EFFECTS OF COGNITIVE RESTRUCTURING AND SOCIAL SKILLS TRAINING COUNSELLING TECHNIQUES ON AVOIDANT PERSONALITY DISORDER AMONG SECONDARY SCHOOL STUDENTS IN KANO METROPOLIS

BY

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MARCH, 2016

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

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

MARCH, 2016

Declaration

I hereby declare that the work in this Thesis entitled '**Effects of Cognitive Restructuring and Social Skills Training Counselling Techniques on Avoidance Personality Disorder among Secondary School Students in Kano Metropolis**' has been carried out by me in the Department of Educational Psychology and Counselling, Ahmadu Bello University, Zaria. The information derived from the literature has been duly acknowledged in the text and lists of references were provided. No part of this Dissertation was previously presented for another degree or diploma at this or any other institution.

……. **……..**

Mujtaba LAWAN **Date**

CERTIFICATION

This Thesis entitled "EFFECTS OF COGNITIVE RESTRUCTURING AND SOCIAL SKILLS TRAINING COUNSELLING TECHNIQUES ON AVOIDANT PERSONALITY DISORDER AMONG SECONDARY SCHOOL STUDENTS IN KANO METROPOLIS" by Mujtaba LAWAN meets the regulation governing the award of PhD in Guidance and Counselling of the Ahmadu Bello University, Zaria and is approved for its contribution to knowledge and literary presentation.

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DEDICATION

This research study is dedicated to my late parents Malam Lawan Jibrin Kurawa and Binta Abdullahi (May their souls rest in peace).

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ABSTRACT

The study examined the effect of Cognitive Restructuring (CR) and Social Skills Training (SST) counselling Techniques on Avoidant Personality Disorder (APD) among Secondary School Students in Kano Metropolis. The study is a quasi experimental design involving pre-test-post-test-control group design. The population of the study consist of Senior Secondary School two Students in Kano Metropolis who exhibited APD. Three male and three female senior secondary schools, making six schools, were selected in Kano Metropolis. A sample of 72 respondents from the six schools, twelve from each school, were sampled and put into 3 experimental groups (CR, SST and control group). Each group consists of 12 male and 12 female students. APD test (DSM-5) was used for data collection in the study. Each treatment group, either CR or SST, received treatment for 12 consecutive weeks (3 minutes a week) counselling sessions. Seven research questions and seven null hypotheses were formulated and the hypotheses were tested at 0.05 alpha levels of significance while Standard Deviation and t-test for independent sample were used to analyze the data collected. Also ANOVA was used on the pre-test results to confirm that there is no difference in the level of APD among the groups. The results indicated that CR Counselling Technique has effects in the reduction of APD (t=8.086, p=0.000). SST Counselling Technique has effects in the reduction of APD (t=8.884, p=0.000). There is no differential effect base on the technique between CR and SST (t=0.617, p=0.540).There is a differential effect base on gender in the CR treatment in favor of male (t=014, p=0.006) while there is no differential effects base on gender in the SST (t=0.309, p=0.760). Base on the findings of the study this research recommend among others; a structured treatment package of the two techniques (CR and SST) used in this study should be used by the school counsellors in conjunction or isolation for the treatment of APD among students. CR and SST counselling techniques could be use in the treatment of APD in both school and clinical settings. CR and SST counseling techniques should be designed and incorporated into national curriculum of secondary schools. And lastly, gender differences of the clients should be considered when structuring and implementing CR counselling techniques in the treatment of APD.

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ABBREVIATIONS

APD: Avoidance Personality Disorder

SP: Social Phobia

OCD: Obsessive Compulsive Personality Disorder

CR: Cognitive Restructuring

SST: social skills training

CBT: Cognitive Behavior Therapy

CBGT: Cognitive Behavior Group Therapy

BCBT: Brief Cognitive Behavior Therapy

CT: Cognitive Therapy

RET: Rational Emotive Therapy

DSM: Diagnostic and Statistical Manual of Mental Disorder

SSS: Senior Secondary School

SSSMB: Senior Secondary School Management Board

OUT OF FOG: Out of Fear Obligation & Guilt

ICD: International Statistical Classification of Diseases and Related Health Problems.

OPERATIONAL DEFINITION OF TERMS

The following is the definition of some basic concept as used in this work:

Avoidant Personality Disorder: Is a personality disorder as a result of excessive shyness and low self-esteem in the contact with unfamiliar people that prevents ordinary social functioning but does not involve loss of touch with reality.

Cognitive Restructuring Technique: Is a Cognitive Behavior Therapy counselling procedure which attempts to reorganize and change a client negative reasoning, intuition or perception to more positive one.

Social Skills Training: Is a Behavioral counselling Technique used to help persons with difficulties in relating to other people to improve ability to function in everyday social situations, through teaching of some inter personal skills like eye contact, as well as verbal and nonverbal behaviors involved in social interactions.

CHAPTER ONE

INTRODUCTION

1.1 **Background to the Study**

Avoidant Personality Disorder (APD) is one of the personality disorder manifested on students in schools which is characterized by feelings of extreme social inhibition, inadequacy and sensitivity to negative criticism and rejections. It causes significant problems to students with avoidant behaviors which lead to inability to interact with others and maintain relationships in academic life. It makes them to avoid work or school activities as a result of fear of rejection or low self-esteem.

Avoidant Personality Disorder is cluster 'C' types of personality disorder where the person appears painfully shy, socially inhibited, feels inadequate and is extremely sensitive to rejection. The person may want to be close to others, but lacks confidence to form a close relationship. This is why some time known as Anxious Personality Disorder, it is afflicting to persons when they display a pervasive pattern of social inhibition, feeling of inadequacy, extreme sensitivity to negative evaluation, and avoidance of social interactions. People with APD cannot stop thinking about their own shortcomings. They form relationships with other people only if they believe they will not be rejected otherwise they choose to be lonely rather than risk trying to connect with others (Blair, Smallwood, Groves & Rivas-Vazquez, 2008).

The major symptoms of APD are low self-esteem, strong feelings of inadequacy, sensitive to rejection, self-conscious, excessive shy, inhibited, fear of criticism or rejection and inferiority feeling to others. The central fear of people with APD is

rejection, ridicule and humiliation by others. It often interferes with occupational functioning, work and school avoidance especially one that requires inter-personal contact and they are also reluctant to take risks or engage in new activities.

The model age of onset of APD is during adolescence as Turner (1986) found that persons with APD reported an average of 21 years of social distress caused by the disorder and an average of 15 years during which they avoided the feared social situation. Numerous studies have found that a person with APD makes it difficult for them to attain and maintain satisfying social relationships and perfume well at school or work and they are likely to be less employed, less to be married and less to earn as much as their counterparts. APD is also associated with an increased risk of having another psychiatric disorder.

The level of impairment associated with Avoidance Personality Disorder (APD) is high; employment, interpersonal relationships, and global functioning are all negatively affected. The prevalence of the disorder is about 5% in US and Canada communities and predicatively the most prevalent personality disorder in Nigeria communities. It occurs about equally between male and females. One of the major symptoms of APD is avoids occupational activities that involve significant interpersonal contact because of fears of criticism, disapproval or rejections.

As the researcher observed, APD is among the most common personality disorder among senior secondary schools students and it is associated with significant social, occupational, health and educational impairments. The problem of APD continues to plague many schools and communities across Nigeria although not been aware and

identified for early and appropriate actions. APD if left unchecked is a risk factor that leads to a serious delinquency such as truancy, school drop-out, drug addiction, unwanted pregnancy and the like. Therefore it is critical to identify strategies that intervene effectively with youth who have APD behavior in schools and that will interrupt the progress to more serious problem.

Counselling is considered to be the most effective and more permanent treatment for this condition. APD is treated by using many Counselling approaches like cognitive behavioral therapy, social skills therapy, life skills therapy, differential reinforcement technique, miscellaneous behavior change, self-instructional strategies, assertiveness among others which many researches show their effectiveness in the treatments of APD (Sheldon & West, 1990). This work is going to assess the impact of two Counselling techniques on the treatment of APD i.e Cognitive Restructuring (CR) and Social Skills Training (SST) counselling techniques.

The problems concerning treatment of APD symptoms with psychotherapeutic means is that most of the people in Nigerian schools and community including school counsellors, parents, and school administrators consider APD symptoms as a symptom of sprits attack so they prefer some herbal and traditional or religious interventions to cure the scourge of the illness. But the affected students uncomprehended and unprepared remain with their problems in their academic environment and their schooling process. They tend to adopt many inappropriate defensive mechanism which consequently lead them to many delinquent act like truancy, pretending physical illness and alike.

Cognitive Restructuring (CR) as one of the Cognitive Behavior Therapy (CBT) is a Counselling process of learning to identify and dispute irrational or maladaptive thoughts and dispute irrational thoughts which are commonly associated with many mental health disorders such as APD. It is being used to help individuals experiencing a variety of psychiatric conditions including depression, anxiety disorders, bulimia, and social phobia, APD, among others. It is also a useful technique for understanding what lies behind negative moods. CR is a useful tool for understanding and turning around negative thinking. It helps put unhappy, negative thought, under the microscope challenging them and in many cases receipting the negative thinking that lies behind them. In doing this it can help person to approach situations in a positive frame of mind. A number of studies demonstrated considerable efficacy in using CR-based therapist, this is why this study will try to examine its efficacy in the treatments of APD comparable to Social Skills Training technique.

The second Counselling Technique to examine in this study is Social Skills Training (SST) counselling technique. One of the most significant problems for people with APD is difficulty in social interactions. SST can be employed in the treatment of APD in order to gradually increase social contacts. A key issue in the treatment is gaining and keeping the patients trust and making them to begin challenging their exaggerated negative beliefs about themselves. But many school counsellors handling or treating students with avoidant behavior often fail to identify the problem and so over look the diagnosis. It is against this background this research is going to examine the effects of CR and SST counselling techniques in the treatment of Students with the symptoms of APD among secondary school students in Kano metropolis-Nigeria.

1.2 Statement of the Problem

Poor academic achievement is one of the major problems faced by students with the symptoms of APD because they tend to avoid any academic activities that required group work or expressing their views in public as a result of excessive shyness or feeling of inadequacy. And as a result of their avoidant behavior they could not get peer support. Psychological treatment can reduce the symptoms of the APD, unfortunately, observations shows that the psychological process is been neglected and receive less attention in the treatment of the disorder. The persistent of the symptoms of APD among secondary school students in Kano metropolis whose experiences provide too little support for the development of a positive view of self and who find the world as they see it hostile and unpredictable are subjected to a kind of alienation that leads to low self-esteem and worth. Indeed, these symptoms may cause students to avoid participating in all academic activities of the school or general teaching and learning activities in the school. It was observed that, the attitude of teachers, counsellors and all concerned towards students with the Avoidance Personality Disorder (APD) especially in secondary schools is very alarming.

If students with APD receive effective treatment may develop and improve some ability to relate to others, and can participate in all social activities especially in school or work place. But without proper treatment especially at early stage they may become resigned to a life of near total isolation, they may go on to develop a second psychiatric disorder such as substance abuse or mood disorder such as depression. APD can be treated effectively with Cognitive Restructuring Therapy or Social skills Training counselling technique by addressing the underlying reasons behind their disorders through psychotherapy

treatment of professional guidance counsellors. Thus the concern of this study is to investigate the treatment effects of CR and SST counselling techniques on secondary school students with APD. Because CR actively alter maladaptive thought patterns and replace them with more realistic and constructive thoughts, while SST technique on the other hand aimed at Counselling clients to interact effectively with others.

1.3 Objectives of the Study

The following are the objectives of the study:

(1) To find out the effect of Cognitive Restructuring (CR) counselling technique on Avoidant Personality Disorder (APD) among secondary school students in Kano metropolis.

(2) To find out the effect of Social Skills Training (SST) counselling technique on APD among secondary school students in Kano metropolis.

(3) To determine the effects of CR and SST on APD base on technique among secondary school students in Kano metropolis.

(4) To determine the effect of CR on male and female secondary school students in Kano metropolis.

(5) To determine the effect of SST on male and female secondary school students in Kano metropolis.

1.4 Research Questions

The following research questions were formulated to guide this study:

(1) What effect would cognitive restructuring (CR) counselling technique have on students with avoidance personality disorder (APD) among senior secondary school students in Kano State metropolis?

(2) What effect would social skills training counselling technique have on students with avoidance personality disorder (APD) among senior secondary school students in Kano State metropolis?

(3) What is the differential effect of CR and SST counselling technique treatment of students with APD among senior secondary school students in Kano State metropolis?

(4) What is the effect of CR counselling technique on APD of students exposed to CR treatment and those in control group among senior secondary school students in Kano State metropolis?

(5) What is the effect of SST counselling technique on APD of students exposed to SST treatment and those in control group among senior secondary school students in Kano State metropolis?

(6) What is the effect of CR counselling technique treatment on male and female students with APD among senior secondary school students in Kano State metropolis?

(7) What is the effect of SST counselling technique treatment on male and female students with APD among senior secondary school students in Kano State metropolis?

1.5 Hypotheses

The following null hypotheses were formulated and tested in order to achieve the objectives of this study:

(1) There is no significant effect of CR counselling technique on APD among senior secondary school students in Kano State metropolis.

(2) There is no significant effect of SST counselling technique on APD among senior secondary school students in Kano State metropolis.

(3) There is no differential effect of CR and SST counselling technique treatment on APD among Senior Secondary School Students in Kano State metropolis.

(4) There is no significant effect of CR on students with APD base on those exposed to CR counselling treatment and those in control group among Senior Secondary School Students in Kano State metropolis.

(5) There is no significant effect of SST on students with APD base on those exposed to SST counselling treatment and those in control group among Senior Secondary School Students in Kano State metropolis.

(6) There is no differential effect of CR counselling technique treatment on male and female students with APD among senior secondary school students in Kano metropolis

(7) There is no differential effect of SST counselling technique treatment on male and female students with APD among senior secondary school students in Kano metropolis.

1.6 Assumptions of the Study

(1) It is assumed that Cognitive Restructuring (CR) programmed used in counselling session can be effective in reducing symptoms of APD since it will actively alter maladaptive thought patterns and will replace them with more realistic and constructive one.

(2) It is assumed that CR is more effective than SST counselling techniques in reducing APD symptoms among senior secondary school students since how individual think and view himself affects his social behavior. Since CR helps the client to think differently about a situation, event, thought or belief.

(3) It is assumed that CR counselling technique will be more effective on male students than female with the APD behavior.

(4) It is assumed that the SST counselling technique will be more effective on female students with APD behavior than male counterpart.

1.7 Significance of the Study

The research efforts in personality disorder especially in Avoidance Personality Disorder (APD), particularly those that involve constructing a practical teachable modules or units in counselling techniques i.e Cognitive Restructuring (CR) and Social Skills Training (SST) provided the needed tools to those secondary schools teachers and school counsellors for developing ability to think, self concept and self esteem of their affected students that will lead to their social development.

The finding of this study made significant contribution to the students of counselling and psychology especially those who are conducting research in the area of personality disorder by helping them to further their understanding of the symptoms, treatment and causes of Avoidant Personality Disorder. The finding of this work will provide more empirical information on effectiveness of two counselling technique i.e CR and SST. This definitely will motivate teachers and school counsellors not only in Kano state but in Nigeria to use psychotherapy techniques in the treatment of personality disorders in schools rather than medication.

The findings of the present study, however, noteworthy contributions to knowledge in prevalence, causes, nature, symptoms and treatment of students with the symptoms of APD by helping parents, teachers, school counsellors and even health workers to be aware of the disorder and convince them to realize that Avoidant personality disorders can be treated using many psychotherapies techniques in school situations. And also it is very significant by making them to realize that with early detection of the symptoms of APD and successful treatment make students to relax a bit and improve ability to connect to others and form lifelong relations. But if not treated on time children with the symptoms may face a life of isolation and even developing other personality disorders or give in to drug and alcohol abuse.

In addition, the findings of this study will be useful to teachers and practicing counsellors by showing that Cognitive Behavior Therapy is the most recommended form of therapy for APD especially among SSS students who are in their teen ages. Most of the parents consider the symptoms of APD on their ward as an adolescence characteristics and it will soon be over, therefore, this study will be of significant importance to them by making

them to further understand the prevalence of the disorder and need to seek the assistant of professional therapist to get their children evaluated and treated.

Finally, it is hoped that this study will stimulate more counselling research in the area of psychotherapy techniques on personality disorder in Nigeria. And will be a relevant literature that provide resources to parents, students conducting research, school counsellors, school administrators and Education policy makers on personality disorders especially avoidance personality disorder.

1.8 Scope and Delimitation of the Study

The scope of the present study is to assess the effect of two counselling technique: Cognitive Restructuring and Social Skills Training counselling technique on APD among public senior secondary school students in Kano metropolis under Senior Secondary Schools Management Board (SSSMB). And also all other personality disorder were delineated from the study.

The study therefore delimited to senior Secondary two students because they have enough time for the research. Senior Secondary (SSS) School one students are not very conversant with the school and are yet to be socialized with the school environment, teachers and other students, while SSS three are busy taking their SSCE examination, so they do not have enough time for the research. The study was delimited to six (6) SSS in Kano metropolitan which comprise 3 male and 3 female schools in Kano state metropolis.

The study also delimited to only twelve weeks and twelve sessions of thirty minute using a structured treatments program of CR and SST on student's identified with the symptoms of APD using DSM-5 diagnostic criteria for APD.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

2.1 Introduction

This chapter presented a review of available literature on all the variables concerning these psychotherapeutic techniques and Avoidance Personality Disorder. It discussed the concept of personality, basic dimensions of personality, personality disorder, types of personality disorder, gender difference in the prevalence of personality disorder, avoidant personality disorder (APD), **symptoms and diagnosis of avoidant personality disorder,** types of avoidant behavior, characteristic of people with avoidant personality disorder, treatment of avoidant personality disorder, psychotherapy and avoidant personality disorder (APD), behavioral theories, classical conditioning, operant conditioning, cognitive theories, cognitive social learning theory, **cognitive behavior therapy (CBT),** Duration and Frequency of Sessions in Cognitive Behavior Therapy, Techniques of CBT in the Treatment of APD, cognitive restructuring, Applications of Cognitive Restructuring, social skills training, Content of Social Skills Training, and lastly, review of some empirical studies and summary of the study were all presented.

2.2 Conceptual Framework

2.2.1 Concept of Personality

The concept of personality has been widely explained by various psychologists in various theoretical systems in their interest about self-understanding. Personality is an elusive concept because psychologists have disagreed for a long time about exactly how to define

personality (Carver, Scheier, & Weintraub, 1989). Psychologists use the word personality as an abstract concept that can be applied to everyone. Some defined personality as the total all round developmental aspects of the individual person like character, intelligent, honesty, generosity, abilities, emotion, social traits, interest, and attitudes in which a person impresses or attracts other people. Wayne (2008, p.45) defined Personality as an individual's unique constellation of consistent behavioral traits. Magnavita (2004, p.5) clarified that, "Personality is an individual's habitual way of thinking, feeling, perceiving and reaction to the world".

Allport as cited in Carver Scheier & Weintraub (1989, p.268) defines personality as dynamic organization, inside a person and psychophysical systems that create person's characteristics patterns of behavior, thought and feelings. The following assumptions were made by Carver, Scheier & Weintraub (1989, p.267) base on the above definition:

- Personality is not just an accumulation of bits and piece, it has organization.
- Personality does not just lie there; it is active with processes of some sort.
- Personality is a psychological concept, but it is tied to the physical body.
- Personality is a causal force that helps determine how the person related to the world.
- Personality shows up in patterns- recurrences and consistencies.
- Personality is displayed not just one way but many ways, in behavior, thought and feelings.

The above characteristics of personality revealed that lack of organization in a personality is a personality disorder, it can be treated through psychological process, and it could

only be observed indirectly. For one to have a sound personality must to have sound behavior, thought and feelings.

Personality is also viewed as relatively consistent ways in which people feel, behave, think, and relate to others. Individual personality reflects the ways in which other people generally describe them such as calm, anxious, easily angered, mellow, thoughtful, impulsive, inquisitive, or standoffish. All people differ on the usual personalities from time to time but for the most personalities remain fairly stable overtime (Elliott and Smith, 2009).

The two determinant factors affecting the personality of an individual are **Temperament** and C**haracter.** Temperament refers to innate bases of personality such as natural tendencies of organic drives, the effect of glandular balance on the emotions or other physiological causes which affect the person's behavior. While character on the other hand is personality evaluated against the current standards of the culture pattern. Thus it refers to traits such as honest, reliable, and truthful or their opposites, which are either approved or disapproved by the society. Therefore, personality is a factor that affects the directionality of human energies that is how an individual see themselves in relation to the goals they set to achieve, as well as in relation to other individuals. The kind of persons people believe themselves to be and the kind of fears and aspirations they have would determine their performance.

There are two core cases as regard to the concept of personality i.e individual differences and interpersonal functioning. Individual differences means that no two personalities are quite alike even among identical twins. For instance some people are sociable while some

are shy and reclusive. That is to say the central feature of a person is different (Elliot and Smith, 2009). In this sense the major aspect of personality is the uniqueness of the individual.

While interpersonal functioning on the other hand, means a set of processes within the person known as "dynamic organization" of system. That is the personality is not as that one could proud in each situations enter. Instead, there are processes that go on inside individuals, leading them to act the way they do, such processes can create a sense of continuing within the person, even if the person acts differently in different circumstances. That is, the same processes are engaged even if the results differ in different situations (Elliot and Smith, 2009). Some psychologists for instance believe that people's behavior is a product of their motives; motivational tendencies rise and fall over time and across changes. In situations where motive is strongest at any given time determines what the person does at that time. That is to say the dynamic process or interpersonal functioning is the major aspect of personality.

Personality has many perspectives but the major perspective of personality is "human nature". This implies a way of viewing what people are like, different theorists have had very different views about human nature ranging from human nature as primitive beast to human nature as robot. It is very important for us to look at personality from different perspective as it is been explained in many theories.

The following are some major theoretical perspectives on personality as described in Elliot and smith (2009, p.64):

- The dispositional perspective: This is based on the idea that people have fairly stable qualities (dispositions) that are displayed across diverse setting. Human nature, from this point of view, is set of relatively permanent qualities built into the person.
- Biological perspective: emphasizes the fact that human are biological creatures. This approach says personality is genetically based i.e dispositions are inherited. They view that personality reflects the working of the body we inhabit. This biological view focuses on how the nervous system and harmony influence the kind of person one become.
- Psychoanalytic Perspective: It is based on the idea that personality is a set of internal forces that complete and conflict with one another. The focus of this perspective is the dynamics of these forces and the way they influence behavior. Human nature from this viewpoint entails a set of pressure inside the person that sometimes work with each other and sometimes and at war with each other.
- Neoanalytic Perspective: The major emphasis of this perspective concerns with the ego and its development, and importance of social relationships in personality.
- The learning perspective: that is the key quality of human nature, from this perspective it is leant that, behavior changes systematically as a result of experience. They viewed that person's personality is the integrated of whatever the person has learned up till now.
- Phenomenological Perspective: This perspective traces two ideas; the first is that everyone's subjective experience is important, valuable, meaningful and unique. The second is that people tend naturally towards self-perfection and that all

people can move themselves in that direction by exercising their free will to do so. The central view of this perspective is the sense of self-determination of human nature. A person's personality, in this view, is partly a matter of the uniqueness hidden within, and partly a matter of what person chooses to make of that uniqueness.

- Cognitive Self-Regulation Perspective: this view holds that cognitive process is the underpinnings of personality. The nervous system is a huge matrix of buzzing neuron, all sending messages to other neurons. That is to say people are self-regulating systems, setting goals and progressing towards those goals. Somehow the nervous system manifests systematic set of decisions rules. It uses information in organized, coherent, patterned ways rather than randomly.

2.2.2 Basic Dimensions of Personality

The following are the five factors (big-fire) as enumerated in Carver, Scheier & Weintraub (1989, p.268) which are considered very relevant to the symptoms of Avoidance Personality Disorder (APD):

i- Extraversion: - Sometimes this factor seems grounded in assertiveness, an open expression of impulse. Sometimes it is based in a kind of dominance and confident assurance, sometimes a quality of happiness, Extraversion is often thought of as implying a sense of sociability or a by-product.

ii. Agreeableness: - This trait is often characterized as being concerned with the maintaining of relationships; Digman as cited in Carver Scheier & Weintraub, (1989) argued that it is not just a quality of being warm and likeable versus being

cold. Some see it as including a kind of decide compliance. It can also imply a sense of nurturance and emotional supportiveness, requiring inhibition of negative affect (Graziano & Eisenberg as cited in Carver, Scheier & Weintraub (1989, p.276).

Disagreeableness is the opposite of agreeableness. It has an oppositional or antagonistic quality verging toward hostility. People with low agreeableness choose displays of power as way of resolving social conflict more than people with higher in agreeableness and also they experience more conflicts. These people are more vulnerable to APD.

iii. Conscientiousness: It is a quality of planning persistence, and purposeful striving towards goal. Digman as cited in Carve Scheier & Weintraub (1989, p.271) noted that several studies have linked this quality to educational achievement. Dollinger and Orf as cited in Carve, Scheier Weintraub (1989 p280) explain conscientiousness as a "will achieve or simply will". It may also call constraint and responsibility.

iv. Neuroticism or emotionality: It is been referred to as emotional disorganization, because the items contributing to it convey more than the mere presence of emotion. Carve, Scheier & Weintraub (1989, p.280) lamented that heart of this factor is the subjective experience of anxiety.

v. Intellect: It is a trait factor that represents the imaginative and logical side of the personality. Intelligence provides a basis for the broader sense of openness. And openness is relevant to human social experience.

Biological perspective of personality is the genetic influence on personality which refers to temperaments. Temperaments are the person's overall emotional nature. Bush and Robert as cited in Carves, Scheier & Weintraub (1989, p.269) explain temperaments as inherited personally traits present in early childhood. Temperaments are genetically based. They affect what people do, and how people do what they do. Temperament includes three normal personality qualities which include activity level, sociability and emotionality. Therefore the temperamental nature of an individual is very relevant to many causes of personality disorder especially Avoidant Personality Disorder.

2.3.1 Personality Disorder

Since this study is on the treatment of Avoidant Personality Disorder (APD), after brief discussion on the concept of personality, it is pertinent to also discuss on the concept of personality Disorder. Personality is a specific and habitual pattern of individuals, relating to their physical and social environment. Personality can be normal or abnormal (Ozodi, 2010). Where it is normal the individual more or less, gets along with other people in their world in a harmonious manner and is able to hold down schooling, job and make a living. Where the personality is abnormal it is call disorder, that is where the individuals have social conflicts and they are unable to get along with other people where as their intellectual functioning may be well, they have social disorder. This refers to personality disorder (Ozodi, 2010).

Personality Disorders are a variety of personality types, distinguished by **specific sets of behaviors that deviate from what are considered to be spectrums of normal functioning**. Disorders of this kind are marked by severe and chronic disturbances in the

overall development of the personality, with increasingly dysfunctional cognition and behavioral tendencies. Invariably these disturbances manifest as perpetual disruptions in personal relationships and come to affect virtually every aspect of an individual's life (http:// www. dualdia gnosis drug rehab.com, retrieved 2013).

The emerging influence of the five-factor model of personality has led to renewed interest in the traits associated with one particular class of disorder (personality disorder). Carver and Scheer (2004 p267) defined personality disorder as stable, enduring patterns of behavior that deviate from normal cultural expectations and interfere with the person's life or the lives of others. A number of recent research indicates that personality disorder are essentially rigid and extreme manifestations of several of the big five traits (Larstone, Jang, Livesley, Vernon & Wolf in Carver and Scherer, 2004). For example, Cannor and Dyce in Carver, Scherer & Weintraub, (1989 p269) reported finding that represent within the five-factor model. Also Reynolds and Clark in Carver, Scheirer & Weintraub, (1989, p.269) similarly found that the big five did a good job in presenting personality disorder, and that the face scales which narrow scales within the five domains did even better. Personality disorder also refers to a deeply ingrained and maladaptive pattern of behavior that manifest in adolescent and causing long term conditions in which an individual differs significantly from an average person, in terms of how they think, perceive and feel to relate to others. Most model proposed that personality disorder grow from temperamental characteristics that are present from childhood (Millon, in Kantor, 2003)

Personality disorders are typically emerging in adolescence and continue into adulthood. They may be mild, moderate or severe and people may have period of 'remission, where

they function well. It may be associated with genetic and family factors. It also associated with distress experience or fear during childhood, such as neglect or abuse. The American Psychiatric Association (1994, p.3) defined personality disorder as an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture. This pattern is manifested in two or more of the following areas:

1. Cognition: Ways of perceiving and interpreting self, other people and events.
2. Affectivity: The range, intensity, liability, and appropriateness of emotional response.
3. Interpersonal functioning.
4. Impulse control.

One of the distinctive features of personality disorder is the intractability of the individual's perceptions and responses. The individual's patterns of behavior do not vary from situation to situation, but remain constant, and typically only make sense to the person. Overtime this develops into a set of traits that are completely maladaptive and which generate constant conflict, depression, or anxiety. One of the hallmarks of Personality Disorders is inability to sustain personal relationships on any level, attended by the presence of constant upheaval in the personal histories of the sufferer. It is assumed that the emergence of these behaviors has their origins in childhood development, and is often traced back to the quality and kind of relationship the person experienced with a primary care-giver. The rigidity of the behaviors, reactions, and characteristics is striking, and applies to all varieties of the disorder (http:// www. dual diagnosis drugrehab. Com. retrieved 2013).

2.3.2 Types of Personality Disorder

Persons with a personality disorder display more rigid and maladaptive thinking and reacting behaviors that often disrupt their personal, professional, and social. Personality disorder can be broadly group into three clusters: A, B or C categorize in Diagnostic and Statistical Manual of Mental Disorder (DSM-5, www.dsm5, 2013):

1. **Cluste**r **A-** Person with a clusters 'A' personality disorder tends to have difficulty in relating to others usually shows patterns of behavior most people would regard it as odd and eccentric behaviors. The following is the examples of odd/eccentric (Cluster A) personality disorders:
    a. ***Paranoid Personality Disorder:*** Persons with this disorder are often cold, distant, and unable to form close, interpersonal relationships. Often overly, yet unjustifiably, suspicious of their surroundings, persons with paranoid personality disorder generally cannot see their role in conflict situations and often project their feelings of paranoia as anger onto others. Lezenweger et. al. as cited in Out of Fear, Obligation & Guilt (OUT OF FOG, 2007) maintained that, the Comorbidity odds ratio with a person diagnosed with APD and paranoid personality disorder is 0.70 which is very significant.
    b. ***Schizoid personality Disorder:*** Persons with this disorder are often cold, distant, introverted, and have an intense fear of intimacy and closeness. Persons with schizoid personality disorder are often too absorbed in their own thinking and daydreaming that they exclude themselves from attachment with persons and reality.

c. ***Schizotypal Personality Disorder:*** Similar to schizoid personality disorder, persons with this disorder are often cold, distant, introverted, and have an intense fear of intimacy and closeness. Yet, with schizotypal personality disorder, persons also exhibit disordered thinking, perception, and ineffective communication skills. Many symptoms of schizotypal personality disorder resemble schizophrenia, but are less mild and intrusive.

2. **Cluster B**- Person with a cluster 'B' Personality Disorder struggles to regulate their feelings and often swings between positive and negative views of others describe as dramatic, unpredictable and disturbing. The following are examples of dramatic/erratic (Cluster B) personality disorders:

   a. ***Borderline Personality Disorder:*** Persons with this disorder present instability in their perceptions of themselves, and have difficulty maintaining stable relationships. Moods may also be inconsistent, but never neutral - their sense of reality is always seen in "black and white." Persons with borderline personality disorder often feel as though they lacked a certain level of nurturing while growing up and, as a result, incessantly seek a higher level of caretaking from others as adults. This may be achieved through manipulation of others, leaving them often feeling empty, angry, and abandoned, which may lead to desperate and impulsive behavior.

   b. ***Antisocial Personality Disorder:*** Persons with this disorder characteristically disregard the feelings, property, authority, and respect of

others, for their own personal gain. This may include violent or aggressive acts involving or targeting other individuals, without a sense or remorse or guilt for any of their destructive actions.

c. ***Narcissistic Personality Disorder:*** Persons with this disorder present severely overly-inflated feelings of self-worth, grandiosity, and superiority over others. Persons with narcissistic personality disorder often exploit others who fail to admire them, and are overly sensitive to criticism, judgment, and defeat.

d. ***Histrionic Personality Disorder:*** Persons with this disorder are overly conscious of their appearance, are constantly seeking attention, and often behave dramatically in situations that do not warrant this type of reaction. The emotional expressions of persons with histrionic personality disorder are often judged as superficial and exaggerated.

3. **Cluster C-** Person with a cluster 'C' Personality Disorders struggles with persistent and overwhelming feelings of anxiety and fear. They may show patterns of behavior most people would regard as antisocial and withdrawn. The following are examples of anxious/inhibited (Cluster C) personality disorders:

   a. ***Avoidant Personality Disorder:*** Persons with this disorder are hypersensitive to rejection and thus, avoid situations with any potential conflict. This reaction is fear-driven; however, persons with avoidant personality disorder become disturbed by their own social isolation, withdrawal, and inability to form close, interpersonal relationships. Persons with APD appear painfully-shy- socially inhibited, feels,

inadequate and extremely sensitive to rejection. The person may want to be close to others, but lack confidence to form a close relationship. Others include: Fearful and anxious behaviors, dependent and obsessive–compulsive.

b. ***Dependent Personality Disorder:*** Persons with this disorder rely heavily on others for validation and fulfillment of basic needs. Often unable to properly care for themselves, persons with dependent personality disorder lack self confidence and security, and are deficient in making decisions.

c. ***Obsessive-Compulsive Personality Disorder:*** Persons with this disorder are inflexible to change and bothered by a disrupted routine due to their obsession disorder. Thus, they experience anxiety and have trouble completing tasks and making decisions. Persons with obsessive-compulsive personality disorder often become uncomfortable in situations that are beyond their control and have difficulty maintaining positive, healthy interpersonal relationships as a result.

2.3.3 Severe Personality Disorder

To vividly understand APD one need to know how severe the disorder is. Severity could be defined in terms of the harm personality disorder done to others, even if this would apply only to small subgroup of people with personality disorders. Personality disorders have not typically been graded in terms of severity, partly because of the tradition of using categorical descriptions. However, it has long been recognized that not all personality disorders cause the same degree of dysfunction. Millon in Kantor, (2003,

p.160) suggests that borderline, paranoid and schizotypal personality disorders are the most severe types within a social system, because these personality styles characteristically produce significant social incompetence and isolation. Blackburn (2000) suggests that individuals with dependent, histrionic, narcissistic and antisocial personality disorders are deemed to be the least severely disordered in terms of social adaptation. However, if severity is defined by the degree of disorganization caused by a personality disorder within a society, then antisocial and narcissistic personality disorders may both be defined as 'severe'. Here the meaning of the word 'severe' depends on whether one understands it in terms of individual social adaptation or the impact of the individual on a social group.

Severity of personality disorder implies something quite different if the categorical approach of the international classificatory systems is employed. There is some disagreement between the ICD and DSM systems on the types and number of personality disorders that they respectively recognize as existing. It has been suggested that the threshold for making a diagnosis of personality disorder is lower in ICD-10 (Tyrer, in Kantor, 2003), although DSM-5 recognizes Ten different types of the personality disorder, compared with the eight endorsed by ICD-10. The two systems also differ in their respective recommended guidelines for diagnosing personality disorder. The DSM-IV is a more rigid system that advocates a checklist approach to diagnosis, in that a specific number of observable behaviors have to be present for a diagnosis. The ICD-10, trait-based system, allows the clinician a greater degree of flexibility in establishing a diagnosis.

Royal College of Psychiatrists (1999 p45) reviewed the diagnosis of psychopathic and antisocial personality disorders and proposed an additional category, defined as those who manifest 'gross societal disturbance'. A gross disturbance was defined as having one cluster B diagnosis and a personality disorder in at least one other cluster. However, the UK Home Office and the Department of Health (1999) identified a subgroup of offenders with personality disorders who were violent and defined them as having Dangerous and Severe Personality Disorder (DSPD). The DSPD condition, perhaps extrapolating from the recommendations of the College, was defined as the presence of (Hare, 1991):

(a) Two or more personality disorders,

(b) Psychopathic Checklist score of over 30, and

(c) Functional link between the disorder and the violence.

2.3.4 Gender difference in the prevalence of personality disorder

Ronald (2014, p. 67) explained that Cluster A personality disorders are much more common among men than women, is consistent with the suggestion in the DSM–5 (2013) that all three Cluster A personality disorders (paranoid, schizoid and schizotypal) are most common among men. The insignificant association between gender and Cluster B personality disorders, in comparison, is indirectly consistent with the suggestion in the DSM– (2013) that some Cluster B personality disorders are more common among women (histrionic and borderline), whereas others are more common among men (antisocial, narcissistic), with these opposite-sign patterns possibly cancelling out in analyses at the level of the cluster. The DSM–5 (2013) also suggests that some Cluster C personality disorders are more common among men (obsessive–compulsive disorder) and

others among women (avoidant, dependent), raising the possibility that higher prevalence of Cluster C personality disorders among men than women reflects the former pattern dominating the latter pattern **(**Ronald, 2014, p.69).

Therefore considering the above it strengthens the fact that gender difference exist in the prevalence of APD in favor of women gender.

2.4.1 Avoidant Personality Disorder (APD)

After we understand the concept of personality and personality disorder let us go straight to elaborate the concept of Avoidant Personality Disorder (APD) since it is the central focus of this research. As explained in American Psychiatric Association, (2000) Avoidant Personality Disorder (APD) is also known as anxious personality disorder is affecting to people when they display a pervasive pattern of social inhibition, feelings of inadequacy, extreme sensitivity to negative evaluation, and avoidance of social interaction. Kantor, (2003, p.36) emphasized that, People with avoidant personality disorder often consider themselves to be socially inept or personally unappealing and avoid social interaction for fear of being ridiculed, humiliated rejected or dislike. In another narration of American Psychiatric Association, (2000) APD also refers in general to widespread pattern of inhibition around peoples' feeling of inadequate and being very sensitive to being evaluated negatively, since early adulthood and occurring in a range of situations.

In their attempt to trace the origin of the disorder Millon and Martinez as cited in Kantor (2007, p.36) explained that, avoidant personality has been described in several sources as

far back as the early 1900s, although it was not so named for some time. Swiss psychiatrist Bleuler described patients who exhibited signs of avoidant personality disorder in his 1911 work *Dementia Praecox (the Group of Schizophrenias)*.They also maintained that avoidant and schizoid patterns were frequently confused or referred to as synonymously until Kretschmer in1921 who provided the first relatively complete description and developed a distinction between the two (Millon and Martinez, 1995). Avoidant Personality Disorder is listed in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-5, 2013) as a "Cluster C" anxious or fearful disorder. The DSM-5 reports that APD affects approximately 2.4 percent of the population (American Psychiatric Association, 2013). Among patients in outpatient psychiatric clinics, there is between 10% and 20% of that population affected by APD.

APD is characterized by a pattern of withdrawal, self-loathing and heightened sensitivity to criticism. People who suffer from APD often consider themselves as socially unsuccessful and tend to remove themselves from social situations in order to avoid the feeling or the risk of being rejected by others. People who suffer from APD may use withdrawal as a form of communication or as a form of emotional control over friends, partners and family members. Grohol (2015, p.67) maintained that people with avoidant personality disorder experience a long-standing feeling of inadequacy and are extremely sensitive to what others think about them. This leads to the persons to be socially inhibited and feel socially inept.

All social phobic are avoidant, not all avoidance are social phobic, for example, a patient with a social phobic takes the form of a fear of public speaking is technically an avoidant because he or she avoids relating to others, if only in limited way. But many patients who are shy and withdrawn do not complain of being afraid of speaking in public or anything like that. Individual with APD is primarily characterized by diffuse, ongoing dysfunctional relationship which characterized by remoteness, shyness, and/or a tendency to run from closeness and intimacy.

There is a great similarity between social phobic and APD, example person with social phobia like those with APD often avoid the feared social situation making avoidance a key feature of the disorder. To this view Turner in Nancy (2004, p.384) found that 86 percent of a sample of person with social phobia reported avoiding social situation. Nancy as cited in Mark & Michiel (2007, p.385) reported that APD and social phobia appear to be similar in terms of their somatic and cognitive symptom but that behavioral responses may vary. In another the differences between patients with social phobia alone and those with APD was that the later group was also characterized by social skills deficits (Marks in Brown, Heimberg & Juster, 1995).

Avoidant personality disorder (APD) is an enduring pattern of feelings of inadequacy, hypersensitivity to being negatively evaluated by others, and extreme shyness that begins by early adulthood and endures over time, is inflexible and present in a variety of situations, differs from an individual's cultural norms, and results in significant distress or impairment in occupational, social, or other areas of functioning. People with APD generally desire social connection, but are crippled by a sense of personal inadequacy and intense fears of social rejection (Sanislow, Bartolini, and Zoloth, 2012).

Avoidant Personality Disorder (APD), also known as anxious personality disorder, is a Cluster 'C' personality disorder recognized in the Diagnostic and Statistical Manual of Mental Disorders handbook as afflicting a person when they display a pervasive pattern of social inhibition, feelings of inadequacy, extreme sensitivity to negative evaluation, and avoidance of social interaction (American psychiatric Association, 2000). People with avoidant personality disorder often consider themselves to be socially inept or personally unappealing and avoid social interaction for fear of being ridiculed, humiliated, rejected, or disliked. Avoidant personality disorder is usually first noticed in early adulthood. Childhood emotional neglect and peer group rejection. Example bullying is associated with an increased risk for the development of APD.

Avoidant Personality Disorder (APD) described in the World Health Organization's International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10) by the alternate name Anxious Personality Disorder or Anxious (Avoidant) Personality Disorder (OUT of FOG, 2007). Avoidant personality disorder is a mental health condition in which a person has a lifelong pattern of feeling very shy, inadequate, and sensitive to rejection (Blais, Smallwood, Groves, Rivas-Vazquez, 2008).

There is controversy as to whether avoidant personality disorder is a distinct disorder from generalized social phobia and it is contended by some that they are merely different conceptualizations of the same disorder, where avoidant personality disorder may represent the more severe form (Huppert, 2009). This is argued because generalized social phobia and avoidant personality disorder have similar diagnostic criteria and may share a similar causation, subjective experience, course, treatment, and identical

underlying personality features, such as shyness (Ralevski, Sanislow, Grilo, Skodol, Gunderson, Tracie & Bender, 2005).

Avoidant Personality Disorder (APD) is a serious condition which has been found in clinical studies to affect between 1.8% to 6.4% of the general population in USA (But there is no statistical data showing the prevalence of the disorder in Nigeria). It was listed in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-5, 2013) as a "Cluster C" anxious or fearful disorder. APD characterized in OUT of FOG (2007, p.45) as pattern of withdrawal, self-loathing and heightened sensitivity to criticism. People who live in a relationship with a person who suffers from avoidant personality disorder often recognize that something is not quite right with the behavior of their family member or loved-one but often do not know what to do about it or that there is even a name for it. They may feel trapped in the relationship and frustrated by their loved-one's tendency to pull them away from family, friends and other "everyday" social settings (OUT of FOG, 2007, p.67).

Descriptively, the individuals with avoidant personality disorder feel not good enough and feel that if other persons come close to them that they would see them as they are not good, and as such would not like them and would reject them. To avoid their anticipated social rejection they avoid other persons and mostly keeps to them only those who they sure that they accept them not rejecting them. Deep down they feel alone and wish to be related to other persons but fear rejection so much so that they withdraw from people. That is to them social avoidance is a means of maintaining their fictional ideal, perfect self, a self that they dare not expose to other people.

OUT of FOG (2007, p.67) maintained that people who are in a relationship with a person who suffers from APD may also experience pressure to isolate themselves along with them or pressure to protect them from criticism or to create an artificial or dysfunctional "bubble" or ideal environment around them in which they can escape the risk of negative self-thought. People who suffer from APD may use withdrawal as a form of communication or as a form of emotional control over friends, partners and family members. People with avoidant personality disorder experience a long-standing feeling of inadequacy and are extremely sensitive to what others think about them. This leads to the person to be socially inhibited and feel socially inept. Because of these feelings of inadequacy and inhibition, the person with avoidant personality disorder will seek to avoid work, school and any activities that involve socializing or interacting with others (Psych Central, 2013).

Also Psych Central (2013) claims that individuals with Avoidant Personality Disorder often vigilantly appraise the movements and expressions of those with whom they come into contact. Their fearful and tense demeanor may elicit ridicule from others, which in turn confirms their self-doubts. They are very anxious about the possibility that they will react to criticism with blushing or crying. They are described by others as being shy, timid, lonely, and isolated.

The major problem associated with this disorder is that it occurs in social and occupational functioning. The low self-esteem and hypersensitivity to rejection are associated with restricted interpersonal contacts. These individuals may become relatively isolated and usually do not have a large social support network. Psych Central

(2013) conclude that avoidant behaviors can also adversely affect occupational and or schooling functioning because these individuals try to avoid the types of social situations that may be important for meeting the basic demands of the job or for advancement and academic achievement (Psych Central, 2013).

In addition, APD is a **mental health condition characterized by chronic patterns of social inhibition.** The distinguishing features of the disorder are a vulnerability to the criticism of others and a crippling fear that they will be negatively assessed by family, friends, strangers or peers. Because the feelings of inadequacy are so pervasive, behavioral patterns emerge that over time adversely impact every area of the person's life. One of the most common features of this disorder is to experience extreme doubt regarding one's ability to communicate or connect with others, which occurs along with a chronic expectation that they will be the victim of ridicule or humiliation. The conviction that they are inadequate, or that they do not measure up to the standards of others is so overwhelming that virtually every aspect of the person's existence is affected, leading to evasion of any situations in which they will need to interact or socialize. In time, avoidance of these threatening scenarios becomes the primary, operative impulse, leading to extreme isolation and feelings of disconnection. At its most extreme, the entire spectrum of normal social experiences becomes curtailed and one is impaired occupationally, socially, and academically (http://www.dualdiagnosisdrugrehab.com. Retrieved, 14/10,2014).

2.4.2 Symptoms and Diagnosis of Avoidant Personality Disorder

According to the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5, 2013) avoidant personality disorder (APD) is a psychological condition characterized by *a pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation.*

The major symptoms of APD as enumerated in Alsayouf (2014, p.56) include the following three behaviors:

1. Avoiding work, social or school activities for fear of criticism or rejection. This is because people with APD have a low threshold for criticism and often imagines themselves to be inferior to others. Thus, they are certain no one will like them, and expect others will ridicule them. This leads them to avoid social situations because they anticipate these encounters will be painful and unpleasant experiences to them. Because of these thoughts, it is unlikely they will have any fun at parties, classroom interactions, extra-curricular activities or other social events and so they miss opportunities to have a fulfilling social life.

2. Low self-esteem: People with an APD tend to think they are completely flawed and inferior to others. Persons with an Avoidant Personality Disorder are unable to recognize both their good and bad qualities. Their extremely negative self-image convinces them that other people see them in the same way as flawed and inferior. They might avoid social situations or avoid public speaking and hence miss out on professional and networking opportunities that usually benefit career development and advancement.

3. Self-isolation: When in social situation, a person with APD may be afraid to speak up for fear of saying the wrong thing, blushing, stammering, or otherwise getting embarrassed. They may also spend a great deal of time alone in isolation anxiously studying those around them for signs of approval or rejection.

Therefore, avoidant personality disorder can be recognizing correctly by understanding its symptoms and taking note of them. The following are the most important symptoms visible in people with APD (http://www.peopleskillsdecoded.com, 2013, Retrieved, March, 2014):

- Avoiding social activities and spending huge amounts of time alone;
- Having a very small social circle and only carrying brief interactions with the people in it;
- A major reluctance to meeting new people and a strong feeling of inadequacy when dealing with them;
- Being generally reserved and quiet when interacting with others, due to fear of saying something improper and being shamed;
- Being over-preoccupied with how they are seen by others, due to fear of being disliked or rejected;
- Frequently fantasizing about having social interactions that turn out the way they want them to;
- Not rising up to their potential in their career, due to running away from opportunities that require them to be social;
- Seeing themselves as socially unskilled, awkward or inferior to others.

People with avoidant personality disorder are preoccupied with their own shortcomings and form relationships with others only if they believe they will not be rejected. Loss and rejection are so painful that these individuals will choose to be lonely rather than risk trying to connect with others. The following include the major symptoms of APD as outline in Healthline Networks, (2003, p1):

- Hypersensitivity to rejection/criticism
- Self-imposed social isolation
- Extreme shyness or anxiety in social situations, though the person feels a strong desire for close relationships
- Avoids physical contact because it has been associated with an unpleasant or painful stimulus
- Feelings of inadequacy
- Severe low self-esteem
- Self-loathing
- Mistrust of others
- Emotional distancing related to intimacy
- Highly self-conscious
- Self-critical about their problems relating to others
- Problems in occupational functioning
- Lonely self-perception, although others may find the relationship with them meaningful
- Feeling inferior to others
- In some more extreme cases — agoraphobia

- Utilizes fantasy as a form of escapism and to interrupt painful thoughts.

Millon, in Magnavita (2004, p.56) demonstrate that, psychologists note that because most patients present a mixed picture of symptoms, their personality disorder tends to be a blend of a major personality disorder type with one or more secondary personality disorder types. Therefore he identified four adult subtypes of avoidant personality disorder and their features as follows:

- **Phobic** (including dependent features)**:** one of the subtypes of APD is phobic that is general apprehensiveness displaced with avoidable tangible percipient; qualms and disquietude symbolized by repugnant and specific dreadful object or circumstances.
- **Conflicted** (including negativistic features)**:** Internal discord and dissension; fears of independence and dependence; unsettled; unreconciled within self; hesitating, confused, tormented, paroxysmal, embittered; irresolvable angst.
- **Hypersensitive** (including paranoid features): Intensely wary and suspicious; alternately panicky, terrified, edgy, and timorous, thin-skinned, high-strung, petulant, and prickly.
- **Self-deserting** (including depressive features): Blocks or fragments self-awareness; discards painful images and memories; casts away untenable thoughts and impulses.

The World Health Organization's ICD-10 (International Statistical Classification of Diseases and Related Health Problems, 1992) lists avoidant personality disorder as

anxious (avoidant) personality disorder. It is characterized by at least four of the following (ICD-10, 1992):

1. persistent and pervasive feelings of tension and apprehension;
2. belief that one is socially inept, personally unappealing, or inferior to others;
3. excessive preoccupation with being criticized or rejected in social situations;
4. unwillingness to become involved with people unless certain of being liked;
5. restrictions in lifestyle because of need to have physical security;
6. avoidance of social or occupational activities that involve significant interpersonal contact because of fear of criticism, disapproval, or rejection.

The essential features of a personality disorder are impairments in personality (Self and interpersonal) functioning and the presence of pathological personality traits. To diagnose avoidant personality disorder, the following criteria must be met (DSM-5 2013):

1. Avoids occupational activities that involve significant interpersonal contact, because of fears of criticism, disapproval, or rejection.
2. Is unwilling to get involved with people unless certain of being liked.
3. Shows restraint initiating intimate relationships because of the fear of being ashamed, ridiculed, or rejected due to severe low self-worth.
4. Is preoccupied with being criticized or rejected in social situations.
5. Is inhibited in new interpersonal situations because of feelings of inadequacy.
6. Views self as socially inept, personally unappealing, or inferior to others.
7. Is unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing.

A formal diagnosis of APD requires a mental health professional to identify at least four out of the above seven criteria as positive. Some people with APD may exhibit all the seven but most of the people exhibit only a few. Even normal healthy people will experience or exhibit a few of the above criteria from time to time but this does not make a person APD.

Avoidant personality disorder is social withdrawal due to intense, anxious or shyness. People with avoidant personalities are reluctant to interact with others unless they feel certain of being liked. They fear being criticized and rejected. Often they view themselves as socially inept and inferior to others. Earlier theorists proposed a personality disorder with a combination of features from borderline personality disorder and avoidant personality disorder, called "avoidant-borderline mixed personality" (Kantor, 2003). Research suggests that people with avoidant personality disorder, in common with sufferers of chronic social anxiety disorder (also called social phobia), excessively monitor their own internal reactions when they are involved in social interaction. However, unlike social phobic they also excessively monitor the reactions of the people with whom they are interacting. The extreme tension created by this monitoring may account for the hesitant speech and taciturnity of many people with avoidant personality disorder; they are so preoccupied with monitoring themselves and others that producing fluent speech difficult.

The following are the most common features of Avoidance Personality Disorder as outline in http://www.dualdiagnosisdrugrehab.com, (retrieved 14/10/2014, p.9):

- Extreme anxiety regarding to rejection.

- Chronic isolating.
- Extreme stress in social situations, even when the desire for friendship is present.
- Avoiding physical contact.
- Associating physical contact with negative experiences.
- Evading personal relationships.
- Intense feelings of inadequacy.
- Crippling sense of low self-esteem.
- Fostering self-loathing.
- Paranoia regarding the motives of others.
- Anxiety regarding issues of intimacy.
- Preoccupied with self.
- Hyper-sensitivity regarding criticism.
- Inability to relate to others
- Recurring problems regarding occupational consistency.
- Intense loneliness, to the extent that it defines their self-image.
- Feeling inferior to others.
- Crippled by an inability to try new activities or to take risks.

People with this disorder cannot stop thinking about their own shortcomings. They form relationships with other people only if they believe they will not be rejected. Loss and rejection are so painful that these people choose to be lonely rather than risk trying to connect with others (http://www.dualdiagnosisdrugrehab.com, retrieved 14/10/2014, p.9).

A person with avoidant personality disorder as describe in Blais, Smallwood, Groves, & Rivas-Vazquez (2008, p.1) may:

- Be easily hurt when people criticize or disapprove of them.
- Hold back too much in intimate relationships.
- Be reluctant to become involved with people.
- Avoid activities or jobs that involve contact with others.
- Be shy in social situations out of fear of doing something wrong.
- Make potential difficulties seem worse than they are. and
- Hold the view they are not good socially, not as good as other people, or unappealing.

Personality disorders such as avoidant personality disorder are typically diagnosed by a trained mental health professional, such as a psychologist or psychiatrist. Family physicians and general practitioners are generally not trained or well-equipped to make this type of psychological diagnosis. So while you can initially consult a family physician about this problem, they should refer you to a mental health professional for diagnosis and treatment. There is no laboratory, blood or genetic tests that are used to diagnose avoidant personality disorder (American Psychiatric Association, 1994). Avoidant personality disorder is diagnosed based on a psychological evaluation that assesses the history and severity of the symptoms. (Blais, Smallwood, Groves, & Rivas-Vazquez, 2008).

Also according to American Psychiatric Association (1994) many people with avoidant personality disorder do not seek out treatment until the disorder starts to significantly interfere or otherwise impact a person's life. This most often happens when a person's coping resources are stretched too thin to deal with stress or other life events. A diagnosis

for avoidant personality disorder is made by a mental health professional comparing the symptoms and life history with those listed in the criteria manual. They make a determination whether the symptoms meet the criteria necessary for a personality disorder diagnosis. (American Psychiatric Association, 1994).

A formal diagnosis of APD requires a mental health professional to identify four (4) or more out of the following seven (7) diagnostic criteria as positive to Avoidant Personality Disorder (APD) (DSM-5 2013):

1. Avoids occupational activities that involve significant interpersonal contact, because of fears of criticism, disapproval, or rejection.

2. Is unwilling to get involved with people unless certain of being liked.

3. Shows restraint initiating intimate relationships because of the fear of being ashamed, ridiculed, or rejected due to severe low self-worth.

4. Is preoccupied with being criticized or rejected in social situations.

5. Is inhibited in new interpersonal situations because of feelings of inadequacy.

6. Views self as socially inept, personally unappealing, or inferior to others

7. Is unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing.

Some people with APD may exhibit all seven (7) while most will exhibit only a few. Nobody's perfect. Even normal healthy people will experience or exhibit a few of the

above criteria from time to time. This does not make a person APD (OUT OF FOG 2007).

2.4.3 Types of Avoidant Behavior

For one to understand and be able to identified person with APD need to be aware of the different types of avoidants behavior Kantor (2003) distinguishes the following four types of avoidant behavior according to the specific way their underlying social or relationship anxiety becomes manifest clinically:

(1) Types I: Shy/Social phobic Avoidant: these types are distinguished by their use of withdrawal mechanism to manage their social anxiety. This is further categorized into two subtypes; shy and social phobic avoidant.

i- *Shy type I avoidant* have difficulty forming relationships. They are seriously isolated individuals and they found it difficult to work in team or with coworkers or even in crowed large city. The following are the major characteristics of Shy type I aviodants as summarize from Kantor (2003, p.52):

- Type I shy aviodants are less isolated; they have a few friends selectively in fear of disregard or disgrace. They only meet with others occasionally but no close intimates. They sometimes complained about being lonely and isolated.
- They tend to be, and come across to others as, self-conscious, introverted, and lacking in self-confidence.
- They are neophobes; they initiate relationship because they fear what are call unknown fate holds in store for them.

- Other type I shy avoidant do manage to get out, and even got so mixed, parties, or gathering. However they function poorly once they get there, standing off completely by themselves, or speaking only to the person they came in with. They regularly complain that they are dissatisfied with the narrowness of their lives, but just as regularly add that however had they try to change their luck they can never seem to do any better.

ii- *Social phobic type I avoidants* also use withdrawal mechanisms to handle their social anxiety. However they display their withdrawal mainly symbolic calling and they do so specially in situations where they feel called upon to perform such as being asked to write a check or speak in public.

(2) Type II "Mingles" Avoidants: Type II or mingles avoidant give just the opposite impression. They look, at least superficially, as if they are well-related and sometime even better related than average. Unlike type I shy avoidant, type II mingles avoidant are very comfortable socializing and are even neophiles who want to, can, and like to attend social functions and initiate relationship once they get there. However, while they found it easy to form new relationships, they find it hard to keep them going.

The following are the several subtypes II Mingle avoidants as summarize from Kantor (2003, p.53):

i- The Anxious type: Anxious type II aviodants are too fearful to maintain new relationship because they are both too highly attuned to the possibility of being criticized, humiliated, and rejected and because they take actual criticism, humiliations, and

rejections too seriously. The following are some characteristics of anxious type II avoidants (Kantor, 2003):

- ❖ They are rejection sensitive because they expect too much from the world.
- ❖ They forget that rejection is part of life's give and take.
- ❖ They expect miracles on a regular basis.
- ❖ In many cases a catastrophic reaction follows.
- ❖ They are rejection sensitive because their self-esteem is very low.

ii- The Ambivalent Type: Ambivalent Type II avoidants are too uncertain to pursue relationships without seriously vacillating. They simultaneously experiencing or expressing opposing or contradictory feelings, beliefs or motivations. For example they condemn others for being too remote and unfriendly act very dependent and beg others to love them.

iii- The Masochistic Type: Masochistic type II aviodants prove the truth of the Freudian formulation that behind every fear is a hidden wish. (Driving pleasure from abuse, being punished, or dominated). While they manifestly complain about fearing rejection, they secretly desire it, because they fear acceptance even more, and with it the success that acceptance brings. As such they arrange to have their relationship fail. They might arrange to fail by pursuing quantity over quality. Or they might arrange to fail by joining groups of other aviodants with the same or similar problems. Each group member seeing to it that the other members meet no one outside of the group heavy drinking or drugs abuse is a common features or this group. Another example of people with masochistic type II aviodants is that, they might arrange to fail by selecting distant unavailable people to relate to, or people with a fatal flow, such as those who dislike them or those who are

already taken, may be because they are already married or highly influence person. Masochistic aviodants often have rescue fantasies in which they long to turn impossible situations around, then make efforts to do so, even knowing that their efforts are virtually certain to come to nothing. For example a man who want to marry a married women by other person.

iv. The Disassociate Type: Disassociate type II aviodants, when faced with the danger, as they see it, of being accepted and getting what they want, go into a trance or enter another one of their multiple personalities. Sometimes disassociation/trance behaviors was meant to be protective but was actually self-destructive.

v- The Hypomanic Type: Hypomanic type II aviodants never seem to be able to settle down. Many of them are overly active in the singles' scene. They frantically socialize looking for a mate only to jump one situation that does not work to another that works just as badly, continuing that pattern in spite of its obvious futility. A chic and sophisticated lifestyle often fills their days with insignificant others who function for them as more hood ornaments. Their major goal in life is to impress people. They decorate and redecorate themselves, their apartment so that it would look stunning when they are in crowd or people came to visit them. When actually rejected, Hypomanic type II aviodants make an especially frantic attempt to feel loved once again. They rush about looking for lovers, grabbing the first accepting person who comes along; not for any winning quality that person might have, but to get unrejected, and to undo a sense of despair and a feeling of emptiness.

(3) Type III Seven Year Itch Avoidant: The Type III seven years itch aviodants are able to form more-or-less and satisfactory relationship, but they can only do so for a finite period of time. They have difficulty committing fully right relationship in a long period of time. They may start right from the beginning a healthy relationship, or at least appear to do so, and they do so for a long time. Eventually, however they feel restless, question their commitment, and opt out without necessary reason to do so.

Type III aviodants fear not rejection but continuance. They are neophiles because they fear oldness, that is, familiarity. They grow impatient with the old relationship, and grab at the new. Becoming restless and impulsive, they are defective compare to past or future company, discarding present partners summarily, and saying that they plan to look for someone new who can better serve their needs. They convinced that it is easier to find a new love than it is to tolerate an old relationship they begin to date again,

(4) **Type IV: Dependent/ Codependent Aviodants:** Type IV dependent aviodants are those who are too close to their parents, live at home with no lover or spouse. Even less obviously avoidant are immersion codependent aviodants who seem nonaviodants because in a close, all-encompassing loving, permanent relationship, but are, however, not so much relating to one as they are hiding from all. They use to form relationship of mutual need in a situation with avoidant person so that to have codependent behavior and feeling. So often they are not the healthy if overly dependent relationships they appear to be at first glance, but are rather unhealthy hostile-dependence relationship.

2.4.4 Characteristic of People with Avoidant Personality Disorder

The following is the main characteristics of people who are suffering from avoidant personality disorder as elaborated in Kantor (2003, p.36):

i- Behavior of the Avoidant: Not all avoidant act overtly shy and fearful. Some avoidant, particularly Type I avoidant, convert their shyness into nonverbal-expressive somatic displays of avoidant anxiety. They hide their anxiety as a sexual problem, such as a man's impotence or a woman's dyspareunia when used as a way to detach from a partner. In contrast, type II "mingles" avoidant distance not by being fearful or shy but by withdrawing partially, not completely. They detach themselves either by making sensible choices of friends and lovers only to withdraw when closeness threatens, or by selecting friends and lovers whom they sense will be wrong for or unavailable to them right from the start. For example, they select partners who are too handsome or beautiful to be readily attainable. Type III avoidant distance themselves by growing weary of perfectly good ongoing relationships and abandoning suitable partners seemingly without warning. Also, type IV avoidant distance by merging into a relationship with one person to detach themselves from the rest of the world. In short all avoidant, Type I–IV, are capable of distancing by being either openly or covertly (passive-aggressively) hostile.

ii- Speech Rate of the Avoidant : There are two groups of avoidant. The first tends to be silent, and the second tends to be over talkative. In the realm of the silent avoidant, Galvin in Kantor (2003, p.36) notes that, "for a rabbit, freezing on a lawn is a sign of fear". That is to say speechlessness is a similar diagnostic sign for APD. There is a circuit in the brain that controls our vocal cords, and becoming quiet can be one sign of fear.

Extreme introverts have a difficult time beginning conversation at a place where they do not know anyone. The first hour can be painful and also how exterior sluggishness and inactivity can be a cover-up for chronic tension (Millon in Kantor 2003).

In the realm of the over talkative avoidant, here underlying interpersonal anxiety or panic is expressed not as impoverishment of speech or outright silence but as an effusive garrulousness often with over inclusiveness, tangentiality, and circumstantialities of speech that may be accompanied by a degree of disorganization of thought. This effusive garrulousness may originate as a direct manifestation of adrenergic discharge; in an affective process (hypomania); in cognitive error.

iii- Speech Content of the Avoidants: Unendearing "foot-in-the-mouth" blunders and other off-putting conversation-stoppers are characteristic of the more hostile avoidants. These include throwing-cold-water-in-the-face retorts, insinuations/indelicacies, and outright social blunders. For instance Talking about oneself too much is a common method Type II avoidants use to put distance between themselves and others. Boring topics thrust on an unwilling listener also belong in this category, such as one man's need to debate, every chance he got, Off-putting verbal tics that drive others to despair are also found, such as calling everything "little" to devalue it; overusing the trite expressions "well" and "you know" or both together as "well, you know"; including all of one's second thoughts in every pronouncement for purpose of accuracy and or using the same questioning word or phrase over and over again, like the obsessional uncertainty/apology of ending every sentence with, "Is that right?" or "Is that okay?" to indicate personal hesitation and to express intrusively an excessive need for confirmation and love.

iv- Thought of the Avoidant: Avoidant thought consists of a number of *cognitive errors* that lead the avoidant to conclude that he or she should fear relationships. To anticipate, avoidants who think catastrophically, they feel and believe that any sign of uninterested in them becomes a turndown, a turndown becomes a rejection, and a rejection becomes an event of tragic proportions. The inability in waking life to make and keep personal contacts has its counterpart dreams whose theme is being unable to relate, being abandoned, being alone, and being lonely. In some dreams the sense of isolation/failure is expressed directly, while in others the expression is symbolic.

v- Affect of the Avoidant: Some avoidants deal with their fears of being rejected by developing a protective bluntness of affect that comes across as a removal. Others deny the possibility of being rejected by becoming hypomanic. Still others become depressed in order to become inured to a rejection that they are certain will come. As mentioned throughout, many avoidants are hostile people. Thus Millon in Kantor (2003, p.160) notes the presence of "tension, sadness and anger in avoidants, "states that avoidant profiles are often shared with passive-aggressive" (avoidant-passive-aggressive mixed personality), and notes that avoidants have "strong elements of counter hostility". Also, Frances and Widiger in Kantor (2003, p.38) state that avoidants are, like passive aggressive, likely to be higher on hostility than dependents. Anger in avoidants can be part of their temperament; a defense against relating, for example, identifying with the aggressor and becoming critical of others.

vi- Good Insight of the Avoidant: Avoidant with good insight are aware that they have relationship anxiety and that it is a problem for them. They read books about their

avoidance, analyze themselves, and consult therapists for help in getting over their inhibitions so that they can be free to express the loving that they have inside.

vii- Partial/Compromised Insight of the Avoidant: Many avoidant lack a degree of insight into their avoidance. Their insight is partial or compromised in one of a number of ways. In one form of partial or compromised insight, avoidant do seek change for their difficulty relating, but they do not seek that change through treatment. Rather they seek it through discovering the new and better club, apartment, house in the country, clothier, hairstylist, or dating service. In another form of partial or compromised insight, avoidant have good superficial but impaired deep insight. Such avoidant may be aware that they are avoidant but not why. They view their inability to connect as a natural, expected response to inner or outer circumstances beyond their control. They blame their biology, physical problems, or advanced age, or remain convinced that bad luck, fate, and the stars explain why they cannot meet their ambitions. Finally, partial/compromised insight is often the product of a comorbid emotional disorder. For example, in depressed avoidant insight is typically present but self-punitive. Depressed avoidant do not, like paranoid avoidant, externalize their forbidden impulses so that they may attribute them to others and criticize them accordingly. Rather they heap abuse on themselves for their difficulties. As a result they close off constructive dialogue by viewing themselves not as troubled and conflicted but as too dim-witted to be helped.

Viii- Poor Insight avoidant: Still other avoidant have little insight, superficial or deep. Characteristically, uninsightful avoidant have simply built their avoidance into their lives, unquestioningly, with little or no idea of why they are so uncomfortable and dissatisfied with their existence. They avoid certain situations, objects, activities, fields of interest or

qualities of feeling without being aware of the avoidance. They have relationships, but they are unaware that what relationships they have are not truly intimate. Rather their relationships are what Sullivan in Kantor (2003) has called “ritual preoccupations” and what Fenichel in Kantor (2003) has called “substitute gratifications”. They believe that some of their prejudices, such as homophobia, are an appropriate negative response to real.

2.4.5 Causes of Avoidance Personality Disorder (APD)

The causes of avoidant personality disorder are not clearly defined, and may be influenced by a combination of social, genetic, and psychological factors. The disorder may be related to temperamental factors that are inherited. Specifically, various anxiety disorders in childhood and adolescence have been associated with a temperament characterized by behavioral inhibition, including features of being shy, fearful, and withdrawn in new situations. These inherited characteristics may give an individual a genetic predisposition towards APD. Childhood emotional neglect and peer group rejection are both associated with an increased risk for the development of APD (Eggum, Eisenberg, Spinrad, Valiente,Edwards, Kuefer and Reiser, 2009).

Alden (2002, p.29) suggested that biological predisposition and environmental factors which transform the predisposition into the long-standing behavioral pattern. Alden add that some socially shy and avoidant clients described developmental histories that involved emotional or physical abuse, where as others identified more benign environmental factors, such as coming from large family, as the primary causes of their shyness.

The background of the people with avoidance personality disorder probably have some medical (biological) issues (which ought to be treated medically) that make them feel inadequate and inferior. That is to say that there is a biological aspect to their personality disorder. Additionally, their fear of social rejection is so complex because they invented an ideal, important, powerful self, a false self, and want other persons to accept that deluded grandiose self and fears that they would not accept it. Therefore they avoid other people to prevent them from rejecting their imaginary ideal, important selves (Ozodi, 2010).

The precise causes of APD are not well understood. Genetic traits and child abuse or neglect are most often associated with the disorder, but no conclusive study exists. Most people who suffer from Avoidant Personality Disorder are, by nature, reluctant to seek out treatment and programs such as individual therapy, couples therapy and group therapy are likely to make someone with APD feel very uncomfortable. As a result, most cases of APD go undiagnosed and untreated and it is left to spouses, partners and family members and friends to do the best they can (OUT OF FOG 2007). For those who have sought treatment, some symptoms of APD have been found to be reduced through prescription of SSRI antidepressants. Therapy programs typically involve social skills training, cognitive behavioral therapy and group therapy (OUT OF FOG, 2007).

Researchers today do not know what causes avoidant personality disorder. There are many theories, however, about the possible causes of avoidant personality disorder. Most professionals subscribe to a biopsychosocial model of causation that is, the causes are likely due to biological and genetic factors, social factors such as how a person interacts

in their early development with their family and friends and other children, and psychological factors the individual's personality and temperament, shaped by their environment and learned coping skills to deal with stress. This suggests that no single factor is responsible rather; it is the complex and likely intertwined nature of all three factors that are important. If a person has this personality disorder, research suggests that there is a slightly increased risk for this disorder to be "passed down" to their children (American Psychiatric Association, 1994).

There is no direct cause of APD but it's speculated to be a combination of social, genetic and biological factors. Those with the condition often fear rejection and criticism so intensely that they will literally remove themselves from social situations and spend the majority of their time by themselves. If forced into a social situation, APD sufferers will usually come off as awkward or distant, making building meaningful personal relationships incredibly difficult and their behavior is generally off-putting by those around them. Many doctors are reluctant to diagnose those under the age of 18 for the disorder, as symptoms can be seen in those who have little to no experience in real world social situations.

Cause of avoidant personality disorder is unknown. Genes or a physical illness that changed the person's appearance may play a role. About 1% of the USA population has avoidant personality disorder. (Blais, Smallwood, Groves, & Rivas-Vazquez, 2008).

2.4.6 Treatment of Avoidant Personality Disorder

Treatment of personality disorder is not the process of killing the virus but is through the process of imposing *new way of thinking, feeling and behaving.* The methods of intervention that have been *proven to work best for overcoming avoidant personality disorder are cognitive-behavioral therapy and coaching which include Cognitive Restructuring, Social Skills Training, systematic Desensitization, Modeling, Assertive Training, to mention few*. There is a raft of research that confirms the success of these methods. Blais, Smallwood, Groves and Rivas-Vazquez (2008) maintained that, talk therapy is considered to be the most effective treatment for *avoidant personality disorder*. It helps persons with this disorder be less sensitive to rejection. Antidepressant drugs may be used in addition. No other methods even come close to the elegance and effectiveness of cognitive-behavioral method (http://www.peopleskillsdecoded.com, 2013).

The treatment of APD is typically involves the following three folded process of using cognitive-behavioral principles and techniques as described in http:// www. peopleskillsdecoded.com (2013 p. 54):

1) Challenging and changing dysfunctional thinking. People with avoidant personality disorder tend to have a lot of limiting beliefs, plus an unrealistic view of social standards and of themselves. These need to be corrected by consciously changing the way they think.

2) Gradual exposure. People with avoidant personality disorder need to gradually face those exact situations they are afraid of and they typically avoid. Systemic exposure,

combined with combating unrealistic thinking that will set their mind and emotions on the right path.

3) Improving people skills. Since individuals with APD avoid social situations as much as they can, their people skills have often atrophied or they have never truly developed at all. Thus, training key people skills and learning how to start a conversation, how to keep it going or how to connect with people is crucial.

Unfortunately, the mix of symptoms and causes for APD create an unending cycle of social anxiety that can only get worse if left untreated. Those with APD will become increasingly self-conscious and self-critical of themselves until they begin avoiding social situations altogether. Not only will they begin avoiding these situations but they will also begin to fear them, eliminating any social contacts and ensuring a drop in the quality of their lives. Treatment options vary from psychological evaluations to cognitive-behavioral therapy in hopes of creating new coping methods with their fears. Group therapy may also be incredibly beneficial for treating APD, as they offer safe, secure environments in which they are encouraged to interact with others dealing with the same internal issues. There is no way to live a healthy life when you avoid any and all social situations (Blais, Smallwood, Groves, Rivas-Vazquez, 2008).

Treatment of avoidant personality disorder can employ various techniques, such as social skills training, cognitive therapy, exposure treatment to gradually increase social contacts, group therapy for practicing social skills, and sometimes drug therapy (comer, 1996). A key issue in treatment is gaining and keeping the patient's trust, since people with avoidant personality disorder will often start to avoid treatment sessions if they

distrust the therapist or fear rejection. The primary purpose of both individual therapy and social skills group training is for individuals with avoidant personality disorder to begin challenging their exaggerated negative beliefs about themselves (Ecleberry, 2000).

People with this disorder may develop some ability to relate to others. With treatment this can be improved. Without treatment, a person with avoidant personality disorder may lead a life of near or total isolation. They may go on to develop a second mental health disorder such as substance abuse or a mood disorder such as depression. People with APD can improve social awareness and skills, but with deep-seated feelings of inferiority and significant social fear, these patterns usually do not change dramatically (HealthLine Network, 2003).

Treatment of avoidant personality disorder typically involves long-term psychotherapy with a therapist that has experience in treating this kind of personality disorder. Medications may also be prescribed to help with specific troubling and debilitating symptoms (American Psychiatric Association, 1994). Most people who suffer from Avoidant Personality Disorder are, by nature, reluctant to seek out treatment and programs such as individual therapy, couples therapy and group therapy which are likely to make someone with APD feel very uncomfortable. As a result, most cases of APD go undiagnosed and untreated and it is left to spouses, partners and family members and friends to do the best they can (OUT OF FOG, 2007). For those who have sought treatment, some symptoms of APD have been found to be reduced through prescription of SSRI antidepressants. Therapy programs typically involve social skills training, cognitive behavioral therapy and group therapy (OUT OF FOG, 2007).

The treatment of Avoidant Personality Disorder includes such therapeutic tools Cognitive Therapy, Cognitive Behavioral Therapy, Group Therapy, what is referred to as Social Skills Training, Cognitive Restructuring and various medications. Because one of the chief characteristics of APD is a chronic mistrust of others establishing a trusting relationship with the person suffering is pivotal to successful treatment. Despite the differences of these various modalities, what is consistent is the need to help the sufferer deconstruct the belief-system which keeps them ill.

One of the key differences between Avoidant Personality Disorder and other personality disorders is that APD clients are usually able to perform some kind of reality testing, and thereby circumvent the minimizing, denial, and externalization that so characterizes disorders like Borderline or Narcissism. It is surmised that individuals with APD suffer such intense psychic pain that in certain circumstances they actively seek out treatment and are therefore more amenable to the demands treatment makes.

Talk therapy is considered to be the most effective treatment for this condition. It helps persons with this disorder be less sensitive to rejection. Antidepressant drugs may be used in addition. Treatment methods are widely available and APD treatment begins with an acknowledgement of the issue and a willingness to undergo social skills training (Blais, Smallwood, Groves, Rivas-Vazquez, 2008).

2.4.7 Avoidant Personality Disorder and Affective Disorder (Comorbidity)

Avoidant personality disorder is reported to be especially prevalent in people with anxiety disorders, although estimates of Comorbidity vary widely due to differences in diagnostic instruments. Research suggests that approximately 10–50% of people who

have panic disorder with agoraphobia have avoidant personality disorder, as well as about 20–40% of people who have social phobia (social anxiety disorder). Some studies report prevalence rates of up to 45% among people with generalized anxiety disorder and up to 56% of those with obsessive-compulsive disorder in USA (Van Velzen, 2002).

People who are diagnosed with Avoidant Personality Disorder also frequently meet the criteria for other personality disorders. The table below shows statistically how likely it is that a person who is diagnosed with APD will also meets the criteria for another personality disorder. The more *positive* the number, the *more* likely it is that a person will be diagnosed with the second personality disorder listed. The more *negative* the number, the *less* likely it is that a person will be diagnosed with the second personality disorder in the table. (OUT OF FOG 2007):

	Personality Disorder	***Comorbidity Odds-Ratio***
1	Paranoid Personality Disorder	**0.70**
2	Schizoid Personality Disorder	**0.55**
3	Schizotypal Personality Disorder	**0.53**
4	Antisocial Personality Disorder	**0.05**
5	Borderline Personality Disorder	**0.54**
6	Dependent Personality Disorder	**0.70**
7	Obsessive-Compulsive Personality Disorder	**0.63**

Source: Lenzenweger, Lane, Lorange & Kessler (2007).

2.3.7.1 Avoidant Personality Disorder and Depression

The following are the simultaneous appearance of avoidant personality disorder with depression as summarized from Kantor (2003, p.92):

i- Self-Destructiveness: Avoidants who are not depressed often try to get over being avoidant by developing their old and finding new relationships. To this end, instead of allowing their appearance and behavior to deteriorate, they take special Schizotypal and pains to maintain and improve their interpersonal appeal in the hope that they will meet new people who will be part of their recovery. In contrast, avoidants who are simultaneously depressed enhance their avoidance by staying stuck in the mire of their depression, deliberately failing to make repairs so that they can stay unappealing to others, even setting out to antagonize or horrify others just so that they can make disappointment, rage, grief, and hypersensitivity.

ii- Hypersensitivity: Depressed avoidant take everything much too seriously and imagine that they are being rejected when they are not. For example, they get angry even at a little joke that is in any way at their expense, or misinterpret positive gestures as negative.

iii- Selfishness: Depressed avoidant tend to be selfish people who act as if they are the only ones with feelings and needs. For example, one such depressed avoidant never attended funerals because "death bothers me," knowing that he would, and actually hoping to, antagonize family and friends also bothered by death.

iv- Anger: Depressed avoidants, like other depressives, are angry people but instead of internalizing their anger, hoping to keep it to themselves to spare others' feelings, they express it freely, then excuse themselves with a convenient rationalization.

v- Low Self-Esteem: Depressed avoidants develop low self-esteem that leads to an increased need for approval from others. This increases the likelihood that they will interpret any sign that they are not fully accepted as evidence that they have been rejected. As a result they constantly feel criticized, humiliated, rejected, and abandoned, and require full reassurance that they will be accepted before they can even think about relating. What many require is a "parental" stamp of approval before starting or pursuing a relationship. Depressed avoidants use their low self-esteem to hold others off or drive them away. Their low self-esteem takes on a critical quality toward others as they attack others with their self-criticisms.

vi- Apathy and Boredom: In depressed avoidant apathy and boredom is a way to send the off putting message to present company that "you are not worth my time and attention." The message is either sent in words alone or nonverbally in behavior via a certain restlessness whose message is "you are too dull and too boring to hold my attention for long."

vii- Anxiety/Panic: Instead of suppressing panic for the greater good, depressed avoidant encourage it in themselves in the hope that it will become contagious, just so that they can give their misery some company.

viii- Grief: For the depressed avoidant, grief is an opportunity to live in the past as a way to tell others in the present that they don't match up to former friends and lovers. During the difficult transitional period after a loss, instead of grieving for old relationships because they are gone, and instead of grieving to maintain old relationships, if only in fantasy, depressed avoidant grieve predominantly in order to make a retrospective

positive distortion of a partly or entirely negative relationship so that they can treat any new relationship as inferior, and as an infidelity, to an old one. Whereas for grieving non avoidant every new relationship is a fresh sign of hope, for grieving avoidant every new relationship, by recalling the old relationship lost, becomes a fresh reason for despair.

2.4.7.2 Avoidant Personality Disorder and Hypomania

The following are the simultaneous appearance of avoidant personality disorder with Hypomania as summarized from Kantor (2003, p.95):

i- Compulsive Sexual Behavior: Compulsive Sexual Behavior is non paraphilic compulsive sexual behavior which is "normative sexual behavior taken to a compulsive extreme. Non paraphilic compulsive sexual behavior is classified as affective to emphasize how this behavior is primarily a Hypomanic defense against depression. Hypomanic avoidant often act out sexually, doing so in one of the five ways as delineates by Coleman in Kantor (2003, p.95): compulsive cruising and multiple partners, where cruising is ritualistic and trance inducing; compulsive fixation on an unattainable partner; compulsive autoeroticism; compulsive multiple love relationships; and compulsive sexuality in a relationship.

ii- Superficial Euphoric Franticness: Hypomanic superficial euphoric franticness is a way for avoidant to relate poorly while simultaneously fooling themselves and others into thinking that they are relating well. They relate to large numbers of people in order not to have to relate to one significant other or even to a few intimates. While actually keeping people at bay, they maintain the illusion of making/having meaningful relationships via a hyper relatedness that serves the purpose of denying their remoteness and isolation to

themselves. Some relate to an anonymous them, as did the avoidant who had a relationship with his fan club to avoid having a relationship with a personal fan. They disrupted relationships that worked with people they knew for relationships that might not work with people they hardly knew. Although they instinctively perceived that as they grew older leaving the familiar to try out the new was a dangerous way to live, they often moved on just to tempt fate, only to later become depressed, and wildly lament their future prospects.

iii- Grandiosity and Narcissism: Grandiose narcissistic hypomanic avoidants are selfish people who recognize their own but not others' needs, give only in anticipation of getting, have a "what did you do for me lately" attitude that makes others only as good as their latest contributions, and develop an undue comfort about exacting greater and greater tribute while feeling neither beholden to those who give it nor the need to pay them back.

2.4.7.3 Avoidant Personality Disorder and Social Phobia

Avoidant personality disorder (APD) is highly comorbid with social phobia (SP), particularly the specific subtype of SP, Generalized Social Phobia (GSP). Patients with SP and APD have greater social impairment and depressive Comorbidity. GSP patients with APD reported significantly higher levels of depression than GSP patients without APD. Similarly GSP patients with APD also reported significantly greater social fear and avoidance than the patients with GSP alone. No significant differences were found between two groups regarding hopelessness, alexityhmia, anxiety, and functional

impairment. When occurring with GSP, APD increased the degree of psychopathology; however, this did not result in greater functional impairment. (Alberta, 2013, p.201).

Social phobia, also known as Social Anxiety Disorder (SAD), is defined as the pervasive fear of social or performance situations due to concerns about being judged or embarrassed (American Psychiatric Association, 2000). To be diagnosed with social phobia according to current nosological standards (i.e., the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision criteria), social fears must lead to avoidance behaviors or intense anxiety in unavoidable situations and be associated with clinically significant impairment or distress. Indeed, research suggests that social phobia tends to be a pervasive, chronic, and debilitating condition that affects occupational, social, and academic functioning, resulting in diminished social occupational achievement, restricted social relationships, and substance abuse (Bruch, Fallon, and Heimberg, 2003).

The relationship between social phobia and APD continued to be an area of controversy. In the revised third edition of the Diagnostic and Statistical Manual of Mental Disorder (DMM-lll- R; American Psychiatric Association, 1987), defined social phobia as a fear of one or more situation 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, while APD in the other hand was defined as a pervasive pattern of social discomfort, fear of negative evaluation, and timidity which present in a variety of contexts.

But, APD and Social Phobia are different disorders classified on different diagnostic axes. Brown, Heimberg and Juster (1995) reported that scores on measures of social anxiety were higher among individuals with generalized social phobia and APD than those without APD. Individuals with social phobia (social anxiety disorder) and avoidant personality disorder typically hold a distorted and negative view of themselves as a social object. An extreme case of social phobia with avoidant personality disorder, illustrates the complex interrelatedness between the perception of social norms, interpersonal relationships, and the self. Considering these variables in treatment can translate into powerful intervention strategies. The interventional therapy should combine basic behavioral principles and novel cognitive intervention strategies to specifically modify his distorted sense of self as a social object. This intervention led to a dramatic improvement, which was maintained at a 1-year follow-up assessment (Hofmann, 2007).

Base on numerous studies (Lenzenweger, Lane, Lorange & Kessler, 2007) the prevalence of APD appears to be at least twice the prevalence of social phobia. The prevalence of social phobia has been estimated to be about 8 percent in recent studies. The most widely accepted estimates of social phobia have based on large, nationally representative epidemiological studies. Also Carducci & Zimbardo, 1995 and Spieberger, Poland & Worden, 1984 reported the estimate prevalence of APD are much higher than rates of social phobia, ranging from 20 - 48 percent. Although variability in the prevalence estimates of both APD and social phobia exist and may reflect differences in methodology, the prevalence estimates of APD are consistently higher than those of social phobia. These prevalence studies suggest that APD and social phobia are not the same condition.

APD is often found in association with other Axis I disorders (Clinical Disorders) and with other Axis II disorders (Personality Disorders). These comorbid disorders alter the clinical presentation, the dynamics, and the treatment of APD. The following are some of the examples of comorbidity impact on APD as summarized from Alden, Loposa ,Taylor & Ryler (2002):

- Avoidants who are also *depressed* tend to be resistant because they see anything other than pure encouragement on the part of the therapist as nonsupport.
- Avoidants who are also *masochistic* tend to be resistant because they respond to getting better by feeling worse, a negative therapeutic reaction that if not recognized and managed correctly from the start can lead to therapeutic failure.
- Avoidants who are also *obsessive compulsive* tend to be resistant due to being volatile, unpredictable and stubborn individuals who respond to treatment by taking one step backward for every step forward.
- Patients who simultaneously present with Avoidant and Schizotypal Personality Disorder are highly impaired in their ability to relate to others. But their impairment is relative, not as some observers would have it, absolute, that is, it is due to anxiety, not to a basic incapacity for interpersonal relationships. These individuals remain capable of intense relationships but they withdraw from them defensively, to an extreme. A homeless man who was diagnosed both with Avoidant Personality Disorder and Schizotypal Personality Disorder complained that the shelters for the homeless were so bad that he preferred to live out on the streets. A schizotypal avoidant only occasionally spoke to others, and then spoke a few words only. He also grew a long beard, and rarely bathed.

- Avoidants also diagnosed with schizoid personality disorder tend to be shy and withdrawn to the extreme. Some observers are thus led to conclude that they have a primary deficit in their ability to relate. Others conclude that, as with schizotypal patients, their lack of relatedness is secondary, that is, due to anxiety.
- Avoidant personality disorder and paranoid personality disorder. In these paranoid avoidants are very sensitive to criticism, humiliation, and rejection which were fueled by an inability to trust others. Paranoid avoidants lose their ability to trust others because they question others' motives based on incorrect assumptions they make about what others are thinking. Many of these incorrect assumptions originate with defensive projection that amounts to attributing their own negative thoughts to others. As a result, paranoid avoidants conclude that others disdain them the same way they disdain themselves, and that others dislike them the same way they dislike others. They then withdraw after becoming wrongly convinced that others hate them a withdrawal they secretly planned all along.

2.5.0 Theoretical Frame of Work

Psychotherapy is the practice of spending time with a psychological professional trained counsellor to help diagnose and treat mental and emotional problems. Therapy can take various forms like cognitive behavioral therapy, mindfulness-based cognitive therapy, psychodynamic therapy, psychoanalysis, etc. or a combination of these but at the center of each is the caring relationship between a professional counsellor and a client. Since this research is coin to study the effect of cognitive restructuring counselling technique

and social skills training on students with the symptoms of Avoidance personality Disorder among secondary school students the both two techniques are base on Cognitive-Behavioral Therapy, therefore the theoretical basis of this work is ***Cognitive-Behavioral Theory (CBT)*** which is a combination of two therapies i.e Cognitive and Behavioral Theories. It is based on the belief that using both cognitive therapy and behavioral therapy is more effective than just one of these types. Robert (2006) explained that the boundaries between behavioral and cognitive learning theories have become increasingly indistinct in recent years as each school of thought has incorporated the findings of the others.

2.5.1.1 Cognitive Behavior Therapy (CBT)

Cognitive behavior therapy (CBT) is a form of psychotherapy that helps person to change unhelpful or unhealthy thinking habits, feelings and behaviors. It is also a form of psychotherapy that treats problems and boosts happiness by modifying dysfunctional emotions, behaviors, and thoughts. Unlike traditional Freudian psychoanalysis, which probes childhood wounds to get at the root causes of the conflict, CBT focuses on solutions, encouraging patients to challenge distorted cognitions and change destructive patterns of behavior (http://www.psychologytoday .com, 2014).CBT is used to help people of all ages, but the therapy should be adjusted based on the age of the patient with whom the therapist is dealing.

Cognitive Therapy (CT) or Cognitive Behavior Therapy (CBT) was pioneered by Aaron T. Beck in the 1960s, while he was a psychiatrist at the University of Pennsylvania. Cognitive behavior therapy is based on the cognitive model: “the way we

perceive situations influences how we feel emotionally" (Academy of Cognitive Therapy, 2014). It focuses on changing unhelpful or unhealthy thoughts and behaviors. It is a combination of two therapies: '***cognitive therapy'*** and '***behavior therapy'***. The belief of both these techniques is that healthy thoughts lead to healthy feelings and behaviors. Cognitive behavior therapy is based on a cognitive theory of psychopathology. The cognitive model describes how people's perceptions of, or spontaneous thoughts about, situations influence their emotional, behavioral and often physiological reactions. Individuals' perceptions are often distorted and dysfunctional when they are distressed. They can learn to identify and evaluate their "automatic thoughts" (spontaneously occurring verbal or imaginable cognitions), and to correct their thinking so that it is more closely resembles reality. (http:// www.beckinstitute. org/beck-cbt, 2013).

Grohol, (2015, p.15) maintained that Cognitive Behavior Therapy (CBT) combines two very effective kinds of psychotherapy: cognitive therapy and behavioral therapy. Behavior therapy helps to weaken one connection between stimuli (people, situations, or events) and their habitual, undesirable reactions to them. These undesirable reactions may include fear, sadness, anger, self-defeating or self-damaging behavior, worry, panic, including avoidant behavior. Behavior therapy also teaches relaxation strategies to calm the mind and body so that one can feel better and think more clearly.

Cognitive therapy emphasizes the role of thinking in how we feel and what we do. Cognitive therapists instruct clients to identify unhealthy thoughts that can lead to unwanted feelings and behavior. Clients are taught how to replace unhealthy thoughts with healthier thoughts that lead to more desirable reactions (Grohol, 2015, p.68). When Cognitive therapy combined into CBT, behavior therapy and cognitive therapy provide

very powerful tools for stopping symptoms of worry, fear, anxiety, anger, depression, shynes, sensitive to rejection and low self esteem.

Cognitive and behavioral methods are used to modify dysfunctional thoughts and beliefs. The therapist and client engage in a laid back, collaborative process of testing the validity of dysfunctional thoughts. The objective of treatment is to change the client's dysfunctional worldview, self concept, automatic negative thoughts and distorted cognitive processes.

Cognitive behavior therapy is one of the few forms of psychotherapy that has been scientifically tested and found to be effective in hundreds of clinical trials for many different disorders. In contrast to other forms of psychotherapy, cognitive behavior therapy is usually more focused on the present, more time-limited, and more problem-solving oriented. In addition, patients learn specific skills that they can use for the rest of their lives. These skills involve identifying distorted thinking, modifying beliefs, relating to others in different ways, and changing behaviors (http://www.beckinstitute.org, 2014). Cognitive behavioral therapy can be thought of as a combination of psychotherapy and behavioral therapy.

Martin (2007, p.15) explained c**ognitive behavioral therapy a**s a short-term, goal-oriented psychotherapy treatment that takes a hands-on, practical approach to problem-solving. Its goal is to change patterns of thinking or behavior that are behind people's difficulties, and so change the way they feel. It is used to help treat a wide range of issues in a person's life, from sleeping difficulties, avoidant behavior or relationship problems, to drug and alcohol abuse. CBT works by changing people's attitudes and their behavior

by focusing on the thoughts, images, beliefs and attitudes that they hold (cognitive processes) and how this relates to the way they behave, as a way of dealing with emotional problems.

Generally speaking, CBT is a style of therapy in which the therapist works with the client to deconstruct negative self-images and focus on altering the dysfunctional thinking that has developed as a response to triggering stimuli, and requires the client to adopt modified behaviors in situations where exposure to a danger is present. One of the primary advantages of Cognitive Behavioral Therapy is its tendency to alleviate symptoms while simultaneously curtailing the condition itself. The central premise is to help the client develop new coping strategies in the face of impending or inevitable arousal (http://www.dualdiagnosisdrugrehab.com, 2013).

Martin, (2007, p.38) described the important advantage of cognitive behavioral therapy as it tends to be short, taking four to seven months for most emotional problems. Clients attend one session per week, each session lasting approximately 50 minutes. During this time, the client and therapist are working together to understand what the problems are and to develop a new strategy for tackling them. CBT introduces them to a set of principles that they can be apply whenever they need to, and which will stand them in good stead throughout their lives.

Cognitive Behavioral styles include cognitive restructuring, rational-emotive and behavior therapy, rational-emotive therapy, systematic desensitization and social skills training. The goal of cognitive therapy is to focus on dismantling the cognitive distortions

that occur in regards to self-worth and self-image. The guiding principle is to have the therapist assist the person to identify negative thought patterns and discern their origin.

A typical CBT programme consists of face-to-face sessions between patient and therapist, made up of 6-18 sessions of around an hour per each session. Brief Cognitive Behavioral Therapy (BCBT) is a form of Cognitive Behavioral Therapy (CBT) which has been developed for situations in which there are time constraints on the therapy sessions. BCBT takes place over a couple of sessions that can last up to 12 accumulated hours by design (http://www.psychologytoday .com, 2014).

Cognitive theories rose to prominence in response to the early behaviorists' failure to take thoughts and feelings seriously. The cognitive movement did not reject behavioral principles. Rather, the idea behind the cognitive movement was to integrate mental events into the behavioral framework. Cognitive Behavioral theories are considered to be "cognitive" because they address mental events such as thinking and feeling. They are called "behavioral" because they address those mental events in the context of the learning theory that was the basis for the pure behavioral theory described above. (Rashmi, Nataie and Mark, 2007).

2.5.1.2 Duration and Frequency of Sessions in Cognitive Behavior Therapy

It is very pertinent to discuss the issue of duration and frequency of treatment sessions especially CR and SST which are both CBT technique. Two advantages of CBT are that it is relatively brief in duration and quite flexible in implementation. CBT typically has been offered in 12 to 16 sessions, usually over 12 weeks (Carroll, 1998). The form of

CBT used in NIAAA's Project MATCH (Kadden, Carrol, Donova, Cooney, Monti, Abrahams & Hester, 1992) consisted of 12 sessions, administered as individual therapy, meeting once per week. The sessions included eight "core" sessions that dealt with alcohol-related issues (e.g., coping with craving, drink refusal, relapse emergency planning) and general problem-solving skills that all clients were expected to receive, and four "elective" topic areas chosen from a menu of more general social and interpersonal issues based on individually assessed problem areas. A 12-session CBT for cocaine addicts suggested that this length of treatment is sufficient to achieve and stabilize abstinence from cocaine (Carroll, 1998). However, not all clients will respond in that amount of time. In such cases, an initial trial CBT can serve as preparatory to a more intensive treatment experience.

Hofmann as cited in http://www.beckinstitute.org, 2014 summarized the modern CBT approaches as it tends to be short, taking six weeks to six months. Clients will usually attend a session once a week, each session lasting either 50 minutes or an hour. Together with the therapist they will explore what the problems are and develop a plan for tackling them. They will learn a set of principles that they can apply whenever they need to and they may find them useful long after you have left therapy.

2.5.1.3 Techniques of CBT in the Treatment of APD

The dominant theme in the treatment is the patients' image of low self-esteem as it accounts at least in part, for their "unfriendly behaviors and actions". Therefore the therapist use behavioral techniques to help patients correct the consequence of their illogical thinking by reducing the anxiety of practicing social skills.

Ronald (1998) as cited in Kantor (2003, p.28) suggests a cognitive approach to shyness and social public unitizing the following techniques, among others:

i. Motivate yourself by recording why you want to change.

ii. Develop self-control.

iii. Learn how to interpret and think about situation and other people more realistically. For example by learning that feedings and emotions and directly caused by thoughts, attitudes and beliefs, not by the things going on outside.

iv. Identify and change basic beliefs and unwritten laws such as everyone must like me and if I am not liked I am worthless.

v. Identify and challenge basic fear the things that make you anxious

vi. Don't over estimate the likelihood that bad things will happen in social situations. Ask 'What is the evidence for the expectation? And, reassuringly, tell yourself, if the worst should occur, "so what?

vii. Use meditation and relaxation to reduce anxiety

viii. Practice attention strengthening exercise to help pay strict attention to the task and hand

ix. Engage in previously avoided behavior gradually one step at a time, stay in a situation until you start to calm down, and don't be discouraged by had days.

x. Enhance your results by getting feedback from people you trust and by videotaping yourself so that you can see yourself as others see you.

Also in CBT approach Anthony and Swinson in Kantor (2003) laid out specific for teaching the patient how to interact and communicate effectively with other people. They offer patients social skills training for example, they help them to learn to listen, modify off-putting nonverbal communication and develop conversational skills. They teach them how to go on job interviews, how to communicate assertively instead of too passively hesitantly, shyly or passive aggressively, how to meet new people, make new friends, and date; and how to develop public speaking skills.

Benjamin in Kantor (2003) suggests that the therapist should help avoidant patients block maladaptive patterns with "desensitization" she recommends group therapy for some avoidant noting that new skills can be developed in the group and normal social development can follow. The Quality Assurance Project as cited in Kantor (2003, p.160) essentially agreeing with Benjamin note that sometimes "social skills training can lead to areas of increased social activities with decreased associated anxiety, a lessening of social isolation with diminished depression, and the loss of many irrational social beliefs".

Gradual exposure technique is suitable for shy avoidant and social publics such as those afraid of public speaking do not work well for vacillating avoidant who cannot settle down, commitment phobic who fear closeness and intimacy, seven years itch avoidant who become restless in at least what appear to be steady, non problematical relationships and feel, to their own detriment and to that of their partners, that they simply have to move on, and dependant- regressed avoidant who hide out in one bodice to avoid ever having to face the world out there beyond their all engulfing bosom.

CBT could enhance the coping strategies already being employed by people with APD. The following characteristics of coping training were described by Tai and Turkington, in Turkington and Kingdon (2000, p.29):

1. Emphasis on the normal and general process of dealing with adversity (psychosis is an example of adversity).
2. Use of over learning, simulation, and role playing.
3. Addition of coping strategies together to progress toward *in-vivo* implementation.
4. Provision of a new response set to ongoing problems.
5. Coping skills that often begin with external verbalization, which then diminishes as the procedure becomes internalized.
6. Behavioral coping skills that are learned through graded practice or rehearsal.

Turkington and Kingdon (2000, p.29) also summarize the main techniques as follows:

1. Develop a therapeutic alliance based on the patient's perspective
2. Develop alternative explanations of APD symptoms
3. Reduce the impact of positive and negative symptoms
4. Offer alternatives to the medical model to address medication adherence.

The following are the six phases of Cognitive Behavior Therapy Turkington and Kingdon (2000, p.30):

1. Assessment or Psychological assessment;;
2. Reconceptualization;
3. Skills acquisition;

4. Skills consolidation and application training;
5. Generalization and maintenance;
6. Post-treatment assessment follow-up.

Cognitive Behavioral Therapy (CBT) is perhaps the most researched therapeutic approach over the last half Century. It has the advantage of being able to be broken down into brief discrete strategies and used in opportunistic moments, of being effective in addressing a wide range of mental conditions, and being especially effective with depression, anxiety, anti- social disorder and addictions. Perhaps even more importantly, it can be effective when the client/patient is using prescription medicine and/or is, as is often the case, affected by more than one condition.

2.5.1.4 History of Cognitive Behavioral Therapy

CBT was primarily developed through an integration of behavior therapy with cognitive psychology therapy. Many works conducted by Donald and several other authors with the label of cognitive behavior modification in the late 1970s. This tradition thereafter merged with earlier work of a few clinicians, labeled as cognitive therapy (CT), developed by Aaron Beck, Cognitive Restructuring, and Ration Emotive Therapy (RET) developed by Albert Ellis. While rooted in rather different theories, these two traditions have been characterized by a constant reference to experimental research to test hypotheses, both at clinical and basic level. Common features of CBT procedures are the focus on the "here and now", a directive or guidance role of the therapist, a structuring of the psychotherapy sessions and path, and on alleviating both symptoms and patients' vulnerability (Martin, 2007).

In the 1960s, Aaron T. Beck, a psychiatrist, observed that during his analytical sessions, his patients tended to have an **internal dialogue** going on in their minds, almost as if they were talking to themselves. But they would only report a fraction of this kind of thinking to him (Martin, 2014). Beck realized that the link between thoughts and feelings was very important. He invented the term **automatic thoughts** to describe emotion-filled thoughts that might pop up in the mind. (Martin, 2007).

Beck called it cognitive therapy because of the importance it places on thinking. It is now known as cognitive-behavioral therapy (CBT) because the therapy employs behavioral techniques as well. The balance between the cognitive and the behavioral elements varies among the different therapies of this type, but all come under the umbrella term cognitive behavior therapy. CBT has since undergone successful scientific trials in many places by different teams, and has been applied to a wide variety of problems (Martin, 2007). Cognitive therapy makes the assumption that thoughts precede moods and that false self-beliefs lead to negative emotions. Cognitive therapy aims to help the patient recognize and reassess his patterns of negative thoughts and replace them with positive thoughts that are more closely reflecting reality (Rupke, David and Marjorie, 2006).

As a result of his findings, Beck began to look for other ways of conceptualizing depression. He found that depressed patients experienced streams of negative thoughts that seemed to arise spontaneously. He called these cognitions "automatic thoughts." He found that the patients' automatic thoughts fell into three categories. The patients had negative ideas about themselves, the world and/or the future. Therefore he began helping patients identify and evaluate these automatic thoughts. He found that by doing so,

patients were able to think more realistically. As a result, they felt better emotionally and were able to behave more functionally. When patients changed their underlying beliefs about themselves, their world and other people, therapy resulted in long-lasting change. Beck called this approach "cognitive therapy." It has also become known as "cognitive behavior therapy" (Martin, 2007).

Since its introduction, CBT has been studied and proven effective in treating a wide variety of disorders. More than 500 studies have demonstrated its efficacy for psychiatric disorders, psychological problems and medical problems with a psychiatric component. Today, research continues into cognitive therapies for suicide prevention, and schizophrenia and other psychopathologies (Martin, 2007). Beck drew on many sources when he developed cognitive therapy. In turn, current researchers and theorists have expanded on his work, and several forms of cognitive therapy have evolved. Although these variants emphasize different things, all share common characteristics of Beck's therapy (Martin, 2007).

In initial studies, cognitive therapy was often contrasted with behavioral treatments to see which was most effective. During the 1980s and 1990s, cognitive and behavioral techniques were merged into cognitive behavioral therapy. Pivotal to this merging was the successful development of treatments for panic disorder by David M. Clark in the UK and David H. Barlow in the US.

Cognitive behavior therapy (CBT) has a well-elaborated theoretical background and documented standard therapeutic process, fulfilling the criteria for a true system of psychotherapy by virtue of the fact that it provides a comprehensive theory of

psychopathology and a body of knowledge and empirical evidence to demonstrate its effectiveness. It also retains a certain degree of flexibility in its philosophy and theory, allowing for the accommodation of new modalities. On the treatment implementation level, CBT is continually evolving, with technique-related developments appearing as a consequence of integrating new research results. CBT is considered to be the most heavily researched form of psychotherapy Simos as cited in Szentagotai, (2005), reflecting the scientist-practitioner model, which is generally regarded as being the essence of contemporary CBT (Martin, 2007).

2.5.5 How Does Cognitive Behavioral Therapy Differ From Other Therapies

Cognitive-behavioral therapy differs from many other types of psychotherapies because sessions have a structure, rather than the person talking freely about whatever comes to mind. At the beginning of the therapy, the client meets the therapist to describe specific problems and to set goals they want to work towards. The problems may be troublesome symptoms, such as sleeping badly, not being able to socialize with friends, or difficulty concentrating on reading or work. Or they could be life problems, such as being unhappy at work, having trouble dealing with an adolescent child, or being in an unhappy marriage (Academy of Cognitive Therapy, 2014).

The focus and method of cognitive behavioral therapy sets it apart from other, more traditional therapies in the following ways as enumerated in Martin (2007, p.45):

- ***CBT is based on two specific tasks:*** cognitive restructuring, in which the therapist and patient work together to change thinking patterns, and behavioral activation --

in which patients learn to, overcome obstacles to participating in enjoyable activities. CBT focuses on the immediate present: what and how a person thinks more than why a person thinks that way.

- ***CBT focuses on specific problems:*** In individual or group sessions, problem behaviors and problem thinking are identified, prioritized, and specifically addressed.
- ***CBT is goal oriented:*** Patients working with their therapists are asked to define goals for each session as well as longer-term goals. Longer-term goals may take several weeks or months to achieve. Some goals may even be targeted for completion after the sessions come to an end.
- ***The approach of CBT is educational.*** The therapist uses structured learning experiences that teach patients to monitor and write down their negative thoughts and mental images. The goal is to recognize how those ideas affect their mood, behavior, and physical condition. Therapists also teach important coping skills, such as problem solving and scheduling pleasurable experiences.
- CBT patients are expected to take an active role in their learning, in the session and between sessions. They are given homework assignments at each session. Some of them graded in the beginning and the assignment tasks are reviewed at the start of the next session.
- CBT employs multiple strategies, including Socratic questioning, role playing, imagery, guided discovery, and behavioral experiments.
- CBT is time limited. Typically, treatment with CBT lasts 14 to 16 weeks.

CBT therapy also differs from other therapies in the nature of the relationship that the therapist will try to establish. Some therapies encourage the client to be dependent on the therapist, as part of the treatment process. The client can then easily come to see the therapist as all-knowing and all-powerful. The relationship is different with CBT (Academy of Cognitive Therapy (ACT), 2014).

The following are the major goals of CBT (http://www.beckinstitute.org, 2014):

- Cognitive behavior therapy (CBT) is a type of psychotherapy that helps the person to change unhelpful or unhealthy habits of thinking, feeling and behaving.
- CBT involves the use of practical self-help strategies, which are designed to affect positive and immediate changes in the person's quality of life.
- CBT can be as effective as medication to treat depression and anxiety.

2.5.1.6 The Effectiveness of CBT

In hundreds of clinical trials, CBT has been demonstrated to be an effective treatment for a wide variety of disorders. It has been found useful in (http://www.beckinstitute.org, 2014):

- ***Personality disorders*** such as depression, the full range of anxiety disorders, eating disorders, substance abuse, Avoidance personality disorders, bipolar disorder and schizophrenia to mention a few;

- ***Medical disorders with a psychological component,*** including several conditions involving chronic or acute pain, chronic fatigue syndrome, pre-menstrual

syndrome, colitis, sleep disorders, obesity, Gulf War syndrome, and somatoform disorders; and

- ***Psychological problems*** such as anger, relationship difficulties, and compulsive gambling.

CBT is also used to address stress, low self-esteem, grief and loss, work-related problems and problems associated with aging which are the symptoms of APD.

2.5.1.7 Issues to Consider Before Choosing CBT

Before choosing CBT, issues you may like to consider include:

- CBT may not be the best form of therapy for people with any type of brain disease or injury that impairs their rational thinking.
- CBT requires you to actively participate in treatment. For example, you may be asked to keep detailed diaries on thoughts, feelings and behaviors. If you are not prepared to put in the work, you may be disappointed with the results of therapy.
- CBT involves a close working relationship between you and your therapist. Professional trust and respect is important. If you don't like the therapist at the first interview, look for another one.
- While CBT is considered a short-term form of psychotherapy, it may still take months or longer for you to successfully challenge and overcome unhealthy patterns of thinking and behavior. CBT may disappoint you if you are looking for a 'quick fix'.

2.5.1.8 Basic Principles of Cognitive Behavior Therapy

There are several approaches to CBT. These include Rational Emotive Therapy, Rational Behavior Therapy, Rational Living Therapy, Cognitive Restructuring Therapy, Social Skills Training and Dialectic Behavior Therapy. In general, most of these approaches follow the principles listed below (Grohol, 2015 and Beck, 2011):

1: Cognitive behavior therapy is based on an ever-evolving formulation of patients' problems and an individual conceptualization of each patient in cognitive terms.

2: Cognitive behavior therapy requires a sound therapeutic alliance.

3: Cognitive behavior therapy emphasizes collaboration and active participation.

4: Cognitive behavior therapy is goal oriented and problem focused.

5: Cognitive behavior therapy initially emphasizes on the present.

6: Cognitive behavior therapy is educative, aims to teach the patient to be her own therapist, and emphasizes relapse prevention.

7: Thoughts cause us to feel or behave in certain ways, not external things like people, situations, and events. This is the foundation of CBT. The benefit of this fact is that healthier thinking can lead to feeling better and reacting better even if people, situations, or events around us do not change.

8: CBT works best when the therapist or coach teaching the principles has a positive relationship with the client.

9: CBT is based on an educational model. The goal is to help clients unlearn their unwanted reactions and to learn a new way of reacting to people, situations, or events.

10: Homework is important in CBT. Instructors who use a CBT model will frequently assign homework to their clients. The purpose of homework is to practice healthy ways of thinking and reacting to people, situations, or events.

An approach that has gained widespread application in the treatment of APD is cognitive behavioral therapy (CBT). Its origins are in behavioral theory, focusing on classical conditioning, operant conditioning and cognitive social learning theories. The idea concerning observational learning, the influence of modeling, and the role of cognitive expectancies in determining behavior are been taken from social learning theory; and cognitive theory which focus on the thoughts, cognitive schema, beliefs, attitudes, and attributions that influence one's feelings and mediate the relationship between antecedents and behavior is adopted. Although there are a number of similarities across these three seminal perspectives (Carroll, 1998), each has contributed unique ideas consistent with its theoretical underpinnings. However, in the process of APD treatment, the prominent features of these three theoretical approaches are merged into a cognitive-behavioral model (http://www.ncbi.nlm.nih.gov/books/NBK64948/l). In this way this study reviewed both techniques behavioral and cognitive therapy.

2.5.1 Behavioral Theories

The emphasis of behavioral theories is on how one learns to behave in certain ways. People are constantly learning new behaviors and how to modify the existing behavior. Behavioral theories are a psychological approach that focuses on how learning takes

place (McLeod, 2007, Retrieved March, 2014). Pure behaviorists are not concerned with internal process, but with external exhibitions. The aim of behavioral therapy is to teach the person techniques or skills to alter their behavior. For example, a person who behaves shyly at a party may have negative thoughts and feelings about himself. Behavioral therapy teaches the person more helpful behaviors. For example, they may be taught conversational skills that they practice in therapy and in social situations (Sometimes through Social Skills Training). Negative thoughts and feelings reduce as the person discovers they can enjoy themselves in social situations. Robert (2006) explained that, behavioral theories try to discover principles or behaviors that apply to all living beings. Behavioral learning Theories focus on the ways in which pleasurable or unpleasant consequences of behavior change individuals' behavior over time and ways in which individuals model their behavior on that of the others. The literature reviews the following two main behavioral theories `which involved: Classical conditioning and Operant Conditioning.

2.5.2.1 Classical Conditioning

Classical conditioning is a type of behavioral theory which discovered by Russian physiologist Ivan Pavlov, classical conditioning is a learning process that occurs through associations between an environmental stimulus and a naturally occurring stimulus. (htt://psychologyabout .com, 2013). Most psychologists believe that classical conditioning occurs when a person forms a mental association between two stimuli, so that encountering one stimulus makes the person think of the other. People tend to form

these mental associations between events or stimuli that occur closely together in space or time (Mazur, 2009)

The following is a simple description of how classical conditioning works as enumerated in htt: //psychologyabout .com (2013):

- **The Unconditioned Stimulus:** The unconditioned Stimulus e is one that unconditionally, naturally, and automatically triggers a response. For example, when you smell one of your favorite foods, you may immediately feel very hungry. In this example, the smell of the food is the unconditioned stimulus.
- **The Unconditioned Response:** The unconditioned response is the unlearned response that occurs naturally in response to the unconditioned stimulus. In our example, the feeling of hunger in response to the smell of food is the unconditioned response.
- **The Conditioned Stimulus:** The unconditioned stimulus is previously neutral stimulus that, after becoming associated with the unconditioned stimulus, eventually comes to trigger a conditioned response. In our earlier example, suppose that when you smelled your favorite food, you also heard the sound of a whistle. While the whistle is unrelated to the smell of the food, if the sound of the whistle was paired multiple times with the smell, the sound would eventually trigger the conditioned response. In this case, the sound of the whistle is the conditioned stimulus.

- **The Conditioned Response:** The conditioned response is the learned response to the previously neutral stimulus. In our example, the conditioned response would be feeling hungry when you heard the sound of the whistle.

2.5.2.2 Principles of Classical Conditioning

Following his initial discovery, Pavlov spent more than three decades studying the processes underlying classical conditioning. He and his associates identified four main processes as explain in Mazur, (2009, p.74): acquisition, extinction, generalization, and discrimination.

1. Acquisition: The *acquisition* phase is the initial learning of the conditioned response for example, the dog learning to salivate at the sound of the bell. Several factors can affect the speed of conditioning during the acquisition phase. The most important factors are the order and timing of the stimuli. Conditioning occurs most quickly when the conditioned stimulus (the bell) precedes the unconditioned stimulus (the food) by about half a second. Conditioning takes longer and the response is weaker when there is a long delay between the presentation of the conditioned stimulus and the unconditioned stimulus. If the conditioned stimulus follows the unconditioned stimulus; for example, if the dog receives the food before the bell is rung; conditioning seldom occurs.

2. Extinction: Once learned, a conditioned response is not necessarily permanent. The term *extinction* is used to describe the elimination of the conditioned response by repeatedly presenting the conditioned stimulus without the unconditioned stimulus. If a dog has learned to salivate at the sound of a bell, an experimenter can gradually

extinguish the dog's response by repeatedly ringing the bell without presenting food afterward. Extinction does not mean, however, that the dog has simply unlearned or forgotten the association between the bell and the food. After extinction, if the experimenter lets a few hours pass and then rings the bell again, the dog will usually salivate at the sound of the bell once again. The reappearance of an extinguished response after some time has passed is called *spontaneous recovery*.

3. Generalization: After an animal has learned a conditioned response to one stimulus, it may also respond to similar stimuli without further training. If a child is bitten by a large black dog, the child may fear not only that dog, but other large dogs. This phenomenon is called *generalization.* Less similar stimuli will usually produce less generalization. For example, the child may show little fear of smaller dogs.

4. Discrimination: The opposite of generalization is *discrimination,* in which an individual learns to produce a conditioned response to one stimulus but not to another stimulus that is similar. For example, a child may show a fear response to freely roaming dogs, but may show no fear when a dog is on a leash or confined to a pen.

2.5.2.3 Application of Classical Conditioning in the Treatment of APD

Pavlov continue his work on classical conditioning examining what then was referred to as neurosis demonstrated that dogs could discriminate between an ellipse and a circle, as they received food along with the presentation of a circle, whereas a shock was administered with the presentation of an ellipse. However, when the administration of stimuli was changed to where it became more difficult to distinguish the ellipse from the

circle, the dogs began to show agitation. These findings demonstrated that confusion or unpredictability was conditioned to elicit anxiety which can cause Avoidant Behavior (Jasper, 2004).

In an attempt to discuss the application of Classical Condition in treatment of APD Jasper (2004) maintained that, the first study that demonstrated the fear (Avoidant Behavior) could be acquired through classical conditioning in humans was conducted by Watson and Rayner who conditioned and eleven-month-old boy named Albert Conditioned fear generalized, as he started displaying fearful responses when presented with other white furred objects and small animals. This outcome of this study suggested that anxiety (Avoidant Behavior) can be learned through pairing of a noxious stimulus with an innocuous stimulus. This logically means that since Avoidant Behavior is learned therefore it can be unlearned through structured psychotherapy.

Also in his two-factor theory, Mowrer in Jasper (2004, p.38) outline the two processes involved in the acquisition of avoidance behavior. First, fear is elicited through classical conditioning. Thus, a previously innocuous stimulus is conditioned (CS) to elicit a fear response (CR). Second, this link between the CS and CR implies that termination of the CS is associated with fear reduction, negatively reinforcing responses. This negative reinforcing quality of fear reduction drives the termination of the CS. Thus conclude that avoidance is a learned response, acquire to terminate the CS and the associated fear response.

Base on the work of Pavlov and Mowrer in Jasper (2004, p.56) propose that:

1. The strength and the likelihood of the fear of rejection or ridicule would be directly proportional to:

    a. The number of repetitions of the association between the stimuli and the fear response, and
    b. The intensity of the fear response in the presence of the stimuli.

2. That fear reactions (avoidant behavior) are more likely to be elicited in situations of excessive confinement.

3. That fear (avoidant behavior) could also be acquired vicariously (i.e modeling) or through transmission of information.

Classical Conditioning techniques are also useful in the treatment of most personality disorder which includes phobias, anxiety problems or APD. Counsellors are able to apply classical conditioning in the session by creating a positive interactive environment to help students overcome low self esteem, avoiding social activities, anxiety, excessive shyness or fear, which are the major symptoms of APD. Pairing an anxiety-provoking situation, such as performing in front of a group, with pleasant surroundings helps the student learn new associations. Instead of feeling anxious and tense in these situations, the child will learn to stay relaxed and calm (Nevid, 2013).

Classical conditioning can be used to increase the amount of a positive behavior (positive social activities), but it can also be used to decrease negative behavior (avoiding sound

social relation). Some therapies associated with classical conditioning are aversion therapy, systematic desensitization, flooding and Social Skills Training. Many researches show applicability of these techniques in the treatment of APD. Navid (2013) explained that, the influence of classical conditioning can be seen in emotional responses such as phobia, disgust, nausea, anger, and sexual arousal etc. these disorders are all symptoms of APD.

Carlson (2010, p.75) explained that psychologists use classical conditioning procedures to treat phobias and other unwanted behaviors, such as alcoholism and addictions. To treat phobias of specific objects, the therapist gradually and repeatedly presents the feared object to the patient while the patient relaxes. Through extinction, the patient loses his or her fear of the object. In one treatment for alcoholism, patients drink an alcoholic beverage and then ingest a drug that produces nausea. Eventually they feel nauseous at the sight or smell of alcohol and stop drinking it. The effectiveness of these therapies varies depending on the individual and on the problem behavior.

2.5.2.4 Operant conditioning

Operant conditioning is a type of Behavioral theory in which an individual's behavior is modified by its antecedents and consequences. Instrumental conditioning was also referred to as *Type II reflexes*. Mechanisms of instrumental conditioning suggest that the behavior may change in form, frequency, or strength. The expressions "operant behavior" and "respondent behavior" were popularized by Skinner who worked on reproduction of Konorski's experiments. The operant behavior is an item of behavior that is initially

spontaneous, rather than a response to a prior stimulus, but whose consequences may reinforce or inhibit recurrence of that behavior (Schacter, 2011).

To implement his empirical approach, Skinner invented the operant conditioning chamber in which subjects such as pigeons and rats were isolated from extraneous stimuli and free to make one or two simple, repeatable responses (Schacter, 2011). Another invention, the cumulative recorder, produced a graphical record of these responses from which response rates could be estimated. These records were the primary data that Skinner and his colleagues used to explore the effects on response rate of various reinforcement schedules. A reinforcement schedule may be defined as "any procedure that delivers a reinforcer to an organism according to some well-defined rule" (Staddon, 2003). The effects of schedules became, in turn, the basic experimental data from which Skinner developed his account of operant conditioning. He also drew on many less formal observations of human and animal behavior (Mecca, 2004).

Behavior which is reinforced tends to be repeated (i.e. strengthened); behavior which is not reinforced tends to die out-or be extinguished (i.e. weakened). McLeod, (2007) maintained that, Skinner studied operant conditioning by conducting experiments using animals which he placed in a "*Skinner Box*" which was similar to Thorndike's puzzle box. Considering the Skinner's classic studies on pigeons' behavior McLeod, (2007, p.s57) identified the following major assumptions of behaviorists approach:

- Psychology should be seen as a science, to be studied in a scientific manner. Skinner's study of behavior in rats was conducted under carefully controlled laboratory conditions.

• Behaviorism is primarily concerned with observable behavior, as opposed to internal events like thinking and emotion. Note that Skinner did not say that the rats learnt to press a lever because they wanted food. He instead concentrated on describing the easily observed behavior that the rats acquired.

• The major influence on human behavior is learning from our environment. In the Skinner study, because food followed a particular behavior the rats learned to repeat that behavior, e.g. classical and operant conditioning.

There is little difference between the learning that takes place in humans and that in other animals. Therefore research (e.g. classical conditioning) can be carried out on animals (Pavlov's dogs) as well as on humans (Little Albert). Skinner proposed that the way humans learn behavior is much the same as the way the rats learned to press a lever.

2.5.2.5 Principles of Operant Conditioning

Skinner identified a number of basic principles of operant conditioning that explain how people learn new behaviors or change existing behaviors. The main principles are reinforcement, as listed in Mazur, (2009 p.38) include: punishment, shaping, extinction, discrimination, and generalization.

1. *Reinforcement:* In operant conditioning, reinforcement refers to any process that strengthens a particular behavior that is, increases the chances that the behavior will occur again. There are two general categories of reinforcement, positive and negative. The experiments of Thorndike and Skinner illustrate positive reinforcement, a method of strengthening behavior by following it with a pleasant stimulus. Positive reinforcement is

a powerful method for controlling the behavior of both animals and people. For people, positive reinforcers include basic items such as food, drink, sex, and physical comfort. Other positive reinforcers include material possessions, money, friendship, love, praise, attention, and success in one's career. This is why Social Skills Training uses reinforcement in the treatments of APD since they are very reluctant to any treatments.

2. Reinforcement schedule is a rule that specifies the timing and frequency of reinforcers. In his early experiments on operant conditioning, Skinner rewarded animals with food every time they made the desired response a schedule known as *continuous reinforcement.* Skinner soon tried rewarding only some instances of the desired response and not others a schedule known as partial reinforcement. To his surprise, he found that animals showed entirely different behavior patterns. Skinner and other psychologists found that partial reinforcement schedules are often more effective at strengthening behavior than continuous reinforcement schedules.

3. Punishment: Whereas reinforcement strengthens behavior, punishment weakens it, reducing the chances that the behavior will occur again. As with reinforcement, there are two kinds of punishment, positive and negative. Positive punishment involves reducing a behavior by delivering an unpleasant stimulus if the behavior occurs. Parents use positive punishment when they spank, scold, or shout at children for bad behavior. Societies use positive punishment when they fine or imprison people who break the law. *Negative punishment,* also called omission, involves reducing a behavior by removing a pleasant stimulus if the behavior occurs. Parents' tactics of grounding teenagers or taking away various privileges because of bad behavior are examples of negative punishment.

4. Shaping: is a reinforcement technique that is used to teach animals or people behaviors that they have never performed before. In this method, the teacher begins by reinforcing a response the learner can perform easily, and then gradually requires more and more difficult responses. For example, to teach a rat to press a lever that is over its head, the trainer can first reward any upward head movement, then an upward movement of at least one inch, then two inches, and so on, until the rat reaches the lever. Psychologists have used shaping to teach children with severe mental retardation to speak by first rewarding any sounds they make, and then gradually requiring sounds that more and more closely resemble the words of the teacher. Animal trainers use shaping to teach elephants to stand on one leg, tigers to balance on a ball, dogs to do backward flips, and killer whales and dolphins to jump through hoops.

5. Extinction: As in classical conditioning, responses learned in operant conditioning are not always permanent. In operant conditioning, extinction is the elimination of a learned behavior by discontinuing the reinforcer of that behavior. If a rat has learned to press a lever because it receives food for doing so, its lever-pressing will decrease and eventually disappear if food is no longer delivered. With people, withholding the reinforcer may eliminate some unwanted behaviors. For instance, parents often reinforce temper tantrums in young children by giving them attention. If parents simply ignore the child's tantrums rather than reward them with attention, the number of tantrums should gradually decrease.

6. Generalization and Discrimination: Generalization and discrimination occur in operant conditioning in much the same way that they do in classical conditioning. In

generalization, people perform a behavior learned in one situation in other, similar situations. For example, a man who is rewarded with laughter when he tells certain jokes at a bar may tell the same jokes at restaurants, parties, or wedding receptions. *Discrimination* is learning that a behavior will be reinforced in one situation but not in another. The man may learn that telling his jokes in church or mosque or at a serious business meeting will not make people laugh. Discriminative stimuli signal that a behavior is likely to be reinforced. The man may learn to tell jokes only when he is at a loud, festive occasion (the discriminative stimulus). Learning when a behavior will and will not be reinforced is an important part of operant conditioning.

2.5.2.6 Operant Conditioning in the Treatment of APD

Behavioral theories are firmly rooted in extensive empirical research rather than clinical intuition. Skinner's ideas have shed light on how environmental consequences and conditioning mold people's characteristic behavior (Wayne, 2008). Behavior modification is a set of therapies / techniques based on operant conditioning. Behavior modification therapy is much used in clinical and educational psychology, particularly with people with learning difficulties and personality disorder. The main principle of operant conditioning comprises changing environmental events that are related to a person's behavior (Skinner, in McLeod, 2007). For example, one of the principle symptom of APD is avoiding work or school activities especially the one that involve group work, therefore reinforcement of desired behaviors (attending to group work) and ignoring or punishing undesired ones (i.e avoidance behavior) is the main principle of operant conditioning.

There are different types of positive reinforcements. Primary reinforcement is when a reward strengths a behavior by itself. Secondary reinforcement is when something strengthens a behavior because it leads to a primary reinforcer. Examples of behavior modification therapy include token economy and behavior shaping (McLeod, 2007). A simple way of giving positive reinforcement in behavior modification is in providing compliments, approval, encouragement, and affirmation; a ratio of five compliments for every one complaint is generally seen as being the most effective in altering behavior in a desired manner. (McLeod, 2007). In this the therapist can use some Token strategies to reinforce social activities of the avoidant and shape the behavior to improve self esteem.

2.5.2.7 Operant conditioning to change Avoidant behavior

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

1. **State goal** (aims for the study) That is, clarify exactly what changes are to be brought about.
2. **Monitor behavior** (log conditions) Keep track of behavior so that one can see whether the desired effects are occurring.
3. **Reinforce desired behavior:** give reward for proper behavior
4. **Reduce incentives to perform undesirable behavior.**

These above protocol are very useful tool especial in using Social Skills Training by the counsellor in reducing the symptoms of APD.

2.5.3 Cognitive Theories

As explained earlier CBT is a combination of behavior and cognitive therapy. Since we discussed behavior therapy in the proceeding topics let us discuss the cognitive therapy. Cognitive theory defines learning as "a semi-permanent change in mental processes or associations." Cognitivists do not require an outward exhibition of learning but focus more on the internal processes and connections that take place during learning. Cognitive therapies are similar to behavioral therapies in that they focus on specific problems. However, they emphasize changing beliefs and thoughts, rather than observable behaviors. Cognitive therapists believe that irrational beliefs or distorted thinking patterns can cause a variety of serious problems, including depression and chronic anxiety. They try to teach people to think in more rational, constructive ways (Mazur, 2009).

2.5.3.1 Assumption of Cognitive Therapy

Cognitive theories emphasize on unobservable mental processes that people use to learn and remember new information or skills. The following is the assumptions of Cognitive Therapy as described in Mazur, (2009).

- Abnormal behavior is caused by abnormal thinking processes.
- One interacts with the world through mental representation of it.
- Mental and emotional disorder occurs when one mental representation or ways of reasoning are inaccurate or inadequate.

The cognitive therapist teaches clients how to identify distorted cognitions through a process of evaluation. The clients learn to discriminate between their own thought and reality. They learn the influence that cognition has on their feelings, and they are taught to recognize observe and monitor their own thoughts.

The behavior part of the therapy involves setting homework for the client to do (e.g keeping a diary of thoughts). The therapist gives the client tasks that will help them challenge their own irrational beliefs. The idea is that the client identifies their own unhelpful beliefs and then proves them wrong. As a result, their beliefs begin to change. For example, someone who is anxious in social situations may be set a homework assignment to meet a friend at the public occasions.

2.5.3.2 Cognitive Social Learning Theory

To clearly understand cognitive therapy this review is going to discuss cognitive social learning. Wayne (2008, p.29) explained that Bandura is one of several theorists who have added a cognitive flavor to behaviorism. He consider Skinner's theory as pure behaviorism, as he pointed out that humans obviously are conscious, thinking, feeling beings. Therefore Bandura in postulating his theory argue that in neglecting cognitive processes, Skinner ignored the most distinctive and important feature of human behavior. Bandura and like-minded theorists originally called their modified brand of behaviorism *social learning theory.* Today, Bandura refers to his model as *social cognitive theory.* Social Learning theories focus on the effects of thought on action and action on thought. Bandura's social cognitive theory has expanded the horizons of behaviorism and increased its relevance to the study of personality by increasing psychology's awareness

of how situational factors shape behavior (Wayne, 2008). Albert Bandura is well regarded for his Social Cognitive Theory. It is a learning theory based on the ideas that people learn by watching what others do, and that human thought processes are central to understanding personality. This theory provides a framework for understanding, predicting and changing human behavior. His approach emphasized on cognitive and information-processing capabilities that facilitate social behavior. Bandura in Wayne (2008) pointed out that people proactively choose and shape their environments raises. The main tenets of Bandura's theory of Cognitive Social Learning Theory as enumerate in Boeree, (2008, p.48) are that:

- People learn by observing others
- The same set of stimuli may provoke different responses from different people, or from the same people at different times
- The world and a person's behavior are interlinked
- Personality is an interaction between three factors: the environment, behavior, and a person's psychological processes.

The above tenets is been employed in using CR and SST which are the independent variables of this research. The research upon which this theory rests contains many facets that help to explain how people acquire the knowledge about human social behavior that is needed in order to function. One of the important facets of human social learning is modeling. Bandura (1986, p.57) established that there are certain steps involved in the modeling process which include: attention, retention, reproduction and motivation.

1. Attention: In order for an individual to learn something, they must pay attention to the features of the modeled behavior.
2. Retention: Humans need to be able to remember details of the behavior in order to learn and later reproduce the behavior.
3. Reproduction: In reproducing a behavior, an individual must organize his or her responses in accordance with the model behavior. This ability can improve with practice.
4. Motivation: There must be an incentive or motivation driving the individual's reproduction of the behavior. Even if all of the above factors are present, the person will not engage in the behavior without motivation.

Thus, social learning theory predicts that people will often behave differently in different situations. Boeree, (2008, p.48) stressed that; Bandura has had a large impact on personality theory and therapy. His action-oriented and problem-solving approaches appeal to those who want to make changes. Also Tuckman (1992) observed that, Bandura posits that portions of an individual's knowledge acquisition can be directly related to observing others within the context of social interactions, experiences, and outside media influences. Bandura rejects Skinner's highly deterministic view that behavior is governed by environment and that freedom is an illusion. Bandura argues that internal mental events, external environmental contingencies, and overt behavior all influence one another (Wayne, 2008).

Bandura (1986, p.56) proposes that people are neither driven by inner forces nor automatically shaped and controlled by external stimuli. Rather, human functioning is

explained in terms of a model of triadic reciprocal determinism. In this model, which can be visualized as an equilateral triangle, behavior, cognitive and other personal factors and environmental events all operate as interacting determinants of each other. The nature of persons is then defined within this triadic perspective. Therefore the nature of the person who emerges is unique even though all people are defined within the triad. Because people possess self directive capabilities they are able to exercise significant control over their thoughts, feeling and actions. This self-regulatory function forms an important part of the social cognitive theory. There is a continuous interplay between the self-generated and the external sources of influence. People create guides for their behavior, self motivators for courses of action and then respond to their behaviors in a self evaluative way.

Bandura's conceptualization of modeling is far more comprehensive than earlier ones and contains provision for developing new and creative thought. He suggests that we observe others and encode the information that will serve as a guide for later action. Modeling is a very efficient method of social learning in that it can be done vicariously, simply through the observation of others. The five kinds of social behavior that can be learned this way as stated in Tuckman, (1992, p.76) are:

1. New cognitive skills and behaviors;

2. Strengthened or weakened previously learned inhibitions;

3. Social prompts or inducements;

4. How to use the environment;

5. When to become aroused and what emotional reaction to express.

These social behaviors must to be included in treatment package of CR and SST. Bandura (1986) proposed that observational learning can occur in relation to the following three models:

- Live model in which an actual person is demonstrating the desired behavior
- Verbal instruction in which an individual describes the desired behavior in detail, and instructs the participant in how to engage in the behavior
- Symbolic in which modeling occurs by means of the media, including movies, television, Internet, literature, and radio. This type of modeling involves a real or fictional character demonstrating the behavior.

2.5.3.3 Cognitive Social Learning Theory and Avoidant Personality Disorder

According to Bandura, both classical and operant conditioning can occur vicariously when one person observes another's conditioning. For example, watching your sister get humiliated or disgrace by someone could strengthen your avoidance tendency to be suspicious of others. Although your sister would be the one actually experiencing the negative consequences, they might also influence you through observational learning (Wayne, 2008).

The major contribution of Cognitive Social Learning Theory of Bandura is in improving self efficacy, because one of the principles symptoms of APD is low self esteem. Self-efficacy is a major concept in Bandura's theory of behavior and motivation. According to Bandura self efficacy is one's judgment of one's own capability to carry out a course of

action successfully. Bandura's theory predicts that people will choose, persist in, and expend effort on tasks that they believe they can carry out successfully. This theory also suggests that people will avoid situations that they believe exceed their coping skills. Bandura further theorizes that a good sense of self efficacy provides the resilience for creative individuals to persist in pursuing an objective even after being rejected many times. People must have fairly robust feelings of self efficacy today because of the complexities of today's societies. So besides the necessary skills needed to function in society is added the need of a fairly strong sense of self efficacy (Bandura, 1986).

Social learning theory is a perspective that states that social behavior (any type of behavior that we display socially) is learned primarily by observing and imitating the actions of others. The social behavior is also influenced by being rewarded and/or punished for these actions. Social learning theory was derived in an attempt by Robert Sears and other scholars to merge psychoanalytic and stimulus-response learning theory into an inclusive explanation of human behavior. Sears and the others draw their conclusions off of the clinical richness of the former and the rigor of the latter. Albert Bandura, conversely, abandoned the psychoanalytic and drive features of the approach. Both theories proposed were envisioned as a general context for the understanding of human behavior, but Bandura's theory provided a stronger theoretical beginning.

Another relevant of Bandura theory to APD could be seen in the identification of the causes of APD, as Bandura in Wayne (2008, p.663) maintained that people's characteristic patterns of behavior are shaped by the *models* that they are exposed to. In observational learning, a model is a person whose behavior is observed by another. At

one time or another, everyone serves as a model for others. Wayne (2008, p.664) further explained that Bandura's key point is that many response tendencies are the product of *imitation.* As research has accumulated, it has become apparent According to social learning theory, people try to gauge the reinforcement contingencies and adjust their behavior to the circumstances. For example, if you believe that hard work in your job will pay off by leading to raises and promotions, you'll probably be diligent and industrious. But if you think that hard work in your job is unlikely to be rewarded, you may act lazy and irresponsible.

2.5.5.1 Psychotherapy and Avoidant Personality Disorder (APD)

Psychotherapy is a form of treatment for emotional and psychological problems where a person talks with a mental health professional such as a psychiatrist, psychologist or counsellor. The following are some of the different types of psychotherapy on the treatment of APD.

2.5.5.2 ***Psychoanalytic and Psychodynamic Approaches*** attempt to uncover childhood memories of the roots of avoidance. They explore the avoidant's anxiety provoking fantasist as they occur in the patient's present life as well as in his or her transference to the therapist.

2.5.5.3 ***Interpersonal Therapy*** places the focus of therapy on anxiety. They suggest "confronting anxiety". They describe the treatment goal a potential freedom from fear, anxiety, and the entanglement of greed, envy, and jealously. This goal will also be actualized by the development of the capacity for self-realization, the ability to form durable relationship of intimacy with others, and the ability to give and accept matured

love. Person who is reasonably free from anxiety, greed, envy, and jealousy and who is able to experience interpersonal intimacy will be capable of expressing this interns of satisfactory sexual activities".

2.5.5.4 ***Supportive Therapy:*** The APD's pattern is an especially intense version of the 'generic' patient position. He or she wants to be accepted and loved, and 'holds back' because of poor self-concept and fears of humiliation. The 'generic' therapist position addresses this 'generic' patient position with generous doses of empathy and warm support which delivered without a hint of judgmentalism or rejection. Gradually, as the APD person shares intimacies and feelings of inadequacy or gulf and shame, the therapist can provide evidence of safe haven. The therapist's benign and nonjudgmental acceptance of the APD person helps the APD begin to accept him or herself. As the therapy relationship strengthens, the patient can begin to explore his or her patterns. (Benjamin in Kantor 2003)

2.5.5.5s Eclectic Therapy: It is a psychotherapeutic counselling approach that adopts the key points or doctrinenes, finding, techniques selected from different theoretical systems (Akinade, 2005). Oldham and Morris (1995) suggest an eclectic approach in the following context:

- Desensitizing the avoidant's anxiety,
- Helping avoidant learn social skills,
- Helping avoidant consciously change some of their self-destructive thinking patterns, and

- Using insight psychotherapy, which is highly beneficial for the Avoidant person who has the courage to face instead of running away from his or her problems.

Eclectic schema for treating avoidance involves multitasking using individual behavioral, interpersonal, cognitive, self-image (self-worth-enhancing), intrapsychic, and pharmacological therapy (Millon and Davis, 1996). Millon and Davis as cited in Kantor (2007, p.30) also advocate the following group and family Eclectic approaches when dealing specifically with avoidant patients:

1. Understand their avoidance developmentally and dynamically;

2. Focus on increasing pleasure;

3. Increase contact to acquire critical social skills;

4. Learn to understand others;

5. Learn to differentiate between real, incidental, and imagined threats;

6. Develop internal (and internalized) realistic reference points by which to judge their behavior;

7. Use cognitive corrections and rework aversive schemas cognitively and behaviorally;

8. Use distraction methods, such as positive social interaction;

9. Improve self-image;

10. Learn to control fretful-expressive behavior while simultaneously establishing and improving friendships;

11. try new experiences, which can help both directly and indirectly by maintaining motivation, and providing the opportunity to monitor behavior and correct maladaptive, automatic thoughts and irrational beliefs; and

12. Use pharmacotherapeutic agents when indicated, such as beta blockers, monoamine oxidase inhibitors (MAOI), or serotonin uptake inhibitors to reduce anxiety.

Widiger in Kantor (2003, p.31) also recommends an eclectic approach for the treatment of avoidance. His approach offers a combination of uncovering/insight, cognitive-behavioral therapy including exposure to the avoided stimuli, and supportive therapy including empathic group therapy techniques. Additionally he suggests the use of anxiolytics to help patients cope with their fear and antidepressants to help relieve any superimposed panic disorder.

Widiger in Kantor (2003, p.31) lamented that "I recommend an eclectic, action-oriented approach to the treatment of APD person". He suggests the following points:

- In the realm of the *analytic contribution*, the therapist obtains and imparts insight from a study of the patient's past avoidances, current fantasies, and transference behavior.
- In the realm of the *cognitive contribution*, the therapist identifies and corrects negative interpersonal illogical distortions, particularly those with a paranoid caste, and emphasizes the positive aspects of those relationships the patient views as all negative.
- In the realm of the *behavioral contribution*, the therapist gives the patient a series of graded non-avoidant interpersonal tasks of progressive difficulty. In the realm

of the *interpersonal contribution*, the therapist shows the patient how he or she makes others uncomfortable with his or her off-putting shyness and recommends consultative action, asking the patient to share his or her fears with others, owning up to his or her interpersonal anxieties instead of retreating in silence to save face. This brings avoidance out into the open, both exposing it to the cleansing light of day and getting others to understand and sympathize rather than reacting negatively to the patient's shyness.

- In the realm of the *educative contribution,* a therapist increases motivation by enumerating the virtues of relating over being isolated.
- In the realm of the *supportive contribution*, the therapist provides the patient with a warm reassuring, healing environment, which helps reduce relationship anxiety directly with such reassurances as, "You will get over your anxiety if you patiently persevere."

Finally, avoidant who withdraw by becoming hypromanic to deal with their fear of criticism and rejection may overcompensate by primping excessively as their way to be liked, not rejected. They might over dress or use too much makeup hoping to be bred, if not for themselves them at least for their looks.

2.6.1 Cognitive Restructuring Counselling Technique (CR)

Cognitive Restructuring is a cognitive-behavioral therapy technique used to identify and correct negative thinking patterns. It is the idea of revising irrational thought. The technique involves altering negative automatic thoughts that occur in anxiety provoking situations by replacing them with more rational beliefs. As thoughts are challenged and disputed, their ability to elicit anxiety is weakened. Umezulke & Eneasator (2010)

maintained that cognitive restructuring is a technique derived from Albert Ellis the proponent of rational Emotive Therapy (RET) and listed it under classical conditioning techniques.

In other words, Cognitive restructuring is a psychotherapeutic process of learning to identify and dispute irrational or maladaptive thoughts, such as all-or-nothing thinking (splitting), magical thinking and emotional reasoning, which are commonly associated with many mental health disorders. Cognitive Restructuring (CR) employs many strategies, such as Socratic questioning, thought recording and guided imagery and is used in many types of therapies, including CBT and Rational Emotive Therapy (RET). A number of studies demonstrate considerable efficacy in using CR-based therapies.

Cognitive restructuring involves paying attention to thoughts, recognizing when they are irrational thoughts, challenging them, and learning replacement thoughts and behaviors. People learn healthy ways to talk to themselves so that they can let go of the self-defeating talk. (Diana, 2013).

Cognitive Restructuring as one of the Cognitive Behavioral Therapy is an expedient tool for understanding and setting aside negative thinking. It helps us toss away negative and unhappy thoughts as well as to increase our level of awareness to overcome any faulty thinking errors. Cognitive Restructuring is a course that changes our subconscious thoughts which aids in how we can deal with various situations in order to have a more positive frame of mind.

This is meant to teach a set of very useful techniques that we call cognitive restructuring. These techniques were pioneered by Albert Ellis and Aaron Beck, among others. The phrase "cognitive restructuring" was used because it sounds more learned and respectable than something like "thinking more useful thoughts." The word cognition is simply another word for thought. The basic idea of cognitive restructuring is that people's emotions and behavior can be greatly affected by what they think. If people can consciously change their habits of what they say to themselves and what mental images they present to themselves, they can make themselves happier or kinder or more productive or can accomplish any of several other positive changes.

The key idea behind this tool, as with the other tools in this section, is that our moods are driven by what we tell ourselves, and this is usually based on our interpretations of our environment. Cognitive Restructuring helps us evaluate how rational and valid these interpretations are. Where we find that these assumptions and interpretations are incorrect, then this naturally changes the way we think about situations and changes our moods.

Cognitive Restructuring is similar to the Thought Awareness, Rational Thinking and Positive Thinking tool. The Thought Awareness tool is a quick technique that is useful for dealing with spontaneous or simple negative thinking. Cognitive Restructuring can help where issues are more significant.

Cognitive Restructuring is a useful tool for understanding and turning around negative thinking. It helps us put unhappy, negative thoughts "under the microscope", challenging them and in many cases rescripting the negative thinking that lies behind them. In doing

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

Cognitive restructuring, also called cognitive reframing, is a behavioral technique associated with cognitive therapy. Cognitive restructuring involves learning how to think differently, to change fundamental faulty thinking, and replace it with more rational, realistic, and perhaps positive thinking. Through **cognitive restructuring**, we can learn how to control our thoughts not to simply be optimistic in all things, but be realistic as well (Diana, 2013).

Cognitive restructuring refers to any methods which help people to think differently about a situation/event/thought/belief. Really, this could apply to anything done in (or outside of) a therapy session. Typical approaches to promote cognitive restructuring in therapy include (Diana, 2013):

- traditional CBT thought records which help clients to challenge unhelpful Negative Automatic Thoughts
- behavioral experiments which help clients to test beliefs which may be unhelpful

- Socratic questioning to explore a client's belief

Cognitive Therapy is now one of the main techniques used to manage anxiety and depression, among others. It focuses on helping its users understand the negative thought processes that can cause problems, and on restructuring these so that they are fair and balanced. Cognitive Restructuring is a stripped down version of this approach focused on managing “normal” negative thinking. Therefore Cognitive Restructuring is one of the most suitable approaches to treat APD, because one of the major causes of avoidant personality disorder is negative thinking. Cognitive restructuring involves four steps as listed in Hope, Burns, Hyes Herbert and Warner (2010, p.67):

1. Identification of problematic cognitions known as "automatic thoughts" (ATs) which are dysfunctional or negative views of the self, world, or future
2. Identification of the cognitive distortions in the ATs
3. Rational disputation of ATs with the Socratic dialogue
4. Development of a rational rebuttal to the ATs

There are six types of automatic thoughts (Hope, Burns, Hyes Herbert and Warner, 2010):

1. Self-evaluated thoughts
2. Thoughts about the evaluations of others
3. Evaluative thoughts about the other person with whom they are interacting
4. Thoughts about coping strategies and behavioral plans
5. Thoughts of avoidance

6. Any other thoughts that were not categorized

2.6.2 Applications of Cognitive Restructuring

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

In book written by Mueser, Rosenberg & Rosenberg, (2009) describes a flexible, low-stress, manualized program for treating PTSD in the individuals, who often have limited social support and resources and face multiple life challenges. The program emphasizes the use of cognitive restructuring to help clients recognize, challenge, and change negative and unhelpful thoughts and feelings related to their past traumatic experiences. The program is brief just 12–16 sessions and focuses on building lasting skills that can be applied to treating the after effects of past traumas, lessening the impact of ongoing stressors, and helping clients to more effectively manage their lives. The program is solidly based on research and clinical practice, with modifications to accommodate the unique challenges of special populations. In contrast to exposure-based treatments for PTSD, this treatment is designed to minimize stress and to help participants increase social supports during and following treatment. This accessible volume includes everything needed to implement the program, including session-by-session instructions,

sample dialogues to demonstrate techniques, and user-friendly handouts and worksheets that can be photocopied and used in sessions. It will be useful to social workers, primary care providers, mental health counsellors, clinical psychologists, addiction treatment providers, psychiatrists, and other helping professionals who interact with special populations and trauma victims.

RET also classifies four types of irrational beliefs: dire necessity, feeling awful, cannot stand something, and self-condemnation. It is described as cognitive-emotional retraining. The rationale used in cognitive restructuring attempts to strengthen the client's belief that 'self-talk' (interpersonal communication) can influence performance, and in particular self-defeating thoughts or negative self-statements can cause emotional distress and interfere with performance, a process that then repeats again in a cycle. Mood repair strategies are implemented in cognitive restructuring in hopes of contributing to a cessation of the negative cycle (Frojan-Pargol, Calero-Elviva, and Montana, 2009). Deacon, Fawzy and Lickel (2011) hypothesized that cognitive restructuring would produce significant improvement in the distress and believability associated with negative self-referential thoughts. Because cognitive restructuring is thought to be an acquired skill whose benefits accrue after repeated real-world practice, Cognitive restructuring aim to reduce the believability of negative thoughts, we hypothesized that decreased believability of negative self-referential thoughts would significantly predict a decrease in the distress elicited by these thoughts in each treatment condition.

When utilizing cognitive restructuring in (CBT), it is combined with psychoeducation, monitoring, in vivo experience, imaginable exposure, behavioral activation and

homework assignments to achieve remission. The cognitive behavioral approach is said to consist of three core techniques: cognitive restructuring, training in coping skills, and problem solving. (Frojan-Pargol, Calero-Elviva, and Montana, 2009). Huppert, (2009, p.245) maintain that there are many methods used in cognitive restructuring, which usually involve identifying and labeling distorted thoughts, such as, all or none thinking, disqualifying the positive, mental filtering, jumping to conclusions, catastrophizing, emotional reasoning, should statements, and personalization. Huppert (2009, p.243) lists the following methods commonly used in cognitive restructuring:

- Socratic questioning
- Thought recording
- Identifying cognitive errors
- Examining the evidence (pro-con analysis or cost-benefits analysis)
- Understanding idiosyncratic meaning/semantic techniques
- Labeling distortions
- Decastastrophizing
- Reattribution
- Cognitive Rehearsal
- Guided imagery
- Listing rational alternatives

There is plenty of solid evidence that how we think about what is going on in our lives can greatly contribute to whether or not we find events in our lives stressful. Cognitive distortion, or patterns of faulty thinking, can impact our thoughts, behaviors and

experience of stress. Self talk as the internal dialogue that runs in our heads, interpreting, explaining and judging the situations we encounter, can actually make things seem better or worse, threatening or non-threatening, stressful or well, one get the picture. Some people tend to see things in a more positive light, and others tend to view things more negatively, putting themselves at a disadvantage in life. But, as our self-talk develops starting in childhood, how does one go about changing these habitual thought patterns? The answer is through Cognitive Restructuring Technique. Cognitive restructuring, a process of recognizing, challenging, and changing cognitive distortions and negative thought patterns can be accomplished with the help of a therapist trained in cognitive therapy or cognitive behavioral therapy (Rupke, David and Marjorie, 2006).

The following are the two steps to follow in Cognitive restructuring intervention as enumerated in Nancy as cited in Mark and Marjorie (2006, p.384):

I. Awareness: Become aware of your cognitive distortions of choice. The first step in loosening the grip of cognitive distortions is to become aware of them. And
II. Recognize Your Power: Studies on burnout show that people tend to get more stressed when they feel that they do not have a choice in what happens to them. In some situations, such as within the context of a job, there is very little choice (Locus of control).

The term "cognitive distortion" refers to errors in thinking or patterns of thought that are biased in some way, they may include:

(a) Interpretations that are not very accurate and which selectively filter the available evidence.

(b) Evaluations that are harsh and unfair, and/or

(c) Expectations for one and for others that is rigid and unreasonable. The more a person's thinking is characterized by these distortions, the more they are likely to experience disturbing emotions and to engage in maladaptive behavior.

Cognitive therapy recognizes the following ten common patterns of faulty thinking, which are known as cognitive distortion (Rupke, David and Marjorie, 2006 p.6):

- *All-or-Nothing Thinking*: Failing to recognize that there may be some middle ground. Characterized by absolute terms like *always*, *never,* and *forever*.
- *Overgeneralization*: Taking an isolated case and assuming that all others are the same.
- *Mental Filter*: Mentally singling out the bad events in one's life and overlooking the positive.
- *Disqualifying the Positive*: Treating positive events like they don't really count.
- *Jumping to Conclusions*: Assuming the worst about a situation even though there is no evidence to back their conclusion.
- *Magnification and Minimization*: Downplaying positive events while paying an inordinate amount of attention to negative ones.
- *Emotional Reasoning*: Allowing your emotions to govern what you think about a situation rather than objectively looking at the facts.
- *Should Statements*: Rigidly focusing on how you think things should be rather than finding strategies for dealing with how things are.
- *Labeling and Mislabeling*: Applying false and harsh labels to oneself and others.

- *Personalization*: Blaming yourself for things that are out of your control.

A number of common patterns of cognitive distortions have been identified, including:

1. Filtering: Taking the negative details and magnify them while filtering out all positive aspects of a situation. For instance, a person may pick out a single, unpleasant detail and dwell on it exclusively so that their vision of reality becomes darkened or distorted.

2. Polarized Thinking (or "Black and White" Thinking): In polarized thinking, things are either "black-or-white." We have to be perfect or we are a failure there is no middle ground. You place people or situations in "either/or" categories, with no shades of gray or allowing for the complexity of most people and situations. If your performance falls short of perfect, you see yourself as a total failure.

3. Overgeneralization: In this cognitive distortion, we come to a general conclusion based on a single incident or a single piece of evidence. If something bad happens only once, we expect it to happen over and over again. A person may see a single, unpleasant event as part of a never-ending pattern of defeat.

4. Jumping to Conclusions: Without individuals saying so, we know what they are feeling and why they act the way they do. In particular, we are able to determine how people are feeling toward us. For example, a person may conclude that someone is reacting negatively toward them but doesn't actually bother to find out if they are correct. Another example is a person may anticipate that things will turn out badly, and will feel convince that their prediction is already an established fact.

5. Catastrophizing: We expect disaster to strike, no matter what. This is also referred to as "magnifying or minimizing." We hear about a problem and use *what if* questions (e.g., "What if tragedy strikes?" "What if it happens to me?").

For example, a person might exaggerate the importance of insignificant events (such as their mistake, or someone else's achievement). Or they may inappropriately shrink the magnitude of significant events until they appear tiny (for example, a person's own desirable qualities or someone else's imperfections).

6. Personalization: Personalization is a distortion where a person believes that everything others do or say is some kind of direct, personal reaction to the person. We also compare ourselves to others trying to determine who smarter, better looking, etc is. A person engaging in personalization may also see themselves as the cause of some unhealthy external event that they were not responsible for. For example, "We were late to the dinner party and *caused* the hostess to overcook the meal. If I had only pushed my husband to leave on time, this wouldn't have happened."

7. Control Fallacies: If we feel *externally controlled*, we see ourselves as helpless a victim of fate. For example, "I can't help it if the quality of the work is poor, my boss demanded I work overtime on it." The fallacy of *internal control* has us assuming responsibility for the pain and happiness of everyone around us. For example, "Why aren't you happy? Is it because of something I did?"

8. Fallacy of Fairness: We feel resentful because we think we know what is fair, but other people won't agree with us. As our parents tell us when we're growing up and

something doesn't go our way, "Life isn't always fair." People who go through life applying a measuring ruler against every situation judging its "fairness" will often feel badly and negative because of it. Because life is not "fair" things will not always work out in your favor, even when you think they should.

9. Blaming: We hold other people responsible for our pain, or take the other track and blame ourselves for every problem. For example, "Stop making me feels bad about myself!" Nobody can "make" us feel any particular way only we have control over our own emotions and emotional reactions.

10. Shoulds: We have a list of ironclad rules about how others and we should behave. People who break the rules make us angry, and we feel guilty when we violate these rules. A person may often believe they are trying to motivate themselves with shoulds and shouldn'ts, as if they have to be punished before they can do anything.

11. Emotional Reasoning: We believe that what we feel must be true automatically. If we feel stupid and boring, then we must be stupid and boring. You assume that your unhealthy emotions reflect the way things really are "I feel it, therefore it must be true."

12. Fallacy of Change: We expect that other people will change to suit us if we just pressure or cajole them enough. We need to change people because our hopes for happiness seem to depend entirely on them.

13. Global Labeling: We generalize one or two qualities into a negative global judgment. These are extreme forms of generalizing, and are also referred to as "labeling"

and “mislabeling.” Instead of describing an error in context of a specific situation, a person will attach an unhealthy label to themselves.

For example, they may say, “I am a loser” in a situation where they failed at a specific task. When someone else’s behavior rubs a person the wrong way, they may attach an unhealthy label to him, such as “He is a real jerk.” Mislabeling involves describing an event with language that is highly colored and emotionally loaded. For example, instead of saying someone drops her children off at daycare every day, a person who is mislabeling might say that “she abandons her children to strangers.”

14. Always Being Right: We are continually on trial to prove that our opinions and actions are correct. Being wrong is unthinkable and we will go to any length to demonstrate our rightness. For example, “I do not care how badly arguing with me makes you feel, I am going to win this argument no matter what because I am right.” Being right often is more important than the feelings of others around a person who engages in this cognitive distortion, even loved ones.

15. Heaven is Reward Fallacy: We expect our sacrifice and self-denial to pay off, as if someone is keeping score. We feel bitter when the reward doesn’t come.

CBT holds that most of our emotions and behaviors are the result of what we think or believe about ourselves, other people, and the world. These cognitions shape how we interpret and evaluate what happens to us, influence how we feel about it, and provide a guide to how we should respond. Unfortunately, sometimes our interpretations, evaluations, and underlying beliefs thoughts contain distortions, errors, or biases, or are

not very useful or helpful. This results in unnecessary suffering and often causes us to react in ways that are not in our best interest *(*Nelson, 2011*).*

Cognitive restructuring is a set of techniques for becoming more aware of our thoughts and for modifying them when they are distorted or are not useful. This approach does not involve distorting reality in a positive direction or attempting to believe the unbelievable. Rather, it uses reason and evidence to replace distorted thought patterns with more accurate, believable, and functional ones (Nelson, 2011).

2.6.3 Process of Cognitive Restructuring

Cognitive restructuring refers to the process of replacing cognitive distortions with thoughts that are more accurate and useful. Cognitive restructuring has two basic steps as enumerated in Burns (1980, p.56):

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

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

In *cognitive restructuring***,** the therapist guides the client through the process of becoming more aware of what they are telling themselves and helps them to evaluate, and when appropriate, to modify their own thinking. In essence, the therapist teaches the client a process that will help them distinguish distorted thinking from more accurate and useful thinking. Cognitive restructuring emphasizes that this is best done as a collaborative

process in which the client is assisted in taking the lead as much as possible. The therapist refrains from assuming that the client's thoughts are distorted and instead attempts to guide the client with questions that encourage the client to make their own discoveries. Clients are also encouraged to engage in his process on their own during their time between sessions by using a written format.

2.6.4 Cognitive Restructuring Worksheet

When using Cognitive Restructuring, it is very helpful to use a worksheet designed to guide the process. Below is an example of a completed Cognitive Restructuring Worksheet (Mueser, Rosenberg, & Rosenberg, 2009).

Part I: Identifying emotion-causing thoughts

Instructions: When experiencing a negative emotion use the following procedures to identify the emotion-causing thoughts.

1. Situation: Briefly describe the situation that led to the emotions.

2. Emotions ratings: Identify the emotions you are experiencing and any physical sensations. Emotions can be described by single words, such as sad, nervous, afraid, angry, guilty, or ashamed.

3. Automatic thoughts ratings: Identify the thoughts or images connected to the emotions and record them in brief simple declarative sentences or statements. For examples, see the completed worksheet below. (These thoughts are called "automatic" because they

tend to occur automatically or habitually). Burns (1980, p.67) identified questions that may help you to identify thoughts as:

1. What is going through my mind as I am feeling this emotion?
2. What am I telling myself about this situation?
3. What am I afraid might happen?

Once you identify a thought, you can further explore the meaning of the thought to you and record these thoughts. Questions that may be helpful are (Burns, 1980,):

1. If this thought is true, what does this say about me as a person?
2. What does it say about my life, and my future?
3. What is the worst thing that could happen if it is true?
4. What does this mean about how other people think about me?
5. What does this mean about how I think of other people?
6. What images or memories do I have in this situation?

Part II: Evaluating and modifying thoughts

The second part of cognitive restructuring involves evaluating your automatic thoughts and perhaps developing a new perspective that is more accurate and useful.

Instructions: Choose one or more "hot thoughts" to work on. It is best to focus on only one or two of these thoughts at a time.

1. Identify any cognitive distortions: Identify if the thought contains any cognitive distortions (refer to the list of common cognitive distortions).

2. Evaluate and modify the thought: Evaluate the accuracy and usefulness of the thoughts, and if warranted, modify the thoughts in a more accurate and useful direction.

Some questions can help you evaluate the accuracy of a thought (Beck in Grohel, 2015):

1. What is the evidence that supports or contradicts this thought?
2. Is there an alternative explanation? Is there another way of looking at it?
3. Am I overestimating the probability of the negative event occurring? What is the worst that could happen? What is most realistic?
4. Am I overestimating the severity of the consequences of the event (should it occur)? Is it really a terrible catastrophe if X happens? Could I cope with it?
5. Does X have to = Y (e.g., "Does not having a dating partner being a loser?")
6. If a friend had this thought, what would I tell them?

Brittany & Thompson (2009, p.346) explained the following questions that can help you evaluate the usefulness of a thought:

1. What are the advantages of telling myself this? And what are the disadvantages?
2. What might be a more useful or helpful way of thinking about this?

3. To the degree that this belief is true, what should I do about it?

4. Be sure to record any data that contradicts the thought, and the more rational thoughts you may have composed.

5. Summarize your new perspective: Summarize or highlight the key points you discovered as a result of the work you have done.

6. Go back and re-rate your degree of belief in the hot thoughts and the intensity of your original emotions. Note whether there has been a change in your emotions.

2.6.5 Cognitive Restructuring and APD

Cognitive Restructuring (CR) according to Essuman, Nwachuku and Nwaogu (1990, p.67), is attempting to teach a client how to reduce negative reactions by getting clients to interpret situations/ events with greater accuracy. In this line one of the symptoms causes of APD is negative reactions in social environments. Therefore CR is useful techniques in teaching APD since it involves changing the way a client thinks or adheres to certain maladaptive beliefs.

Low self-esteem and fear of rejection are among the symptoms of APD causes by irrationality that lead to emotional problems, Ellis as explained in Shertzer and Stone (1980, p.209) sees a duality in human nature as both rational and irrational and there is close link between thinking and emotion and they are fused, and for pragmatic purposes, the two processes, must be regarded as the same. Emotional problems are not caused by the event but by the individuals philosophies and believes (self talk) with which the individual keeps indoctrinating themselves in most cases a chain of false sentences been developed over a long time. These false sentences are the creators of feeling of in-apt and fear of rejection and they can be destructed through CR counselling techniques such as re-education, confrontation, direct teaching and home work.

2.7.1 Social Skills Training

Social skills training (SST) is a second counselling technique to use in this study. Social skills training (SST) is a form of behavior therapy used by teachers, therapists, and trainers to help persons who have difficulties relating to other people (Susan, 2013). A major goal of social skills training is teaching persons who may or may not have emotional problems about the verbal as well as nonverbal behaviors involved in social interactions. There are many people who have never been taught such interpersonal skills as making "small talk" in social settings, or the importance of good eye contact during a conversation. In addition, many people have not learned to "read" the many subtle cues contained in social interactions, such as how to tell when someone wants to change the topic of conversation or shift to another activity. Social skills training helps patients to learn to interpret these and other social signals, so that they can determine how to act appropriately in the company of other people in a variety of different situations. SST proceeds on the assumption that when people improve their social skills or change selected behaviors, they will raise their self-esteem and increase the likelihood that others will respond favorably to them. Trainees learn to change their social behavior patterns by practicing selected behaviors in individual or group therapy sessions. Another goal of social skills training is improving a patient's ability to function in everyday social situations. Social skills training can help patients to work on specific issues. For example, improving one's telephone manners that interfere with their jobs or daily lives (Susan, 2013).

Social Skills Training as a method of helping people who have problems interacting with others. Clients learn basic social skills such as initiating conversations, making eye contact, standing at the appropriate distance, controlling voice volume and pitch, and responding to questions (Mazur, 2009). The therapist first describes and models the behavior. Then the patient or client practices the behavior in skits or role-playing exercises. The therapist watches the exercises and provides constructive criticism and further modeling. Therapists often conduct this kind of training with groups of people with similar problems. Social skills training often can help people with schizophrenia function more easily in public situations and reduce their risk of relapse or rehospitalization.

This technique teaches people, often those who are shy; to make appropriate responses when someone does something to them that seems inappropriate or offensive or violates their rights. For example, if a woman has trouble saying no to a coworker who inappropriately asks her to handle some of his job responsibilities, she may benefit from learning how to become more assertive. In this example, the therapist would model assertive behavior for the client, who would then role-play and rehearse appropriate responses to her coworker (Mazur, 2009).

2.7.2 Treatment of Specific Disorders with Social Skills Training

A person who lacks certain social skills may have great difficulty building a network of supportive friends and acquaintances as he or she grows older, and may become socially isolated. Moreover, one of the consequences of loneliness is an increased risk of developing emotional problems or mental disorders. Social skills training have been

shown to be effective in treating patients with a broad range of emotional problems and diagnoses. Some of the disorders treated by social skills trainers as suggested by Susan, (2013).include shyness; adjustment disorders; marital and family conflicts, anxiety disorders, attention-deficit/hyperactivity disorder , social phobia , alcohol dependence; depression; bipolar disorder ; schizophrenia ; developmental disabilities; ***avoidant personality disorder*** ; paranoid personality disorder ; obsessive-compulsive disorder ; and schizotypal personality disorder .

A specific example of the ways in which social skills training can be helpful includes its application to alcohol dependence. In treating patients with alcohol dependence, a therapist who is using social skills training focuses on teaching the patients ways to avoid drinking when they go to parties where alcohol is served, or when they find themselves in other situations in which others may pressure them to drink. (Susan, 2013).

Another example is the application of social skills training to social phobia or shyness. People who suffer from social phobia or shyness are not ignorant of social cues, but they tend to avoid specific situations in which their limitations might cause them embarrassment. Social skills training can help these patients to improve their communication and social skills so that they will be able to mingle with others or go to job interviews with greater ease and self-confidence. Some studies indicate that the social skills training given to patients with shyness and social phobia can be applied to those with avoidant personality disorder, but more research is needed to differentiate among the particular types of social skills that benefit specific groups of patients, rather than treating social skills as a single entity. When trainers apply social skills training to the treatment

of other personality disorders, they focus on the specific skills required to handle the issues that emerge with each disorder. For example, in the treatment of obsessive-compulsive personality disorder (OCD), social skills trainers focus on helping patients with OCD to deal with heavy responsibilities and stress (Susan, 2013).

People with disabilities in any age group can benefit from social skills training. Several studies demonstrate that children with developmental disabilities can acquire positive social skills with training. Extensive research on the effects of social skills training on children with attention-deficit/hyperactivity disorder shows that SST programs are effective in reducing these children's experiences of school failure or rejection as well as the aggressiveness and isolation that often develop in them because they have problems relating to others.

2.7.3 Social Skills Training in Combination with Other Therapies

Social skill training is often used in combination with other therapies in the treatment of mental disorders. For example, in the treatment of individuals with alcohol dependence, social skills training has been used together with cognitive restructuring and coping skills training. Social skill training has also been integrated with exposure therapy, cognitive restructuring, and medication in the treatment of social phobia. Social skill training has been used within family therapy in the treatment of marital and family conflicts. Moreover, SST works well together with medication for the treatment of depression. For the treatment of schizophrenia, social skills training have often been combined with pharmacotherapy, family therapy, and assertive case management.

Social skills training should rest on an objective assessment of the patient's actual problems in relating to other people. It is important for therapists who are using SST to move slowly so that the patient is not overwhelmed by trying to change too many behaviors at one time. In addition, social skill trainers should be careful not to intensify the patient's feelings of social incompetence. This caution is particularly important in treating patients with social phobia, who are already worried about others' opinions of them.

An additional precaution is related to the transfer of social skills from the therapy setting to real-life situations. This transfer is called generalization or maintenance. Generalization takes place more readily when the social skills training has a clear focus and the patient is highly motivated to reach a realistic goal. In addition, social skills trainers should be sure that the new skills being taught are suitable for the specific patients involved.

2.7.4 Techniques in Social Skills Training

Therapists who use social skills training begin by breaking down complex social behaviors into smaller portions. Next, they arrange these smaller parts in order of difficulty, and gradually introduce them to the patients. For example, a therapist who is helping a patient learn to feel more comfortable at parties might make a list of specific behaviors that belong to the complex behavior called acting appropriately at a party, such as introducing oneself to others; making conversation with several people at the party rather than just one other guest; keeping one's conversation pleasant and interesting; thanking the host or hostess before leaving; and so on. The patient would then work on

one specific behavior at a time rather than trying to learn them all at once. The specific techniques use in SST as described in Carter, (1998) are:

- instruction,
- modeling ,
- role-playing,
- shaping,
- feedback, and
- reinforcement

For example, instruction may be used to convey the differences among assertive, passive, and aggressive styles of communication. The technique of monitoring may be used to ask patients to increase their eye contact during a conversation. In role-playing exercises, group members have the opportunity to offer feedback to one another about their performances in simulated situations. For example, two members of the group may role-play a situation in which a customer is trying to return a defective purchase to a store. The others can then give feedback about the customer's assertiveness or the clerk's responses.

Outcome studies indicate that social skills training (SST) has moderate short-term effects, but limited long-term effects. SST programs that include social perspective-taking may have greater long-term effects than traditional SST programs based on cognitive-behavioral models. In general, social skills training tends to generalize or transfer to similar contexts rather than to contexts that are not similar to the training. SST programs for patients with developmental disabilities should include programming for

generalization, so that the patients can transfer their newly acquired skills more effectively to real-life settings. One approach to improving generalization is to situate the training exercises within the patient's work, living, or social environment (Carter, 1998). Some studies strongly suggest the need for follow-up support after an initial course of social skills training. One study showed that follow-up support doubled the rate of employment for a group of patients with schizophrenia, compared to a group that had no follow-up.

2.7.5 Content of Social Skills Training

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

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

unspoken messages is as important as learning conversational skills. A social skills program may include the following skills related to the perceptual processing of the conversation of other individuals as discuss in Antony and Richard (2000):

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

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

Generalization or transfer of skills: Current trends in social skills training are aimed at developing training programs that meet the demands of specific roles or situations. This need developed from studies that found that social skills acquired in one setting or situation are not easily generalized or transferred to another setting or situation. To assist patients in using their new skills in real-life situations, trainers use role-playing, teaching, modeling, and practice.

Preparation for social skills training requires tact on the therapist's part, as patients with such disorders as social phobia or paranoid personality disorder may be discouraged or upset by being told that they need help with their social skills. One possible approach is through reading. The social skills therapist may recommend some self-help books on social skills in preparation for the treatment. Second, the therapist can ease the patient's self-consciousness or embarrassment by explaining that no one has perfect social skills. An additional consideration before starting treatment is the possibility of interference from medication side effects. The therapist will usually ask the patient for a list of all medications that he or she takes regularly.

One of the most critical tasks in preparation for social skills training is the selection of suitable target behaviors. It is often more helpful for the therapist to ask the patient to identify behaviors that he or she would like to change, rather than pointing to problem areas that the therapist has identified. The treatment should consider the patient's particular needs and interests. Whereas social skills training for some patients may include learning assertiveness on the job, training for others may include learning strategies for dating. Therapists can prepare patients for homework by explaining that the homework is the practice of new skills in other settings; and that it is as relevant as the therapy session itself.

Canney and Byrne (2006, p.5) categorized social skills according to the level of complexity and interaction as:

i. Foundation Skills for basic social interaction: example ability to maintained eye contact, maintain appropriate personal space, understand gestures and facial expressions

ii. Interaction Skills for interaction with others: examples resolving conflicts, taking turns, learning how to begin and end conversations, determine appropriate topics for conversation and interacting with authority figures.

iii. Affective Skills for understanding oneself and others: examples identifying one's feelings, recognizing the feelings of others, demonstrating empathy, decoding body language and facial expressions, determining whether someone is trustworthy.

iv. Cognitive Skills in order to maintain more complex social interactions: example social perception, making choices, self-monitoring, understanding community norms, determining appropriate behavior for different social situations.

2.8 Review of Empirical Studies

The Empirical studies examined in this studies include the use of CBT, Cognitive Restructuring Technique, Social Skills Training on individual with APD, Social Anxiety because they have a higher Comorbidity symptoms and in comparative with other therapeutic techniques. Most of the technique reviewed were used in studies conducted outside Nigeria but it is presume that it will be applicable to Nigeria situation, hence the adaption.

The relative research conducted on psychotherapeutic outcome of client variables, therapist variables, and technique variables contributed a lot to the development of psychotherapy. There is considerable evidence that psychotherapy in general is effective, at least when compared to non psychotherapy. For example, in examining more than 1,000 studies of psychotherapy outcome, found psychotherapy in general to be effective.

Lambert (1992) also concluded that psychotherapy is effective. But what accounts for this general level of effectiveness and its variability across clients, therapists, and techniques is open to question.

Rupke, David and Marjorie (2006, p.6) Studies have shown that cognitive therapy is an effective treatment for depression. It is comparable in effectiveness to antidepressants and interpersonal therapy or psychodynamic therapy. The combination of cognitive therapy and antidepressants has been shown to be effective in managing severe or chronic depression. Cognitive therapy has also proven beneficial to patients who have only a partial response to antidepressants. There is good evidence that cognitive therapy reduces relapse rates. In addition, some evidence has shown that cognitive therapy is effective in treating adolescent depression.

Also on the empirical studies conducted on the treatment of APD using psychotherapeutic approach, Lambert (1992) has summarized outcome research indicating the amount of variance accounted for by different classes of variables. He reported that about 40% of outcome variance could be accounted for by extra therapeutic change, including client variables (e.g. ego strength, hardiness) and environmental variables (e.g. fortuitous events, social support) this variables are closely related to the symptoms of APD. Furthermore, it has been found that clients who are relatively healthy tend to improve more than clients who are less healthy (Garfield, 1994). In other words, those who need psychotherapy the least tend to improve the most.

Emmelkamp (2006) examined the effectiveness of brief dynamic therapy and cognitive-behavioral therapy for the people with APD and found that, patients who received

cognitive behavioral therapy showed significant improvements on a number of measures in comparison with those who had brief dynamic psychotherapy or were in control group and the results were maintained at follow-up. Finally he concluded that CBT is more effective than dynamic therapy and control group.

Lynum, Wilberg and Karterud (2008) study, compared self-esteem in patients with avoidant personality disorder (APD) and borderline personality disorder (BPD). Patients diagnosed with one or more personality disorders answered the questionnaire Index of Self Esteem as part of a comprehensive evaluation within the setting of a treatment trial. They tested the following four hypotheses:

i. Both patients with APD and patients with BPD would report low levels of self-esteem.
ii. Patients with APD would report lower self-esteem than patients with BPD.
iii. Patients with higher levels of depression would report lower levels of self-esteem,
iv. Both borderline and avoidant personality pathology would contribute to explain variance in self-esteem beyond what would be accounted for by depression.

The results from this study showed a significant difference in self-esteem level between the two personality disorders, patients with APD reporting lower self-esteem than patients with BPD. Subjects with both disorders were measured to have self-esteem levels within the range that presumes clinical problems. Self-esteem represents an important quality of subjective experience of the self, and the study of self-esteem in

Personality Disorder can offer new and important knowledge of Personality Disorder as self-pathology.

Also in a study conducted by Cummings, Hayes, Cardaciotto, and Newman, (2012) examined self-esteem variability in a sample of 27 patients with Avoidant and Obsessive-Compulsive Personality Disorders who received Cognitive Therapy (CT). A therapy coding system was used to rate patients' positive and negative views of self expressed in the first ten sessions of a 52-weeks treatment. Ratings of negative (reverse scored) and positive view of self were summed to create a composite score for each session. Self-esteem variability was calculated as the standard deviation of self-esteem scores across sessions. More self-esteem variability predicted more improvement in personality disorder and depression symptoms at the end of the treatment, beyond baseline and average self-esteem. Early variability in self-esteem, in this population and context, appeared to be a marker of therapeutic change.

Lenzenweger, Lane, Loranger, and Kessler, (2007, p.553) study the effect of Social Skills Training in the treatment of APD, Twenty-eight outpatients who met DSM-III diagnostic criteria for avoidant personality disorder completed 14 one and a half hour sessions of social skills training in the clinic only or a combination of four sessions in the clinic, four sessions in real-life and six follow-up sessions in the clinic. Subjects were assessed before treatment began, after four sessions, at the end of treatment and at three month follow-up points. Training in real-life did not enhance social skills training; no significant difference between the groups at any assessment points was found. In both groups improvement in time was significant and clinically worthwhile. The treatment effects

were maintained up to the three month follow-up, where available. Therefore according to this study Social skills training appear to be a useful and promising intervention for avoidant personality disorder.

The criterion of desire for affection and acceptance was eliminated from the definition of avoidant personality disorder in the DSM-III-R. But clinical experience in our setting suggests that attachment pathology related to such desires is an important diagnostic feature and a frequent focus of clinical intervention with avoidant individuals. Forty-seven patients receiving a clinical diagnosis of avoidant personality disorder completed a brief questionnaire which rated desire for an attachment relationship, fear of an attachment relationship and level of social skills. The results support our hypotheses that attachment security is distinct from general social skills and that desire for but fear of an attachment relationship is more characteristic of those diagnosed with avoidant personality disorder than a low level of social skills. (Sheldon, and West, 1995)

In another study conducted by Fahlen (1995), it discovered that Patients with social phobia often describe a general interpersonal sensitivity and meet criteria for DSM-III-R avoidant personality disorder. This study addresses the question of whether patients with social phobia have characteristic abnormal personality traits. A questionnaire with 140 items for self-rating personality traits was constructed for the study. Ratings obtained from 63 patients with social phobia were compared with ratings from 58 healthy controls. Structured interviews were also conducted with the patients to establish whether their disorders met the criteria for the DSM-III-R avoidant and/or dependent personality disorders. Ninety-one items on the questionnaire were rated significantly ($p < .01$) differently by the patients and the controls. These items were divided into two item-

groups, one relating to avoidant social behavior (subdivided by factor analysis into six factors) and another relating to more general depressive-anxious traits (five factors). The total scores had a normal distribution among the patients. With the 95th percentile of the controls as the cutoff point, only 22% of the patients had a total score within normal limits on avoidant social behavior. Avoidant personality disorder was diagnosed in 60% of the patients. The results support the hypothesis that patients with social phobia generally have characteristic abnormal personality traits, but lend no support to a division of the symptoms and traits into two separate diagnoses.

Herbert, Hope and Bellack (1992) on their work on Validity of the distinction between generalized social phobia and avoidant personality disorder maintained that Disorders of pervasive social anxiety and inhibition are divided into two categories; generalized social phobia (GSP) and avoidant personality disorder (APD). They explored the discriminative validity of this categorization by examining the comorbidity of GSP and APD and by comparing these groups on anxiety level, social skills, dysfunctional cognitions, impairment in functioning, and presence of concurrent disorders. In this study, Results from twenty-three subjects showed high comorbidity of the two diagnoses: All subjects who met criteria for APD also met criteria for GSP. APD was associated with greater social anxiety, impairment in functioning, and Comorbidity with other psychopathology, but no differences in social skills or performance on an impromptu speech. GSP and APD seem to represent quantitatively different variants of the same spectrum of psychopathology rather than qualitatively distinct disorders

In another development Reichborn-Kjennerud, Czajkowski and Torgersen, (2007) in their study on the relationship between avoidant personality disorder and social phobia, tried to determine the sources of Comorbidity for social phobia and dimensional representations of avoidant personality disorder by estimating to what extent the two disorders are influenced by common genetic and shared or unique environmental factors versus the extent to which these factors are specific to each disorder. Young adult female-female twin pairs (N=1,427) from the Norwegian Institute of Public Health Twin Panel were assessed at personal interview for avoidant personality disorder and social phobia using the Structured Interview for DSM-IV Personality and the Composite International Diagnostic Interview. Bivariate Cholesky models were fitted using the Mx statistical program. They discovered that the Avoidant personality disorder and social phobia were influenced by the same genetic factors, whereas the environmental factors influencing the two disorders were uncorrelated. Within the limits of statistical power, these results suggest that there is a common genetic vulnerability to avoidant personality disorder and social phobia in women. An individual with high genetic liability will develop avoidant personality disorder versus social phobia entirely as a result of the environmental risk factors unique to each disorder.

Tignol, et al. (2001), in their work conducted on Case study--relationship between prevalence of shyness, social phobia and avoidant personality in male sexual disorders, compared males with sexual disorders to non-sexual disorder males on diagnosis of social phobia, avoidant personality disorder and shyness. They conducted a case-control study comparing a group of male patients seeking care for sexual disorders and a control group of male subjects without sexual disorder, regarding the diagnosis of social phobia,

avoidant personality disorder and shyness. They adopted a structured diagnostic interview (CIDI) for the diagnosis of social phobia and a list of criteria (DSM IV) for avoidant personality disorder as well as through standardized scales (Fear Questionnaire, CBSHY, Cottraux male sexual problems questionnaire) in the study. Severity of shyness was evaluated through visual analog scales. The study found strong significant statistical differences between cases and controls regarding the percentage in each group of social phobia, avoidant personality disorder and shyness. Their results are in favor of one or several factors in common between social phobia, avoidant personality disorder and shyness, which would be strongly related to male sexual disorders.

In addition, another study conducted by Tillfors and Ekselius (2009) on the issue of Social phobia and avoidant personality disorder: are they separate diagnostic entities or do they reflect a spectrum of social anxiety? Explain that the Axis I disorder social phobia and the Axis II disorder avoidant personality disorder were first introduced in the DSM nomenclature in 1980. Since then a major nosological theme in research has concerned whether or not social phobia and avoidant personality disorder represent distinct clinical categories. They tried to summarize both the current situation regarding this conceptual debate, as well as what do still not know. In the present review they described the evolution of these disorders as they have been addressed over time, from their introduction in the DSM-III system to their current descriptions in the DSM-IV. Thereafter, they evaluated the earlier empirical literature concerning this conceptual debate, with the main focus on comorbidity between social phobia and avoidant personality disorder. They searched PsycINFO and PubMed electronic databases for studies, and complementary searches of references in articles and books were conducted.

To conclude, the studies summarized provide support for the view that social phobia and avoidant personality disorder are more than arbitrary cutoffs along a continuum of social anxiety.

Nancy (2004) reported in his PhD work that the larger majority (71%) people diagnosed with social phobia avoided formal speaking in public and over half (57%) avoided informal speaking in parties, or with coworkers and the remaining persons with social phobia denied such avoidance but reported that they felt significant distress in social situation which is also one pf the symptom of APD. Nancy also reported that some studies suggest that avoidance of social situations is an important feature of APD. He maintained that Jones et al (1986) found social avoidance to be an important factor among APD patients based on a factor analysis.

In their research work, Francis, Last and Strauss (1992) on Avoidant disorder and social phobia in children and adolescents examined characteristics of avoidant disorder and social phobia by comparing outpatient youngsters with avoidant disorder, social phobia, and avoidant disorder plus social phobia on demographic variables and patterns of comorbidity. The psychiatric groups were compared with matched normal controls on symptom measures of depression and fear. Findings indicated that the three psychiatric groups were strikingly similar on all but one variable, age at intake. These findings question the notion of avoidant disorder and social phobia as distinct disorders in children and adolescents.

Rettew (2000) in his research work on Avoidant personality disorder generalized social phobia, and shyness: putting the personality back into personality disorders discovered

that APD and GSP, Comorbidity rates have varied from approximately 25% to numbers high enough that the ability to diagnose one disorder without the other was questioned. Comparisons of the characteristics of APD and GSP have yielded few qualitative differences, although some studies have shown evidence that APD may represent a more severe form of GSP with respect to levels of symptoms, fear of negative evaluation, anxiety, avoidance, and depression. He maintained that Personality dimensions including, but not limited to, shyness have been found to be strongly associated with GSP and APD, and there is some evidence that persons who suffer from social anxiety also suffer from fears and avoidance across nonsocial domains.

In a work by Ohman and colleagues as reported in Jasper (2004) has added on the existing conditioning theories for APD. Building on the concept of "preparedness", which was introduced by selgman in 1971, Ohman and colleagues conducted a series of experiments examining whether social fears may be driven by a predisposition to acquire fears of angry, critical or rejecting faces as CSs was superior to conditioning with happy faces as CSs.

In a study conducted by Deacon, Fawzy, Lickel, and Wolitzky-Taylor (2011) compare the impact of cognitive diffusion with that of cognitive restructuring in a sample of participants distressed by negative thoughts about their body shape. Participants received a detailed rationale and training followed by instructions to practice the assigned technique as homework for 1 week. Results indicated that both cognitive techniques produced substantial improvements that generalized well beyond the specific thoughts targeted for treatment. David, McMahon, Macavei, and Szentagotai, (2005) in their work

elaborated several techniques hypothesized to control mental contamination, tested the efficacy of mental contamination during cognitive restructuring in cognitive-behavioral and rational-emotive therapy, in blocking mental contamination. They adapted and tested in the clinical setting using single case experiment design-multiple baselines across subjects. In their study they found the following three techniques that proved to be effective in both stimulating the assimilation of new adaptive cognitions and in preventing relapses:

(a) The global restructuring technique;

(b) The rational anticipation technique; and

(c) The incompatible information technique.

Tosi, Donald, Judah, Steven, Murphy, and Michael (1989), also conducted a research which evaluated the effects of Cognitive Restructuring (CR), Hypnosis Only (HO), and a No-treatment control condition on the duodenal ulcer syndrome. The cognitive restructuring was used for self-defeating cognitive, emotional, physiological, and behavioral tendencies. Seven criterion variables were assessed using two standardized instruments and questionnaire data. The standardized instruments included the Millon Behavioral Health Inventory (MBHI) and the Common Beliefs Survey ID (CBS III). Twenty-five volunteer duodenal ulcer patients served as subjects for the study. The research design, a 4 X 3 factorial design with repeated measures, consisted of four treatment levels (Control, CR, HO, and RSDH) and three time periods (pretest, posttest, and follow-up) over which the subjects were observed. MANOVA on residualized change scores revealed a significant treatment effect. Univariate effects were observed on

the MBHI personality coping styles, CBS III evaluation and locus of control scales, and gastrointestinal disturbance. GET appeared to have an ameliorative effect on psychological factors associated with duodenal ulcer.

In the issue of causal factors of Personality Disorder, a research conducted by Kendler, Czajkowski, & Tambs, (2006), on Dimensional representations of DSM-IV cluster a personality disorders (PD) in a population-based sample of Norwegian twins. The Cluster-A personality disorders (PDs) - paranoid, schizoid and schizotypal PDs were created in DSM-III with little empirical foundation. They examined the relationship between the genetic and environmental risk factors for dimensional representations of these three personality disorders. They also assessed these personality disorders using the Structured Interview for DSM-IV Personality (SIDP-IV) in 1386 young adult twin pairs from the Norwegian Institute of Public Health Twin Panel. Using Mx, a single-factor independent pathway twin model was fitted to the number of endorsed criteria for the three disorders. The best-fit model included genetic and unique environmental common factors and genetic and unique environmental effects specific to each personality disorder. Total heritability was modest for these personality disorders and ranged from 21% to 28%. Loadings on the common genetic and unique environmental factors were substantially higher for schizotypal than for paranoid or schizoid PD. In support of the validity of the Cluster A construct, dimensional representations of schizotypal, paranoid and schizoid PD are all modestly heritable and share a portion of their genetic and environmental risk factors. In their study they found no evidence for shared environmental or sex effects for these Personality Disorders. Schizotypal PD most closely reflects the genetic and environmental liability common to all three Cluster A disorders.

Alexis, Christopher, Annie & Lejuez (2010) in his work on the Effectiveness of Cognitive Behavioral Therapy for Personality Disorders explained that Cognitive Behavior Group Therapy (CBGT) interventions for APD draw upon strategies that have been shown to be effective in treating social phobia and patients with interpersonal problems, including graduated exposure, cognitive restructuring and social skills training.

The core of CBGT treatments for APD is graduated exposure, in which patients are encouraged to approach situations that are feared or avoided. Group sessions are used to prepare for upcoming exposure exercises, and to review previous exposures, while also providing a real-world opportunity for sustained exposure to a social situation (Blurm, Pfoll& St.John in Alexis, Christopher, Annie & Lejuez, 2010).

Alden (1989) maintained that one of the elements of CBGT interventions is cognitive restructuring, in which he used the subjects who are willing to participate in the treatment. He also maintained that, some CBGT approaches include an interpersonal skills training component, based on the assumption that individuals with APD lack the social skills necessary to interact effectively or appropriately.

Stravynski, Marks & Yule (1982) conducted a research on CBGT interventions for APD include multiple treatment elements, their findings suggest that multi-component treatments do not necessarily produce better outcomes. They randomized 22 participants with APD and generalized social phobia either to a treatment that included exposure, Social skills training and cognitive restructuring (n = 11), or to a treatment that included only exposure and social skills training (n = 11). Treatment consisted of 12 weekly group sessions. Both groups showed significant improvements in symptoms of depression,

anxiety, and symptomatic behavior (e.g., fewer irrational beliefs, less social isolation), however, the inclusion of cognitive restructuring did not improve outcomes beyond the effects of exposure and social skills training.

In another subsequent trial, Stravynski, Belise & Marcouiler (1994) questioned whether the didactic component of social skills training was necessary, or whether informal exposure to skills through group discussions would produce similar improvements in social functioning. Patients with APD *n* = 21) served as their baseline and participated in five sessions of social skills training and five sessions of group discussions that addressed skills without providing instruction. Exposure homework was assigned in both treatments. In terms of overall social functioning, patients benefited as much from the general discussion group as they did from overt skills training. Findings suggest that patients with APD may not require explicit instruction to function effectively in social situations; rather, patients may benefit from the informal modeling of skills, planning, rehearsal and feedback that occur during group discussions.

Alden (1989) conducted a randomized controlled trial comparing three active CBGT treatments to a control group (*n* = 76). Standard CBGT included exposure with a limited cognitive component (e.g., increasing awareness of fearful thoughts). The second group consisted of standard CBGT in addition to general social skills training (e.g., listening skills, assertiveness), and the final group consisted of standard CBGT plus intimacy-focused skills training (e.g., how to foster a friendship with an acquaintance). All active treatment conditions produced improvements in symptoms of anxiety and depression, reductions in symptomatic behavior (e.g., self-reported shyness, anxious mannerisms),

and improvements in social functioning, with gains maintained three months after treatment. In general, the addition of skills training did not improve outcomes beyond the effects of the standard CBGT However, the group that received of intimacy-focused skills reported greater involvement in and enjoyment of social activities than patients in the other active treatment conditions. Although patients in all treatment conditions made gains over the course of treatment, it is noteworthy that the majority of patients remained impaired in terms of self-esteem, social reticence and overall social functioning. Alden (1989) therefore concluded that residual symptoms may be due to the brevity of GCBT. Consistent with this suggestion, there is evidence that the efficacy of CBGT may be compromised when treatment is delivered over a short period of time or in a small number of sessions.

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

term, comprehensive interventions may be necessary to change longstanding cognitive and behavioral patterns.

Strauss Hayes & Johnson (2006) conducted an open trial of treatment outcomes among outpatients with APD (*n* = 24) and OCPD (*n* = 16). All patients received up to 52 weekly sessions of individual CBT and were assessed before and after treatment. Among those with APD, the majority reported clinically significant improvements across a range of symptoms and problematic behaviors. For example, 67% of patients no longer met diagnostic criteria for APD at the end of treatment, and 65% experienced remission of depressive symptoms. These encouraging findings as reported in Alex Christopher, Annie & Lejuez, (1989) were replicated in an RCT conducted by Emmelkamp Banner & Klupers (2006) in which patients were assigned to CBT (*n* = 26), brief dynamic therapy (BDT; *n* = 28) or a waitlist condition (*n* = 16). The two active treatments consisted of 20 sessions delivered over six months, and patients were assessed at the end of treatment and six months after treatment termination. Although both CBT and BDT both produced significant improvements in anxiety symptoms, behavioral avoidance and dysfunctional beliefs at the end of treatment, CBT was significantly superior to BDT on all outcome measures. Moreover, BDT did not differ from the control group on any measure at the end of treatment. At follow-up, treatment gains were maintained, with 91% of the CBT group and 64% of the BDT group no longer meeting diagnostic criteria for APD, a statistically significant difference.

2.9 Summary

The literature review stated and explained some concept that could be utilized as guiding principles on using Cognitive Restructuring (CR) and Social Skills Training techniques in the treatment of APD. It clearly explained the meaning of personality as an individual's habitual way of thinking, feelings, perception and reaction to the world. Personality can be normal or abnormal, where it is normal the individual gets along with other people in harmonious manner and is able to hold down schooling, job and make living. Where the personality is abnormal it is call personality disorder that is where the individuals have social conflicts and they are unable to get along with other people.

APD is a cluster 'C' personality disorder and it is affecting to people when they display A pervasive pattern of social inhibition, feelings of inadequacy, extreme sensitivity to negative evaluation and avoidance of social interactions. The major symptoms of APD are avoiding work, social interaction or school activities, low self-esteem and self-isolation.

The major treatment intervention that have been proven to work best for overcoming APD are cognitive behavioral therapy which include cognitive restructuring, social skills training, systematic desensitization, modeling, assertive training to mention few. Therefore the theoretical basis of this study is Cognitive Behavioral Theory (CBT) which is a combination of two very effective form of psychotherapy that helps a person to change unhelpful or unhealthy thinking, habit, feelings and behaviors by modifying dysfunctional emotions, behavior and thoughts. Through this review, two main

behavioral theories were reviewed which involved classical conditioning and operant conditioning.

The chapter base on this reviewed the two main counselling techniques to be used in this study Cognitive Restructuring (CR) and Social Skills Training (SST) in order to further our understanding on them as psychological processes related to the treatment of APD. CR is a CBT psychotherapeutic process of learning to identify and dispute irrational or maladaptive thoughts. While SST is also a form of CBT method of helping people who have problems interacting with others change their social behavior patterns by practicing selected behaviors in individual or group therapy sessions.

On the whole, most of the empirical studies reviewed in this chapter emphasized on using a combination or single CBT approach on treating APD rather than identifying which technique is more relevant to particular category of clients (students). But more research is needed to differentiate among the particular types of counselling skills that benefit specific groups of students.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter presented the research design, population, sampling and sampling technique. Other issues discussed are conceptual model to be used in the conduct of the research, instrumentation, the validity and reliability of the instrument, procedure for data collection, experimental treatment and control procedures, pilot testing, breakdown of the counselling sessions and procedure for data analysis.

3.2 Research Design

The design adopted for the study was quasi experimental design involving pretest post test design. Quasi experimental design is a design that does not provide full control of subjects and does not include random assignment of subjects. It permits the researcher to reach reasonable conclusions even though full control is not possible. (Ary, Jacobs and Razariely 2002). The design can be represented symbolically as follows: -

E1	Y1	X1	Y4
E2	Y2	X2	Y5
C	Y3	-	Y6

Where: -

E1 – Treatment group one (CR)

E2 – Treatment group two (SST)

C – Control group (No treatment)

Y1 – Pretest to administer to Treatment group one (CR)

Y2 – Pretest administer to Treatment group two (SST)

Y3 – Pretest to control group

X1 – Treatment with (CR)

X2 – Treatment with (SST)

Y4 – Post test administer to Treatment group one (CR)

Y5 – Post test administer to Treatment group two (SST)

Y6 – Post test to control group

This research was a quasi experimental design since it was conducted in school situation, schedules cannot be disrupted and only group of students that show higher symptoms of APD participated in the research. In this work six groups were marked out by the researcher. Out of these six groups two were treated using Cognition Restructuring (CR), others two with Social Skills Training (SSI) counselling technique sessions and the remaining two served as a control group. The last group which is the control group received treatment which has no relevant to any variables of the research.

3.3 Population

The populations in this study were Senior Secondary School Two (S.S.S. II) students in Kano metropolis who demonstrate symptoms of APD. The Kano State metropolis comprises of eight local governments and there are 426 senior secondary schools across the Kano metropolis. SSS II students were selected because of the view that the APD is more prevalent at adolescent period towards adulthood, and they are selected because they stayed enough at the school and are not being affected by the terminal effect of the secondary schooling i.e or preparation for SSCE examination.

3.4 Sample and Sampling Techniques

Purposive sampling was used in drawing up the sample schools involved in this study. Three local governments were purposevely selected from the eight local governments in the metropolis and two schools were also be purposely selected from each local government one male Senior Secondary School and one female Senior Secondary School, making six (6) schools. A sample size of 72 students 12 students from each sampled schools were drawn using APD test which was administered to all SSS II students in the sampled schools.

Also the test was used to select students who show highest level of APD symptoms base on the scoring procedure according to DSM-5 (2013) that is any score from 28 to 44. Therefore, the sample size was based on respondents who had the highest scores in the levels of symptom of APD. The entire students sampled in the sampled school were randomly put into three groups i.e. treatment group I, treatment group II and control

group. The following is the table showing the distribution of obtained sample size by schools:

Table 3.2: Distribution of Obtained Sample Size of Senior Secondary School Students with the Symptoms of APD by Schools:

S/NO	NAME OF SCHOOLS	TOTAL NO. OF RESPONDENT STUDENTS	NO. OF STUDENTS IDENTIFIED WITH APD	SAMPLE OF STUDENTS	TREATMET GROUPS
1	AKCC	60	36 (60%)	12	CR
2	GGC Dala	60	33 (55%)	12	CR
3	GGSS M/ Abacha	60	31 (51.67%)	12	SST
4	GSS G/Dutse	60	32 (53%)	12	SST
5	Rumfa college	60	28 (46.67%)	12	CONTRO L
6	GGSS SHEKARA	60	26 (43.33%)	12	CONTROL
	TOTAL	**360**	**186 (51.67%)**	**72**	

Source: - Data collected by the researcher and volunteered teachers using APD Test (November, 2015)

3.4 Conceptual Model

Conceptual Model of this study dealt with the specification of research variables and their interrelationship. The variables used of this study are dependent, independent and intervening variables because the study is a quasi experimental in nature. The researcher in this study manipulated the two independents variables and sees its effects on the

dependents variables. And the intervening variables was controlled to be sure that the observed changes are due to the effect of independent variables on the dependent one.

In this study, the independent variables were cognitive restructuring and social skills training counselling technique while the dependent variable as the symptoms of APD that is imminent in the secondary school students in Kano metropolis. The extraneous variables include the following;

i. Absence of the subject from the treatment
ii. Language of the treatment and test instruments.
iii. Selection of the subjects to participate in the research
iv. Interaction between the experimental group and the control group.

3.5.1 Instrumentation

To collect the data for the study for the identification of students with the symptoms of Avoidant Personality Disorder (APD) and in the pretest and post test the researcher used the Avoidant Personality Test (DSM – 5 APD).

Avoidant personality disorder test is a tool developed by DSM –5 (2013) to measure symptoms of Avoidance personality disorder. The instrument contains 11 Items that can be used to measure one of the major symptoms of APD that is avoiding work, interpersonal relationship and school activities. The instrument was used in USA to assess the symptoms of APD hence its adoption in Nigeria is appropriate. This instrument used to identify the subjects who met the criteria of DSM-5 symptoms of APD. It was administered by the help of classroom teachers. Thus the test results helped to determine who participated in the research.

3.5.2 Administration of Avoidant Personality Disorder Test

The subjects of this study who were senior secondary school students two of sampled schools are the respondents of the APD test. Some volunteer teachers of the school helped in the administration of the test instruments to many students. The test was administered in their respective classes for the first time in order to select the adequate number of students with symptoms of APD to participate in the course of the treatment. The researcher explained the need of the respondents to give reliable and objective responses.

At every school two teachers who volunteer were chosen as research assistants and they were trained on how to administer the APD test. The subjects responded to the test within 40 minutes which was administered by the researcher and volunteer teachers and the test was explained in Hausa languages item-by-item in their classes to make them understand the questions effectively. And they also assured that all responses will be treated confidentially. After the subjects have appropriately ticked the items on the scale, the researcher collected the same for further scoring in order to get the adequate sample avoidant subjects that needed for the experimental and control groups.

3.5.3 Scoring of APD Test

Respondents of APD test were scored on a 4 point likert scale to identify the students with the symptoms of APD. The responses categories of APD test were weighted by assigned numerical value as Strongly Agree (SA) received a weight of 4 points, Agree (A) - 3 points, Disagree (D) - 2 points and Strongly Disagree (SD). The sum of the weight of all the items chose by the subjects represent the individual's total score.

Therefore any students score 40% (28 points) and above indicate the extent to which they have the symptoms of APD, and such students need psychotherapy treatment to reduce avoidant behaviors. But scores below 40% (28 points) indicate that the respondent is coping well.

3.5.4 Validity of the Instrument

The validity of APD test was attested by Reich (1990) in Harvard medical school Massachusetts mental Health Center who used eleven (11) items of the instruments in a 4 point likert scale to assess the relationship between DSM- III Avoidant personality disorder and dependent personality disorder; and found the instrument to be a valid and reliable in measuring the symptoms of APD. For it to be valid in Nigeria, Kano state, it was assessed in collaboration with experts in the field of psychology and Guidance and counselling Ahmadu Bello University, Zaria. Some of their observation is to clearly elaborate some abbreviations, to explain the content in Hausa language, to put it in tabular form and interpretation of some ambiguous meaning according to the culture of the respondents.

3.5.5 Reliability of the Instrument

The reliability of the instrument used in this study was established in a study by Reich (1990) which has demonstrated a good reliability coefficient index of 0.6 using the Cronbach alpha statistics when assessing the relationship between APD and dependent personality disorder.

However, in the present study the reliability of the APD test was established using the test re-tests method. Twenty SSS two students identified with the symptoms of APD were

sampled to conduct a pilot study. The instrument was administered to them for the first time and second time within an interval of three weeks. Pearson product moment correlation co-efficient used in computing the correlation co-efficient of the instrument. A reliability co-efficient of 0.90 was obtained therefore the instrument was statistically adjudge to be reliable and considered suitable for research use.

3.6 Experimental Phase

3.6.1 Pre-treatment Session

After the students with the symptoms of Avoidance Personality Disorder are identified by their teachers with the help of DSM-III criteria for APD at sampled schools, the students was then undergo pre-test using APD test. Then the treatment group was exposed to twelve (12) weeks of thirty (30) minute twelve counselling sessions.

3.6.2 Treatment Session

This part formed an interactive meeting between the researcher and the students identifies with the symptoms of APD in a sampled schools. They were identified through their scores in APD test and observations by their teachers for the treatment. It also provides the researcher the opportunity to discuss symptoms associated with APD behaviors, its negative effect on their studies, career and their general social life. And it critically looked into the importance of reducing and managing avoidance behaviors.

At each school the participants were randomly divided into three different groups, two treatment groups and one control group. The first treatment group was given Cognitive

Restructuring Technique and Social Skills Training for second treatment group. Twelve weeks counselling sessions of thirty (30) minute was carried out one session per week.

In formulating guidelines for the treatment of APD it was bearded in mind that this disorder shares many similarities with the social phobia and dependent personality disorder. And also it was been bear in mind that patients with APD are particularly sensitive to scrutiny, even in a therapy situations. They may be reluctant to openly express their internal experience for fear or shynes. Therefore a strong rapport and confidentiality was established which create in the participants a commitment to a course of treatment.

Cognitive restructuring (CR) is one of the most effective psychological treatments for common personality disorders. It is a useful tool for understanding and turning around negative thinking through putting unhappy and negative thoughts 'under the microscope' challenging them and in many cases re-scripting the negative thinking that lies behind them. In doing this it help the clients with APD behavior approach situations in a positive frame of mind. The assumption of CR here is that negative thinking is not only unpleasant but also reduces the quality of performance and undermines working and social relationships with other people.

Social Skills Training (SST) is a form of behavior therapy used to address social skills deficits, excessive shyness and low self esteem. This SST is purposively designed to effectively improve social skills for those with APD regardless of the social problem. It improves confidence and self esteem and reduce anxiety about social situations. It focuses on teaching skills that can be learned rather than emphasizing the internal or

biological determinants of social adequacy. It improves social functioning by reducing the anxiety effects of acquiring skills.

3.6.3 Post Treatment (Post-Test) Session

The APD test was used again to re-test the subjects used in the study. These include those who receive cognitive restructuring and social skill Training Counselling intervention as well as control group who received treatment which has no relevant to any variables of the study.

3.7 Procedure for Data Collection

The researcher collected a letter of introduction from Department of Educational Psychology and Counselling ABU, Zaria and presented to Kano State Senior Secondary School Board for appropriate data and seeking permission to conduct the study at the sampled schools. After granting the permission the researcher went round to sampled schools to contact the principals for discussion on the conduct of the research sessions and choosing the volunteer teachers who helped in the conduct of the study. There after the instrument was administered to all SSS II in the sampled schools with the help of these volunteer teachers those with higher symptoms of APD were chosen to participate in the research using standardize APD Test.

3.8 Statistical Procedures

The statistical tools used in this study are t-test and covariance statistics.

1- Mean scores and standard deviation were used to answer research questions.

2- The t-test for independent sample was used to test the null hypothesis stated in the study.

3- The Analysis of variance (ANOVA) used to confirm that there is no difference in the level of APD among the groups in the study to make sure all other differences in the post-test is due to the effect of the treatment.

CHAPTER FOUR

RESULTS AND DISCUSSIONS

4.1 Introduction

This chapter presents the analysis of data collected from the experimental study. Summary of major findings and discussion of results were also presented in the chapter. The basis for the determination of the rejection or acceptance of the hypotheses is 0.05 levels of significance. Both inferential and descriptive statistics that suits each hypothesis and research questions were used in arriving at conclusions. T-test for independent sample was used to test hypotheses while one-way analysis of variance (ANOVA) was used on the Pre-test results of all groups to confirm that there is no difference in the level of APD among the groups in the study and to make sure all other differences in the post-test scores is due to the effect of the treatment. Mean and standard Deviation were used for the descriptive analysis in answering research questions a lower mean score indicates reduction in avoidance personality disorder symptoms of participants.

4.2 Presentation of Data

The result of data analysis is presented here with tables indicating different result of the findings from table 4.1 to 4.20 below:

Table 4.1 Showing the Prevalence of APD Frequency and Percentage of the Respondents Senior Secondary School Students Identified with APD Symptoms:

S/NO	NAME OF SCHOOLS	TOTAL NO. OF RESPONDENT STUDENTS	NO. OF STUDENTS IDENTIFIED WITH APD	SAMPLE OF STUDENTS	TREATMET GROUPS
1	AKCC	60	36 (60%)	12	CR
2	GGC Dala	60	33 (55%)	12	CR
3	GGSS M/ Abacha	60	31 (51.67%)	12	SST
4	GSS G/Dutse	60	32 (53%)	12	SST
5	Rumfa college	60	28 (46.67%)	12	CONTRO L
6	GGSS SHEKARA	60	26 (43.33%)	12	CONTROL
	TOTAL	**360**	**186 (51.67%)**	**72**	

Table 4.1 above showed that a total number of sixty (60) senior secondary school students responded to APD test in each of the sampled six (6) schools. It showed that a total of one hundred and eighty six (186) (51.67%) were identified with APD symptoms out of them seventy two (72) students were sampled twelve from each school.

Table 4.2 Showing Distribution of Respondents by Gender

Gender	Frequency	Percentage
Male	36	50%
Female	36	50%
Total	75	100%

Table 4.2 above shows the distribution of respondents according to gender. It shows that the male respondents were 36 representing 50% while the female respondents were 36 representing 50%.

Table 4.3 Showing Distribution of Respondents into Experimental and Control Groups and Schools:

Group	Frequency	Percentage
Experimental Male	24	33.3%
Experimental Female	24	33.3%
Control Male	12	16.7%
Control Female	12	16.7%
Total	**75**	**100%**

Table 4.3 above shows the distribution of respondents into groups. The experimental group consisted of twenty four (24) male and twenty four (24) female respondents representing 33.3% each and the control group consist twelve (12) male and twelve (12) female respondents representing 16% each.

Table 4.4 Showing Distribution of Respondents into Treatments and Control Groups by Gender:

Group	School	Gender	Frequency	Percentage
Cognitive Restructuring	AKCCC	Male	12	16.7%
	GGC Dala	Female	12	16.7%
Social Skills Training	GSS G/Dutse	Male	12	16.7%
	Maryam Abacha GGC	Female	12	16.7%
Control Group	Rumfa Collage	Male	12	16.7%
	Shekara GGSS	Female	12	16.7%
	TOTAL		72	100%

Table 4.4 above shows the distribution of respondents into treatment and control group APD test was administered randomly to three hundred and sixty (360) senior secondary school two students (SSS II) in six different school sixty student each by the researcher and volunteer teachers. Out of all students responded to APD test seventy two (72) students who scored higher marks were identified to have symptoms of APD and they met the criteria of DSM IV- TR (2000) than they were group into treatments and control group.

In this study, APD test was used to identify the subjects to participate in the research. Any student who score from 28-44 according to the scoring procedure of APD test was considered as APD patient. The higher the score, the more avoidant behavior is. In study the scores obtained by the students were rated and the first twelve students who have higher scores out of 60 student from each participating school were sample to participate

in the three group i.e CR treatment group, SST treatment group and control group. Twelve (12) male and twelve (12) female SSS II students representing (16.7%) each were used as experimental groups treated with cognitive restructuring (CR), twelve (12) male and twelve (12) female SSS-II students were also used as experimental groups treated with social skills technique (SST) and twelve (12) male and twelve (12) female each were used as a control groups.

4.3 Answers to Research Questions

The seven research questions raised in chapter one was answered below using mean scores and standard deviation of the groups.

Table 4.5 Showing Descriptive of Pre-Test APD Mean Scores and standard deviation Between Senior Secondary School Students Distributed as CR treatment, SST treatment and those in Control Group:

Schools	Treatment Group	N	Mean	SD	Std. Error
AKCC	CR	12	33. 67	1.497	0.432
GGC Dala	CR	12	35. 92	1.929	0.557
GSS Abacha	SST	12	34. 83	3.099	0895
GSS G/Dutse	SST	12	34. 58	2.275	0.657
Rumfa college	Control	12	35. 42	3.753	1.083
GSS Shekara	Control	12	36. 25	2.896	0.836
	Total	72	35.11	2.730	0.322

Table 4.5 above shows the pre-test APD mean scores of participants' schools exposed to CR, SST counselling treatment groups and those in control group. The pre-test APD mean scores in all the groups shows that they are almost equal, therefore there is no

significant difference (33.67, 35.92, 34.83, 34.58, 35.42 and 36.25). Therefore this analysis implies that any significant difference recorded in post-test is due to the treatment not from the group before treatment. Therefore the reduction in the mean score between post-test and pre-test would be attributed to the effect of the treatment of CR or SST counselling treatment.

Research Question One:

What effect would cognitive restructuring (CR) counselling technique have on students with Avoidance Personality Disorder (APD) among senior secondary school students in Kano State metropolis?

Table 4.6: Showing pre-test and Post- test APD Mean Scores of Students Treated with Cognitive Restructuring Counselling Technique.

Treatment	Group	N	Mean	Std. deviation	Std. Error
Pre-test	CR	24	34.79	2.043	0.417
Post – test	CR	24	25.33	5.354	1.093

Table 4.6 above shows the pre-test and post- test mean scores of students exposed to CR counselling technique. The pre-test APD mean score of students treated with CR is (34.79) while the post-test mean scores of students treated with CR is (25.33). This shows the reduction in the avoidant behavior is as a result of the exposure to CR treatment. This has therefore shown that CR counselling technique is effective in the treatment of APD.

Research Question Two:

What effect would social skills training counselling technique have on students with avoidance personality disorder (APD) among senior secondary school students in Kano State metropolis?

Table 4.7: Showing pre-test and post-test APD mean scores of students treated with social skills counselling technique (SST):

Treatment	Group	N	Mean	Std. deviation	Std. Error
Pre-test score	SST	24	34.71	2.662	0.543
Post-test scores	SST	24	26.17	3.886	0.793

Table 4.7 above shows the pre-test and post-test mean scores of students exposed to SST counselling technique. The pre-test APD mean scores for students treated with SST is (34.71) while the post-test mean scores of the students treated with SST is (26.17). This implies the reduction of the avoidant behavior as a result of the SST treatment. This has therefore shown the effect of SST in the reduction of APD.

Research Question Three.

What is the differential effect of CR and SST counselling technique treatment of students with APD among senior secondary school students in Kano State metropolis?

Table 4.8 Showing CR and SST counselling technique post-test APD mean scores:

Treatment	N	Mean	SD	Std. Error
Post-test (CR)	24	25.33	5.354	1.093
Post-test (SST)	24	26.17	3.886	0.793

Table 4.8 above shows the post – test APD mean scores of CR and that of SST counselling technique. It shows that there is no significant difference in the mean score of

CR (25.33) and the mean score of SST (26.17). This implies that the two techniques are equally effective in the treatment of APD among secondary school student in Kano metropolis.

Research Question Four:

What is the effect of CR counselling technique on APD of students exposed to CR treatment and those in control group among senior secondary school students in Kano State metropolis?

Table 4.9 Showing post test APD mean scores of students exposed to CR treatment and those in control group:

Group	N	Mean	SD	Std. Error
Post-test Scores				
Control Group	24	33.08	2.827	0.577
Post-test Scores				
Experimental (CR)	24	25.33	5.354	1.093

Table 4.9 above shows the post–test APD mean scores of students exposed to CR and those in control group. The post-test APD mean scores of student in control group is (33.08) while the post-test mean scores of APD students exposed to CR counselling treatment is (25.325). Therefore, this analysis showed greater difference in the mean scores between CR technique treatment and those in control group and the different is as a result of the treatment, this implies that CR counselling technique consider to be effective in the treatment of APD.

Research Question Five:

What is the effect of SST counselling technique on APD of students exposed to SST treatment and those in control group among senior secondary school students in Kano State metropolis?

Table 4.10 Showing post test APD mean scores of students exposed to CR treatment and those in control group.

Group	N	Mean	SD	Std. Error
Post-test Scores				
Control Group	24	33.08	2.827	0.577
Post –test Scores				
Experimental (SST)	24	26.17	3.886	0.793

Table.4.10 Above shows the post test means scores of students exposed to SST and those in control group. The post-test APD mean scores of students in control group is (33.08) while that of post-test mean scores of APD students exposed to SST counselling technique treatment is (26.17). This shows reduction of the APD as a result of the exposure to SST treatment. Therefore this analysis shows greater difference in the mean scores between SST treatment and those in control group and the difference is as a result of the treatment. This implies that using SST counselling technique is effective in the treatment of APD.

Research Question Six:

What is the effect of CR counselling technique treatment on male and female students with APD among senior secondary school students in Kano State metropolis?

Table 4.11 Showing post-test APD mean scores of male and female students exposed to CR treatment.

Group	N	Mean	**SD**	**Std. Error**
Post-test Score				
Male (CR)	12	22.50	5.196	1.500
Post-test Score				
Female (CR)	12	28.17	3.927	1.134

Table 4.11 above shows the post-test APD mean scores of Male and female student exposed to CR treatment. It shows that the means scores of female students exposed to CR treatment is (28.17) while the APD mean scores of male students expose to CR treatment is (22.50), this shows that CR counselling technique is more effective on male students than female one. This shows that there is significant gender difference in the effect of CR counselling technique in the treatment of APD.

Research Questions Seven:

What is the effect of SST counselling technique treatment on male and female students with APD among senior secondary school students in Kano State metropolis?

Table 4.12 Showing male and female post-test APD mean scores of students exposed to SST treatment:

Group	N	Mean	SD	Std. Error
Post-test score Male SST	12	25.92	4.033	1.164
Post-test score Female SST	12	26.42	3.895	1.125

Table 4.12 above shows the post-test APD mean scores of male and female students exposed to SST treatment. It shows that there is no significant difference between the APD mean scores of female students exposed to SST treatment (26.42) and that of male students APD means scores (251.92) exposed to SST. This shows that there is no significant gender difference in the effectiveness of SST counselling technique in the treatment of APD.

4.4 Hypotheses Testing

Seven (7) null hypotheses were raised specifically to determine the effect of CR and SST counselling techniques on APD among senior secondary school students in Kano State metropolis. The hypotheses were tested and results were presented as follows:

Table 4.13 showing the analysis of variance (ANOVA) on pre-test APD mean scores of student exposed to CR and SST treatment and those in control group.

Source	Sam of square	df	Mean square	F	Sig.
Between Groups		5	10.756	1.493	0.204
Pre-test	53.778				
Within groups		66	7.202		
Pre-test	475.333				
Total	529.111	71			

Table 4.13 above shows the pretest APD mean scores of respondents identified with APD behavior from their respective schools exposed to CR, SST and those in control group. The F value for pre-test APD scores is 1.493 and P-value of 0.204 was obtained which is higher than 0.05 alpha level of significant. This analysis shows that no significant difference exists among the groups.

The analysis of variance was conducted to evaluate whether sampled subjects identified with APD could be combined as a group. It examines pre-treatment differences among groups in order to ascertain the differential effects of the two treatments. Therefore analysis of variance (ANOVA) was conducted to removes effects of any source of variation that would otherwise inflate the experimental effects. Therefore any other differential effects observed between pre-test and post-test or control group is due to treatment effect not group variations.

HO1 Hypotheses one:

There is no significant effect of CR counselling technique on APD among senior secondary school students in Kano State metropolis.

Table 4.14 showing t-test analysis for pre-test and post-test APD mean scores of senior secondary school students exposed to CR treatment:

	N	Mean	SD	Std. Error	t-cal	t-critical	df	P-value (2-tailed)
Pre-test								
CR	24	34.79	2.043	0.417	8.086	2.021	46	0.000
Post-Test								
CR	24	25.33	5.354	1.093				

Table 4.14 above shows t-test analysis for pre-test and post-test APD mean scores of senior secondary school students exposed to CR treatment. Since t- calculated as indicate in the table is greater than t-critical (8.080>2.021), the test is significant at 0.05 level of significance and 46 degree of freedom, as such the null hypothesis one is rejected and the alternative one retained and concluded that there is a significant effect of CR counselling technique on APD among senior secondary school students in Kano State metropolis. Therefore this analysis revealed that SSS student who were exposed to CR treatment had their Avoidant Personality Disorder level significantly reduced when compare with their pretest mean scores.

HO2 Hypothesis Two:

There is no significant effect of SST counselling technique on APD among senior secondary school students in Kano State metropolis.

Table 4.15 showing t-test analysis for pre-test and post-test APD mean scores of Senior Secondary School Student exposed to SST treatment:

	N	Mean	SD	Std. Error	t-cal	t-critical	df	P-value (2-tailed)
Pre-test SST	24	34.79	2.662	0.543	8.884	2.021	46	0.000
Post-test SST	24	26.17	3.886	0.793				

Table 4.15 above shows that t-calculated is greater than t-critical (8.883> 2.021), the test is significant at 0.05 level of significance and 46 degree of freedom, as such the null hypothesis two is rejected and the alternative one rained and concluded that there is a significant effect of SST counselling technique on APD among senior secondary school students in Kano State metropolis. Therefore the analysis revealed that senior secondary school students who were exposed to SST treatment had their avoidant personality disorder level significantly reduced when compare with their pre-test mean scores.

HO3 Hypothesis Three:

There is no differential effect of CR and SST counselling technique treatment among Senior Secondary School Students in Kano State metropolis.

Table 4.16 showing t-test analyses for and post-test APD mean scores of Senior Secondary School Students exposed to CR and SST treatment:

	N	Mean	SD	Std. Error	t-cal	t-critical	df	P-value (2-tailed)
Post-test CR	24	25.33	5.354	1.093	0.617	2.021	46	0.540
Post-Test SST	24	26.17	3.886	0.793				

Table 4.16 above indicated that t-calculated is less than t-critical (0.617>2.021) the test is significant at 0.05 level of significance and 46 degree of freedom, as such null hypothesis three is thereby retained and the alternative one is rejected and concluded that there is no differential effect of CR and SST counselling technique treatment among Senior Secondary School Students in Kano State metropolis.

HO4 Hypothesis Four:

There is no significant effect on students with APD base on those exposed to CR counselling treatment and those in control group among Senior Secondary School Students in Kano State metropolis.

Table 4.17 showing t-test analysis for post test APD mean scores of Senior Secondary School Students exposed to CR treatment and those in control group.

	N	Mean	SD	Std. Error	t-cal	t-critical	df	P-value (2-tailed)
Post-test Control Group	24	33.08	2.827	0.577	6.271	2.021	46	0.000
Post-Test CR Treatment	24	25.33	5.354	1.093				

Table 4.17 above shows that t-calculated is greater than t-critical (6.271 > 2.021), the test is significant at 0.05 level of significance and 46 degree of freedom, as such the null hypothesis four is rejected and the alternative one retained and concluded that there is a significant effect on students with APD base on those exposed to CR counselling treatment and those in control group among Senior Secondary School Students in Kano State metropolis. Therefore this analysis revealed that CR counselling techniques is significantly effective in the reduction of APD.

HO5 Hypothesis Five:

There is no significant effect on students with APD base on those exposed to SST counselling treatment and those in control group among Senior Secondary School Students in Kano State metropolis.

Table 4.18 showing t-test analyses for post test APD mean scores of senior secondary school students exposed to SST treatment and those in control group.

	N	Mean	SD	Std. Error	t-cal	t-critical	df	P-value (2-tailed)
Post-test Control Group	24	33.08	2.827	0.577	7.051	2.021	46	0.000
Post-Test SST Experimental	24	26.17	3.886	0.793				

Table 4.18 above indicated that t-calculated is greater than t-critical (7.051 > 2.021), the test is significant at 0.05 level of significance and 46 degree of freedom, as such the null hypothesis five is rejected and the alternative one retained and conclude that there is a significant effect of CR on students with APD base on those exposed to SST counselling treatment and those in control group among Senior Secondary School Students in Kano State metropolis. Therefore this analysis revealed that SST counselling technique is significantly effective in the reduction of APD.

HO6 Hypothesis Six:

There is no differential effect of CR counselling technique treatment on male and female students with APD among senior secondary school students in Kano metropolis.

Table 4.19 Showing t-test Analysis For Post-Test APD Mean Scores Male and Female Senior Secondary School Students Exposed CR treatment.

	N	Mean	SD	Std. Error	t-cal	t-critical	df	P-value (2-tailed)
Post-test Scores								
Male: CR	12	22.50	5.196	1.500	3.014	2.074	22	0.006
Post-Test Scores								
Female: CR	12	28.17	3.927	1.134				

Table 4.19 indicated that t-calculated is greater than t-critical (3.014 > 2,074), the test is significant at 0.05 level of significance and 46 degree of at 0.05 level of significance as such the null hypothesis six is rejected and the alternative one retained and concluded that there is a deferential effect of CR counselling technique treatment on male and female students with APD among senior secondary school students in Kano metropolis. Therefore this analysis revealed that CR counselling technique has a differential gender effect. And CR is more effective to male students than female as female APD mean scores is greater than that of male.

HO7 Hypothesis Seven:

There is no differential effect of SST counselling technique treatment on male and female students with APD among senior secondary school students in Kano metropolis.

Table 4.20 Showing t-test analyses for post test APD mean scores of male and female senior secondary school students exposed to SST counselling technique treatment.

	N	Mean	SD	Std. Error	t-cal	t-critical	df	P-value (2-tailed)
Post-test scores								
Male SST	12	25.92	4.033	1.164	0.309	2.074	22	0.760
Post-test scores								
Female SST	12	26.42	3.895	1.125				

Table 4.20 above indicated that t-calculated is less than t-critical (0.309 > 2,074), the test is significant at 0.05 level of significance and 46 degree of freedom, as such the null hypothesis seven is thereby retained and the alternative one rejected and concluded that there is no differential effect of SST counselling technique treatment on male and female students with APD among senior secondary school students in Kano State metropolis. This analysis revealed that SST counselling technique has a differential gender effect. Therefore this revealed that SST counselling techniques is equally effective between male and female in the reduction of APD.

4.5 Summary of Major Findings

The major findings of the study are as follows:

1. Cognitive Restructuring (CR) counselling technique is significantly effective in the treatment of APD among senior secondary school students of Kano State Metropolis. The pre-test APD mean scores of students exposed to CR treatment was 34.79 while the post-test of CR was 25.33 a mean difference of 9.46 was observed and P-value of (0.000).

2. Social Skills Training (SST) counselling technique is significantly effective in the treatment of APD among senior secondary school students. The pre-test APD mean scores of students exposed to SST treatment was 34.71 while the post-test APD mean scores of SST was 26.17, a mean difference of 8.54 and P-value of (0.000).
3. There is no differential effect on students exposed to CR counselling technique treatment and those exposed to SST. The post-test APD mean scores of CR treatment was 25.33 while that of SST treatment was 26.17, a mean difference of 0.84 and P-value of (0.540).
4. There is a significant effect of CR in the reduction of APD base on students exposed to CR and those in control group. This also shows that CR treatment is significantly effective. The post-test APD mean scores of students exposed to CR treatment was 25.33 while that of control group was 33.08, a mean difference of 7.75 and P-value of (0.000).
5. There is a significant effect of SST in the reduction of APD base on students exposed to CR and those in control group. This also shown that SST treatment is significantly effective. The post-test APD mean scores of students exposed to SST treatment was 26.17 while that of control group was 33.08 a mean difference of 6.91 and P-value of (0.00).
6. There is a deferential effect of CR counselling technique treatment on male and female students with APD among senior secondary school students in Kano metropolis. This shown that CR counselling technique treatment is significantly effective on male than female. The post test APD mean scores of male students

was 22.50 while that of female students was 28.17, a mean difference of 5.67 and P-value at (0.006).

7. There is no deferential effect of SST counselling technique treatment on male and female students with APD among senior secondary school students in Kano State metropolis. The post-test mean scores of male student exposed to SST treatment was 25.92, while that of female exposed to SST treatments was 26.42, a mean difference of 0.5 and P-value at (0.760).

4.6 Discussion of Results

The result of this study found out that Cognitive Restructuring (CR) and Social Skills Training (SST) counselling technique are significantly effective in the treatment of Avoidance Personality Disorder (APD). The analysis of first hypothesis discovered that there is no significant difference in the APD means scores of the students identified with APD symptoms (F. value 1.493 sig 0.204). This implies that all the significant differences obtained in this study were as a result of treatment effect. Sixty students were randomly respond to APD test in each of the six schools, the test was scored and select the student with higher scores to participate in the study as CR treatment group, SST treatment group and control group.

This study found the existence of significant effect of two CBT counselling technique as CR and SST counselling technique on the students with APD in senior secondary schools of Kano State metropolis. This is in line with the finding of Eilissa, Richad and Harlan (1995) when examined the impairments of social phobia, APD and outcome of cognitive behavioral treatment. They revealed that cognitive behavior therapy is very effective in the treatment of patients diagnosed with APD symptoms. Turner (1987) in Elissa,

Rechard and Harlan (1995) who also investigated the effect of cognitive behavioral therapy on 13 patients with social phobia and APD, they discovered a significant improvement in the reduction of APD symptoms.

Alden (1989) examine forty two men and 34 women mean age 27.5 when met DSM III criteria for APD were randomly assigned to 1 of 3 treatment conditions or to a waiting-list (control group) Who participated in 10 week group treatment program displayed significantly greater improvement than un-treated control group. Therefore Alden (1989) concluded that short-term CBT can make significant improvement in APD reduction when compared to a control group.

In another study of Rupke, David Maijorie (2006) shows that Cognitive Restructuring (CR) is an effective treatment for depression which is one of the causes of APD. Another study which is in line with the present study is that of Emmelkamp (2006), who examined the effectiveness of brief therapy and CBT for the people with APD and found that, patients who received CBT showed significant improvement on a number of measures in comparison with those who had brief dynamic psychotherapy or who were in control group. Therefore, the present study concluded that using CBT especially both CR and SST in the treatment of APD since both techniques boost self-esteem, reduce excessive shyness and equip individual with skills needed to participate positively in any social interaction in schools.

Another finding of this study rejected the null hypothesis and maintained the alternative one that Cognitive Restructuring (CR) counselling technique is significantly effective in the treatment of APD among senior secondary school students of Kano State Metropolis.

The pre-test APD mean scores of students exposed to CR treatment was 34.79 while the post-test of CR was 25.33 a mean difference of 9.46 was observed and P-value of (0.000). This analysis shows that CR counselling technique is significantly effective in the treatment of APD. The present finding is in line with the research work of Deacon, fawzy, lickel and wolitzky-Taylor (2011) who compares the impact of cognitive diffusing with CR on patients distressed by negative thoughts about their body shape. They indicated that both-cognitive technique produced substantial improvements beyond the specific thoughts targeted for treatment. Also Mattick (1989) found CR to be more significantly effective in the treatment of social phobia than exposure therapy. Essere and Idowu (2002) while assessing the effectiveness of CR in resolving mental conflicts among couple in Ilorin reveals a significant effect of CR on the pre-test mean scores of 59.9 and post-test mean scores of 60.3 thereby concluded that CR treatment made a substantial impact in resolving marital conflicts, thereby improving the couples marital relationship.

The second hypothesis discovered that SST counselling technique is significantly effective in the reduction of APD among senior secondary school students. The pre-test APD mean scores of students exposed to SST was 34.71 while that of post-test was 26.17 with mean difference of 8.54 and P. value of 0.000. This present study was in line with the work of Lenzenwager, Lane, Lorenge and Kessler (2007) on the treatment of avoidant personality disorder by social skill in the clinic or real life setting, after the treatment session and three month follow-up, they concluded that social skills training appear to be a useful and promising intervention for avoidant personally disorder but its long term impact remains to be investigated as they conclude.

Another work that investigates effectiveness of SST is that of Herbert, Gaudiano, Rheingold Myers, Dalrymple and Nolan (2005). Their findings showed that SST in treating Social Anxiety Disorder (SAD) is effective whether used alone or in combination with another form of treatment. Kilmer,(2010) reported one study which examined the usefulness of social skills training, found significant improvement in measures of avoidance and anxiety after SST treatment which consist of graduated hierarchy of behavioral modifications, modeling the therapist and role rehearsal, as well as feedback from the therapist and group. This study also found no significant difference in results between conducting this training within a clinical setting or in public within the opportunity for clients to interact with strangers. Also Kilmer (2010) in explaining the study conducted by stravynski, Marks and Yule (1982) found that Social Skills Training in combination with Cognitive Modification did not demonstrate significantly different result than Social Skills Training alone, nor where there significant differences between outcomes of those treated within a group versus individually.

Another research on the effects of SST is that of Eikenar in kilmer (2010) discovered that constant exposure to interactive social situation can help individual with APD. Another core symptom to APD is the reluctance to move outside daily routines SST also exposes individual to a variety of new experience and skills to function in social situation like eye contact conversation, dating, confrontations, topic of discussion etc.

Jasper, (2004) explained that SST is among the most researched behavioral interventions since it aim to provide the patient with a skill that can be applied when confronted with the feared situation by teaching a patients skills required for effective social interactions. It is important to note that, interpersonal problems play a role in the etiology and

maintenance of psychiatric disorders. Therefore, by using techniques such as modeling, rehearsal, corrective, feedback and homework SST focuses on enhancing patients intrapersonal skills such as conversation initiation as well as performance related skills such as formal presentations.

Another finding of the present work revealed that there is no differential effect on students exposed to CR counselling technique treatment and those exposed to SST. The post-test APD mean scores of CR treatment was 25.33 while that of SST treatment was 26.17, a mean difference of 0.84 and P-value of (0.540). This signifies that the two techniques should be use by the school counsellors in treating APD behavior. Since the major goals of CR is to encourage clients to think in more accurate and adaptive ways, which facilitate effective problem solving and living a more satisfying life (Deacon, fawzy & Lickel, 2011) while SST on the other hand is aiming at equipping the client with different socially acceptable behavior which enable an individual to enter interpersonal relations and interaction with others. The social skills behaviors equips the patients with as explained in Elliot and Busse (1991) are: cooperation, assertion, responsibility, empathy and self-control.

Therefore by examine the major goals of the two techniques one conclude that they are very relevant and effective in the reduction of APD symptom which include: low self esteem, feeling of inferiority, poor social competence, excessive shyness which could lead to avoiding school social activities both curricular and extracurricular activities.

However some studies like that of Paula, Hayley & Jeffery (1999) view CR as more powerful and promising technique in the treatment of APD. They suggested that even

though an individual may possess appropriate social skill (through SST) to interact effectively with peers, feeling of insecurity resulting from negative self perception and social behavior may inhibit expression of pro-social behavior. And several studies which were highlighted in Deacon, Fawzy & Lickel (2011) considered such inhibition of pro-social behavior as an important determinant of social withdrawal and increases the probability of peer rejection which all these are taking care in the CR technique.

Another discovery of present study is that there is a significant effect of CR in the reduction of APD base on students exposed to CR and those in control group. This also shows that CR treatment is significantly effective. The post-test APD mean scores of students exposed to CR treatment was 25.33 while that of control group was 33.08, a mean difference of 7.75 and P-value of (0.000). A significant difference is clearly exist, the post-test APD mean scores of students exposed to CR treatment was 25.33 while that of control group 33.08 a mean difference of 7.75 and P-value of 0.000. This is in line with Deacon, fawzy & Lickel (2011) explanation that CR is the most clearly established effective psychotherapy that exists for the treatment of APD. Also in their experimental work in the effectiveness between Cognitive Diffusion versus Cognitive Restructuring in the treatment of negative self-referential though. They revealed that the participants tended to rate cognitive restructuring as somewhat more credible (d=0.43) and more likely to be effective (d=0.44) than cognitive diffusion. In relation to this, Deacon, Fawzy and Lickel (2011) citing Hofman & Asmundson (2008) therapist and patient collaboratively identify Irrational or maladaptive thought and challenge their reality in CR technique using strategies such as logical disputation, Socratic questioning and behavioral experiments, would encourage clients to view themselves through CR as

socially competent, boosting higher self-esteem, and making them to interact with people confidently with courage.

However there are some writers who opposed the effectiveness of CR like Eifert and Forsyth (2005), they characterized CR as engaging patients in an attempt to master' and control' their thoughts by teaching them to become better suppressors and avoiders of their unwanted thoughts, thereby arming them with a potentially unworkable strategy to avoid experiencing negative emotions (APD). In response to this criticism Deacon, fawzy & Lickel (2011) explain that cognitive therapist have vigorously disputed the notion that CR encourage the suppression and avoidance of negative thought.

In another development this work reveals that there is a significant effect of SST in the reduction of APD base on students exposed to CR and those in control group. This finding emphasizes the fact that SST is also significantly effective counselling technique in the treatment of APD. In present study the post-test APD mean cores of students exposed to SST treatment were 26.17 while that of control group was 33.08 a mean difference of 6.91 and P-value of 0.000. SST as explained in Encyclopedia of mental disorders (2013) is a form of behavior therapy used by teachers, therapist and trainers to help person who have difficulties relating to other people. As the researcher observed the participants the major problem face by APD students is lack of social skills in using both verbal and non verbal communication skills. The major goal of SST is teaching person who may or may not have emotional problems about the verbal as well the nonverbal behaviors involved in social interactions. As observed many students have never been taught such interpersonal skills as making 'small talk' in social setting or the importance

of eye contact during a conversation many of the students are not aware about reading of nonverbal cues in every day conversation.

In addition many people have not learned to read the many subtle cues contained in social interaction such as how to tell when someone wants to change the topic of conversation or shift to another activity. Therefore SST is very importance in helping students with APD to lean to interpret these and their social signals, so that they can determine how to act appropriately in the company of the people in a verity of different situation rather than avoiding them.

Major symptoms of APD involve excessive shyness, low self-esteem, inept in social situation etc. all these is been characterize as due to proosocial skills, therefore SST is aiming at equipping the student with these social skills. SST ware categorized into the following as tabulated in Canney & Byrne, (2006, p.12):

- Foundation skills; these are basic social interaction.
- Interaction skills; these are skills needed to interact with others.
- Affective skills; these include skills needed for understanding oneself and others. and
- Cognitive skills; these include skills needed to maintain more complex social interaction.

Some of the importance of SST benefit is that it is both academic and interpersonal to develop social competences which include: acceptance by peers, positive self-concept, academic achievement and successful employment (De Geoge 1998; Elksnin and Elksnin, 2000). Another advantage of SST is that social skills can be fairly easily

integrated into a special or general education curriculum using a variety of method. A structured approach would involve identifying critical social skills and then teaching them through modeling, role playing and performance feedback (Peterson et al, P2 2006). In essence SST is significantly effective in the treatment of APD with the assumption that when APD students improve their social skills or change selected behaviors, they will raise their self esteem and increase the livelihood that others will respond favorably to them.

In another development, this research reveals that there is a deferential effect of CR counselling technique treatment on male and female students with APD among senior secondary school students in Kano metropolis. This indicated that CR counselling technique treatment is significantly effective on male than female in the reduction of APD. In this finding the post-test APD mean score of male students exposed to CR treatment was 22.50 while that of female students exposed to SST was 28.17, a mean difference of 5.67 and P-value at (0.006).

Different studies examined gender difference in social skills. Some of these studies include that of Cillessan & Mayeax (2004) who have examined gender difference in aggression. They recorded higher level of physical and overt aggression for boys while a higher level of relational/indirect aggression (APD) is typical for girls. Therefore this direct aggression for boys and indirect aggression for girls may be causal factor for male to respond to CR treatments more than female, because differential effect is not expected between male and female since analysis of variance (ANOVA) in the first hypotheses identified no significant variation between the groups of school both that of male and that of female. Macheal & Clifford (1991) examine gender difference in response to

treatment of depression. They revealed that men are more likely to improve than woman as a result of the treatment. But they concluded that there would be no gender difference in response to that specific antidepressant.

In another scenario, treatment could appear equally effective for man and woman, yet a difference in placebo response rates would revealed that one gender was actually more specifically treatment responsive than the other (Machael & Clifford, 1991). One of the process involve in CR is self-evaluation, therefore, Machael & Clifford, (1991) suggested that reflected appraisals, self-perceptions and social comparison are primary sources of information from which self evaluation derive. Therefore male and female may learn to embrace difference criteria for self-evaluation.

The present study was in line with that of Olufunmilo (2003) on the efficacy of cognitive restructuring and behavior rehearsal on conduct disorder, who revealed that there was significant gender difference in the conduct disorder of the participants that were exposed to the CR (t= 1.058, df-28 P=0.299 two tailed) but conduct disorder is difference from APD so they may likely to response to treatment differently. Esere & idowu (2001) in examine the effect or CR in resolving marital conflict among couples in Ilorin found no significant gender difference in the effectiveness of CR counselling technique. in addition to that John (1996) explained that cognitive restructuring can have beneficial impact on clients who experience low self-esteem.

The present study presents that there is no significant difference in post – test APD mean scores between male and female students exposed to SST treatment. The post-test APD mean scores of male students exposed to SST treatment was 25.92, while that of female

expose to SST treatment was 26.42 a mean difference of 0.5 and P-value at 0.760. This analysis shows that there is no gender difference in the treatment response to SST. This is in line with the view of Machael and Clifford (1991) that woman attach greeter importance to reflected appraisals then do men, while men attach greater importance to social comparisons than do women. Reflection appraisal is a person's perception of how others see and evaluate him or her. Although the mean scores of this finding favor men response to SST than woman this may be to their emphasis on how other view them rather than how they are, this may inform the reason why they are reluctantly responded to CR. And men attached greater importance to social comparison that is whereby individuals assess their own ability and virtues by comparing themselves to others. Therefore this may tend to predict why men also effectively response to SST as they do for CR.

Maliha & Rehana (2010) while exploring the emotional intelligence of the students in relation to gender, age and academic achievement discovered that there was no significant difference in the mean EQi scores of male and female students except in stress management score where male students score higher than female students. Since low emotional intelligence is one of the symptoms of APD this may dictate the gender difference or otherwise in response to SST treatment. Poor stress management ability may also be a contributory factor for making female students to be more reluctant to CR or SST treatment, thereby school counsellors dealing with APD students should consider this differences in their counselling sessions. Female students need more motivation and encouragement to participate fully in the treatment sessions.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATION

5.1 Introduction

This chapter present the summary of work on effect of cognitive restructuring and social skills Training on Avoidance Personality Disorder among Senior Secondary School Students of Kano State Metropolis. It also brings the conclusion of the study, recommendations and suggestion for further studies.

5.2 Summary

One of the major concern of this study on students with APD in our schools especially secondary school is that, most of the school counsellors as observed in this study are not aware about the scourge of the disorder almost 99%. And the disorder prevalence as discovered in this study is paramount and beyond expectation. It is affecting academic, vocational and person social life of the students. The two CBT techniques used in this study were found to be effective in the treatment of APD.

This study designed to find out the effect of CR and SST on secondary school students with the symptoms of APD in Kano metropolitan. Chapter one introduced the basic issues that consider very vital to the achievement of the objectives of the study as to find out the effect of CR and SST counselling technique on APD among senior secondary school students whether there is significant difference between the effect of the two techniques and to identify whether gender difference exist in the effectiveness of the two technique. These objectives of the study were developed into research questions, hypothesis and assumption of the study in the chapter.

This work reviewed extensively various areas relevant to the variables of the study. Earlier work of the people who tremendously contributed to this area of study. It was discovered in the literature that APD is characterized by a pattern of social inhibition, feeling of inadequacy and hypersensitivity to negative evaluation. These individuals avoid activities that require social interaction unless certain of being liked. These individuals demonstrate intense fear of critism, disapproval and rejection, and view themselves as inadequate, socially inept, personally unappealing and inferior. The major symptoms of the disorder include: excessive fear of negative evaluation by others, excessive shyness, low self esteem and inept in social interaction. It interfere into the academic and social development of the students as avoiding school work, avoiding school social activities both curricular and extracurricular activities of the school, looping group work and peer assessment. The literature revealed that the causes of APD are different factors classified into two environmental and biological factors. The environmental factors include childhood upbringing warmness of the parent. And people surrounding within and outside the family, types of the family system and religious tolerant. It was noted that individual with the APD often experience condemnation socially rejected by peers and parents these and many more cause them to learn non complementary skills to social situation, inferiority feeling and fear of rejections.

The literature review also dwell on CR are SST counselling technique which are both CBT. Classical conditioning, operant condition as well of cognitive social learning in the review was related to the treatment of APD. CR as a CBT involves altering negative automatic thoughts that occur in anxiety provoking situation by replacing them with more rational beliefs. The assumptions here is that thoughts affect human emotion as well as

behavior and irrational beliefs are mainly responsible for avoidant behavior such as low self esteem, excessive fear of rejection and sensitive to negative criticism. The major goals of the second counselling technique as identified in the literature review is teaching persons about the verbal as well as nonverbal interpersonal behavior involved in social interaction. The assumption here is that person suffering from APD tent to avoid social situations due to lack of social skills, so by improving their communication and social skills through SST they could be able to mingle with others, attend school work ete with greater ease and self-confidence. The literature revised many empirical studies conducted on the use of psychotherapy, CBT, CR and SST in both group and individual counselling sessions for the treatment of APD.

The research design adopted in this research was quasi experimental design which involve pretest post-test design, the population of the study comprised senior secondary school two (SSS.II) student in Kano metropolis who demonstrate symptoms of APD, purposive sampling technique was used to draw a sample of 72 SSS II students in different 6 secondary schools, 12 students per each school and the sampled students were grouped into treatment and control groups. Two groups receive CR treatment another two SST treatment and the remaining two were placed as a control group receiving treatment which has no relevant with the variables of the study. The instrument used in this study is APD test, and its validity and reliability was ascertained.

In this work the statistical analysis of data collected for the study was extensible discussed. Tables were used to display the results of the data which revealed that five (5) out of the seven (7) null hypotheses were rejected. Summary of the basic findings of the study were presented followed by discussion of major finding using relevant literature to

backup the findings. The agreement and disagreement between the findings were display in a form of discussion.

5.3 Conclusion

Base on the outcomes of this study, the following conclusions were drown:

1. The result of this study has shown that cognitive restructuring (CR) counselling technique has significant effect in the reduction of Avoidance Personality Disorder (APD). This is when the analysis of pre-test and post-test results of senior secondary school students in Kano metropolis exposed to CR counselling treatment was conducted.
2. The result of this study has shown that Social Skills Training (SST) counselling technique has significant effect in the reduction of Avoidance Personality Disorder (APD) behavior. This is when the analysis of pre-test and post-test results of senior secondary school students in Kano metropolis exposed to SST counselling treatment was conducted.
3. In comparison between the effect of the two techniques CR and SST it has been concluded that there is no differential effect on the two techniques. Although the mean scores favor CR than SST but the difference is not significant. Therefore it concluded that the both two technique have a significant effect equally in the treatment of APD among senior secondary school students in Kano metropolis.
4. With the relevance to the findings of the effects of the CR counselling technique treatment between treatment group and control group. It was observed that CR treatment have significant effects in the reduction of APD. Therefore the

conclusion is that CR technique has strong effect in the treatment of APD among senior secondary school students in Kano metropolis.

5. Similarly base on the outcome of the finding of the research on the effects of SST counselling technique treatment between treatment group and control group. It was observed that SST treatment have significant effect in the reduction of APD. Therefore the conclusion is that SST technique has strong effect in the treatment of APD among senior secondary school students in Kano metropolis.
6. In comparison between the effects of CR counselling technique treatment on male and female students with APD a deferential effect was recorded and it was identified that male students respond more significantly to CR counselling technique than female one among senior secondary school students in Kano metropolis.
7. In comparison between the effects of SST counselling technique treatment on male and female students with APD it was observed that there is no differential effect of SST counselling technique treatment on male and female students with APD among senior secondary school students in Kano metropolis.

5.4 Recommendations

Base on the outcome of this research work the following recommendations were made:

1. Since the findings of this work discovered the effectiveness of CR counselling technique in the treatment of APD among senior secondary school students in Kano metropolis, a standardized structured CR counselling technique treatment

should be designed and incorporated into national curriculum of senior secondary schools.

2. Since the findings of this work discovered the effectiveness of SST counselling technique in the treatment of APD among senior secondary school students in Kano metropolis, a standardized structured SST counselling technique treatment should be designed and incorporated into national curriculum of senior secondary schools.
3. Since both technique CR and SST are tested and found significantly effective in the treatment of APD among senior secondary school students in Kano metropolis, it is recommended to be use by school counsellors as their treatment package in conjunction or isolation.
4. Similarly the finding of this study discovered strong effect of CR in comparison between control and treatment group among senior secondary school students in Kano metropolis who received CR treatment, therefore it is strongly recommended that CR counselling technique could be use in the treatment of APD in both school and clinical settings.
5. Similarly the finding of this study discovered strong effect of SST in comparison between control and treatment group among senior secondary school students in Kano metropolis who received SST treatment, therefore it is strongly recommended that SST counselling technique could be use in the treatment of APD in both school and clinical settings.
6. As identified in the finding of the study that male students respond more significantly to CR counselling technique more than the female one among senior

secondary school students in Kano metropolis, therefore it is recommended that gender differences, socialization and cultural background of the clients should be consider when structuring and implementing CR counselling technique in the treatment of APD.

7. Also in comparison of the effectiveness of SST between male and female students with APD it observed no significant difference in terms of effectiveness between genders. Therefore it was recommended that the same SST technique treatment package could be used in the treatment of APD between male and female students.

5.5 Suggestion for Further Studies

The following recommendations were made for further studies:

1. The scope of this study covered only Senior Secondary School Students, thus it is important to extend this empirical study to other institutions like correctional institutions, tertiary institutions and other non-educational institutions.
2. One of the limitations of this study is that it did not examine whether group or individual session with CR or SST is significantly different. Therefore a further study is been recommended to examine the effectiveness of group or individual counselling session of CR or SST in the treatment of APD.
3. This study used a structured CR and SST treatment package, therefore an extensive research should be conducted to find out the more reliable and standardize treatment package to suit Nigeria communities.
4. Few literature attempts to discuss the causes of APD, therefore a survey studies in recommended to evaluate some variables like types of parental care, parental

background, ethnicity, marital status, religious tolerate and other personality disorders, to find out the actual causes of APD for prevention which is better than care.

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APPENDIX I

RESEARCH INSTRUMENT

AVOIDANT PERSONALITY DISORDER TEST (APD)

This APD test can help determine whether one might have the symptoms of APD to further diagnosis and treatment of APD.

Instructions: please, read the statements listed below, and for each item tick to indicate the extent to which you agree or disagree with the statement.

SA= Strongly Agree, A= Agree, D= Disagree and SD= Strongly Disagree.

Name of Student …….

Gender: Male ☐ Female ☐

Age……..

S/NO	***TEST ITEMS***	***SA***	***A***	***D***	***SD***

1	I avoid works that require active personal interaction.				
2	I fear criticism, disapproval, or rejection.				
3	I try not to get involved with people unless I am certain that they may like me.				
4	I am reserved within intimate relationship because of the fear of being shamed or ridiculed.				
5	I am preoccupied with being criticized or rejected in social situations.				
6	I cannot release in new interpersonal situations because of feelings of inadequac225y				
7	I regard myself as socially inept				
8	I regard myself as personally unappealing				
9	I consider myself inferior to others				
10	I avoid taking personal risks because it could prove my inadequacy				
11	I avoid to be engaged in any new activities because they may prove embracing.				

Source: Psy med. Inf. (2010) *Avoidant Personality Test*. http: // psymed: info/default.a spx?m= Test 8.id. Retrieved 24 August, 2013

APPENDIX II

Treatment Session One (Cognitive Restructuring Counselling Technique)

First Week

First session: Orientation and Establishing Counselling Relation:

i. Introduction; greeting the participant by the researcher.

ii. The researcher tells the participants more about himself; name, address, profession and his purpose.

iii. Participants introduce themselves; name, class, age and family, address, likes and dislike.

iv. Building rapport by showing a sign of regard and caring, helping them to settle down comfortably.

v. confidentiality: Assuring the participant on keeping their information, identity and problems secret.

vi. Discuss on the benefit of the session.

vi. Setting on rules and regulations to guide the counselling sessions.

Second Week

Second Session: **Introduction:**

i. Discussion on the major objectives and goals of cognitive restructuring counselling technique as a technique to be use in the treatment sessions.

a) Identification of maladaptive behavior and in-effective or self-defeating thought.

b) Helping in reaction to reality situation.

c) Changing these thought pattern.

d) Rationality and validity of the assumptions.

ii. Explanation of avoidant personality Disorder.

iii. Description on major characteristics and symptoms of Avoidant Personality Disorder (APD):

- Avoiding school work and social activities
- Avoiding school's social activities.

- Sensitive to rejection.
- Low self-esteem.
- Excessive shyness

v. **Homework**: The participants will be asking to select out of the list of APD behaviors' characteristics and symptoms that match their behavior.

vi. Explain how to overcome these symptoms

Third Week

Third Session: Functional Analysis: identification of the upsetting situation

i. Explanation on APD behaviors

ii. Identifies thought patterns that cause APD behavior.

a) Rational thinking (positive)
b) Irrational thinking (negative)
c) Examples of each?

iii. The researcher will use Socratic questions strategies to ask participant numerous questions in order to help them identify needed changes to explore thought patterns.

iv. **Homework**: The participants will be given stories of thought pattern to read and understand.

Briefly describe the situation or experiences that lead to APD behavior.

Forth Week

Forth Session: Positive Thought Pattern

i. Ask the participants to explain the types of thought pattern they identified at home.

a) Realistic interpretation of events

b) Relationship between 'Thinking, Feeling and Behavior'

ii. Discussion on unwanted reactions and pattern that cause APD behaviors.

iii. Identify positive responses to stress and anxiety by asking participant about many instances in their life.

iv. **Homework**: Ask the participants to write at least twenty negative thought they can think they are making (false sentences which upset them)

Fifth Week

Fifth Session: Focus on Realistic Interpretations of Events.

I. Identify common cognitive distortions and

1. All-or-nothing thinking: black and white statement only bad or success.
2. Catastrophizing: predicting the future without considering other outcome. Or thinking the worst will happen.
3. Emotional reasoning: believe in the validity of something because you feel it ignoring any evidence contrary.
4. Discounting the positive: whatever one achieve is a lucky not one effort.
5. Labeling: fixed generalization label on ourselves or others.

6. Magnification/Minimization: evaluating our selves or situation while unreasonably magnifying or minimizing the positive.
7. Mental filter: paying attention of thinking to one nagetive detail rather than seeing the big picture.
8. Mind reading: assuming that we know others are thinking wrongly.
9. Over generalization: sweeping negative conclusions that extend far beyond the scope of the present situation
10. Personalization: believing that others are are acting negatively because of us without considering others.
11. Tunnel vision: this is when we are only able to see the negative aspects of a situation

ii. Discussion on ABC rational Emotive Therapy strategies.

iii. Discussion with examples on rational and irrational thinking that is related to their APD behavior.

iv. **Homework**: The participant will be given a list of Tips to change negative thinking to read and explain how to use them to change their negative thinking.

Sixth Week

Sixth Session: **How to change negative thinking:**

i. Understanding thinking styles; examples:

- View self as complete, success or failure in every situations i.e. (black and white) thinking.

ii. How to stop thinking negatively.

iii. How to cope with criticism.

iv. How to gain control of your emotional reactions situations by allowing the thinking part of the brain to take over.

v. How to recognize distorted thoughts and replace them with realistic ones.

vi. **Homework**: The participants will be given thought-diaries to be completing daily before next sessions.

Seventh Week

Seventh Session: Modifying the Negative or Self-Defeating Thought

i. Modifying the negative or self-defeating automatic thought process or perceptions as identify by the participant that seems to perpetuate the symptoms of APD.

ii. Show how internal influences i.e. our thought cause our feelings and behaviors.

iii. Learn how to interpret their environment differently; for instance, people will laugh at me, if Mr. X is around I must fail.

Eight Week

Eighth Session: construction of Realistic and Balance Thought

1. Avoid using negative language such as ‘I cannot’, ‘I would not’, or ‘never’

2. Find the connection between emotion and negative thought

3. How to construct more realistic objective.

4. Choose realistic or positive explanations

5. Acknowledge what you are grateful for.

6. Practice mindfulness

7. Treat each day as new opportunity to achieve a goal.

8. Accept change

iii. Improve participating in class work, group assignment, and team work.

vi. **Homework:** The participants will be asked to find as many as three new friends before next sessions and explain how they firstly interact with them.

Ninth Week

Ninth Session: Improving Self-Esteem

i. What is self-esteem in relation to APD behaviors?

ii. Important of self-esteem.

iii. Causes of Low self esteem.

iv. Strengthen self esteem.

iv. Avoiding social situations as a result of low self-esteem.

v. Negative thought about one's ability or appearances as a result of low self-esteem.

vi. Pass up opportunity for advancement at work or at school as a result of low self-esteem.

vii. The researcher will narrate many stories and instances on how to improve self-esteem for the reduction of APD behaviors.

Ninth Week

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Tenth Week

Tenth Session: **Reducing Sensitivity to Rejection**:

i. Write down the situations that triggered the negative thoughts.

ii. Identify the moods that you felt in the situation.

iii. Write down the automatic thoughts that you experienced when you felt the mood.

iv. Identify the evidence that support these hot thought.

v. Identify the evidence that does not support these hot thoughts.

vi. Identify fair and balanced thoughts about the situations.

vii. Finally, ask the participant to observe their mood now and think about what they are going to do.

Eleventh Week

Eleventh Session: **Reduction of Excessive Shyness:**

i. What is shyness in relation to APD behavior?

ii. Causes of excessive shyness.

iii. Negative effect of excessive shyness; poor group work, group assignment, truancy, introverting, etc.

iv. Tips to reduce excessive shyness.

Twelfth Week

Twelfth Session: **Evaluating the Restructuring Process:**

i. interpreting positive self talk (internal dialogue) that runs in our heads; and then compare them with that of previous thought.

ii. How to interpret, explain and judge the situations we encounter and they impact our behavior (APD behavior).

iii. How does one go about changing these habitual thought patterns; beginning with an honest acknowledgement of a realistic negative aspect of the situation.

iv. How to improve optimism and pessimisms thought.

v. How to become aware of patterns of faulty thinking.

vi. How to challenge these faulty thought more and more.

- Look for exception if you are an all or nothing thinker.
- Make it a point to look for evidence.
- Try to find alternate conclusions.
- Practicing emotional reasoning.

APPENDIX III

Treatment Sessions Two: Social Skills Training Counselling Technique

First Week

First Session: Orientation and Establishing Counselling Relation:

i. Introduction; greeting the participants by the researcher.

ii. The researcher tells the participants more about himself; name, address, profession and his purpose.

iii. Participants introduce themselves; name, class, age and address.

iv. Building rapport by showing a sign of regard and caring, helping them to settle down comfortably.

v. Confidentiality: assuring the participant on keeping their information, identity and problem secret.

vi. Setting on rules and regulations to guide the counselling sessions.

Second Week

Second Session: Introduction:

i. Discussion on the major objectives and goals of **Social Skills Training** counselling technique as a technique to be use in the treatment sessions.

ii. Make an assessment through enquiries about historical experiences. Example: which social interactions they can find most challenging or which skills they find the most challenging or which skills they feel could be improved.

iii. Explanation of avoidant personality Disorder

iv. Description on major characteristics and symptoms of Avoidant Personality Disorder (APD).

v. Homework: The participants will be asking to select out of the list of APD behaviors' characteristics and symptoms that match their behavior.

Third Week

Third Session: Interpersonal Skills:

i. Strategies for conversations, dating, friendship, etc.

ii. How to make small talk.

iii. The researcher will practically make a formal and informal small talk in public and then the participant will practice after then.

iv. Eye contact during conversations.

v. **Homework**: The participant should be asked to identify cues contained in social interactions.

Forth Week

Forth Session: Subtle cues contained in social interactions.

i. How to change topics of conversation.

ii. How to shift to another activity.

iii. Improving telephone manners.

iv. **Home Work: T**he participants will be asked to:

- Record the date and descriptions of situations in which they felt socially anxious.
- Write down physical symptoms which they experienced in anxious situations.

Fifth Week

Fifth Session: Learning Social Sign:

i. Responding

ii. Negotiation

iii. Risk-taking

Practicing selected behaviors in group and interpersonal contact

i. Group work attitudes.

ii. Group assignment

iii. Dating.

iv. Formal and Informal occasions

v. Friendship

vi. Engaging in new activities

vii. Cooperation in groups.

viii. Group rules and regulations

ix. Critical/important situations

Sixth Week

Sixth Session: Ways to reduce avoidant behavior:

i. Avoid fear of rejection by others

ii. Avoid fear of ridicule by others.

iii. Reduce fear of humiliation by others.

Seventh Week

Seventh Session: Improve social skills:

i. Attending social gathering.

ii. Intermingle with others.

iii. School interview.

iv. Job interviews.

v. Self-confidence

vi. **Homework**: The researcher will organize simulation situations to practice the above social skills with participant.

Eight Week

Eighth Session: Breaking Down Complex Behavior:

i. The participant will work on one specific behavior at a time through the use of Instruction, Modeling, Role-playing and Shaping.

ii. Ability to perceive and act on social cues, social sign, noticing and understanding other peoples' cues.

The target for this session include social skills like eye contact, public speaking, mode of dress, mode of approach, convincing, greetings, laughing, crying and facial expressions.

For example how to carry on a conversation may be break down into smaller pieces such as: introducing yourself, making small talk and leaving, verbal behaviors and nonverbal one.

Homework: The participants will be asking to observe themselves when they are making conversation with parents, peers and elders at home.

Ninth Week

Ninth Session: Instruction

Once the specific target areas are identified, the techniques for improving social skills are introduced.

Instruction is the educational component of appropriate social behaviors. Here the identified specific social deficits will be one by one demonstrated in the best way to conduct it.

Feedback and reinforcement of positive interactions:

i. persuasion

ii. planned ignoring.

iii. Problem solving

Tenth Week

Tenth Session: Improving social competencies and communication skills:

i. Nonverbal and assertive communication.

ii. Beginning, holding and ending conversations.

iii. Expressing feelings in appropriate ways.

iv. The participants will be group into different small group and give them some new social skills and ask them to practice it in a simulated situation.

v. The researcher will go round group by group to provide corrective feedback during practice sessions.

Eleventh Week

Eleventh Session: Social Anxiety or Excessive Shyness as A Symptom of APD.

The researcher will use Role-playing, Instruction, Modeling and practice to:

i. Reduce self-consciousness or embarrassment; as no one has perfect social skills.

ii. Reduce excessive shyness or inhibition preoccupied with being rejected, inferiority feeling, etc.

iii. Reduce low self esteem.

iv. Reduce strong feelings of inadequacy.

v. Reduce sensitivity to rejection

NB. " APD can lead to impairment in functioning in most areas of person's life."

Twelfth Week

Twelfth session: Brainstorming session

i. Avoidance hierarchy: It is a least of situations that cause ranked from least distressing to most distressing.

ii. Ask the participants to come up with about ten situations that personally cause them the most fear and anxious.

iii. From the list choose which exposures to practice in the session.

- Some examples of Avoidance hierarchies include; attending wedding, talking to people in authority, intermingling with strangers, answering questions in class, and so on.

Homework: the researcher will give the clients list of many avoidance hierarchy to rearrange them according to their most fearful and avoidance situations.

Appendix IV

ANOVA (PRE-TEST)

Descriptives

PRETESTSCORES

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
AKCCC	12	33.67	1.497	.432	32.72	34.62	32	37
GGC DALA	12	35.92	1.929	.557	34.69	37.14	34	41
GGSS MARYAM ABACHA	12	34.83	3.099	.895	32.86	36.80	31	41
GSS G/DUTSE	12	34.58	2.275	.657	33.14	36.03	32	39
RUMFA COLLEGE	12	35.42	3.753	1.083	33.03	37.80	28	41
GGSS SHEKARA	12	36.25	2.896	.836	34.41	38.09	32	42
Total	72	35.11	2.730	.322	34.47	35.75	28	42

ANOVA

PRETESTSCORES

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	53.778	5	10.756	1.493	.204
Within Groups	475.333	66	7.202		
Total	529.111	71			

Appendix V

Hypothesis (1)

PRE-TEST VS POST-TEST (CR)

Group Statistics

	GROUP OF SCORES	N	Mean	Std. Deviation	Std. Error Mean
SCORES	PRE-TEST	24	34.79	2.043	.417
	POST-TEST	24	25.33	5.354	1.093

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
SCORES	Equal variances assumed	38.436	.000	8.086	46	.000	9.458	1.170	7.104	11.813
	Equal variances not assumed			8.086	29.556	.000	9.458	1.170	7.068	11.849

Appendix VI

Hypothesis (2)

PRE-TEST VS POST-TEST (SST)

Group Statistics

	GROUP OF SCORES	N	Mean	Std. Deviation	Std. Error Mean
SCORES	PRE-TEST	24	34.71	2.662	.543
	POST-TEST	24	26.17	3.886	.793

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
SCORES	Equal variances assumed	5.022	.030	8.884	46	.000	8.542	.961	6.606	10.477
	Equal variances not assumed			8.884	40.688	.000	8.542	.961	6.599	10.484

Appendix VII

Hypothesis (3)

CRT VS SST (POST-TEST)

Group Statistics

	TYPES OF TECHNIQUES	N	Mean	Std. Deviation	Std. Error Mean
SCORES	CRT	24	25.33	5.354	1.093
	SST	24	26.17	3.886	.793

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
SCORES	Equal variances assumed	6.228	.016	-.617	46	.540	-.833	1.350	-3.552	1.885
	Equal variances not assumed			-.617	41.969	.541	-.833	1.350	-3.559	1.892

Appendix VIII

Hypothesis (4)

T-TEST, CONTROL VS EXPERIMENTAL (CR)

Group Statistics

	GROUP OF RESPONDENTS	N	Mean	Std. Deviation	Std. Error Mean
POST TEST SCORES	CONTROL	24	33.08	2.827	.577
	EXPERIMENTAL(CRT)	24	25.33	5.354	1.093

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
POST TEST SCORES	Equal variances assumed	20.633	.000	6.271	46	.000	7.750	1.236	5.262	10.238
	Equal variances not assumed			6.271	34.900	.000	7.750	1.236	5.241	10.259

Appendix IX

Hypothesis (5)

T-TEST, CONTROL VS EXPERIMENTAL (SST)

Group Statistics

	GROUP OF RESPONDENTS	N	Mean	Std. Deviation	Std. Error Mean
POST TEST SCORES	CONTROL	24	33.08	2.827	.577
	EXPERIMENTAL(CRT)	24	26.17	3.886	.793

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
POST TEST SCORES	Equal variances assumed	4.115	.048	7.051	46	.000	6.917	.981	4.942	8.891
	Equal variances not assumed			7.051	42.019	.000	6.917	.981	4.937	8.896

Appendix X

Hypothesis (6)

MALES VS FEMALES (CR)

Group Statistics

	GENDER OF THE RESPONDENT (CRT)	N	Mean	Std. Deviation	Std. Error Mean
SCORES	MALE	12	22.50	5.196	1.500
	FEMALE	12	28.17	3.927	1.134

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
SCORES	Equal variances assumed	1.308	.265	-3.014	22	.006	-5.667	1.880	-9.566	-1.767
	Equal variances not assumed			-3.014	20.476	.007	-5.667	1.880	-9.583	-1.750

Appendix XI

Hypothesis (7)

MALES VS FEMALES (SST)

Group Statistics

	GENDER OF THE RESPONDENT (SST)	N	Mean	Std. Deviation	Std. Error Mean
SCORES	MALE	12	25.92	4.033	1.164
	FEMALE	12	26.42	3.895	1.125

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
SCORES	Equal variances assumed	.106	.747	-.309	22	.760	-.500	1.619	-3.857	2.857
	Equal variances not assumed			-.309	21.974	.760	-.500	1.619	-3.857	2.857