EFFECT OF BEHAVIOUR CONTRACT ON SOCIAL PHOBIA AMONG JUNIOUR SECONDARY SCHOOL STUDENTS IN ZARIA METROPOLIS OF KADUNA STATE, NIGERIA

BY

Maimunat ALIYU
P16EDPC8017

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

FACULTY OF EDUCATION,
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DECLARATION

I hereby declare that this dissertation titled "EFFECT OF BEHAVIOUR CONTRACT ON SOCIAL PHOBIA AMONG JUNIOUR SECONDARY SCHOOL STUDENTS IN ZARIA METROPOLIS OF KADUNA STATE, NIGERIA" was carried out by me in the Department of Educational Psychology and Counseling. To the best of my knowledge, it has never been presented anywhere for the award of higher Degree of any form. It was done under the supervision of Dr Hadiza Adamu and Dr. U. Yunusa.

Maimunat ALIYU	Sign	Date

CERTIFICATION

This thesis title "EFFECT OF BEHAVIOUR CONTRACT ON SOCIAL PHOBIA AMONG JUNIOUR SECONDARY SCHOOL STUDENTS IN ZARIA METROPOLIS OF KADUNA STATE, NIGERIA", by Maimunat Aliyu, Meets the regulations governing the Award of a Degree of Master of Education (M.Ed), in Guidance and Counseling Education of Ahmadu Bello University, Zaria, Nigeria and is approved for its contribution to knowledge and literary presentation.

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DEDICATION

This research is dedicated to my parents, Alhaji Aliyu Mohammad and Hajia Hafsat Ahmed.

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OPERATIONAL DEFINITION OF TERMS

-Social phobia- is a fear of being judged by others and or the feeling of being embarrassed. It involves fear of attending social gathering, such as clubs and social activities and quiz competition and so on. so strong that it get in the way of going to work or school or engaging in daily activities.

-Behaviour contract-A written contract between a student and a Counsellor, where by the child's sign an undertaking or outlining the child's behavioural obligations in meeting the demand of acceptable behaviuor with the aim of or decreasing the child's unacceptable behavior.

ABSTRACT

The study investigated the "Effect of Behaviour Contract on Social Phobia Among Junior Secondary School Students in Zaria Metropolis of Kaduna State, Nigeria". Three objectives guided the study, related to these are three research questions and three null hypotheses. The design adopted in this study was quasi-experimental design involving the pre-test and post-test design. The population of the study consist of all 85 Students identified with social phobia problem in the five selected secondary schools located in Zaria Local Government Area of Kaduna State. A sample size of 10 Junior Secondary School (JSS II) students was selected from GJSS Gyellesu. This consists of 5 male and 5 female students that were identified with mild and moderate levels of social phobia. These students served as the treatment group and were subjected to a training on the package tagged ''Behaviour Contract Training Package (BCTP)''. The researcher used purposive sampling technique in identifying students with social phobia , The Social Phobia Inventory (SPIN),) was adapted in this study. The data collected from the pilot study were statistically analyzed to ensure the reliability co-efficient. The Cronbach Alpha Reliability Co-efficient was used to calculate the reliability coefficient of the instrument. Consequently, reliability co-efficient of alpha level of 0.822 was obtained for the instrument. The analysis presents the bio data variables of gender and social phobia Levels of the students in frequency and percentages. Descriptive statistics of frequency, item mean and standard deviation were used in answering the research questions, t test was used for testing hypothesis one and analysis of covariance(ANCOVA)was used in testing hypothesis two and three. It reveals that behavior contract had a significant effect on reducing social phobia among junior secondary school students. with a significant decrease in Social phobia;(F=0.000)and there was no significant gender differences in the effect of behaviour contract among male and female Juniour Secondary School Student,(F=0.228,)(P=0.641); and there is no significant differential effect of behavior contract on mild and moderate levels of social phobia among Juniour Secondary School Students(F=1.309;(P=0.269.) It was recommended that counselors and Psychologists should make use of behaaviour contract in handling problems of social phobia among Juniour secondary school students. counselling technique in assisting students that exhibits characteristics of social phobia

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

Speaking in public places is one of the most difficult thing some people have especially when it is persistent because they find it difficult to interact socially and because of social phobia condition. Social phobia is a medical condition characterized by extreme and consistent fear of meeting new people or embarrassing oneself in social situations. Social phobia is different from the occasional nervousness or shyness one may feel before social event, which dramatically limit one's ability to engage in social activities. Social phobia is one of the most common anxiety disorders in adults, though, it affects about one percent of children (Connor & Jonathan, 2010). It is possible that the incidence is higher than one percent because children's symptoms may wrongly be attributed to shy personality rather than a treatable condition. The tendency to develop social phobia involves both genetic and environmental factors, life events and experiences. For instance, if a child is born with a cautious nature have stressful experience, it can make them more cautious and shy. Feelings of pressure to interact in ways they are not ready for, feelings of being criticized or humiliated, or having fears and worries can make it more likely for a shy or fearful person to develop social phobia or anxiety. Students who constantly receive critical or disapproving reactions may grow to expect that others will judge them negatively. Being teased or bullied will make students who are already shy to likely retreat into their shells. They will be scared to make a mistake or disappointing someone, and will be more sensitive to criticisms. It is natural for any students to feel self-conscious, nervous, or shy in front of others. Any student can

have a racing hearts, sweaty palms, or flittering stomach when trying out for chorus in the school assembly ground, or on the first day of school resumption, or giving a class presentation. Most students manage to get through these moment when the need arise. But for some, social phobia or anxiety that goes with feelings of shyness or self-conscious can be extreme.

It may get to an unbearable level for such students to an extent that they might feel too nervous to make eye contact with classmates in the school, or avoid charting with others at lunch. Schneier,Fyer and Liebowitz (2006) support that when students feel so self-conscious and anxious so much that it prevents them from speaking up or socializing, it may be an anxiety condition called social phobia. Students with social phobia can usually interact easily with family and a few close friends, but meeting new friends, talking in group, or speaking in public could cause them extreme shyness. With social phobia, a person's extreme shyness, self-consciousness, and fears of embarrassment gets in the way of life. Instead of enjoying social activities, students with social phobia might dread them and avoid some of their mates completely.

With social phobia, a student's fear and concerns are focus on their social performance whether it is a major class presentation or small talk at the lockers. Students with social phobia tend to feel self-conscious and uncomfortable about being noticed or judged by others. They are more sensitive to fears that they will be embarrassed; they look foolish, make mistakes, or be criticized or laugh at. No one wants to experience things like these. But most people do not really spend much time worrying about it. With social phobia, thoughts and fears about what others think get exaggerated in someone's

mind. The person begins to focus on the embarrassing things that could happen, instead of good ones.

Behaviour contract is a simple positive-reinforcement intervention that is widely used by Counsellors to change student behaviour. Xinyin, Rubin and Boshu (2009), points that, behaviour contract spells out in detail the expectations of students and Counsellors (and sometimes parents) in carrying out the intervention plan, making it a useful planning document. Also, because the student usually has input into the conditions that are established within the contract of earning rewards, the student is more likely to be motivated to abide by the terms of the behaviour contract than if those terms had been imposed by someone else. For example, a goal may be stated in the contract that a student will participate in class activities by raising his hand and being called upon by the counsellor before offering an answer or comment. Art, gym, or library instructors would then rate the student's behaviour in these out of class setting and share these ratings with the classroom counsellor.

According to Carns and Carns, (2004), behavioural contracting is an intervention used by schools to help monitor and change student behaviour. Using a simple contract, the expectations of an individual student or class are spelled out in detail, along with the adult responses to achievement of those expectations, making it a useful planning document. This intervention is widely used in schools around the country, and it presents a positive, goal-oriented method to motivate behavioural change. Behaviour contracts can be implemented in isolation or as part of a larger packaged program (Cooper, Heron, and Heward.

1.2 Statement of the Problem

A normal student is expected to be active in the classroom and also perform effectively in extracurricular activities without any fear; students are expected to have confidence in the classroom especially when the teacher asks question he should answer it confidently.

In secondary schools the researcher observes that young students are frequently preoccupied with negative view of themselves. Some children are afraid to speak in public, act foolishly; feel rejected, scared that others will laugh at them and feels that they will fail when performing a task in school. They are generally less adapted to social interactions as compared to children who speak in public confidently, who are smart, social, friendly with peers, and who also participate in school activities.Students with social phobia often have negative view of themselves suffers academically; their academic performance especially students' general progress in school is poor. Such students are afraid to answers' questions confidently because of feeling shy or fear of being embarrassed. This has led to major problem affecting learning readiness, attention and participation of the student to achieve success in academics. So it affects their writing, as they may also fail test and examination, students are also unable to express themselves in the classroom, or in social gathering, and they find it difficult to participate in school social activities such as social clubs, press club, drama, creativity day, debate and many more. These behaviours are characterized by students who experience social phobia in childhood and these can be distinguished from temporal social awkwardness which many children briefly experience in new environments. Social phobia, if not taken care of, could have negative effects on the academic performance of the students. Hence,

this motivated the researcher in to investigating the effect of behaviour contract on social phobia among junior secondary school students in Zaria Metropolis of Kaduna State.

1.3 Objectives of the Study

The study focused on the following objectives

1. To assess the effect of behaviour contract on social phobia among Juniour secondary school students in Zaria Metropolis of Kaduna State.
2. To determine the differential effects of behaviour contract among male and female students in Zaria Metropolis of Kaduna State.
3. To find out the differential effect of behaviour contract on mild and moderate levels of social phobia among Juniour secondary school students Zaria Metropolis of Kaduna State.

1.4 Research Questions

The following are the research questions:

1. Is there any effect of behaviour contract on social phobia among Juniour secondary school students in Zaria Metropolis of Kaduna State?
2. Is there any differential effect of behaviour contract among male and female students in Zaria Metropolis of Kaduna State?
3. Is there any differential effect of behaviour contract on mild and moderate levels of social phobia among Juniour secondary school students Zaria Metropolis of Kaduna State?

1.5 Research Hypotheses

The study tested the following Null Hypotheses:

1. There is no significant effect of behaviour contract on social phobia among Juiour secondary school student in Zaria Metropolis of Kaduna State.

2. There is no significant differential effect of behaviour contract among male and female Juniour student in Zaria Metropolis of Kaduna State.
3. There is no significant differential Zaria Metropolis of Kaduna State.l effect of behaviour contract on mild and moderate levels of social phobia among Juniour secondary school students Zaria Metropolis of Kaduna State.

1.6 Basic Assumptions.

For the purpose of this study it was assumed that;

1. Behaviour contract could be effective in the treatment of social phobia among Juniour secondary school students in Zaria Metropolis of Kaduna State.
2. Behaviour contract could have differential effect of social phobia among male and female secondary school students in Zaria Metropolis of Kaduna State.
3. Behaviour contract could have differential effect on mild and moderate levels of social phobia among Juniour secondary school students in Zaria Metropolis of Kaduna State.

1.7 Significance of the Study

The study will provide relevant information to students in understanding how behaviour contract works and the effect of behaviour contract on social phobia conditions among students. The findings derived from this study will be of help to parents in knowing when a child falls a victim of social phobia. The study will also help parents to devise means that will help a child who exhibits signs of social phobia. The study will also provide parents with general information on what kind of parental styles a child should be subjected to, especially at early stage of child's growth and development.

The study will assist the school counsellors and psychologists to assist cases of social phobias in students like, social anxiety problems and understand the imperative of applying behaviour contract as a technique to reduce the social phobia conditions among Secondary School students in our educational system. The study will also provide counselors and psychologists with general therapy that should be given to clients with related problems.

The findings of this study will be of significant benefits to the society as the study will reveal the effects of social phobia conditions on students' mental wellbeing. It will also be useful to members of the society to be able to understand how behavioural contract works and the effectiveness of behaviour contract in reducing problem related to social phobia conditions among students in order to become useful to themselves, their family and the society at large.

The findings of this study will encourage Government at all levels in formulating critical educational policies and the necessary guidelines for effective implementation in all various level of educational system. Non-Governmental Organization (NGO's) will also benefit from the findings of this work as the study will create awareness about the danger of social phobia among secondary school Students as well as the understanding of the techniques in behavioural contract to check the social phobia problems. They will get to know about the significance of the study through journals, seminars, conferences and workshops

1.8 The Scope and delimitation of the Study

This study is about the effect of behaviour Contract on social phobia among junior secondary school students in Zaria Metropolis. The study did not cover other

junior secondary schools, senior secondary schools and other private schools in the study area and schools outside T/Wada were not covered and the study concentrated on low and moderate levels of social phobia. The study is delimited to cover all the Junior Secondary Schools in Zaria Education zone. It concentrated on 5 Junior Secondary Schools in the zone, the Schools are Government Secondary School Gyellesu, Government Girls Junior Secondary School Chindit, Government Junior Secondary School Tudun Wada, Government Junior Secondary School Dogon Bauchi, Government Girls Secondary School Zaria. The researcher investigated the effect of Behaviour Contract on Social Phobia.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

2.1 Introduction

The literature was reviewed under the following headings: Concept of behaviour contract, concept of social phobia. Theory of anxiety/fear by Aeron Beck (1978),social learning theory by Albert Bandura and operant conditioning theory served as the theoretical frame work of the study. Some empirical studies related to social phobia were reviewed.

2.2 Conceptual Framework

The main concepts under this study are behaviour contract and social phobia

2.2.1 Concept of Behaviour Contract

Behaviour contract is a simple positive-reinforcement intervention that is widely used by Counsellors to change student behaviour. Xinyin, Rubin and Boshu (2009), points that, behaviour contract spells out in detail the expectations of students and Counsellors (and sometimes parents) in carrying out the intervention plan, making it a useful planning document. Also, because the student usually has input into the conditions that are established within the contract of earning rewards, the student is more likely to be motivated to abide by the terms of the behaviour contract than if those terms had been imposed by someone else. For example, a goal may be stated in the contract that a student will participate in class activities by raising his hand and being called upon by the counsellor before offering an answer or comment. Art, gym, or library instructors would then rate the student's behaviour in these out of class setting and share these ratings with the classroom counsellor.

According to Carns and Carns, (2004), behavioural contracting is an intervention used by schools to help monitor and change student behaviour. Using a simple contract, the expectations of an individual student or class are spelled out in detail, along with the adult responses to achievement of those expectations, making it a useful planning document. This intervention is widely used in schools around the country, and it presents a positive, goal-oriented method to motivate behavioural change. Behaviour contracts can be implemented in isolation or as part of a larger packaged program (Cooper, Heron, and Heward, 2007). In addition to being efficient and effective in eliciting more appropriate school and home behaviours in children, behavioural contracting can also be implemented as an alternative to suspension (Carns and Carns, 2004).

According to Brownstein, (2010) behaviour contract is a written contract between a student and a counsellor, administrator or counsellor outlining the child's behavioural obligations in meeting the terms of the contract, as well as the counsellor's obligations once the child has met his or her agreement. Usually the later entails privileges or other reinforces desirable to the student. Abolkasemi,D,shahnam.A. (2003) opined that contract is then signed by the counsellor or Counsellor, student, and others who participate in the contract. He further explained that behaviour contracts are practical and creative way for counsellors to help students of all ages improves various problematic behaviours, such as: classroom and social behaviour, substance abuse, school attendance. While contracts can be used with an entire class or small group, Most often it is a strategy used with an individual child who is at-risk, has an emotional or behaviour disorder, or has already been in trouble or suspended for behavior

2.2.2 Types of Behaviour Contract.

There are two main types of behaviour contract; oral and written behaviour contract Daniel,D and plomin,R (1985) observed that the school councellor can use both oral and written contract.

1. The oral contracts are often used in determining behavior within the counseling session. Counsellor may wish to develop an agreement with the students, which determine how the counseling sessions are to be structured. Such a contract may specify the kinds of problems or topics with which the counselling sessions will deal with.
2. The written contract, when the contract conditions become complex so that misunderstanding might occur, then the written contract should be used. Such a contract might include the responsibility for all parties, making clear what each is expected to do and what each will receive if his part of contract is fulfilled or not fulfilled. In using the written contract. It is essential that all participants sign the contract that they agree to the conditions stated.

The key difference between the oral and written contract is simply whether or not the conditions of the contract are to be written down and agreed to by each individual. Such a distinction rests entirely on the nature of the agreement being negotiated and the relationship between the parties who are involved.

The behaviour contract is typically a positive-reinforcement intervention that includes a listing of the specific student behaviours that are to be increased and the inappropriate behaviours to be reduced (Intervention Central, 2011). It also includes reinforces or actions of the adults when those behaviours happen. Behavior contracts

often include “Who, What, When, and How well” components, who specifies, who will perform the task and receive the agreed upon reward. What includes the task that the student must perform? The When emphasizes what time the task or behavior will be completed? Finally How well aspect of the contract highlights to what degree, how frequently, or to what extent the behavior must be performed (Cooper, J.O., Heron, T.E. & Heward 2007).

Also included within the contract is a section explaining the minimum conditions under which the student can earn a “reward” for showing appropriate behaviours, which can take the form of a sticker, collecting points, a privilege, special activity or another reinforce agreed on by the student. The reward given must be contingent on completing the goals indicated, so if the student meets the behavior goals stated in the contract, the reward is then received (Gurrad, Weber, & McLaughlin, 2002). Because of this contingent relationship, behaviour contract is sometimes referred to as “contingency contracting” within the professional literature. In their book on classroom management, Jones & Jones (2010) recommends that behavior contracts include a statement related to the following variables: What is the contract’s goal?, Why has the contract been developed?, What specific behaviours must the student perform in order to receive rewards or incur the agreed-on consequences?, What rein forcers or consequences will be employed?, What are the time dimensions?, Who will monitor the behavior and how will it be monitored? And how often and with whom will the contract be evaluated?

In developing the contract the educator can discuss the goals with the student soliciting input from the student on the development of the contract. It also permits effective reinforce to be identified. This process builds commitment on behalf of the student to successfully complete the contract.

2.2.3 Negotiation of Behaviour Contract

When preparing a behavioral contract, Stopa & Clark (2011) observes that it is important that the clinician negotiate the terms of the contract with the student. The clinician should bargain with the student if necessary, by suggesting possible deals or compromises, or by making counter proposals. The clinician should find out how the student feels about the contract, and empathize with him or her. One of the most important benefits of contracting, in addition to increasing desired behavior, is teaching negotiating skills. Hofman,S..G,&Smith,A.J (2008), note that behavior contracts have been used to address a wide range of anti-social behaviours including: harassment of residents or passersby, verbal abuse, criminal damage, vandalism, noise nuisance, writing (graffiti), engaging in threatening behaviour in large groups, racial abuse, smoking or drinking alcohol while under age, substance misuse, social phobia, joy riding, begging, and prostitution.

2.2.4 Steps for Behaviour Contract

According to Brownstein,R.(2010), the following Steps should be followed while using behavioural Contract are necessary in implementing this Intervention.

1) The Counsellor decides which specific behaviours to select for the behavior contract. When possible, Counsellors should define behavior targets for the contract in the form of positive, pro-academic or pro-social behaviours. For example, Counsellors may be

concerned that a student frequently calls out answers during lecture periods without first getting permission from the Counsellors to speak. For the contract, the Counsellors' concern that the student talks out may be restated positively as "The student will participate in class lecture and discussion, raising his hand and being called upon by the Counsellors before offering an answer or comment." In many instances, the student can take part in selecting positive goals to increase the child's involvement in, and motivates him towards the behavioral contract.

2) The Counsellors meets with the student to draw up a behavior contract. (If appropriate, other school staff members and perhaps the student's parent(s) are invited to participate as well). The Counsellors next meets with the student to draw up a behavior contract. The contract should include:

i.) A listing of student behaviours that are to be reduced or increased. As stated above, the student's behavioral goals should usually be stated in positive, goal oriented terms. Also, behavioral definitions should be described in sufficient detail to prevent disagreement about student compliance (Baumeister & Leary, 2009). The Counsellors should also select target behaviours that are easy to observe and verify. For example, completion of class assignments is a behavioral goal that can be readily evaluated. If the Counsellor selects a goal such as "student will not steal pens from other students, "this goal will be very difficult to observe and confirm.

ii.) A statement or section that explains the minimum conditions under which the student will earn a point, sticker, or other token for showing appropriate behaviours. For example, a contract may state that "Johnny will add a point to his good behavior chart

each time he arrives at school on time and hands in his completed homework assignment to the Counsellors.

iii.) The conditions under which the student will be able to redeem collected stickers, points, or other tokens to redeem for specific rewards. A contract may state, for instance, that "When Johnny has earned 5 points on his good behavior chart; he may select a friend, choose a game from the play-materials shelf, and spend 10 minutes during free time at the end of the day playing the game (Baumeister & Leary, 2009).

iv.) Bonus and penalty clauses (optional). Although not required, bonus and penalty clauses can provide extra incentives for the student to follow the contract. A bonus clause usually offers the student some type of additional pay-off for consistently reaching behavioral targets. A penalty clause may prescribe a penalty for serious problem behaviours; e.g., the student disrupts the class or endangers the safety of self or of others.

v.) Areas for signature. The behavior contract should include spaces for both Counsellors and student signatures, as a sign that both parties agree to follow their responsibilities in the contract. Additionally, the instructor may want to include signature blocks for other staff members (e.g., a school administrator) and /or the student's parent(s).Behavior contracts can be useful when the student has behavioral problems in school locations other than the classroom (e.g., art room, cafeteria). Once a behavior contract has proven effective in the classroom, the instructor can meet with the student to extend the terms of the contract across multiple settings.

2.2.5 Steps in Implementing Behaviour Contract

The following steps were identified by Gilbert (2013)in implementing behavioral Contract.

a.) Make Preparations; identify the behaviours to be increased or decreased. Avoid vague definitions. Instead, select behaviours that are observable and measurable. It may be necessary to break some behaviours into smaller steps to increase student success rate. During negotiations, the student will identify several rewards that he/she would like to earn. However, it's best to be prepared with a menu of items that you think the student might like and that you would be willing to offer. The basic rule in choosing reinforces is that they should be motivating, inexpensive, and require little time. Often, the most powerful reinforces are found in the classroom.

b.) Define the criterion; **t**his is a description of what the student must do in exchange for a reward. The contract criterion includes:

i). The behaviour.

ii). Amount of reinforcement.

iii).The time limits. Use a bonus to encourage the student to meet a criterion in the least amount of time. Occasionally, a penalty clause is necessary. If so, keep these consequences small and mild by simply withdrawing a privilege. Some examples of penalties are:

i.) lose part of a recess if an assignment is not finished.

ii.) Staying after school if disruptive behavior continues.

iii.) Waiting for 3 minutes after the bell rings for talking out in class.

c.) Negotiate, start negotiations by explaining why the contract is necessary. Lay down the rules for negation. Students may negotiate the behavior, the rewards, and the criterion but not the need for the contract itself.

Share your ideas and describe the behavior you want to work on with the student. Discuss rewards and criterion. Be sure to ask the student for his/her input, but watch out. When setting criteria, students often place unrealistically high expectations for themselves. Explain that it's important to start slowly; then gradually increase the requirement. Let the student know the contract is open to renegotiation at any time.

d.) Write it: write the negotiated terms on a contract form (i.e., behaviours, consequences, time, and any special conditions of the contract). Be specific to avoid later misunderstandings. Written contracts decrease the probability of disagreements after the contract has started. It may be necessary to read the contract to the student.

e.) Sign it**;** be sure the student, Counsellors, and other participants sign the contract.

f.) Postit: Position the contract will enhance its effectiveness (Gilbert, 2013).

2.2.6 The Role of Behaviour Contract in Minimizing Social Phobia

The role of behavioral contract in reducing social phobia cannot be over emphasized. However, according to Pini, Maser & Dell' Osso (2010), behavioral contract influences the reduction of social phobia among students due to the fact that:

1) Behavioral Contract is Precise, behavioral contract have measurable outcomes, such as the change in the frequency of a behavior. Measurable outcomes allow for accurate assessment of an intervention's efficacy and timely modification of ineffective intervention procedures;

2) Behavioral contract facilitate empowerment when done correctly, do not seek to control people. Instead, they enable individuals to exert more control over their environment and their own behavior, including behaviours that help them attain their goals or that interfere with goal attainment.

3) Empowerment is realized through providing safe environments, clarifying the choices available to the student, teaching independent living skills, and acquiring self-management techniques that give individuals more control in their environment;

4) Behavioral Contract is Collaborative, Behavioral contract is developed jointly by student and treatment provider through the identification of goals, target behaviours and methods for change. Interventions are clearly described, making treatment understandable to the student, which fosters participation (Pini, Maser & Dell' Osso, 2010);

5) Behavioral Contract Focus on Accessible, Measurable Phenomena, Behavioral contract focus on observable (by staff and/or student) behaviours. Target behaviours are described quantitatively, which allows for objective hypothesis testing and evaluation of student progress;

6) Behavioral Contract is Effective with a wide Range of Disorders and Ability Levels, behavior therapy is effective for students with different levels of cognitive ability and with a variety of problem behaviours and psychiatric diagnosis;

7) Behavioral Contract is Conducive to Effective Treatment Planning, Behavior therapy focus on target behaviours which allows for the clear identification of goals in treatment planning. Adequately detailed descriptions of behavioral interventions are likely to meet

the documentation requirements of accrediting agencies. Pini, Maser & Dell' Osso (2010) add that

8) Behavioral Contract is Conducive to Program Evaluation and Development; The objective, quantifiable nature of behavioral interventions allows for easy data collection and facilitates program evaluation and program development.

According to Anthony & Coons (2006), people with social phobia tend to:

i) Be very anxious about being with other people and have a hard time talking to them, even though they wish they could;

ii) Be very self-conscious in front of other people and feel embarrassed;

iii) Be very afraid that other people will judge them.

iv) Worry for days or weeks before an event where other people will be;

v) Stay away from places where there are other people;

vi) Have a hard time making friends and keeping friends;

vii) Blush, sweat, or tremble around other people; and

viii) Feel nauseous or sick to their stomach when with other people.

2.3 Concept of Social Phobia

Social phobia is a strong fear of being judged by others and of being embarrassed. This fear can be so strong that it get in the way of going to work or school or engaging in daily activities. Everyone has felt anxious or embarrassed at one time or the other (Connon & Jonathan, 2010). For example, meeting new people or giving a public speech can make anyone nervous or people with social phobia may get worried about these and other thing for weeks before the speech is to be delivered.

Social phobia may affect three domain of individual. These domains are: cognitive, behavioral and psychological domain Pini, Maser & Dell' Osso (2010).

1) Cognitive Aspects: In cognitive models of social anxiety disorder those with social phobias experience dread over how they will be presented to others (Leibowitz, 2009).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 other 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 review anything that may have possibly been abnormal or embarrassing. These thoughts do not simply terminate soon after the encounter, but may extend for weeks or longer.

Cognitive distortions are a hallmark, and are learned about in Cognitive-Behavioral Therapy (CBT). Thoughts 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 (Garcia-Lopex, Hidalgo, Beidel, Olivares, & Turner, 2008). An example of an instance may be that of an employee presenting to his co-workers. During the presentation, the person may stutter a word, upon which he or she may worry that other people significantly noticed and think that their perceptions of him or her as a presenter have been tarnished. This cognitive thought propels further anxiety which compounds with further stuttering, sweating, and, potentially, a panic attack.

2) Behavioural Aspects: Social anxiety disorder is a persistent fear of one or more situations in which the person is exposed to possible scrutiny by others and fears that he or she may do something or act in a way that will be humiliating or embarrassing. It exceeds normal "Shyness" as it leads to excessive social avoidance and substantial social or occupational impairment (Piqueras, Espinosa Fernandez, Garcia-Lopez, & Beidel 2012). Feared activities may include almost any type of social interaction, especially small groups, dating, parties, talking to strangers at restaurants and interviews.

Those who suffer from social anxiety disorder 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. Students who suffer from this disorder may behave a certain way or say something and then feel embarrassed or humiliated after. As a result, they 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 group of people. In some cases they may show evidence of this disorder by avoiding eye contact or blushing when someone is talking to them. According to Skinner (1978), phobias are controlled by escape and avoidance behaviours. For instance, a student may leave the room when talking in front of the class (escape) and refrain from doing verbal presentations because of the previously encountered anxiety attack (avoid).

Major avoidance behaviours could include an almost pathological/compulsive lying behaviour in order to preserve self-image and avoid judgment in front of others. Minor avoidance behaviours are exposed when a person avoids eye contact and crosses his/her arms to avoid recognizable shaking. A fight or fight response is then triggered in

such events. Recent safety behaviour has been described as “Shadow friend”. Preventing these automatic responses is at the core of treatment for social anxiety.

3) Physiological Aspects: Physiological effects, similar to those in other anxiety disorders, are present in social phobia. In adults, it may be tears as well as excessive sweating, nausea, difficult 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. These visible symptoms further reinforce the anxiety in the presence of others. It has been found that the area of the brain called the amygdale, part of the limbic system, is hyperactive when patients are shown threatening faces or confronted with frightening situations. They found that patients with more severe social phobia showed a correlation with the increased response in the amygdale (Vieira, Salvador, Matos & Beidel, 2013).

There is high degree of resemblance with other psychiatric disorders. Social phobia often occurs alongside with low self-esteem and clinical depression, perhaps due to a lack of personal relationships and long periods of isolation related to avoidance of social situations. To try to reduce their anxiety and alleviate depression, people with social phobia may use alcohol or other drugs, which can lead to substance abuse. It is estimated that one-fifth of patients with social anxiety disorder also suffer from alcohol dependence (Merikangas, Avenevoli, Dierker & Grillon, 2009). The most common complementary psychiatric condition is clinical depression. In a sample of 14,263 people, of the 2.4 percent of persons diagnosed with social phobia, 16.6 percent also met the criteria for clinical depression. After depression, the most common disorders diagnosed

in patients with social phobia are panic disorder (33 percent), generalized anxiety disorder (19 percent), and attempted suicide (23 percent) (Pilling, Mayo-Wilson, Mavranexouli, Kew, Taylor, Clark, Guideline Development, Group, 2013). In one study of social anxiety disorder among patients who developed comorbid alcoholism, panic disorder, or depression, social anxiety disorder preceded the onset of alcoholism, panic disorder and depression in 75 percent, 61 percent, and 90 percent of patients, respectively (Kendler, Karkowski & Prescott, 1999). Avoidant personality disorder is also highly correlated with social phobia. Patients who suffer from both alcoholism and social anxiety disorder are more likely to avoid group-based treatments and are more likely to relapse compared to people who do not have both disorders simultaneously.

Although the criteria state that an individual cannot receive a diagnosis of social anxiety disorder if their symptoms are better accounted for by one of the autism spectrum disorders such as autism and Asperger syndrome, some people suffer from these disorders along with social anxiety disorder. One study found a comorbidity of 28%, and it is more common in higher-functioning individuals who have a desire for social interactions, but who are also aware of their social deficits (Warren, Huston, Egeland & Sroufe, 2012). Because of its close relationship and overlapping symptoms with other illnesses, treating people with social phobia may help understand underlying connection in other psychiatric disorders. There is research indicating that social anxiety disorder is often correlated with bipolar disorder and attention deficit hyperactivity disorder. Some researchers believe they share an underlying cyclothymic-anxious-sensitive disposition. In addition, studies showed that more socially phobic patients treated with anti-depressant

medication develop hypomania than non-phobic controls. The hypomania can be seen as the medication creating a new problem (Schwartz, Snidman & Kagan, 2000).

Researches into the causes of social phobia are wide-ranging, encompassing multiple perspectives from neuroscience to sociology. Scientists have yet to pinpoint the exact causes. Studies suggest that genetic can play a part in combination with environmental factors. According to Mineka & Zinbarg (2001), asserts that social phobia is not caused by other mental disorders or by substance abuse. Generally, social anxiety begins at a specific point in an individual's life. This will develop over time as the person struggles to recover. Eventually, mild social awkwardness can develop into symptoms of social anxiety or phobia.

According to Connor and Jonathan (2010) social phobia or Social Anxiety Disorder (SAD) is the most common anxiety disorder. It is one of the most common psychiatric disorders, with 12% of Americans having experienced it in their lifetime. It is characterized by intense fear in one or more social situations, causing considerable distress and impaired ability to function in at least some parts of daily life. These fears can be triggered by perceived or actual scrutiny from others. While the fear of social interaction may be recognized by the person as excessive or unreasonable, overcoming it can be quite difficult. Some people suffering from social anxiety disorder fear a wide range of social situations while others may only show anxiety in performance situations. In the latter case, the specified "performance only" is added to the diagnosis. Shields (2004) asserts that social anxiety disorder is known to appear at an early age in most cases. Fifty percent of those who develop this disorder have developed it by the age of 11. This early age of onset may social anxiety disorder being particularly vulnerable to

depressive illnesses, drug abuse and other psychological conflicts. Physical symptoms often accompanying social anxiety disorder include excessive blushing, sweating (hyperhidrosis), trembling, palpitations and nausea. Stammering may be present, along with rapid speech. Panic attacks can also occur under intense fear and discomfort. An early diagnosis may help minimize the symptoms and the development of additional problems, such as depression.

The first treatment for social phobia or social anxiety disorder is cognitive behavioural therapy. Cognitive behaviour therapy is effective in treating social phobia, whether delivered individually or in a group setting. The cognitive and behavioural components seek to change the patterns and physical reactions to anxiety-inducing situations. The attention given to social anxiety disorder has significantly increased since 1999. According to Stein (2009), 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, or use a public restroom. Most people who have social phobia know that they shouldn't be as afraid as they are, but they can't control their fear. Sometimes, they end up staying away from places or events where they think they might have to do something that will embarrass them. For some people, social phobia is a problem only in certain situations, while others have symptoms in almost any social situation. Social phobia usually starts during youth. A doctor can tell that a person has social phobia if the person has had symptoms for at least 6 months. Without treatment, social phobia can last for many years or a life time, it is a serious social problem that needs to be tackled by all.

2.3.1 Causes of Social Phobia

Causes of social phobia are wide-ranging, encompassing multiple perspectives from neuroscience to sociology. Scientists are yet to pinpoint the exact causes. Studies suggest that genetic can play a part in combination with environmental factors. Mineka and Zinbarg, (2001) asserted that social phobia is not caused by other mental disorders or by substance abuse. Generally, social anxiety begins at a specific point in an individual's life. This will develop over time as the person struggles to recover. Eventually, mild social awkwardness can develop into symptoms of social anxiety or phobia. Mineka and Zinbarg (2001) further highlight the following factors as the causes of social phobia:

Research into the causes of social anxiety and social phobia is wide-ranging, encompassing multiple perspectives from neuroscience to sociology (*Xinyin Rubin & Boshu, 2013)*. Scientists have yet to pinpoint the exact causes. Studies 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. Generally, social anxiety begins at a specific point in an individual's life. This will develop over time as the person struggles to recover. Eventually, mild social awkwardness can develop into symptoms of social anxiety or phobia (*Mathew, Coplan, &Gorman, 2010)*.

a. Genetic and Family Factors

Social phobia sometimes runs in families, but no one knows for sure why some people have it, while others don't. Researchers have found that several parts of the brain are involved in fear and anxiety. By learning more about fear and anxiety in the brain,

scientists may be able to create better treatments. Researchers are also looking for ways in which stress and environmental factors may play a role. It has been shown that there is a two to threefold greater risk of having social phobia if a first-degree relative also has the disorder (Biedel and Turner, 2012). 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 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.

La Greca, Dandes, Wick, Shaw and Stone (2000), indicated that, 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. Studies suggest that parents of those with anxiety disorder tend to be more socially isolated themselves (Bruch and Heimberg, 1994; Caster et al., 1999), and shyness in adoptive parents is significantly correlated with shyness in adopted children (Daniels and Plomin, 1985).Growing up with overprotective and hypercritical parents has also been associated with social anxiety disorder. 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 It has been shown that there is a two to threefold greater 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.

Growing up with overprotective and hypercritical parents has also been associated with social anxiety disorder (*Rapee, 2011)*. 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.

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 (Allgulander Bandelow & Hollander *(2013),* 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.

b. Social Experiences

A previous negative social experience can be a trigger to social phobia, perhaps particularly for individuals high in 'interpersonal sensitivity'. For around half of those diagnosed with social anxiety disorder, a specific traumatic or humiliating social event appears to be associate with the onset or worsening of the disorder; this kind of event appears to be particularly related to specific (performance) social phobia, for example regarding public speaking (Stemberg et al., 2005). As well as direct experiences, observing or hearing about the socially negative experiences of others (e.g. a faux pas committed by someone), or verbal warnings of social problems and dangers, may also make the development of a social anxiety disorder more likely. Social anxiety disorder may be caused by the longer-term effects of not fitting in, or being bullied, rejected or

ignored (Beidel and Turner, 2008). Shy adolescents or avoidant adults have emphasized unpleasant experiences with peers or childhood bullying or harassment (Gilmartin, 2007). In one study, popularity was 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. Socially phobic children appear less likely to receive positive reactions form process and anxious or inhibited children may isolate themselves.

Other research has explored the impact that limited social involvement may have on the development of social fear and avoidance. In a study where both socially anxious individuals and their parents were asked to retrospectively examine their level of social interaction when their child lived at home, Rapee and Melville (1997), found that the child and parents both reported significantly lower socialization scores than healthy controls. Likewise, Bruch and Heimberg (1994) found that persons with social anxiety, as compared to healthy controls, retrospectively perceived their parents as overemphasizing the opinions of others, as well as wanting to isolate them. In other words, it was common for these parents to view social situations as potentially harmful, and that the best way to deal with them was by avoiding them.

These studies appear to show that parents who shelter their children from the social world, perhaps by limiting their independent social interaction, place their children at a greater risk for being socially awkward and incompetent, and subsequently, socially fearful. In addition, this research implies that parents who examine their child's appearance and performance in an evaluative and perfectionist way may further instill this form of sensitivity that appears so central to the maintenance of social anxiety.

c. Environmental Factors

In addition to the genetic, cognitive, and familial theories of social anxiety, some researchers and clinicians believe that the onset of social anxiety disorder may be influenced by early traumatic social experiences (Hudson & Rapee, 2000). Negative experiences included being laughed at or severely criticized during a date, oral presentation, or party. Other findings have demonstrated the impact of traumatic experiences at least in regards to making someone who might be already shy and insecure to someone who is severely phobic of the judgment and criticism of others (Stemberger, Turner, Beidel, & Calhoun, 1995).

This etiological theory follows the classical conditioning model where fear of social or performance situations are learned from pairings with aversive stimuli (criticism or embarrassment). Not all socially anxious adults can trace the onset of their disorder to a specific traumatic event (Menzies & Clarke, 1995), which implies that early traumatic social experiences are not necessarily a necessity in developing social anxiety. Most researchers of anxiety today see the etiology as more multi-causal and multi-dimensional. In other words, no single factor predicts the onset of social anxiety disorder, but more a combination of genetic, cognitive, and environmental forces (Barlow, 2002).

d. Social/cultural influences

Cultural factors that have related to social anxiety disorder include a society's attitude towards shyness and avoidance, affecting the ability to form relationships or access employment or education, and shame. According to Blanco, Bragdon, Schneier

and Liebowitz, (2012), problems in developing social skills, or 'social fluency', may be a cause of some social anxiety disorder, through either inability or lack of confidence to interact socially and gain positive reactions and acceptance from others. What does seem clear is that the socially anxious perceives their social skills to be low. 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'. An interpretational 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.

e. Psychological Factors

Research has indicated the roles of 'core' or 'unconditional' negative beliefs (such as. "I am inept") and 'conditional' beliefs nearer to the surface ("If I show myself, I will be rejected"). They are thought to develop based on personality and adverse experiences and to be activated when the person feels under threat. One line of work has focused more specifically on the key role of self-presentational concerns. The resulting anxiety states are seen as interfering with social performance and the ability to concentrate on interaction, which in turn creates more social problems, which strengthens the negative schema.

Also highlighted has been a high focus on worry about anxiety symptoms themselves and how they might appear to others. A similar model emphasizes the development of a distorted mental representation of the self and overestimates of the

likelihood and consequences of negative evaluation, and of the performance standards that others have. Such cognitive-behavioural models consider the role of negatively biased memories of the past and the processes of rumination after an event, and fearful anticipation before it. Studies have also highlighted the role of subtle avoidance and defensive factors, and shown how attempts to avoid feared negative evaluations or use 'safety behaviours' (Clark and Wells, 2005) can make social interaction more difficult and the anxiety worse in the long run. This work has been influential in the development of Cognitive Behavioural Therapy for social anxiety disorder, which has been shown to have efficacy.

f. Neurobiological Factors

When we are afraid, neuro imaging techniques such as PET scan and MRI can register increased activity in the amygdala, an "almond-shaped set of neurons" in the medial temporal lobe region of the brain. The amygdala is involved in the regulation of fear, and also, emotional memory consolidation. The amygdala reacts to input from the sense-organs by sending signals that trigger physiological responses in the body, and after communication with the cortex region of the brain, initiates increased or decreased fear related behavior in response to the sensory input. The initial input from the amygdala to the cortex has an advantage compared to the returning input from the cortex to the amygdala, since the pathways are more developed from the amygdala to the cortex regions. In the cortex the sensory input is analyzed and in some cases dismissed, but due to the less developed path ways back to the amygdala, the messages from the cortex aren't as effective as the other way round. Some people are believed to have a more reactive amygdala than others, or in other words, a heightened "alarm system" in the

brain. Further, the effectiveness of the cortical activity in regulating the activity in the amygdala increases with successful psychotherapy, indicating that the influence of the cortex on the amygdala might be even smaller in people with anxiety disorders. These findings seem to part explain how excessive fear is developed and maintained. Less effective transmission of seroton in and dopamine has also been found in people with social anxiety, adding to the understanding of the development of the disorder from neuro psychological perspective (Furmark, 2009). Biological and cognitive changes in adolescence and early adulthood, such as a developing ability to reflect on one's experiences and thoughts,

g. Substance-induced

While alcohol initially relieves social phobia, excessive 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 tranquillisers (Mathew, Coplan, & Gorman, 2010). Benzodiazepines possess anti-anxiety properties and can be useful for the short-term treatment of severe anxiety. Like the anticonvulsants, they tend to be mild and well tolerated, although there is a risk of habit-forming. Benzodiazepines are usually administered orally for the treatment of anxiety; however, occasionally lorazepam or diazepam may be given intravenously for the treatment of panic attacks (*Xinyin Rubin & Boshu, 2013).*

The World Council of Anxiety does not recommend benzodiazepines for the long-term treatment of anxiety due to a range of problems associated with long-term use including tolerance, psychomotor impairment, cognitive and memory impairments, physical dependence and a benzodiazepine withdrawal syndrome upon discontinuation of benzodiazepines. (Allgulander Bandelow & Hollander 2013). Despite increasing focus on the use of antidepressants and other agents for the treatment of anxiety, benzodiazepines have remained a mainstay of anxiolytic pharmacotherapy due to their robust efficacy, rapid onset of therapeutic effect, and generally favorable side effect profile. Treatment patterns for psychotropic drugs appear to have remained stable over the past decade, with benzodiazepines being the most commonly used medication for panic disorder.

Approximately half of patients attending mental health services for conditions including anxiety disorders such as panic disorder or social phobia are the result of alcohol or benzodiazepine dependence.(Allgulander Bandelow & Hollander 2013). Sometimes anxiety pre-existed alcohol or benzodiazepine dependence but the alcohol or benzodiazepine dependence act to keep the anxiety disorders going and often progressively making them worse(Bruce, Vasile, Goisman, Salzman, Spencer, Machan &Keller, 2012). Many people who are addicted to alcohol or prescribed benzodiazepines when it is explained to them they have a choice between ongoing ill mental health or quitting and recovering from their symptoms decide on quitting alcohol or their benzodiazepines(Bruce, Vasile, Goisman, Salzman, Spencer, Machan &Keller, 2012). It was noted that every individual has an individual sensitivity level to alcohol or sedative hypnotic drugs and what one person can tolerate without ill health another will suffer very ill health and that even moderate drinking can cause rebound anxiety syndromes and

sleep disorders. A person who is suffering the toxic effects of alcohol or benzodiazepines will not benefit from other therapies or medications as they do not address the root cause of the symptoms.[*citation needed*] Symptoms may temporarily worsen however, during alcohol withdrawal or benzodiazepine withdrawal (Mathew, Coplan, &Gorman, 2010).

2.4 Theoretical Framework

The theoretical frame work for this study was hinged on theories; The Social learning Theory by Albert Bandura, Aeron Beck's Theory of anxiety/fear and Operant Conditioning Theory by B. F. Skinner

2.4.1 Social Learning Theory-Albert Bandura (1986)

Social cognitive theory revolves around the process of knowledge acquisition or learning directly correlated to the observation of models. The models can be those of an interpersonal imitation or media sources. Effective modeling teaches general rules and strategies for dealing with different situations. (Bandura, 1986)

To illustrate that people learn from watching others, Albert Bandura and his colleagues constructed a series of experiments using a Bobo doll. In the first experiment, children were exposed to either an aggressive or non-aggressive model of either the same sex or opposite sex as the child. There was also a control group. The aggressive models played with the Bobo doll in an aggressive manner, while the non-aggressive models played with other toys. They found that children who were exposed to the aggressive models performed more aggressive actions toward the Bobo doll afterward, and that boys were more likely to do so than girls (Bandura, 1986).

Following that study, Albert Bandura tested whether the same was true for models presented through media by constructing an experiment he called Bobo Doll Behavior*: A Study of Aggression*. In this experiment Bandura exposed a group of children to a video featuring violent and aggressive actions. After the video he then placed the children in a room with a Bobo doll to see how they behaved with it. Through this experiment, Bandura discovered that children who had watched the violent video subjected the dolls to more aggressive and violent behavior, while children not exposed to the video did not. This experiment displays the social cognitive theory because it depicts how people reenact behaviors they see in the media. In this case, the children in this experiment reenacted the model of violence they directly learned from the video.

Observations should include:

***Attention*:** Observers selectively give attention to specific social behavior depending on accessibility, relevance, complexity, functional value of the behavior or some observer's personal attributes such as cognitive capability, value preference, preconceptions.

Retention: Observe a behavior and subsequent consequences, then convert that observation to a symbol that can be accessed for future reenactments of the behavior. **Note:** When a *positive behavior* is shown a positive reinforcement should follow, this parallel is similar for *negative behavior*.

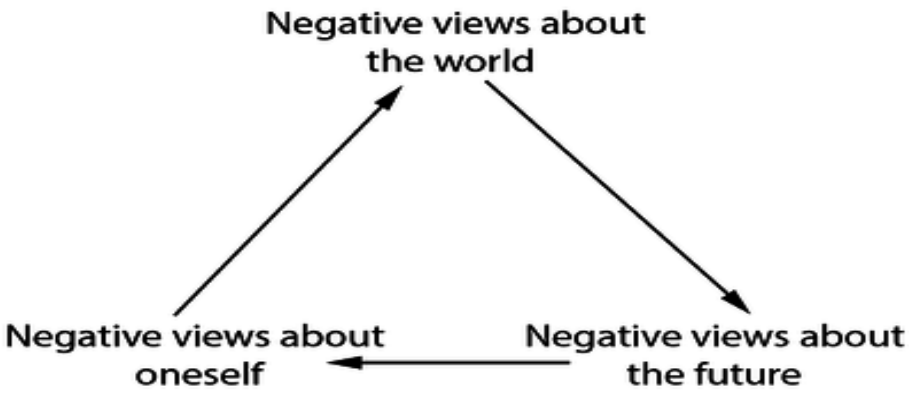
Production: Refers to the symbolic representation of the original behavior being translated into action through reproduction of the observed behavior in seemingly appropriate contexts. During reproduction of the behavior, a person receives feedback from others and can adjust their representation for future references.

Motivational Process: Reenacts a behavior depending on responses and consequences the observer receives when reenacting that behavior.

Modeling does not limit to only live demonstrations but also verbal and written behaviour can act as indirect forms of modeling. Modeling not only allows students to learn behaviour that they should repeat but also to inhibit certain behaviours. For instance, if a teacher glares at one student who is talking out of turn, other students may suppress this behavior to avoid a similar reaction. Teachers model both material objectives and underlying curriculum of virtuous living. Teachers should also be dedicated to the building of high self-efficacy levels in their students by recognizing their accomplishments. The reason for the chosing this theory is because Social Phobia may be learnt from observation of parents.

2.4.2 Aaron Beck's Cognitive Theory (Beck, 1976)

From a cognitive perspective, depressive disorders are characterized by people's dysfunctional negative views of themselves, their life experience (and the world in general), and their future.



People with depression often view themselves as unlovable, helpless, doomed or deficient. They tend to attribute their unpleasant experiences to their presumed physical, mental, and/or moral deficits. They tend to feel excessively guilty, believing that they are worthless, blameworthy, and rejected by self and others. They may have a very difficult time viewing themselves as people who could ever succeed, be accepted, or feel good about themselves and this may lead to withdrawal and isolation, which further worsens the mood.Sadock, Ruiz& Alcott, (2009*)*.The theory proposes that we all have deep cognitive structures called schemas that enable us to process incoming information and interpret our experiences in a meaningful way (Beck, Rush, Shaw, & Emery, 1979). Symptoms of psychopathology *(emotions, cognitions, and behaviors)* result when pathological *schemas* are activated by *stressful events.* Beck (1976; Beck, Rush, Shaw, & Emery, 1979) first proposed his cognitive theory as an account of depression and he and others have since adapted it to account for a wide variety of disorders and problems, including anxiety.

Symptoms in Beck's model are conceptualized as made up of behaviors, automatic thoughts, and emotions. Behaviors include both physiological responses (e.g., increased heart rate) and overt motor behaviors (leaving the room). "Automatic thoughts" are described by (Beck, 1976) as thoughts that occur automatically—that is, without effort and attention--and that we are often unaware of until we are asked to focus on them. Automatic thoughts can include images (Beck, 1995; Hackmann, 1998). Beck uses the word "emotion" to refer to subjective experience

Beck's theory proposes that when schemas are triggered, they cause Symptoms. The notion that change in automatic thoughts can lead to schema changes consistent with

the fact that it is frequently difficult to distinguish automatic thoughts from schemas (e.g., "I'm worthless"). Schemas distort multiple aspects of thinking, including perception, imagery, memory, judgment, and decision-making (R. E. Ingram, 1984), and they drive behavior, including facial expression, somatic arousal, and motor behavior.

Beck's states that schema are learned from early experiences, especially early experiences with significant others. So, for example, the child who is regularly physically abused by his mentally ill parents may develop schema of others as likely to harm or mistreat him. In support of this proposal, (Barlow & Chorpita, 1998) reviewed evidence showing that individuals who later develop anxiety disorders frequently have childhood experiences that lead them to develop schema of the self as helpless and of the world as uncontrollable.

Schemas do not change easily, for many reasons. One is that the schemas themselves bias retrieval of information from memory, interpretation of ambiguous events and other cognitive processes thus making it difficult for individuals to acquire information that disconfirms distorted schemas. In fact, (Giesler, Josephs, & Swann, 1996) showed that depressed individuals seek out information that confirms their negative self-schemas.

The rationale for the choice of this theory is because the researcher intends to change the maladaptive behaviour of the subjects (social phobia) through reinforcement of their behaviour by using Behaviour Contract.

2.4.3 Operant Conditioning Theory by Skinner (1978)

According to Skinner (1978) Operant conditioning is a type of learning in which an individual's behaviour is modified by its antecedents and consequences. Instrumental

conditioning was first discovered and published by Jerzy Konorski and was also referred to as Type II reflexes. Mechanisms of instrumental conditioning suggest that the behaviour may change in form, frequency, or strength. The expressions "operant behaviour" and "respondent behaviour" were popularized by B. F. Skinner who worked on reproduction of Konorski's experiments. The former refers to "an item of behaviour that is initially spontaneous, rather than a response to a prior stimulus, but whose consequences may reinforce or inhibit recurrence of that behaviour".

Operant conditioning is distinguished from classical conditioning (or respondent conditioning) in that operant conditioning deals with the reinforcement and punishment to change behaviour. Operant behaviour operates on the environment and is maintained by conditioning of reflexive (reflex) behaviours which are also elicited by antecedent conditions, while classical conditioning is maintained by its antecedents and consequences. Behaviours conditioned through a classical conditioning procedure are not maintained by consequences. They both, however, form the core of behaviour analysis and have grown into professional practices. Consequences that shape behaviour: Reinforcement, punishment, and extinction.

Reinforcement and punishment are the core tools of operant conditioning. It is important to realize that some terminology in operant conditioning is used in a way that is different to everyday use. Positive means a stimulus is delivered following a response. Negative means a stimulus is withdrawn following a response. Reinforcement is a consequence that causes a behaviour to occur with greater frequency. Punishment is a consequence that causes a behaviour to occur with less frequency. Antecedent stimuli (Precede): Occurs before a behaviour happens. Extinction is caused by the lack of any

consequence following a behaviour. When a behaviour is inconsequential (that is, producing neither favorable nor unfavorable consequences) it will occur less frequently. When a previously reinforced behaviour is no longer reinforced with either positive or negative reinforcement, it leads to a decline (extinction) in that behaviour.

Operant Conditioning Theory principle is based on believe that behaviour is learnt and can also be unlearnt. This proposition will help the school counsellor to assist students with social phobia condition with believe that social phobia behaviour is learnt and can also be unlearnt through the use of operant conditioning techniques for behavioural modification.

Techniques in Operant Conditioning to Change Human Behaviour

Researchers have found the following protocol to be effective when they use the tools of operant conditioning to modify human behaviour:

1. State goal (aims for the study) That is, clarifies exactly what changes are to be brought about. For example, is to reduce the anxiety.
2. Monitor behaviour (log conditions) Keep track of behaviour so that one can see whether the desired effects are occurring. For example, keep a chart of daily weights.
3. Reinforce desired behaviour (give reward for proper behaviour) for example; congratulate the individual on weight losses. With humans, a record of behaviour may serve as reinforcement. For example, when a participant sees a pattern of weight loss, this may reinforce continuance in a behavioural weight-loss program. A more general plan is the token economy, an exchange system in which tokens

are given as rewards for desired behaviours. Tokens may later be exchanged for a desired prize or rewards such as power, prestige, goods or services.

4. Reduce incentives to perform undesirable behaviour For example, remove candy and fatty snacks from kitchen shelves.

2.5 Related Empirical Studies

A study conducted by Uzonwanne, (2014) titled Prevalence of Social Phobia, Gender and School Type among Young Adults in Nigerian Universities. The study adopted a survey research design, The survey population of study is students from 5 Nigerian universities; University of Ibadan, University of Lagos, Obafemi Awolowo University Ife, Babcock University and Redeemers University. The adolescents were randomly selected and volunteered to participate in the study. The objectives of the study were to examine the prevalence of social phobia among young adults in Nigerian universities while determining the influence of school type and gender on social phobia. The result from hypothesis one which states that there will be a significant difference in the socio phobic health of male and female adolescent in Nigerian Universities, showed no apparent significant difference. This finding however appears to be both consistent and inconsistent with the previous empirical findings. McClean et al (2011) found that women had higher rates of lifetime diagnosis for each of the anxiety disorders examined, except for social anxiety disorder which showed no gender difference in prevalence. Turk et al (1998) however investigated gender differences in a large sample of persons with social phobia. Some differences between men and women emerged in their report of severity of fear in specific situations. Women reported significantly greater fear than men while talking to authority, acting/performing/giving a talk in front of an audience,

working while being observed, entering a room when others are already seated, being the center of attention, speaking up at a meeting, expressing disagreement or disapproval to people they do not know very well, giving a report to a group, and giving a party. Men reported significantly more fear than women regarding urinating in public bathrooms and returning goods to a store. Additionally, there were some differences in the proportion of men and women reporting fear in different situations. Specifically, more women than men reported fear of going to a party, and more men than women reported fear of urinating in a public restroom (Turk et al., 1998).

Gender differences in DSM-IV anxiety disorders were examined in a large sample of adults (N=20,013) in the United States using data from the Collaborative Psychiatric Epidemiology Studies (CPES) (McClean et al., 2011). The lifetime and 12-month male: female prevalence ratios of any anxiety disorder were 1:1.7 and 1:1.79, respectively. No gender differences were observed in the age of onset and chronicity of the illness. However, women with a lifetime diagnosis of an anxiety disorder were more likely than men to also be diagnosed with another anxiety disorder, bulimia nervosa, and major depressive disorder. Furthermore, anxiety disorders were associated with a greater illness burden in women than in men, particularly among European American women and to some extend also among Hispanic women.

A study was conducted by Sadeghi & Mohammadi, (2014) on The Effectiveness of Narrative Therapy on the Decrease of Social Phobia in the Female High School Students. The study is of quasi-experimental type with an experimental group and a control group. All the female high school students in Isfahan constituted the statistical population of the study. Research sample included 30 female high school students selected by convenience sampling and randomly put in an experimental group and a control group (each group consisted of 15 students).

Therefore, narrative therapy was done on the experimental group in 8 sessions. Pretest was done before the intervention, and post test, after 8 weeks. Data collected was subjected to the Analysis of Variance Statistics, results showed that The mean scores of social phobia were 65.73 for the experimental group in the post test level and those of the control group, 104.40. Furthermore, the results showed a meaningful difference between social phobia scores of control and experimental groups in the post test level: $P<0.01$. As the students' mean scores of social phobia in the post test level decreased in comparison with the pretest level, it can be concluded that narrative therapy is effective on the decrease of students' social phobia.

The findings of the study is similar to those of Abulqasemi (2003), Tahmasebi Moradi (2005), Dadsetan et al. (2006), Anari (2006) & Naziri et al. (2009), in the point that among the cognitive-behavioral therapies to cure the patients suffering from anxiety disorder, narrative therapy and drama therapy had a positive effect on the decrease of anxiety and anxious thoughts. Using narrative therapy training, Headman (1999, quoted by Falah Chai) showed a significant decrease of anxiety disorders in the experimental group after training. Considering the above-mentioned result, it can be stated that narrative therapy had a positive effect on the life of people. In fact, by narrative therapy, they gained new attitudes towards the realities of life, reduced negative thinking and feelings like fear, phobia, and anxiety about future, and improved their interpersonal relations. Since the control group received no narrative therapy training, no meaningful differences were observed in pretest and post test levels.

A study conducted by Ponniah and Hollon (2007) examines psychological interventions for social phobia in adults, a qualitative review method of Randomized Controlled Trials (RCTs) of psychological interventions for social phobia was used. Articles were identified through searches of electronic databases and manual searches of

reference lists. They were classified by psychological interventions evaluated. Data regarding treatment, participants and results were then extracted and tabulated. They identified which psychological interventions are empirically supported, using the scheme proposed by Chambless and Hollon (1998). Thirty (30) studies evaluating the efficacy of social skills training (SST), exposure therapy and/or cognitive treatments were identified. Cognitive behaviour therapy (CBT), involving cognitive restructuring and exposure to feared and avoided social situations or behavioural experiments, was found to be an efficacious and specific treatment for social phobia. The findings shown that exposure therapy was found to be an efficacious treatment since most of the evidence of its efficacy was from comparisons with no treatment. There were mixed findings regarding the relative efficacy of CBT and in vivo exposure. Some studies reported that the interventions were equivalent, while others found that patients treated with CBT had a better outcome. There was little evidence to support the use of SST. CBT is the psychological intervention of choice for social phobia. The findings of this review are compared to those of other major reviews and limitations are discussed.

Another study conducted by Gurrad et al., (2002) illustrated the effects of a behavioural contract on decreasing interrupting behaviours and increasing academic participation during reading lessons of a student with social anxiety disorder. The contract specifically included a changing criterion for the number of interruptions allowed in each reading lesson, as well as candy rewards for meeting performance goals. As the criterion continued to decrease, so did the number of interruptions by the study participant. Again, although implementing behaviour contracts is often an individual undertaking, increasing the sample size for behaviour contracting intervention research

will be necessary in drawing firm conclusions about the success of these techniques. Dodge, Nizzi, Pitt, and Rudolph (2007) used a larger sample of 89 third graders to highlight the effectiveness of behavioural contracts and positive reward systems in improving student responsibility. In particular, students improved on the outcomes of turning in assignments, staying on-task, and follow a daily routine. Hawkins et al. (2011) echoed these findings when implementing behaviour contracts for assaultive, destructive, and out of seat behaviours displayed by four students with autism. Their findings suggest that behaviour contracts are a cost effective, proactive intervention that serves as an alternative to exclusionary discipline practices. According to some researchers, behaviour contracting should be considered to be an evidence-based practice (Simonsen, Fairbanks, Briesch, Myers, and Sugai 2008). While the research on behavioural contracting is promising, few studies have examined the intervention in the last 10 years. More research on behaviour contracting is warranted, including research utilizing larger sample sizes. In many cases, behaviour contracts can also be beneficial as an element included in a larger intervention package for more complex issues, such as truancy. The factors that contribute to truant behaviours in adolescence range from individual student variables to parenting practices to systemic level variables (e.g., lack of consistent consequences for truancy in schools). Behaviour contracts may increase student or client compliance in addressing these issues.

Enea and Dafinoiu (2009) conducted a study in which they implemented a multi-modal intervention for truant behaviours that consisted of motivational interviewing, solution-focused counselling, and successive approximations of behaviour, behaviour contracts, and reinforcement techniques. This study also had a relatively small sample

size (i.e., 19 students each in the control and experimental groups) but found that the intervention group demonstrated considerable gains over the control group. The experimental group showed a 61% decrease in truancy for the experimental group, while there was a 0% decrease in truancy for the control group. In this study, the researchers used a written contract that specified the actions agreed upon by the client for the attainment of particular behavioural and counselling goals. Therefore, behaviour contracts can be effective interventions in isolation, but also serve an important function as part of larger intervention modules.

A study conducted by Schneier, Spitzer, Gibbon, Fyer, and Liebowitz, (2001) on the relationship of social phobia subtypes and avoidant personality disorder among students. Social anxiety disorder is known to appear at an early age in most cases. Fifty percent (50%) of those who develop this disorder have developed it by the age of 11 and 80% have developed it by age 20. Results of this study showed that early age of onset may lead to people with social anxiety disorder being particularly vulnerable to depressive illnesses, drug abuse and other psychological conflicts.

An early study of parent-child behaviour contracting conducted by Smith (1994) reported that implementing a parent training workshop and parent workbook (i.e., behavioural contract, evaluation and monitoring charts, award (certificates) intervention resulted in goal completion for 65% of intervention students as compared to 19% of control students. Although this study only had 12 participants in each group, it emphasizes the importance of home-school communication in developing behavioural goals and contracts. The training also aided parents in identifying measurable goals, delivering corresponding rewards, and communicating with their child's Counsellors.

With respect to the empirical studies cited above, it was discovered that many of the studies were carried out to examine psychological interventions for social phobia in adults, a qualitative review method of Randomized Controlled Trials (RCTs) of psychological interventions for social phobia was used, investigate the effects of a behavioural contract on decreasing interrupting behaviours and increasing academic participation during reading lessons of a student with ADHD ,effectiveness of behavioural contracts and positive reward systems in improving student responsibility, a multi-modal intervention for truant behaviours that consisted of motivational interviewing, solution-focused counseling, successive approximations of behaviour, behaviour contracts, and reinforcement techniques, relationship of social phobia subtypes and avoidant personality disorder among students. But, none of the studies practically finding solutions to social phobia problems which have created a knowledge gap that this current study is trying to fill; This justify the reason why the researcher want to find out the effect of behaviour contract on social phobia among secondary school students in Zaria Local Government Area of Kaduna State, Nigeria.

2.6 Summary

The chapter reviewed conceptual framework by defining concepts of behaviour contract and social phobia. Theoretical frame work: reviewed the theories like Social learning theory by Albert Bandura (1978), Aeron Beck theory of anxiety/fear, and operant conditioning theory by Skinner (1978) were applicable. Social learning theory explains how people acquire and maintain certain behavioural patterns, while also providing the basis for intervention strategies. He maintained that the evaluation of behavioural change depends on environment, people and behaviour factors. He continued

that the environment provides model for behaviour. To him, observational learning occurs when a person watches the actions of another People with depression often view themselves as unlovable, helpless, doomed or deficient. They tend to attribute their unpleasant experiences to their presumed physical, mental, and/or moral deficits. They tend to feel excessively guilty, believing that they are worthless, blameworthy, and rejected by self and others. They may have a very difficult time viewing themselves as people who could ever succeed, be accepted, or feel good about themselves and this may lead to withdrawal and isolation, which further worsens the mood. *Sadock, Ruiz & Alcott, (2009).*

The theory of Aeron Beck proposes that we all have deep cognitive structures called schemas that enable us to process incoming information and interpret our experiences in a meaningful way (Beck, Rush, Shaw, & Emery, 1979). Symptoms of psychopathology (*emotions*, *cognitions*, and *behaviors*) result when pathological *schemas* are activated by *stressful events.* (Beck, Rush, Shaw, & Emery, 1979) first proposed his cognitive theory as an account of depression and he and others have since adapted it to account for a wide variety of disorders and problems, including anxiety

Symptoms in Beck's model are conceptualized as made up of behaviors, automatic thoughts, and emotions. Behaviors include both physiological responses (e.g., increased heart rate) and overt motor behaviors (leaving the room). "Automatic thoughts" are described by (Beck, 1976) as thoughts that occur automatically—that is, without effort and attention--and that we are often unaware of until we are asked to focus on

them. Automatic thoughts can include images (Beck, 1976). Beck uses the word "emotion" to refer to subjective experience

Beck's theory proposes that when schemas are triggered, they cause Symptoms. The notion that change in automatic thoughts can lead to schema changes consistent with the fact that it is frequently difficult to distinguish automatic thoughts from schemas (e.g., "I'm worthless"). Schemas distort multiple aspects of thinking, including perception, imagery, memory, judgment, and decision-making (R. E. Ingram, 1984), and they drive behavior, including facial expression, somatic arousal, and motor behavior.

Beck's states that schema are learned from early experiences, especially early experiences with significant others. So, for example, the child who is regularly physically abused by his mentally ill parents may develop schema of others as likely to harm or mistreat him. In support of this proposal, (Barlow & Chorpita, 1998) reviewed evidence showing that individuals who later develop anxiety disorders frequently have childhood experiences that lead them to develop schema of the self as helpless and of the world as uncontrollable.

Operant Conditioning Theory principle is based on believe that behaviour is learnt and can also be unlearnt. This proposition will help the school counsellor to assist students with social phobia condition with believe that social phobia behaviour is learnt and can also be unlearnt through the use of operant conditioning techniques for behavioural modification, all the theories were linked because they all talked about the causes of social phobia, behaviour modification and reward and punishment Finally, some related empirical studies were reviewed. Most studies recommended the use of behaviour contract in reducing social phobia problem and social phobia relating

conditions among secondary school students. This research work is unique compared to other empirical studies because all the theories were linked to the study and was done on Junior Secondary School Students. While other empirical studies investigated on universities and psychiatric patients. In order words, behaviour contract was used in reducing social phobia problem among Junior Secondary School Students in Zaria Metropolis of Kaduna State.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter presents the design, population of the study, sample and sampling technique, instrumentation, validity of the instrument, and pilot testing. Others include reliability of the instrument, procedure for data collection, procedure for data analysis and the treatment sessions.

3.2 Research Design

The design adopted in this study was quasi-experimental design involving the pre-test and post-test design. This is because the design is more appropriate for studying cause and effect of relationship between variables and manipulate the results. Quasi-experimental design is most often performed in natural settings where the research question is very important but not practicable to conduct a true experimental research and it is different from true experimental design because subjects are randomly assigned to either the treatment or control group. According to Emmanuel (2013), most researches in education use quasi-experimental design, because it must be conducted on real students in real schools without disrupting the education processes of schools. The pre-test-post-test design is represented by the following notation signs:

Pre-test	**Treatment**	**Post-test**
O1	**X**	**O2**

Where:

O1= refers to the observation before the treatment (pre-test)

X= refers to the treatment administered to the treatment group(Behaviour contract)

O2= refers to observation after treatment (post –test)

3.3 Population of the Study

The population of the study consists of 85 students identified with social phobia problem by using social phobia inventory(SPIN) in the five selected secondary schools located in Metropolis of Kaduna State, The selected schools include Government Girls Secondary School Gyallesu, Government junior secondary school Tudun Wada, Government Girls Secondary School Dogon Bauchi and Government Girls Secondary School Zaria.Two of the schools consists of male and female students only while three (3) are all female students as shown on table 3.1 below:

Table 3.1: Population of the Study

S/N	Name of School	Male	Female	Total	%
1	G. J. S. S Gyellesu	15	5	20	24
2	G. J. S. S T|wada	13	7	20	24
3	G. G. S. S Dogon Bauchi	-	13	13	15
4	G. G. S. S Chindit	-	10	10	11
5	G.G.S.S Zaria	-	22	22	26
Total		**28**	**57**	**85**	**100**

3.4 Sample and Sampling Technique

A sample size of 10 (JSS II) students were selected from the population of the study that were identified with mild and moderate levels of social phobia. The researcher adopted the random sampling to select the subjects who served as the treatment group and were subjected to a training on the package tagged ‘’Behaviour Contract Training Package (BCTP)’’. The researcher used purposive sampling technique in identifying students with social phobia because it gave the researcher a focus on particular characteristics of the population and also because the students were very few in number,

which best enabled the subjects to answer questions and random sampling technique was used to select the Schools for the study. Those who scored between 21-30 points were classified as exhibiting mild level of social phobia while those who scored between 31-40 were classified as moderate. These two groups were involved in the study. The researcher used group counselling for the treatment group. According to Kolo, (2003) group counseling members could vary between three (3) and ten (10) persons. In other words, a group should be between four to ten members with similar problem.

3.5 Instrumentation

The Social Phobia Inventory (SPIN), developed by Connor (2000) was adapted in this study. The instrument consists of two sections (A and B). Section A sought for the biodata of the subjects while Section B consists of seventeen (17) items on social phobia inventory. The items are structured to give the best feelings of the subjects and some of the items are positive statement while others are negative statements.

3.5.1 Scoring of the Instrument

The inventory consists of seventeen (17) items. The lowest possible scores by the respondents is 20 while the highest possible score is 50. The items were based on 4-point Likert scales of measurement with the following scale points: Not at all=0; Mild=1; Moderate=2; Severe=3.. The scores less than 20 points denotes not at all; scores from 21-30 denotes mild; scores from 31-40 denote moderate; scores from 41-50 denotes severe. Those students who scored 20 and below were not associated with social phobia problem while those students who scored 21- 40 are found associated with social phobia problem and they constitute the subjects used for the experiment. 10 of such students (5 male and 5 female students) were selected from this group

3.5.2 Validity of the Instrument

In order to ensure that the instrument is valid for the study, copies of the instrument were shown to the supervisors and other experts in Department of Educational Psychology and Counseling, Ahmadu Bello University, Zaria, who checked and ascertained its face validity, content validity, and construct validity for the study. The researcher made necessary corrections based on the input made by the experts.

3.5.3 Pilot Testing

To ensure the reliability index of the instrument, pilot testing was carried out using thirty (30) JSS II(15males and 15females) students at Abubakar Gumi College of Higher Islamic Studies, T/wada Zaria with permission obtained from the principal of the school. After which ten (30) copies of the instrument were administered to (15 males and 15 females) respondents twice within an interval of three weeks, using test-retest exercise. The school was not part of the schools selected for the actual study but located within the same Local Government Area. The data obtained were delivered to expert analysts for measurement of internal consistency.

3.5.4 Reliability of the Instrument

The data collected from the pilot study was statistically analyzed to ensure the reliability co-efficient. The Cronbach Alpha Reliability Co-efficient was used to calculate the reliability coefficient of the instrument. Consequently, a reliability co-efficient of alpha level of 0.822 was obtained for the instrument. This reliability co-efficient was considered appropriate for the internal consistence of the instrument. According to Akem, (2004)an instrument is reliable if it lies between 0 and 0.99, and that the closer the calculated reliability coefficient is to zero, the less reliable is the instrument, and the

closer the calculated reliability co-efficient is to 1, the more reliable is the instrument. These therefore, indicate that the instrument is reliable.

3.6 Procedure for Data Collection

A letter of introduction was obtained from the Department of Educational Psychology and Counselling, Ahmadu Bello University Zaria, which served as a form of introduction for the researcher to the principal, when permission was sought from the principal of the school under study, the researcher visited the students and other valuable information needed for the study. The researcher employed the services of the Counsellors in the school who were trained to serve as the research assistants. The procedure was divided into two phases: In the first phase of the data collection; that is pre-test, the social phobia inventory (SPIN) was administered to the subjects while the second phase of the data collection; that is post- test, was done after the treatment by re-administering Social Phobia Inventory (SPIN) to the subjects to see the changes.

The treatment was done with the help of the research assistants for a period of six (6) weeks.

Treatment Sessions (Behaviour Contract Session)

The treatment sessions of behaviour contract took place at GJSS Gyallesu with 10 subjects involved the researcher; school Counsellors and students. There are six steps followed in implementing the behaviour contract before, during and after the treatment of the subjects. The Gilbert (2013) five (5) steps of implementing the contract was used which include:

1. Making of Preparation for the behaviour contract, this was done by identifying the behaviour to be increased or decreased.

2. Define the criterion, like the behaviour, amount of reinforcement to reduce consequences, and time limits.
3. Negotiate/start negotiation by explaining why the contract is necessary, lay down the rules for negotiation.
4. Write down the contract.
5. Sign the contract; be sure that Counsellors, parent and student sign the contract. Post the contract; position the contract will enhance its effectiveness.

3.7 Procedure for Data Analysis

The data obtained will be subjected to statistical analysis using Statistical Package for Social Sciences (SPSS 20th edition). Descriptive statistics such as frequency and simple percentage was used to present the demographic variables of the subjects. Descriptive statistics of frequency, item mean and standard deviation were used in answering the research questions. The null hypotheses were tested with the inferential statistics of the paired sample t test for hypotheses one and the independent t test for hypotheses two and three. All hypotheses were tested at 0.05 alpha level of significance.

CHAPTER FOUR
RESULTS AND DISCUSSION

4.1 Introduction

The study is on the effect of behaviour contract on social phobia among junior secondary school students in Zaria Metropolis, Kaduna State, Nigeria. A total of 10 students identified as having social phobia were exposed to the treatment of behaviour contract in this study. The analysis presents the bio data variables of gender and social phobia Levels of the students in frequency and percentages. The research questions were answered using the descriptive mean statistics. The null hypotheses were tested with the inferential statistics of the paired sample t test for hypotheses one and the independent t test for hypotheses two and three. All hypotheses were tested at 0.05 alpha level of significance.

4.2 Descriptive Data

Frequency count and percentage were used in analyzing the demographic data

Table 4.2.1: Distribution of Respondents

Category	Frequency	Percent
1. Gender		
Male	5	50.0
Female	5	50.0
2. Social Phobia Levels		
Mild	6	60.0
Moderate	4	40.0
Total	10	100.0

Table 4.1 above indicated that on the basis of the students' gender, 5 or 50.0% are males and the rest 5 or 50.0% are females. These are the students that were identified as having social phobia that are used in the study.

On the basis of their social phobia levels, a total of 6 or 60.0% are termed students as moderate level the rest 4 or 40.0% are grouped into mild levels of students.

4.3 Hypotheses Testing

The null hypotheses were tested with the inferential statistics of the paired sample t- test for hypotheses one and Analysis of Covariance (ANCOVA) was used to test hypotheses two and three. All hypotheses were tested at 0.05 alpha level of Significance.

Null Hypothesis One:

There is no significant effect of behaviour contract on social phobia among secondary school student in Zaria Metropolis, Kaduna State.

Table 4.3.1:T-test showing the effect of Behaviour Contract on Social Phobia of Students Between Pre-test and Post-test Scores.

Test Groups		N	Mean	Std. Dev.	Std. Error Mean	Mean diff. effect	Df	t- cal	p
Scores of social phobia	Pretest	5	32.100	4.677	1.479	5.200	9	9.390	0.00
	Posttest	5	26.900	3.755	1.187				

Calculated p < 0.05, computed t > 1.96 at df 9

Results of the paired sample t test statistics above showed that their computed social phobia level before and after treatment with the behaviour contract were 32.100 and 26.900 implying a mean decrease of 5.2000 as a result of their being exposed to the treatment. This is because the calculated p value of 0.000 lower than the 0.05 alpha level of significance and the computed t value of 9.390 is greater than 1.96 t critical at df 9. Therefore the null hypothesis which states that there is significant effect of behavior contract on social phobia among secondary school student in Zaria Metropolis of Kaduna

State, is hereby rejected, it was rejected because the p value is 0.000 which is lower than 0.05 level of significance.

Null Hypothesis Two:

There is no significant differential effect of behaviour contract among male and female student in Zaria Metropolis, Kaduna State.

Table 4.3.2: Analysis of Co Variance (ANCOVA) on Differential Effect of Behaviour Contract on Social Phobia among Male and Female Secondary School Student

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	186.000[a]	3	62.000	2.793	.074
Intercept	17052.800	1	17052.800	768.144	.000
Tests	168.200	1	168.200	7.577	.014
Genders	12.800	1	12.800	.577	.459
tests * genders	5.000	1	5.000	.225	.641
Error	355.200	16	22.200		
Total	17594.000	20			
Corrected Total	541.200	19			

Outcome of the independent t test statistics above showed that the computed social phobia level for Male and Female students are p = 0.641 is higher than 0.05 and f value of 0.225 lower than the critical value of 2.6000.This shows that behaviour contract is effective on both male and female students exposed to training. Therefore the null hypothesis which states that there is no significant differential effect of behaviour contract among male and female student in Zaria Metropolis of Kaduna State, is hereby

accepted, it was accepted because the p value of 0.641 is greater than 0.05 level of significance.

Null Hypothesis Three:

There is no significant differential effect of behaviour contract on levels of social phobia among Juniour Secondary School Students Zaria Metropolis, Kaduna State.

Table 4.3.3: Analysis of Co Variance (ANCOVA) on Differential Effect of Behaviour Contract on Levels of Social Phobia Among Secondary School Students

Source	Type III Sum of Squares	Df	Mean Square	F	Sig.
Corrected Model	386.283[a]	3	128.761	13.299	.000
Intercept	17112.408	1	17112.408	1767.392	.000
Levels	205.408	1	205.408	21.215	.000
Tests	180.075	1	180.075	18.598	.001
levels * tests	12.675	1	12.675	1.309	.269
Error	154.917	16	9.682		
Total	17594.000	20			
Corrected Total	541.200	19			

a. R Squared = .714 (Adjusted R Squared = .660)

Outcome of the ANCOVA statistics above showed that the computed social phobia level for Mild and Moderate levels students are p = 0.269 is higher than 0.05 and f value of 1.309 lower than the critical value of 2.6000. Implying that there is no significant differential effect of behaviour contract on levels of social phobia among secondary school students Zaria Metropolis, Kaduna State. Therefore the null hypothesis is hereby accepted because the p= 0.269 is greater than 0.05 level of significance.

4.4 Summary of Major Findings

The following are the summary of the major findings.

1.Behaviour contract had a significant effects on students exposed to training in behaviour contract on social phobia among secondary school students in Zaria metropolis,(t = 9.390, p=0.000).Students exposed to behaviour contract had a significant reduction on social phobia among secondary school students in Zaria metropolis.

2.There is no significant difference between male and female students on the effect of behaviour contract on social phobia of students. This shows that behaviour contract is effective on both male and female secondary school students in Zaria metropolis(f = 0.228, p= 0.641).

3.There is no significant differential effect found between mild and moderate levels of social phobia among secondary school students (f =1.309 and p=0.269).This shows that behaviour contract is effective on both mild and moderate levels of social phobia among Junior Secondary School Students in Zaria Metropolis of Kaduna State.

4.5 Discussions of Results

Findings reveals that students exposed to training in behaviour contract had a reduced social phobia (p=0.00) and significant difference do not exists in the effect of behaviuor contract on reducing social phobia among junior secondary school students (p=0.000).

The finding was not surprising as many techniques have found to be effective in treatment of the behaviour, the finding is in agreement with that of a study conducted by Sadeghi and Mohammadi, (2014) on the Effectiveness of Narrative Therapy on the Decrease of Social Phobia in the Female High School Students. The study is of quasi-

experimental type with an experimental group and a control group. All the female high school students in Isfahan constituted the statistical population of the study. Research sample included 30 female high school students selected by convenience sampling and randomly put in an experimental group and a control group (each group consisted of 15 students). Therefore, narrative therapy was done on the experimental group in 8 sessions. Pretest was done before the intervention, and posttest, after 8 weeks. Data collected was subjected to the Analysis of Variance Statistics, results showed that the mean scores of social phobia were 65.73 for the experimental group in the posttest level and those of the control group, 104.40. Furthermore, the results showed a meaningful difference between **social** phobia scores of control and experimental groups in the posttest level: $P<0.01$. As the students' mean scores of social phobia in the posttest level decreased in comparison with the pretest level, it can be concluded that narrative therapy is effective on the decrease of students' social phobia. The findings of the study is also similar to those of Abulqasemi (2003), Tahmasebi Moradi (2005), Dadsetan et al. (2006), Anari (2006) & Naziri et al. (2009), in the point that among the cognitive-behavioral therapies to cure the patients suffering from anxiety disorder, narrative therapy and drama therapy had a positive effect on the decrease of anxiety and anxious thoughts. Using narrative therapy training, Headman (1999, quoted by Falah Chai) showed a significant decrease of anxiety disorders in the experimental group after training.

Findings reveals that gender is not significant factor in the effect of behaviour contract on reducing social phobia ($p=0.641$)and significant differences do not exists between male and male and female students in the effect of behaviour contract on social phobia($f=0.225$) It was found out that the behavior contract is positively effective in

reducing the social phobia of both male and female students in the same manner, findings of this study is in agreement with the findings of a study conducted by Uzonwanne, (2014) titled Prevalence of Social Phobia, Gender and School Type among Young Adults in Nigerian Universities. The study adopted a survey research design, The survey population of study is students from 5 Nigerian universities; University of Ibadan, University of Lagos, Obafemi Awolowo University Ife, Babcock University and Redeemers University. The adolescents were randomly selected and volunteered to participate in the study. The objectives of the study were to examine the prevalence of social phobia among young adults in Nigerian universities while determining the influence of school type and gender on social phobia. The result from hypothesis one which states that there will be a significant difference in the socio phobic health of male and female adolescent in Nigerian Universities, showed no apparent significant difference. This finding however appears to be both consistent and inconsistent with the previous empirical findings. McClean et al (2011) found that women had higher rates of lifetime diagnosis for each of the anxiety disorders examined, except for social anxiety disorder which showed no gender difference in prevalence. Turket al (1998) however investigated gender differences in a large sample of persons with social phobia. Some differences between men and women emerged in their report of severity of fear in specific situations. Women reported significantly greater fear than men while talking to authority, acting/performing/giving a talk in front of an audience, working while being observed, entering a room when others are already seated, being the center of attention, speaking up at a meeting, expressing disagreement or disapproval to people they do not know very well, giving a report to a group, and giving a party. Men reported significantly

more fear than women regarding urinating in public bathrooms and returning goods to a store. Additionally, there were some differences in the proportion of men and women reporting fear in different situations. Specifically, more women than men reported fear of going to a party, and more men than women reported fear of urinating in a public restroom (Turk et al., 1998).

Findings reveals that no significant differential effect was found between mild and moderate social phobia among junior secondary school students(p=0.269),(f=1.309) This finding further showed the efficacy of the technique as an agreement with the findings of Dodge, Nizzi, Pitt, and Rudolph (2007) used a larger sample of 89 third graders to highlight the effectiveness of behavioural contracts and positive reward systems in improving student responsibility. In particular, students improved on the outcomes of turning in assignments, staying on-task, and follow a daily routine. Hawkins et al. (2011) echoed these findings when implementing behaviour contracts for assaultive, destructive, and out of seat behaviours displayed by four students with autism. The study also reported that including a home component as part of the behaviour contract helped to generalize behavioural improvements.

Behaviour contracting has also been found to be related to more on-task behaviour and completing daily homework assignments (White-Blackburn, Semb, & Semb, 1977), better grades (Williams and Anandam, 1973), better self-control by the student (Drabman, Spitalnik, and O'Leary, 1973), and better student productivity (Kelley and Stokes, 1984). Their findings suggests that behaviour contracts are a cost effective, proactive intervention that serves as an alternative to exclusionary discipline practices. According to some researchers, behaviour contracting should be considered to be an

evidence-based practice (Simonsen, Fairbanks, Briesch, Myers, and Sugai 2008). While the research on behavioural contracting is promising, few studies have examined the intervention in the last 10 years. More research on behaviour contracting is warranted, including research utilizing larger sample sizes. In many cases, behaviour contracts can also be beneficial as an element included in a larger intervention package for more complex issues, such as truancy.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter being the last one, attempts to presents the Summary, Conclusion, Recommendations and suggestions for further studies

5.2 Summary

Chapter one served as the foundation for the study, it moderate lighted the background to the study, statement of the problem, and there research objectives were stated that guided the work. Related to these are three research questions and three null hypotheses, basic assumptions were made, significance of the study moderate lighted and scope and delimitation of the study stated.

Chapter two reviewed related literature to. Social phobia and behaviour contract, conceptual framework by defining concepts of behaviour contract and social phobia. Theoretical frame work: reviewed the theories like Social learning theory by Albert Kundura (1986), Aaron Beck (1976), and operant conditioning theory by Skinner (1978) were applicable. Social cognitive theory explains how people acquire and maintain certain behavioural patterns, while also providing the basis for intervention strategies. He maintained that the evaluation of behavioural change depends on environment, people and behaviour factors. He continued that the environment provides model for behaviour. To him, observational learning occurs when a person watches the actions of another person and the reinforcement that person receives.

Beck's model are conceptualized as made up of behaviors, automatic thoughts, and emotions. Behaviors include both physiological responses (e.g., increased heart rate)

and overt motor behaviors (leaving the room). “Automatic thoughts” are described by thoughts that occur automatically—that is, without effort and attention--and that we are often unaware of until we are asked to focus on them. Automatic thoughts can include images . Beck uses the word “emotion” to refer to subjective experience

Beck’s theory proposes that when schemas are triggered, they cause Symptoms. The notion that change in automatic thoughts can lead to schema changes consistent with the fact that it is frequently difficult to distinguish automatic thoughts from schemas (e.g., “I’m worthless”). Schemas distort multiple aspects of thinking, including perception, imagery, memory, judgment, decision-making and they drive behavior, including facial expression, somatic arousal, and motor behavior.

Beck’s states that schema are learned from early experiences, especially early experiences with significant others. So, for example, the child who is regularly physically abused by his mentally ill parents may develop schema of others as likely to harm or mistreat him. In support of this proposal, reviewed evidence showing that individuals who later develop anxiety disorders frequently have childhood experiences that lead them to develop schema of themselves as helpless and of the world as uncontrollable.

Operant Conditioning Theory principle is based on believe that behaviour is learnt and can also be unlearnt. This proposition will help the school counsellor to assist students with social phobia condition with believe that social phobia behaviour is learnt and can also be unlearnt through the use of operant conditioning techniques for behavioural modification. Finally, some related empirical studies were reviewed. Most studies recommended the use of behaviour contract in reducing social phobia problem and social phobia relating conditions among secondary school students. In order words,

behaviour contract is use in reducing social phobia problem among Junior Secondary School Students in Zaria Local Government Area of Kaduna State.

Chapter three presented the methodology adopted for the study; the design adopted in this study was quasi-experimental design involving the pre-test and post-test design. The population of the study consist of all the students 85 identified with social phobia problem in the five selected secondary schools located in Zaria Local Government Area of Kaduna State. A sample size of 10 Junior Secondary School (JSS II) students was selected from GJSS Gyellesu. This consists of 5 male and 5 female students that were identified with low and moderate levels of social phobia. These students served as the treatment/experimental group and were subjected to a training on the package tagged ‘’Behaviour Contract Training Package (BCTP)’’. The researcher used purposive sampling technique in identifying students with social phobia because it gave the researcher a focus on particular characteristics of a population that are of interest which best enabled the subjects to answer questions, The Social Phobia Inventory (SPIN), developed by Connor (2000) was adopted in this study. The data collected from the pilot study were statistically analyzed to ensure the reliability co-efficient. The Cronbach Alpha Reliability Co-efficient was used to calculate the reliability coefficient of the instrument. Consequently, reliability co-efficient of alpha level of 0.822 was obtained for the instrument.

Chapter four presented the data collected from the field, it analysis and results. The Statistical package IBM version 23 was used for the analysis. The research questions were analysed using item statistics of frequency, percentages and item means. Null hypothesis one was tested using the inferential statistics of t- test statistics while null

hypotheses two and three were tested using the Analysis of Covariance (ANCOVA). Each hypothesis is tested at 0.05 alpha level of significance. It was found out that there is positive effect of behavior contract on students social phobia with a significant decrease in phobia; the behavior contract is positively effective in reducing the social phobia of both male and female students in the same manner; and the behavior contract is positively effective in reducing the social phobia of both mild and moderate students.

5.3 Conclusion

The following conclusions could be deduced from the outcomes of the study;

Behaviour contract had significant effects on students exposed to training in behaviour contract had a reduced social phobia among secondary school students in Zaria metropolis.There is no significant difference between male and female students in the effect of behaviour on social phobia and there is significant differential effect found between mild and moderate levels of social phobia among secondary school students.

5.4 Contribution to Knowledge

The following are the contribution of this study to knowledge based on the research findings.

1. Students exposed to training in behaviour contract had a reduced social phobia among secondary school students in Zaria metropolis. This shows that behaviuor contract can be used to reduce social phobia among junior secondary school students.
2. There is no significant difference between male and female students in the effect of behaviour on social phobia .

3. There is no significant differential effect found between mild and moderate levels of social phobia among secondary school students in Zaria Metropolis.

5.5 Recommendations

The following are recommendations made based on the research findings.

1. Counsellors and psychologist should make use of behaviour contract in handling students with of social phobia.
2. The new technique should be used without bias to gender of the students.
3. Behaviour contract should be used for students with mild and moderate levels of social phobia.

5.6 Suggestions for Further Studies

The following suggestions are made for further studies

1. The effect of behaviour contract on social phobia among primary school students in other Local Government Area of the State.
2. The effect of the behaviour contract technique on social phobia among secondary school students in different States.
3. The effect of behaviour contract techniques on social phobia among senior secondary school students in Zaria metropolis.

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APPENDIX I

THE SOCIAL PHOBIA INVENTORY (SPIN)

This questionnaire is a part of the research for a Master Thesis titled "Effect of Behviour Contract on Social Phobia among Junior Secondary School Students in Zaria Local Government Area Kaduna State". Kindly help fill this inventory as careful as possible. Your response will be used strictly for the purpose of this research only. Any information you provided will be treated with utmost confidentiality.

Instruction: please tick (√) at the appropriate box below.

Thanks for your co-operation.

SECTION A: DEMOGRAPHIC DATA OF RESPONDENTS

Gender: Male ( ), Female ( )

SECTION B:

Instruction: The **following statements are designed to measure social phobia of students. Please carefully indicate by ticking** (√) on the appropriate answer to show the options that best suits your feelings in each of the items. Keys: Not at all=0; Mild=1; Moderate=2; Severe=3; extremely=4.

S|n	Items	Not at all	Mild	Moderate	Severe	Extremely
1	I am afraid of Counsellors in school					
2	I am bothered by blushing in front of class mates					
3	Parties and social events scare me					
4	I avoid talking to people I don't know					
5	Being criticized do scare me a lot					
6	Fear of embarrassment causes me to avoid doing things or speaking in school					
7	Sweating in front of people causes distress					
8	I avoid going to debates					
9	I avoid activities in which I am the center of attention					
10	Talking to strangers scares me					
11	I avoid having to give speeches in class					
12	I would do anything to avoid being criticized in school					
13	Heart palpitations bother me when I am around the school					

14	I am afraid of doing things when people might be watching					
15	Being embarrassed or looking foolish are among my worst fears in class					
16	I avoid speaking to anyone in school					
17	Trembling or shaking in front of Counsellors is distressing to me					

Source: Adapted from Connor, (2000)

Appendix II
Student Behaviour Contract

[Name of School]

To: Parent/Guardian and Student

[Name of Student_____] to be contracted on date _____,to help in assuring his/her success. This contract will be used to assist in determining their future at _____School.

Goals for Student:

1.
2.
3.
4.

Rewards if Goals are met:

1.
2.
3.
4.

Consequences if Goals are not met:

1.
2.
3.

By signing this contract all parties agree to the stipulations in the document and will following accordingly. The following contract will be reviewed by the student, parent/guardian, counselor and principal on the following date and time:

_____

(Signature of Student) Date

_____

(Signature of Principal) Date

_____

(Signature of Counsellors or Counselor) Date

APPENDIX III

PILOT TESTING RELIABILITY RESULT FOR SOCIAL PHOBIA INVENTORY

Scale: Social Phobia Reliability Test

		N	%
Cases	Valid	30	100.0
	Excluded[a]	0	0
	Total	30	100.0

a. Likewise deletion based on all variables in the procedure

Reliability Statistics

Cronbach's Alpha	Part 1	Value	.801
		N of Items	2[a]
	Part 2	Value	1.000
		N of Items	1[b]
	Total N of Items		30
Correlation Between Forms			.867
Spearman-Brown Coefficient	Equal Length		.893
Guttman Split-Half Coefficient	Unequal Length		.822

APPENDIX IV

First Week: Behaviour Contract Treatment Package (BCTP) Counselling Technique.

Introduction

1. All the selected subjects were taken to a class which was assigned to the researcher by the principal of the school for the treatment sessions.

2. The subjects were welcomed by the researcher and told them her aims in the school was to assist them to achieve in all their academic endeavours and also in their social life within the school and also at home, this was done to make the subjects to feel free with the researcher and also to attend the treatment sessions without failure or being absent and to win their attention during the treatment sessions.

3. The researcher introduced her name, work, discipline, favourite and other things that might interest the subjects to hear as they were allowed to answer questions.

4. The subject were asked by the researcher to introduce themselves by name, age, class, sport and game. What would they to become after their educational pursuit and other things they would like the class members to know about them. The researcher solicited for the co-operation of the subjects and also assured them of confidentiality throughout the periods of the treatment sessions.

Second session

Activity One: Define the criterion for Behavioural Contract

Time: 30 minutes

Group size: 10 subjects that were classified as mild and moderate levels in the pretest scores

Attitudes/values: Appreciate how the researcher and students effectively utilized behaviour contract

Objectives (Identifying the Behaviour)

1. The main objective of this is to analyze individual area of behaviour which needs to be contracted (Social Phobia).

Assighnment

1**.** All the group members explained the meaning of behaviour contract.

2**.** Individually, participants completed Behaviour contract Worksheet One:

3. In groups of two, students discussed the worksheet.

Third Week

Activity Two: Negotiate/start the contract

Time: 30 minutes

Group Size: 10 subjects that were classified as mild and moderate levels in the pretest scores.

Objectives for students

Attitudes/values: Understanding"Who?" as the first component of Behaviour Contract.

Skills: Develop the "Who" skill in Behaviour Contract.

Learning Experience

1. The subjects were given the Behaviour Contract Worksheet
2. In groups of five, studentss discussed how to use behaviour contract to positively shape the abnormal behaviour of the students.

3. The students wrote one behaviour each that they can do to

Objectives

1. To negotiate/start negotiation by explaining why the contract is necessary.
2. To lay down the rules for negation.
3. To know the meaning of "Who" in behaviour contract specifies who will perform the task and receive the agreed upon rewards.
4. To know that the contract is typically a positive-reinforcement intervention that includes a listing of the specific student behaviours that are to be increased and the inappropriate behaviours to be reduced.
5. To be sensitive to students' feelings and ensure a safe and positive learning environment.
6. To make them feel good about themselves. eg I will engage myself in school social activities.

Assignment

In small group "How would you feel about the following circumstances?

1. Do you feel like running away from the classroom when asked a question by the Counsellors.
2. Do you get disorganized when you are in social gathering.

Fourth Week

Activity three: Writing the Contract

Time: 30minutes

Group size:10 subjects that were classified as mild and moderate levels in the pretest scores.

Objectives

1. To explain why the contract is necessary.
2. The Students and the researcher negotiated the behaviour and reward.
3. The sharing of positive comment between students to promote good behaviour.
4. To encourage students to know their positive qualities.

Assignment

1. Explain why the contract is necessary?

Fourth Week

Activity Four: Signing the Contract

Time: 30 minutes

Group size: 10 subjects that were classified as mild and moderate levels in the pretest scores

Objectives

1. To know the Importance of signing of contract.
2. To express and share with others the importance of timing in behaviour contract.
3. To know the Importance of Counsellors and students for signing the contract.
4. To make them understand that "When" emphasizes what time the task or behaviour will be completed?

Assighnment

What time is really convenient to you?

Individually, students wrote down their responses to the following statements.

i. The time that is really important to me is during school hours.

ii. The time that is not important to me at present after school hours.

iii. Obstacle that can influence the timing of contract is when I am sick.

iv. In groups of five, they shared and discussed the responses listed above.

Fifth Week Treatment Session

Activity Five: How to Sign the Behaviour Contract

Time: 30 minutes

Group size: 10 subjects that were classified as mild and moderate levels in the pretest scores.

Objectives

1. To Explain the importance of "How" in behaviour contract.
2. To Explain the importance of "How" in behaviour contract.
3. The Subjects should be aware of "How" as a component of behaviour contract.

Assignment

Explain and share "How" as aspect of behaviour contract subjects that were classified as mild and moderate levels in the pretest scores contract.

The researcher and the students have signed the contract

Sixth Week

Activity Six: Evaluation Stage (Post the Contract)

Time: 30 minutes

Group size: 10 subjects that were classified as mild and moderate levels in the pretest scores.

Objectives:

1. The students should be able to know their personality and observe their positive characteristics.

Assignment

1. Discuss your dreams, interests and hopes.
2. The students should express their views to their colleagues on what they have learnt on behaviour contract and social phobia.

Evaluation Phase

The behaviour contracting sessions was evaluated through the use of questionnaires to the subjects after several hours. The evaluation of the results of the behaviour contracting questionnaire was deferred for several days, at least for several hours. The results collected from the two administrations of the questionnaires that is, result from post-test a were analysed in order to determine the effectiveness of the behaviour contract package on students with mild and moderate social phobia.

Seventh week

Closing Remarks

- Prayers from the researcher with the hope that all what was learnt would be put into use.
- The researcher expressed gratitude for the work done.
- The behaviour contract work sheets were collected from the students with mild and moderate social phobia.
- Distribution of biscuits and drinks, in relation to the previous assignments and for the job well done
- The researcher terminated the counseling sessions and say goodbye.