundto find me boring" or "it'll be a disaster if he doesn't like me").

These thoughts are then examined to see whether they are justified. If possible, they are replaced bymore realistic, and often more positive thoughts.

ii. Acquiring social skills:-It has been shown that some people with a social phobia become anxious because they have defective social skills. The risk of rejection is greater if someone does not know how to initiate aconversation or turn down a request. Acquisition of social skills is usually carried out in groups.Social behaviour options are discussed, demonstrated and practiced by role-playing.

iii. Overcoming avoidance:-Behaviour therapy cannot be successful unless avoidance is overcome. A highly effective approachis the use of "exposure exercises". In this case, the exposure is to situations that arouse anxiety.Usually a start is made with something easy, which is then followed by increasingly difficultsituations. Someone with a social phobia will practice, for example, by going to a party, returning adefective article to a shop, or drinking something (even if with shaking hands) in a cafe. Theanxiety these exercises at first arouse will gradually decrease. When exercises are performed, it isoften found that the expected unpleasant events do not occur. The next situation can then be tackledwith increased confidence.Another key element in virtually all anxiety and phobia treatments based on behaviour therapy isthe use of relaxation exercises. These reduce physical tension, making other exercises less difficult.

An important point in all three forms of behaviour therapy is that independent activity is required ofthe patient. He must write down, read and select things. As a result he is a more focused on, and aware of his symptom during the treatment. This may well lead to a period of dejection orincreased symptoms. However, this passes when it becomes clear that the treatment is havingpositive results. Also the

patient has to do exercises that at first cause anxiety. Patientswho invest the most energy in the treatment achieve the greatest progress. Many people think it isnecessary to think and talk a lot about past experiences that could be at the root of the social phobia.However, studies have shown that the energy and effort required are more profitably invested inpractical exercises. In contrast to treatments based on talking about the past, behaviour therapies areknown to produce good results in social phobia.

Pharmacotherapy

Drugs exist that are helpful in depression (antidepressants). A certain class of antidepressants (known as reversible inhibitors of monoamine oxidase-A or RIMAs, likemoclobemide) is alsoeffective in social phobia, particularly in generalized social anxiety. Physical symptoms of tensioncan be reduced with drugs known as beta blockers (such as propranolol or atenolol). These are oftenprescribed for occasional use in situations where it is feared that physical symptoms may occur (like fear of trembling when giving a speech or musical recital).

The chances of achieving lasting positive effects by the use of antidepressant drugs relieson the application of supplementary psycho-social therapy.In anxiety disorders in general, a combination of medication and behaviour therapy appears to offerprospects of success (Baumeister & Leary 2015).

2.3 Cognitive Restructuring

2.3.1 Concept of Cognitive Restructuring

Cognitive Restructuring is a cognitive-behavioral therapy technique used to identify andcorrect negative thinking patterns. It is the idea of revising irrational thought.

Thatinvolves altering negative automatic thoughts that occur in anxiety provoking situations by replacing them with more rational beliefs. As thoughts are challenged and disputed, their ability to elicit anxiety is weakened. Cognitive restructuring is a psychotherapeutic process of learning to identify and dispute irrational or maladaptive thoughts, such as all-or-nothing thinking (splitting), magical thinking and emotional reasoning, which are commonly associated with many mental health disorders. Cognitive Restructuring (CR) employs many strategies, such as Socratic questioning, thought recording and guided imagery and is used in many types of therapies. A number of studies demonstrate considerable effectiveness in using CR-based therapies.

Umar, Abdullahi, Oliagba, Sambo, and Abdulwahid, (2014) maintained that cognitiverestructuringdescribestheprocessoflearningtorefute cognitivedistortionorfundamental faulty thinkingofclientswiththegoal ofreplacingone'sirrational beliefswithmoreaccurate andbeneficial onesofnoteliciting the undesired behaviour. Cognitive restructuring involves paying attention to thoughts, recognizing when they are irrational, challenging them, and learning replacement thoughts and behaviors. People learn healthy ways to talk to themselves so that they can let go of the self-defeating talk. (Diana, 2013).

Cognitive Restructuring as one of the Cognitive Behavioral Therapy techniques is an expedient tool for understanding and setting aside negative thinking. It helps incasting away negative and unhappy thoughts as well as to increase our level of awareness to overcome any faulty thinking errors. Cognitive Restructuring is a technique that changes our subconscious thoughts which aids in how we can deal with various

situations in order to have a more positive frame of mind. This is meant to teach a set of very useful techniques that we call cognitive restructuring. These techniques were pioneered by Albert Ellis and Aaron Beck, among others.

Cognitive Restructuring is a useful tool for understanding and turning around negative thinking. It helps us put unhappy, negative thoughts "under the microscope", challenging them and in many cases rescripting the negative thinking that lies behind them. In doing this, it can help us approach situations in a positive frame of mind. This is obviously important because not all negative moods are unpleasant for us, they also reduce the quality of our performance and undermine our working and social relationships with other people. The key idea behind this tool, as with the other tools in this section, is that our moods are driven by what we tell ourselves, and this is usually based on our interpretations of our environment. Cognitive Restructuring helps us evaluate how rational and valid these interpretations are. Where we find that these assumptions and interpretations are incorrect, then this naturally changes the way we think about situations and changes our moods.

Cognitive restructuring involves learning how to think differently, to change fundamental faulty thinking, and replace it with more rational, realistic, and perhaps positive thinking. Through cognitive restructuring, we can learn how to control our thoughts not to simply be optimistic in all things, but be realistic as well. Cognitive restructuring refers to any methods which help people to think differently about a situation/event/thought/belief. Really, this could apply to anything done in (or outside of) a therapy session (Diana, 2013).

CR can be described as a therapeutic process used to identify and confront negative thought patterns that cause social phobia and help people understand that these thoughts are ineffective or disruptive, with the goal to ultimately overcoming the disorder.It is now one of the main techniques used to manage anxiety and depression, among others. It focuses on helping its users understand the negative thought processes that can cause problems, and on restructuring them so that they are fair and balanced. Cognitive Restructuring as a therapeutic approach focuses on managing abnormal negative thinking. Therefore Cognitive Restructuring is one of the most suitable approaches to treat social phobia, because one of its major causes is negative thinking. Cognitive Restructuring (CR) for the purpose of this study is defined asstructured, goal-directed, and collaborative intervention strategies that focus on the exploration, evaluation, and substitution of the maladaptive thoughts, appraisals, and beliefs that maintain psychological disturbancerenderd to secondary school students with a certain degree of social phobia in order to overcome it.

Cognitive restructuring involves four steps as listed in Hope, Burns, Hyes, Herbert and Warner (2010):

1. Identification of problematic cognitions known as "automatic thoughts" (ATs)

which are dysfunctional or negative views of the self, world, or future

2. Identification of the cognitive distortions in the ATs

3. Rational disputation of ATs with the Socratic dialogue

4. Development of a rational rebuttal to the ATs

2.3.2 Application of Cognitive Restructuring to Social Phobia.

Cognitive restructuring has been used to help individuals experiencing a variety of psychiatric conditions, including depression, anxiety, bulimia, social phobia, borderline personality disorder, attention deficit hyperactivity disorder, gambling, avoidance personality disorder and others (Pull, 2007). Frojan-Pargan, Calero-Elvira, and Montana (2009) maintained that when utilizing cognitive restructuring the emphasis is on the following two central notions: thoughts affect human emotion as well as behavior, and irrational beliefs are mainly responsible for a wide range of disorders.

Deacon, Fawzy and Lickel (2011) hypothesized that cognitive restructuring would produce significant improvement in the distress and believability associated with negative self-referential thoughts. Because cognitive restructuring is thought to be an acquired skill whose benefits accrue after repeated real-world practice. Cognitive restructuring aim to reduce the believability of negative thoughts, they hypothesized that decreased believability of negative self-referential thoughts would significantly predict a decrease in the distress elicited by these thoughts in each treatment condition.

Cognitive restructuring is a set of techniques for becoming more aware of our thoughts and for modifying them when they are distorted or are not useful. This approach does not involve distorting reality in a positive direction or attempting to believe the unbelievable. Rather, it uses reason and evidence to replace distorted thought patterns with more accurate, believable, and functional ones (Nevid, 2013).

2.3.3 Process of Cognitive Restructuring

Cognitive restructuring refers to the process of replacing cognitive distortions with thoughts that are more accurate and useful. Cognitive restructuring has two basic steps asenumerated in Burns (1999):

(1) Identifying the thoughts or beliefs that are influencing the disturbing emotion;

(2) Evaluating them for their accuracy and usefulness using logic and evidence, and if warranted, modifying or replacing the thoughts with ones that are more accurate and useful.

In cognitive restructuring, the therapist guides the client through the process of becoming more aware of what they are telling themselves and helps them to evaluate, and when appropriate, to modify their own thinking. In essence, the therapist teaches the client a process that will help them distinguish distorted thinking from more accurate and useful thinking. Cognitive restructuring emphasizes that this is best done as a collaborative process in which the client is assisted in taking the lead as much as possible. The therapist refrains from assuming that the client‘s thoughts are distorted and instead attempts to guide the client with questions that encourage the client to make their own discoveries. Clients are also encouraged to engage in his process on their own during their time between sessions by using a written format.

Tools for Change

Cognitive therapists shift the focus from the client (or student) with the problematic behaviour to the system (such as fellow students, teachers, family and other significant

persons) to help engage in shared responsibility. The therapists use the following specific techniques:

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

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

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

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

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

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

2.3.4 Cognitive Restructuring working template

TheCognitive Therapy template involves the following phases:

Phase 1: Joining and Building Rapport

Cognitive therapists should be genuine, empathic, and active listeners and convey understanding by asking clarifying questions and validating all the group members. Assignment begins in the first session and is an ongoing process throughout therapy. To prepare clients for the assessment, (Cuncic, 2014) recommended communicating the purpose, such as the following:

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

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

“How did you make the decision to come to therapy?”

“What are your present concerns in your life?”

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

Phase 2: Understanding the Issue

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

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

“What feelings are you experiencing when you think of these situations?”

“What do these situations prevent you from doing?”

“What thoughts make you feel worse?”

“How would you feel if you did not have these thoughts?”

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

Phase 3: Assessment of (students) Group Dynamics

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

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

“How do others respond to you when this happen?”

To the students: “What do each of you think when your (class mate) has these experiences?

How do these thoughts affect your interactions?”

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

Phase 4: Goals

In CR, the clients decide the counselling goals. The counsellor helps the clients to change problematic thinking so that feelings and behaviour will change. Here are some comments or questions that a counsellor might use during this phase:

“What would you each like to be that you are doing at the same time in your life? “Who in your class do you think would be most relieved when (a class mate) is no longer having these problems?”

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

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

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

Phase 5: Amplifying Change

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

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

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

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

Phase 6: Termination

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

2.4 Social Skills Training

2.4.1 Concept of Social Skills Training

Rowaand Antony(2015) mentioned that Social Skills Training (SST) is predicated on the notion that social phobia is the result of impoverished or underused social skills. In SST, clients receive direct instruction in both verbal and nonverbal skills (for example, eye contact, tone and volume of speech, conversational skills, and assertiveness training). Skills are also acquired through modelling by the therapist, role-playing in therapy, obtaining direct feedback from therapists, and implementing skills in the client's life.

Social Skills Training is a treatment that involves improving interpersonal skills such as communication and how to act in a social setting through the techniques of modelling and behavioural rehearsal. Modelling involves encouraging the client to watch friends and colleagues in their social settings to see how to act appropriately. Behavioural rehearsal involves clients rehearsing their social skills in the therapy session and eventually moving to real-life situations. Shaping involves the client gradually building up to handling difficult social situations. Social skills can be defined as different classes of social behaviours existing in the repertoire of an individual to adequately cope with the demands of interpersonal situations (Alden 2012).

In some cases, the most devastating effects of psychological and mental disorders are their effects on the social aspect of life. Humans are social creatures and thrive on interaction with others. Without this, depression and isolation are inevitable, leading to further detrimental consequences on one's mental health. Equipping people who otherwise have no social skills or practice in social skills with the necessary tools is becoming a prominent technique in psychotherapy (Beidel, Rao, & Murray 2014).

Social skills training is a type of psychotherapy that works to help people improve their social skills so they can become socially competent. SST is predominantly a behavioural therapy butcognitive therapy can also be used in some situations to maximise the success of SST. This psychotherapy can be done one-on-one or in a group situation. (Kavale, &Mostert, 2014)SST involves explicit teaching of positive social behaviours and social problem solving skills to groups of children or adolescents who are experiencing difficulties with social relationships (Wiener &Timmermanis, 2012). The aims of SST interventions are to teach new skills, enhance existing skills, and facilitate maintenance of previously learned skills.

Social skills training (SST) is a form of behaviour therapy used by teachers, therapists, and trainers to help persons who have difficulties relating to other people.(Alden2001). He emphasized that it is mainly used for individuals that are diagnosed with certain mental or psychological disorders and whose symptoms involve poor social functioning. However, anyone who wants to improve their social skills and social confidence can benefit from this psychotherapy. The major disorders that are accompanied with social dysfunction are:Social phobia, Autism and Schizophrenia.

Nowicki, (2013) is of the view that it is important to note that, although SST can be very effective in helping people learn the necessary skills, it is very rare for SST to be a standalone therapy. There are always underlying reasons why people are experiencing social difficulty and these too need to be treated, either with drugs or a combined psychotherapy.There are many reasons a person could have developed social phobias or social anxiety. It is important to first gain insight into why the person has the condition, and what aspect of socializing they are fearful of. The social skills commonly focused on in social phobias are:

Appropriate speech volume: People with social phobias tend to speak very quietly, making it difficult for them to communicate with others.

Intonation: Learning which words to emphasize in conversation is important for conveying different meanings. "Is Dave going home?" has a different meaning to "Is Dave going home?".

Expressing opinions: It is very difficult for some people to express their opinions on certain topics, particularly when the environment seems intimidating (e.g. the workplace). SST helps people learn how to voice their feelings in a non-threatening manner.

Self-confidence: People who are fearful in social situations are, more often than not, the people who get bullied and walked over because they cannot stand up for themselves. SST helps people learn how to stand up for their own rights.

Awareness: People with social anxiety are often irrational about how much others are judging them. No one else can tell when your palms are sweaty and your heart is

racing, but when people obsess over these physiological processes, they become more stressed and anxious. SST teaches people to focus on what is happening in the social environment rather than their internal physiology (Wiener, &Timmermanis, 2012).

The main goal of SST is to provide the patient with a wide and varied repertoire of more adaptive social behaviours, reducing passivity and feelings of impotence or anger, taking into consideration the patient's characteristics and the social group they belong to. SP patients often report difficulties with starting, establishing, maintaining and ending a conversation; maintaining the focus and interest in the topic being discussed; tolerating silences; selecting topics to discuss and knowing how to discuss them; changing the subject if necessary; establishing and maintaining friends. These difficulties are addressed in SST. The training should initially occur during the visits with the therapist and should take place in familiar environments, followed by practicing skills in the wider social environment with friends and neighbors.

Social skills training is a form of therapy in which clients aretrained in social and interpersonal relationships skills to reduce their social phobia. Social skills are the behaviours, verbal and non-verbal, that we use in order to communicate effectively with other people. Social skills are governed by culture, beliefs and attitudes. They continuously change and develop throughout our lives. Somebody that uses social skills to effectively interact with friends, family, workmates and strangers is said to have social competence.Some examples of social skills are: Eye contact with others during conversation, Smiling when greeting people, Shaking hands when meeting someone, Using the right tone and volume of voice, Expressing opinions to others, Perceiving how others are feeling and showing empathy. The list of social skills goes on and on. Many of

us do not even realise that these are skills but treat them as part of everyday life. Unfortunately, for some people socialising is not that easy, perhaps because they lack social skills or do not feel comfortable using their social skills they eventually fall into social phobia. Therefore, such people need psychotherapy to be able to adjust to the demand of a social situation, among which is social skills training (SST).

STEP-BY-STEP PROCEDURES

As noted earlier, social skills training is actually a collection of techniques. Not all training programs utilize every one of these techniques, but the better developed and more successful programs use most of them. Many of the techniques presented below can be successfully implemented in individual or group settings (O'Donohue& Fisher 2008)

1. Assessment: Determine the specific area of the client's social skills deficits through self-reports,behavioral observations, and/or third party assessments.

2. Direct Instruction/Coaching: Teach and explain the basis of effective and appropriate social behaviors to the client along with specific suggestions for how to enact such behaviors.

3. Modeling: Show the client models enacting appropriate social behaviors, and receiving positive reinforcements for doing so. The modeling of inappropriate behaviors along with critiques and explanations may also be helpful.

4. Role-Playing: Encourage the client to practice certain social behaviors in a controlled environment, typically with the therapist

and perhaps an assistant. Provide feedback to the client immediately after enacting the role-plays.

5. Homework Assignments: Instruct the client to enact certain social behaviors in the ‘‘real world.’’ Start with easy behaviors and graduate to more complex ones. Debrief in the following session.

6. Follow-up: A thorough social skills training program must involve some form of follow-up. Social skills, like most other skills, will decay unless practiced somewhat diligently. There is little reason to believe that social skills training can be successfully accomplished via one-shot training procedures that teach skills, and then send people out into the world with no follow-up.

2.4.2 Social Skills Training Working Template

Secondary school students receive treatment through the following phases

Phase 1: Assessment

Determine the specific area of the client’s social skills deficits through self-reports,behavioral observations, and/or third party assessments.

Phase 2: Direct Instruction/Coaching

Teach and explain the basis of effective and appropriate social behaviors to the client along with specific suggestions for how to enact such behaviors.

Phase 3: Modeling

Show the client models enacting appropriate social behaviors, and receiving positive reinforcements for doing so. The modeling of inappropriate behaviors along with critiques and explanations may also be helpful.

Phase 4: Role-Playing

Encourage the client to practice certain social behaviors in a controlled environment, typically with the therapist

and perhaps an assistant. Provide feedback to the client immediately after enacting the role-plays.

Phase 5: Homework Assignments

Instruct the client to enact certain social behaviors in the ‘‘real world.’’ Start with easy behaviors and graduate to more complex ones. Debrief in the following session.

Phase 6: Termination

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

2.5 Theoretical framework

2.5.1 Ivan Pavlov Classical Conditioning Theory

Give me a dozen healthy infants, well-formed, and my own specified world to bring them up in and I'll guarantee to take any one at random and train him to become any type of specialist I might select - doctor, lawyer, artist, merchant-chief and, yes, even beggar-man and thief, regardless of his talents, penchants, tendencies, abilities, vocations and the race of his ancestors. (Watson & Rayner 1920).

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

Stage 1: Before Conditioning:

In this stage, the unconditioned stimulus (UCS) produces an unconditioned response (UCR) in the organism. In basic terms this means that a stimulus in the environment has produced a behaviour / response which is unlearned (i.e. unconditioned) and therefore is a natural response which has not been taught. In this respect no new behaviour has been learned yet. For example, a stomach virus (UCS) would produce a response of nausea (UCR). In another example a perfume (UCS) could create a response of happiness or desire (UCR).

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

Stage 2: During Conditioning:

During this stage a stimulus which produces no response (i.e. neutral) isassociated with the unconditioned stimulus at which point it now becomes known as the conditioned stimulus (CS). For example a stomach virus (UCS) might be associated with eating a certain food such as chocolate (CS). Also perfume (UCS) might be associated with a specific person (CS). Often during this stage the UCS must be associated with the CS on a number of occasions, or trials, for learning to take place. However, one trail learning can happen on certain occasions when it is not necessary for an association to be strengthened over time (such as being sick after food poisoning or drinking too much alcohol).

Stage 3: After Conditioning:

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

Little Albert Experiment (Social Phobia)

Ivan Pavlov could only show that classical conditioning applied to animals; butdid not show how it also applies to humans (McLeod, 2014). In a famous (though ethically dubious) experiment, Watson and Rayner (1920) showed that it did. Little Albert was a 9-month-old infant who was tested on his reactions to various stimuli. He was shown a white rat, a rabbit, a monkey and various masks.

Albert described as "on the whole stolid and unemotional" showed no fear of any of these stimuli. However what did startle him and cause him to be afraid was if a hammer was struck against a steel bar behind his head. The sudden loud noise would cause "little Albert‖ to burst into tears. When "Little Albert" was just over 11 months old the white rat was presented and seconds later the hammer was struck against the steel bar. This was done 7 times over the next 7 weeks and each time "little Albert" burst into tears. By now "Little Albert only had to see the rat and he immediately showed every sign of fear. He would cry (whether or not the hammerwas hit against the steel bar) and he would attempt to crawl away.

Watson and Rayner had shown that classical conditioning could be used to create any form ofphobia; including social phobia. A social phobia is an irrational fear of social situations, that is,. a fear of social interactions that is out of proportion (McLeod, 2014).

Application of Classical Conditioning to social Phobia

Various principles derived from Classical Conditioning of Pavlov. are acquisition, extinction, spontaneous recovery, stimulus generalization, stimulus discrimination and higher order conditioning among others. Pavlov have noted, that classical conditioning occursin three phases—acquisition, extinction, and spontaneous recovery.

Acquisition: This refers to the period during which a response is being learned An individual gradually learns—or acquires—the CR. When the CS (fearful noise) and UCS (a little white rat) are paired over and over again, the CR (fear or social phobia) increases progressively in strength. In general, the closer in time the pairing of CS and

UCS, the faster learning occurs, with about a half second delay typically being the optimal pairing for learning.

Longer delays usually decrease the speed and strength of the organism‘s response.A student may acquire social phobia (CR) while attending social situation (UCS) one day; he fell into the hands of a bully who embarrass or scare him or if he behaves wrongly and becomes embarrassed or humiliated (CS). The next thing is that he will start developing phobia (CR) forsocial interactions.

Extinction: It is regarded as a procedure whereby the repeated presentation of conditioned stimulus (CS) in the absence of unconditioned stimulus (UCS) with which it was previously paired. Following a series of CS-only presentations, the conditioned response (CR) that was established during the preceding acquisition phase gradually diminishes. In a process called extinction, the CR decreases in magnitude and eventually disappears when the CS is repeatedly presented alone, that is, without the UCS. After numerous presentations of the tone without meat power, Pavlov‘s dogs eventually stopped salivating. The CR fades away over repeated trials, just as many memories gradually decay. Yet the truth is more complicated and interestingthan that. Extinction is an active, rather than passive, process. During extinction a new response, which in the case of Pavlov‘s dogs was the absence of salivation,gradually ―writes over‖ or inhibits the CR, namely, salivation. The extinguished CR does not vanish completely; it is merely overshadowed by the new behaviour.

The extinction principle can be used to make the client to unlearn undesirable behaviour like social phobia. therapist can utilize extinction by exposing the client to

the anxiety provoking stimuli (social interactions) without causing the client the previous stress associated with attending social interactions.Thus the unwarranted response (social phobia) is extinct.

Spontaneous Recovery: In a phenomenon called spontaneous recovery, a seemingly extinct CR reappears (often in somewhat weaker form) if the CS is presented again. It‘s as though the CR were lurking in the background, waiting to appearfollowing another presentation of the CS. In a classic study, Pavlov presented the CS (tone from a metronome) alone again and again and extinguished the CR (salivation) because there was no UCS (mouth watering meat powder) following it. Two hours later, he presented the CS again, and the CR returned. The animal had not really forgotten the CR, just suppressed it. Spontaneous recovery in terms of reappearance or reoccurrence of social phobia may happen if andwhen social skills training is not preceded with education or when it is haphazardly used by therapists. Therefore, therapists treating social phobia with SST or CR are advised to give the client good education before embarking on treatment.

Stimulus Generalization and Discrimination:-As much as classical conditioning helps us adapt to and learn new things, it would be virtually useless if we could not apply it to new situations. As Greek philosopher Heraclitus observed, ―We never step into the same river twice. No two stimuli are identical; even our friends and family may look a tiny bit different every time we see them. We need to learn to respondto stimuli that differ somewhat from those we originally encountered during conditioning. By the same token, we do not want to go around shouting ―Mom! at every woman who has the same height and hair style as our mothers. Pavlov found that, following classical

conditioning, his dogs salivated not merely to the original tone or sound but to sounds similar to it. This phenomenonis stimulus generalization: the process by which CSs that are similar, but not identical, to the original CS elicit a CR. Stimulus generalization occurs along a generalization gradient. The more similar to the original CS the new CS is, the stronger the CR will be. Pavlov found that his dogs showed their largest amount of salivation to the original sound, with progressively less salivation to sounds that were less and less similar to it in pitch. Stimulus generalization allows us to transfer what we have learned to new things. In the same vein, a social phobic who was traumatized by a senior student may develop a social phobia because of fear of all senior students.

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

Criticisms against Classical Conditioning

Classical conditioning emphasizes the importance of learning from theenvironment, and supports nurture over nature (McLeod, 2014). However, it is limiting to

describe behaviour solely in terms of either nature or nurture, and attempts to do this underestimate the complexity of human behaviour. It is more likely that behaviour is due to an interaction between nature (biology) and nurture (environment).Strength of classical conditioning theory is that it is scientific. This is because it's based on empirical evidence carried out by controlled experiments. For example, Pavlov (as cited in McLeod, 2008)) showed how classical conditioning can be used to make dog salivate to the sound of a bell.Classical conditioning is also areductionist explanation of behaviour. This is because complex behaviour is broken down into smaller stimulus - response units of behaviour. Supporters of a reductionist approach say that it is scientific. Breaking complicated behaviours down to small parts means that they can be scientifically tested. However, some would argue that the reductionist view lacks validity. Thus, whilst reductionism is useful, it can lead to incomplete explanations.

2.5.2 Operant Conditioning Theory of B. F Skinner

Another behavioural theory accounting for the development of fears is based on the operant conditioning model (McLeod, 2014). Skinner is regarded as the father of Operant Conditioning. By the 1920s John B. Watson had left academic psychology and other behaviorists were becoming influential, proposing new forms of learning other than classical conditioning (Watson as cited in McLeod, 2014). Perhaps the most important of these was Burrhus Frederic Skinner. Although and for obvious reasons, he is more commonly known as B.F. Skinner. Skinner believed that human beings do have such a thing as a mind, but that it is simply more productive to study observable behaviour rather than internal mental events. He believed that the best way to understand behaviour is to look at the causes of an action and its consequences.

He called this approach operant conditioning. Skinner's theory of operant conditioning was based on the work of Thorndike . Edward Thorndike studied learning in animals using a puzzle box to propose the theory known as the 'Law of Effect'.Skinner introduced a new term into the Law of Effect - Reinforcement. Behaviourwhich is reinforced tends to be repeated (that is, strengthened); behaviour which is not reinforced tends to die out-or be extinguished (that is, weakened). Skinner studied operant conditioning by conducting experiments using animals which he placed in a 'Skinner Box' which was similar to Thorndike‘s puzzle box.

Skinner coined the term operant conditioning. The term refersto a roughly changing of behaviour by the use of reinforcement which is given after the desired response. He identified three types of responses or operant that can follow behaviour. Neutral Operant: A response from the environment that neither increases nor decreases the probability of a behaviour being repeated.

Reinforcer: A response from the environment that increases the probability of a behaviour being repeated. A reinforcer can be either positive or negative.

Punisher: A response from the environment that decreases the likelihood of a behaviour being repeated. Punishment weakens behaviour.

Experiment

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

Application of Principles of Operant Conditioning to social Phobia

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

Negative Reinforcement

The removal of an unpleasant reinforcer can also strengthen behaviour. This is known as negative reinforcement because it is the removal of an adverse stimulus which is rewarding to the animal or person. Negative reinforcement strengthens behaviour because it stops or removes an unpleasant experience. For example, if a child escapes being embarrassed by not participating in any social event, he or she may want to continue staying away to escape being embarrassed; thus strengthening social phobia.

Skinner showed how negative reinforcement worked by placing a rat in his Skinner box and then subjecting it to an unpleasant electric current which caused it some discomfort. As the rat moved about the box it would accidentally knock the lever. Immediately it did so the electric current would be switched off. The rats quickly learned to go straight to the lever after a few times of being put in the box. The consequence of escaping the electric current ensured that they would repeat the action again and again. In fact Skinner even taught the rats to avoid the electric current by turning on a light just before the electric current came on. The rats soon learned to press the lever when the light came on because they knew that this would stop the electric current being switched on.Escape Learning and Avoidance Learning are known as leaned responses (McLeod, 2014)

Punishment

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

Merits of Operant Conditioning

Operant conditioning has been conducted in a scientific manner. Skinner's study of behaviour in rats was conducted under carefully controlled laboratory conditions. It is

primarily concerned with observable behaviour, as opposed to internal events like thinking and emotion. The major influence on human behaviour is learning from our environment. In the Skinner study, because food followed a particular behaviour the rats learned to repeat that behaviour, for example, operant conditioning. There is little difference between the learning that takes place in humans and that in other animals. Therefore research in operant conditioning can be carried out on animals as well as on humans. Skinner proposed that the way humans learn behaviour; especially fear and or social phobia is much the same as the way the rats learned to press a lever.The emphasis laid by Skinner is on how any type of phobia including social phobia is maintained are in certain ways. The social phobic is constantly learning new behaviours and how to modify such existing behavior is possible through the application of various principles of operant conditioning. Operant conditioning can be used to explain a wide variety of behaviour, from the process of learning, to addiction and acquisitionof social phobia. It also has practical application which can be applied in schools, classrooms, prisons and psychiatric hospitals.

Criticism against Operant Conditioning

Operant conditioning have been criticized of failing to take into account the role of inherited and cognitive factors in learning, and thus is an incomplete explanation of the learning process in humans and animals. For example, Kohler (as cited inMcLeod, 2014) found that primates often seem to solve problems in a flash of insight rather than be trial and error learning. Also social learning theory (Bandura, as cited in McLeod, 2014) suggests that humans can learn automatically through observation rather than through personal experience. The use of animal research in operant conditioning

studies alsoraises the issue of extrapolation. Some psychologists argue we cannot generalize from studies on animals to humans as their anatomy and physiology is different from humans, and they cannot think about their experiences and invoke reason, patience, and memory or self-comfort.

2.5.3Albert Bandura's Social Learning Theory

The social learning theory was proposed by Albert Bandura. The works of Ewen in Ford-Martins, (2014) have contributed to our understanding of the social Learning theory. The social learning theory proposed by Albert Bandura has become perhaps the most influential theory of learning and development. While rooted in many basic concepts of traditional learning theory, Bandura believed that direct reinforcement could not account for all types of learning. Thus, Bandura was quoted to have said that:

"Learning would be exceedingly laborious, not to mention hazardous if people had to rely solely on the effects of their own actions to inform them what to do. Fortunately, most human behaviour is learned observationally through modeling: from observing others, one forms an idea of how new behaviours are performed, and on later occasions, this coded information serves as a guide for action". Asonibare(2014) has stated that modeling, imitation, observational learning or social learning is used by various experts interchangeably to refer to the same thing. Thus he further stated that modeling at times is referred to as imitative, observational learning or social learning.Bandura has stressed the importance of social and cognitive factor as well as the role of observational models in determining behaviour as an opposition to Skinner's emphasis on environment as a determinant of organisms (or man's) behaviour. He

represents behaviour as a function of the person and the environment called reciprocal determination. This interaction among person, behaviour and environment demonstrates how the world and the person cause each other. Ford-Martins, (2014) thus argued that social learning theory states that people learn by watching others in social setting and modeling behaviour they think will lead to favourable outcomes, while avoiding behaviour they think may lead to punishing consequences. social phobia is an attempt by children to avoid stressful events in the school.

Bobo Doll Experiment

In famous "Bobo doll experiment in 1961, Bandura demonstrated that children learn and imitate behaviours they have observed in other people (Davis, &Ollendick, 2015). The children in Bandura's study observed an adult acting aggressively toward a Bobo doll. When the children were later allowed to play in a room with the Bobo doll, they began to imitate the aggressive acting they had previously observed. In the study, Bandura identified three basic models of observational learning which include:

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

All these according to Bandura, connote that people can learn through observation. A student who has escaped or survived a cult attack that led to death of many students,

including his close friend may suffer social phobia. Ordinary news broadcast on radio or television can influence social phobia in some students.

Application of Social Learning Concepts to Social Phobia

Ford-Martins, (2014)has identified the basic learning concepts as observational learning, intrinsic reinforcement, the modeling process such as attention, retention, reproduction and motivation. However, a revision has been effected on this theory by Bandura in 1986 to include agents of experience.

Observation Learning

Observation learning theory stresses the importance of unique experience in family, school, community and so on and so forth (Ford-Martins, 2014). According to this view point, we learn behaviours through observing and mimicking the behaviours of others. Children who have observed other students being mocked or embarrassed by other students may acquire fear of social interaction at a very trivial provocation.

Intrinsic Reinforcement

Mental states are important to learning (Ford-Martins, 2014). Bandura had argued that external, environmental reinforcement was not the only factors that influence learning and behaviour (as proposed by Skinner and other operant conditioning psychologists). Bandura described intrinsic reinforcement as a form of internal reward, such as pride, satisfaction, and a sense of accomplishment. For example, a student who is usually praised by his parents for always staying out of trouble (though an extrinsic reinforcement or the self motivation) may avoid school for fear of failure which may

result into embarrassment; and the consequent self image which may be dented in front of his parents. The emphasis on internal thoughts helps connect learning theory to cognitive developmental theories. While many textbooks place social learning theory with behavioural theories, Bandura himself describes his approach as a 'social cognitive theory' (Ford-Martins, 2014).

The Modeling Process

In a sharp reaction to behaviourists who believed that learning led to a permanent change in behaviour, observational learning demonstrates that people can learn new information without demonstrating new behaviours. It is not all the observed behaviours that are effectively learnt. Factors involving both the model and the learner can play a role in whether social learning is successful. (Ford-Martins, 2014) argued that certain requirements and steps must be followed.

To corroborate the above assertion, Asonibare (20014) regarded the requirements as characteristics of effective models which include that:

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

The therapist who is to treat social phobic is, by this concept, requires to present a high degree of prestige, competence, warmth, confidence, and positive regard for the clients who may have social phobia.Bandura has stated that the following steps are involved in social learning and modeling process (Carbonel, 2014).

Attention

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

Retention

The ability to store information is also an important part of the learning process. The learner must be able to do what the teacher, the person or model have said or done. Only when the learner can retain some representation of the model's or teacher's action or

words in memory can he or she perform similar action at later times or acquire useful information. Retention can be affected by a number of factors, but the ability to pull up information later and act on it is vital to social learning. Social phobic might have learnt about events that influenced the fear but may present the unwarranted behaviour at a later time. In another way, therapist using CR and SST needs to make his clients to retain the techniques learnt in upsetting social phobia.

Reproduction

Once the learner has paid attention to the model and retained the information, he or she must be able to perform the behaviour he observed. This aspect of social learning is termed a production process which depends on the learner's abilities. If he cannot perform the behaviour in question, have a clear representation of it in his memory, then, the learning is of little use. In addition, the learner's capacity to monitor his own performance and adjust until it matches that of the model (Carbone, 2014). Therapist should treat client with a view to the latter reproducing the techniques overcoming social phobia.

Motivation

Motivation plays a vital role in social learning. Learners often acquire information through observational learning but may not put it into immediate use in their behaviour. In order for observational learning to be successful, learners must be motivated to imitate the behaviour of the model. Learner may have no need for the someone tie a bow tie but have no plan behaviour may involve high risk of punishment, as when he observed a model cheating during an examination, but do not want to try it himself. In another

example, if the learner sees another student with social phobia he (the learner) may not start to show the behaviour until something in the environment urges or motivate him to develop it.Therapist also needs to motivate clients to seek for therapy when they harbor fear of social interactions especially in school activities.

Bandura in (Carleson, 2008) refined the social cognitive theory with "agents of experience and features of agency. These are stated below:

Agents of Experience

Bandura asserted that people are agents of experiences rather than simply undergoers of experience (Emslie, 2018). He re-emphasized that people are not machines passively serious as victims of their environment. He laid much emphasis on the role agency plays in learning. Human being have five basic capabilities which distinguished them from dogs, cats, rats, birds or animal in behaviorists experiment. Human beings can form hypothesis, set goals, make judgment, and regulate the reciprocal interactions among person, behaviour, and environment. Human beings have abilities to symbolize, self-directed forethought, the ability to learn vicariously or through experiences of others, self-regulation, and self-reflection. Therefore, therapists and all stakeholders in secondary school affairs need to reassure students of their safety.

Feature of Agency

Bandura said that the choices people make shape the neuronal functional structure of their brains while referring to emerging research into brain development. By regulating their motivation and activities, people or learners can produce the experiences that form the functional neurobiological substrate of symbolic, social, psychomotor and other

skills. For this to occur, Bandura proposed four core features of personal agency which includes intentionality, forethought, self-reactiveness and self-reflectiveness.

Ford-Martins (2014)states that the criticisms levied against the social learning theory is that Bandura has proposed his theory ignoring such important and complicated aspects of behaviour as conflicts, both conscious and unconscious, and for an excessive bias against psychoanalysis. He accepted the negative findings of outdated and outmoded laboratory studies of defense mechanisms, and he rejects the value of clinical data without considering the other side of the story. Despite these criticisms, social learning theory has been accepted and used by many researchers. Among the generally accepted findings is the observation of aggression that tends to increase the likelihood of behaving aggressively. Modelling is more likely to be more effective, if the model is attractive.This shows that a student is likely to imitate a socially phobic model and start eliciting the behavior especially when the model perform poorly or in a humiliating or embarrassing manner. He is also likely to aquire social phobia when he observesthe model or any other individual being embarrassed humiliated, histhougth will be "I will be embarrassed or humiliated the way this person is.

2.5.4 Aaron Beck's Cognitive Restructuring Theory

The terms cognitive therapy (CT) and the generic term cognitive-behaviour therapy (CBT) are frequently used as synonyms to describe psychoterapy based on the cognitive model. The term CBT is also used for a group of techniques in which a cognitive approach and a set of behavioural procedures are combined. CBT has been used as an

umbrella term to include both standard CT and a theoretical combination of cognitive and behavioural strategies (Beck, 2005).

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

1) To construct a comprehensive theory of psychopathology that articulated well with the thrapeutic approach;

2) To investigate empirical support for the theory; and

3) To conduct empirical studies that tested the efficacy of the therapy.

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

Research and clinical practice have shown CBT to be effective in reducing symptoms and relapse rates, with or without medication, in a wide variety of psychiatric disorders. Beck applied CBT's theoretical and therapeutic set of principles systematically to a sequence of disorders starting with depression, suicide,anxiety disorders and learning difficulties, panic disorder, personality disorders, and substance abuse,. Interpersonal problems and anger, hostility, and violence, were also studied. In addition, more recent work with this approach has shown an additional effect over medication treatment of severe psychiatric disorders such as schizophrenia and bipolar disorder (Lam, McCrone, Wright & Kerr, 2005). Ongoing adaptations of cognitive-behavioural protocols for an increasingly wider range of psychological and medical disorders have been tested for chronic pain, marital distress, childhood somatic disorders, as well as for bulimia nervosa and overeating problems. There are now over 330 outcome studies on cognitive-behavioural interventions, and research production has continued (Butler, Chapman, Foreman, & Beck, 2006). A few neuro-imaging outcome studies have recently confirmed what was already thought: CBTs produce physiological and functional changes in many brain sites.

(1) Theoretical Foundations

The cognitive model was originally constructed following research studies conducted by Aaron Beck to explain the psychological processes in depression, in an atempt to prove Freudian's theory of depression as repressed retroflexed hostility. Instead of hostility and anger, the research on clients' dreams showed a "sense of defeat, failure and loss" (Beck & Ward, 1961).Depressed clients' themes while dreaming were consistent with their waking themes; dreams could simply be a reflection of the person's thoughts. Based on

systematic research and clinical observations, Beck proposed that the symptoms of depression could be explained in cognitive terms as biased interpretations of events attributed to the activation of negative representations of the self, the personal world, and the future (the cognitive triad).

As a natural consequence, Beck began to increasingly question the psychoanalytic unconscious motivational model and therapeutic method, especially the psychoanalysis' emphasis on motivational-affective conceptualizations of emotional disorders, which largely ignored cognitive factors, as it was substantiated by his research findings on depression.Laying the grounds for cognitive theory and technique, Beck started differentiating the cognitive from the psychoanalytic approach, focusing the treatment on present problems, as opposed to uncovering hidden traumas from the past, and on analyzing accessible, rather than unconscious, psychological experiences .Nevertheless, the experience with psychoanalysis was important in the initial development of the therapeutic concepts and strategies of CT. An important contribution to the foundations of CT was given by the Freudian formulation of hierarchical structuring of cognition into a primary process (i.e., out of awareness and based on fantasies and wishes) and a secondary process (i.e., accessible to awareness and based on the principles of objective reality), as well as the concept that symptoms are based on pathogenic ideas.Since his psychoanalysis training and along his professional career, Beck identified himself with neo-analysts, such as Alfred Adler, Karen Horney, Otto Rank and Harry Sullivan, who emphasized the importance of understanding and dealing with patients' conscious experiences as well as the need to treat the meanings patients give to events they experience in their lives. Cognitive theory with its focus on intrapsychic processes rather

than overt behaviour is more a legacy from psychoanalytic theory, although therapeutic procedures are more similar to behaviour counselling (Beck &Ward 1961).

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

Influences from cognitive sciences and cognitive psychology also accounted for the foundations of CT. The writings of cognitive psychologist George Kelly had a prominent impact, especially his personal construct theory, which, along with Piaget's idea of schemata, evolved into Beck's similar definition of schemas. The cognitive theory of emotions by Lazarus &Alfert, the problem-solving approach,the self-management models by Bandura and Meichenbaum,along with cognition-oriented writers also influenced cognitive theory. CT's emphasis on a problem-solving approach to conscious problems was also adopted by Ellis's rational-emotional-behaviour counselling.

The scientific approach espoused by behaviour counselling contributed to diverse therapeutic procedures and strategies, such as the session structure, the greater activity by the counsellor, the setting of treatment goals for the entire counselling as well as of an

agenda for each session, the formulation and test of hypotheses, the elicitation of feedback, the use of problem-solving techniques and social skills training, the assignment of between-sessions homework and experiments, and the measurement of mediational variables and outcomes. However, from a philosophical point of view, CT may be seen as much more humanistic, exploratory, as it works with constructs such as the mind, and deals with feelings and thoughts, whereas many would see behaviour counselling as too mechanistic.

(2) Principles of CT

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

Cognitive therapy posits that there are thoughts at the fringe of awareness that occur spontaneously and rapidly, and are an immediate interpretation of any given situation (Beck &Waed 1961).These are called automatic thoughts and are distinguished from the ordinary flow of thoughts observed in reflective thinking or free association. They are generally accepted as plausible, and their accuracy is taken for granted. Most people are not immediately aware of the presence of automatic thoughts, unless they are trained at monitoring and identifying them. He further states that, “it is just as possible to perceive a thought, focus on it, and evaluate it as it is to identify and reflect on a sensation as pain”.

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

Schemas are acquired early in an individual's development, and act as "filters" through which current information and experience is processed. These beliefs are moulded by personal experiences and derived from identification with significant others and from the perception of other people's attitudes toward them.

Cognitive Distortions

1) Catastrophizing – thinking that the worse in a situation will happen, without taking into account the possibility of other outcomes believing that what has happened or will happen will be terrible and unbearable. Examples: Losing may job will be the end of my career". "I will not stand separating from my wife". "if I lose control the will be my end"

2) Emotional Reasoning (emotionalizing) – Presuming that feelings are facts. Thinking that something is true because one has a very strong feeling (actually, a thought) about it. Leaving the feelings to guide the interpretation of reality. Presuming that the emotional reactions necessarily reflect the real situation. Examples: "I feel that my wife does not like me anymore". "I feel that I'm the laughing – stock of my colleagues" "I feel desperate, thus the situation should be desperate".

3) Polarization (all-or-nothing, dychotomic thought) – Looking at a situation in only two categories, mutually exclusive, rather than in a continuum. Perceiving events or people in absolute terms. Examples: "everything went wrong in the party". "I should always get the highest grade, otherwise I'll be a failure". "Something is either perfect or worthless"."Everything was a total waste of time".

4) Selective abstractions (tunnel vision, mental filter, negative filter) – One aspect of a complex situation is the focus of attention, whereas other relevant aspects of the situation are ignored. One negative (or even neutral) part of a whole situation is highlighted, and all which remains is not perceived. Examples "Look at all the people who do not like me". "My boss gave me a poor assessment" (focusing on only one negative comment and neglecting all the positive comments).

5) Mental Reading – Presuming, without any evidence, that one knows what the others are thinking, not taking into consideration other possible hypotheses. Examples: "she does not like my talking". "He is thinking I'm inopportune". "he did not like my project.".

6) Labelling – Putting a global, rigid label on oneself, a person or a situation rather than labelling the specific situation or behaviour. Examples: "I'm incompetent". He is a bad person". "She is stupid".

7) Minimization and Maximization – Characteristics and experiences which are positive in themselves in other people or situations are minimized, while the negative aspect is magnified. Examples: "I have an excellent job but everybody does". "Getting good grades does not mean that I'm smart, the others can get better grades that I do".

8) **Imperatives ("I should have" and "I have to") –** Interpreting events in terms of how things should have been rather that simply focusing on how things are absolute statements in an attempt to provide motivation or modifying a behaviour. Self demands, demands to the others and to the world to prevent the consequences of not meeting these demands. Examples: "I have to be in control of all things". "I should be perfect in everything I do". "I shouldn't be upset by my wife"(Beck, 2005).

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

There is a reciprocal relationship between affect and cognition, as increasing emotional and cognitive impairment may result from one reinforcing the other. A crucial hypothesis of the cognitive model has been the notion that certain beliefs constitute a vulnerability to emotional disorders (stress-diathesis model). For example, if an individual holds a

cognitive vulnerability to themes of loss and failure, the emotional and behavioural consequences will include sadness, a sense of hopelessness, and social withdrawal, as found in depression. If other individuals hold danger-oriented beliefs, anxiety will prevail and predispose them to narrow their attention to perceived threat, make catastrophic interpretations of ambiguous or even neutral stimuli (Beck & Ward, 1961),and engage in dysfunctional "safety behaviours"; they will be impelled to seek escapes or avoid the risk of perceived rejection, embarrassment or death. The danger-oriented biases – which occur automatically and are not necessarily under conscious control – are found in every phase of information processing (perception, interpretation, and recall)across all anxiety disorders. In clients with vulnerability to themes of humiliation, unfairness or the like, anger will be the tone, and a behavioural response in a retaliatory manner might be justified as a self-defense.Each personality disorder is also characterized by a specific personal set of dysfunctional cognitive contents, such as defectiveness, abandonment, dependency, or need for a special status, which constitute the individual's cognitive vulnerability. When activated by external events, drugs, or endocrine factors, these schemas tend to bias the information processing and produce the typical cognitive content of a specific disorder, with its own cognitive constellation and idiosyncratic set of beliefs.

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

(3) Procedures and Techniques

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

1) Monitor and identify automatic thoughts;
2) Recognize the relationships among cognition, affect, and behaviour;
3) Test the validity of automatic thoughts and core beliefs;
4) Correct biased conceptualizations by replacing distorted thoughts with more realistic cognitions; and
5) Identify and alter beliefs, assumptions, or schemas that underlie faulty thinking patterns (Beck, 2005).

In contrast to psychoanalytical technique, CT sessions have a structure in which the cognitive therapist plays an active role in helping the client identify and focus on important areas, proposing and rehearsing specific cognitive and behavioural techniques,

and collaboratively planning between-sessions assignments. A treatment plan for the whole treatment and the agenda for each session are discussed with the client, and a feedback of the client's thoughts about the ongoing session and the whole treatment is routinely asked in order to create the opportunity to treat and handle any misconceptions and misunderstandings that might arise over the course of counselling. The cognitive counsellor has to be a good strategist to devise specific treatment procedures that have higher chances of producing specific changes for that particular client.

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

(4) Cognitive and Behavioural Techniques

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

behavioural activation. Conversely, when the patient does not primarily need behavioural activation, more purely cognitively oriented procedures may be applied. For patients with anxiety disorders, an understanding of the fundamental principles of the cognitive model will probably be necessary before the introduction of any behavioural experiment.

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

Initial treatment focuses on the increase of the clients' awareness of automatic thoughts, and further work will focus on core and underlying beliefs. Treatment may start by identifying and questioning automatic thoughts, which can be done in different ways. The psychologist can guide clients to assess their automatic thoughts, especially when there is a perceived emotional arousal during the session, by simply asking: "What is going through your mind?", or any variation of this question. Cognitive distortions may be unveiled by asking, for example, "What are the evidences for your conclusion?", "Are you omitting contradictory evidence?" "Does your conclusion follow logically from the observations you have made?", "Are there alternative explanations that may be more accurate in explaining this particular episode?". When asked to reflect on alternative explanations, clients may realize that their initial explanations evolved through invalid inferences, which leads them to think of different interpretations of events, thus attaching new attributions and meanings to them (Beck &Rector, 2005).

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

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

Behavioural techniques are integrated into a CT treatment program in many different forms. When chronic and severely depressed clients have their activity level reduced, and are reluctant to commit themselves to any goal because they have low expectations about any achievements, behavioural activation procedures should be promoted. For example,

counsellor and client may assign experiments collaboratively to see whether the client's negative expectations are valid or come from wrong inferences about him/herself, other people and the future. For instance, a depressed woman may believe she is no more capable of preparing a Sunday dessert that her grandchildren liked so much; as a matter of fact, she even believes she is unable to stay out of bed long enough to do almost anything, let alone to prepare a dessert. To gather evidence of her expected capacity of mastery on dessert preparation and expected capacity of experiencing pleasure with her cooking skills, she is stimulated to rate her mastery and pleasure expectations before performing the task on Sunday morning and compare them to what her thoughts and feelings actually were after she completed the assigned task. She will probably receive, as usual, many positive feedbacks, which will help her correct inaccurate mastery and pleasure ratings. Frequently depressed people have dysfunctional expectations about their capabilities when feeling depressed, and are surprised at a much better outcome than they expected. As the client puts them to test, the outcome brings a different perspective. As clients are able to appraise their thoughts more objectively, a whole set of thoughts become hypotheses that have to be submitted to reality testing. Because most clients need to proceed in small steps, a number of graded-task behavioural assignments are tailored for individual clients to progressively promote greater successful experiences without overwhelming them with tasks greater than their present coping capacities.

Much of cognitive therapy is devoted to problem-solving techniques; social phobia clients will learn to follow the necessary steps, such as defining the problem, generating alternative ways of solving it and implementing alternative solutions. A client that fears social situations and has poor social performance will benefit from role-playingthe feared

situation with the therapistto build up inhibited skills and overcome the problem. The therapist acts as a role model so that clients can learn to perform socially. After sufficient role-playing at the office, clients are stimulated to perform in real life situations what they have built in the office.Cognitive restructuring has been developed for application in individual, group, couples and family formats, for adults, adolescents and children, in a variety of treatment contexts. The indications for cognitive restructuringare determined by client and therapist, rather than by the nature of the disorder.Therefore CR can be applied in treating social phobia among secondary school students with the aim of overcoming the disorder.

2.5.5Clarck and Wells' CognitiveModel for Social Phobia

Social phobia is characterised by anxiety and apprehension in social or evaluative situationsin which the individual may be subject to scrutiny by others. Individuals with social phobiaare concerned that they will perform in a way that may be humiliating and/or embarrassing. This often consists of a fear of showing anxiety symptoms such as trembling, sweating,blushing, or babbling. However, other types of concerns may also be evident, such asconcerns about being boring, or appearing inadequate or stupid. Two sub-types of socialphobia are identified in the diagnostic and statistical manual of mental disorders (DSM-IV,APA, 2013). A generalised sub-type is characterised by a fear of most social situations,while more specific manifestations of social phobia can be identified in which the individualfears a particular type of situation. For example, fear of public speaking or using publictoilets would constitute a specific social phobia. Exposure to feared social situations almostalways provokes anxiety in social phobia, and those with this problem realise that their fearis irrational. The experience of social anxiety is often

accompanied by physical symptomssuch as sweating, trembling, and, blushing, and, as introduced above, these symptoms maybe the predominant focus of the social phobic's concerns.

Cognitive behavioural therapies (CBT) of social phobia have consisted of several approachesthat can be broadly classified as anxiety management therapies (Butleret al., 1984), social skills training (Marzillier et al., 1976), exposure treatments (Emmelkamp et al., 1985), and combination treatments consisting of cognitive therapy andexposure. Cognitive therapy interventions have been based on rational emotive therapy(Emmelkamp et al., 1985) or cognitive therapy based on Beck's cognitive theory(DiGiuseppe et al., 1990). Treatment has been applied in an individual and in a groupformat. For instance, Heimberg et al (1998) have developed and evaluated a cognitive behaviouralgroup therapy of social phobia.

Heimberg et al. (1998) reported that patients receiving cognitive behavioural group therapycontinue to do well after treatment. The effectiveness of CBT does not allow room for complacency.However,existing treatments appear to produce only modestlevels of improvement in negative cognitions (fear of negative evaluation [FNE]), anda proportion of patients receive little benefit overall.

Partially in response to the modest effects of existing CBT on negative thoughts insocial phobia, Clark & Wells (2002) proposed a cognitive model of problem maintenance based on cognition and information processing theory.As a result of past experience, individuals with social phobia acquire assumptions andbeliefs about social situations and the self as a social object. These beliefs, when activated,contribute to negative appraisals

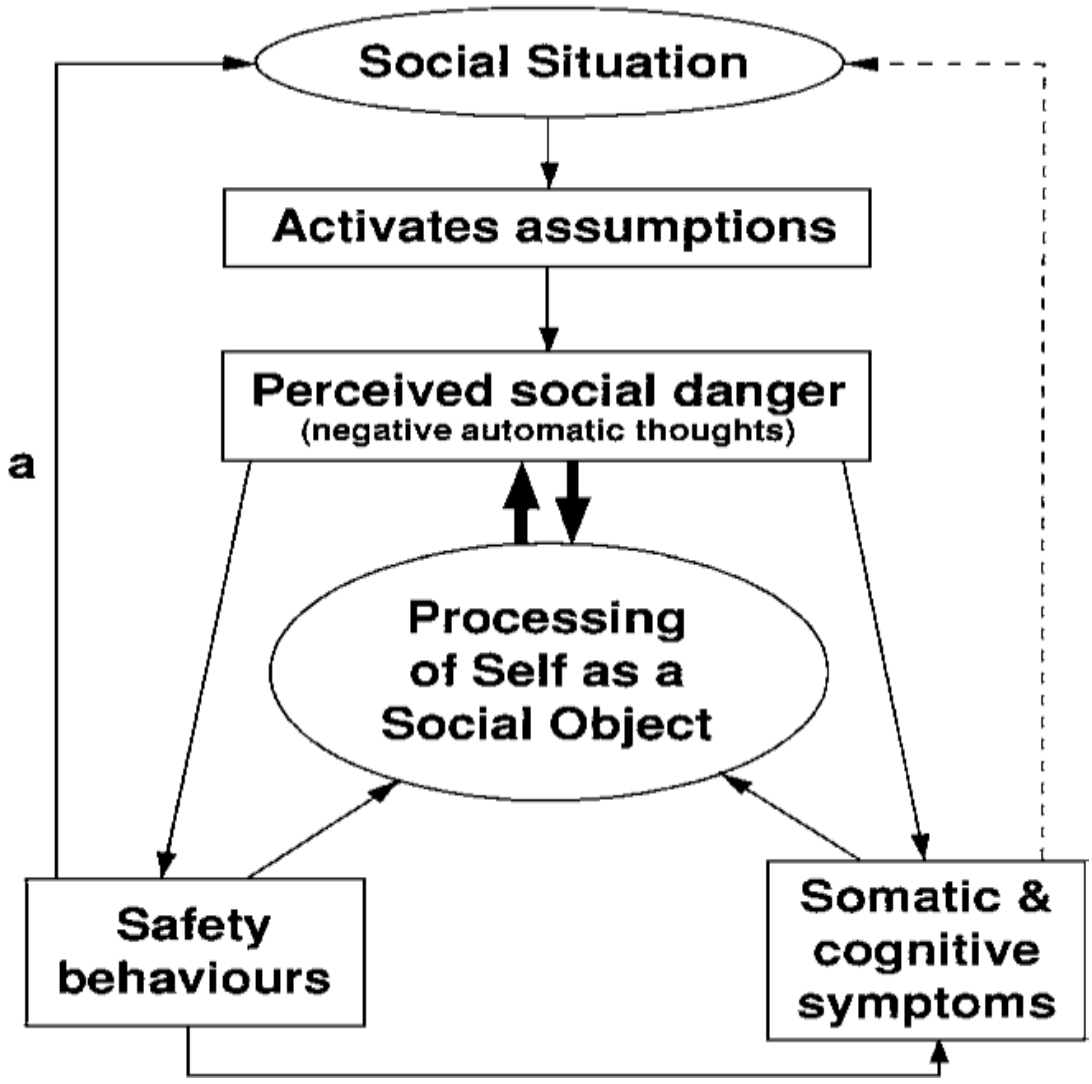
of social situations and the cyclical processes that maintainsocial phobia. Three types of assumptions and beliefs are identified in the model:

1. Unrealistic rules for social performance ("I must always convey a favourableimpression")
2. Conditional assumptions ("If I show signs of anxiety, people will think I'm incompetent")

3. Unconditional beliefs about the self in a social domain ("I'm boring, I'm weird").

One or more categories of these beliefs may be identified in individual cases.Aproblem withhigh standards and rules for social performance is that they are vulnerable to being brokenby circumstances. At this point the individual may become self-absorbed and is likely toappraise the self negatively and activate cyclical processes, as depicted in Figure 2.1.

Figure 2.1 A cognitive model of social phobia.



Wells, A., (1997), Cognitive Therapy of Anxiety Disorders: A Practice Manual and Conceptual Guide.

On entering an anxiety-provoking social situation, these negative beliefs are activatedand those with social phobia become concerned about their ability to make a favourableimpression. This concern is manifest as negative automatic thoughts; for example, “whatif I shake”, “I am going to blush”, “they’ll see I’m nervous”, and “what if I can’t think ofanything to say”. Negative automatic thoughts of this kind are

accompanied by a shift inthe direction of attention in which affected individuals become self-conscious and focusattention inward on symptoms and an impression of how they think they appear to others.

Aside from negative self-processing, a further central component of the social phobiamodel concerns the coping responses which patients engage in to try to avert social threat andprevent feared catastrophes. These behaviours are labelled safety behaviours.

Common examples of safety behaviours include avoiding eye contact, saying little, hiding one's face (to conceal blushing), censoring sentences before speaking (to preventbabbling/incoherence), and wearing extra layers of clothing (to conceal sweating). Thesesafety behaviours are problematic in several respects and contribute to the maintenance ofsocial phobia in the following ways:

1. Safety behaviours are prone to increase or maintain self-consciousness. This is problematic because the individual pays less attention to external aspects ofthe social environment that may provide information capable of challenging negativethoughts. When chronic or inflexible, self-consciousness may also interfere with fluentsocial performance, thereby reinforcing negative self-appraisals. Self-consciousness alsointensifies awareness of symptoms.

2. Safety behaviours can support a bias in the interpretation of events in which the non-occurrenceof social catastrophes can be attributed to use of the safety behaviour, and notto the fact that social catastrophes are unlikely or not as catastrophic as predicted. Forexample, after giving a brief (Five-minute) presentation as a behavioural assessment testin a treatment session, Rachel was asked how she thought she had performed. She

repliedthat it “wasn’t too bad, I didn’t lose control because I was able to ask questions ratherthan talk a lot, and I was able to control the shaking in my voice” (safety behaviours). Inthis case, use of the safety behaviour prevented Rachel from discovering that she wouldnot have “lost control” despite her anxiety.

3. Some safety behaviours intensify the somatic and cognitive symptoms of anxiety. Forexample, speakingslowly, mentally rehearsing sentences and focusing on one’s voicecan increase the likelihood of “blanking out” and the experience of subjective difficultyin speaking.

4. Safety behaviours may contaminate the social situation. Behaviours such as avoiding eye contact, avoiding self disclosureand saying little in social situations can lead other people to think that theperson with social phobia is uninterested in them or is aloof and unfriendly.

Anticipatory and Post-event Processing

Emotional distress in social phobia is not restricted to the time spent in social situations.Social phobic individuals experience considerable anxiety and apprehension in the days or weeksleading to social encounters, and negative emotions and thoughts occur in the hoursor days after a social event. This “anticipatory processing” takes the form of negativethoughts about what might happen and may consist of plans of how to cope. Mental planningor preparation that occurs during the anticipatory period can be viewed as a safetybehaviour. The problem with anticipatory processing is that it is most often negative andit primes the individual for self-focused attention prior to entering the socialsituation. Moreover, if social catastrophes do not occur, the individual can attribute thenon-occurrence of catastrophe to the anticipatory processing, and thus negative

beliefsand predictions concerning the consequences of failed or imperfect performance remainunchallenged.

Evidence for the Model

Several key features of the model are supported by research on individuals with socialphobia. In particular, the model predicts that socialphobia and social anxiety should be associated with heightened self-focused attention, andthis relationship is supported by numerous studies.Acentral component of the model is the idea that social phobics negativelyappraise their own performance and behaviour in social situations, and this is supported bythe available research evidence (Rapee& Lim, 2012; Stopa& Clark, 2013). For instance,Stopa& Clark showed that highly socially phobic individuals reported significantlymore negative self-evaluative thoughts than lowsocially phobicindividuals.However, these subjectsdid not differ in frequency of negative thoughts concerning negative evaluation by others.

Furthermore, sociallyphobics appear to overestimate how anxious they appear to other.Consistent with the observer perspective hypothesis derived from the model, social phobicsshow an observer perspective in images of recent anxiety-provoking social situations.However, they show a field perspective for non-social situations. Moreover, these observer perspective images appear to occur spontaneously.

Rachman (1977) explored the nature of post-event processing in individuals highin social anxiety. He found that post-event processing (the post-mortem) was greaterin highly socially anxious than lowly socially anxious individuals. In addition, negativethoughts during post-event processing were rated as intrusive experiences inviting comparisonwith the concept of failures in emotional processing.

Finally, the model predicts that the commission of safety behaviours in social situationsinterferes with reductions in negative beliefs and anxiety. Therefore, instructions toabandon safety behaviours during brief exposures should facilitate reductions in negativebeliefs and anxiety. In a test of this hypothesis, used a repeatedmeasures crossover design comparing the effects of brief exposure plus abandonmentof safety behaviours with brief exposure alone, when each was presented with a specificrationale. The results of this study showed that brief exposure plus abandonmentof safety behaviours was more effective than brief exposure alone in reducing anxietyand negative beliefs. It is important to note that this was not a study intended tocompare the relative effectiveness of two types of treatment, but was intended merelyto assess the effects of dropping safety behaviours during brief encounters with socialsituations.

Cognitive Therapy for Social Phobia

A specific form of treatment for social phobia has been developed on the basis of thepresent model. This treatment has a particular focusthat distinguishes the approach from more eclectic treatments. In particular, the modelsuggests that it is necessary to modify specific maintenance processes during the course ofeffective treatment. The treatment aims to correct dysfunctional negative self-appraisals andbeliefs, and this may be facilitated by modifying unhelpful safety behaviours and redirectingattention during exposure in order to correct faulty beliefs.Acourse of treatment is typicallyimplemented over a 12–14-session time-frame in which sessions are held weekly and eachsession is normally 60 minutes in duration. The theoretical approach adopted here suggeststhat

treatment should followa particular sequence in maximising the efficiency of cognitivechange.

Structure of CR

Sessions 1–3of treatment usually consist of case formulation, socialisation, and cognitivepreparation for restructuring, involving manipulations of safety behaviours and of attention.

Sessions 4–6 typically focus on a continuation of behavioural experiments, ofteninvolving exposure to test negative appraisals and predictions, and also video feedbackmethods to correct the distorted self-image.

Sessions 7–9 continue with cognitive andbehavioural reattribution methods, and introduce bandwidth manoeuvres aimed at furtherinterrogating the environment and discovering that social catastrophes are unlikely, even inthe event of failed performance.

Sessions 10–12,Involvesconsolidation of material learned, relapse prevention, and a continuation of work on theremaining issues (residual negative beliefs and avoidance). Clearly, there is flexibilityin the number of sessions devoted to these phases of treatment, and this partitioning issomewhat arbitrary, but it serves here to provide a basic conceptual structure for planningspecific interventions.If we turn our attention briefly to the sequencing of treatment strategies, it is a logicalderivation from the model to use strategies early in treatment that reconfigure the client's behaviours and focus of attention in a way that maximises subsequent changein negative thoughts and beliefs. More specifically, if behavioural experiments involvingexposure proceed without modifying the use of maladaptive safety behaviours and reducingself-focused attention, the effectiveness of such strategies may be impaired.

Experiments that involve deliberate displays of anxiety or poor social performance can be described as “bandwidth” manoeuvres. Individuals with social phobic often operate within strict and narrow bandwidthsof what they believe are “safe” social behaviours. As treatment progresses, experiments aredevised that widen bandwidths so that patients can discover that a wide range of behavioursare relatively risk free.

Before the termination of treatment, it is important to ensure that avoidanceof social situations which may be indicative of underlying unresolved fears is explored andaddressed. Residual negative thoughts and avoidance should be conceptualised and targetedwith renewed verbal and behavioural reattribution methods. After treatment, booster sessionsare normally scheduled at 3 and 6 months’ follow-up. These provide an opportunityto consolidate treatment gains and reinforce the implementation of treatment strategies.

2.6 Review of Empirical Studies

Umaru et at (2014) conducted a study to find out the Effect of Cognitive Restructuring Intervention on Tobacco Smoking among Adolescents in Senior Secondary School In Zaria Kaduna State, Nigeria. The study employed a quasi-experiment, non-equivalent control group, pretest-posttest design in investigating the effect of Cognitive Restructuring Intervention Program on tobacco smoking among adolescents in senior secondary school in Zaria Educational Zone of Kaduna State, Nigeria. The sample was 129 (71 male and 58 females) schooling Adolescents drawn from four schools in Zaria Educational zone. An instruction tagged cognitive behaviours intervention scale (CBIS) was adopted and used for the study. Data were analyzed using means t-test and analysis

of covariance (ANCOVA). Findings indicate that cognitive restructuring intervention program (CRIP) significantly affects tobacco use cessation. Recommendations are by made which include a call for psychologists/counsellors to be employed in schools and taught how to use new skills in curtailing tobacco smoking among students.

Lawan (2016) conducted a study which examined the effect of Cognitive Restructuring (CR) and Social Skills Training (SST) counselling Techniques on Avoidant Personality Disorder (APD) among Secondary School Students in Kano Metropolis. The study was a quasi experimental design involving pre-test-post-test-control group design. The population of the study consist of Senior Secondary School two Students in Kano Metropolis who exhibited APD. Three male and three female senior secondary schools, making six schools, were selected in Kano Metropolis. A sample of 72 respondents from the six schools, twelve from each school, were sampled and put into 3 experimental groups (CR, SST and control group). Each group consists of 12 male and 12 female students. APD test (DSM-5) was used for data collection in the study. Standard Deviation and t-test for independent sample were used to analyze the data collected. Also ANOVA was used on the pre-test results. The results indicated that CR has effects in the reduction of APD (t=8.086, p=0.000). SST has effects in the reduction of APD (t=8.884, p=0.000). There is no differential effect base on the technique between CR and SST (t=0.617, p=0.540).There is a differential effect base on gender in the CR treatment in favor of male (t=014, p=0.006) while there is no differential effects base on gender in the SST (t=0.309, p=0.760). Base on the findings of the study this research recommend among others; a structured treatment package of the two techniques (CR and SST) used in this study should be used by the school counsellors

in conjunction or isolation for the treatment of APD among students. CR and SST counselling techniques could be use in the treatment of APD in both school and clinical settings. CR and SST counselling techniques should be designed and incorporated into national curriculum of secondary schools. And lastly, gender differences of the clients should be considered when structuring and implementing CR counselling techniques in the treatment of APD.

Shina (2015) investigated the effects of cognitive restructuring and graded exposure counselling technique on school phobia among secondary school students in Kaduna Metropolis, Nigeria. The study was guided by five (5) research questions and five (5) null hypotheses. This study employed a quasi-experimental, non-equivalent control group, pre-test - post-test design. The population of this study was 415 junior secondary school students whereas 36 students were purposively sampled and used for the study. The instrument used for data collection was, Screen for Child Anxiety Related Disorders (SCARED). Data were analyzed using mean, standard deviation, t-test and ANCOVA. Findings revealed that; Male and female students exposed to CRT had a reduced school phobia in favour of female students with ($t = 0.819$, $p = 0.432$), Male and female students exposed to GET had a reduced school phobia in favour of male secondary school students with ($t = 0.948$, $p = 0.366$), Students exposed to CRT such as validity testing, modelling, and systematic positive reinforcement had a reduced school phobia as compared to those in control group ($t = 20.108$, $p = 0.000$), Students exposed to GET such as hierarchy of fears had reduced school phobia than their counterparts in the control group ($t = 18.432$, $p = 0.000$) and Gender was not a significant factor among those exposed to both CRT and GET on reducing school phobia among secondary school

students (f= 0.76, p=0.783). It was therefore recommended that School Principals, Counsellors, Psychologists and form teachers should be exposed to training in CRT and GET in re-addressing students with school phobia among others.

In Lawan (2016), Alden conducted a randomized controlled trial comparing three active CBGT treatments to a control group (n = 76). Standard CBGT included exposure with a limited cognitive component (increasing awareness of fearful thoughts). The second group consisted of standard CBGT in addition to general social skills training (listening skills, assertiveness), and the final group consisted of standard CBGT plus intimacy- focused skills training (how to foster a friendship with an acquaintance). All active treatment conditions produced improvements in symptoms of anxiety and depression, reductions in symptomatic behaviour (self-reported shyness, anxious mannerisms), and improvements in social functioning, with gains maintained three months after treatment. In general, the addition of skills training did not improve outcomes beyond the effects of the standard CBGT However, the group that received of intimacy-focused skills reported greater involvement in and enjoyment of social activities than patients in the other active treatment conditions. Although patients in all treatment conditions made gains over the course of treatment, it is noteworthy that the majority of patients remained impaired in terms of self-esteem, social reticence and overall social functioning. Alden (2012) therefore concluded that residual symptoms may be due to the brevity of GCBT. Consistent with this suggestion, there is evidence that the efficacy of CBGT may be compromised when treatment is delivered over a short period of time or in a small number of sessions.

Alexis, Christopher, Annie andLejuez (2010) found comparably modest rates of recovery following a very brief but intensive CBGT intervention. The treatment consisted of exposure and social skills training delivered over four eight hour (full-day) group sessions. Although 40% of patients were considered recovered on their basis of one outcome score (fear of negative evaluation), much lower rates of recovery were observed for symptoms of depression (27% recovered), anxiety (25% recovered), social avoidance/distress (22% recovered), and overall social functioning (8% recovered). In sum, there is data to support the efficacy of short-term CBGT in reducing symptoms of APD, anxiety, depression, as well as symptomatic behaviour and overall social functioning. Although cognitive restructuring and social skills training are both associated with positive gains in treatment, they do not seem to improve outcomes beyond the effect of graduated exposure. But they suggested Longer- term, comprehensive interventions may be necessary to change longstanding cognitive and behavioural patterns.

Beidel, (2014) examined the impact of social skills training (SST) for the treatment of Social Phobia (SP).Using a sample of 106 adults who were endorsed for the treatment across numerous social settings, participantswere randomized to exposure therapy (imaginal and in vivo) alone, SST or a wait list control. The assessment strategyincluded self-report measures, blinded clinical ratings and blinded assessment of social behaviour.Both interventions significantly reduced distress in comparison to the wait list control and atpost-treatment, 67% of patients treated with SST and 54% of patients treated with exposure therapyno longer met diagnostic criteria for SP, a difference that was not statistically significant. Whencompared to exposure therapy, SST produced superior outcomes ($p < .05$) on measures of socialskill and general clinical status. In

addition to statistical significance, participants treated with SST orexposure reported clinically significant decreases on two measures of self-reported social phobia andseveral measures of observed social behaviour. Both interventions produced efficacious treatment outcome, although SST provided additional benefit on measures of social distress and social behaviour.

Butler et al. (2006) reviewed the meta-analyses of treatment outcomes of CBT/CT for a wide range of psychiatric disorders and medical conditions. A search in the literature from 1967 to 2003 pooled a total of 16 methodologically rigorous meta-analyses encompassing more than 9000 subjects from 330 studies. The review focused on effect sizes that contrasted outcomes of CBT with the outcomes for control groups for each disorder, providing an overview of the efficacy of CBT/CT. Because the literature reviews generally combine studies labelled CBT and CT under the CBT scope, the findings of these reviews were pooled and, whenever possible, pinpointed the more evident CT studies. Among the limitations of the meta-analytic approach are the assumptions of uniformity across the studies in the samples, in the content of therapy, and in therapists.Butler et al's findings reveal that large effect sizes (grand mean = 0,90) were found for adult unipolar depression, adolescent unipolar depression, generalized anxiety disorder, panic disorder with or without agora phobia, social school phobia, post-traumatic stress disorder, and childhood depressive and anxiety disorders. Finally, the review reported that CT was found to be superior to supportive/nondirective therapy in two comparisons for adolescent depression (ES = 0.84) and two comparisons for generalized anxiety disorder (ES = 0.71).CBT has also shown promising results as adjunct to pharmacotherapy in the treatment of schizophrenia: the average uncontrolled

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

Bolsoni-Silva,andLoureiro (2014) conducted a study aimed to compare the behavioural indicators of social skills presented by university students with social anxiety in relation to a non-clinical group, and to verify the predictive value of the social skills for social anxiety. Participants were 288 university students, 144 with Anxiety Disorder and 144 non-clinical. Social skills were assessed using the QHC-University (Social Skills, Behaviours and Context Assessment Questionnaire for University Students) and the IHS-Del-Prette instruments. Mental health indicators were assessed through screening and diagnostic instruments. Through univariate and multivariate analysis an association was found between social skills and anxiety, highlighting public speaking, potential, difficulties, and the total social skills score as predictors of social anxiety, which contributes to demonstrating the role the resources and difficulties play in this.

Bernstein et al, (2014) investigated the efficacy of 8 weeks of imipramine versus placebo in combination with cognitive-behavioural therapy (CBT) for the treatment of school-refusing adolescents with co-morbid anxiety and major depressive disorders. The study used a randomized, double-blind trial with 63 subjects entering the study and 47 completing. Outcome measures were weekly school attendance rates based on percentage of hours attended and anxiety and depression rating scales. Over the course of treatment, school attendance improved significantly for the imipramine group ($z = 4.36$, $p < .001$)

but not for the placebo group (z = 1.26, not significant). School attendance of the imipramine group improved at a significantly faster rate than did that of the placebo group (z = 2.39, p = .017). Over the 8 weeks of treatment, there was a significant difference between groups on attendance after controlling for baseline attendance; mean attendance rate in the final week was 70.1% +/- 30.6% for the imipramine group and 27.6% +/- 36.1% for the placebo group (p < .001). Defining remission as 75% school attendance, 54.2% of the imipramine group met this criterion after treatment compared with only 16.7% from the placebo group (p = .007). Anxiety and depression rating scales decreased significantly across treatment for both groups, with depression on the Children's Depression Rating Scale-Revised decreasing at a significantly faster rate in the imipramine group compared with the placebo group (z = 2.08, p = .037). Imipramine plus CBT is significantly more efficacious than placebo plus CBT in improving school attendance and decreasing symptoms of depression in school-refusing adolescents with comorbid anxiety and depression.

Goldfried,Linehan, and Smith (1978) investigated thereduction of test anxiety through cognitive restructuring. The study used 36 18-49 year old Students compared two procedures for reducing test anxiety with a waiting list control. In the first, systematic rational restructuring, the participants were trained to realistically re-evaluate imaginally presented test-taking situations. In thesecond; a prolonged exposure condition, were presented the same hierarchy items but with no instructions for coping cognitively. Treatment was administered following measures of test anxiety; the S-R Inventory of Anxiousness, Achievement Anxiety Test, Test Anxiety Questionnaire, Fear of Negative Evaluation, Social Avoidance and Distress Scale, and the Trait Scale of the Stait- Trait

Anxiety Inventory. Findings show greater anxiety reduction in the systematic rational restructuring condition, followed by the prolonged exposure group, with no changes for the control. Only those in the rational restructuring condition reported a significant decrease in subjective anxiety when placed in an analogue test-taking situation. Ss in the restructuring condition also reported greater generalized anxiety reduction in social-evaluative situations. Within the broader context of cognitive behaviour therapy, these results indicate that the cognitive reappraisal of anxiety-provoking situations can offer an effective treatment procedure for the reduction of anxiety.

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

CRIM group than the WL group, with large between – group effect sizes (clinician – Administered PTSD Scale: $d = 0.93$, $p < 0.001$).

2.7 Summary

This chapter reviewed related literatures on cognitive restructuring and social skills training and social phobiain Nigeria and the rest of the world. Furthermore, conceptual perspective of social phobia, cognitive restructuring and social skills training were reviewed.The chapter also reviewed classical conditioning theory, operant conditioning theory, Bandura's social learning theory, Aaron Beck theory of cognitive restructuring, and the cognitive model of social phobia. Related empirical studies were also reviewed in the chapter.

The review shows that most studies use MANCOVA, ANCOVA and ANOVAin analysing the data of their study. Most of the study were done out side the countryin the western world. Only few were done in Nigeria. Even those carried out in Nigeria issues related to social phobia and its components were not studied. Furthermore, the study serves as a spring board for further researchers mainly on cognitive restructuring and social skills training in re-addressing social phobia.

CHAPTER THREE

METHODOLOGY

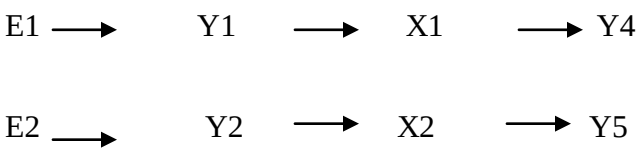
3.1 Introduction

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

3.2 Research design

The study adopted Quasi experimental designinvolving pre-test/post-testtwo experimental group design. Inthis design,participants are assigned intotwo experimental groups to receive two different treatments. Quasi experimental design is a design that does not provide full control of subjects. It permits the researcher to reach reasonable conclusions even though full control is not possible as explained by Cohen, Manion and Morrison (2007). In this study, students with fear, physiological manifestations and avoidance of social interactions were exposed to Cognitive Restructuringin group A, while another set of students with fear, physiological manifestations and avoidance of social interactions were exposed to Social Skills Trainingin group B. Pre-test and post test are conducted to measure changes in their Social phobia in the two groups.

The design can be symbolically represented as follow: -



Where: -

E1 – Treatment group one (CT)

E2 – Treatment group two (SST)

Y1 – Pre-test administered to Treatment group one (CT)

Y2 – Pre-test administered to Treatment group two (SST)

X1 – Treatment with (CT)

X2 – Treatment with (SST)

Y3 – Post-test administered to Treatment group one (CT)

Y4 – Post-test administer to Treatment group two (SST)

3.3 Population of the study

The population of the study consists of the public junior secondary school students identified with social phobia in Kaduna Metropolis, Nigeria. All together, 1715 Junior Secondary School students were identified from 20 secondary schools. The reason for involving JSS I students is that students at this level are newly admitted into secondary school and are likely to face the challenges of being in a new environment where they

meet and interact with new teachers and fellow students. Another reason why JSS I was used for the study is that many literature reviewed show that Social Phobia emanates in school setting during transition period and adolescence stage. Therefore, such treatment at the onset may be more effective.

3.4 Sample and Sampling Techniques

Purposive sampling wasused in drawing up the samples involved in this study.The sample consisted of 40Junior Secondary Class One (JSS1) students with symptoms of social phobia, in the categories of mild and moderate as measured with the Social Phobia Inventory (SPIN). Fromthe sample twoclasses consisting of 20 each was drawn from two Junior Secondary Schools in Kaduna metropolis, Nigeria. The researcher randomly assigned the two secondary schools into CR and SST treatment groups.

3.5 Instrumentation

The SPIN (Social Phobia Inventory) wasadapted and used as instrument for the study. It is a 17-item self-rating scale for social phobia developed by Connor (2000).The scale includes items assessing each of the symptom domains of social Phobia (fear, avoidance, and physiological manifestations). It is measured on a five-pointlikert scale ranging from 1 = Not at all, 2 = A little bit, 3 = Somewhat,to 4 = Very much, 4 = Extremely. The total score which ranges between 17 and 68 determines the individual's severity of social phobia.

Items **1, 3, 5, 6, 14** and **15**measure fear of social interactions. While items **4, 8, 9, 11, 12** and **16** measure avoidance of social interactions.And items **2, 7, 10, 13,** and **17** measure physiological manifestation of social interactions.

The scale measures the severity of the disorder and categorise it as follow:

Table 3.1: Social Phobia Severity

Severity		Score
None	=	Less than 20
Mild	=	21 – 30
Moderate	=	31 - 40
Severe	=	41 – 50
Very severe	=	51 and above

This study worked on students that fall under two categories – Mild and Moderate. Severe and very severe case are beyond the scope of this study. Students under these categories were reported to the school authorities for clinical referral.

The instrument was used in other countries to assess the symptoms of Social Phobia, hence its adoption in Nigeria is appropriate. This instrument was used to identify the subjects who met the criteria of the research. It wasadministered by the help of classroom teachers. Thus the test results helped in determining the students that participated in the research.

3.5.1 Validation of Instrument

The SPIN was validated by lecturersin the Department of Educational Psychology and Counselling of Ahmadu Bello University, Zaria.Theinputs of these experts contributed to the final form of the instrument that was used for this study.

3.5.2 Reliability of the Instrument

The Social Phobia Inventory (SPIN) was pilot tested on JSS1 students drawn from GovernmentSecondary School Rigachikunin Igabi Local Government Area, Kaduna state, Nigeria. In order to determine the stability of Social Phobia Inventory (SPIN), a test retest reliability analysis to determine the stability of the instrument was conducted. In order to achieve this, second administration of Social Phobia Inventory (SPIN)was done after two weeks and the score obtained from both administrations were correlated using Pearson Correlation Formula. This yielded 0.811. This became necessary since the same Social Phobia Inventory (SPIN)was intended to be used for both pre-test and post-test.

3.5.3 Control of Extraneous Variables

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

1. Randomization of the subjects into the treatment groups was not possible because of the problem of disrupting the normal classes.The researcher randomly assigns the selected schools into the treatment condition through simple balloting techniques.
2. To minimize student's sensitivity to the treatment, all the assessment was announced to the students as the normal continuous exercise.
3. The trainers were also introduced to the students at the schools to be used in the study and are equippedwith the following techniques.

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

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

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

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

3.6 Procedure for Data Collection

The researcher obtained a letter of introduction from the Department of Educational Psychology and counselling (see Appendix B). The letter was taken to Kaduna State Ministry of Education where two other letters(Appendix C and D) were given to researcherand were taken to two zonal education offices at the zones where the selected schools are located –Kaduna and Sabon Tasha zonal education offices.-After that, letters were given to the researcher from each of the two zonal education offices to the principals of the selected schools and approval wasgranted to the researcher to conduct the research. After the approval of the secondary school principals, the attendance registers of JSS1 students was checked. The screening of the students' attendance was limited to the last and current term (the term in which the study took place). Apart from that, the students identified to be truants and those that avoid one lesson or the other or any school activities were presented with the SPIN (shown in Appendix A). This wasdone for identification purpose only. Schools identified with highest cases of social

phobia wereselected for the treatment (Cognitive Restructuring and Social Skills Training) groups. The SPIN wasadministered to the students. 20 students participated in the pre-test for each of the two treatment groups.

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

3.6.1 Treatment Procedure

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

Treatment Programmes: CR and SST programme wereused in the treatment schools.

Treatment Procedure

Pre-Treatment: before the commencement of the training, the therapist took time to familiarize himself with the subjects to ascertain for instance, their competency, interest and the academic problems they encounter in school. This helped the therapist in determining how best to motivate the subjects to acquire the new skills.

Immediately after assigning the classes to treatment groups, the SPIN was administered to them to obtain pre-test data.. In order not to disrupt the school

programme, instructions on CR and SST wasdone during free periods. The experiment was designed to last for six weeks.

Treatment Programmes: CR and SST programme were used in training the treatment schools.

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

TREATMENT 1: COGNITIVE RESTRUCTURING (CR)

Week 1

Session 1: Establishing the Relationship

Session 2: Nature Purpose and Process of CR. The client recalls a problem from the past, and the counsellor and the client work together to develop strategies to the problem so that if it occurs in future, the client has a plan.

Week 2

Session 3: Validity Testing: The therapist tested the validity of the client's beliefs or thoughts, giving the client time to defend his or her viewpoint. If the client cannot defend the beliefs or thoughts they are said to be invalid.

Session 4: Writing in a Journal: The client were asked to journal thoughts and situations that occur daily. The counsellor and the client then review the journal to figure out any maladaptive thought patterns that could affect the client's behaviour.

Week 3

Session 5: Guided Discovery: The therapist guides the client through a scenario; enabling the client to understand any cognitive distortions.

Session 6: Modelling: This involves role –playing exercises by the therapist so that the client may learn new ways of responding to certain situation.

Week 4-5

Session 9: Homework: The therapist commonly gives assignments to clients to help them learn new ways of dealing with social phobia.

Session 10: Systematic Positive Reinforcement: This technique involves the client performing a desirable behaviour and then being provided with a pleasant reinforcement or reward.

Week 6

Session 11: Revision of the CR

Session 12: The Re-administration of the study SPIN

TREATMENTS 2: SOCIAL SKILS TRAINING (SST)

Secondary school students receive treatment through the following phases

Session 1: Assessment

Determine the specific area of the client's social skills deficits through self-reports,behavioral observations, and/or third party assessments.

Session 2: Direct Instruction/Coaching

Teach and explain the basis of effective and appropriate social behaviours to the client along with specific suggestions for how to enact such behaviours.

Session 3: Modelling

Show the client models enacting appropriate social behaviours, and receiving positive reinforcements for doing so. The modelling of inappropriate behaviours along with critiques and explanations may also be helpful.

Session 4: Role-Playing

Encourage the client to practice certain social behaviours in a controlled environment, typically with the therapistand perhaps an assistant. Provide feedback to the client immediately after enacting the role-plays.

Session 5: Homework Assignments

Instruct the client to enact certain social behaviours in the ‘‘real world.’’ Start with easy behaviors and graduate to more complex ones. Debrief in the following session.

Session 6: Termination

The Re-administration of the study SPIN

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

3.7 Procedure for Data Analysis

The data collected after administering the research instrument was collated, organized and analyzed. Paired-sample t-test was used to testhypothesis 1 to 6 whereas Independent-sample t-testwas usedto test hypothesis 7. All the hypotheses were tested at 0.05 level of significance.

CHAPTER FOUR

RESULTS AND DISCUSSION

4.1 INTRODUCTION

This study investigated the effect of Cognitive Restructuring and Social Skills Training on Social Phobia among secondary school students in Kaduna Metropolis, Nigeria. Therefore, this chapter presents the results of data analysis and discussion of the findings.Statistical package of version IBM 23 was used to analyze the data. The students were grouped into two equal groups of 20 each. One group exposed to Cognitive Restructuring and the other group exposed to Social Skills Training with the view of determining their effect on social phobia of the respondents. The first section presents the bio data variables in frequencies and percentages, these include the respondents gender status, study groups. The second section answers the seven research questions with the descriptive statistics of means and standard deviations. The third section uses the inferential statistics of Paired sample t test and in dependent t test to test the seven research null hypotheses. All the hypotheses were tested for rejection or acceptance at 0.05 alpha level of significance.

4.2 Results

4.2.1 Descriptive Statistics

Table 4.1: Distribution of participants into two groups; Cognitive Restructuring (CR) and Social Skills Training (SST) groups.

	Treatment Groups	
	Frequency	**Percent**
CR (Cognitive Restructuring)	20	50.0
SST (Social Skills Training)	20	50.0
Total	40	100.0

Table 4.1 showed that 20 of the respondents representing 50.0% of the total sample were exposed toCognitive Restructuring(CR) while the remaining 20 representing 50.0% were exposed to SST (Social Skills Training)

Table 4.2: Distribution of participants by gender

Gender	Frequency	Percent
MALE	15	37.5
FEMALE	25	62.5
Total	40	100.0

Table 4.2 showed that a total of 15 of the respondents representing 37.5% are males and the rest 25 representing 62.5% are females used for the study

Table 4.3: Distribution of the participants into two groups; Cognitive Restructuring and Social Skills Training groups versus distribution of subjects by gender

Gender * Groups Cross Tabulation

Gender	Groups		Total
	CR (Cognitive Restructuring)	SST (Social Skills Training)	
MALE	8	7	15
FEMALE	12	13	25
Total	20	20	40

Table 4.3 showed cross tabulation of gender distribution across the two study groups.

4.2.2 Hypotheses Testing

Hypothesis One: The null hypothesis statesthat there is no significant effect of Cognitive Restructuring on Fear of social interactions among secondary school students in Kaduna Metropolis, Nigeria. Result of the analysis is presented in table 4.4

Table 4.4: Paired sample t-test on the effect of Cognitive Restructuring on Fear of social interactions among secondary school students.

Variable	Tests	N	Mean	SD	df	t-cal	P
fear scores	Pre-test	20	11.700	1.417	19	4.530	0.001
	Post-test	20	9.450	1.503			

P< 0.05, t computed > 1.96 at df 19

Results of the Paired sample t-test statistics in table 4.4 showed thatCognitive Restructuring (CR) has significant effect on Fearof Social Interactions(t = 4.530, p = 0.001). The mean score of the participantsFear of Social Interactionsbefore exposure to the treatment was 11.700 and it was reduced to 9.450 after exposure to the treatment of Cognitive Restructuring, implying a mean reduced difference of 2.250 in favour of

the post test scores. This shows that Cognitive Restructuring has positive effect on their Fear of Social Interactions. Therefore the null hypothesis which states thatthere is no significant effect of Cognitive Restructuring on Fear of Social Interactions among secondary school students is rejected.

Hypothesis Two: The null hypothesis statesthat there is no significant effect of Social Skills Training on Fear of Social Interactions among secondary school students in Kaduna Metropolis, Nigeria. Result of the analysis is presented in table 4.5

Table 4.5: Paired sample t test on the effect of Social Skills Training on Fear of Social Interactions

Variable	Tests	N	Mean	SD	Df	t cal	P
Fear scores	Pre-test	20	12.5500	1.637	19	5.771	0.000
	Post-test	20	8.8500	1.814			

P< 0.05, t computed > 1.96 at df 19

Results of the Paired sample t-test statistics in table 4.5 showed that Social Skills Training has significant effect on Fear of Social Interactions (t = 5.771, p = 0.000). The mean score of the participants on Fear of Social Interactions before exposure to Social Skills Training was 12.550 and it was reduced to 8.800 after exposure to the treatment of Social Skills Training, implying a mean reduced difference of 3.750 in favour of the post-test scores.This showsthat Social Skills Traininghas positive effect on Fear of Social Interactions. Therefore the null hypothesis which states thatthere is no significant effect of Social Skills Training on Fear of Social Interactions among secondary school students is rejected.

Hypothesis Three: The null hypothesis states that there is no significant effect of Cognitive Restructuring on Physiological Manifestations of Social Interactions among secondary school students in Kaduna Metropolis, Nigeria. Result of the analysis is presented in table 4.6

Table 4.6: paired sample t-test on the effect of Cognitive Restructuring on Physiological manifestations of social phobia

Variable	Tests	N	Mean	SD	Df	t-cal	P
Physiological manifestationscores	Pre-test	20	9.950	1.431	19	3.414	0.003
	Post-test	20	8.250	1.888			

P< 0.05, t computed > 1.96 at df 19

Results of the Paired sample t-test statistics in table 4.6 showed thatCognitive Restructuring has significant effect on Physiological Manifestations of Social Phobia (t = 5.414, p = 0.003).The mean scoreof the participants on Physiological Manifestations of Social Phobia before exposure to the treatment was 9.950 andit was reduced to 8.250 after exposure to the treatment of Cognitive Restructuring, implying a mean reduced difference of 1.700 in favour of the post-test scores.This shows that the Cognitive Restructuring has positive effect on Physiological Manifestations of Social Phobia. Therefore the null hypothesis which states thatthere is no significant effect of Cognitive Restructuring on Physiological Manifestations of Social Phobiaamong secondary school studentsis rejected.

HypothesisFour: The null hypothesis statesthat there is no significant effect of Social Skills Training on Physiological Manifestations of Social Phobiaamong secondary

school students in Kaduna Metropolis, Nigeria. Result of the analysis is presented in table 4.7

Table 4.7: paired sample t-test on the effect of Social Skills Training on Physiological Manifestations of social phobia

Variable	Tests	N	Mean	SD	df	t-cal	P
Physiological Manifestation scores	Pre-test	20	9.800	2.330	19	6.114	0.000
	Post-test	20	5.400	2.112			

P< 0.05, t computed > 1.96 at df 19

Results of the Paired sample t-test statistics in table 4.7 showed that Social Skills Training has significant effect on Physiological Manifestation of Social Phobia (t = 6.114, p = 0.000). The mean score of the participantson Physiological Manifestation of Social Phobiabefore exposure to of Social Skills Training was 9.800 and it was reduced to 5.400 after exposure to the treatment of Social Skills Training, implying a mean reduced difference of 4.400 in favour of the post-test scores,implying that Social Skills Training has positive effect on Physiological Manifestation of Social Phobia. Therefore the null hypothesis which states thatthere is no significant effect of Social Skills Training on Physiological Manifestation of Social Phobiaamong secondary school studentsis rejected.

HypothesisFive: The null hypothesis states that there is no significant effect of Cognitive Restructuring onSocial InteractionsAvoidance among secondary school students in Kaduna Metropolis, Nigeria. Result of the analysis is presented in table 4.8

Table 4.8: paired sample t-test on the effect of Cognitive Restructuring on social interactionsavoidance

Variable	Tests	N	Mean	SD	Df	t-cal	P
Social Avoidance Scores	Pre-test	20	13.650	1.424	19	5.451	0.000
	Post-test	20	10.600	1.902			

P< 0.05, t computed > 1.96 at df 19

Results of the Paired sample t-test statistics in table 4.8 showed thatCognitive Restructuring has significant effect on Social Interactions Avoidance (t = 5.451, p = 0.000). The mean score of the participantson Social Interactions Avoidance before exposure to the treatment was 13.650 and it was reduced to 10.600 after exposure to the treatment of Cognitive Restructuring, implying a mean reduced difference of 3.500 in favour of the post test scores.This shows that the Cognitive Restructuring has positive effect on their Social InteractionsAvoidance. Therefore the null hypothesis which states thatthere is no significant effect of Cognitive Restructuring onSocial Interactions Avoidance among secondary school students in Kaduna Metropolis, Nigeria, is rejected.

Hypothesis Six: The null hypothesis states that there is no significant effect of Social Skills Training on Avoidance of social interactions among secondary school students in Kaduna Metropolis, Nigeria. Result of the analysis is presented in table 4.9

Table 4.9: paired sample t test on the effect of Social Skills Training on Avoidancesocial interactions.

Variable	Tests	N	Mean	SD	df	t-cal	P
Social Avoidance scores	Pre-test	20	15.250	1.371	19	10.102	0.000
	Post-test	20	10.650	2.007			

P< 0.05, t computed > 1.96 at df 19

Results of the Paired sample t-test statistics in table 4.9 showed that Social Skills Training has significant effect on Social Interactions Avoidance (t = 10.102, p = 0.000).

The mean score of the participantsonSocial Interactions Avoidance before exposure to the Social Skills Training was 15.250 and it was reduced to 10.650 after exposure to the treatment of Social Skills Training,implying a mean reduced difference of 4.600 in favour of the post-test scores.This shows that Social Skills Training has positive effect on Social InteractionsAvoidance. Therefore the null hypothesis which states thatthere is no significant effect of Social Skills Training on Social Interactions Avoidanceamong secondary school students in Kaduna Metropolis, Nigeria, is rejected.

Hypothesis Seven: The null hypothesis statesthat there is no significant differential effect of Cognitive Restructuring and Social Skills Training on Social Phobia among secondary school students in Kaduna Metropolis, Nigeria. Result of the analysis is presented in table 4.10

Table 4.10: Independent t-test on differential effect of Cognitive Restructuring and Social Skills Training on Social Phobia.

Variable	Study Groups	N	Mean	SD	Df	t-cal	P
Social Phobia Scores	CR	20	28.300	3.540	38	2.733	0.009
	SST	20	24.940	4.290			

P< 0.05, t computed > 1.96 at df 38

Results of the Independent sample t-test statistics in table 4.10 was obtained by comparing the post-test result of the Cognitive Restructuring and Social Skills Training groupsand it showed that significant differential effect existsbetween Cognitive Restructuring and Social Skills Training on Social Phobia ($t = 2.733$, $p = 0.009$). Their mean scores on Social Phobia for Cognitive Restructuring (CR) was 28.300 and Social Skills Training was 24.940 , implying a mean difference of 3.400 in favour

of Social Skills Training.This shows that Social Skills Training has more effect than Cognitive Restructuring on social Phobia. Therefore the null hypothesis which states thatthere is no significant differential effect of Cognitive Restructuring and Social Skills Training on Social Phobia among secondary school students in Kaduna Metropolis, Nigeria, is rejected

4.3 Summary of findings

The major findings of the study are as follow:

1. The mean scores of the participants on Fear before exposure to the treatment was 11.700 and reduced to 9.450 after exposure to the treatment of Cognitive Restructuring. Implying a mean reduced difference of 2.250 in favour of the post-test score. Therefore, Cognitive Restructuring has significant effect on Fear of Social Interactions among secondary school students in Kaduna Metropolis, Nigeria.
2. The mean scores of the participants on Fear before exposure to Social Skills Training was 12.5500 and reduced to 8.800 after exposure to the treatment of Social Skills Training. Therefore, Social Skills Training has significant effect on Fear of Social Interactions among secondary school students in Kaduna Metropolis, Nigeria.
3. The mean scores of the participants on Physiological Manifestations before exposure to the treatment was 9.950 and reduced to 8.250 after exposure to the treatment of Cognitive Restructuring. Implying a mean reduced difference of 1.700 in favour of the post-test scores. Therefore, Cognitive Restructuring has significant effect on Physiological Manifestations of Social Phobia among secondary school students in Kaduna Metropolis, Nigeria..

4. The meanscores of the participants on Physiological Manifestations before exposure to the treatment of Social Skills Training was 9.800 and reduced to 5.400 after exposure to the treatment of Social Skills Training. Implying that Social Skills Training has positive effect on Physiological Manifestations of Social Phobia. Therefore, Social Skills Training has significant effect on Physiological Manifestations of Social Phobia among secondary school students in Kaduna Metropolis, Nigeria.
5. The mean score of the participants on Social Interactions Avoidance before exposure to the treatment was 13.650 and reduced to 10.600 after exposure to the treatment of Cognitive Restructuring. Implying a mean reduced difference of 3.050 in favour of the post-test scores. Therefore, This shows that the Cognitive Restructuring has positive effect on Social Interactions Avoidance
6. The mean score of the participants on SocialInteractions Avoidance before exposure to the treatment of Social Skills Training was 15.250 and reduced to 10.650 after exposure to the treatment of Social Skills Training. Implying a mean reduced difference of 4.600 in favour of the post-test scores. This shows that Social Skills Training has significant effect on Social Interactions Avoidance among secondary school students in Kaduna Metropolis, Nigeria.
7. The mean score of the participants on Social Phobia for Cognitive Restructuring was 28.300 and that of Social Skills Training was 24.940 . Implying a mean difference of 3.400 in favour of the Social Skills Training. Therefore, Significant differential effect exist between Cognitive Restructuring and Social Skills Training on Social Phobia among secondary school students in Kaduna Metropolis, Nigeria.

4.4 Discussion of findings

The result of this study found out that Cognitive Restructuring (CR) and Social Skills Training (SST) are significantly effective in the treatment of Social Phobia (SP). The analysis of the hypotheses revealed that CR has significant effect on reduction of Social Phobia among secondary school students in Kaduna Metropolis, Nigeria. This is in line with the finding of Shina (2015) who investigated the effect of Cognitive Restructuring and Graded Exposure Technique on school phobia among secondary school students in Kaduna Metropolis, Nigeria. His findings revealed that Students exposed to CR had a significantly reduced school phobia as compared to those in control group. The finding of this study is also in line with the finding of Lawal (2016) who conducted a study in which he examined the effect of Cognitive Restructuring (CR) and Social Skills Training (SST) counselling Techniques on Avoidant Personality Disorder (APD) among Secondary School Students in Kano Metropolis. The results indicated that CR has significant effects in the reduction of APD. It is also in line with the finding of Umaru et at. (2014) were they investigated the effect of Cognitive Restructuring Intervention on Tobacco Smoking among Adolescents in Senior Secondary Schools in Zaria, Kaduna State, Nigeria. Findings of the study indicated that Cognitive Restructuring Intervention Program (CRIP) significantly affects tobacco use cessation.

Furthermore, the finding of this study also agree with the finding of Goldfried, Linehan, and Smith (1978) where they investigated the reduction of test anxiety through cognitive restructuring. Findings show that cognitive restructuring is significantly effective in anxiety reduction. This also agrees with Aeron Becks theory of Cognitive therapy where he maintain that abnormal behaviour is a result of distortion in thinking pattern and when

clients are taught how to identify their distorted thoughtsand challenges and replace them with more rational ones so as to reduce or handle their abnormal behaviour. It has been developed for application in individual, group, couples and family formats, for adults, adolescents and children, in a variety of treatment contexts. The indications for cognitive restructuring are determined by client and therapist, rather than by the nature of the disorder. In this work therefore, CR is proved to be effective in reducing social phobia among secondary school students with the aim of overcoming the disorder.

Another finding of this study reveals that Social Skills Training has significant effect in reducing social phobia among secondary school students in Kaduna Metropolis. The findings of this study is in line with the finding of Beidel, (2014) who examined the impact of social skills training (SST) for the treatment of Social Phobia (SP). They revealed that patients treated with SST show significant reduction of social Phobia. The finding of this study also agrees with that of Lawan (2016) where he conducted a study which examined the effect of Cognitive Restructuring (CR) and Social Skills Training (SST) counselling Techniques on Avoidant Personality Disorder (APD), his findings revealed that SST has effects in the reduction of APD. This finding also relates to Bandura's social learning theory which explains that learning would be exceedingly laborious, not to mention hazardous if people had to rely solely on the effects of their own actions to inform them what to do. Fortunately, most human behaviour is learned observationally through role playing, modelling and imitation which are the core-components of Social skills Training. From observing others, one forms an idea of how new behaviours are performed, and on later occasions, this coded information serves as a guide for action.

This finding is also in line with Skinner's Operant Conditioning Theory. Operant conditioning has been conducted in a scientific manner. Skinner's study of behaviour in rats was conducted under carefully controlled laboratory conditions. It is primarily concerned with observable behaviour, as opposed to internal events like thinking and emotion. The major influence on human behaviour is learning from our environment. In the Skinner study, because food followed a particular behaviour the rats learned to repeat that behaviour, for example, operant conditioning. There is little difference between the learning that takes place in humans and that in other animals. Therefore research in operant conditioning can be carried out on animals as well as on humans. Skinner proposed that the way humans learn behaviour; especially fear or phobia is much the same as the way the rats learned to press a lever. The emphasis laid by Skinner is on how any type of phobia including social phobia is managed in certain ways. The socially phobic is constantly learning new behaviours and to modify such behaviour is possible through the application of various principles of operant conditioning.

The findings also agrees with Pavlov's Classical Conditioning Theory. Pavlov have noted, that classical conditioning occursin three phases—acquisition, extinction, and spontaneous recovery. Acquisition refers to the period during which a response is being learned An individual gradually learns—or acquires—the CR. When the CS (fear or phobia) and UCS (a Harassment or bullying in school) are paired over and over again, the CR (fear or social phobia) increases progressively in strength. In general, the closer in time the pairing of CS and UCS, the faster learning occurs, with about a half second delay typically being the optimal pairing for learning.The extinction

principle can be used to make the client to unlearn undesirable behaviour like social phobia. therapist can utilise extinction by exposing the client to the anxiety provoking stimuli (social interactions) without causing the client the previous stress associated with attending social interactions. Thus the unwarranted response (social phobia) is extinct.Spontaneous recovery in terms of reappearance or reoccurrence of social phobia may happen if andwhen the treatment is not preceded with education or when it is haphazardly used by therapists. Therefore, therapists treating social phobia with SST or CR are advised to give the client good education before embarking on treatment.

The findings of this study also agrees with Beck's Cognitive Theorywhich posits that there are thoughts at the fringe of awareness that occur spontaneously and rapidly, and are an immediate interpretation of any given situation.These are called automatic thoughts and are distinguished from the ordinary flow of thoughts observed in reflective thinking or free association. They are generally accepted as plausible, and their accuracy is taken for granted. Most people are not immediately aware of the presence of automatic thoughts, unless they are trained at monitoring and identifying them. Social phobia clients will learn to follow the necessary steps, such as defining the problem, generating alternative ways of solving it and implementing alternative solutions. A client that fears social interactions and has poor social performance will benefit from role-playingthe feared situation with the therapist to build up inhibited skills and overcome the problem. The therapist acts as a role model so that clients can learn to interact socially. After sufficient role-playing, clients are stimulated to perform in real life situations.

Another finding of this study reveals that significant differential effect existsbetween Cognitive Restructuring and Social Skills Training on Social Phobia among secondary school students. This could be due to the fact that social skills training involves training in social activities which are acquired through observation, imitation and role-playing and the students will perform among themselves frequently. The finding shows that SST is significantly more effective than CR in the treatment of social Phobia among secondary school students. However, this finding contradictsthe finding of Lawal (2016) where he investigated the effect of Cognitive Restructuring and social skills training (SST) counselling Techniques on Avoidant Personality Disorder (APD), his findings revealed that there was no significant differential effect between Cognitive Restructuring and Social Skills Training on Avoidant Personality Disorder, this may be due to the fact that his investigation centred on one dimension of social phobia only which is Avoidant Personality Disorder (APD).

CHAPTER FIVE

Summary, Conclusion and Recommendations

5.1 Introduction

This chapter presents the summary of this work on effect of Cognitive Restructuring and Social Skills Training on Social Phobia among Secondary School Students in Kaduna Metropolis Nigeria. It also presents the conclusion of the work, recommendations and suggestion for further studies.

5.2 Summary of the Study

The major concern of this study is on students with Social Phobia in our schools especially secondary school. Mostschool psychologists and counsellors as observed in this study are not aware about the scourge of the disorder. And the prevalence of the disorder as discovered in this study is alarming and beyond expectation. It is affecting academic, vocational and persono-social life of the students. The two CBT techniques used in this study were found to be effective in the treatment of the disorder. This study was designed to find out the effect of CR and SST on Social Phobia among secondary school students in Kaduna metropolis. Chapter one introduced the basic issues that are considered very vital to the achievement of the objectives of the study as to find out the effect of CR and SST on Social Phobia among secondary school students and whether there is significant difference between the effect of the two techniques. These objectives of the study were developed into research questions, hypothesis and assumption of the study in the chapter.

In chapter two, the work reviewed extensively various areas relevant to the variables of the study. Earlier work of other people who tremendously contributed to this area of

study was reviewed. It was discovered in the literature that Social Phobia emanates in three dimensions: emotional symptoms (fear), physiological manifestations (sweating, palpitation, headaches or nausea), and behavioural symptoms (avoidance of social situations) exhibited by secondary school students. They avoid activities that require social interaction, they also demonstrate intense fear of criticism, disapproval and rejection, and view themselves as inadequate, socially inept, personally unappealing and inferior. The major symptoms of the disorder include: fear of negative evaluation by others, shyness, low self esteem and inept in social interaction. It interferes into the academic and social development of the students which lead to behaviour such as avoiding school work, avoiding school social activities both curricular and extracurricular activities of the school, looping group work and peer assessment. The literature revealed that the causes of Social Phobia are different factors classified into two main categories: environmental and biological factors. The environmental factors include childhood upbringing, warmness of the parents, and people surrounding within and outside the family, types of the family system and religious tolerant. It was noted that individual with the Social Phobia often experience condemnation socially rejected by peers and parents these and many more cause them to learn non complementary skills to social situation, inferiority feeling and fear of rejections. Biologically,it has been shown that there is a great risk of having social phobia if a first-degree relative also has the disorder. This could be due to genetics and/or due to children acquiring social fears and avoidance through processes of observational learning or parental psychosocial education.

In the Literature Review, CR and SST therapeutic techniques which are both CBT were also discussed. Classical conditioning, operant conditioning as well as cognitive social

learning theories were related to the acquisition and treatment of Social Phobia. CR as a CBT involves altering negative automatic thoughts that occur in anxiety provoking situation by replacing them with more rational beliefs. The assumptions here is that thoughts affect human emotion as well as behavior and irrational beliefs are mainly responsible for Social Phobia characteristics such as, fear, physiological manifestations and avoidant behavior. The major goals of the second therapeutic technique as identified in the literature review is teaching the clients about the verbal as well as nonverbal interpersonal behavior involved in social interaction. The assumption here is that person suffering from Social Phobia tend to avoid social situations due to lack of social skills, so by improving their social skills through SST they could be able to mingle with others, attend school work with greater ease and self-confidence. The literature revised many empirical studies conducted on the use of psychotherapy, CR and SST in both group and individual therapy sessions for the treatment of Social Phobia.

In chapter three, the researcher discussed the research design adopted in this research. The design was quasi experimental design which involved pretest post-test design, the population of the study comprised junior secondary school One (JSS.I) student in Kaduna metropolis who demonstrate symptoms of Social Phobia, purposive sampling technique was used to draw a sample of 40 JSS I students in two different Junior secondary schools, 20 students per each school and the sampled students were grouped into two treatment groups. The two groups received treatment in CR and SST. The instrument used for data collection in this study is Social Phobia Inventory (SPIN). In this work t-test and was used for the statistical analysis of the data collected for the study.

In chapter four, results of the data analyzed were presented. Tables were used to display the results of the data which revealed that the seven (7) null hypotheses were rejected. Summary of the basic findings of the study were presented followed by discussion of finding using relevant empirical studies and literature to backup the findings. The agreement and disagreement between the findings and that of other studies were displayed in the form of discussion.

In chapter five, the researcher summarized the content of the research as summary of the study, and also made conclusions that Cognitive Restructuring is effective in the treatment of Social Phobia and that Social Skills Training is also effective in the treatment of Social Phobia. In comparison between the two techniques, it was concluded that Social Skills Training yielded greater effectiveness than Cognitive Restructuring in the treatment of Social Phobia. Recommendations were also made that School Principals, Counsellors, Psychologists and form teachers should be exposed to training in CR in re-addressing students with social phobia. It is also recommended that Seminar, workshop and conferences should be organized by stakeholders in education for psychologists, counsellors, and teachers on how to use CR and SST in reducing social phobia. And finally, suggestions for further studies were made that Effect of Cognitive Restructuring and Social Skills Training on Social Phobia among primary school pupils should be investigated.

5.3 Conclusion

Based on the findings of this study, it was concluded that result of this study has shown that Cognitive Restructuring is effective in reducingsymptoms of Social Phobia (Fear of social interactions, Physiological Manifestations and Avoidance of Social Interactions). This is when the analysis of pre-test and post-test results of secondary school students in Kaduna metropolis, Nigeria exposed to Cognitive Restructuring intervention was conducted.

The result of this study has shown that Social Skills Training is effective in reducingsymptoms of Social Phobia(Fearof social interactions, Physiological Manifestations And Avoidance Of Social Interactions). This is when the analysis of pre-test and post-test results of secondary school students in Kaduna metropolis, Nigeria exposed to Social Skills Training intervention was conducted. In comparison between the effect of the two techniques Cognitive Restructuring and Social Skills Training, it has been concluded that there is differential effect among them, SST has a greater effect than Cognitive Restructuring, and that both the two techniques are effective in the treatment of Social Phobia among secondary school students.

5.4 Recommendations

Base on the findings of this study, the following recommendations1were made:

1. Educational psychologists and counsellors should be encouraged to use cognitive restructuring in handling social phobia.
2. Educational psychologists and counsellors should be encouraged to use social skills training in handling social phobia.

3. Educational psychologists and counsellors should shouldsensitise educators, para-psychologists, social workers and school heads/principals in the use of cognitive restructuring in addressing social phobia mainly those suffering from mild to moderate.
4. Educational psychologists and counsellors should shouldsensitise educators, para-psychologists, social workers and school heads/principals in the use of social skills training in addressing social phobia mainly those suffering from mild to moderate.

5.5Suggestions for further studies

1. The focus of this study was directed at investigating the effect of CR and SST in reducing SP among secondary school students in Kaduna metropolis. Therefore, further studies should investigate the effect of Cognitive Restructuring and Social Skills Training on Social Phobia among primary school pupils and on tertiary institutions' students.
2. This study did not examine whether group or individual session with CR or SST is significantly different. Therefore a further study is being recommended to examine the differential effectiveness of group and individual treatment sessions of CR or SST in the treatment of Social Phobia
3. Few literature attempted to discuss the causes and prevalence of Social Phobia, therefore survey studies are recommended to evaluate some variables like parental style, parental background, ethnicity, marital status, Culture and other personality variables, to find out the causes of Social Phobia for prevention which is better than care.

5.6 Contribution to Knowledge

This study established that

i. Cognitive Restructuring is effective in reducingsymptoms of Social Phobia such as Fear of social interactions, Physiological Manifestations and Avoidance of Social Interactions).

ii. Social Skills Training is effective in the reduction of symptoms of Social Phobia such as Fear of social interactions, Physiological Manifestations and Avoidance of Social Interactions.

iii. In comparison between the effect of the two techniques, it has been established that there is differential effect among them, that Social Skills Training has a higher effect than Cognitive Restructuring.

References

Acarturk, C.; De Graaf, R.; Van Straten, A.; Have, M. T.; Cuijpers, P. (2018). "Social phobia and number of social fears, and their association with comorbidity, health-related quality of life and help seeking".*Social Psychiatry and Psychiatric Epidemiology* . 43 (4): 273–9. doi :10.1007/s00127-008-0309-1 .

Alden L. (2012). Short-term structured treatment for avoidant personality disorder. Journal of Clinical Psychology. 57:756–764 Journal of Consulting and Clinical Psychology, Vol 57(6), Dec 1989, 756- 764

Alexi A., Christopher D., Annie J. &Lejuez P. (2010). Empirically supported treatments for specific phobia in children: Do efficacious treatments address the components of a phobic response? *Clinical Psychology-Science and Practice,12,*144-160.

American Psychiatric Association.(2013). Diagnostic and statistical manual of mental disorders.(5thEdition). Washington, DC: Author

Asonibare, B. (2014). *Modifying maladaptive behaviour in schools*. In A. I. Idowu (Ed.), Guidance and counselling in education (205-226) Ilorin: Indemac Publication.

Bandura, A. (1965). Vicarious processes: *A case of no-trial learning*. In L. Berkowitz (Ed).*Advances in experimental social psychology*.Vol. 2. New York: Academic Press.

Baumeister R, Leary M (2015). "The need to belong: desire for interpersonal attachments as a fundamental human motivation". Psychol Bull. 117 (3): 497–529. doi : 10.1037/0033-2909.117.3.497 .PMID 7777651 .

Beck, A.T. (1984).*Cognitive therapy, behaviour therapy, psychoanalysis, and pharmacotherapy: A cognitive continuum.* In J. B. W. Williams & R. L Spitzer (Eds.), *Psychotherapy research: Where are we and where should we go?* New York: Guilford.

Beck, A.T., & Rector, N.A. (2005). Cognitive approaches to schizophrenia: Theory and therapy. *Annu Rev Clin Psychol*., *1*, 577-606.

Beesdo, K.; Bittner, A.; Pine, D. S.; Stein, M. B.; Höfler, M.; Lieb, R.; Wittchen, H. U. (2017). "Incidence of Social Anxiety Disorder and the Consistent Risk for Secondary Depression in the First Three Decades of Life".*Archives of General Psychiatry 64 (8): 903–912*.doi :10.1001/archpsyc.64.8.903 . PMID 17679635 .

Beidel, D.C., & Turner, S.M. (2015).*Shy children, phobic adults: The nature and treatment of social phobia*. American Psychological Association Books.

Beidel D. C., Rao P. A., &Murray M., J. (2014) Social skills interventions for children with Asperger's syndrome or high-functioning autism: A review and recommendations.*Journal of Autism and Developmental Disorders.; 38(2): 353-61*.

Beidel, D., C., (2014) The impact of social skills training for social anxiety disorder: A randomized controlled trial. *Journal of Anxiety Disorders 28 908–918*

Bella, T.,T.; &Omigbodun O., (2009) Social Phobia in Nigerian university students: Prevalence, Correlates and Co-mobidity. *Social Psychiatry. 44, 458-463.* doi:10.1007/s00127-008-0457-3.

Bernstein, G., Borchardt, C., Perwien, A., Crosby, R., Kushner, M.,&Thuras, P., (2014). Imipramine plus cognitive-behavioural therapy in the treatment of school refusal.*Journal of the American Academy of Child & Adolescent Psychiatry*, *39*(3), 276-283.

Bolsoni-Silva, A., T., & Loureiro S., R., (2014), The Role of Social Skills in Social Anxiety of University StudentsPaidéia Vol. 24, No. 58, 223-232. doi: 10.1590/1982-43272458201410

Burns, D. D. (1999). Feeling Good: The New Mood Therapy. Avon Books: New York.

Butler, A.C., Chapman, J.E., Foreman, E.M., & Beck, A.T.(2006) The empirical status of cognitive-behavioural therapy: A review of meta-analyses. *Clin Psychol Rev., 26* (1), 17-31.

Carbonel, D. (2014). Exposure therapy for fears and school phobias.Retrieved on 6th May, 2014 from anxietycoach.com.

Carleson, P. (2008). *Learning about automatic thoughts and cognitive distortions*. Retrieved on 4th May, 2014 fromwww.articlesbase.com

Chris, S. & Terry, K. (2015). "Social skills deficits among the socially anxious: Rejection from others and loneliness" .*Motivation and Emotion* . 19 (1): 1–24. doi :10.1007/BF02260670 .

Clark, D. A., & Wells, A. (2002).A cognitive model of social phobia. In R. Heimberg, M.Liebowitz, D.A. Hope,&E.R. Scheier (Eds.), *Social phobia: Diagnosis, assessment and treatment*(pp. 69–93). New York: Guilford Press.

Clark, D. A., Beck, A. T., & Brown, G. K. (1992). Sociotropy, autonomy and life event perceptions in dysphoric and nondysphoricindividuals.*CognitTher Res., 16,* 635-52.

Connor, K.M. (2000) Psychometric Properties of the Social Phobia Inventory *Br. J. Psych.; 176: 379-386.*

Cuncic, A. (2014). *What is cognitive restructuring?* Retrieved on 5/4/2014 from socialauxietydisorder.about.com

Diana, R. (2013). Cognitive Restructuring: What is it. Medically reviewed by Lindsey Marcellin, M. D. retrieved from http:www.everydayhealth.com.

Deacon, B. J.; Fawzy, T. I.; Lickel, J. J. and Wolitzky-Taylor, K. B. (2011). Cognitive Diffusion versus Cognitive Restructuring in the Treatment of Negative Self-Referential Thoughts: An Investigation of Process and Outcome: Journal of Cognitive Psychotherapy, Volume 25, No 3, 2011, pp. 218-232 (15). Springer Publishing Company.

DiGiuseppe, R., McGowan, L., Sutton-Simon, K., & Gardner, F. (1990).A comparative outcomestudy of four cognitive therapies in the treatment of social anxiety.*Journal of Rational-Emotiveand Cognitive-Behaviour Therapy*, **8**, 129–146.

Ellis, A. (1962). *Reason and emotion in psychotherapy*. New York: Stuart.

Emslie, G. J. (2018). Pediatric anxiety: Under-recognizedand undertreated. *Th e New England Journal of Medicine,359,* 2835.

Emmelkamp, P.M.G., Mersch, P.P., Vissia, E., & van de Helm, M. (1985). Social phobia: a comparativeevaluation of cognitive and behavioural interventions. *Behaviour Research and Therapy*, **23**,365–369.

Erk, R. R. (2014). *Counselingtreatment for children and adolescents with DSM-IV-TR disorders.*New Jersey: Pearson.

Ford-Martins, P. (2014). *Cognitive therapy: Purpose, treatment, techniques, preparation, and typical result*. Retrieved on 16th June, 2014 from http://psychology.jrank.org

Frojan-Parga, M. X., Calero-Elvira, A. & Montano-Fidalgo, M. (2009). Analysis of the Therapist's Verbal Behavior during Cognitive Restructuring Debates: a case study. Psychotherapy Research, 19: 30-41.

Goldfried, M. R., Linehan, M. M., & Smith, J.L. (2008).Reduction of test anxiety through cognitive restructuring.*Journal of Consulting and Clinical Psychology, 46*(1), 32-39.

Heimberg, R.G., Liebowitz, M., Hope, D.A., Schneier, F.R., Holt, C.S.,Welkowitz, L.A., Juster, H.R.,Campeas, R., Bruch, M.A., Cloitre, M., Fallon, B., & Klein, D.F. (1998). Cognitive behaviouralgroup therapy vs phenelzine therapy for social phobia.*Archives of General Psychiatry*, **55**,1133–1141.

Heimberg RG, Stein MB, Hiripi E, &Kessler RC (2015). "Trends in the prevalence of social phobia in the United States: a synthetic cohort analysis of changes over four decades" . Eur. Psychiatry . 15 (1): 29–37. doi : 10.1016/S0924-9338(00)00213-3 .PMID 10713800 .

Hope, D.A., Burns, J.A., Hyes, S.A., Herbert, J.D., & Warner, M. D. (2010). Automatic thoughts and cognitive restructuring in cognitive behavioural group therapy for social anxiety disorder. *Cognitive Therapy Research, 34,* 1-2.

Inam, A., Mahjabeen A., &Abiodullah M., (2017) Causes of Social Anxiety among Elementary Grade Children Bulletin of Education and Research, Vol. 39, No. 2 pp. 31-42

Jung A. &Steil F. (2014). "Shyness: Anxious social sensitivity and self-isolating tendency". Adolescence . 19 (76): 903–911. PMID 6516936 .

Kaduna State Ministry of Education (2017).*The annual school census.* Kaduna State: Ministry of Education.

Kavale, K. A., & Mostert, M. P. (2014).Social skills interventions for individuals with Learning Disability Quarterly, 27 (1), 31 -43.

Kendler K, Karkowski L, &Prescott C (2013). "Fears and phobias: reliability and heritability". PsychologyMed . 29 (3): 539–53. doi : 10.1017/S0033291799008429 .PMID 10405076 .

Lawan, M., (2016) Effects of Cognitive Restructuring and Social Skills Training Counselling Techniques on Avoidant Personality Disorder Among Secondary School Students in Kano Metropolis. Unpublished PhD Thesis submitted to Post-Graduate School of Ahmadu Bello University (A B U) Zaria.

La Greca A, Dandes S, Wick P, Shaw K, &Stone W (2013). "Development of the social anxiety scale for children: Reliability and concurrent validity". Journal of Clinical Child Psychology .17 : 84–91. doi : 10.1207/s15374424jccp1701_11 .

MacLeod, A. K. (2014). Approachand avoidance goals and plans: Their relationship to anxietyand depression. *Cognitive Therapy and Research, 28,*415-43

Matos, M. G., Tome, G., Borges, A.I., Manso, D., Ferreira,P., & Ferreira, A. (2008). Anxiety, depression, andcoping strategies: Improving the evaluation and understandingof these dimensions during pre-adolescence andadolescence. *Journal of Cognitive and Behavioural Psychotherapies8,* 169¬-184.

Merikangas, AvenevoliS., Dierker L., &Grillon C. (2014). "Vulnerability factors among children at risk for anxiety disorders". BiolPsychiatry . 46 (11): 1523–1535. doi :10.1016/S0006-3223(99)00172-9 .PMID 10599480 .

Mineka S,&Zinbarg R (2015) Conditioning and ethological models of social phobia. In: Heimberg R, Liebowitz M, Hope D, Schneier F, (editors). Social Phobia: Diagnosis, Assessment, and Treatment. New York: The Guilford Press, 134–162

National Institute of Mental Health.(2014). *Social anxiety disorder*. Bethesda, MD: Author.http://www.nimh.nih.gov/health/topics/anxiety-disorders/index.shtml

Nevid, J. S. (2013). Psychology: Concepts and Applications. Belmont, CA: Wadsworth.

Nowicki, E. A. (2013). A meta-analysis of the social competence of children with learning disabilities compared to classmates of low and average to high achievement. Learning.*Disability Quarterly, 26 (3), 171-188.*

Okano K (2014). "Shame and social phobia: a transcultural viewpoint". *Bull Menninger Clinical Research Jounal*. 58 (3): 323–38.

Pull, C.B. (2007). Combined Pharmacotherapy and Cognitive- Behavioural Therapy for Anxiety Disorders. *Current Opinion in Psychiatry,* 20, 30–35.

Rapee R., M.,& Lim L. (2012). "Discrepancy between self- and observer ratings of performance in social phobics" . Journal AbnormalPsychology . 101 (4): 728–31. doi : 10.1037/0021-843X.101.4.728 . PMID 1430614 .

Rubin K., H.,& Mills R., S., (1988). "The many faces of social isolation in childhood" . *Journal of Consult. Clin. Psychol. 56 (6): 916–24.* doi : 10.1037/0022-006X.56.6.916. PMID 3204203 .

Rowa K., & Antony M. M., (2015) Psychological Treatments for Social Phobia. *The Canadian Journal of Psychiatry50:308–316)*

Schneier, F., (2016). "Social Anxiety Disorder".*The New England Journal of Medicine .355 : 1029–1036.* doi : 10.1056/nejmcp060145 .PMID 16957148 .

Schwartz C, Snidman N, &Kagan J (2012). "Adolescent social anxiety as an outcome of inhibited temperament in childhood". J Am Acad Child AdolescPsychiatry . 38 (8): 1008–1015.

Shina, A. M. (2015) Effect of Cognitive Restructuring and Graded Exposure Counselling Techniques on School Phobia among Secondary School Students in Kaduna Metropolis Unpublished PhD Thesis submitted to Post-Graduate School of Ahmadu Bello University (A B U) Zaria.

Spence SH, Donovan C, &Brechman-Toussaint M (2014). "Social skills, social outcomes, and cognitive features of childhood social phobia" .*Journal of Abnormal Psychology . 108 (2): 211–21.*doi : 10.1037/0021-843X.108.2.211 .PMID 10369031.

Stein, M. B.; Fuetsch, M.; Müller, N.; Höfler, M.; Lieb, R.; &Wittchen, H. U. (2011). "Social Anxiety Disorder and the Risk of Depression: A Prospective Community Study of Adolescents and Young Adults".*Archives of General Psychiatry . 58 (3): 251–256*.doi : 10.1001/archpsyc.58.3.251 . PMID 11231832 .

Stopa L, & Clark D (2013). "Cognitive processes in social phobia". Behav Res Ther . 31 (3): 255–67. doi : 10.1016/0005-7967(93)90024-O .PMID 8476400 .

Terra M. B., Figueira I, &Barros H., M. (2014). "Impact of alcohol intoxication and withdrawal syndrome on social phobia and panic disorder in alcoholic inpatients" .*Rev HospClinFac Med Sao Paulo . 59 (4): 187–92*.doi : 10.1590/S0041-87812004000400006 . PMID 15361983 .

Umar, Y., Abdullahi, M. I., Oliagba, O., Sambo, S. &Abdulwahid, U. (2014).The effect of cognitive restructuring on tobacco smoking among adolescents in senior secondary schools in Zaria, Kaduna State, Nigeria.European Scientific Journal, 10(5), 327-336.

Wagner, A. P. (2015). *Worried no more: Help and hopefor anxious children* (2nd ed). Rochester, New York: Lighthouse.

Warner, M. C., Colognori, D., Brice, C., & Sanchez, A. (2015) School-based interventions foradolescents with social anxiety disorder. Annette La Greca: Luis-Joaquin

Warren S, Huston L, Egeland B, &Sroufe L (2017). "Child and adolescent anxiety disorders and early attachment". *J Am Acad Child AdolescPsychiatry . 36 (5): 637–644.*

Watson, J., & Rayner, R. (1920). Conditioned emotional reactions. *J. Exp. Psychol., 3*, 1-22.

Wells, A., &Papageorgiou, C. (2001). Brief cognitive therapy of social phobia: A single case series.*Behaviour Research and Therapy*, **6**, 713–720.

Wiener, J. &Timmermanis, V. (2012) *Social relationships of children and youth with learning disabilities*: In Wong, Y.L. and Butler, D. L. (Eds). Learning about Learning Disabilities. Elsevier, pp. 89-140.

Xinyin C, Rubin KH, Boshu L (1995). "Social and school adjustment of shy and aggressive children in China".*Development and Psychopathology.7 : 337–349*.doi : 10.1017/s0954579400006544 .

APPENDIX A

Social Phobia Inventory (SPIN)

Dear Respondent,

This study intended to find out the Effect of Cognitive Therapy and Social Skills Training on Social Phobia among Secondary School Students in Kaduna Metropolis, Kaduna State, Nigeria. The study has been instituted as an Academic study. Please, respond to the following items as objectively as possible. The confidentiality of your responses will be strictly maintained, for that your name is not required.

Thank you in advance.

SECTION 'A'

Gender: Male ☐ Female ☐

Name of School……

Identifier Date

Please indicate how much the following problems have bothered you during the past week. Mark only one box for each problem, and be sure to answer all items.

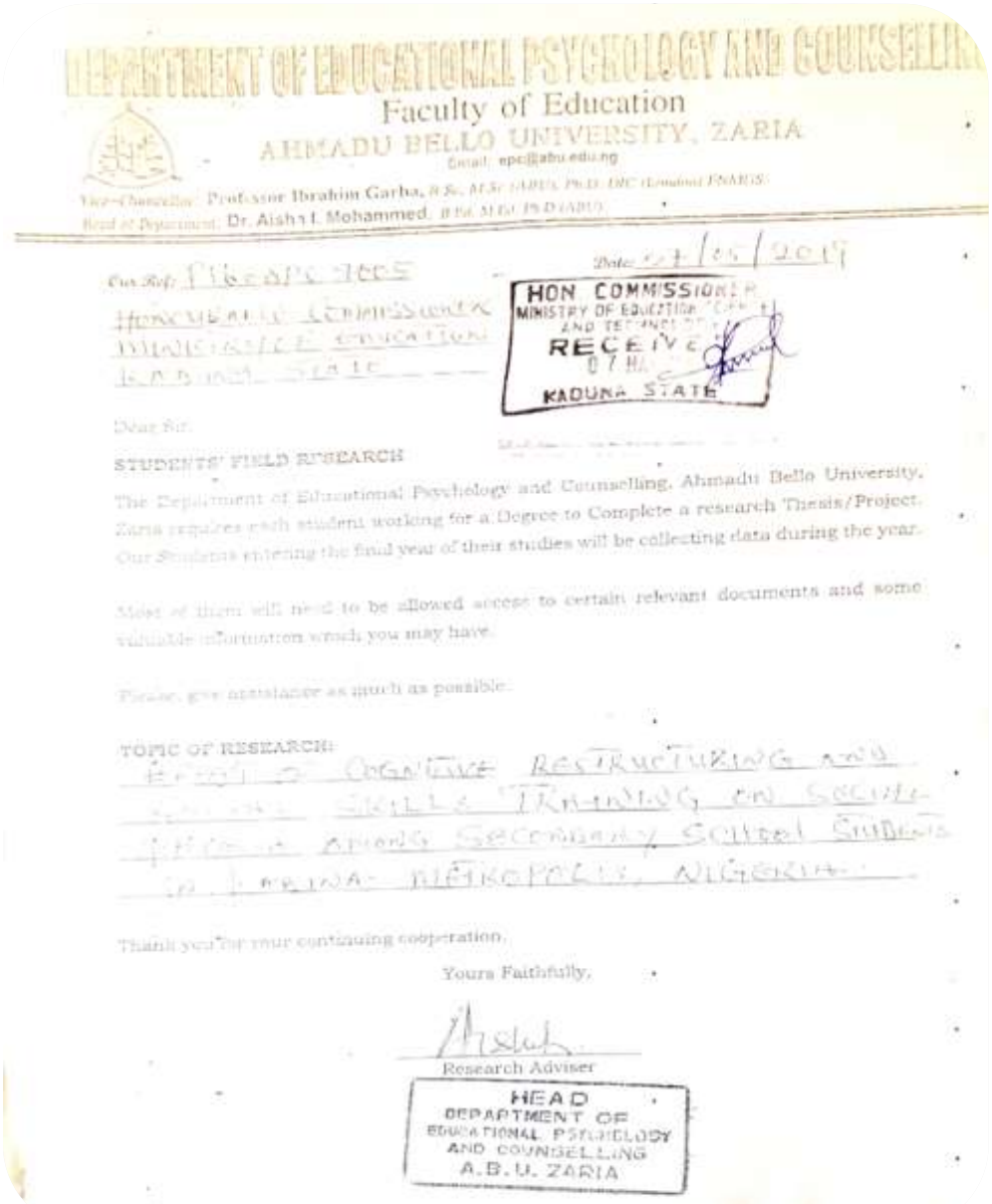
0 = Not at all 1 = A little bit 2 = Somewhat 3 = Very much 4 = Extremely

S/N	STATEMENT	0	1	2	3	4
1	I am afraid of people in authority					
2	I am bothered by sweating in front of people					
3	Social events scare me					
4	I avoid talking to people I don't know					
5	Being criticized scares me a lot					
6	Fear of embarrassment causes me to avoid doing things or speaking to people					
7	Sweating in front of people causes me distress					

8	I avoid going to social events					
9	I avoid activities in which I am the centre of attention					
10	Talking to strangers scares me					
11	I avoid having to give speeches					
12	I would do anything to avoid being criticized					
13	Heart palpitations bother me when I am around people					
14	I am afraid of doing things when people might be watching					
15	Being embarrassed or looking stupid is among my worst fears					
16	I avoid speaking to anyone in authority					
17	Trembling or shaking in front of others is distressing to me					
TOTAL SCORE						
COMMENT						

Source: Connor, K.M. *et al*. (2000) Psychometric Properties of the Social Phobia Inventory.

APPENDIX B



DEPARTMENT OF EDUCATIONAL PSYCHOLOGY AND COUNSELLING

Faculty of Education

AHMADU BELLO UNIVERSITY, ZARIA

Email: epc@abu.edu.ng

Vice-Chancellor: Professor Ibrahim Garba, B.Sc, M.Sc (ABU), Ph.D, DIC (London) FNAEGS

Head of Department: Dr. Aisha I. Mohammed, B.Ed, M.Ed, Ph.D (ABU)

Our Ref: EP&C/APC/1005

Date: 27/05/2019

HONOURABLE COMMISSIONER
MINISTRY OF EDUCATION
KADUNA STATE

HON COMMISSIONER
MINISTRY OF EDUCATION
AND TECHNOLOGY
RECEIVED
07 HA
KADUNA STATE

Dear Sir,

STUDENTS' FIELD RESEARCH

The Department of Educational Psychology and Counselling, Ahmadu Bello University, Zaria requires each student working for a Degree to Complete a research Thesis/Project. Our Students entering the final year of their studies will be collecting data during the year.

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

Please, give assistance as much as possible.

TOPIC OF RESEARCH:

EFFECT OF COGNITIVE RESTRUCTURING AND SOCIAL SKILLS TRAINING ON SOCIAL-ISATION AMONG SECONDARY SCHOOL STUDENTS IN KANO METROPOLIS, NIGERIA.

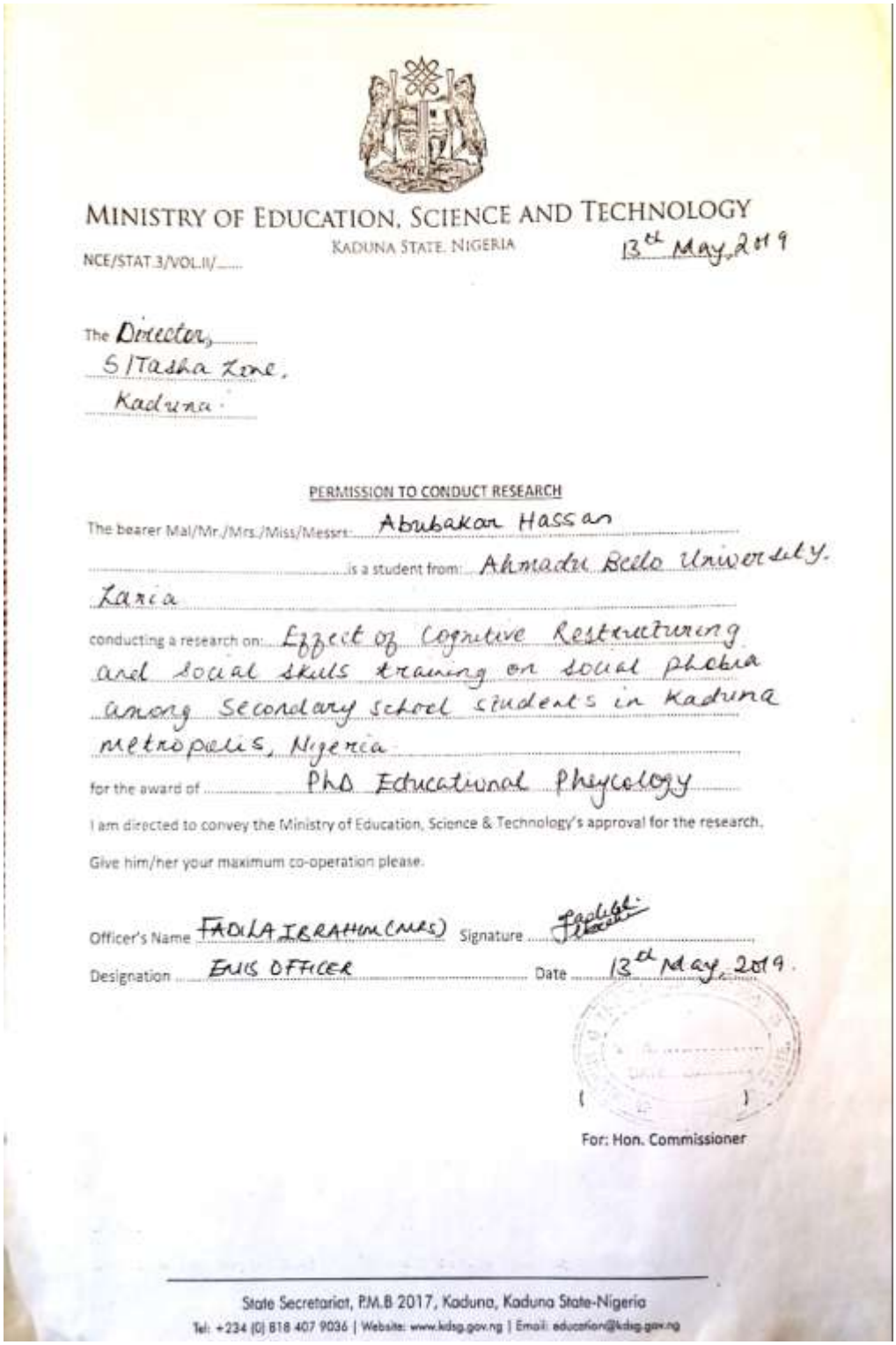
Thank you for your continuing cooperation.

Yours Faithfully,

Research Adviser

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

APPENDIX C



MINISTRY OF EDUCATION, SCIENCE AND TECHNOLOGY
KADUNA STATE, NIGERIA

NCE/STAT.3/VOL.II/.....

13th May, 2019

The Director,
S/Tasha Zone,
Kaduna.

PERMISSION TO CONDUCT RESEARCH

The bearer Mal/Mr./Mrs./Miss/Messrs: Abubakar Hassan
.....is a student from: Ahmadu Bello University.
Zaria
conducting a research on: Effect of Cognitive Restructuring and Social Skills Training on Social Phobia among Secondary School Students in Kaduna metropolis, Nigeria
for the award of PhD Educational Phycology

I am directed to convey the Ministry of Education, Science & Technology's approval for the research.

Give him/her your maximum co-operation please.

Officer's Name FADILA IBRAHIM (MRS) Signature .....
Designation EMIS OFFICER Date 13th May, 2019.

( )
For: Hon. Commissioner

State Secretariat, P.M.B 2017, Kaduna, Kaduna State-Nigeria
Tel: +234 (0) 818 407 9036 | Website: www.kdsg.gov.ng | Email: education@kdsg.gov.ng

APPENDIX D

MINISTRY OF EDUCATION, SCIENCE AND TECHNOLOGY
KADUNA STATE, NIGERIA

NCE/STAT.3/VOL.II/.....

13th May, 2019

The Director,
Zonal Quality Assurance Office
Kaduna

PERMISSION TO CONDUCT RESEARCH

The bearer Mal/Mr./Mrs./Miss/Messrs: Abubakar Hassan
is a student from: Ahmadu Bello University
Zaria, Kaduna:
conducting a research on: Effect of Cognitive Restructuring and Social Skills training on Social phobia among Secondary School Students in Kaduna metropolis, Nigeria
for the award of PhD Educational Phycology

I am directed to convey the Ministry of Education, Science & Technology's approval for the research.

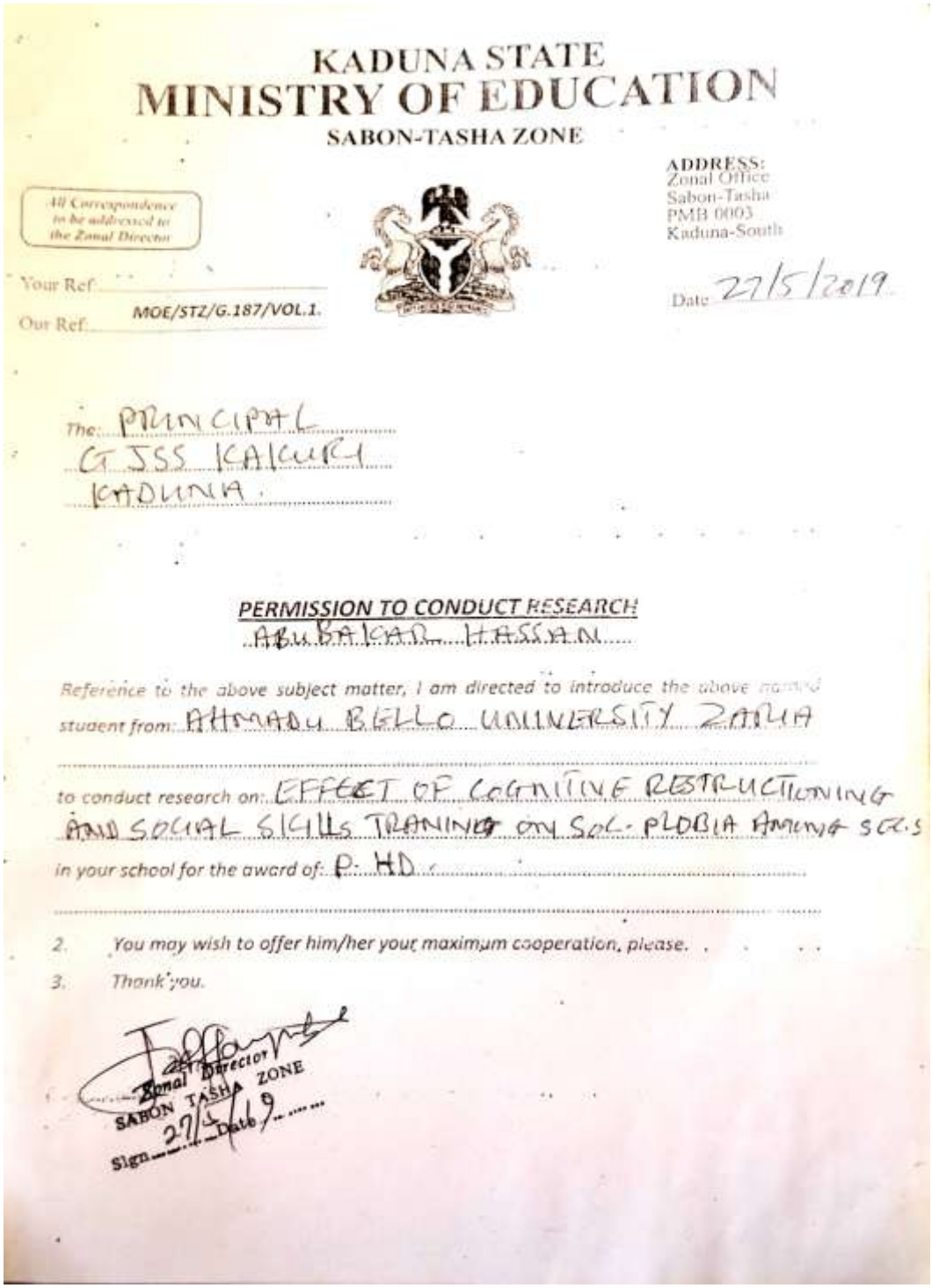
Give him/her your maximum co-operation please.

Officer's Name: FADILA IBRAHIM (MRS) Signature:
Designation: EMIS OFFICER Date: 13th May, 2019

For: Hon. Commissioner

State Secretariat, P.M.B 2017, Kaduna, Kaduna State-Nigeria

APPENDIX E



KADUNA STATE
MINISTRY OF EDUCATION
SABON-TASHA ZONE

All Correspondence to be addressed to the Zonal Director

ADDRESS:
Zonal Office
Sabon-Tasha
PMB 0003
Kaduna-South

Your Ref:
Our Ref: MOE/STZ/G.187/VOL.1.

Date 27/5/2019

The: PRINCIPAL
GJSS KALCURI
KADUNA.

PERMISSION TO CONDUCT RESEARCH
ABUBAKAR HASSAN

Reference to the above subject matter, I am directed to introduce the above named student from: AHMADU BELLO UNIVERSITY ZARIA

to conduct research on: EFFECT OF COGNITIVE RESTRUCTURING AND SOCIAL SKILLS TRAINING ON SOC-PHOBIA AMONG SCC.S

in your school for the award of: P. HD.

2. You may wish to offer him/her your maximum cooperation, please.
3. Thank'you.

Zonal Director
SABON TASHA ZONE
Sign 27/5 Date 9

APPENDIX F

EXPERIMENTAL GROUP1: COGNITIVE THERAPY SESSIONS

Session one

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

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

iii) Establish a therapeutic relationship with the clients

Step I: The therapist introduces self to the clients

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

Step III: The therapist explains to the clients the therapist's responsibilities while the therapeutic sessions last

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

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

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

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

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

EXPERRIMENTAL GROUP 1: COGNITIVE THERAPY SESSIONS

Session Two

Objectives:

1. To properly explain to the clients what social phobia is.
2. To introduce to the clients what the treatment can do to change behaviour;
3. To introduce cognitive therapy technique to the client.

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

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

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

IV. The therapist also explains to the students their own responsibilities e.g. punctuality, follow therapist'sinstructions, indicate when an event makes you fear, and indicate when fear reduces or disappears and so on.

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

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

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

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

IX. The therapistgives the students home work which will form part of the session to come.

EXPERIMENTAL GROUP 1: COGNITIVE THERAPY SESSIONS

Session Three

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

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

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

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

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

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

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

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

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

EXPERIMENTAL GROUP 1: COGNITIVE THERAPY SESSIONS

Session Four

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

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

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

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

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

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

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

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

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

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

EXPERIMENTAL GROUP I: COGNITIVE THERAPY SESSIONS

Session Five

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

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

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

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

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

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

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

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

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

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

EXPERIMENTAL GROUP I: COGNITIVE RESTRUCURING COUNSELLING SESSIONS

Session Six

Objectives:

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

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

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

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

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

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

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

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

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

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

EXPERIMENTAL GROUP I: COGNITIVE THERAPY SESSIONS

Session Seven

Objectives:

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

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

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

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

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

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

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

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

EXPERIMENTAL GROUP 1: COGNITIVE THERAPYSESSIONS

Session Eight

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

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

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

Step I Thecoun therapist welcomes the clients to another session.

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

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

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

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

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

VII Lets the students ask questions or make further comments.

VIII Session comes to an end.

EXPERIMENTAL GROUP 1: COGNITIVE THERAPYSESSIONS

Session Nine

Objective: I) Replacement negative thought with desirable behaviour.

II) Modelling desirable behaviour

III) Systematic reinforcing desirable behaviour

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

ii) The therapist appreciates the collaborative efforts they had throughout the weeks of the therapeutic process

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

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

v) Modelling of desirable behaviour to clients.

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

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

viii) Session comes to an end.

EXPERIMENTAL GROUP 1: COGNITIVE THERAPYSESSIONS

Session Ten

Objective: I) Continuation of modelling of desirable behaviour.

II) Systematic positive reinforcement of desirable behaviour continues.

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

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

ii) The therapist appreciates the collaborative efforts they had throughout the weeks of the therapeutic process.

Step ii) therapist models desirable behaviour.

Step iii) therapist leads students to model desirable behaviour.

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

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

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

Step vii) Session comes to an end.

EXPERIMENTAL GROUP 1: COGNITIVE RESTRUCTURING THERAPY

SESSIONS

Session Eleven

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

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

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

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

ii) The therapist appreciates the collaborative efforts they had throughout the weeks of the therapeutic process

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

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

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

vii) Session comes to an end.

E**XPERIMENTAL GROUP 1: COGNITIVE THERAPIST SESSIONS**

Session Twelve

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

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

III) To round off therapeutic relationship.

IV) To administer the posttest on the students.

Step i) A short drama is staged on modeling desirable behaviour against social phobia

Step ii) Therapist treat comments and questions of students.

Step iii) Therapist appreciate the collaborative efforts of the students.

Step iv) Therapist informs and administers SPIN to the students.

Step v) The therapist informs the students about the end of the treatment.

APPENDIX G

EXPERIMENTAL GROUP II: SOCIAL SKILLS TRAINING SESSIONS

Session one

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

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

iii) Establish a therapeutic relationship with the clients

Step I: The therapist introduces his self to the clients.

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

Step III: The therapist explains to the client the therapist's responsibilities while the therapy sessions last.

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

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

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

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

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

EXPERRIMENTAL GROUP II: SOCIAL SKILLS TRAINING SESSIONS

Session Two

Objectives:

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

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

iii) To introduce social skills training to the client.

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

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

Step III: The therapist explains to the students the therapist's responsibilities while therapist sessions last.

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

Step V: The therapistthen explains to the students the importance of adopting a collaborative relationship for the success of the sessions.

Step VI: The therapist then asks the studenst to respond to these points by accepting the commencement of the process or otherwise;

Step VII: The therapist then explains to the students what social skills training is and how it can be used to minimize social phobia.

Step VIII: The goals to the treatment will then be set collectively between the therapist and the students.

Step IX: The therapist gives the students home work which will form part of the session to come. They are to list ten social phobias e.g. List some reasons why you think students may have social phobia.

Step X: The therapist informs students that we have come to the end of the session.

EXPERMENTAL GROUP II: SOCIAL SKILLS TRAINING SESSIONS

Session Three:

Objectives

I) Introduce the client to the concept of social phobia

II) Identify the events that precipitate social phobia to the client.

III) Guide the clients in arranging the social phobia provoking event according to its intensity in the individual.

Step I: The therapist will welcome the clients as usual, into another stage of the social skills training process, called Social phobia concept. Details of what it means will be explained to clients after brief discussion on the homework.

Step II: The therapist then explains to the clients what social phobia is, and its position in the social skills training concept.

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

Step IV: The therapist and students will use the homework submitted for a sample of a social phobia.

Step V: The therapist presents various social phobic events or situations and discuss them with the students.

Step VI: The clients will then be asked to mention related events or situations that make them sometimes fear, physiological arousal or avoid school.

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

* Making a speech in front of the school general assembly.
* Standing and making a speech in front of the school general assembly.
* Entering the principal's office
*. Standing and making a presentation in front of the class facing other students.
*. To approach and talk teachers in school.
* To be asked to answer a question in the class
* To ask a question during lesson in the class.
*To enter the classroom or hall filled up with students.
* To talk to students of opposite sex in the school
*To talk to students am not familier with before
* To stay in the mist of students am not familier with.
* And other related social phobic situations as may be mentioned by the students.

Step VIII: The therapist gives clients homework to rate their social phobia according to their intensity.

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

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

EXPERIMENTAL GROUP II: SOCIAL SKILLS TRAINING SESSIONS

Session Four

Objective:

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

ii. To explain to the client the importance of social phobia hierarchy in social skills training

iii. To introduce to the client, the concept of basic social skills.

iv. To exemplify some of the basic skills mentioned;

Step 1: The therapist welcomes the clients to another stage in the therapeutic process

Step ii: The therapist asks the clients to explain what they understand by basic social skills.

Step iii: The therapist gives more explanation of basic social skills.

Step iv: The therapist examplifies and models some basic social skills

Step v: The clients are then asked to role play the skills discussed.

Step vi: The clients are then given a homework to list the events that makes them fear school.

Step vii: The clients are given the opportunity to ask any questions relevant to what has been discussed

Step viii: The clients are given home work to mention as many basic skills as possible. They are to present the list in the next session

Step ix: Therapist informs students about the coming to an end of that session.

EXPERIMENTAL GROUP II: SOCIAL SKILLS TRAINING SESSIONS

Session Five

Objective:

I) To introduce students to the concept and processes in conversation skills.

II) To introduce students to the skills of self expression or expression of feelings

III) To introduce students to the skills that keep conversation on

Step I: The therapist welcomes students back to another therapeutic session.

Step II: The therapist reviews the last session with the students with the homework

Step III: The students are reminded of the basic social skills discussed during last session. Therapist informs the students to signify by raising their left hand up if they are now able to put into practice the skills they are exposed to and reinforce them for that

Step IV: The therapist informs the students of the commencement of another set of skills: starting a conversation skills.

Step V: The therapist informs the students of the skills of self expression

Step VI: The therapist demonstrate to the students the skills of self expression through modelling.

Step VII: The therapist ask the students to role model the skillare discussed.

Step VIII: The clients are given the opportunity to ask any questions relevant to what has been discussed

Step IX: The clients are given home work to mention as many conversation skills as possible. They are to present the list in the next session

Step X: Therapist informs students about the coming to an end of that session.

EXPERIMENTAL GROUP II: SOCIAL SKILLS TRAINING SESSIONS

Session Six

Objective:

I) To continue the process in Social Skillsin the therapeutic sessions.

II) To continue the conversation skills

III) To introduce the students to assertiveness skills

Step: I: The therapist welcomes students back to another therapeutic session.

Step II: The therapist reviews the last session with the students with the homework

Step III: The students are reminded of the conversation skills discussed in the previous session and are asked to signify by raising their hand up if they can put into practice the skills learned when they are mending situations.

Step IV: The therapist informs the students of the commencement of assertiveness skills training

Step V: The therapist explains with examples and demonstration the assertiveness skills.

Step VI: The therapist ask the students to role model the skills discussed.

Step VII: The clients are given the opportunity to ask any questions relevant to what has been discussed

Step VIII: The clients are given home work to mention as many assertiveness skills as possible. They are to present the list in the next session

Step IX: Therapist informs students about the coming to an end of that session.

EXPERIMENTAL GROUP II: SOCIAL SKILLS TRAINING SESSIONS

Session Seven

Objective

i. to review the achievement recorded in the last session:

ii. to review the effects the client is beginning to feel on his social phobia

iii. to continue with the social skills training on the social phobia provoking events.

Step i: The therapist welcomes back the clients to another session of the treatment

Step ii: The therapist will request the clients to individually express their feelings about the effects of the treatment on them while reviewing the previous home work.

Step iii: The clients will be informed of the next social skill task known as social perseption skills

Step III: The students are reminded of the assertiveness skills discussed in the previous session and are asked to signify by raising their hand up if they can put into practice the skills learned.

Step IV: The therapist informs the students of the commencement of social perception skills training

Step V: The therapist explains with examples and demonstration the social perception skills.

Step VI: The therapist ask the students to role model the skills discussed.

Step VII: The clients are given the opportunity to ask any questions relevant to what has been discussed

Step VIII: The clients are given home work to mention as many social perception skills as possible.

Step IX: Therapist informs students about the coming to an end of that session.

EXPERIMENTAL GROUP II: SOCIAL SKILLS TRAINING SESSIONS

Session Eight

Objective

I) To recapitulate on the achievement made so far

II) To find out about the feelings of the clients

III) To continue the social skills training.

STEP i) The therapist welcomes the students back to the therapeutic session

STEP ii) The therapist ask students about their feelings on the achievement made so far.

STEP iii) The therapist listens to students' comments while reviewing the home work.

STEP iv) The therapist engages the students on the next higher stage of social phobia in the school i.e. perticipation in class activities

STEP v: The students are reminded of the assertiveness skills discussed in the previous session and are asked to signify by raising their hand up if they can put into practice the skills learned.

STEP vi: The therapist informs the students of the commencement of social perception skills training

STEP vii: The therapist explains with examples and demontration the class perticiption skills.

STEP viii: The therapist ask the students to role model the skills dicussed.

STEP ix: The clients are given the opportunity to ask any questions relevant to what has been discussed possible.

STEP x: Therapist informs students about the coming to an end of that session.

EXPERIMENTAL GROUP II: SOCIAL SKILLS TRAINING SESSIONS

Sessions Nine

Objective:

I) To recapitulating the achievement so far recorded;

II) To assess the feeling of the clients about the session

III) To continue with the treatment procedure.

Step i: The clients will be welcomed back into another session in the treatment

Step ii: The clients will be requested to give account of the effects of the treatment far felt in their social phobia

Step iii: The clients will be guided to enter a full class when a teacher is there make a presentation. They will be requested to raise their hands when they have fear of the scene. The scene will be stopped and repeated until the fear disappeared.

Step IV: The therapist asks about the students' feeling and about the effects of the treatment.

Step v: The therapist informs the students about the end of the session.

EXPERIMENTAL GROUP II: SOCIAL SKILLS TRAINING SESSIONS

Sessions Ten (Social Skills Training)

Objective:

I) To review the achievement recorded in the last session.

II) To review the effect the clients is feeling on school phobia.

III) To continue with the next higher level of school phobia hierarchy

STEP i : The therapist welcomes the clients back to the therapeutic session.

STEP ii: The therapist requests the clients to express their feelings about the effects of the treatment.

STEP iii: The therapist leads the students to the last stage of the social phobia hierarchy. The least fear provoking stage, as usual, must be confronted by the clients before the higher fear provoking one.

STEP iv: The therapist makes the clients repeat any skill.

STEP v: The Therapist asks students to express their feeling on the effect of the treatment on their social phobia.

STEP vi: The Therapist informs the clients about the end of that session.

EXPERIMENTAL GROUP II: SOCIAL SKILLS TRAINING SESSIONS

Sessions Eleven (Social Skills Training)

Objective:

I) To review the last session

II) To assess the feelings of the clients about the treatment

III) To continue social skills training

STEP i: The Therapist welcomes the clients back to the session

STEP ii: The clients are made to express their feeling about the effect of the treatment on their feeling.

STEP iii: Students are engaged in more social skills training

STEP iv: Students are made to make comments about the session

STEP v: The Therapist informs the clients about the end of that session.

EXPERIMENTAL GROUP II: SOCIAL SKILLS TRAINING SESSIONS

Sessions Twelve (Social Skills Training)

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

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

III) To round off Therapeutic relationship.

VI) To administer the posttest on the students.

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

Step ii) Therapist treats comments and questions of students.

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

Step iv) Therapist informs and administers SPIN to the students.

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

APPENDIX G

Output on group tabulation base on number per group and gender.

Groups

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	CR (Cognitive Restructuring)	20	50.0	50.0	50.0
	SST (Social Skills Training)	20	50.0	50.0	100.0
	Total	40	100.0	100.0	

Gender

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	MALE	15	37.5	37.5	37.5
	FEMALE	25	62.5	62.5	100.0
	Total	40	100.0	100.0	

CROSSTABS

Crosstabs

[DataSet1] C:\Users\Ojo\Documents\ABUBAKAR HASSAN.sav

gender * groups Crosstabulation

Count

		Groups		Total
		CR (Cognitive Restructuring)	SST (Social Skills Training)	
gender	MALE	8	7	15
	FEMALE	12	13	25
Total		20	20	40

APPENDIX H

Hypo 1
T-Test

Paired Samples Statistics

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	PreTest_ Fear	11.7000	20	1.41793	.31706
	Posttest Fear	9.4500	20	1.50350	.33619

Paired Samples Correlations

		N	Correlation	Sig.
Pair 1	PreTest_ Fear &Posttest Fear	20	-.156	.513

Paired Samples Test

		Paired Differences					t	df	Sig. (2-tailed)
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
					Lower	Upper			
Pair 1	PreTest_ Fear - Posttest Fear	2.25000	2.22131	.49670	1.21040	3.28960	4.530	19	.0001

```
USE ALL.
COMPUTE filter_$=(group=2).
VARIABLE LABELS filter_$ 'group=2 (FILTER)'.
VALUE LABELS filter_$ 0 'Not Selected' 1 'Selected'.
FORMATS filter_$ (f1.0).
FILTER BY filter_$.
EXECUTE.
T-TEST PAIRS=PreFear WITH PostFear (PAIRED)
  /CRITERIA=CI(.9500)
  /MISSING=ANALYSIS.
```

APPENDX I

Hypo 2
T-Test

Paired Samples Statistics

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	PreTest_ Fear	12.5500	20	1.63755	.36617
	Posttest Fear	8.8500	20	1.81442	.40572

Paired Samples Correlations

		N	Correlation	Sig.
Pair 1	PreTest_ Fear &Posttest Fear	20	-.378	.100

Paired Samples Test

		Paired Differences					t	df	Sig. (2-tailed)
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
					Lower	Upper			
Pair 1	PreTest_ Fear - Posttest Fear	3.70000	2.86724	.64113	2.35809	5.04191	5.771	19	.000

```
USE ALL.
COMPUTE filter_$=(group=1).
VARIABLE LABELS filter_$ 'group=1 (FILTER)'.
VALUE LABELS filter_$ 0 'Not Selected' 1 'Selected'.
FORMATS filter_$ (f1.0).
FILTER BY filter_$.
EXECUTE.
T-TEST PAIRS=PrePshiol WITH PostPhysiol (PAIRED)
  /CRITERIA=CI(.9500)
  /MISSING=ANALYSIS.
```

APPENDIX J

Hypo 3
T-Test

Paired Samples Statistics

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	Pretest Physiological	9.9500	20	1.43178	.32016
	Posttest Physiological	8.2500	20	1.88833	.42224

Paired Samples Correlations

		N	Correlation	Sig.
Pair 1	Pretest Physiological &Posttest Physiological	20	.122	.609

Paired Samples Test

		Paired Differences					T	df	Sig. (2-tailed)
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
					Lower	Upper			
Pair 1	Pretest Physiological - Posttest Physiological	1.70000	2.22663	.49789	.65790	2.74210	3.414	19	.003

```
USE ALL.
COMPUTE filter_$=(group=2).
VARIABLE LABELS filter_$ 'group=2 (FILTER)'.
VALUE LABELS filter_$ 0 'Not Selected' 1 'Selected'.
FORMATS filter_$ (f1.0).
FILTER BY filter_$.
EXECUTE.
T-TEST PAIRS=PrePshiol WITH PostPhysiol (PAIRED)
  /CRITERIA=CI(.9500)
  /MISSING=ANALYSIS.
```

APPENDIX K

Hypo 4
T-Test

Paired Samples Statistics

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	Pretest Physiological	9.8000	20	2.33057	.52113
	Posttest Physiological	5.4000	20	2.11262	.47240

Paired Samples Correlations

		N	Correlation	Sig.
Pair 1	Pretest Physiological &Posttest Physiological	20	-.047	.844

Paired Samples Test

		Paired Differences					t	df	Sig. (2-tailed)
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
					Lower	Upper			
Pair 1	Pretest Physiological - Posttest Physiological	4.40000	3.21837	.71965	2.89376	5.90624	6.114	19	.000

```
USE ALL.

COMPUTE filter_$=(group=1).
VARIABLE LABELS filter_$ 'group=1 (FILTER)'.
VALUE LABELS filter_$ 0 'Not Selected' 1 'Selected'.
FORMATS filter_$ (f1.0).
FILTER BY filter_$.
EXECUTE.
T-TEST PAIRS=PreAVoid WITH PostAvoid (PAIRED)
  /CRITERIA=CI(.9500)
  /MISSING=ANALYSIS.
```

APPENDIX L

Hypo 5
T-Test

Paired Samples Statistics

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	Pretest Avoidance	13.6500	20	1.42441	.31851
	Post test Avoidance	10.6000	20	1.90291	.42550

Paired Samples Correlations

		N	Correlation	Sig.
Pair 1	PretestAVoidance&Post test Avoidance	20	-.113	.636

Paired Samples Test

		Paired Differences					t	df	Sig. (2-tailed)
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
					Lower	Upper			
Pair 1	Pretest Avoidance - Post test Avoidance	3.05000	2.50210	.55949	1.87898	4.22102	5.451	19	.000

APPENDIX M

Hypo 6

T-Test

Paired Samples Statistics

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	Pretest Avoidance	15.2500	20	1.37171	.30672
	Post test Avoidance	10.6500	20	2.00722	.44883

Paired Samples Correlations

		N	Correlation	Sig.
Pair 1	PretestAVoidance&Post test Avoidance	20	.320	.169

Paired Samples Test

		Paired Differences					t	df	Sig. (2-tailed)
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
					Lower	Upper			
Pair 1	PretestAVoidance - Post test Avoidance	4.60000	2.03651	.45538	3.64688	5.55312	10.102	19	.000

```
SE ALL.
COMPUTE filter_$=(group=2).
VARIABLE LABELS filter_$ 'group=2 (FILTER)'.
VALUE LABELS filter_$ 0 'Not Selected' 1 'Selected'.
FORMATS filter_$ (f1.0).
FILTER BY filter_$.
EXECUTE.
FILTER OFF.
USE ALL.
EXECUTE.
DATASET ACTIVATE DataSet1.
COMPUTE Scores=_Fear+Avoidance+Physiological_Manifestation.
EXECUTE.
UNIANOVA Scores BY groups Tests
  /METHOD=SSTYPE(3)
  /INTERCEPT=INCLUDE
```

APPENDIX N

Hypo 7
T-Test

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
Scores	Equal variances assumed	1.520	.225	2.733	38	.009	3.40000	1.24393	.88179	5.91821
	Equal variances not assumed			2.733	36.679	.010	3.40000	1.24393	.87881	5.92119

Group Statistics

	Groups	N	Mean	Std. Deviation	Std. Error Mean
Scores	CR (Cognitive Restructuring)	20	28.3000	3.54074	.79173
	SST (Social Skills Training)	20	24.9000	4.29075	.95944