LEFKOE AND COGNITIVE BEHAVIOUR THERAPIES IN THE MANAGEMENT OF PUBLIC SPEAKING ANXIETY AMONG SECONDARY SCHOOL ADOLESCENTS IN THE IBADAN METROPOLIS, NIGERIA

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CERTIFICATION

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This work is dedicated to my family who really endured my long absence from home and prayed to see the work successfully completed. Their creative love supplied the energy and the determination to reach this level. May God continue to protect them.

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ABSTRACT

Public Speaking Anxiety (PSA), the fear of giving an oratory in public because of the expectation of being negatively evaluated, is a major hinderance to effective public speaking. Extant literature have shown that many secondary school adolescents exhibit PSA in the Ibadan Metropolis, Nigeria. Previous studies on PSA had been on prevalence and antecedents using survey, with little attention given to psychological interventions for managing PSA. This study, therefore, was designed to determine the effects of Lefkoe Therapy (LT) and Cognitive Behaviour Therapy (CBT) in the management of PSA among secondary school adolescents in Ibadan, Nigeria. The moderating effects of gender and assertiveness skills were also examined.

The Social Learning Theory served as the anchor, while the pretest – posttest control group quasi-experimental design, with a 3 x 2 x 2 factorial matrix was used. South-West Local Government Area (LGA) was purposively selected being one of the LGAs with high concentration of secondary schools in the Ibadan Metropolis. The simple random sampling technique was used to select three secondary schools in the LGA. The students were selected through a screening process based on their reported speech anxiety on the Personal Report of Confidence as a Speaker instrument (PRCS – α = 0.72) and those who scored below the norm of 30% were selected and randomly assigned into LT (40), CBT (40) and control (40) groups. The instruments used were McCroskey's Personal Report of Communication Apprehension Scale (α = 0.78) and Assertiveness Inventory (α = 0.89). The treatment lasted 10 weeks. Data were analysed using Analysis of covariance at 0.05 level of significance.

The participants' age ranged between 14 and 23; males had a mean score of 60.10, while their female counterparts had a mean score of 55.83 respectively. There was a significant main effect of treatment on PSA among secondary school adolescents (($F_{(3; 116)} = 29.74$, partial $\eta^2 = .35$). The participants exposed to LT obtained the lowest mean score (51.35), followed by CBT (53.65) and control (mean = 68.90) groups. There was a significant main effect of assertiveness skill on PSA ($F_{(2, 117)} = 10.88$, partial $\eta^2 = .09$). The participants with high assertiveness skill scored lower mean (47.73) on PSA than those with low assertiveness skill (62.53). There was no significant main effect of gender on PSA. There were no significant two-way interaction effects of treatment and gender, treatment and assertiveness skill as well as gender and assertiveness on PSA. The three-way interaction effect was not significant.

Lefkoe and cognitive behaviour therapies reduced public speaking anxiety among secondary school adolescents, with Lefkoe therapy being more efficacious. Counselling and educational psychologists should adopt these strategies in the management of public speaking anxiety among secondary school adolescents.

Keywords: Lefkoe and cognitive behaviour therapies, Management of public speaking anxiety, Assertiveness skills, secondary school adolescents in Ibadan.

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CHAPTER ONE
INTRODUCTION

1.1 Background to the Study

Anxiety is a relatively natural response to a situation which appears threatening or to which one is not accustomed. Most people suffer from anxiety at some stage in their lives or the other. People are sometimes quite naturally anxious about passing tests, going for job interviews, or even speaking in public. They may experience 'butterflies' in their stomachs, sweaty palms, restlessness, insomnia, or even slight dizziness. Anxiety in itself is not a bad experience since a certain amount of anxiety is required to perform optimally. However, scholars and researchers have reported that when anxiety becomes chronic or intense it affects a person's day to day functioning and hampers performance. Put differently, anxiety can be generally associated with "threats to self -efficacy and appraisals of situations as threatening" (Pappamihiel, 2002).

Public speaking refers to the communication practice of a speaker sharing ideas with an audience primarily through speech. It encompasses a great many communication contexts, including events as different as delivering an oral report on company profits to a closed meeting of a board of trustees, speaking in front of peers and giving a toast at a wedding among others. The fundamental notion underlying public speaking as a form of communication is that it is embodied and it is also an oral act. Regardless of someone's occupation the success depends a great deal upon the individual's ability to communicate effectively. Whether running a meeting, selling a product, making a presentation, motivating co-workers or just communicating with one-on-one with others far better results can be achieved if one can speak persuasively, smoothly and intelligently. Unlike written communication, public speaking is complicated because sharing meanings with others through language is difficult. The challenges of public speaking are heightened since the speaker shares meaning not only through words but also through body, voice, and visuals.

Furthermore, the public speaking experience, traditionally, is transitory; a speaker has only one opportunity to accomplish his or her goal – to be understood by the listeners. While readers can re-read documents until they understand the gist of the message, listeners, typically, cannot hear a speech again.

It is documented that a major challenge associated with public speaking experience is anxiety. It is documented that a major challenge associated with public speaking experience is anxiety. Public speaking anxiety therefore, refers to anxiety associated with giving a public speech. Fear of public speaking interchangeably used in this study as speech fright, speech anxiety, stage fright and public speaking anxiety are essentially the same thing – anxiety associated with giving a public speech. Fear of public speaking is a common type of social anxiety identified in the Diagnostic and Statistical Manual of Mental Disorder (DSM-IV) (2000).

Other anxiety disorders include panic disorder, obsessive-compulsive behaviours, agoraphobia and specific disorder phobia. Social anxiety disorder is defined as a "marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or possible scrutiny by others" (American Psychiatric Association, 2000). According to DSM-IV TR, an individual with social anxiety disorder typically tries to avoid those social performance situations or endures them with dread (APA, 2000). A survey conducted by American National Institute of Mental Health (2013) show that 74% Percent of men and 75 % of women suffer from speech anxiety

Mokuolu (2013) posited that anxiety associated with public speaking derives from feelings of insecurity or fear related to the result of the task (performance) as an emotional reaction typical of situations of judgment arising from evaluation situations. This description fits into Spielberger (1983) definition of anxiety as “the subjective feeling of tension, apprehension, nervousness, and worry associated with an arousal of the autonomic nervous system”. Similarly, (Zeidner, 1998) observed that test situations evoke anxiety for many people when the impact of tests on one’s life is considered, including the educational, vocational, emotional and other aspects. Adebule and Kolawole (2012) in their description of anxiety related it to a given task when they noted that anxiety is "a state of conceptual or central nervous system characterized by activity of the behavioural inhibition system" p. 231.

Undoubtedly, everyone experiences anxiety especially when the individual is speaking in front of an audience. Akosijade (2013) averred that public speaking will get even

the most prepared person anxious and afraid when they are on the stage interacting with the audience. More specifically, when the audience remains silent, the speakers will get much anxious, and forget what they want to say (Kenneth & Melvin, 2008). Phillips (1991) aver that fear of speaking in public is different from anxiety about social contact. True Public speaking anxiety means that the sufferers see more value in keeping quiet in all circumstances (even in conversation) than they do from talking.

A study shows that up to 5 percent of the world population and hundreds of millions people aged between 18 and 54 year experience glossophobia (social phobia related to self-presentation in front of an audience) in any given year (Anderson, 2006). These premises are in line with evidence found in empirical research pointing to a negative relation between anxiety and (non-specific) performance; that is, the greater the anxiety the poorer the performance (Arogundade, 2012; Olufemi and Oluwatayo, 2014). The fear of having to perform is an all too common experience for many individuals. Perhaps one of the most feared performance situations is public speaking. One study showed that public speaking is the greatest fear among Americans, ranking even higher than death (Cosnett, Dennet, Anderson, and Whiteford, 1990). However, there are numerous situations that require public speaking, making the task of understanding public speaking anxiety difficult. For example, young executives giving business presentations, teachers lecture their students, and college students giving in-class speeches. Even though all of these individuals may experience public speaking anxiety, there may be very different factors that contribute to their anxiety. Each of the above mentioned individuals, have to perform the same task, public speaking, but in very different situations.

Perhaps differences in these situational factors would account for the differences in their experience of public speaking anxiety. Whereas the basic component of most public speaking includes a speaker and an audience, the reasons and context of the presentation, skill and expertise of the presenter, and audience characteristics vary in many ways. For example, again, with regard to the college students giving their classroom presentations, these students may be concerned with many aspects of the presentation situation including how their peers will perceive them, the evaluation for a grade by their instructor, as well as their ability to accurately convey their knowledge of the topic.

As research on public speaking anxiety has developed some decades ago scholars have discovered that the fear of public speaking is actually only one type of

anxiety housed within a general condition called communication apprehension. An individual's communication skills pervade all dimensions of life. The act of communicating allows individuals to connect with one another, satisfy a need for belonging, seek and exchange information, and both give and receive social support. In the academic environment, ability to communicate publicly is considered imperative for student success. Yet, despite the usefulness of this skill some students have communication apprehension (Yahya, 2013). Those who experience high levels of communication anxiety seek to avoid communication, report emotional distress regarding communication, and are perceived, both by others and themselves, to be less competent and less successful (McCroskey & Sheahan, 1978).

The school plays a major role in the socialization of the young in every society. It is the first venue for the child's interaction with the world outside his home. The school provides basic lessons in human relationships and in the regulation of individual behaviour. Perhaps, more importantly, is the fact that the school provides opportunities for the acquisition of needed competencies for different careers and vocations. However, one major factor among several others that militates against the attainment of these objectives of schooling is anxiety regarding public speaking. Communication apprehension has serious implications for students at the secondary school levels. Students with Public speaking anxiety tend to avoid engaging in behaviours that facilitate success such as asking questions during class, meeting with instructors, and collaborating with peers. Students who fail to adopt academically supportive behaviours due to high communication apprehension are more likely to drop out of college than their peers (McCroskey and Beatty, 1998).

It is well documented that student involvement is paramount to student success and retention. Astin (1985) averred that students learn by becoming involved. In support of this proposition, Pascarella and Terenzini (2005) opined that the individual student plays a central role in determining the extent of growth experienced according to the nature of involvement with their institution. Similarly, Tinto (1987) contends that students enter schools with various personal and academic characteristics including predispositions regarding college attendance and goals. It is the students' interactions with the institution and its representatives, such as teachers, counsellors and peers, which influence integration with the institution. Positive interactions are presumed to lead to better integration thereby reducing student attrition. Thus, a student's ability to communicate publicly enables him to access all

the necessary supports required for his success. Moreover, this skill is of particular importance in courses where oral communication tasks are basis for evaluation.

As an attempt to unravel the causes of public speaking anxiety, researchers have documented several factors to account for public speaking anxiety. It includes, lack of preparation; feeling that they have either too many points to cover in the allotted time period; worries that the audience will be overly critical; fear about not entertaining or arousing the interest of people (Amini & Naghadeh, 2013). Other possible causes of anxiety could be the fear of potential negative outcomes and stuttering or difficulty to finding words, dislike in being the centre of attention and also low self-confidence. This claim is supported by Brydon and Scott (1997) who opine that students who feel they have skill deviancies in public speaking often experience anxiety. While, in the context of speaking English as a second language, Young (1991) listed six potential causes of language anxiety which include both personal and interpersonal factors, learners' beliefs, instructors' beliefs, instructor-learner interactions, classroom procedures and language tests. However, to date, findings by Horwitz (1986) have been the most influential. They identified three causes of public speaking anxiety, namely, communication apprehension, test anxiety and fear of negative evaluation. Based on these three components they also designed a thirty-three items scale, a Foreign Language Classroom Anxiety Scale (FLCAS). This scale was later used widely by researchers to measure foreign language learners' anxiety and examine the effect of anxiety on learning in different situations.

In trying to understand why some people have public speaking anxiety while others do not have many different theories have been postulated. Some theorists believe that public speaking anxiety is genetic and are purely chemical in nature. There is some evidence for this, as anxiety disorders very often tend to run in families, even when children have been adopted at birth and never meet their biological parents. Researchers such as (Kelly and Keaten, 2000; Wrench, Brogan, McCroskey and Jowi, 2006) have investigated communication apprehension as a trait in which a person's biological makeup is believed to constitute the individuals personality traits. Recent attention has been directed toward the role one's biology plays in explaining both personality and human behaviour (Beatty, McCroskey, and Heisel, 1998). In an earlier study, McCroskey, Daly and Sorensen (1976) identified personality correlates of individuals with public speaking anxiety. In general, those with high levels of public speaking anxiety were found to be negatively correlated with general measures of personality

including emotional maturity, confidence, self-control, tolerance for ambiguity, and need to achieve.

On the contrary, researchers such as, (McCroskey and Beatty, 2000) explained factors responsible for communication behaviours from a communibiological perspective and also agreed with other dispositional approaches which contend that a person's behavioural differences are largely a result of neurobiological functioning. Important to this line of research, however, is that contrary to basic assumptions about a genetic-based model, people can and do change with proper cognitive information. Therefore, given the confines of a biological model, researchers assert that change, which is based on something other than one's temperament, can occur (McCroskey & Beatty, 2000).

Like the communibiological paradigm suggests, a person's trait does not account entirely for all behaviours. Some situational factors, that are transitory in nature, also play a role in a person's disposition. In early studies, communication apprehension was measured on a single, uniform response occurring either psysiologically, psychologically or behaviourally. Research investigations were characterized by both neurobiological and psychological measures which explored communication anxiety as a static personality-type variable. This trait approach (that is, the anxiety is due to a rather stable personality characteristics) failed to account for a change in anxiety such as that experienced with a specific event such as when orally addressing a large audience. The dimensional nature of anxiety was uncovered when psychologist, Spielberger (1966) distinguished social anxiety as a manifestation of either a trait or a state. Accordingly, McCroskey (1997) notes: "Human behaviour is the product of at least two interacting factors, characteristics predisposition of the individual (traits), and of the situational constraints on behaviour at a given time (States). Individual traits are relatively enduring overtime, whereas states are highly variable" anxiety experienced as a state response, in contrast to a trait, is an episodic, temporary, transistory state which occur in response to a specific stimulus. Scholars such as, Spielberger (1966); Richmond (1978); and (McCroskey and Richmond, 1982b) have developed self-report instruments to measure an individual's state anxiety. Their measurements have largely included three types of ratings: the speaker's own perception of anxiety; observer ratings of perceived speaker anxiety; and physiological arousal levels. They contend that to measure the speaker's own perception of anxiety, the use of self-report measures is an appropriate approach to

empirical studies. Self-report measures, when used to obtain information about the individual, are preferred approaches if the person both knows the answer and is willing to tell the truth (McCroskey, 1997). This approach is well suited to investigations into a person's perceived anxiety in that, logically, researchers argue that the best method of finding out something about a person is to ask him or her. However, there is a contrary evidence to show that "Self-report measures are amenable to either trait or state concerns with communication apprehension. Respondent can report their general feelings, feelings in broad categories of communication situations, and their feelings in specific situations with equal ease" (McCroskey, 1997).

Due to the usefulness of public speaking skill in different contexts such as organisations, schools, hospitals among others, public speaking anxiety has attracted the interest of researchers. As a result, interventions have been developed to help people cope with communication apprehension. Such interventions include: Rational Emotive Therapy (RET), Ellis and Harper, 1975; Cognitive restructuring, Miechenbaum, Gilmore & Fedoravicious, 1971; Visualization (Ayres & Hopf, 1985, 1991); Skills Training, (Fremouw & Zitter, 1978); Systematic Desensitization, (Wolpe, 1958); and Multiple Treatments, (Leary, 1995). Not surprisingly, mixed results were reported. This is probably because the researchers failed to anchor their interventions on cognitions and affect which is reported to influence behaviours especially the act of speaking in public. Therefore, as an attempt to fill the above identified research gap and also to contribute to literatures in this field of study, the study examined the effectiveness of Lefkoe treatment and Cognitive Behaviour Therapy in reduction of public speaking anxiety among secondary school adolescents in Ibadan, Oyo state, Nigeria.

In 1988 Morty Lefkoe developed a theory out of which the Lefkoe therapy was adapted. This therapy, according to Sechrest (2006), is an effective, quick and easy method to eliminate fear of speaking in public and that the therapy works by "undoing" the two main causes of the fear of public speaking – negative beliefs and emotional conditioning. Researchers who carried out a study in (2006) with people who feared public speaking stated that: "The large positive changes on all outcome measures subsequent to treatment give strong support to the claim of efficacy of the Lefkoe therapy to reduce public speaking anxiety. The treatment resulted in substantial decreases or complete elimination of fear, accompanied by positive changes in confidence and reduced negative sensations felt during speaking in pubic in the experimental group".

Cognitive Behaviour Therapy (CBT) is another therapy found to be effective in treating social phobias. CBT is a psychotherapeutic approach that addresses dysfunctional emotions, behaviours and cognitions through a goal-oriented, systematic process. As the name implies it refers to a combination of basic behavioural and cognitive researches. The premise of Cognitive Behavioural Therapy is that changing maladaptive thinking leads to change in affect and behaviour. Therapist or computer – based programs use CBT techniques to help individuals challenge their patterns and beliefs and replace "errors in thinking such as over – generalizing, magnifying negatives, minimizing positives and catastrophizing" with more realistic and effective thoughts, thus decreasing emotional distress and self-defeating behaviour".

Cognitive Behaviour Therapy was used to make participants in this study become aware of thought distortions and irrational fears which have been inhibiting them from having confidence to speak in the public and to replace such with rational thought processes.

With regard to gender difference in public speaking, studies show that males and females may have different reaction and processing method in handling PSA. Spielberger (1983: 19), in her study on state anxiety found that females are more emotionally stable than males in their reactions to highly stressful and relaxing circumstances. Similarly, in Kitano's (2001) study cited in Gobel and Matsuda (2003) male Japanese college students have been found to feel more anxious when they perceive they are less competent than female; however, such a relationship was not observed among female students. On the contrary, Machida (2001) found no differences in class anxiety based on gender.

Campbell and Shaw (1994) revealed that male students felt more anxious in using a foreign language than female students do. Aida (1994) claimed that Japanese students with previous speech experiences showed a significantly lower level of anxiety than those of novice speakers. In addition, Hsu (2008) also pointed out that male students became more anxious, worrying about their insufficient english ability in class, while female students felt more anxious because of insufficient preparation before speaking in class. It was therefore hypothesized that female's anxiety is generated from within such as: academic stress and fear of inadequate preparation. The general consensus among scholars is that because of childhood socialization men may be more

loquacious and assertive while women are more focused on feelings, expressive and wanting to really "connect" with others.

Another variable that could influence public speaking anxiety is the level of assertiveness. Assertiveness is the ability to honestly express one's opinions, feelings, attitudes, and rights without undue anxiety, in a way that doesn't infringe on the rights of others. Assertive communication requires a range of skills and techniques. These include "initiating and maintaining conversations, encouraging assertiveness in others, responding appropriately to criticism, giving negative feedback respectfully, expressing appreciation or pleasure, being persistent, setting limits or refusing requests, and expressing opinions and feelings appropriately" (Hasan, 2008). Those who are assertive are able to clearly and openly express their needs, wants, feelings and opinions in a manner which is respectful to themselves and others (Morrissey & Callaghan, 2011). Assertive individuals are also able to make requests without belittling, abusing or dominating other people (Dale, Carnegie & Training, 2009). People who are assertive when speaking in the public appear to be self-confident, and composed, maintains eye contact, speaks firmly and positively. Assertive behaviour falls within the centre of a spectrum ranging from passivity at one end to aggression at the other (Hasan, 2008).

Public speaking skill can help students in many ways, such as improving retention and enhancing learning motivations. Appropriate public speaking training is necessary to help improve communication skills and help students succeed academically. After all, public presentations and group discussions are common activities required for academic success, hence, the need to investigate the effectiveness of Lefkoe and Cognitive Behaviour Therapies on reduction of public speaking anxiety among secondary school adolescents in Ibadan, Oyo State, Nigeria.

1.2 Statement of the Problem

Public speaking anxiety has serious implications for secondary school adolescents because such students tend to avoid engaging in behaviours that facilitate success, such as, asking questions during class, meeting with teachers and collaborating with peers. Students who fail to adopt academically supportive behaviours as listed above due to high communication apprehension are more likely to drop out of college than their peers. Those who experience high levels of communication anxiety seek to avoid communication, report emotional distress regarding communication, and are

perceived; both by others and themselves, to be less competent and less successful (McCroskey et al., 1989). Dropping out of school has its attendant problems and consequences. For example, dropping out of school has been indirectly linked to other social vices such as drug addiction, robbery and alcohol abuse (Animashaun & Saka, 2011); (Ogundokun & Alamu, 2011).

Besides, inability to seek peer support, consult teachers or make presentation in some examinations which require speaking in public due to public speaking anxiety has resulted in poor academic performance. Though optimal level of arousal and mindset is necessary to best complete a task such as an examination, perform an act or compete in an event, however, when the anxiety or level of arousal exceeds that optimal level, the result is decline in performance. Anxious students may experience perceptual distortions of non-psychotic proportions, which may reflect in attention processes and thereby critically affect the cognitive performance and information processing.

Public speaking anxiety is a threat to the realization of the purpose of Education in Nigeria. The purpose of Education in Nigeria as spelt out in National Policy on Education (2004) is an "Instrument par excellence for effecting national development; to use education as a tool to achieve its national objectives; to make such education relevant to the needs of the individual and set its goal in terms of the kind of society desired in relation to the environment and realities of the modern world and rapid social changes" Education therefore, is a tool designed to holistically coordinate the cognitive, affective and psychomotor, aspects of human persons simultaneously for the survival of individual and of society. The above – mentioned laudable objectives cannot be achieved due to poor academic performance of students caused by public speaking anxiety.

Again, the school plays a major role in the socialization of the young in every society. As the first venue for the child's interaction with the world outside his home, the school provides basic lessons in human relationships and in the regulation of individual behaviours. Perhaps, more importantly, is the fact that the school provides opportunities for the acquisition as needed competencies for different careers and vocations. Regrettably, the achievement of the above-mentioned laudable objectives by the educational system is militated by high drop out of school due to poor academic performance and mass failure in national and international. Examination, all traceable to public speaking anxiety. For example, this is evident in the result of the 2014 Joint Admission and Matriculation Board (JAMB) result, which shows that only 47

candidates scored above 250 in the Paper Pencil Test (PPT) across the country. Similarly, even though the number of students who enrolled for English Language in WAEC in Oyo State increases from 42,376 in 2010 to 53,313 in 2013, only 41.26% pass was recorded, while 58.74% performed below average. (Oyo State Ministry of Education, 2013).

Furthermore, in the academic environment, ability to communicate publicly is considered imperative for student success because it enables the student to access all the necessary support needed for his academic success. Again, public speaking anxiety can prevent the student from being assertive enough to achieve the necessary academic success. People with public speaking anxiety may experience health and other associated problems, like, depression, loneliness, insomnia or even light dizziness.

1.3 Purpose and Objectives of the Study

The purpose of this study was to investigate the effectiveness of Lefkoe and Cognitive Behaviour Therapies in reducing public speaking anxiety among secondary school school adolescents in Ibadan, Oyo State, Nigeria. This study further examined which of the two therapeutic techniques is more effective in reducing public speaking anxiety among secondary school adolescents. The influence of gender and assertiveness skill of the participants on public speaking anxiety among secondary school adolescents was also investigated.

Specifically, this study investigated the effects of:

1. Treatment on public speaking anxiety among secondary school adolescents.
2. Assertiveness skill on public speaking anxiety among secondary school adolescents.
3. Gender on public speaking anxiety among secondary school adolescents. As well as the interaction effects of.
4. Treatment and assertiveness skill on public speaking anxiety among secondary school adolescents
5. Treatment and gender on public speaking anxiety among secondary school adolescents.
6. Assertiveness skill and gender on public speaking anxiety among secondary school adolescents.
7. Treatment, assertiveness skill and gender on public speaking anxiety among secondary schools adolescents.

1.4 Significance of the Study

This study is significant in several ways. For example, it will be of immense direct benefits to the students who participated in the study while those who did not participate directly can gain indirectly through peer tutoring and mentoring and thereby improve the students level of public speaking skills.

Counseling psychologist's understanding of human behaviour especially in the area of anxiety will be enhanced through findings to enable them make for accurate diagnosis, control and management of public speaking anxiety among secondary school students. Counselors will also readily apply the two interventions in remediating public speaking anxiety of clients in diverse settings considering the peculiarities of each setting.

The study can provide document with which policy makers will refer to when making education related policies especially for secondary school students in Ibadan, Oyo States Education Policy makers may due to the outcome of this research expunge some outdated and mundane policies and practices in teaching especially and replace such with updated ones. Based on the outcome of this study, policy makers will be able to see the need to formulate educational policies and possibly inclusion of the therapies in the school curriculum.

School teachers especially those in secondary schools can be better equipped with tools to diagnose, assess, monitor and change deficit public speaking skills required by the students for self-actualization. The outcome of this study would provide empirical evidence to suggest the use of Lefkoe and Cognitive behaviours is the elimination of fears and modification of irrational beliefs and thought processes concerning public speaking anxiety. Social workers and remediation workers will derive input from the outcome of the study to reinstate students who have dropped out of school due to inability to cope with the act of speaking in public, speaking assistance from peers and teachers. This study will also add to existing literatures on anxiety with specific emphasis on public speaking anxiety.

The findings of this study will further crease research gaps for other researchers who may decide to examine the effect of other treatments on public speaking anxiety among secondary school students. To future researchers, it will serve as a reference

material to consult in their scientific endeavours, recommendations from the study and suggestions could also be a research topic for future studies.

1.5 Scope of the Study

This study was limited to the investigation of the effectiveness of Lefkoe treatment and Cognitive Behaviour Therapy on the reduction of public speaking anxiety. Geographically, only students in Senior Secondary two (SS II) in Ibadan South-West Local Government, Oyo State, Nigeria were targeted. Students not in SSII and without public speaking anxiety as evident in the pre-selection scores were excluded from the study. The study was also restricted to pretest -posttest control group quasi experimental design.

1.6 Operational Definition of Terms

The following concepts are operationally defined as used in the study.

Public Speaking Anxiety: this refers to the anxiety secondary school adolescents experience when making speech before peers, asking teachers for academic supports and relationship generally.

Assertiveness Skill: this is the skill that enables secondary school adolescents to feel free to express their opinions, feelings and desires without undue anxiety.

The Lefkoe Therapy: this is a therapeutic intervention that empowers secondary school adolescents to overcome or deal with fears of public speaking.

Cognitive Behavioural Therapy: it is a therapy that assists secondary school adolescents in replacing negative thoughts with positive ones.

CHAPTER TWO
LITERATURE REVIEW

This chapter makes a critical review of related literature that are germane to the study. In line with this, major concepts and variables involved in this study are discussed and their relationship examined. Therefore the review of the literature is categorized into two: Theoretical and Empirical Review.

2.1 Theoretical Review

2.1.1 Concept of Anxiety

"Anxiety is a psychological construct, commonly described by psychologists as a state of apprehension, a vague fear that is only indirectly associated with an object" (Hilgard, Atkinson, & Atkinson, 1971 cited in Scovel, 1991: p. 18). Anxiety, as perceived intuitively by many language learners, negatively influences language speaking and has been found to be one of the most highly examined variables in all of psychology and education (Horwitz, 2001: p. 113).

Anxiety in itself is not a bad thing since a certain amount of anxiety can motivate a learner to learn, acquire, and speak confidently. However, researchers have noticed that there is a high level of anxiety which negatively affects many language learners' behavioural and their educational outcomes, too. It may cause fear or unwillingness to communicate with others in that language. According to Brown (1993), "anxiety is associated with feelings of uneasiness, frustration, self-doubt, apprehension and worry". It can be described as "the feeling of tension and apprehension specifically associated with second language texts, including speaking, listening, and learning" (MacIntyre & Gardner, 1994, as quoted in Subaşı, 2010). It also plays an important role in learning and speaking because it can be positive or negative according to how greatly it is felt by the learner. It is anxiety of this extreme that no doubt hinders students' performance.

2.1.2 Types of Anxiety

Psychologists make a distinction between three categories of anxiety: trait anxiety, state anxiety, and situation-specific anxiety. Trait anxiety is relatively stable personality characteristic, 'a more permanent predisposition to be anxious' (Scovel, 1978: cited in Ellis, 1994) while state anxiety is a transient anxiety, a response to a particular anxiety – provoking stimulus such as an important test (Spielberger, 1983: cited in Horwitz, 2001). The third category, situation – specific anxiety, refers to the persistent and multi-faceted nature of some anxieties (MacIntyre & Gardner, 1991a: cited in 2001: 113). It is aroused by a specific type of situation or event such as public speaking, examinations, or class participation (Allis, 1994: 480).

2.1.3 Adolescents and Anxiety

Anxiety is a normal human emotion that everyone experiences at times. Many people feel anxious, or nervous, when faced with a problem at work, before taking a test, or making an important decision. Anxiety disorders, however, are different. They can cause such distress that it interferes with a person's ability to lead a normal life. An anxiety disorder is a serious mental illness. For people with anxiety disorders, worry and fear are constant and overwhelming, and can be crippling. Psychiatric Diagnoses are categorized by the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition. Better known as the DSM-IV, the manual is published by the American Psychiatric Association and covers all mental health disorders for both children and adults. It categorized anxiety disorders into four recognized types which can occur to individuals, namely;

- Panic disorder: People with this condition have feelings of terror that strike suddenly and repeatedly with no warning. Other symptoms of a panic attack include sweating, chest pain, palpitations (unusually strong or irregular heartbeats), and a feeling of choking, which may make the person feel like he or she is having aheart attack or "going crazy".
- Social anxiety disorder: Also called social phobia, social anxiety disorder involves overwhelming worry and self-consciousness about everyday social situations. The worry often centers on a fear of being judged by others, or behaving in a way that might cause embarrassment or lead to ridicule.

- Specific phobias: A specific phobia is an intense fear of a specific object or situation, such as snakes, heights, or flying. ,the level of fear is usually inappropriate to the situation and may cause the person to avoid common, everyday situations.
- Generalized anxiety disorder: This disorder involves excessive, unrealistic worry and tension, even if there is little or nothing to provoke the anxiety.

Adolescents and Social Anxiety Disorder

Social anxiety disorder (SAD), also known as social phobia, is an anxiety disorder characterized by an intense fear in one or more social situations causing considerable distress and impaired ability to function in at least some parts of daily life. These fears can be triggered by perceived or actual scrutiny from others (Webmd, 2010). It is the most common anxiety disorder and one of the most common psychiatric disorders, with 12%.

Cognitive Aspects

In cognitive models of social anxiety disorder those with social phobias experience dread over how they will be presented to others. They may feel overly self-conscious, pay high self-attention after the activity, or have high performance standards for themselves. According to the social psychology theory of self-presentation, a sufferer attempts to create a well-mannered impression towards others but believes he or she is unable to do so. Many times, prior to the potentially anxiety-provoking social situation, sufferers may deliberately review what could go wrong and how to deal with each unexpected case. After the event, they may have the perception that they performed unsatisfactorily. Consequently, they will review anything that may have possibly been abnormal or embarrassing. These thoughts do not simply terminate soon after the encounter, but may extend for weeks or longer (Acarturk, De Graaf, Van Straten, Have, and Cuijpers, 2008). Cognitive distortions are a hallmark, and are learned about in CBT (cognitive-behavioural therapy).

Thoughts are often self-defeating and inaccurate. Those with social phobia tend to interpret neutral or ambiguous conversations with a negative outlook and many studies suggest that social anxious conversations with a negative outlook and many studies distressed (Furmark 2006). An example of an instance may be that of an employee presenting to his co-workers. During the presentation, the person may

stutter a word, upon which he or she may worry that other people significantly noticed and think that their perceptions of him or her as a presenter have been tarnished. This cognitive thought propels further anxiety which compounds with further stuttering, sweating, and potentially, a panic attack.

Behavioural Aspects

Social anxiety disorder is a persistent fear of one or more situations in which the person is exposed to possible scrutiny by others and fears that he or she may do something or act in a way that will be humiliating or embarrassing. It exceeds normal "shyness" as it leads to excessive social avoidance and substantial social or occupational impairment. Feared activities may include almost any type of social interaction, especially small groups, dating, parties, talking to strangers, restaurants, interviews etc.

Those who suffer from social anxiety disorder fear being judged by others in society. In particular, individuals with social anxiety are nervous in the presence of people with authority and feel uncomfortable during physical examination (Schneier, 2006). People who suffer from this disorder may behave a certain way or say something and then feel embarrassed or humiliated after. As a result, they choose to isolate themselves from society to avoid such situations. They may also feel uncomfortable meeting people they do not know, and act distant when they are with large groups of people. In some cases they may show evidence of this disorder by avoiding eye contact or blushing when someone is talking to them.

According to psychologist B.F. Skinner, phobias are controlled by escape and avoidance behaviours. For instance, a student may leave the room when talking in front of the class (escape) and refrain from doing verbal presentations because of the previously encountered anxiety attack (avoid). Major avoidance behaviours could include an almost pathological/compulsive lying behaviour in order to preserve self-image and avoid judgement in front of others. Minor avoidance behaviours are exposed when a person avoids eye contact and crosses his/her arms to avoid recognizable shaking. A fight-or-flight response is then triggered in such events.

Physiological Aspects

Physiological effects, similar to those in other anxiety disorders, are present in social phobics. In adults, it may be tears as well as excessive sweating, nausea, difficulty breathing, shaking, and palpitations as a result of the fight-or-flight response. The walk disturbance (where a person is so worried about how they walk that they may lose balance) may appear, especially when passing a group of people. Blushing is commonly exhibited by individuals suffering from social phobia. These visible symptoms further reinforce the anxiety in the presence of others. A 2006 study found that the area of the brain called the amygdale, part of the limbic system, is hyperactive when patients are shown threatening faces or confronted with frightening situations. They found that patients with more severe social phobia showed a correlation with the increased response in the amygdale (Schneier, 2006).

2.1.4 Concept of Public Speaking Anxiety

Anxiety about public speaking is a common fear among people from all walks of life (Gibson, Gruner, Hanna, Smythe & Hayes, 1973). Many individuals experience some degree of communication apprehension or "fear associated with real or anticipated communication with another person or persons" (McCroskey, 1984), and public speaking is perceived as a particularly stressful and anxiety-producing experience. Moreover, "public speaking anxiety represents a cluster of evaluative feelings about speech making" (Daly, Vangelisti, Neel, & Cavanaugh, 1989, p. 40), such that anxious speakers simultaneously experience several negative or distracting feelings associated with the public speaking context. For decades, communication scholars have investigated many details surrounding the psychological and physiological aspects of public speaking anxiety, often with a view toward developing interventions that will minimize the negative effects of anxiety for public speakers.

Fear of public-speaking is high in community samples and for some people, it can have an extremely negative impact (Furmark, 2002). Some may experience anxiety or panic when anticipating, or faced with public speaking situations (Behnke & Sawyer, 1999; Behnke & Sawyer, 2000, Harris, Sawyer & Behnke, 2006; Sawyer & Behnke, 2002). Physiological arousal, such as an increased heart-rate, blood pressure or sweating is also experienced (Clements & Graham, 1996; Feldman, Cohen, Hamrick, & Lepore, 2004; McCroskey, Beatty, Kearney, & Plax, 1985; Porhola, 2002). This can lead to the avoidance of public speaking situations, which

negatively can impact on the social and occupational functioning of individuals (Stien, Walker, & Forde, 1996).

Speech anxiety is a general term for the sense of fear or panic that overtakes a person when he or she is called upon to speak or otherwise perform in public. There are other ways to refer to it: anxiousness, nervousness, "the jitters", stage fright, fear of public speaking, performance anxiety, reticence, communication apprehension, etc. It usually strikes when someone has to deliver a presentation before a group of people. It makes little difference whether the audience is large or small, composed of familiar or unfamiliar faces. Psychologists consider speech anxiety to be a special case of what is commonly known as shyness.

Zimbardo (1977), the well-known cognitive psychologist has found that the root of speech anxiety is shyness. He has devoted decades to the study of the "shyness factor" as it affects people of different ages, backgrounds, businesses, and cultures. He found that shyness figures in everyone's life. Most people admitted to him that when under pressure they experience symptoms of anxiety: the jitters, sweaty palms, knocking knees, facial flushes, watery eyes, leathery tongue, dry mouth, wild heartbeats, shortness of breath, memory lapses, mental confusions, high anxiety levels …. (to limit the list to one dozen symptoms of chronic shyness). Zimbardo found that there are differences in the ways that shyness is handled by peoples of different countries and cultures. Such differences may account for variations in reporting the levels of shyness and presumably in experiencing high or low levels. For instance, people he interviewed in Japan admitted to experiencing a greater degree of shyness when meeting with strangers than did people he interviewed in Israel. But across the board he found that everyone owned up to some degree of shyneness, some people to an alarmingly high degree. Shyness is thus a characteristic of human nature brought about by our physiology, neurology, psychology, and social conditioning.

Some direct approaches that are cognitive and behavioural in nature have been found to be of use. Zimbarndo's insight into the dynamics of shyness is that shyness is a learned behaviour. The good news is that the distressing expressions of anxiety may be examined and modified. The bad news is that the mechanism that generates these expressions will always be present because they are essential parts of the physiological, neurological, and celebral systems – of the body, the emotions, and the brain. But they respond to "keying" or "cueing" and their expression, having been patterned, may be re-patterned.

Sigmund Freud (1900), the founder of psychoanalysis, placed great emphasis on the fact that we are born naked and helpless. From birth we experience panic and we express it in cries and in tears. As adults we may not express the panic directly by crying out loud or weeping in public, but we still feel this initial sense of dread when we have to "expose ourselves" before the eyes of others. Freud saw the level of anxiety to be a reversion to infantile behaviour.

Carl Jung (1921), the analytical psychologist, also expresses his view on human frailty and public speaking fears. He noted that human beings display the characteristics of archetypal figures, especially heroes of Ancient Greece. The warrior hero Achilles is one such figure. Achilles was invulnerable to his enemies except for one part of his anatomy: his "Achilles heel". Except for this tendon, he was invulnerable and impervious to the attacks of his enemies. Achilles resembles the 20th century comic-book character superman, the caped superhero who is all-powerful except in the presence of Kryptonite, rocks from his home planet Krypton. Each of us has an Achilles heel or fears Kryptonite. It is our zone of vulnerability. According to Jung, we assumed our enemies – our listeners – are aware of our secret weakness. They know we are vulnerable and hence we feel fear.

Alfred Adler (1923), the Austrian psychiatrist, made many contributions to individualistic and humanistic psychology. After examining the nature of neurosis, he popularized the concept of the "inferiority complex". It was Adler's view that, when we "present" ourselves before others, we stand. We project our talents and abilities, our information and knowledge, into other people. We empower them, but at the same time we disempower ourselves. We elevate them as we lower our sense of self. This projection leaves us feeling uneasy, uncanny, and vulnerable.

2.1.5 Types of Public speaking Anxiety

Researchers (McCroskey, 2001; Witt, Brown, Roberts, Weisel, Sawyer, & Behnke, 2006) have outlined the following types of Public speaking anxiety;

a. Trait Anxiety

Some people are just more disposed to communication apprehension than others. According to Witt, Brown, Roberts, Weisel, Sawyer, and Behnke (2006) "trait anxiety measures how people generally feel across situations and time periods." Somatic anxiety patterns before, during and after giving a public speech. This means that some

people feel more uncomfortable than the average person regardless of the context, audience, or situation. It doesn't matter whether he is raising his hand in a group discussion, talking with people he meets at a party, or giving speeches in a class, he is likely to be uncomfortable in all these settings if he experience trait anxiety. While trait anxiety is not the same as shyness, those with high trait anxiety are more likely to avoid exposure to public speaking situations, so their nervousness might be compounded by lack of experience or skill.. Somatic anxiety patterns before, during and after giving a public speech. People who experience trait anxiety may never like public speaking, but through preparation and practice, they can learn to give effective public speeches when they need to do so.

b. Audience Anxiety

For some individuals, it is not the communication context that prompts anxiety; it is the people in the audience they face. Audience anxiety describes communication apprehension prompted by specific audience characteristics. These characteristics include similarity, subordinate status, audience size, and familiarity. The individual may have no difficulty talking to an audience of his peers in student government meetings, but an audience composed of parents and students on a campus visit might make him nervous because of the presence of parents in the audience. The degree of perceived similarity between him and his audience can influence his level of speech anxiety. Every individual prefers to talk to an audience that he believes shares his values more than one that does not. The more dissimilar he is compared to his audience members, the more nervous he is likely to become. Studies have shown that subordinate status can also contribute to speaking anxiety (Witt, Brown, Roberts, Weisel, J., Sawyer, and Behnke, (2006). Talking in front of a boss or teacher may be intimidating, especially if one is being evaluated. The size of the audience can also play a role: the larger the audience, the more threatening it may seem. Finally, familiarity can be a factor. Some people rather prefer talking to strangers than to people they know well. Others feel more nervous in front of an audience of friends and family because there is more pressure to perform well.

c. Situational Anxiety

Situational anxiety, McCroskey explains, is the communication apprehension created by "the unique combination of influences generated by audience, time and context."(McCroskey, 2001). Each communication event involves several dimensions: physical, temporal, social-psychological, and cultural. These dimensions combine to create a unique communication situation that is different from any previous communication event. The situation created by a given audience, in a given time, and in a given context can coalesce into situational anxiety. For example, I once had to give a presentation at a general faculty meeting on general education assessment. To my surprise, I found myself particularly nervous about this speech. The audience was familiar to me but was relatively large compared to most classroom settings. I knew the audience well enough to know that my topic was controversial for some faculty members who resented the mandate for assessment coming from top administration.

d. Novelty

Additionally, most of us are not experienced in high-tension communication settings. The novelty of the communication context we encounter is another factor contributing to apprehension. Anxiety becomes more of an issue in communication environments that are new to us, even for those who are normally comfortable with speaking in public. Most people can learn through practice to cope with their anxiety prompted by formal, uncertain, and novel communication contexts. Fortunately, most public speaking classroom contexts are not adversarial. The opportunities one has to practice giving speeches reduce the novelty and uncertainty of the public speaking context, enabling most students to learn how to cope with anxiety prompted by the communication context.

e. Formality

Some individuals can be perfectly composed when talking at a meeting or in a small group; yet when faced with a more formal public speaking setting, they become intimidated and nervous. As the formality of the communication context increases, the stakes are raised, sometimes prompting more apprehension. Certain communication contexts, such as a press conference or a courtroom, can make even the most confident individuals nervous. One reason is that these communication

contexts presuppose an adversarial relationship between the speaker and some audience members.

f. Uncertainty and context

In addition, it is hard to predict and control the flow of information in such contexts, so the level of uncertainty is high. The feelings of context anxiety might be similar to those you experience on the first day of class with a new instructor: you don't know what to expect, so you are more nervous than you might be later in the semester when you know the instructor and the class routine better. Context anxiety refers to anxiety prompted by specific communication contexts. Some of the major context factors that can heighten this form of anxiety are formality, uncertainty, and novelty.

2.1.6 Theories of Public speaking anxiety

2.1.6.1 Psychological Theory

Research has identified four important psychological variables that predict a psychological vulnerability to anxiety. These are:

- Perceived control;
- Cognitive appraisals;
- Cognitive beliefs;
- Cognitive distortions.

Perceived control:

One of the world's leading experts on anxiety disorders Barlow, According to Barlow (2002), people may develop psychological vulnerabilities to anxiety as a result of early life experiences. One such vulnerability is the lack of "perceived control" over stressful life circumstances. Researchers have found the actual presence of stressors alone do create anxiety. Rather, anxiety is greatly determined by a person's perceived ability to control a potentially stressful event. It is important to realize that this lack of control may, or may not, be accurate. Instead, it is the person's perception about their degree of control that is important.

Childhood experiences can heavily influence someone's perceived sense of control. When children repeatedly experience a lack of control over the events in their lives, they may come to view the world as unpredictable and dangerous. This

worldview may lead to feelings of helplessness. As a result, they develop a tendency to expect negative outcomes, no matter how they may try to prevent them. Several types of early life experiences can later influence a person's perception of control. One of these is family dynamics, particularly parenting style. An overly protective parenting style can communicate the world is a dangerous place. Furthermore, this parenting style limits a child's opportunity to develop coping skills. Its opposite, an under-protective, low-care style, results in an unstructured, chaotic world filled with stress. Another early life experience affecting perception of control is the loss of, or separation from, primary caregivers. A third type of experience is ongoing trauma such as childhood abuse (physical, emotional, and/or sexual). This is not to say that our psychological trajectory is fixed in childhood and that nothing can be done to change it. Instead, it simply means that early experiences can contribute to a psychological vulnerability. It explains, in part, why some people are more prone to experience anxiety than others are. The perceived lack of control extends to a person's experience of their anxiety disorder. People with anxiety disorders often report they have no control over their symptoms. This lack of control is highly distressing to them. This may explain why the well-intentioned attempts of loved ones to offer reassurance, are often met with doubt by the person with an anxiety disorder.

Cognitive Appraisals

The term "cognitive appraisal" simply means the way we evaluate and assess a particular environmental event or situation. Cognitive appraisal is a key concept in understanding one's susceptibility to stress and anxiety. According to Lazarus and Folkman (1984), cognitive appraisal is made up of two separate types of beliefs. These beliefs are referred to as "primary" and "secondary" appraisals. Primary appraisal refers to an individual's subjective evaluation of a situation. An individual's primary appraisal determines whether the situation has any direct relevance to that person's well-being. Secondary appraisal refers to an individual's evaluation of their ability to cope with that situation.

Primary appraisal can be further broken down into three separate categories including "irrelevant," "benign-positive," and "stressful." An event is considered an irrelevant appraisal when its occurrence does not affect a person's well-being. For example, suppose one is interviewing for a job. The receptionist asks one to sit in a waiting room. One looks around the room and notices most people are sloppily

dressed, while one is meticulously groomed in preparation for this important day. One concludes that the other people must not be waiting for a job interview. One concludes that they must be in the waiting area for some other reason. This is an irrelevant appraisal. In other words, the other people in the waiting room do not affect one's well-being in any way.

A benign-positive appraisal refers to an instance where one's appraisal of an event leads to positive beliefs. These positive beliefs actually enhance positive feelings and/or functioning. Returning to our prior example, suppose one is interviewing for the same job. However, this time when one observes the other sloppily dressed people in the waiting room, one concludes that they are job candidates for the same job. Everyone is waiting for his interview. This appraisal might cause one to believe he has a significant advantage over the other job seekers. One's appraisal of this event would be considered benign positive if one thought to himself, "No problem, I've got this job!" and this extra confidence enabled him to perform well during the interview. In contrast, a stress appraisal refers to an instance where the occurrence of an event leads to beliefs that forecast harm. Such beliefs will lead to an experience of anxiety. For instance, imagine one is a job candidate again. However, this time when one looks around the waiting room, and compares his attire to the other candidates, one decides one is the one who is sloppily dressed. The other candidates appear neat and prepared.

This would be considered a stress appraisal if one believed that his sloppiness will likely hurt one's chances of getting the job. This appraisal may cause one to perform poorly during the interview, because one was highly anxious. From these three examples of a job interview situation, it becomes clear that one's primary appraisals about a circumstance will influence whether one experience anxiety.

Secondary appraisal refers to a person's appraisal of his ability to cope with the circumstance. This is partially determined by his perceived ability to control, or to influence, the situation. It is important to recognize that the protective effect afforded by perceived control does not require an accurate appraisal. It is merely the perception of control, even if that perception is illusory. To illustrate, let's consider a child who regularly experiences abuse. Abuse is certainly a childhood stressor. However, not all abused children develop anxiety disorders. Why might this be? It is possible, that one abused child might come to (falsely) believe that she can control, or prevent, the abuse by being a "good girl." This appraisal may serve to protect this child from anxiety as

it affords her the illusion that her actions can control the abuse. Thus, it may serve as a buffer against developing an anxiety disorder. In contrast, another abused child may appraise her ability to cope with the abuse differently. She might more accurately conclude there is nothing she can do to prevent the abuse. Ironically, while her perception about her lack of control is more accurate, it also puts her at greater risk for developing an anxiety disorder later in life.

Therefore, secondary appraisals include people's assessment of their coping skills and abilities (coping resources). In other words, do they have what it takes to successfully rise to the challenge, or to overcome the stressor? The accuracy of the appraisal does not matter.

As the examples above illustrate, a major cause of individual differences in reaction to stressors are the different ways people appraise a particular event (Lazarus and Folkman, 1984). Their cognitive appraisals will in turn affect whether or not they experience anxiety.

Cognitive Beliefs

So far, we have discussed two psychological variables that influence whether or not someone is likely to experience anxiety. These are perceived control and cognitive appraisals. However, these two variables are actually a reflection of a person's beliefs about themselves and the world around them. The relationship between a person's individual, unique beliefs about an event, and their responses to that event, is central to Rational Emotive Behavioural Therapy (REBT). This particular type of cognitive therapy was developed by Albert Ellis. According to Ellis (1997), the specific stressors in a person's environment do not directly cause their emotional reactions, or problematic behaviour. Instead, unhealthy responses are the result of a person's unique beliefs. These beliefs include not only beliefs about the event itself, but also beliefs about one's ability to cope with, and/or tolerate negative events. Interestingly, our beliefs about a particular situation, and our beliefs about our ability to cope with it, are not necessarily haphazard.

Instead, our understanding of a particular situation is often influenced by underlying attitudes and "core beliefs" about ourselves, and the world around us. Core beliefs refer to organizing principles we use to understand and interpret the events in our environment. According to Aaron T. Beck, the one of the principal founders of cognitive therapy, each of us form strongly held, core beliefs about ourselves, others,

and the world around us. Although these core beliefs fundamentally influence our appraisal of an event, we are often unaware of these beliefs. Therefore, we do not realize their impact on our everyday lives. Unfortunately, these core beliefs may not always represent an accurate portrayal of the situation at hand. These beliefs can cause us to experience undue emotional distress. Cognitive therapy seeks to bring these core beliefs in awareness, and to challenge the accuracy of those beliefs. For more information about cognitive theory and associated therapies please refer to that section.

Cognitive Distortions

Generally, our beliefs are usually not evaluated in terms of their objective validity. The common expression, "You're entitled to your beliefs" reflects this acceptance. However, some beliefs can lead to distorted thoughts. These thoughts in turn may lead to distressing emotions and maladaptive behaviour. According to Beck and Emery (1985), people are prone to make certain types of cognitive "errors" in their appraisals across various situations in their lives. This is particularly true for people with anxiety disorders. These thinking errors are often called cognitive distortions. There are many different types of cognitive distortions that may affect anxiety. However, two of the most common are:

1. The overestimation of threat; and,
2. The underestimation of one's ability to cope with the threat. The overestimation of threat commonly refers to the beliefs an individual holds about the perceived probability, of certainty, of an event's occurrence. This type of cognitive distortion is often called "fortune- telling" (e.g., "I will get lost when I am driving"). A related cognitive distortion refers to Catastrophic prediction, which is a heightened or exaggerated sense of perceived harm. It is also called "catastrophizing." "It will horrible if I get lost." "I will be in grave danger."

It is not hard to imagine that if someone already overestimates the danger of a situation, they are likely to underestimate their ability to cope with it. The cognitive distortion of overestimation of threat, often leads to a second distortion of underestimating one's ability to cope with it. "I will never be able to find my way home." "I will be helpless and I can't tolerate that." Unfortunately, this combination of cognitive distortions will most likely result in a disproportionate amount of anxiety relative to the actual situation. At the same time, these distortions increase the odds

of engaging in maladaptive behaviours (i.e., avoidance). The avoidance of challenging or stressful situations blocks the development of coping skills. For instance, if you avoid going to unfamiliar locations you cannot develop problem-solving skills such as asking for directions or using a map. Avoidance also prevents any opportunity to refute the distorted belief. Therefore, its effect is to strengthen cognitive distortions. For instance, suppose I believe I will always get lost. If I never go anywhere, I cannot refute this belief. By never traveling on my own, I will never have the opportunity not to get lost.

2.1.6.2 Sociological Theory

Biological and psychological vulnerabilities help to explain why some people are more likely than others to develop an anxiety disorder. Nonetheless, you may be wondering, how is it possible that different people come to fear different things? More specifically, what accounts for the different ways that people experience anxiety? For example, why do some people come to experience social situations as extremely frightening, while others may be unaffected by social situations, but are deathly afraid of bridges? Our early social experiences can account for some of these differences. Through the observation of others, a child might focus her anxiety on certain types of objects, and/or certain situations. These social influences represent a third type of vulnerability in the bio-psychosocial model. In fact, these social influences may account for the many different types of anxiety disorders.

A key concept in understanding the role of social experiences in the development of anxiety disorders is the social learning theory (SLT). According to Albert Bandura (1977), the principal founder of SLT, individuals learn new ways of thinking and/or behaving by observing how other people think and behave. Unlike the more traditional view of "behaviourism" that suggests people learn a behaviour because of direct experience. If behaviour is rewarded people learn to increase that behaviour. If behaviour is punished, people learn to discontinue that behaviour. In contrast to this behavioural learning theory, SLT proposes people can learn how to behave vicariously, without ever having direct experience with a particular situation themselves. Instead, individuals are able to learn how to respond to a particular situation simply by observing how others respond. This concept, that learning can take place without any direct experience, has important implications for the formation of

anxiety disorders. It helps to explain the many different ways that people experience anxiety.

According to SLT, people with anxiety disorders may have learned to be anxious through prior contact with other people. Other people may have communicated, via their actions or the information they provided, that certain situations or objects are dangerous and subsequently must be avoided at all costs. For instance, some people with Social Phobia were taught (directly or indirectly) that it was extremely important to receive the approval of other people. For example, a child may watch her parents getting ready for a visit from Grandma. During these preparations, she observes her parents becoming highly anxious. She overhears her parents arguing about the impending visit. Then, her usually friendly parents become very formal and stilted in front of Grandma. In addition, her parents have carefully instructed her about what she can, and cannot, say to grandma with the threat of punishment for any misbehaviour. Her observations before and during grandma's visit may cause this child to learn social interactions stressful. In her experience, social gatherings are not opportunities for rewarding and enjoyable experiences. Instead, social experiences represent potentially threatening and risky situations.

As a natural outcome of these learning experiences, a Social Phobia may develop. Similarly, some people with Panic Disorder may have learned at a young age that any unexplained bodily sensation signals a dangerous or dire illness. This can occur simply by observing the way family members behave. As you can see, the way early role models handled their own anxiety may directly, or indirectly, teach a child to respond in a similar manner. This will influence whether that child will subsequently experience his or her own anxiety. Therefore, through exposure to these early learning experiences, people may come to "mimic" the anxious behaviours of others. SLT suggests that this learning can take place simply through observation. Therefore, people may learn to avoid certain objects or situations without ever having any independent knowledge or experience. As such, they have no opportunity to form their own beliefs or opinions about the accuracy of the information they were provided. It is irrefutable. Therefore, the avoidance of objects or situations that are feared by caregivers is nearly guaranteed. Although a large portion of social learning stems from direct interaction with caregivers, social learning may also occur through the observation of other influential role models. These role models may include actors and actresses, musical artists, prominent business people, politicians, etc. This

influence may be exerted through a variety of mediums, such as television, movies, and videogames.

The social environment provides a guide for coping with anxiety. Additionally, the social environment is a key factor in the development of certain beliefs about oneself and one's abilities. Thus, the social environment influences our cognitive appraisals. This heightens the key role that social influences have in the development of an anxiety disorder. Likewise, the social environment can greatly influence whether or not individuals believe they are capable of recovery in the here-and-now, regardless of their past experiences. Indeed, in CBT treatment for anxiety disorders, the therapist becomes an important, new role model in the therapy participant's social environment. The therapist expresses confidence in the participant's abilities. The therapist models helpful or adaptive behaviours. The therapists also support the participant's efforts to apply these new behaviours in their daily life. Thus, while social learning may contribute to the development of an anxiety disorder, it also facilitates recovery from an anxiety disorder.

2.1.6.3 Behavioural Theory

Behavioural learning theory concerns itself with the way behaviours are learned, and subsequently "unlearned." Since the word "learning" is often used throughout this article, it is important to understand what psychologists mean by this term. According to behavioural psychologists, "learning" is indicated by a relatively permanent change in behaviour or knowledge, as a result of a "learning" experience. Thus, "learning" is not limited to the most common usage of the word referencing academic learning (school). In psychological terms, learning can occur without any intention to learn, and without a conscious awareness that something has been learned. Any change in behaviour suggests the person has learned a new response to a particular situation. The term will become clearer as we examine the two primary ways that organisms learn: classical conditioning and operant conditioning.

According to classical learning theory, anxiety disorders may be learned via paired association. A scientist in the 1920's, named John B. Watson (2000), demonstrated this with his famous "Little Albert" experiment. Watson demonstrated that humans can learn to be afraid of neutral objects through the process of classical conditioning. Watson and his assistant, Rosalie Rayner, presented Little Albert (an 11-month-old baby) with a white rat. Initially, Albert was not afraid of the rat. In fact,

he reached out to touch it. Then they struck a steel bar right behind Albert every time they presented him with the rat. The loud noise frightened Albert and he began to cry. A week later, they presented Albert the rat alone, and he attempted to stay away from it. Watson and Rayner later demonstrated that Albert also reacted the same way to similar, white, furry objects (a fur coat, a rabbit, and a Santa Claus mask). Thus, the fear had generalized to other similar objects. It is important to bear in mind these experiments were conducted in the 1920s. It is quite unlikely they would be permitted by today's standards of ethical research.

Classical conditioning provides important insight into the process by which humans may develop a fearful response to previously neutral objects and neutral situations. Classical conditioning also demonstrates how the fear response generalizes to similar and related stimuli. Imagine a child walks by a Golden Retriever dog at a park who barks loudly at her. As a result, she becomes fearful of not only Golden Retrievers, but also all dogs (similar stimuli), parks with dogs in it (related stimuli), as well as large brown furry animals (similar and related stimuli). This is the process of "generalization.

"B.F. Skinner was one of the most prominent psychologists of the last century. He is credited with the discovery of operant conditioning. Skinner attended Harvard University. His goal was to study animal behaviour in a scientific manner. He conducted many famous experiments during his lifetime. These experiments demonstrated that behaviour was influenced not only by what occurred before it (as in classical conditioning, but also by what occurred afterward. Skinner ( ) believed that human beings (and animals) learn behaviour through a system of rewards and punishments. These rewards and punishment occur naturally in the external environment. When psychologists use the word "environment," they are referring to all the external events that are going on around a person. Thus, my boss smiling at me is an external event and part of my environment. In contrast, my thoughts and ideas about my boss smiling at me are internal events. These internal thoughts, called cognitions, are not considered part of my environment. It was not until much later that it was discovered these cognitions also influence behaviour.

This subsequent recognition resulted in the inclusion of the "cognitive" portion of the cognitive-behavioural theory. Skinner's focus on behaviour and the environment was quite unique at the time. Skinner demonstrated that by manipulating the rewards and punishments in the environment, behaviour can be learned (and

unlearned). In behavioural terms, reinforcement (reward) refers to anything that causes behaviour to increase. In contrast, a punishment is something that causes behaviour to decrease. If the environment rewards a behaviour, that behaviour is reinforced. This increases the likelihood that a person will repeat the same behaviour in the future.

Conversely, if the environment punishes a particular behaviour, this decreases the likelihood the behaviour will be repeated. To illustrate, let's imagine you smile every time you pass by your boss at work. Your boss responds by smiling back at you, and greets you with a warm and hearty, "Hello!" This interaction leads to pleasant emotions. These pleasant emotions serve as an environmental reward. Since the response from your boss was rewarding by producing pleasant emotions, it was positively reinforcing. Therefore, it is likely that you will continue to smile at her each morning because smiling was reinforced by your environment.

Skinner's work resulted in many practical applications. These applications ranged from teaching effective parenting skills to improving employee productivity and satisfaction in the workplace. Because of Skinner and other influential researchers of his era, today's cognitive-behavioural psychologists have systematic methods available to help people change problematic behaviours. This is accomplished by evaluating and altering the environmental influences that reward or punish a person's behaviour. Let's use an example to illustrate these concepts. Suppose a family wants their child's temper tantrums to stop. So, they ask a behavioural psychologist to help them. First, the psychologist will observe the child and his family in their natural environment. This is often called a behavioural evaluation. The purpose of the behavioural evaluation is to identify, and to understand, the environmental factors that may be reinforcing the tantrum. The evaluation will record when, where, and with whom, the tantrum occurred. In other words, the evaluation assesses the circumstances in which the tantrum occurred. These are considered the antecedents to the tantrum.

Antecedents are the things that happened before the tantrum occurred. For example, do the tantrums occur more frequently in the evenings, when the mother is busy cooking dinner, and unable to give the child her undivided attention?

The behavioural evaluation will also record of the consequences of the tantrum to identify the environmental factors that may be reinforcing the tantrum. The consequences are the things that happened after the tantrum. When the child begins

to cry, does the mother stop her dinner preparation, and give the child her attention, thereby unwittingly rewarding the tantrum? After identifying all of these important environmental variables, the psychologist would coach the parents to alter the environment so as not to reward the tantrum. This might involve asking the family to simply ignore the tantrum whenever it occurs. This would serve to stop rewarding the tantrum. Likewise, they may be encouraged to reward the child when the tantrum stops. The psychologist may also coach them to provide the child attention for positive behaviour during meal preparation. Perhaps finding the child could be included in the meal preparation in some small way. When the tantrum is no longer reinforced by the mother's attention, it will gradually fade away. In behavioural terms, this is called extinction.

2.1.6.4 Alexander Astin's Involvement Theory

In the 1980s, and now the 1990s, a greater number of student affairs theorists have begun to bridge a perceived gap between theory and practice. One such theorist is Alexander Astin. Astin's acceptance and popularity is in part a result of the relevance his research and writing has to issues of student retention. Since the latter half of the 1970's, when a shrinking national pool of college students left many colleges scrambling to fill seats in their lecture halls, the issue of how to keep matriculated students, not just recruit them, has left administrators hungry for literature such as Astin's (Hossler, 1990). Astin's (1985a) work has filled a need – a need for theory which is practical. Kurt Lewin said, "There is nothing as practical as a good theory" (Rogers, 1991). Why is there a need for practical theory? Student affairs professionals are uniquely equipped to handle the primary concerns that faculty and college presidents struggle with today – diversity of race, orientation, and age; academic transition; and the expansive growth of the university. Theories that assist practitioners in meeting these challenges will bring cohesive definition to the profession.

Astin's Involvement Theory (1985b) has heightened the discussion of practical issues, such as faculty-student interaction. In a preliminary summary of a national survey conducted jointly by the American College Testing Program and the National Center for Higher Education Management Systems, Beal and Noel (1979) reported that two of the most significant positive characteristics influencing retention are: a caring attitude of faculty and staff, and a high level of student involvement. More

recently, Vincent Tinto (1993) claimed that institutions with low retention rates report low levels of faculty-student interaction, while conversely, colleges with high retention rates report high levels c of interaction. In What Matters in College?, Astin (1993) states that one of the primary factors in retention (degree attainment) is student involvement with peers and with faculty. Since Involvement Theory explains the real value of faculty-student interaction, it is important to understand the principles foundational to Astin's theory. Alexander Astin (1985a), currently a Professor of Higher Education and the Director of the Higher Education Research Institute at University of California, Los Angeles, says that "student involvement refers to the amount of physical and psychological energy that the student devotes to the academic experience". The theory is comprised of the following five basic postulates.

1. Involvement refers to the investment of physical and psychological energy in various "objects". The objects may be highly generalized (the student experience) or highly specific (preparing for a chemistry examination).
2. Regardless of its object, involvement occurs along a continuum. Different students manifest different degrees of involvement in a given object, and the same student manifests different degrees of involvement in different objects at different times.
3. Involvement has both quantitative and qualitative features. The extent of a student's involvement in academic work can be measured quantitatively (how many hours the student spends studying) and qualitatively (does the student review and comprehend reading assignments, or does the student simply stare at the textbook and daydream).
4. The amount of student learning and personal development associated with any educational program is directly proportional to the quality and quantity of student involvement in that program.
5. The effectiveness of any educational policy or practice is directly related to the capacity of that policy or practice to increase student involvement.

At the core of Involvement Theory (1985a) is a challenge to the system, the institution's "business as usual" mentality. It challenges the very notion of "academic excellence" as it has been traditionally defined by academe. Rather than judging educational excellence on the basis of institutional reputation and resources, high quality institutions should be judged according to the degree to which they "maximize the intellectual and personal development of students" (Astin, 1985b). Involvement

Theory (1985a) focuses less on what the educator does and more on what the student does – leading the student to be an active participant in the process of learning Student expenditure of physical and psychological energy should be encouraged both inside and outside the classroom. The learning process is a matter of importance to both college faculty and students, therefore, institutions must provide the means and incentive for faculty and students to engage in meaningful relationships.

Due to the increase in the number of students attending college and the predominant role that research plays at large universities, more institutions of higher learning struggle to maintain a high level of faculty-student interaction. The emergence of the multiuniversity, or comprehensive university, does present a challenge to the idea of this type of interaction. The 1960s and 1970s were a tumultuous time of change for American colleges and universities. Some of the student unrest during this time can be attributed to the emergence of the multiuniversity and the accompanying communication challenges, as well as the increasing non-classroom contact between faculty and students (Pascarella, 1980).

With the 1980s, came a new emphasis on the importance of student involvement in the learning process. In part, this was probably a reaction to the growing sense of alienation by many college students. An increasing majority of students were matriculating into the growth industry of higher education – the multiuniversity. Involvement Theory (1985a) was a manifestation of the recognition by educators that academic failure is not always the result of a lack of skills but in many cases due to the devastation students can feel from social isolation (Tinto, 1993). It has been mentioned that Astin's Involvement Theory (1985a) addresses the need to redefine "academic excellence". Astin (1985b) suggests that an alternative to the traditional definition is to think of academic excellence in terms of talent development. Is the institution committed to developing the student to her/his full potential? Astin (1985b) makes it clear that talent development should be the primary purpose of higher education:

The talent development view of excellence emphasizes the educational impact of the institution on its students and faculty members. Its basic premise is that true excellence lies in the institution's ability to affect its students and faculty favorably, to enhance their intellectual and scholarly development, and to make a positive difference in their lives..

Talent development is contingent upon involvement by the student. The student who is involved in the academic life of the institution is more likely to expend the effort to be successful academically than the uninvolved student (Astin, 1975). Talent development is contingent upon more than individual student effort. It requires faculty commitment to interaction with the student. Faculty members who encourage students to be active learners in the classroom also are encouraging students to seek informal contact with them outside of class.

Conversely, students who feel alienated from the learning process are unlikely to seek contact with faculty outside of the classroom (Tinto, 1993). The attitude or openness of faculty to informal contact sends a powerful message to the student. The consequence of student-faculty interaction is critical. Student involvement with faculty has a direct positive relationship to learning, academic performance, and degree attainment (Astin, 1993). Wide-ranging contact with faculty members contributes to student intellectual and social growth. This is true of all students regardless of differences in ability, prior levels of development, and prior educational experience (Pascarella, 1980). Talent development is encouraging and challenging each individual student, regardless of the level of development, to fulfill their potential. This will not be accomplished without faculty who are committed to facilitating the development.

Student-faculty interaction inside the classroom has an inseparable correlation to interaction outside the classroom. Both are important, and one generally does not happen without the other. A variety of factors influence the level of student-faculty interaction. Individual student differences, institutional faculty culture, the degree of peer-culture involvement, and institutional size all have an impact (Pascarella, 1980). Administrators must recognize and identify how these factors affect student-faculty interaction. As a result, institutional administrators will be better equipped to respond appropriately.

2.1.6.5 Trait Theories of Personality

Among the various major theories of personality, trait theories are the primary ones labeled specifically in terms of a dependent variable – traits. Traits are enduring, stable attributes or characteristics of a person. If our behaviour changes, does this mean one of our traits has changed, or has our environment influenced our behaviour? Trait theorists are still arguing about this point. William Sheldon (1899 –

1977), an American medical doctor, first offered in the early 1940s one of the most interesting modern views of such a theory of personality. Sheldon identified three different general forms of human physique, or somatotypes. According to Sheldon each of us could be rated on a 7-point scale as to the amount of each form represented in our body. Thus, a pure endomorph would be described as a 7 – 1 -1. In addition, Sheldon also suggested that there is a close relation between measures of our physique taken from somatotype photographs and our personal temperament (measured by observer ratings). This is, in fact, the single, essential assumption of Sheldon's theory – that continuity, or a high correlation, exists between physique and behaviour. The basic idea in traits theory is that, human behaviour is traced to the joint effects of the organism's inherited capabilities and past experience.

2.1.7 Assertiveness and Public Speaking Anxiety

Assertiveness is the ability to honestly express one's opinions, feelings, attitudes, and rights without undue anxiety, in a way that doesn't infringe on the rights of others. Assertiveness is important because if one does not know how to be assertive, one might experience depression, resentment, frustration and temper/violence. Most people find it easier to be assertive in some situations than in others. This makes perfect sense. It's a lot easier to hold one's ground with a stranger than with someone one loves who might get angry if one expresses one's true feelings. But the more important the relationship is to you, the more important it is to be assertive. Assertive behaviours lead to increased respect from others, their willingness to see you as a person who respects him/herself, a worthwhile person, and a more loveable person. O'Donohue (2003) stated that assertive people have the following characteristics:

- They feel free to express their feelings, thoughts, and desires.
- They are also able to initiate and maintain comfortable relationships with other people.
- They know their rights.
- They have control over their anger.
- This does not mean that they repress this feeling, it means that they control anger and talk about it in a reasoning manner.
    - According to Lloyd (2001), assertive behavioural includes:
- Starting, changing, or ending conversations

- Sharing feelings, opinions, and experiences with others
- Making requests and asking for favours
- Refusing others' requests if they are too demanding
- Questioning rules or traditions that don't make sense or don't seem fair.
- Addressing problems or things that bother you
- Being firm so that your rights are respected
- Expressing positive emotions
- Expressing negative emotions.

Assertive communicators are able to clearly and openly express their needs, wants, feelings and opinions in a manner which is respectful to themselves and others (Morrissey &Callaghan, 2011). Assertive individuals are able to make requests without belittling, abusing or dominating other people (Bolton, 1986; Dale: Carnegie Training, 2009). Learning to be an assertive communicator can be challenging and requires the skills to express one's thoughts and opinions in a self-confident, positive, respectful manner (Kolb & Stevens Griffith, 2009; Sundel & Sundel, 1980). Assertive behavioural falls within the centre of a spectrum ranging from passivity at one end to aggression at the other (Hasan, 2008).

Under-assertive	**Assertive**	**Over-assertive**
Passive	active	aggressive
Submissive	direct	hostile
Meek	self-confident	

Adapted from: (Sundel & Sundel, 1980)

Figure 1: The spectrum of assertive behavioural

Under-assertive individuals are often described as meek, passive, or easily manipulated and identified from nonverbal indicators such as a lack of eye contact, excessively soft voice and hesitating speech (Bolton, 1986; Sundel & Sundel, 1980). Passive individuals will go to almost any length to avoid conflict, often believing they are inferior to others (Hasan, 2008). Morrissey and Callaghan (2011) identify the following characteristics in under-assertive individuals:

- Allowing one-self to be treated with little respect, i.e., being a 'doormat';
- Comparing oneself constantly to others;
- Struggling to identify or state needs and wants;
- Finding it difficult to make decisions;
- Fear of upsetting others and apologising excessively;
- Avoiding confrontation, e.g. saying 'yes' when really they want to say 'no';
- Using self put-downs;
- Dismissing self-worth and their value as a person; and
- Using long rambling sentences that lack focus and avoid the use of 'I(Morrissey & Callaghan, 2011, p. 110).Non-assertive behavioural is often encouraged from an early age with children being praised for acts of caring and selflessness and being encouraged to behave 'nicely', that is, being quiet and obedient (Bolton. 1986).Over-assertive individuals are often perceived as aggressive, hostile, arrogant, coercive, overbearing and intimidating (Sundel & Sundel, 1980). They typically communicate in a loud, abusive or sarcastic manner expressing their own thoughts and feelings at the expense of others (Bolton, 1986). Often, over-assertive individuals are disliked and feared in the workplace (Bolton, 1986; Sundel & Sundel, 1980). Morrissey and Callaghan (2011) outline the following characteristics of over-assertive individuals:

Find it difficult to acknowledge mistakes and blame others;

Use verbal attacks or sarcasm, employing threatening tones and body language which may include finger wagging and a raised voice;

Do not invite others to share their views;

Take over from others and make decisions with minimal consultation;

Use put-downs; and

Give heavy-handed advice (Morrissey & Callaghan. 2011. p. 111).

Few individuals are assertive all of the time but the skills of assertive behaviour are important to develop so they can be utilized in appropriate situations (Morrissey &Callaghan. 2011: Sundel & Sundel, 1980). Individuals should reflect upon the risks and benefits of being assertive as there will be times when assertive behaviour may not be the most appropriate course of action, such as in situations that may result in the potential for injury to themselves or others (DeVito, 2011; Morrissey & Callaghan, 2011).

Assertiveness also has a cultural component whereby individualist cultures that value competition, individual success and independence place a higher worth on assertive behaviour than do collectivist cultures that value cooperation, harmony and group achievement (DeVito, 2011; Morrissey & Callaghan, 2011). Therefore perceptions of assertive behaviour will be mediated by an individual's cultural background. As such, it is important for individuals to gain an understanding of the different cultural customs and rules that may impact on individuals' interpretations and understandings of assertive communication and behaviour (Sundel & Sundel, 1980). In addition, assertiveness can be influenced by gender, age, confidence; life experience and education background (Morrissey & Callaghan, 2011).

Assertiveness is a skill that can be developed and involves making changes to one's thoughts and beliefs as well as behavioural (Grey & Moffett. 2011: Morrissey & Callaghan, 2011). It involves developing self-confidence and valuing one's own worth as a human being (Morrissey & Callaghan, 2011). This is a process which takes time and making even small changes can result in benefits (Sudha, 2005). Balzer-Riley (2012) has identified the following advantages from developing assertiveness:

- Being more likely to get what you want by asking for it clearly
- People respect clear, open, honest communication
- Standing up for your own rights and feel self-respect
- You avoid the invitation of aggression when the rights of others are violated
- You are more independent
- You become a decision-maker
- You feel more peaceful and comfortable with yourself (Balzar-Riley. 2012, p. 9).

Other benefits that have been identified induce being more effective in influencing one's environment; improved self-worth and confidence; decreased levels of anxiety and tension and associated health problems (headaches, stomach upsets, skin

rashes); increased job satisfaction and professional opportunities; and making a better impression on others.

2.1.8 Gender and Public speaking Anxiety

Gender is a term used as a categorical division of human into male and female (Siahaan, 2008: 160). West and Zimmerman (1987), stated (in Eckert 2003: 10) that gender is not something we are born with, and not something we have, but something we do. Gender as a term differs from 'sex' in being about socially expected characteristics rather than biology (Goddard and Patterson, 2000: 1). Eckert and McConnell-Ginet (2003), stated that it is commonly argued that biological differences between males and females determined gender by causing enduring differences in capabilities and dispositions. However, Siahaan (2008) also said that this term has nothing to do with the division on the competence and performance quality on the language forms and uses between men and women. Because, either women or men enter the same process of some stages in acquiring a language even though, sometimes women and men use a different style of language while say about the same thing.

The different style of language between men and women is very interesting to study. As Rochefort issued (in Jespersen 1922p. 237) that women had another language, which is different from the man language, and men have a great many expressions peculiar to them, which women understand but never produce themselves. For example, according to Jespersen, swearing is among the things women object to in language; where a man will say "He told an infernal lie," a woman will rather say, He told a most dreadful fib". This situation then creates a misconception that stipulating the opinions of lots of people to the analysis of the relation between language and gender.

Janet Holmes (1994: p. 1) noted that women and men have different ways of talking and hence, of realizing and interpreting speech acts. She points out that women and men use language in a different way because they have different perceptions of what language is for. Whereas men use language as a tool to give and obtain information (referential function of language), women see language as a means of keeping in touch (affective or social function).

2.1.9 Cognitive Behavioural Therapy

Cognitive Behavioural Therapy (CBT) is a psychotherapeutic approach that addresses dysfunctional emotions, behaviours, and cognitions through a goal-oriented, systematic process. The name refers to behavioural therapy, cognitive therapy, and to therapy based upon a combination of basic behavioural and cognitive research. CBT is effective for the treatment of a variety of conditions, including mood, anxiety, personality, eating, substance abuse, tic, and psychotic disorders. Many CBT treatment programs for specific disorders have been evaluated for efficacy; the health-care trend of evidence-based treatment, where specific treatments for symptom-based diagnoses are recommended, has favored CBT over other approaches such as psychodynamic treatments.

CBT was primarily developed through an integration of behavioural therapy (first popularized by Edward Thorndike) with cognitive therapy (developed by Aaron Beck and Albert Ellis). While rooted in rather different theories, these two traditions found common ground in focusing on the "here and now", and on alleviating symptoms. The premise of cognitive behavioural therapy is that changing maladaptive thinking leads to change in affect and in behaviour. Therapists or computer-based programs use CBT techniques to help individuals challenge their patterns and beliefs and replace "errors in thinking such as over-generalizing, magnifying negatives, minimizing positives and catastrophizing" with "more realistic and effective thoughts, thus decreasing emotional distress and self-defeating behaviour". CBT helps individuals replace "maladaptive thinking, coping skills, cognitions, emotions and behaviours with more adaptive ones' by challenging an individual's way of thinking and the way that he/she reacts to certain habits or behaviour.

According to Gathcel et al. (2008), CBT has six phases:

1. Assessment
2. Reconceptualization
3. Skills acquisition
4. Skills consolidation and application training
5. Generalization and maintenance
6. Post-treatment assessment follow-up

The reconceptualization phase makes up much of the "cognitive" portion of CBT.

There are different protocols for delivering cognitive behavioural therapy, with important similarities among them. Use of the term CBT may refer to different interventions, including "self-instructions (e.g. distraction, imagery, motivational self-talk), relaxation and/or biofeedback, development of adaptive coping strategies (e.g. minimizing negative or self-defeating thoughts), changing maladaptive beliefs about pain, and goal settings". Treatment is sometimes manualized, with brief, direct, and time-limited treatments for individual psychological disorders that are specific technique-driven. CBT is used in both individual and group settings, and the techniques are often adapted for self-help applications. Some clinicians and researchers are cognitively oriented (e.g. cognitive restructuring), while others are more behavioural oriented (e.g. in vivo exposure therapy). Interventions such as imaginal exposure therapy combine both approaches.

Cognitive behavioural therapy is most closely allied with the scientist-practitioner model, in which clinical practice and research is informed by a scientific perspective, clear operationalization of the problem, and an emphasis on measurement, including measuring changes in cognition and behaviour and in the attainment of goals. These are often met through "homework" assignments in which the patient and the therapist work together to craft an assignment to complete before the next session. The completion of these assignments – which can be as a person suffering from depression attending some kind of social event – indicates a dedication to treatment compliance and a desire to change. The therapists can then logically gauge the next step of treatment based on how thoroughly the patient completes the assignment. Effective cognitive behavioural therapy is dependent on a therapeutic alliance between the healthcare practitioner and the person seeking assistance. Unlike many other forms of psychotherapy, the patient is very involved in CBT. For example, an anxious patient may be asked to talk to a stranger as a home-work assignment, but if that is too difficult, he or she can work out an easier assignment first. The therapist needs to be flexible and willing to listen to the patient rather than acting as an authority figure.

Cognitive Behavioural Group Therapy (CBGT) has three primary components: in-session exposure to feared social situations, cognitive restructuring, and homework assignments for in vivo exposure and self-administered cognitive restructuring. In-session exposures form the hub of the protocol, with the cognitive interventions occurring before, during, and after each exposure. After the first few

sessions, homework typically follows from the situation targeted during the in-session exposure. As in the session, clients are asked to engage in cognitive restructuring activities before, during, and after each assigned in Vivo exposure. Exposure to feared situations serves to disrupt the cycle of social anxiety in several ways (Hope et al., 2000). First, it short-circuits avoidance of anxiety-provoking social situations and allows the client to experience the natural reduction in anxiety that comes with staying in the situation long enough on repeated occasions (i.e., habituation). Second, exposure allows the client to practice behavioural skills in situations that may have been long avoided (e.g., asking someone for a date, being assertive). Third, exposure gives the client the opportunity to test the reality of his or her dysfunctional beliefs (e.g., "I won't be able to think of anything to say if I join my coworkers for lunch").

Cognitive restructuring also plays an important role in breaking -the cycle of social anxiety (Hope et al., 2000). Cognitive restructuring provides a direct challenge to clients' beliefs, assumptions, and expectations. Clients are asked to evaluate whether these cognitions really make sense or are helpful and to entertain more realistic and adaptive ways of viewing feared situations. These techniques should supplement and support changes in cognition that follow from exposure to feared situations and increase the probability that clients' negative thinking will not override a successful exposure experience. As the client's assessment of the danger inherent in social situations becomes more realistic, physiological symptoms of anxiety often diminish as well. Furthermore, addressing the client's cognitions often frees up additional attentional resources and allows the client to increase focus on the social task and potentially improve performance. Changing dysfunctional beliefs also helps decrease anticipatory anxiety and avoidance and increases the client's ability to take credit for successes, which, in turn, gives the client the opportunity to experience the naturally occurring positive reinforcement available from other people. Lastly, cognitive restructuring teaches clients to think adaptively about their experiences after they have transpired rather than to enter into a cycle of rumination that might otherwise turn victory into defeat.

In-session exposures allow this process to begin in a protected environment, under the observation and control of the therapists. In this less threatening setting, clients can approach feared situations that are provided at the proper intensity. In-session exposures also provide clients an opportunity to practice their cognitive

restructuring skills and experience success in an approximation of the real situation before they tackle it as part of a homework assignment. Of course, exposure to the feared situation in homework assignments facilitates the transfer of learning to where it matters most, the client's life outside the therapy session. The ultimate goal of homework assignments, and of CBGT as a total package, is for the client to become his or her own cognitive-behavioural therapist, equipped to adaptively confront anxiety-provoking situations in the present and into the future.

Thus CBGT combines in-session exposure, cognitive restructuring, and homework assignments to help clients overcome their anxiety and get more satisfaction in their transactions with themselves and others. The underlying assumption of cognitive – behavioural treatment is that anxiety disorders are maintained by faulty threat appraisals. Cognitive theories of social phobia implicate the tendency to overpredict both the likelihood and the negative valence of negative evaluation. In addition to behavioural techniques such as exposure, contemporary cognitive behavioural treatments for social phobia include specific cognitive technique to alter these maladaptive beliefs (Heimberg, Juster, Hope, and Mattia, 1995).

In cognitive restructuring, patients are first taught to identify their specific threat appraisals, including both estimates of the likelihood and the negative valence associated with the threat. Next, patients are taught to evaluate the accuracy of these beliefs using evidence provided by Socratic questioning, past experiences, and exposure exercises. Lastly, patients are taught to replace their beliefs based on the evidence illuminated in the previous step. As Heimberg (2001) pointed out, the focus of exposure exercises during cognitive restructuring is different from traditional exposure techniques in that they are designed to provide evidence that is inconsistent with threat forecast. In order to facilitate this process, patients are encouraged to fade maladaptive defensive behaviours such as rehearsing sentences in mind before giving a speech, and walking close to walls to manage the fear of tripping. It is thought that fading these safety behaviours enhance their threat disconfirmation process as the individual discontinues to erroneously attribute safety (failure to be harmed) to their safety behaviour (Salkovskis, 1991).

Behavioural Therapy and Cognitive Behavioural therapy are types of treatment that are based firmly on research findings. These approaches aid people in achieving specific changes or goals.

Changes or Goals might involve:

- A way of acting – like smoking less or being more outgoing
- A way of feeling – like helping a person be less cared, less depressed or less anxious.
- A way of dealing with physical or medical problems – like lessening back pain or helping a person stick to a doctor's suggestions; or
- A way of adjusting – like training developmentally disabled people to care for themselves or hold a job.

Behavioural Therapists and Cognitive behavioural therapists usually focus more on the current situation and its solution, rather than the past. They concentrate on a person's views and beliefs about their life, not on personality traits. Behavioural Therapists and Cognitive Behavioural Therapists treat individuals, parents, children, couples, and families. Replacing ways of living that do not work well, with ways of living that work, and giving people more control over their lives are common goals of behavioural and cognitive behavioural therapy. Public Speaking Anxiety (PSA), also known as "stage fright," is viewed as a subset of Communication Anxiety/Apprehension (CA), and PSA/CA can be so severe that it qualifies as a social phobia. McCroskey (1977) defines CA as "an individual's level of fear or anxiety associated with real or anticipated communication with another person or persons" (p. 78). Bourne (2003) defines PSA as "an exaggerated fear of embarrassment or humiliation in situations where you are exposed to the scrutiny of others or must perform" (p.5). This student is particularly concerned with how a basic speech class can help students overcome CA/PSA.

A survey of the literature indicates the following:

(1.) Public Speaking Apprehension/Anxiety [PSA] is experienced by virtually all students.

(2.) No one strategy is more effective than any other, although negative belief systems are the strongest predictor of PSA.

(3.) Most colleges and universities are not financially or practically able to offer students separate courses to manage their Communication Anxiety.

Teachers of public speaking are well aware of the challenge presented by their students' PSA, which ranges from mild anxiety to extreme apprehension provoked by the

prospect of giving a speech. Teachers of fundamental public speaking courses also find particular significance in Bourne's inclusion in his definition of PSA the notation that it is “often accompanied by partial or total avoidance of the situation" (p. 5). However, students cannot always avoid a public speaking course. Because the ability to communicate effectively is essential to personal, academic, and professional success, a fundamental public speaking course is often a requirement in the college curriculum. In a national survey of fundamentals of public speaking courses, Robinson's observation (1997) still holds: the most common pedagogical method for treating CA/PSA in the classroom "is to rely on the textbook...but most of the information given in the textbooks is 'folk wisdom' or information that is rather common...[and] limited." (pp. 189-190).

Before relatively recent advances in neurophysiology and neuropsychology that link biological predisposition and CA/PSA, "stage fright" was thought to be the result of social learning processes. The new “communibiological" perspective drew on previous works in personality theory, and connected psychological processes that depend on brain activity to traits of temperament such as CA and PSA. Various studies linked CA and PSA to inherited personality traits, such as temperament and intelligence. Other theories linked CA and PSA to a different physiological model, a system of behavioural inhibition (BIS) and behavioural activation (BAS), in which new stimuli and the perceived threat of punishment - such provoked by a public speaking situation - activate BIS, which is perceived by the person as anxiety. Those individuals with an inherited lower threshold for BIS stimulation experience greater CA/PSA. Other studies correlated different biologically-based psychological types, as described by psychoanalyst Carl Gunther Jung or the mother-daughter team .Meyers-Briggs - to an individual's predisposition to experience anxiety when communicating.

Of course, if CA and PSA are physiological, inherited traits, the question is why treat a trait that is dictated by genetics? That question has led to further studies to examine whether or not strategies for overcoming CA/PSA can be effective despite any biological causes. Many researchers have found that these strategies can be effective, because of the following:

(1) Environment still plays a role in communication anxiety.

(2) When dealing with an individual's communication anxiety, it is impossible to determine the relative influence of genetics and environment.

(3) Even physiologically-based anxiety is provoked by perceived threat of punishment (as a blow to self-esteem).

Most researchers agree that certain strategies - Systematic Desensitization (SD), Cognitive Therapies, and Skills Training (ST) - constitute the treatment of choice for CA and PSA. However, studies attempting to pinpoint which strategies work for one person and not another have been inconclusive. For this reason, most studies conclude that a "multidimensional" model is the most effective approach, particularly in a group, classroom setting.

2.1.10 The Lefkoe Treatment

The Lefkoe Method (TLM) is a therapeutic approach developed to help people overcome or deal with such fears as public speaking. The aim of the Lefkoe methods is to eliminate, quickly, long-held beliefs and "de-condition" the stimuli that produce fear and other negative emotions, e.g. the fear of speaking in public. Lefkoe has discovered that the fear of public speaking is typically caused by (a) specific beliefs, such as "mistakes and failure are bad" and 'if I make a mistake, I'll be rejected' and (b) conditioning, such as automatically experiencing fear whenever one is, or perceives oneself to be, in a position to be criticized or judged. Two processes in TLM, the Lefkoe belief .Process and the Lefkoe stimulus process, are used to address fear of public speaking.

Many, if not most, psychologists contend that long-held beliefs can be totally eliminated, if at all, only after extensive time, effort, and specific retraining. TLM challenges that assumption and contends that even beliefs formed early in childhood can be permanently eliminated in a matter of minutes. The basis for this claim is thousands of clients who state that a belief that was experienced as true is no longer experienced as true from the belief are permanently eliminated. Moreover, TLM contends that emotions that result from conditioned stimuli, for example, fear that is always experienced when one makes a mistake or is rejected, can be quickly and permanently stopped by de-conditioning the stimuli. This also can be accomplished in a matter of minutes. Those are bold claims, but they can be empirically tested.

The Lefkoe Stimulus Process facilitates de-conditioning the stimuli for negative emotions, which has nothing to do with beliefs. In order to get rid of the fear of public speaking, one has to extinguish the conditioned stimuli that have

become associated with fear, such as facing criticism, feeling that one is not meeting expectations, that one is being judged, or that one is being rejected. The point of this process is to assist the person to realize that initially the current stimulus never produced the emotion. The current stimulus got conditioned to produce the negative emotion because it just happened to be associated with the real original cause in some way.

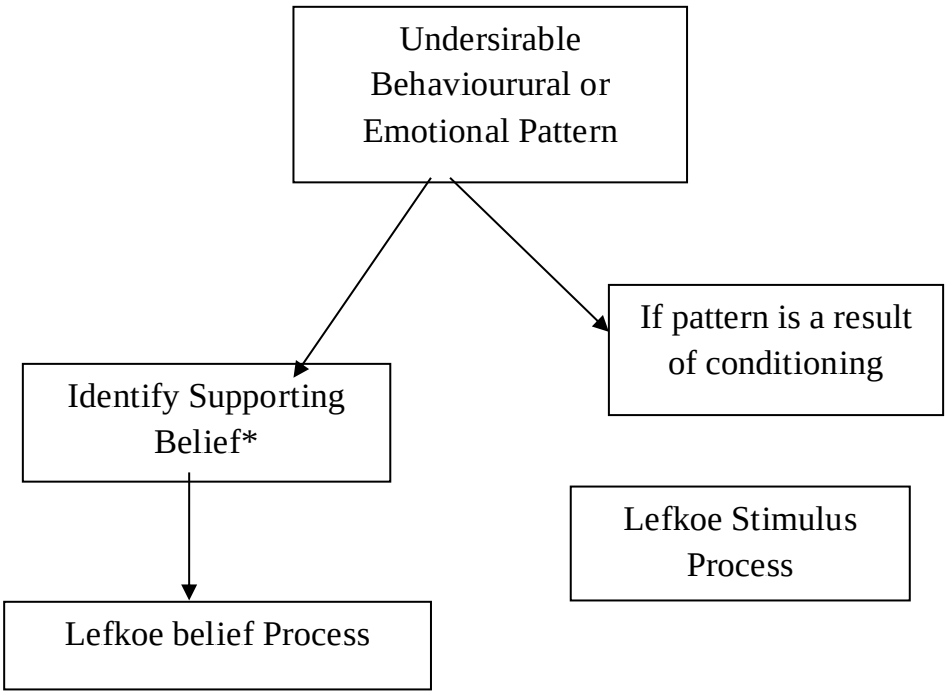


Figure 2: The Lefkoe Treatment Pattern Belief System: Adapted from John Wiley & Sons, Ltd. (2006)

The Lefkoe Method has not previously been subjected to rigorous investigation, although there is reason to believe that it might well be effective in treating a wide range of problems. In 1994 the Lefkoe Institute, in collaboration with Sechrest, conducted a study involving 16 incarcerated youths and adults at two Connecticut institutions. The study indicated fairly strongly that using TLM, specifically the Lefkoe Belief Process, to eliminate such beliefs as 'I'm bad', 'There's something wrong with me', I don't matter' and 'What makes me okay is the power that comes from a gun' improved the self-esteem and reduced the hostility and anti-social behaviour of the subjects. In part because of the small sample, the study, although reflecting statistically significant effects, was never published; the effect was actually fairly large. The study did, however, provide impetus for Lefkoe to continue use and development of his unique intervention.

He and his associates have by now treated over 2000 people with a wide range of problems, and results as he has seen them have been consistently highly favorable. He has also trained a number of other clinicians in the use of his method, and they, too, have, in aggregate, treated, successfully, a very large number of persons. The experiences of these clinicians constitute a strong basis for more systematic testing of the effectiveness of the Lefkoe approach.

An increasing number of case studies and anecdotal reports provide evidence that TLM has been effective in resolving a wide variety of serious psychological issues, including anxiety, drug and alcohol addiction, ADD, bulimia, phobias, the inability to leave abusive relationships, anger, hostility and guilt. It also is successful with everyday issues such as worrying about what people think of you, workaholism, the feeling that nothing one does is ever good enough, procrastination and the inability to express feelings. Whether the anecdotal reports of the effectiveness of TLM with the above-mentioned psychological issues can be replicated in controlled scientific studies remains to the seen. Significant results were obtained in the 1994 study, coupled with the plentiful observational evidence supporting the proposition that TLM might well be both efficient and effective in treating a range of at least mild to moderately severe disorders.

Lefkoe Belief Process

The LBP begins with the client describing an undesirable or dysfunctional pattern of behaviour or feelings that she has been trying unsuccessfully to change. Feeling patterns could include fear, hostility, shyness, anxiety, depression or worrying about what people think of someone. Behavioural patterns could include phobias, relationships that never seem to work, violence, procrastination, unwillingness to confront people, an inability to express feelings, sexual dysfunction or anti-social behaviour. Once the client has identified her undesirable pattern, she is asked what she believes could logically account for that pattern. This step is not the same as asking the client 'why' she acts as she does. Most people either will say they have no idea why they do what they do, or they will come up with a multitude of reasons. A client's 'story', interpretations, and analysis are not at all relevant in the LBP. This step is designed to elicit one or more beliefs (that she probably was not conscious of before the LBP began) that logically would manifest as her undesirable pattern.

A client whose pattern is a fear of public speaking, with a host of physical symptoms when she even thinks about having to give a presentation in front of a group, probably has the following beliefs: mistakes and failure are bad; if 1 make a mistake I'll be rejected; people aren't interested in what I have to say; what I have to say isn't important; I'm not capable; I'm not competent; I'm not good enough; I'm not important; what makes me good enough and important is having people think well of me; change is difficult; public speaking is inherently scary, in other words, the theory that the beliefs (and sometimes additional conditioning) cause the pattern.

Once a belief is identified, the client is asked to say the words of the belief out loud to confirm that she actually does hold this belief. If the client has the belief she will notice negative feelings associated with the statement or a sense that the words themselves are true. Then, the client is asked to look for the earliest circumstances or events that led her to form the belief. Fundamental beliefs about life and about oneself for example, self-esteem-type beliefs-are usually formed before the age of six (Briggs, 1970). For the most part they are based on interactions with one's parents and other primary caretakers, if any. Beliefs in other areas of life, such as work and society, are formed at the lime those areas of life are encountered.

Although the client can usually identify the relevant early events in five or ten minutes, at times she spends as much as half an hour recalling various events from her childhood. At some point she identifies the pattern of events that led her to form the belief in question. Lefkoe's experience with over 2000 clients indicates that beliefs rarely are formed based on only one or two events. Usually a great many similar events are required, unless a really traumatic event occurred. Using the belief, 'I'm not good enough', as an example, the source might be a childhood in which (he client's father was always telling her what to do and what not to do. Nothing she ever did was good enough for him. She never received any praise and was criticized a lot. The next step is to have the client realize that the current belief was, in fact, a reasonable interpretation of her childhood circumstances and that most children probably would have reached a similar conclusion, given their experience and knowledge at that time in their life.

One's beliefs are almost always a reasonable explanation for the events one observes at the time one observes them. Thus the client is never told that her beliefs are irrational or wrong. This is one of the differences between LBP and CT, where a client is told that her beliefs are irrational and wrong, and shown why. The client then is asked to make up some additional interpretations of, or meanings for, the same earlier circumstances, which she had not thought of at the time. In other words, the client as a child observed her father doing and saying various things over a long period of time. The meaning she gave to the events was I'm not good enough.

What the client is asked to do is make up additional meanings or interpretations of her father's behaviour. (In CT clients are often asked to create or are shown other ways to interpret events in the present that they currently feel bad about. This is taught as a skill that can be used to get rid of upsets after they happen and to calm fears- and anxieties before stressful events. In the LBP this technique is used as part of a process to eliminate a belief, so that the upsets and the anxieties do not occur after the client leaves the therapist's office). To continue the illustration we've been using, other reasonable interpretations of her father's behaviour and comments could include the following:

- My father thought I was not good enough, but he was wrong.
- I was not good enough as a child, but I might be when I grow up.

- I was not good enough by my father's standards, but I might be by the standards of others.
- My father is a very critical person and would act that way with everyone, whether they were good enough or not.
- My father's behaviour with me had nothing to do with whether 1 was good enough or not; it was a function of my father's beliefs from his childhood.
- My father's behaviour with me had nothing to do with whether I was good enough or not; it was a function of his parenting style.

Each of these statements is as reasonable a meaning for her father's behaviour as the one she came up with as a child. The point here is not to convince the client that her belief is unreasonable or that any of the other interpretations are more accurate; it is for her to realize that there are many different meanings, each one of which is logically consistent with the events she experienced. Further, notice that not all of these interpretations are 'positive'. They are not designed to make the client feel better. Their only purpose is to help the client realize that her interpretation is 'a' truth, one of many possible interpretations, and not 'the' truth, the only interpretation. This is another difference between the LBP and CBT.

Next the client is asked if, when she formed the belief as a child, it seemed as if she could see in the world that I'm not good enough. Because it feels as if we 'discovered' or 'viewed' our beliefs in the world, the answer is always, yes. It seemed to the client that every time her father criticized her or tailed to praise something she[1] was proud of, she could 'see' that she was not good enough. Clients usually are so certain that their belief was out in the world to be seen that they frequently say, 'If you were there in my house, you would have seen it too'. Lefkoe has verified with thousands of clients that when one looks back on the events that led to the formation of a belief, the meaning one has given the events seem to be inherent in the events; i.e., it seems as if one can 'see' the meaning in the events.

The client is then asked 'Is it clear, right now, that you never really saw the belief in the world?'. In other words, you want the client to realize that she never did see that I'm not good enough. All she really saw was her father's statements and behaviours. I'm not good enough was only one interpretation of the events she actually did see. After the client realizes that she never really did see her belief in the world, she is asked 'If you didn't see I'm not good enough in the world, where has it been all these years?'.

The answer is always 'In my mind'. The client then realizes that the events of her childhood, as painful as they might have been at the time, had no inherent meaning. The events had many possible meanings, but no 'real' meaning before the client assigned the events a meaning. When a client recognizes that something she has held as a belief (the truth) is, in fact, only one of several alternative meanings of what actually occurred (a truth), and when she realizes that she never saw the belief in the world, it ceases to exist as a belief. It literally disappears. A belief is a statement about reality that we think is the truth. When it is transformed into a truth, it is no longer a belief and no longer manifests behavioural or emotional patterns in a client's life.

'The LBP makes the following assumptions: An individual gives one possible meaning to a set of meaningless events, after which one seems to 'see' the meaning (i.e. a belief) when observing the events. It usually is difficult to eliminate a belief because the individual thinks she has 'seen' it in the world, which is the primary way people get their information about the world. 'Seeing is believing. In other words, if you can point to it, it is true. It is very difficult to use logic or ally other technique to 'talk one' out of a belief if one thinks one has 'seen' it in the world. On the other hand, if an individual is able to revisit the events and realize that she imposed one arbitrary meaning on a set of meaningless events, that the meaning has only existed in her mind, that had she come up with a different meaning at the time she never would have had the current belief—the belief will be eliminated.

The difference between TLM and Insight Therapies should be clear from this description of TLM. Insight Therapies assume that a person's behaviour, thoughts and emotions become disordered as a result of the individual's lack of understanding as to what motivates him or her. The LBP postulates that merely understanding that beliefs cause a pattern, or even identifying the specific beliefs that cause a given pattern, will not affect the pattern. The client needs to eliminate all of the beliefs that cause the pattern. Moreover, mere understanding of the source of a belief is not sufficient to eliminate it. The client also must recognize that she never saw it in the world and that the events that, led to the formation of the belief have no inherent meaning. Finally, with the LBP it is not necessary to see the connection between the undesirable behavioural or emotional pattern one wishes to change and the beliefs that cause it. In other words, insight into the cause of the pattern is not necessary as long as the appropriate beliefs are eliminated.

Lefkoe Stimulus Process

Very often people experience negative feelings in their lives on a recurring basis, such as tear, anger, sadness, guilt and anxiety. People experience these feelings every time specific events or circumstances occur, such as fear whenever they make a mistake or someone rejects them, or anger whenever they are asked to do something. In many cases the events that stimulate the feeling in some people do not produce the same feeling in others, and vice versa. Why does an event that is not inherently fearful produce fear in some people and not in others? What appears to have happened is that an event was conditioned in the past to automatically produce emotions in the present. Consider a client who experiences rear whenever he is judged or evaluated. This is not inherently fearful. When did he first experience fear associated with being judged or evaluated? Assume the original source of the fear was a father who was never satisfied with what the client did as a child and who showed his displeasure by yelling and threatening. No matter what the child did, the father was not satisfied.

When the client reviews the cause of the fear, he discovers that what really caused the fear was the meaning he unconsciously attributed to how his father judged and evaluated him, namely, with yelling and punishing. The person he depended on for his very survival seemed to be withdrawing his love. No love, no care; no care, no survival. 'That is what caused the fear. The fear was never caused merely by being judged and evaluated. The client realizes that had he been judged and evaluated by his father in a loving, understanding and supportive way there would have been no fear. It was the way his father acted and the meaning he gave his father behaviour that caused the fear; namely, the yelling and punishment meant his father was withdrawing his love, which meant abandonment to the child. The point of the Lefkoe Stimulus Process is to assist the client to realize that initially the current stimulus never produced the emotion. It was only produced by the meaning lie gave to the original cause; the current stimuli just happened to be associated with the original cause in time.

The Lefkoe Stimulus Process works by helping clients to realize that initially 'being judged or evaluated' never produced fear. The original cause of the fear was the meaning the client attributed to the way he was asked to do something (the anger that accompanied the request), by someone whose survival he depended on (his father). He associated 'being asked to do something' with a loss of love, which

ultimately he experienced as 'a threat to his survival'. When the association is broken, when the client realizes that he made this arbitrary association, the events that got associated (being judged or evaluated) no longer cause fear. Joseph LeDoux (1996), a professor at the Center for Neural Science at New York University, points out 'Extinction (of a conditioned stimulus) appears to involve-the cortical four thinking brain] regulation over the amygdala (the emotional brain)…'. This is precisely what the Lefkoe Stimulus Process does.

Notice the parallel between how the Lefkoe Stimulus Process works and how the Lefkoe Belief Process works: When a client makes a distinction between the events that were the source of a belief and the meaning he attributes to those events, the belief is eradicated. When he makes a distinction between the actual cause of an emotion and its associated elements, the emotion will no longer be produced by those elements.

2.1.11 Theoretical Framework for the Study (Social Learning Theory)

This study is anchored on Bandura (1977) Social Learning Theory. The theory is considered most appropriate because it gave theoretical explanations on how public speaking anxiety which the students have learnt from teachers, educators and society can be unlearned using appropriate therapy. The social learning theory of Bandura emphasizes the importance of observing and modeling the behaviours, attitudes, and emotional reactions of others. Bandura (1977) states: "Learning would be exceedingly laborious, not to mention hazardous, if people had to rely solely on the effects of their own actions to inform them what to do. Fortunately, most human behaviour is learned observationally through modeling: from observing others one forms an idea of how new behaviours are performed, and on later occasions this coded information serves as a guide for action" (p. 22). Social learning theory explains human behaviour in terms of continuous reciprocal interaction between cognitive, behavioural, an environmental influences.

Social learning theory integrated behavioural and cognitive theories of learning in order to provide a comprehensive model that could account for the wide range of learning experiences that occur in the real world. As initially outlined by Bandura and Walters in and further detailed in 1977, key tenets of social learning theory are as follows:

1. Learning is not purely behavioural; rather, it is a cognitive process that takes place in a social context.
2. Learning can occur by observing behaviour and by observing the consequences of the behaviour (**vicarious reinforcement**).
3. Learning involves observation, extraction of information from those observations, and making decisions about the performance of the behaviour (observational learning or **modeling**). Thus, learning can occur without an observable change in behaviour.
4. Reinforcement plays a role in learning but is not entirely responsible for learning.
5. The learner is not a passive recipient of information. Cognition, environment, and behaviour all mutually influence each other (**reciprocal determinism**).

Basic Social Learning Concepts

There are three core concepts at the heart of social learning theory. First is the idea that people can learn through observation. Next is the idea that internal mental states are an essential part of this process. Finally, this theory recognizes that just because something has been learned, it does not mean that it will result in a change in behaviour. In his famous Bobo doll experiment, Bandura demonstrated that children learn and imitate behaviours they have observed in other people. The children in Bandura's studies observed an adult acting violently toward a Bobo doll. When the children were later allowed to play in a room with the Bobo doll, they began to imitate the aggressive actions they had previously observed. Bandura identified three basic models of observational learning:

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

Intrinsic Reinforcement

Bandura noted that external, environmental reinforcement was not the only factor to influence learning and behaviour. He described intrinsic reinforcement as a form of

internal reward, such as pride, satisfaction, and a sense of accomplishment. This emphasis on internal thoughts and cognitions helps connect learning theories to cognitive developmental theories. While many textbooks place social learning theory with behavioural theories, Bandura himself describes his approach as a 'social cognitive theory.'

The Modelling Process

Not all observed behaviours are effectively learned. Factors involving both the model and the learner can play a role in whether social learning is successful. Certain requirements and steps must also be followed. The following steps are involved in the observational learning and modelling process:

- **Attention:**

In order to learn, you need to be paying attention. Anything that detracts your attention is going to have a negative effect on observational learning. If the model interesting or there is a novel aspect to the situation, you are far more likely to dedicate your full attention to learning.

- **Retention:**

The ability to store information is also an important part of the learning process. Retention can be affected by a number of factors, but the ability to pull up information later and act on it is vital to observational learning.

- **Reproduction:**

Once you have paid attention to the model and retained the information, it is time to actually perform the behaviour you observed. Further practice of the learned behaviour leads to improvement and skill advancement.

- **Motivation:**

Finally, in order for observational learning to be successful, you have to be motivated to imitate the behaviour that has been modeled. Reinforcement and punishment play an important role in motivation. While experiencing these motivators can be highly effective, so can observing other experience some type of reinforcement or punishment. For example, if you see another student rewarded with extra credit for being to class on time, you might start to show up a few minutes early each day.

2.2 Empirical Review

2.2.1 Public Speaking Anxiety

Epidemiological studies have shown that the fear of public speaking is the most prevalent fear in the general population (Geer, 1965; Furmark, et al., 2000), irrespective of gender, ethnicity, or age (Phillips, et al., 1997). In a study performed by Stein and colleagues (1996) with a community sample, one third of the respondents reported that they experienced excessive anxiety when speaking to a large audience. In addition, subjects mentioned having anxious cognitions about public speaking, including the following fears: doing or saying something embarrassing (64%), one's mind going blank (74%), being unable to continue talking (63%), saying foolish things or not making sense (59%), and trembling, shaking, or showing other signs of anxiety (80%). In total, 10% of the respondents reported that public-speaking anxiety had resulted in a marked interference with their work (2%), social life (1%) or education (4%), or had caused them marked distress (8%). Twenty-three subjects (5%) had public-speaking anxiety alone (i.e., without evidence of additional social fears).

Public speaking has also been indicated as the most prevalent fear in the generalized subtype of SAD, and the most common symption leading to diagnoses of the circumscribed or non-generalized subtype of the condition. In a study by Baptista (2006), 91.6% of subjects with SAD reported having this fear, compared to 24% of non-SAD subjects. In a national survey of fundamentals of public speaking courses, Robinson's observation (1997) still holds: the most common pedagogical method for treating CA/PSA in the classroom "is to rely on the textbook… but most of the information given in the text books is "folk wisdom" or information that is rather common … (and) limited".

A survey of speech communication departments (Robinson, 1997) found that only 13 percent offer a special treatment programme for communication anxiety, and a little more than half of these said the programme was run as a course. For the remaining half, the treatment programme took the form of workshops, labs or one–on–one counseling (Robinson, 1997). The vast majority of responding departments (81 percent) indicated that communication anxiety is treated in the public speaking classroom. When asked which of the major treatment approaches were incorporated into the public speaking course, nearly all of the respondents (96 percent) reported that skills training is used, 63 percent include cognitive modification, 59 percent employ visualization, and only 25 percent use systematic desensitization (Robinson,

1997). Beyond these treatment approaches, 75 percent or more of respondents indicated that they identify students' fears as normal, encourage speech practice, establish a warm climate in class, teach students to select familiar topics, make speech evaluations a positive experience, emphasize that students become audience centered, and encourage class participation (Robinson, 1997).

Before relatively recent advances in neurophysiology and neuropsychology that link biological predisposition and CA/PSA, "Stage Fright" was thought to be the result of social learning processes. The new "communibiological" perspective drew on previous works in personality theory, and connected psychological processes that depend on brain activity to traits of temperament such as CA and PSA. Various studies linked CA and PSA to inherited personality traits, such as temperament and intelligence. Other theories linked CA and PSA to a different physiological model, a system of behavioural inhibition (BIS) and behavioural activation (BAS), in which new stimuli and the perceived threat of punishment – such provoked by a public speaking situation – activate BIS, which is perceived by the person as anxiety. Those individuals with an inherited lower threshold for BIS stimulation experience greater CA/PSA. Other studies correlated different biologically – based psychological types, as described by psychoanalyst Carl Gunther Jung or the mother – daughter team Meyers – Briggs – to an individual's predisposition to experience anxiety when communicating.

In an early investigation of state anxiety, an individual's physiologic arousal was explored (Behnke & Carlile, 1971). Speakers' heart rates were recorded at specific periods during the speech before, during, and after. A well-delineated pattern of anxiety responses emerged from the data at four periods in time. In the first period, called anticipation speakers were found to experience a heart rate slightly higher than resting level just prior to delivering the speech. The second period, confrontation, measured heart rate the moment the speaker addressed the audience. Here speakers experienced a more rapid heart rate than in the anticipation phase. At the third phase, adaptation heart rate was found to have decreased to a level somewhat above the pre-speech measurement. Finally, in the last phase, release, hear rates had returned to a level at or below the pre-speech measurement. In a similar subsequent investigation into psychological responses of state public speaking anxiety, researchers utilized the State – Trait Anxiety Inventory (STAI) which is designed to measure state anxiety in a variety of situations (Spielberger, Gorush, & Lushene, 1970). Again, a pattern of

anxiety responses emerged in which anxiety peaked before the presentation and then declined throughout the speech and post – speech periods.

Some scholars have continued to focus public speaking research on the speaker's state anxiety (Behnke &Sawyer, 2004; Porhola, 2002; Behnke & Sawyer, 2001; Freeman, Sawyer & Behnke, 1997). Behnke & Sawyer (1998) measured speakers' self-reported anxiety at different points of time during a public speaking assignment. From these key points, or milestones, variations in the level of anxiety were revealed. This narrow banding approach segmented the speaking event into four phases: 1) anticipation one minute before; 2) confrontation – first moment addressing the audience; 3) adaptation – last minute of the speech; and 4) release – immediately after the conclusion of the speech. Subjects reported anxiety levels similar to that uncovered in earlier physiological research, with the most anxious milestone occurring at the anticipatory phase immediately before delivering the speech. Thus researchers have determined that not only is public speaking anxiety experienced differently among individuals, but the level of anxiety fluctuates throughout the duration of the experience (Behnke & Sawyer, 2004; Behnke & Sawyer, 2000; Behnke & Sawyer, 1999; Behnke & Sawyer, 1998).

A number of studies have been done on the attributions that students give to public speaking anxiety. One such study was by Bippus and Daly (1999) on the attributions about stage fright of students from a large public university in the US. The study involved a total of 234 students. Results showed that students usually have one of these 9 reasons for public speaking anxiety: Humiliation, preparation, physical appearance, rigid rules, personality traits, audience interest, unfamiliar role, mistakes and negative results. Participants in the study were from introductory communication courses. At the time of the study, none of the participants had received any instructions about stage fright. The study concluded that the reasons given by naïve speakers to public speaking anxiety were by no means unimportant. The existence of those reasons proved that public speaking anxiety was a common difficulty.

Another study by Proctor, (1994) in Bippus and Daly (1999) discovered 4 factors why students experienced public speaking anxiety. These were: evaluation and criticism, mistakes and failure, attention and isolation and unfamiliar audiences. One limitation of this study was that the reasons were given only by the high apprehensive students. There was therefore no comparison made with the low apprehensive.

2.2.2 Assertiveness and Public Speaking Anxiety

Relevant literature from various perspectives like psychology, psychiatric and psychiatric nursing were taken, to explain the concepts of assertive behavioural was conducted by Promila and Mahija (2010) in Chhattisgarh, India in a CBSE English medium school with 160 students to check the effectiveness of assertiveness training programme on self-esteem and academic achievement in adolescents. The study adopted pre-test - post-test control group design. Experimental group was given assertiveness training but control group was not given any training. After intervention, subjects were tested on the same measures again. It was concluded that assertiveness training programme was effective by 30.25% on self-esteem but no potential effects are found on academic achievement of adolescents.

Kang and Lee (2009) conducted a study to assess the effect of assertiveness training on communication related factors and personnel turnover rate among hospital nurses. A non-equivalent control group pre-test post-test design was used in this study. Nurses were assigned into the experimental or control groups, each consisting of 39 nurses. The assertiveness training was effective in improving the nurses' assertiveness behaviours, but was not effective in improving interpersonal relations, reducing the subjects' communication conflicts, changing the conflict management style or reducing their personnel turnover rate.

A quasi experimental study conducted by Clark, Corbisiero, Procidano and Grossman (2010) on elderly psychiatric hospital outpatient department in geriatric homes in America to find out the effectiveness of assertion training. 19 clients participated in the study with the age between 50-75 years. The training was given for 14 weeks in semi sessions. Pre-intervention scores of the groups were not significant. However, post-test assessment indicated a significant difference between group difference in self-reported assertiveness Dependent t-tests indicated that the experimental group became more assertive but the control group did not.

A descriptive study conducted by Mohamedunni and Noushad, (2010) to assess the level of assertiveness among students of secondary school of Kerala stats, India with 590 samples. The sample was drawn by stratified sampling method giving due representation to factors like gender, locale and type of management of the school. The students, who have problems regarding communication and self-expression, cannot assert for their rights than other students by 55%.Another study was conducted to assess the relationship between assertiveness and group participation among 88 PG

women students in department of psychology, Barllan University, whose age ranged from 21-23 years. Assertiveness was measured using Rathus Assertiveness scale. The findings of the study revealed that 92% highly assertive women participated in group activity and 10% of less assertive women are interested in group participation.

A study was conducted by Devi & Indumathi (2004) in an urban community in Algeria to measure 60 preschool children's aggressive, assertive, and submissive behaviours in play interaction with their mothers. Results indicate that boys were 75% more assertive but not more aggressive or submissive. A similar study was conducted to assess components of assertiveness and depressive symptoms of 183 Chinese undergraduates in their response to the Rathus Assertiveness Schedule and the beck depression inventory. Three dimensions of assertiveness were considered; expressing, confronting, and demanding responses. These components were found to relate differentially to the beliefs in specific assertive rights. Nonassertive response especially in expressing and disclosing oneself correlated with depressed mood.

A study was conducted by Judith and Holden (1999) to assess the level of assertiveness among professional nurses at College of Nursing and Health Sciences, Winona State University, Minnesota. The sample was composed of 500 registered nurses (64% response rate), chosen randomly from the list of active licensees registered with the Minnesota (USA) State Board of Nursing, who completed and returned an assertiveness questionnaire. The questionnaire consisted of the Rathus Assertiveness Schedule (RAS) and a personal/professional data form. The oldest group of nurses (60-76 years) was significantly less assertive (73 5%) than any of the younger groups of nurses. Nurses practicing with a diploma as the highest level of education were significantly less assertive than nurses having a baccalaureate or above. There was a significant difference in assertiveness between groups of nurses practicing in different clinical specialties.

A study was conducted by Kilkus (2011) to investigate the influence of race on rating of assertiveness, using 16 black & 16 white undergraduates evenly divided by sex. Results indicated that Black raters found Black undergraduates assertive response were 40% more aggressive than white raters and that Black female responses were rated as more assertive, aggressive, and appropriate. A study was conducted to investigate the factors affecting assertiveness among student nurses. The study was carried out at Faculty of Nursing, Port-Said University, on 207 student nurses from four

different grades. Rathus Assertiveness Schedule, consisted of 30 items, was used to measure the students' assertiveness level and a 12-item scale developed by Spreitzer was used to measure students' psychological empowerment. The study results showed that 60.4% of the students were assertive, while about half of the students were empowered.

Garrison, Shauon, Jenkins and Jack (1985) conducted a study to investigate the relationship between cognitive process and non-assertiveness among 35 nonassertive individuals & 35 normally assertive individuals. Assertive individuals showed greater score (73.25%) in self-perception, standard setting, and expectations of consequence, coping self-is instruction, attribution process, and self-reinforcement. A study was conducted to evaluate a self-report measure of aggressiveness, assertiveness, and submissiveness, using behaviour observations in naturalistic settings. 45 third-to fifth-grade children were observed over an 8-month period in a wide variety of school activities. The study concluded that boys have higher assertive level (78.28%) than girls.

A study was conducted by Ibrahim (2010) among 215 undergraduate business students to assess their assertive and aggressive consumer behaviour and protective and acquisitive self-presentation style using questionnaire. Results shows that the people with an acquisitive self-presentation style are more assertive (68%) than others in requesting information, seeking redress, and resisting rate requests. Those with a protective self-presentation style were less assertive with respect to these same consumers.

2.2.3 Gender and Public Speaking Anxiety

Gender is a range of characteristics used to distinguish between males and females, particularly in the cases of men and women and the masculine and feminine attributes assigned to them. In the past, women were invisible, yet today they believe that they possess a different voice, different psychology, different experience of love, etc. and also different culture from that of men (Coates 993: 13). When dealing with politeness phenomena, gender is a crucial factor to be taken into account. Janet Holmes (1994: 1) explained about how gender differences may influence and affect linguistic politeness. Holmes presented her idea that women and men have different ways of interacting because women are more polite than men in talking cooperatively and supportively. Holmes also analyzes the use that women and men make of some linguistic devices which serve to increase or reduce the

force of an utterance. These are hedges, boosters tag questions, and pragmatics particle such as you know, I think, sort of, of course.

Gender is often thought to be a factor in assertiveness. The stereotype is that men are more assertive than women. Research has actually produced mixed results in the role of gender in assertiveness. Florian and Zernitsky-Shurka (1987) found no gender differences in the comfort with assertive behavioururs of males and females in their study of Israeli Arab and Jewish university students. Interestingly, they found that females were actually more likely to perform certain assertive behavioururs than males (initiating interaction, giving negative feedback, complimenting others, and admitting personal deficiencies). They postulated that the females in their study were attending "Westernized" universities and may be more likely to assert themselves than the general population of Israel and Arab women. On the other hand, Costa et al. (2001) found that men scored higher in assertiveness than women regardless of their cultural affiliation.

2.2.4 Cognitive Behaviour Therapy and Public Speaking Anxiety

Anxiety disorders can be treated quite effectively with cognitive behavioural therapy (CBT). Research over the past three decades has shown that exposure is rather effective, with exposure in vivo being superior to imagined exposure, especially in the treatment of specific phobias (Emmelkamp, 2003). According to the emotional processing theory of Fou and Kozak (1986), successful exposure therapy leads to new and more neutral memory structures that "overrule" the old anxiety provoking ones. Vincelli et al (2003) conducted a controlled randomized study in which eight sessions of experiential cognitive therapy (ECT) were compared with 12 sessions of cognitive behaviour therapy (CBT) and a waiting list group. Twelve participants with DSM-IV diagnosis of panic disorders with agoraphobia were included.

ECT consisted of psycho-education, virtual reality exposure (an elevator, a supermarket, a subway ride, and a large square), cognitive therapy, interoceptive exposure, exposure in vivo homework assignment, and relapse prevention. CBT consisted of cognitive restructuring, interoceptive exposure, and imaginative exposure to feared situations. Exposure in vivo was not mentioned. Analyses of the data by means of nonparametric tests show a significant decline in anxiety and depression symptoms on all measures for the ECT and BCT groups the waiting list group showed no differences between pre-and post test. Moreover, no differences at post-test were

found between ECT and BCT. These results look promising and should be validated in a large clinical sample. In addition, long-term effects should be investigated.

Public speaking is generally considered to be a stressful social situation (Montorio, Guerrero & Izal 1991) that may have negative consequences leading to poor professional or academic outcomes (Greer 1965, Gutierrez-calvo and Garcia-Gonzalez 1999). Most studies on the fear of public speaking tend to consider it a major source of anxiety (Cano-Vindel & Miguel-Tobal 1999; Gutierrez –Calvo and Garcia-Gonzalez 1999). Fremouw and Breitenstein (1990) describe this fear as a non-adaptive response to environmental events, resulting in inefficient behaviour.

The capacity to control stress has traditionally been considered one of the requisites for interpreting (Longley 1989; Klonowiez 1994; Gile 1995; Moser-Mercer, Kunzli and Korac 1998) and a predictor for interpreting competence (Alexieva 1997). Although the number of empirical studies about the influence of stress in interpreting performance is scarce there is a wide consensus that stress is intrinsic to interpreting – both in the consecutive and simultaneous mode – even though its impart is most clearly defined (Brisan, Godijns & Meuleman 1994). Interpreting research on stress has revolved around the professional realm, focusing mainly on the physiological responses to stress during interpreting and on performance:

Cardiovascular activity (Klonowicz 1994), Causes of stress (Cooper et al, 1982), and the relation between stress and quality in prolonged interpreting turns through chemical and physiological analysis (Moser-Mercer et al 1998) Little empirical research has been carried out on interpreting students (Riccardi et al 1998). The capacity to control stress in interpreting is sometime taken into account in interpreting entrance exams (Moser-Mercer 1985) on those occasions the capacity to cope with a situation of continuous stress during a relatively long time is considered more important than actual performance per se, provided candidates show a minimum number of skills. Apparently some candidates had to aduct that they could not cope and abandoned the test (Moser-Mercer, 1985). It can be inferred, especially from students' comments, that the anxiety they feel when they have first to speak and later to interpret in public may arise basically from fear of public speaking (among other causes).

Cognitive behaviourural therapy (CBT) including exposure, specifically in vivo exposure, is considered the treatment of choice for social phobia and special phobias. Regarding social phobia this intervention has received wide empirical

support from numerous clinical trials (e.g. Mattick, Peters, & Clarke, 1989; Turner, Beidel & Jacob, 1994). The APA report on empirically supported treatments (Task force on promotion and Dissemination of psychological procedures, 1995, last updated by woody Barlow, 1997 Turner, Beidel, & Cooley, 1997). In vivo exposure consists of confronting the feared situation in a gradual and systematic way. It beings with lower-ranked situations and moves up to more highly feared situations. In a typical exposure session the therapist encourages the patient to confront the feared situation. The therapist asks the patient about the degree of fear from 0 to 10 (or 0 to 100) using the subjective units of discomfort (SUDs; Wolpe, 1969) every few minutes. When fear goes down significantly the patient can move on to confront a more difficult situation. Exposure therapy is based on the notion that individuals are able to adjust to anxiety-provoking stimuli through a process known as habituation (Marks, 1987). Foa and Kozak (1986) used the concept of emotional processing to explain fear reduction during expose. They support the hypothesis that exposure to feared stimuli allows the activation of the fear structure and the presentation of corrective information incompatible with the pathological elements of the fear structure.

In vivo exposure is an effective therapy technique, although it is not free of limitations. Some patients (approximately 25 percent of those who start an exposure program) refuse exposure therapy or drop out of therapy (Marks, 1978a, 1992). One reason for this percentage of refusal could be that the main feature of exposure is confronting the feared stimuli; some people may find this too frightening. Furthermore the vast majority (approximately 60 to 85 percent) of those afflicted with specific or social phobias never seek treatment for their problem (Boyd et al., 1990; Magee et al., 1996). In the case of social phobics, they may abstain from seeking treatment because of the embarrassment associated with meeting an unknown person, the psychologist. Finally, in vivo exposure programs and other CBT programs entail an important amount of therapy time. This means an important financial cost for patients and public mental health institutions. Also, it is difficult for some patients living in remote areas (i.e., rural areas) to get CBT treatment. An important goal in clinical psychology is reducing cost of treatment without decreasing effectiveness. The main factor to minimize economic issue is reducing contact with the therapist (Al-Kubaiy et al., 1992 Marks, 1987; Ost Salkovskis, & Hellstrom, 1991). The length of the therapist contact has varied from one visit per week to structure new exposure tasks (Mathews, Gelder, & Johnston, 1981) to no contact at all during the treatment (Ghosh & Marks,

1987; Hellstrom --& Ust, 1995). Self-directly exposure has shown to be as successful as standard therapist-directed treatment (Ghosh & Marks, 1987). In another study the improvement achieved by self-directly exposure was maintained at two-year follow-up (Park et al., 2001).

One way of reducing therapy contact time and overcoming some of these limitations is telepsychology. Telepsychology has been defined as "the use of telecommunication technologies to put patients in contact with the mental health practitioners with the aim of providing a suitable diagnosis, education, treatment, consultations, communication and storage of the patients" records, research data, and other activities" (Brown, 1998, p. 963). One way to deliver telepsychology is through the internet (online therapy). Recently, Schneider, Mataix-Cols, Marks, and Bachofen (2005) compared two internet-guided self-help treatments for phobic and panic disorders, one included exposure instructions and the other did not. They found that at posttest both were equally effective, however at one-month follow-up the internet-guided self-help treatment with exposure instructions was more effective than the other. In the field of social phobia there are some studies that reported data on the use of online telepsychology programs to treat this disorder. These studies could be classified in two groups according to the classification of Glasgow and Rosen (1978): (1) internet-based self-help programs with therapist contact, and (2) internet-based self-help programs without therapist contact.

Regarding the first group, Anderson et al. (2006) combined an internet-based self-help program with therapist contact via e-mail with two group exposure sessions. This treatment showed its efficacy in a controlled randomized study. The same internet program plus weekly therapist contact via e-mail without the group exposure sessions was administered to 26 social phobics (Carlbring, Furmark, Stezko, Ekselius, & Anderson 2006). The participants improved significantly from pre-to posttest and the results were maintained at six-month follow-up. Carlbring et al. (2007) compared in a controlled randomized study their internet program plus weekly phone calls with a waiting-list group. They also found this treatment effective to treat social phobia, and it improved program adherence. This improvement was maintained after one year. There is only one telepsychology treatment program completely delivered over the internet to treat social phobia (Botella et al., 2000). It is an internet-based self-help program for the treatment of fear of public speaking called Talk to Me. This treatment has shown preliminary efficacy in a case study (Botella, Hofmann, & Moscovitch,

2004) and two single case series Gallego et al., 2007; Guillen, 2001). In these studies there are no data of within-exposure sessions.

2.2.5 The Lefkoe Method and Public Speaking Anxiety

Three scientific studies have been conducted to test the effectiveness of a fear elimination procedure called The Lefkoe Method. The first study was conducted in 1995 with incarcerated offenders, both adults and teens, just before they were released. 36 people who had a fear of public speaking were divided into two groups. One group was exposed to The Lefkoe Method. The other group went to Toastmasters meetings. The purpose of the study was: We propose to examine the efficacy of the Decision Maker Process (since renamed the Lefkoe Belief Process) as an intervention to improve self-esteem, enhance an internal locus of control, and to reduce hostility, social alienation and anti-social behaviour in eight incarcerated criminals".

After a few hours of exposure to the Lefkoe Method the first group spoke in public and each member of that group reported that their fear had literally disappeared. The second group spoke in public at the same time and of course they had the same level of fear they had before. However, researchers wanted to be totally sure that The Lefkoe Method produced the results they were witnessing. So they had the second group go through the steps of The Lefkoe Method. This group was asked to speak in public again and each participant reported that he or she had no fear of speaking in public. Of course, by itself, this doesn't prove that the changes are long lasting. So researchers followed up with participants in the study two years later. And they found that participants remained fearless when speaking in public. Sechrest, professor of psychology at the University of Arizona, who conducted the study concluded "The Lefkoe Method is an effective, quick, and convenient procedure to eliminate the fear of speaking in public". Morty Lefkoe, founder of The Lefkoe Institute and published author, was not surprised as he and his colleagues were already helping over 450 people a year to climinate their fear of public speaking at the time the journal article was published. According to Lefkoe, the method works by "undoing" the two main causes of the fear of public speaking negative beliefs and emotional conditioning.

Many people who have the fear of public speaking have beliefs like "mistakes are bad" and "if I make a mistake, I'll be rejected". These beliefs cause them to fear making a mistake in front of an audience, fear looking stupid and fear people even

seeing that they have fear. Emotional conditioning is that familiar phenomenon described by Pavolv's experiments with dogs in which he got them to salivate at the sound of a bell by ringing it when food was given. Once this happened often enough the dogs salivated at the sound of the bell even when no food was given to them. A similar process happens to help you get conditioned to fear the types of events that could happen when you speak in public. For example, many fearful speakers fear being judged or criticized. They form their fear because when they were young their parents were upset at them whenever giving criticism. This caused them to feel fear and to "associate" fear to being criticized and so as adults, they are aware of the mere possibility that they might be judged or criticized when speaking in public, hence, they feel fear. Lefkoe's processes help people to disconnect from past conditioned fears and to stop negative beliefs. To get rid of one's fear, one will have to follow the four steps of The Lefkoe Method:

1. Uncover the beliefs that have been causing your fear.
2. Isolate the events that led to the creation of those beliefs
3. "Get" at a very deep and profound level that these beliefs aren't true now and never have been and that you never actually "saw" them in the world.
4. Dissolve the conditioning that's locking your fear in place on autopilot.

When you do all four of these things you will speak without fear in public for the rest of your life.

Another study was carried out in 2006 with people who feared public speaking. The purpose of this second study was to determine if The Lefkoe Method could totally eliminate the fear of public speaking. The results of this study were published in a peer-reviewed journal. Clinical psychology and psychotherapy and stated: "The large, positive changes on all outcome measures subsequent to treatment give strong support to the claim of efficacy of the TLM for reducing fear associated with speaking in public,… The TLM resulted in substantial decreases or complete eliminations of fear, accompanied by positive changes in confidence and reduced negative sensations felt during speaking in public in the experimental group. Overall, the TLM appears to have potential as an effective, quick, and convenient procedure to eliminate the fear of speaking in public". (Emphasis added).

Specifically, the mean level of fear for subjects before they used TLM at the start of the study was 7, with 1 being no anxiety at all and 10 being extreme fear. After eliminating the relevant beliefs and conditionings, the mean level for fear was 1.5. In a follow up six months later, the fear level was still only 1.9.

The third study which is the latest study, also conducted at the University of Arizona but by different researchers, is finally complete after over a year's worth of testing. A group of people who purchased the Natural Confidence Program (which eliminates 19 of the most common beliefs and 4 of the most common conditionings) with a group of students who used the same program, a group of people who used a Tony Robbins CD program, and with a control group. The effects that were found, were compared with those found in several different studies that used the same measures used to evaluate the impact of Cognitive Behavioural Therapy. The results support most of the claims being made for TLM and Natural Confidence. It was observed that, there were significant improvements in virtually everything measured, including improvements of almost 50% in one area.

2.3 Conceptual Model for the Study

The conceptual model of this study as shown on figure 1 consist of three variables; Independent variables, intervening variables and dependent variables.

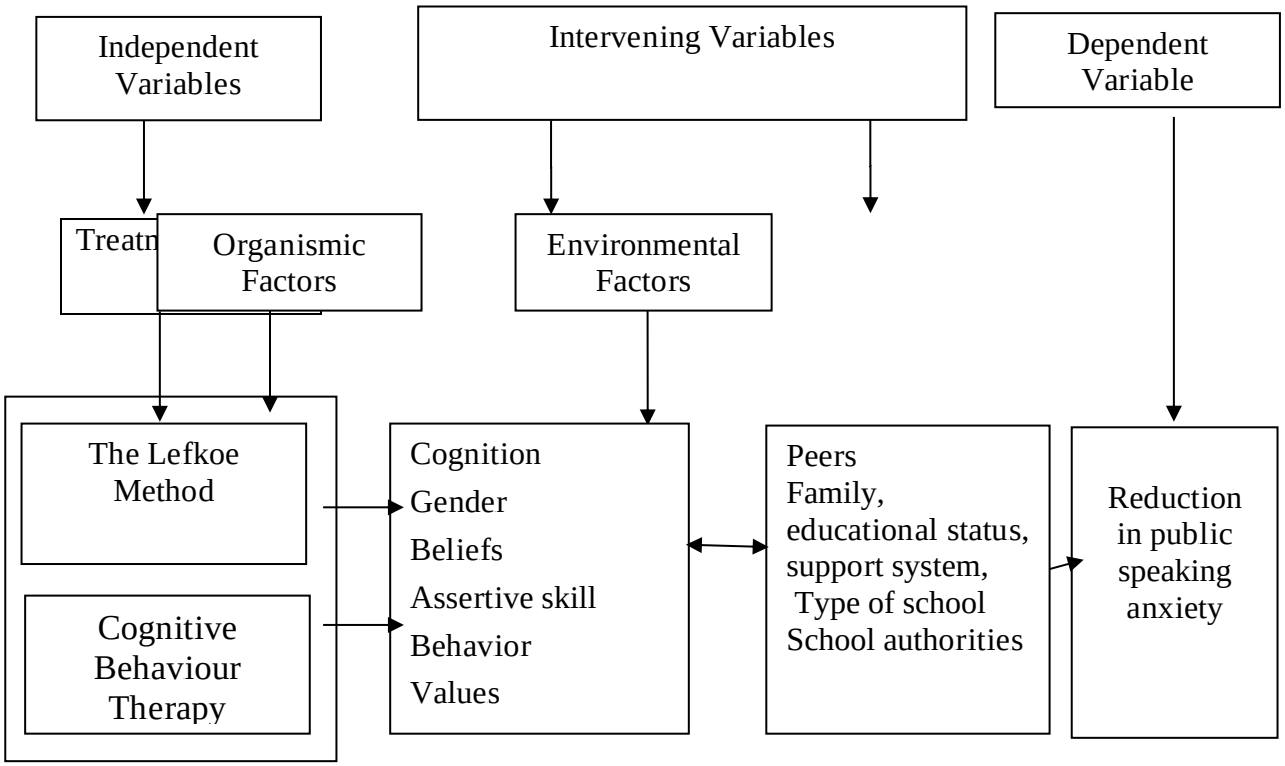
Independent variables: The independent variables also known as predictor variables were manipulated by the researcher in order to observe its effect on the dependent variables. In this study, the independent variables are Lefkoe Treatment, Cognitive Behaviour Therapy and Control Group.

Intervening variables: The intervening variables were some of the factors that were expected to mediate a direct relationship between the independent and dependent variables. The intervening variable has the capacity to affect treatment outcomes if not properly controlled in any study. The intervening variables in this study were classified into two organismic and environmental factors.

Organimisic factors: Organismic factors are the first order intervening variables resident in the participants. The organismic factors in this study were the participants' gender, level of assertiveness skill, cognitive abilities, previous experiences, value, anxiety, interest, level of motivation and self-efficacy

Environmental factors: These were the second order intervening variables, they includes; peer influence, family background, educational status, support system, attitude of teachers, and type of school. These variables were obviously be beyond the control of the researcher but could not affect the outcome of the study since they were properly controlled.

Dependent variables: The dependent variables were the measurable behavioural outcomes that occurred as a result of the effective manipulation of the independent variables. The dependent variable in this study was public speaking anxiety. The total interaction of the variables in this study was represented with the behavioural equations S – O – R (Kanfer, &Philips, 1970). The interaction of the three variables is presented on figure 1



S (Stimulus) ⟶ -O (Organism) ⟶ R (Response)

Figure 3: Conceptual Model for the Study

Key:

S = Stimulus (Independent Variables)

O = Organism (Intervening Variable, factors inherent in the organism)

R=Response (the resultant effect of independent variables).

2.4 Hypotheses

The following null hypotheses were tested at 0.05 level of significance

1. There is no significant main effect of treatments on reduction of public speaking anxiety of the participants.
2. There is no significant main effect of assertiveness on reduction of public speaking anxiety of participants.
3. There is no significant main effect of gender on reduction of public speaking anxiety of participants.
4. There is no significant interactive effect of treatment and gender on reduction of public speaking anxiety of participants.
5. There is no significant interactive effect of treatment and assertiveness on reduction of public speaking anxiety of participants.
6. There is no significant interactive effect of gender and assertiveness on public speaking anxiety of participants.
7. There is no significant three-way interactive effect of treatment, gender and assertiveness on reduction of public speaking anxiety of participants.

CHAPTER THREE
METHODOLOGY

In this chapter, the research design, population of the study, sample and sampling techniques, instrumentation and method of data analysis were discussed.

3.1 Research Design

This study adopted a Pre-test, Post-test, Control group, quasi-experimental design with 3 x 2 x 2 factorial matrix. The 3 in the matrix represents the treatments which comprise the two experimental groups and the control group. It is labeled A_1 and A_2 representing the experimental groups and A_3 representing the control group, which form the row. The first column is the gender of the participants represented as B_1 for male and B_2 for female. While the other column consists of assertiveness skill at two levels which was classified as high C_1 low C_2 as revealed in the screening scores.

Thus the graphical illustration of the factorial matrix for the reduction of public speaking anxiety among secondary school adolescents in Ibadan, Oyo State is presented on table 1

Table 3. 1: 3 x 2 x 2 Factorial Matrix for the Reduction of Public Speaking Anxiety among Secondary School Adolescents

Treatment	**Male (B1)**		**Female (B2)**		**Total**
	Levels of Assertiveness Skill (C)				
	HAS C1	LAS C2	HAS C1	LAS C2	
Lefkoe Treatment (A1)	A1+B1+ C1= 12	A1+B1+C2 = 8	A1+B2+C1 = 12	A1+B2+ C2= 8	n= 40
Cognitive Behaviour Therapy (A2)	A2+B1+C1 = 16	A2+B1+C2 = 4	A2+B2+C1 = 7	A2+B2+ C2= 13	n= 40
Control Group (A3)	A3+B1+C1= 18	A3+B1+C1 = 2	A3+B2+C1 = 18	A3+B2+ C2= 2	n= 40
Total	n = 46	n = 14	n = 37	n = 23	120

Key:

A1 = Lefkoe Treatment

A2 = Cognitive Behaviour Therapy

A3 = Control Group

B1 = Male

B2 = Female

HAS - Participants with High Assertiveness skill

LAS - Participants with Low Assertiveness skill

3.2 Population of the Study

The target population for this study were secondary school adolescents in Ibadan South-West Local Government of Oyo State, Nigeria. Their ages ranged between 14 and 23. There are thirty-three (33) Local Government in Oyo State and Ibadan South-West Local Government is one of them. In this Local Government, there are 29 public secondary schools and 18 private secondary schools. The public schools comprise 2 schools for Boys only; 5 schools for Girls only and 22 mixed schools. The total number of students in the public secondary schools in the local government is 34,732 (Oyo State Ministry of Education, 2015). Public secondary schools were used in order to ensure uniformity.

3.3 Sample and Sampling Technique

One hundred and twenty secondary school students were drawn using multi-stage sampling procedure. Three (South-west, North-west and North) LGAs were randomly selected in the metropolis. The simple random sampling technique was used to select three secondary schools (one per LGA). Personal Report of Confidence Speaker (PRCS – $\alpha = 0.72$) instrument was used to screen the students and those who scored below the norm of 30% were selected. The schools were assigned to LT (40), CBT (40) and control (40) groups.

3.4 Instrumentation

This study utilized three instruments for the collection of data namely;

1. Personal report of confidence as a speaker (PRCS) Mindez, Ingles and Hidalgo (1999).
2. McCroskey's (1982) Personal Report of Communication Apprehension – 24 (PRCA)
3. Assertiveness inventory by Alberti and Emmons (1995).

The above listed instruments comprised two sections, namely sections A and B. Section A was used to obtain the demographic data about the respondents. Items on this section include; age, gender, religion, course of study among others. Section B contained information relating to variables being measured. For example, public speaking anxiety, degree of assertiveness and level of confidence to speak in public

Personal Report of Confidence as a Speaker (PRCS) Mindez, Ingles and Hidalgo (1999)

This measure developed by Gilkinson (1942) is a 104 – item self-report measure of fear of public speaking. The authors hypothesized that lack of confidence in public speaking is synonymous with fear of the situation. Typical items on the scale include; *"I feel relaxed and at ease while I'm speaking"*; *'I feel afraid just at the thought of public speaking'*; 'When I speak in front of an audience, my thoughts get confused and empty. Paul (1966) shortened the instrument to 30 true or false items. Bados (1986) also changed the true-false items format to a five-point Likert scale. Mindez, Ingles and Hidalgo (1999) validated the instrument using a Spanish population they reported a reliability index of α=0.91.

This instrument was adapted for this study to screen the participants who possessed public speaking anxiety. The instrument is structured in simple sentence negative statements which facilitated scoring. High scores (above 30) showed that the subject is afraid to speak in public while low scores (below 30) meant that the respondent was confident to speak in public. In order to make the instrument adaptable in terms of culture and age appropriate, the researcher after consultation with three test and measurement experts reworded some items i.e terrified was changed to shock, mingled to empty e.t.c. The reversed version had only 12 items appropriate to the study objective. As a way of ensuring the consistency of measurement, test-retest after a week interval was used and it showed a reliability index of r=0.72.The questionnaire was therefore, considered to have satisfactory construct validity and reliability to screen the participants for public speaking anxiety. The instrument is attached as appendix one.

McCroskey's (1982) Personal Report of Communication Apprehension Scale

Personal Report of Communication Apprehension Scale was used to obtain pre and post intervention data of the criterion variable. The instrument was a 24 item self- report questionnaire developed and validated by McCroskey, Beatty, Kearney & Plax, (1985). As earlier mentioned, it was a 24 – item, Likert format design questionnaire pertaining to communication apprehension across four contexts: small group, meeting, interpersonal (dyad) and public speaking. Each context subscale presented six items. The respondents were asked to report their agreement to statements about their feelings about communicating with others (e.g. *"I am tense and nervous…"*

"I am very calm and relaxed, "… I get so nervous I forget facts…"). All context subscales and the total score were calculated and analyzed for full exploration of the public speaking and communication anxiety phenomena. The authors reported reliability estimates for all 24 items to range from .93 to .95 Several studies support the construct and criterion – related validity for the instrument for example Rubin, Palmgreen and Sypher (2004). It was a positively worded instrument which makes scoring easy**,** the higher the score, the more significant the level of anxiety. Test and measurement experts certified that the instrument was culturally fair and valid to assess the participants' level of public speaking anxiety. Test re-test after two weeks interval during the pilot study gave a reliability index of r=0.78 using Pearson Product Moment Correlation (PPMC).

Assertiveness Inventory by Alberti and Emmons (1995)

Assertiveness Inventory is a standardized psychological assertiveness inventory adapted from Alberti and Emmons (1995). It is a 17 item self-report scale used in this study to classify the participants based on their level of assertiveness. It is a four point Likertdesign questionnaire which reflect the degree to which the respondents are assertive. The scoring format is as follows; 0=No or never, 1=sometimes, 2 average=3=usually, 4=practically always or entirely. Typical items on the scale include; *'Do you generally express what you feel?'' 'Do you often step in and make decisions for others, "Are you able to refuse requests made by a friend if you do not wish to do what the person wants?"* Do you speak out in protest when someone takes your place in line?

To ensure that the instrument suited the purpose of the study, the instrument was given to the supervisor in addition to three measurement and test experts in the Department of Guidance and Counselling, University of Ibadan. After inter- rater review process, the instrument was certified to have face and content validities. Reliability index was further established during the pilot study, split half reliability co-efficient of α .089 was established making it satisfactory for the study.

3.5 Pilot Study

To ensure that this research was feasible, the researcher conducted a pilot study for a week using students from other schools not participating in the study. The pilot study afforded the researcher the opportunity to train the research assistants, validate the research instruments, and acquaint the research assistants with the procedures for data collection. The pilot study also provided insights on how to handle other logistic matters.

3.6 Ethical Issues

For ethical reasons, participation of respondents was strictly voluntary. Signing of the parents' consent form provided by the researcher (see appendix) was taken as an indication to participate in the study. Moreover, in order to guarantee the anonymity of each participant, their names, classes and other identity information was not included in the questionnaires, codes were used instead. The participant's confidential information given in the course of the research was also not disclosed

3.7 Procedures for Data Collection

A systematic four phase procedures which consisted of pre- treatment, treatment and evaluation and termination were adopted for the study.

Pre-treatment

Before the treatments, the following activities were carried out at the pretreatment stage.

- Advocacy/familiarization visit to schools;
- Obtaining a written approval from the School Principal using the introduction letter from the Head of Department of Guidance and Counselling, University of Ibadan;
- Sensitization Teachers, Guidance Counsellors, and other members of the School community;-
- Orientation of participants to the training goals and objectives,
- Obtaining of the participants consent by calling for volunteers and issuing of consent form signed by the volunteers' parents.

- Personal report of confidence as a speaker (PRCS) (Paul, 1996) was administered to obtain baseline data.
- The Researcher administered the Assertiveness inventory in classifying participants according to levels of assertiveness

Treatment Phase

Respondents who met the inclusion criteria were thereafter treated with either Lefkoe therapy or Cognitive Behaviour Therapy. The treatment lasted for 90 minutes per session for each of the experimental groups. The duration of the therapy was 10 sessions to coincide with one academic session. To ensure uniformity in treatments, the procedures were scripted. Participatory methodologies which included drama, case studies, songs, and role plays were adopted during facilitation. Participants' achievements were evaluated on daily basis. Thereafter, in order to obtain post intervention data, Personal report of confidence as a speaker (PRCS) (Paul, 1996) was administered.

Termination of Therapy

On conclusion of ten sessions of therapy in the experimental groups, the researcher appreciated the three groups for their cooperation and formally terminated therapy.

The Control Group

The control group participated in the pre and post-treatment assessment only. They were not exposed to any therapy. However, a seminar on public speaking using similar treatments was organized for two weeks to ensure that they also benefitted and not just used and dumped after the experiment.

Summary of Sessions for Experimental Group One (LEFKOE Treatment)

Treatment goal:

To eliminate long-held beliefs associated with public speaking, for example, "mistakes and failure are bad" and 'if I make a mistake, I'll be rejected' and de conditioning fear associated with public speaking using Lefkoe Belief Process and the Lefkoe stimulus process

Training materials: Flip charts, markers, flip chart stand ball pens, Information Education and Communication Materials (IEC).

Summary of Sessions:

Session i: General orientation and administration of McCroskey's (1982) Personal Report of Communication Apprehension – 24 (PRCA – 24) scale and assertiveness inventory to obtain baseline data.

Session ii: Introduction to concept of Lefkoe Therapy

Session iii: Explanation of the concept of Lefkoe stimulus process

Session iv: Identification of causes of negative emotions in the lives of individuals

Session v: Explanation of individual differences in emotion due to genetic and environmental factors

Session vi: Extinction of conditioned stimuli associated with negative emotions

Session vii: Identification of participant undesirable pattern of behaviour or feelings

Session viii: Exchanging of meaningless emotion with a positive one

Session ix: Identifying the pattern of events that lead to form the belief

Session x: Administration of Questionnaire (PRCA-24), and Assertiveness Inventory and Termination of Therapy

Summary of Sessions for Experimental Group Two (Cognitive Behaviour Therapy)

Treatment goal:

The goal of CBT which is a combination of cognitive and behaviour therapies is twofold; first, to modify the participants' irrational and maladaptive thoughts, assumptions, beliefs, behaviours, emotions and attitude with the aim of making them to have more realistic appraisal of the anxiety associated with public speaking. Second, to empower the participants with requisite skills to speak in public using series of demonstration, modeling and role play.

Training materials

Flip charts, markers, flip chart stand ball pens, Information Education and Communication Materials (IEC).

Summary of Sessions

Session i: General orientation and administration of McCroskey's (1982) Personal Report of Communication Apprehension – 24 (PRCA – 24) scale and assertiveness inventory to obtain baseline data.

Session ii: introduction of the concept of Cognitive Behaviour Therapy

Session iii: Discussion of the effectiveness of CBT in the remediating anxiety stimulating stimuli such as public speaking

Session iv: Identification of participants distorted thoughts towards public speaking by using STEB

Session v: Confronting problems of over-generalizations.

Session vi: Combating negative "self-talk" with positive self-statements.

Session vii: Reframing cognitive distortions by improving participants' knowledge of anxiety associated with public speaking.

Session viii: Combating thoughts distortions with knowledge of the benefits of public speaking counselling.

Session ix: Demonstration, modeling and role plays of public speaking skills.

Session x: Summary of all the sessions, administration of post intervention questionnaires and termination of therapy.

3.8 Control of Extraneous Variables

The researcher controlled some extraneous variables that may affect the outcome of the experiments using certain strategies that help manage the intrusion of these variables. The researcher ensured randomization in the selection of the participans for the study. Also, the major interventions were administered in two different secondary schools while the control group was located in another secondary school.

Secondly, the researcher ensured that a 3 x 2 x 2 factorial matrix was carefully adhered to in the course of carrying out the study and the selection of participants was strictly based on the outlined criteria.

Thirdly, analysis of covariance (ANCOVA) was used for analysis of data because it has a very high capacity for score moderation through the advantageous use of the inclusive and exclusive factors.

3.9 Criterion for Selection

Inclusion Criteria

- The study inclusion criteria were as follows;
- Only Students who are from the three participating schools were enrolled.
- Students who had public speaking anxiety as evident from the score obtained from the baseline data using Personal Report of Confidence as a speaker (PRCS) (Paul, 1996).
- Only senior secondary school students who responded to the Assertiveness skill questionnaire and scored below 10.
- Only students who volunteered to participate.
- Only students who returned signed parental consent form

3.10 Data Analysis

Four statistical tools were used to analyze data obtained from this study. First, Analysis of Covariance (ANCOVA) by Fisher (1951) was used as the statistical tool to ascertain the effectiveness of the treatments in comparison with the control group. The choice of ANCOVA was based on the fact that the study was a quasi-experimental design which had a non-randomized sample. Some heterogeneity known as covariates might exist among the study sample. ANCOVA will enable the inclusion of those covariates that are not part of the main experimental manipulation but could have influence on the dependent variables. Study also show that ANCOVA has the ability to adjust treatment means, interpret data, estimate missing data, increase precision in randomized experiment, and take correlation between pre- test and post- test measures into account.

Second, Scheffe was used for post hoc analysis to determine the margin of differences between the treatment groups. Third, Multiple Classification Analysis (MCA) was undertaken in order to determine the amount of contributions of the independent variables (LT and CBT) on the prediction of the dependent variable (Public speaking Anxiety). Finally, descriptive statistics was used to describe the demographic profile of the participants' (mean, standard deviation, age range, and percentages).

CHAPTER FOUR

RESULTS

4.1 Results

In this chapter, the statistical results of this study is presented and interpreted, revealing the outcome of the study. The outcome of the study further determined the acceptance or rejection of the stated hypothesis.

Hypothesis One: There is no significant main effects of treatments on public speaking anxiety among secondary school adolescents.

Table 4.1: Summary of 3 x 2 x 2 Analysis of Covariance (ANCOVA) showing the significant interaction main effects of Treatment group, Gender and Assertiveness on Public Speaking Anxiety among Secondary school Adolescents

Source	Sum of squares	DF	Mean square	F	Sig.	Eta^2/Effect size
Corrected Model	11605.272	12	967.106	32.291	.000	.784
Pretest	1264.811	1	1264.811	42.231	.000	.283
Main effect						
Treatment	1781.648	2	890.824	29.744	.000	.357
Assertiveness	325.968	1	325.958	10.884	.001	.092
Gender	67.980	1	67.980	2.270	.135	.021
2-way Interactions	23.951	2	11.976	.400	.671	.007
Treatment x Assertiveness	89.569	2	44.785	1.495	.229	.027
Treatment x Gender	5.012	1	5.012	.167	.683	.002
Assertiveness x Gender						
3-way Interactions	24.830	2	12.415	.415	.662	.008
Treatment x AS x Gender	3204.594	107	29.949			
Error	14809.867	119				
Total						

(R-squared = .784, Adjusted R-squared = .759).

Table 4.1 shows there is a significant main effect of treatment groups on public speaking anxiety among secondary school adolescents ($F(3,116) = 29.7444$, $p<.05$, $\eta^2 = .357$). This implies that there is a significant impact of the treatment on public speaking anxiety among secondary school adolescents. Therefore, the null hypotheses was rejected; the table also reveals the contributing effect size of 3.5%. For further clarification on the margin of differences between the treatment groups and the control group, the pair wise comparison of the adjusted mean was computed and the result is as shown in table 4.2 below:

Table 4.2: Scheffe Post-Hoc Pair wise Analysis of the Significant Differences between the Treatment Groups and the Control Group.

		Subset for Alpha = .05	
TREATMENT GROUPS	N	1	2
LEFKOE	40	51.3500	
C.B.T	40	53.6500	
CONTROL	40		68.9000
Sig.		.442	1.000

From table 4.2 it revealed that after controlling for the effect of public speaking anxiety among secondary school adolescents, participants in experimental group I (Lefkoe therapy) scored lower in public speaking anxiety (mean = 51.35) than those in experimental group II (Cognitive Behavior Therapy) (Mean = 53.65) and control group (mean = 68.90). By implication, Lefkoe therapy is more potent in reducing public speaking anxiety among secondary school adolescents Cognitive Behaviour Therapy. The coefficient of determination (Adjusted R-squared = .759) overall indicates that the differences that exist in the group account for 75.9% in the variation of adolescents public speaking anxiety.

Table 4.3: Multiple Classification Analysis (MCA) showing the magnitude of the contributions of Treatment group, Assertiveness and Gender on Public Speaking Anxiety of Secondary School Adolescents.

Variable + Category Grant Mean = 57.97	N	Unadjusted variation	Eta	Adjusted for independent + covariates deviation	Beta
Treatment Group:					
1. LEFKOE	40	-6.62		-4.42	
C.B.T.	40	-4.32		-3.35	
Control	40	10.93		7.77	
			.70		.50
Assertiveness:					
Low	37	-10.24		-3.34	
High	63	4.56		1.49	
			.62		20
Gender:					
1.	60	2.13		.83	
Male	60	-2.13		-.83	
2.			.19		.07
Female					
Multiple R-squared					.776
Multiple R					.881

In the table, the mean scores of the differences in the Reduction of Public Speaking Anxiety of the Participants.

Treatment Groups:

1. LEFKOE (Grand mean (57.97 – 6.62) = 51.35;
2. C.B.T. (Grand mean (57.97 – 4.32) = 53.65;
3. Control (Grand mean (57.97 + 10.93) = 68.90;

Assertiveness:

1. Low (Grand mean (57.97 – 10.24) = 47.73;
2. High (Grand mean (57.97 + 4.56) = 62.53;

Gender:

1. Male (Grand mean (57.97 + 2.13) = 60.10;
2. Female (Grand mean (57.97 – 2.13) = 55.83.

From the treatment groups, the LEFKOE group had 51.35, C.B.T. had 53.65 and the control group had 68.90. In assertiveness group, the low group had 47.73 while those in the high group had 62.53. However, the result showed that the males had a mean score of 60.10 while their female counterparts had a mean score of 55.83 respectively.

Table 4.4: Estimated Marginal means of the Treatment, Assertiveness skill and Gender on Reduction of public speaking anxiety.

Treatment groups	Assertiveness skill	Gender	Mean	Std. Error
LEFKOE	Low	Male	50.876	2.008
		Female	49.575	2.052
	High	Male	55.104	1.581
		Female	54.752	1.584
C.B.T	Low	Male	49.234	2.842
		Female	50.679	1.620
	High	Male	56.952	1.426
		Female	56.382	2.081
Control	Low	Male	67.043	3.877
		Female	59.315	3.972
	High	Male	68.939	1.385
		Female	65.491	1.333

The above table shows the Mean and Standard Error of estimate of the Treatment, Assertiveness skill and Gender group.

Hypothesis Two: There is no significant main effect of assertiveness on public speaking anxiety among secondary school adolescents. Table 4.1 further shows that there was a significant main effect of assertiveness on public speaking anxiety among in-school adolescents ($F(2,117) = 10.884$, $p<.05$, $\eta^2 = .092$). An approximation of 4.8% scored low in assertiveness as against 6.3% that were high in assertiveness. Therefore the null hypothesis was rejected. This implies there is significant difference between the respondents on the basis of assertiveness.

Hypothesis Three: There is no significant main effect of Gender on public speaking anxiety among secondary school adolescents. Table 4.1 signifies there is no significant main effect of Gender on reduction of public speaking anxiety among secondary school adolescents $F(2,117) = 2.270$, $p>.05$, $\eta^2 = .021$). The null hypothesis is accepted, implying that there is no significant difference between gender groups.

Hypothesis Four: There is no significant interaction effect of treatments and assertiveness on public speaking anxiety among secondary school adolescents. Table 4.1 denotes there is no significant interaction effect between treatments and assertiveness on public speaking anxiety among secondary school adolescents ($F(6,113) = .400$, $p<.05$, $\eta^2 = .007$). This implies that the null hypothesis is accepted. It also implies that there is no significant interaction between treatment and assertiveness.

Hypothesis Five: There is no significant interaction effect of treatment and gender on public speaking anxiety. Table 4.1 denotes there is no significant interaction effect between treatments and gender on public speaking anxiety among secondary school adolescents ($F(6,113) = 1.495$), $p>.05$, $\eta^2 = .027$). Hence the null hypothesis is accepted. This implies there is no significant interaction between treatment group and gender.

Hypothesis Six: There is no significant interaction effect of assertiveness and gender on public speaking anxiety among secondary school adolescents. Table 4.1 reveals

that there is no significant interaction effect of assertiveness and gender on public speaking anxiety among secondary school adolescents (F (4,115) = .167, p>.05, η^2 = .002. It is based on this that the null hypothesis is accepted. Therefore, there is no significant interaction between assertiveness and gender.

Hypothesis Seven: There is no significant interaction effect of treatment, Assertiveness and Gender on public speaking anxiety among secondary school adolescents. Table 4.1 shows that there is no significant interaction effect of treatment, assertiveness and gender on public speaking anxiety among secondary school adolescents (F(12,107) = .415, p>.05, η^2 = .008). To this end, the null hypothesis is accepted. This implies there is no significant interaction between treatment, assertiveness and gender.

4.2 Discussion of Findings

This study examined the effect of Lefkoe and Cognitive Behaviour therapies on public speaking anxiety among secondary school adolescents. To this effect, ANCOVA as a statistical tool was used to analyse the data collected and the findings are discussed below:

Hypothesis One: There is no significant main effect of treatment on public speaking anxiety among secondary school adolescents. The above stated hypothesis was rejected because the result in table 4.1 clearly showed that there was a significant main effect of treatment on the reduction of public speaking anxiety among secondary school adolescents in Ibadan, Oyo State, Nigeria. By implication, both Lefkoe and cognitive behavior therapies were effective in reducing public speaking anxiety among in-school adolescents. Although both interventions were effective, table 4.2 clearly showed the marginal difference between the interventions. It was revealed that Lefkoe therapy was more effective in reducing the public speaking anxiety among secondary school adolescents than the cognitive behaviour therapy. This finding is not consistent with the findings of Foa and Kozak (1986) that used the concept of emotion processing to explain fear reduction during exposure. They support the hypothesis that exposure to feared stimuli allows the activation of the fear structure and the presentation of corrective information incompatible with the pathological elements of the fear structure.

The findings of Emmelkamp (2003 with exposure in vivo especially in the treatment of specific phobias further affirms the findings of this study owing to the fact that they reported that anxiety disorders can be treated quite effectively with CBT. Also, the finding of this study corroborated the study of Vincelli et al (2003 in a controlled randomized study that compared eight sessions of experiential cognitive therapy (ECT) with twelve sessions of cognitive behavior therapy (CBT).

Analyses of the data by means of non parametric tests show a significant decline in anxiety and depression symptoms on all measures for the ECT and CBT group. The waiting list group showed no differences between pre and post test. Moreover, no differences at post-test were found between ECT and CBT. These results look promising. Cognitive behavior therapy (CBT) including exposure, specifically in vivo exposure, is considered the treatment of choice for social phobia and special phobias. Regarding social phobia this intervention has received wide empirical support from numerous clinical trials (e.g. Butler, Cullinton, Munby Amies, & Gelder, 1984; Mattick, Peters, & Clarke, 1989; Turner, Beidel & Jacob, 1994).

In the same vein, this study discovered also that Lefkoe therapy is effective in reducing public speaking anxiety among secondary school adolescents in Ibadan. This finding aligns with the findings of Hellstrom and OSt (1995) who reported a significant effectiveness of the Lefkoe Belief process as an intervention to improve self-esteem, enhance an internal locus of control, and to reduce hostility, social alienation and anti-social behavior in eight incarcerated criminals. Furthermore, the finding in this study is in concordance with the findings of Sechrest (1994) who utilized Lefkoe concepts in his study and concluded "The Lefkoe Method is an effective, quick and convenient procedure to eliminate the fear of speaking in public". Also congruent to the findings of this study is the findings of Lefkoe (1977), the founder of the Lefkoe institute who together with his colleagues helped over 450 people a year to eliminate their fear of public speaking. According to Lefkoe, the therapy works by "undoing" the two main causes of the fear of public speaking, negative beliefs and emotional conditioning.

To further corroborate the efficacy of the Lefkoe therapy, Hamilton (2006) carried out a study to determine if the therapy could totally eliminate the fear of public speaking and the results of the study were published in a peer-reviewed journal and stated: "The large, positive changes on all outcome measures subsequent to treatment give strong support to the claim of efficacy of the TLM for reducing fear associated

with speaking in public the TLM resulted in substantial decreases or complete eliminations of fear, accompanied by positive changes in confidence and reduced negative sensations felt during speaking in public in the experimental group. Overall, the TLM appears to have potential as an effective, quick and convenient procedure to eliminate the fear of speaking in public".

The plausible explanation for the findings of this study, is that cognitive behavior therapy was very effective because it has the capacity to make participants in this study become aware of thought distortions and irrational fears which have been inhibiting them from having confidence to speak in the public and to replace such with rational thought processes. Cognitive behavior therapies (CBTs) have been shown to be efficacious for the treatment of various types of anxiety disorders in children and adolescents. For example, Ansari, Gorji & Shafia, (2013) investigated the impact of speech therapy with Cognitive Behaviour Therapy (CBT) on reducing the severity of stuttering & anxiety for adults who stutter in the city of Isfahan, Iran and reported that speech therapy with CBT reduced the severity of stuttering and anxiety.

Likewise, Lefkoe therapy was also effective in reducing public speaking anxiety among secondary school adolescents just as Lefkoe (1977) rightly pointed out that Lefkoe interventions are particularly good at helping to eliminate long-held beliefs and decondition the stimuli that produce negative emotions such as public speaking anxiety.

Hypothesis Two: There is no significant main effect of Assertiveness skill on reduction of public speaking anxiety among secondary school adolescents.

The hypothesis stated above was rejected because the result in table 4.1 clearly shows that there was a significant main effect of treatment on the reduction of public speaking anxiety among secondary school adolescents. By implication, assertiveness skill has a significant impact on the reduction of public speaking anxiety. The report of this study aligns with the findings of some other studies that discovered the significance of assertiveness to public speaking anxiety. Such studies were carried out by (Morrissey & Callaghan, 2011) and some assertive communicators like (Kolb & Stevens Griffith, 2009; Sundel & Sundel, 1980) respectively. In a descriptive study conducted by Mohamedunni and Noushad, (2010) to assess the level of assertiveness among students of secondary school of Kerala state, India with 590 samples, they discovered that the students who have problems regarding communication and self-

expression cannot assert for their rights than other students by 55%. This report corresponds with the findings of this study. Furthermore, Devi and Indumathi (2004) discovered in their study that boys were 75% more assertive but not more aggressive or submissive. This is in agreement with the findings of this study.

In a similar study conducted to assess components of assertiveness and depressive symptoms of 183 Chinese undergraduates, they discovered that the components were found to relate differentially to the beliefs in specific assertive rights. They affirmed that nonassertive response especially in expressing and disclosing oneself correlated with depressed mood. These findings are congruent to the findings of this study. One possible explanation for this finding could be based on the submission of Morrissey & Callaghan, 2011 who stated that assertive communicators are able to clearly and openly express their needs, wants, feelings and opinions in a manner which is respectful to themselves and others.

Hypothesis Three: There is no significant main effect of Gender on the reduction of public speaking anxiety among secondary school adolescents.

The hypothesis stated above was accepted because the result in table 4.1 clearly portrayed that there was no significant main effect of gender on the reduction of public speaking anxiety among secondary school adolescents in Ibadan. By implication, gender difference has no significant impact on the reduction of public speaking anxiety.

Public speaking anxiety research has shown conflicting results for gender, some studies finding higher levels in males, others in females. Studies such as (Costa et al, 2001) reported significant gender differences in favour of girls. Other studies like King (1998); Super and Thomson (1979) reported significant gender differences in favour of boys. However, Florian and Zernitsky – Shurka (1987) found no significant gender differences between the two gender groups in their study.

Given an explanation to the finding of this study, the researcher is of the opinion that, irrespective of biological differences, capabilities and dispositions, the emphasis should be on competence and performance in public speaking situations provided the two gender groups are given equal opportunities. It is the considered opinion of the researcher that, the personality type cuts across gender (male & female). This implies that male and females could have personality type that allows them to speak in public without fear or anxiety.

Hypothesis Four: There is no significant interactive effect of treatment and assertiveness on the reduction of public speaking anxiety among secondary school adolescents.

The above stated null hypothesis was accepted implying that there was no significant interactive effect of assertiveness on the reduction of public speaking anxiety among secondary school adolescents. This is to say that the assertiveness did not moderate the effect of the treatment on the reduction of public speaking anxiety. This is contrary to the discovery of Ibrahim (2010) who observed that undergraduate business students with an acquisitive self-presentation style were more assertive as compared to the students with a protective self-presentation style. This means that, students with an acquisitive self-presentation style, when speaking in public appear to be self confident, composed, maintain eye contact, speak firmly and positively.

There was no significant interactive effect of treatment and assertiveness among secondary school adolescents probably because there are different presentation of styles of which students in business may exhibit strength in some competencies and weakness in some other competencies, which is also applicable to students in some other discipline. Also contrary to the outcome of the hypothesis is another study conducted to assess the relationship between assertiveness and group participation among women students in department of psychology. Barllan University whose age ranged from 21 – 23 years. Assertiveness was measured using Rathus Assertiveness Scale. The finding of the study revealed that 92% highly assertive women participated in group activity and 10% of less assertive women are interested in group participation.

The researcher is of the opinion that there was no significant interactive effect of assertiveness on the reduction of public speaking anxiety among secondary school adolescents probably because few individuals are assertive all of the time but the skills of assertive behavior are important to develop so they can be utilized in appropriate situations as there will be times when assertive behavior may not be the most appropriate course of action, such as in situations that may result in the potential for injury to themselves or others.

Hypothesis Five: There is no significant interactive effect of treatment and gender on the reduction of public speaking anxiety among secondary school adolescents.

The hypothesis stated above was accepted because there was no significant interactive effect of treatment and gender on the reduction of public speaking anxiety among secondary school adolescents. This simply means that gender did not significantly moderate the effect of treatment on the reduction of public speaking anxiety among secondary school adolescents.

Some findings have proven that the differences that exist between males and females are not just limited to psychological factors. In the past, women were invisible yet today they believe that they possess a different voice, different psychology, different experience of love etc and also different culture from that of men (Coates, 1993). Consequently, gender should be a potent factor in determining the differences in public speaking anxiety. The result of this research supported previous studies on gender which produced mixed results in the role of gender in public speaking.

Janet Holmes (1994) in her study presented her idea that women are more polite than men in talking cooperatively and supportively. On the contrary, Florian et al (1987) found no gender differences in linguistic politeness among males and females in their study. The possible reason why gender could not moderate the effect of treatment on public speaking anxiety is that there are some distinct characteristics of both genders which could serve as determinant factors to be able to adequately measure the extent of differences that exist between them. However, this notable fact was not particularly taken into consideration in the course of carrying out the study.

Hypothesis Six: There is no significant interactive effect of assertiveness and gender on the reduction of public speaking anxiety among secondary school adolescents.

The result in table 4.1 showed that there is no significant interactive effect of assertiveness and gender, on the reduction of public speaking anxiety among secondary school adolescents. Therefore, the null hypothesis is accepted. This finding does not correspond with the findings of Garrison, Shauon, Jenkins & Jack (1985) of whose report showed an interaction between gender and assertiveness. In their study, they discovered that in a wide variety of school activities boys have higher assertive level (78.28%) than girls.

However, Florian and Zernitskey – Shurka (1987), in their study of Israeli Arab and Jewish University students found that females are actually more likely to perform certain assertive behaviours than males (initiating interaction, giving

negative feedback, complimenting others and admitting personal deficiencies). The logical explanation of this result could be attributed to differences in the assertiveness level of participants. Based on this, attention must be given to the strengths and weaknesses of both genders of which was not part of this study.

Hypothesis Seven: There is no significant interactive effect of treatment, assertiveness and gender on the reduction of public speaking anxiety.

This hypothesis was accepted because there was no significant interactive effect of treatment, assertiveness and gender on the reduction of public speaking anxiety among secondary school adolescents. Although table 4.1 clearly showed that there was a significant main effect of treatment on the reduction of public speaking anxiety among secondary school adolescents, however combination of treatment gender and assertiveness did not significantly reduce public speaking anxiety among secondary school adolescents. This implies that the anxiety resulting from public speaking experience is so grave that this study could not infer that gender, assertiveness or treatments are more important than others. Another possible explanation to the finding of this study could be that secondary school adolescents are faced with common challenges associated with public speaking. These adolescents irrespective of the gender and level of assertiveness skill take general courses like "The Use of English" giving them equal opportunity to complete. This situation may account for the insignificance of gender and assertiveness on the reduction of public speaking anxiety, allowing just the main effect of treatment on the reduction of public speaking anxiety.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

This chapter presents a logical explanation on the findings of this study backed up with previous empirical findings. The discussion of the findings is based on the seven hypotheses earlier generated by the researcher. Logical conclusions and recommendations are also provided.

5.1 Summary

This study aimed at examining the effects of Lefkoe and Cognitive Behaviour Therapies on public speaking anxiety among secondary school adolescents. Having carried out the study, the summary of the findings is stated as follows:

3. There was a significant main effect of treatment on public speaking anxiety of the participants.
4. There was a significant main effect of assertiveness on public speaking anxiety of the participants.
5. There was no significant main effect of gender on public speaking anxiety of the participants.
6. There was no significant interactive effect of treatment and assertiveness on public speaking anxiety of the participants.
7. There was no significant interactive effect of treatment and gender on public speaking anxiety of the participants.
8. There was no significant interactive effect of assertiveness and gender on public speaking anxiety of the participants.
9. There was no significant three-way interactive effect of treatment, assertiveness and gender on public speaking anxiety of the participants.

5.2 Conclusion

This study was designed to examine the effect of the Lefkoe and Cognitive behavior therapies on public speaking anxiety among secondary school adolescents in Ibadan, Oyo State, Nigeria. Assertiveness and Gender were the moderating

variables. To this effect the selected participants had to undergo some training, the required data was collected and analysed, revealing the outcome of the study. Based on the findings of this study, the following conclusions are given: Lefkoe and cognitive behavior therapies were effective in reducing the public speaking anxiety of secondary school adolescents. By implication, a proper application of the principles underlying these psychological interventions should produce a similar result. However, Lefkoe therapy was more potent in reducing the public speaking anxiety among secondary school adolescents. This study further discovered that gender and assertiveness had no significant effect in reducing public speaking anxiety.

5.3 Implication of Findings for Counselling Practice

The findings of this study clearly showed that Lefkoe and Cognitive behavior therapies were effective in reducing public speaking anxiety of secondary school adolescents. This finding has implication for the secondary school students, teachers, school counselors, and even other researchers who may discover gaps to carry out further studies. Speech anxiety has serious implications for students at the secondary school levels. Students with public speaking anxiety tend to avoid engaging in behaviours that facilitate success such as asking questions during class, meeting with instructors, and collaborating with peers. Students who fail to adopt academically supportive behaviours due to high communication apprehension are more likely to drop out of college than their peers (McCroskey et al., 1989). This study has established the fact that some psychological interventions as Lefkoe and cognitive behavior therapies are effective in reducing public speaking anxiety among secondary school adolescents.

School counsellors can be confident in utilizing any of these interventions to reduce public speaking anxiety. Though optimal level of arousal and mindset is necessary to best complete a task such as an examination, perform an act or compete in an event, however, when the anxiety or level of arousal exceeds that optimal level, the result is decline in performance. This projects the need to constantly seek ways of reducing the public speaking anxiety of students of which this study has set the pace for such.

Having discovered the effectiveness of Lefkoe and cognitive behavior therapies in reducing the public speaking anxiety among secondary school

adolescents, this study has become a leading light to other researchers to examine the effect of other psychological interventions for same or similar purpose.

5.4 Limitation ot the Study

A major limitation in this study is that, there appears to be scarcity of literature on the relationship between the variables under study. Also, the researcher had challenges retaining some of a participants involved in the study in spite of all measures put in place.

As a result of the bureaucratic process involved in the approved from the ministry of education, the study was a bit delayed. However, despite all these limitations, the results of this study still remain valid.

5.5 Recommendations

The following recommendations are given based on the findings of this study;

1. The effectiveness of Lefkoe and cognitive behavior therapies in reducing public speaking anxiety among secondary school adolescents should be incorporated into the curriculum of secondary schools by way of orientation, as these trainings will better equip secondary school students to effectively manage challenges associated with public speaking anxiety.
2. Students who have public speaking anxiety problems can personally undergo such trainings for effective problem management.
3. The counselling units or centers in the various secondary schools should maximize the rudiments of these psychological interventions used in this study to help reduce public speaking anxiety among secondary school adolescents.
4. Parents should be well informed on the need to reduce external home pressures that could hamper the emotions of their wards in school. Students should not be directly involved in the challenges faced at home because they are faced with other psycho-environmental challenges that could affect their success in school.
5. Teachers should be more accommodating to student's needs so they don't perceive the school as threatening and stay away from attending classes.

5.6 Contributions to Knowledge

1. This study has proven that public speaking anxiety is amenable to treatment.
2. The outcome of this research has also provided empirical evidence to suggest that Lefkoe and Cognitive Behaviour therapies are effective in reducing public speaking anxiety.
3. The findings from this study have shown that Lefkoe therapy is more effective in remediating public speaking anxiety. Counselling psychologists can incorporate this valuable information in designing intervention.
4. This study has contributed to the literature with regard to the independent variables and dependent variables as there are paucity of literature in this area.
5. This study has established that gender has no moderating effect on public speaking anxiety among secondary school adolescents.
6. This stud showed clearly the relationships between public speaking anxiety, assertiveness and gender of secondary school adolescents.

5.7 Suggestions for Further Studies

The effectiveness of Lefkoe and cognitive behavior therapies in reducing public speaking anxiety among secondary school adolescents can be replicated in other states. Other psychological variables other than gender and assertiveness can be examined as moderating variables so as to identify other variables that could possibly influence the effectiveness of Lefkoe and cognitive behavior therapies in reducing public speaking anxiety among secondary school adolescents.

There are other psychological interventions that could be potent in reducing public speaking anxiety among secondary school adolescents which other researchers could explore. The findings of this study can be revalidated by re-conducting the same research using the same target population after a period of time.

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TREATMENT PACKAGES

Treatment Procedures for Experimental Group One: SS 2 Secondary School Students treated with the Lefkoe Method (TLM).

Session One

Topic: General orientation and administration of baseline questionnaires

Objectives:

- To establish rapport with the participants.
- To acquaint the participants with the training logistics.
- To discuss the benefits of participation in the treatment.
- To obtain baseline data.

Stage I: Climate Setting

The researcher welcomed the participants warmly and introduced his research assistants. Participants were requested to introduce themselves in order to establish rapport with the facilitators. They were informed that the success of the therapy was dependent upon their active role. The need for them to adhere to the training logistics was also emphasized.

Stage II: Setting of ground rules

The researcher facilitated the setting of rules that made the training successful and distractions free. Some of the rules include:

- All GSM to be on vibration
- No shouting down of contributors
- Punctuality to sessions
- Good time management
- No side discussion etc.

Evaluation and welfare committees were also constituted to provide feedback and clean the venue respectively.

Stage III: Benefits of participating in the therapy

The researcher informed the participants that they would acquire the knowledge and skills to cope with negative emotions that result from conditioned stimuli, for example, fear that is always experienced when one makes a mistake or is rejected and that such fear can be quickly and permanently stopped by deconditioning the stimuli or is rejected. The researcher also added that the training would improve the knowledge of participants by making them to understand that even beliefs formed

early in childhood can be permanently eliminated in a matter of minutes. Another benefit of the training is that the participants would acquire the skills of participatory methodologies i.e. role plays, debates, classroom presentations for organizing future activities among themselves.

Stage IV: Administration of questionnaires

The researcher with the help of the research assistants distributed McCroskey's (1982) Personal Report of Communication Apprehension – 24 (PRCA – 24) and assertiveness inventory. Adequate instructions on how to fill the protocols were provided. The questionnaires were collected on completion.

Stage V: Behavioural homework and daily evaluation

The session was concluded by asking the participants to discuss what they have achieved in the session. They were asked to record on their diaries their expectations for the training as take home assignment.

Session Two

Topic: Concept of the Lefkoe Method

Objectives:

- To explain the concept of the Lefkoe Method
- To discuss the uses of TLM in public speaking anxiety reduction
- To familiarize the participants with the role that they are expected to play in order for therapy to be effective.
- To obtain the participants' commitment

Stage I: Review of behavioural homework

The researcher randomly asked the participants to discuss their expectations for the training as was recorded on their diaries. The researcher commended their efforts.

Step II: Concept of the Lefkoe Method

The researcher explained that the Lefkoe Method is a therapeutic approach developed to help people overcome or deal with such fears as public speaking. The aim of the Lefkoe Method is to eliminate, quickly, long-held beliefs and "de-condition" the stimuli that produce fear and other negative emotions, e.g. the fear of speaking in public. Lefkoe has discovered that the fear of public speaking is typically caused by (a) specific beliefs, such as "mistakes and failure are bad" and "if 1 make a mistake, I'll be rejected and (b) conditioning, such as automatically experiencing fear

whenever one is, or perceives oneself to be, in a position to be critized or judged. Two processes in TLM, the Lefkoe belief process and the Lefkoe stimulus process, are used to address fear of public speaking.

Stage III: Using the Lefkoe belief process in public speaking anxiety reduction

The Lefkoe belief process enables individual to eliminate such long-held specific beliefs by assisting the participants to:

- realize that their belief actually is one valid meaning of their earlier circumstances. The Lefkoe belief process does not attempt to change beliefs by challenging the validity of the evidence the participant uses to support them. It does not attempt to get the participant to see that, his current belief is wrong or not true or to see it as illogical, does not make sense or reject it as self-defeating. Rather, the belief process actually would validate the participants for forming the belief earlier in life by assisting them to:
- realize that most people probably would have made a similar interpretation under similar circumstances.
- realize that the 'evidence' that people offer is not the actual reason they believe in because such evidence consists of recent observations that appear to substantiate the belief.
- realize that, according to LBP, the source of ones beliefs is interpretations of circumstances earlier in life.
- realize that, fundamental beliefs about oneself and life are usually formed in childhood.
- realize that after a belief has been formed, however, one acts consistently with it, thereby producing "current evidence" for the already-existing belief. In other words, life becomes a self-fulfilling prophecy.
- realize that, because the evidence one presents to validate ones beliefs usually is a consequence of the beliefs, not its source therefore challenging the validity of that evidence is not the most effective way to eliminate them.
- to make participants realize that, because the current belief is totally eliminated by the LBP, there is no need for one to act differently when one goes back "into life"; one's behaviour changes naturally and effortlessly once the belief is gone.

- to make participants realize that the LBP is a tool for the facilitator because the LBP is used by the facilitator to assist clients in eliminating the beliefs that produce negative emotions such as fear, anger, depression hostility etc and when these emotions stop after the beliefs that give rise to them are eliminated, there is no longer a need for a tool for clients to deal with them more effectively.

Stage IV: Making participants opinion public

The therapist asked the participants to publicly express their opinions about the Lefkoe belief process with respect to fear of public speaking.

Stage V: Behavioural homework and daily evaluation

The therapist asked the participants to record on their diaries the information that they have heard about public speaking, their beliefs about it and their attitude towards it. The participants' efforts were commended and the session's activities were concluded.

Session Three

Topic: Discussions of the Concept of Lefkoe stimulus process

Objectives:

- To review the behavioural homework.
- To explain the meaning of stimulus process.
- To empower participants with the skill to cope with the stimulus process.

Step I: Review of homework

The researcher randomly requested volunteers to present what they recorded on their diaries with regard to:

- Previous information about public speaking.
- How to identify the original source of fear.
- Events that were the source of a belief and the meaning attributed to such events.
- Making a distinction between the actual cause of an emotion and its associated elements.

The researcher noted their responses and introduced the session's topic as 'the concept of Lefkoe stimulus process'.

Step II: Concept of Stimulus Process

The researcher explained to participants that, according to the stimulus process initially the current stimulus never produces the emotion. It is only produced by the meaning he gives to the original cause. The current stimulus just happens to be associated with the original cause in time and when the association is broken and the client realizes that he made this arbitrary association, then the events that got associated no longer cause fear. It is important to take note of the parallel between how the Lefkoe stimulus process works and how the Lefkoe Belief process works as thus: When a client makes a distinction between the events that were the source of a belief and the meaning he attributes to those events, the belief is eradicated. When he makes a distinction between the actual cause of an emotion and its associated elements, the emotion will no longer be produced by these elements.

Step III: Behavioural homework

The researcher requested the participants to record on their diaries what they thought about the stimulus process in relation with public speaking.

Session Four

Topic: Causes of negative feelings such as fear, anger, sadness, guilt and anxiety in the lives of people.

Objectives:

- To review behavioural homework
- To enable the participants gain insight into the causes of negative emotions such as these mentioned above.
- To empower the participants with the skill to record their automatic thoughts.

Step I: Review of behavioural homework

The researcher requested volunteers to discuss their recorded experiences. Their contributions were commended.

Step II: Identification of causes of negative feelings

The researcher explained that negative feelings in the lives of people do occur every time specific events or circumstances occur. For example, whenever they make a mistake or someone rejects them, they experience fear or anger whenever they are asked to do something. The therapist would add that the first step in changing negative feelings is to take stock of what the present habits are. What situations would be

needed to handle better? What are the habitual ways of feelings and behaving in those situations? The participants would be encouraged to write down the situation, emotion and behaviour particularly in circumstances that are difficult or where they sense there is room for improvement.

Step III: Recording of negative feelings

The researcher requested the participants to record their feelings about public speaking using the following guidelines:

- The time, the place, the circumstance, and the people involved.
- The setting, the tempo, the environment, and the outcome.
- The situation, feelings and behaviours.

The session was concluded by asking the participants to make a list of what their feelings and observation were concerning the scenario that they had observed.

Session Five

Topic: Understanding the differences in feelings among people.

Objectives:

- To review behavioural homework
- To enable participants to understand the reason for differences in feelings.
- To enable participants to know why an event that is not inherently fearful produce fear in some people and not in others.

Stage I: Review of behavioural homework

The researcher requested volunteers to discuss their recorded experiences. Their efforts would be commended.

Stage II: Understanding the reason for differences in feelings

The researcher explained to participants that, in many cases the events that stimulate the feeling in some people do not produce the same feeling in others. The participants will be told the reason by telling them that, what appears to have happened is that an event was conditioned in the past to automatically produce emotions in the present.

Stage III: Behavioural homework

The researcher asked participants to write on their diaries why the events that stimulate the feeling in some people do not produce the same feeling in others.

Session Six

Topic: Extinguishing conditioned stimuli usually associated with negative emotions.

Objectives:

- To review behavioural homework
- To enable participants to understand that it is not the current stimuli that produce negative emotions.
- To improve participants' ability to become aware of what the stimulus process does to get rid of the negative emotions, such as fear of public speaking.

Stage I: Review of behavioural homework

The researcher requested volunteers to discuss their recorded experiences. Their effort was commended.

Stage II: Understanding the reason why it is not the current stimuli that produce the emotion

The researcher explained to participants that, the current stimuli just happen to be associated with the original cause and that the current stimuli never produce the emotion. The emotion is only produced by the meaning he gives to the original cause. The participants should be made to understand that, the negative feelings such as fear, anger, sadness or guilt that people experience is not caused merely by the occurrence of specific events or circumstances such as to be judged or evaluated but by the way and manner such events are carried out and the meaning given to the behaviour of who carries it out. For example, assuming the original source of the fear was a father who was never satisfied with what the client did as a child and showed his displeasure by yelling and threatening. No matter what the child did, the father was not satisfied. When the client reviews the cause of the fear, he discovers that, what really caused the fear was the meaning he unconsciously attributed to how his father judged and evaluated him, namely, with yelling and punishing. The person he depended on for his very survival, that is, the father, seemed to be withdrawing his love. No love, no care; no care, no survival. That is what caused the fear. The fear was never caused merely by being judged and evaluated. The client realizes that if he had been judged and evaluated by his father in a loving, understanding and supportive way, there would have been no fear. It was the way his father acted that gave rise to the meaning given to his father's behaviour (the yelling and punishment) which according to the client meant the father was withdrawing his love, which meant abandonment to the child.

Stage III: Self awareness/emotional mastery training

The researcher explained to the participants that in order to get rid of the fear of public speaking, one has to extinguish the conditioned stimuli that have become associated with fear, such as facing criticism, feeling that one is not meeting expectations, that one is being judged, or that one is being rejected.

Stage IV: Behavioural homework

The researcher asked participants to write on their diaries what they understand by conditioning, such as automatically experiencing fear whenever one is, or perceives oneself to be, in a position to be criticized or judged.

Session Seven

Topic: Identification of participants undesirable pattern of behaviour or feelings.

Objectives:

- To review behavioural homework
- To enable the participants to know some undesirable behaviour patterns.
- To educate the participants to become aware of some beliefs that could logically account for their behavioural pattern.

Stage I: Review of behavioural homework

The researcher requested volunteers to discuss their recorded experiences. Their effort was commended.

Stage II: Description of undesirable or dysfunctional pattern of behaviour or feelings

The researcher explained to the participants that, such feeling patterns could include fear, hostility, shyness, anxiety and depression. The researcher also explained to the participants that, the behavioural patterns could include phobias, relationships that never seem to work, violence, procrastination, unwillingness to confront people and inability to express feelings.

Stage III: Understanding what the participants believe that could logically account for their behavioural pattern

The researcher elicited one or more beliefs (that they probably were not conscious of before the Lefkoe belief process (LBP) began) that logically would manifest as their undesirable pattern. For example, a participant or client whose pattern is a fear of public speaking, with a host of physical symptoms when he/she thinks about having to give a presentation in front of a group, probably has the following beliefs: mistakes and failure are bad; if I make a mistake I'll be rejected;

people aren't interested in what I have to say; what I have to say isn't important; I'm not capable, I'm not competent, I'm not good enough; I'm not important; what makes me good enough and important is having people think well of me; change is difficult; public speaking is inherently scary. In other words, it is the beliefs that cause the pattern.

Stage IV: Behavioural homework and daily evaluation

The session was concluded by asking the participants to discuss what they have achieved in the session. They were asked to record on their diaries their expectations for the training as take home assignment.

Session Eight

Topic: Confirmation of the beliefs of participants/clients

Objectives:

- To review behavioural homework
- To ensure that the client of participants holds on to the belief.

Stage I: Review of behavioural homework

The researcher requested volunteers to discuss their recorded experiences. Their effort was commended.

Stage II: Practising the words of the belief by saying them out loud

The therapist ensured that, once the belief was identified, he would requested or asked the clients or participants to say the words of the belief out loud to confirm that they actually do hold this belief. If the client has the belief he/she will notice negative feelings associated with the statement or sense that the words themselves are true.

Stage III: Behavioural homework

The researcher concluded the session by asking the participants to discuss what they have learnt in the session. They were also asked to record on their diaries their expectations for the training as take home assignment.

Session Nine

Topic: Identifying the pattern of events that lead to form the belief.

Objectives:

- To review behavioural homework
- To enable participants to look for the earliest circumstances or events that could lead to the formation of the belief.

Stage I: Review of behavioural homework

The researcher requested volunteers to discuss their recorded experiences. Their effort was commended.

Stage II: Formation of beliefs

The researcher explained to participants that, for most part, beliefs are based on interactions with one's parents and other primary caretakers, if any. Beliefs in other areas of life, such as work and society are formed at the time those areas of life are encountered. Although the client can usually identify the relevant early events in five or ten minutes, at times she spends as much as half an hour recalling various events from her childhood.

Stage III: Giving an example of a belief based on childhood circumstances or events

The researcher gave an example, using the belief, "I'm not good enough". The source might be a childhood in which (the client's father was always telling her what to do and what not to do. Nothing she ever did was good enough for him. She never received any praise and was criticized a lot. The next step is to have the client realize that the current belief was, in fact, a reasonable interpretation of her childhood circumstances and that most children probably would have reached a similar conclusion, given their experience and knowledge at that time in their life. One's beliefs are almost always a reasonable explanation for the events one observes at the time one observes them. Thus the client is never told that her beliefs are irrational or wrong. This is one of the differences between LBP and CT, where a client is told that her beliefs are irrational and wrong, and shown why. The client then is asked to make up some additional interpretations of, or meanings for, the same earlier circumstances, which she had not thought of at the time. In other words, the client as a child observed her father doing and saying various things over a long period of time. The meaning she gave to the events was "I'm not good enough. What the client is asked to do is make up additional meanings or interpretations of her father's behaviour. In CT clients are often asked to create or are shown other ways to interpret events in the present that they currently feel bad about. This is taught as a skill that can be used to get rid of upsets after they happen and to calm fears and anxieties before stressful events. In LBP this technique is used as part of a process to eliminate a belief, so that the upsets and the anxieties do not occur after the client leaves the therapist's office.

Stage IV: Statements and Interpretations arising from earlier circumstances or events

The researcher explained to participants that apart from an example given earlier – using the belief "I'm not good enough" there are many other statements with reasonable meanings for a father's behaviour. Examples of such statements include the following:

- My father thought I was not good enough, but he was wrong.
- I was not good enough as a child, but I might be when I grow up.
- I was not good enough by my father's standards, but I might be by the standards of others.
- My father is a very critical person and would act that way with everyone, whether they were good or not.

It is important for the researcher to out that, each of the above statements is as reasonable a meaning for her father's behaviour as the one she came up with as a child.

The purpose was to help the client realize that her interpretation is 'a' truth, one of many possible interpretations, and not 'the' truth, the only interpretation. It is for her to realize that there are many different meanings, each one of which is logically consistent with the events she experienced.

When a client recognizes that something she has held as a belief (the truth) is, in fact, only one of several alternative meanings of what actually occurred (a truth), and when she realizes that she never saw the belief in the world, it ceases to exist as a belief. It literally disappears. A belief is a statement about reality that we think is the truth. When it is transformed into a truth, it is no longer a belief and no longer manifests behavioural or emotional patterns in a client's life.

It is also necessary for the researcher to pass the following information to the participants:

i. When an individual gives one possible meaning to a set of meaningless events but later, after observing the events, he seems to "see" the meaning (i.e. a belief) when observing the events and since "seeing is believing" it would be difficult to talk him out of a belief if he thinks he has "seen" it in the world. On the other hand, if he is able to revisit the events and realizes that he imposed one arbitrary meaning on a set of meaningless events, that the

meaning only existed in his mind, that had he come up with a different meaning at the time he never would have had the current belief – the belief will be eliminated.

ii. The Lefkoe Belief Process (LBP) also postulates that merely understanding that beliefs cause a pattern, or even identifying the specific beliefs that cause a given pattern, will not affect the pattern. The client needs to eliminate all of the beliefs that cause the pattern.

iii. According to LBP, mere understanding of the source of a belief is not sufficient to eliminate it. The client must also recognize that he never saw it in the world and that the events that led to the formation of the belief have no inherent meaning.

iv. Finally, with the LBP it is not necessary to see the connection between the undesirable behaviour or emotional pattern one wishes to change and the beliefs that cause it. In other words, insight into the cause of the pattern is not necessary as long as the appropriate beliefs are eliminated.

Stage V: Behavioural homework and daily evaluation

The researcher asked participants to brainstorm on how the Lefkoe belief process works and how the Lefkoe stimulus process also works. The day's session was evaluated by giving the participants the following take home assignments.

1. Explain what is meant by belief
2. Explain how beliefs are formed
3. Describe how negative emotions are produced
4. Draw the parallel between how the Lefkoe stimulus process works and how the Lefkoe belief process works.

Session Ten

Topic: Administration of post-intervention questionnaires and termination of therapy

Objectives:

- To empower the participants with the skill to maintain therapy gain.
- To obtain post intervention data
- To formally terminate therapy
- To appreciate participants

Stage I: General summary of all sessions

The researcher summarised all the sessions, elicited questions and provided answers and clarifications on issues raised. The researcher taught the participants some strategies to enable them maintain the gains of therapy, thus;

- Avoid environmental stimuli which could provoke fear and anxiety with regard to public speaking situations.
- Avoid friends or colleagues that discourage academically supportive behaviours as regards public speaking situations.
- Create alternative behaviours which are incompatible with fears or anxiety, i.e. joining debating societies and giving talks on public speaking anxiety.
- Encourage friends and colleagues to engage in public speaking activities.

Stage II: Administration of questionnaires

The researcher administered the personal Report of Communication Apprehension – 24 (PRCA-24) as well as Assertiveness Inventory to assess affective and behavioural reactions to public speaking situations for secondary school students and collect them on completion.

Stage III: Appreciation of participants and formal termination of therapy

The researcher appreciated the participants and commended them for being actively involved in the therapy. They were encouraged to maintain the gains of therapy. Participants were entertained with snacks and soft drinks and the therapy was formally terminated.

Treatment Procedures for Experimental Group Two: SS 2 Secondary School Students treated with Cognitive Behaviour Therapy (CBT).

Session One

Topic: General orientation and administration of baseline questionnaires

Objectives

- To establish rapport with the participants.
- To acquaint the participants with the training logistics.
- To discuss the benefits of participation in the treatment.
- To obtain baseline data.

Stage I: Climate Setting

The researcher would welcome the participants warmly and introduced his research assistants. Participants would be requested to introduce themselves in order to establish rapport with the facilitators. They would be informed that the success of the therapy is dependent upon their active role. The need for them to adhere to the training logistics would also be emphasized.

Stage II: Setting of ground rules

The researcher would facilitate the setting of rules that made the training successful and distractions free. Some of the rules include:

- All GSM to be on vibration
- No shouting down of contributors
- Punctuality to sessions
- Good time management
- No side discussion etc.

Evaluation and welfare committees would also be constituted to provide feedback and clean the venue respectively.

Stage III: Benefits of participating in the therapy

The researcher informed the participants that they would acquire the knowledge and skills to cope with negative or distracting feelings, like increased heart-rate, sweating, knocking knees, shortness of breath, memory lapses, mental confusion, etc all of which are associated with the public speaking context. The researcher added that the training would improve their knowledge of public speaking and would minimize the negative effects of anxiety associated with it for them. Another benefit

of the training is that the participants would acquire the skills of participatory methodologies i.e. role plays, debates, class presentations for organizing future activities among themselves.

Stage IV: Administration of questionnaires

The researcher with the help of the research assistants distributed McCroskey's (1982) Personal Report of Communication Apprehension – 24 (PRCA – 24) scale and Assertiveness inventory. Adequate instructions on how to fill the protocols were provided. The questionnaires were collected on completion.

Stage V: Behavioural homework and daily evaluation

The session would be concluded by asking the participants to discuss what they have achieved in the session. They, would be asked to record on their diaries their expectations for the training as take home assignment.

Session Two

Topic: Concept of Cognitive Behaviour Therapy

Objectives:

To explain the concept of Cognitive Behaviour Therapy

- To discuss the uses of CBT in public speaking anxiety reduction
- To familiarize the participants with the role that they are expected to play in order for therapy to be effective.
- To obtain the participants' commitment

Stage I: Review of behavioural homework

The researcher randomly would ask the participants to discuss their expectations for the training as was recorded on their diaries. The researcher would commend their efforts.

Step II: Concept of cognitive behaviour therapy

The researcher explained that cognitive behaviour therapy is a psychotherapeutic approach that addresses dysfunctional emotions, behaviours, cognitive distortions or fundamental "faulty thinking" with the goal of replacing irrational, counter-factual beliefs with more accurate and beneficial ones. Cognitive theorists hold that an individual unrealistic beliefs are directly responsible for generating dysfunctional emotions and their resultant behaviours, such as stress, fear, anxiety, indecision, and social withdrawal. Cognitive behaviour therapy enables individual to change such irrational beliefs and substitute more rational ones.

This is accomplished by assisting the participants to:

- Gain awareness of detrimental thought habits.
- Learn to challenge them.
- Substitute life-enhancing thoughts and beliefs.

Stage III: Using cognitive behaviour therapy in public speaking anxiety reduction

The researcher explained that cognitive behaviour therapy is used to replace irrational beliefs, fears and negative attitude towards public speaking.

Stage IV: Making of public commitment

The therapist thereafter asked the participants to publicly announce their plans to confront fears and irrational beliefs with respect to public speaking.

Stage V: Behavioural homework and daily evaluation

The therapist asked the participants to record on their diaries the information that they have heard about speaking in public, their beliefs about people who are afraid to speak in the public and their attitude towards anxiety-provoking situations. The participants' efforts would be commended and the session's activities would be concluded.

Session Three

Topic: Concept of cognitive distortions

Objectives:

- To review the behavioural homework.
- To explain the meaning of cognitive distortions.
- To empower participants with the skill to identify distorted thoughts.

Step I: Review of homework

The researcher randomly requested volunteers to present what they recorded on their diaries with regard to:

- Previous information about cognitive distortions.
- What the causes of cognitive distortions are.
- What people should do to overcome or minimize this problem.
- Attitude towards speaking in the public.

The researcher noted their responses and introduced the session's topic as "the concept of cognitive distortions".

Step II: Concept of cognitive distortions

The researcher would explain that, thoughts distortions occur when one is thinking negatively, when one fears the future, put oneself down, criticize oneself for errors, doubt abilities, or expect failure. Thought distortion damages confidence, distorts perception, impairs judgement and harms performance. The therapist would add that negative thoughts tend to flit into ones consciousness, do their damage and flit back out again with their significance having barely been noticed. Since they are not challenged, they could be completely incorrect and wrong; however this does not diminish their harmful effect. The researcher would emphasize that in order to live happily, the participants must learn how to make rational decision and replace the irrational fears with a rational one.

Step III: Behavioural homework

The researcher requested the participants to record on their diaries how they would relate or ask a colleague for a date, being assertive or give a colleague the opportunity to test the reality of his or her dysfunctional beliefs (e.g. "I won't be able to think of anything to say if I join my class mates for lunch").

Session Four

Topic: Identification of thoughts distortions using STEB

Objectives:

- To review behavioural homework
- To enable the participants gain insight into their present perception and attitude.
- To empower the participants with the skill to record their automatic thoughts

Step I: Review of behavioural homework

The researcher requested volunteers to discuss their recorded experiences. Their contributions were commended.

Step II: Identification of distorted thoughts using STEB

The researcher explained that STEB is an acronym used for Situation, Thought, Emotion, and Behaviour. The therapist added that the first step in changing negative and irrational thoughts is to take stock of what the present habits are. What situations needed to be handled better? What are the habitual ways of thinking, feeling, and behaving in those situations? What are the automatic thoughts preventing them from accurately assessing the benefits of CBT? The participants would be

encouraged to write down the situation, thought, emotion, and behaviour particularly in circumstances that are difficult or where they sense there is room for improvement.

Step III: Recording of distorted thoughts

The researcher requested the participants to record their thoughts about public speaking anxiety using the following guidelines:

- The time, the place, the circumstance, and the people involved.
- The setting, the tempo, the environment, and the outcome.
- The situation, the thoughts, emotions, and behaviours.

The researcher would give examples of recording of distorted thoughts.

The session was concluded by asking the participants to make list of what they feel and observe concerning the scenario that they have observed.

Session Five

Topic: Confronting over-generalizations, mind-reading and filtering out positives

Objectives:

- To review participants' take home assignment and provide feedback.
- To improve participants' ability to become aware of negative thought patterns.
- To empower the participants with conceptual and perspective thinking skills.
- To equip the participants with the ability to focus on current sensory information.

Stage I: Review of behavioural homework

The therapist reviewed the participants' homework and labelled the recorded public speaking cognitive distortions. Thereafter, some distortions would include; mind reading, labelling, negative self talk, overgeneralization, etc.

Stage II: Combating overgeneralization with conceptual thinking

The researcher explained that overgeneralization occurs when one forms an arbitrary conclusion based on limited previous experience. The belief that since something occurred once, it would occur over and over. For instance, generalizing unfriendly attitude of principals, teachers, non-teaching staff and students in schools.

The researcher used contextual thinking to restructure this distortion by requesting participants to:

- Examine the specifics of schools and their environment and see the differences i.e. the number of students the nature of services offered, personal attributes of the personnel and the type of training.
- To replace the generalized opinion with a specific one i.e. :I will never go to school because of the non-challant attitude of teachers and some other personnel in offering services" with a realistic and rational one such as "I will go to school because it is necessary for my well being". The researcher would explain that school personnels are different due to the specialized services they offer, they are friendly, emphatic and non judgemental etc.

Stage III: Combating "filtering out the positive" with perspective thinking

The researcher explained that one of the cognitive distortions commonly identifiable with the participants is known as filtering out the positive. Filtering out the positive occurs when one excessively dwell on the negative aspect of a person, situation, events, and circumstances. Examples of this include:

- Focusing on the poor quality of teaching.
- Assigning so much importance to attitude of school personnels.
- Underplaying the benefits of school activities.

To deal with this cognitive distortion, participants were asked to apply perspective thinking. The researcher explained that perspective thinking would enable them see both the positive and negative aspect of a person, situation, event and circumstances on the basis of which they could make informed and intelligent decision without bias. Perspective thinking involves asking the following questions about the situation or thing such as:

- What do I like about the situation?
- Are there no benefits in school activities?
- What would I like to change?
- How can I go about making the changes?

Stage IV: Combating "mind reading" by controlling sensory information

The researcher explained that mind reading occurs when one assumes that he or she knows what another person is thinking and acting as if that assumption is true without checking with the other person – one jumps to a conclusion and threat that conclusion as indisputable fact. For instance making the following wrong assumptions about school CBT.

- Believing that the purpose of the training is to enable researchers request for money from Government for their own personal use.
- That fund has been collected from international organizations and is being disbursed through this programme.
- That this programme is being presented as if it is so important.
- Feeling that the programme is encouraging corruption.

The participants were encouraged to focus on current sensory information on daily basis.

Stage V: Behavioural homework

The participants were asked to practise using conceptual and perspective thinking skills in 5 situations at home and in the school. They were also asked to record the behaviours and the outcome achieved.

Session Six

Topic: Combating labelling and negative self statement with reality testing and positive statements

Objectives:

- To review participants' take home assignment and provide feedback.
- To improve participants' ability to become aware of negative thought patterns.
- To empower the participants with abilities of reality testing and positive self statement.

Stage I: Review of behavioural homework

The therapist reviewed the participants' homework and assessed how accurate they have applied the learnt skills in refuting their distorted thoughts. Their efforts were commended.

Stage II: Combating "labelling" using reality testing

Labelling is the cognitive distortion of branding someone or something a particular way, not minding the fact that people, things, events and circumstances are complex, and cannot be permanently categorized.

The participants were counseled to use reality-testing which involves acknowledging behaviour and things the way they are.

Stage III: Combating "negative self statement" with positive self statements

The researcher explained that self-talk is a way of describing all the things we say to ourselves all day long as we confront obstacles, make decisions, and resolve

problems. Negative self statement involves voicing out pessimism about life. Negative self-talk prevents one from solving problem. The participants were encouraged to make positive self-statements when faced with problems.

Stage IV: Behavioural homework

The participants were asked to use 5 positive self statements in different challenging situations at home, in the school and record what was said and in what circumstances it was said in their diaries. Their efforts were commended.

Session Seven

Topic: Reframing Cognitive distortions by improving participants knowledge of anxiety associated with public speaking

Objectives:

- To clarify myths and misconception surrounding public speaking.
- To improve participants' knowledge of public speaking.
- To identify group of people at risk of becoming good public speakers.
- To expose the participants to a number of factors that could make them fall short of a good public speaker.

Stage I: Public speaking myths and misconception clarifications using value voting exercises.

The researcher reviewed previous session and asked the participants to read out information, opinion and beliefs that they have heard about public speaking anxiety as recorded on their diaries.

The researcher clarified some of the myths and misconceptions using value voting exercises. The following statements were made and the participants who agreed stood up while those who disagreed sat down. Each group gave reasons for their choice;

- Good public speakers are not in Nigeria.
- To be a bad public speaker is a punishment from God.
- People who find public speaking a fearful event are unfortunate.

Stage II: Myths and misconception clarifications using direct teaching on public speaking anxiety

The researcher explained to participants what public speaking anxiety means and some of its causes. He informed participants that anxiety is natural and that most people suffer from anxiety at some stage in their lives. The researcher would add that, anxiety is usually a relatively natural response to a situation which appears threatening or to which we are not accustomed. So, for example, people are sometimes quite naturally anxious about passing tests, going for job interviews, or even speaking in public. In fact, 70% to 75% of the U.S. population report experiencing public speaking anxiety. This is to enable the participant to understand the enormity of the problem. The researcher would lead participants to discuss the effect of public speaking anxiety on their academic work.

Stage III: Reasons why people develop public speaking anxiety

The researcher mentioned and explained in detail to the participants the following sources of speech anxiety

- Lack of preparation and practice
- Previous experiences with speaking – lack of or bad experience.
- Unrealistic goals.
- Perception of your audience as hostile or unsympathetic.
- Negative self – talk.
- Misdirected concerns with how you will be evaluated

Stage IV: Group work on how to manage anxiety during their speech and after this speech

The researcher randomly would assign the participants into 2 groups to brain storm. Group one discussed how to manage anxiety during speech while Group two discussed how to manage anxiety after speech. Representative from each group were asked to present the report.

Stage V: Anxiety management strategies

The researcher asked participants to pay attention to the following during speech:

- The audience
- Appearance
- Self-talk

The researcher also informed participants to pay attention to the following after speech.

- Take several deep breaths +when you go back to your seat. This will help to bring down your heart rate.
- Minimize self-talk. You can mentally review your presentation later.
- Look for your instructor's eye contact and tell yourself to relax as you listen to your instructor and classmates.
- Write down what is said. You can check with your instructor later to determine the accuracy of the feedback you recorded.
- Within 24hrs review the entire process and make a list with 2 columns (1) things I did well and (2) areas where I realistically can improve. Refer to the list as you prepare for your next assignment.

Stage VII: Behavioural homework and daily evaluations

The researcher asked the participants to write on their diaries on how anxiety can be managed during and after speech. The session was concluded by randomly asking participants to summarize their experience from the day's activities.

Session Eight

Topic: Combating distortions by discussing the benefits of public speaking counselling

Objectives:

- To review participants' homework and provide feedback
- To improve the participants' knowledge of CBT, procedures of CBT, and benefits of CBT.
- To sensitize participants to the need to uptake CBT services.

Stage I: Review of behavioural homework

The researcher asked participants to present what they have recorded on their diaries with reference to what makes some people to be more vulnerable to public speaking anxiety than others. Feedback on their performance was provided. They were positively reinforced for their contributions.

Stage II: CBT as a major prevention strategy

The researcher explained that in the absence of treatment for public speaking anxiety, that targeted prevention such as the present one is a realistic means of preventing or reducing public speaking anxiety among secondary school students. The researcher added that public speaking anxiety counselling and testing is the entry point to public speaking anxiety prevention, care and support.

CBT involves counselling and testing which is not mandatory but very beneficial. CBT consists of four major processes, pre-test counselling, testing, post test counselling and on-going counselling. The researcher explained that CBT counsellors are friendly, empatic, and acceptable and are trained to keep information confidential.

Stage III: Benefits of CBT

Some of the benefits of CBT extensively discussed include;

- Behaviour Therapists and cognitive behaviour therapists treat individuals, parents, children, couples and families.
- They replace ways of living that do not work well with ways of living that work.
- They give people more control over their lives.
- The researcher explained that people have negative attitude towards public speaking because of unfounded fear and anxiety among others. The researcher encouraged the participants to re-examine their thoughts and beliefs towards public speaking anxiety and see how irrational the thoughts are.

Stage IV: Behavioural homework and daily evaluation

The session was concluded by asking the participants to write down what they felt and how they reacted to counselling and testing with regard to Cognitive Behaviour Therapy.

Session Nine

Topic: Improving attitude towards public speaking anxiety by discussing goal setting skill.

Objectives:

- To review participants behavioural homework and provide feedback on performance.
- To discuss goal setting skill and reasons for setting goals.
- To equip participants with goal setting skill
- To make participants appreciate the importance of setting goal and identifying barriers such as public speaking anxiety which could act as barriers to achieving goal.

Stage I: Review of previous sessions

The researcher randomly called for volunteers to review previous sessions and examined what they had recorded for the behavioural homework. They were also asked to discuss what they had gained from the therapy.

Stage II: Goal setting and types of goals

The researcher explained that setting goal and achieving the goal is very important in life. It was explained that a goal is a thing one would want to achieve in which one directs all his or her efforts towards. Goal setting is an activity that enables individual to plan what he or she wants to achieve in life. The goals that an individual sets depend largely on his or her values, beliefs and attitude. The two types of goals discussed are:

Short term goals: These are goals to be achieved in a short period of time.

Long term goals: These are goals to be achieved over a long period of time.

Stage III: Processes of setting goals

The researcher explained that a good goal must be SMART.

S – Specific

M – Measurable

A – Achievable

R – Realistic

T – Time-bound

The highly structured processes of goal setting was explained as thus;

1. Setting a smart goal.
2. Identifying the steps needed for reaching the goal.
3. Getting adequate information.
4. Setting a reasonable time limit.
5. Working consistently by reviewing the activities.
6. Evaluating progress towards the goal.
7. Reviewing activities.
8. Reinforcing oneself for a job well done.

Stage IV: Importance of goal setting and barriers to achieving goals

The researcher asked for participants' contributions on why they think goal setting is necessary especially with respect to public speaking. Participants' contributions were appreciated. The importance of goal setting was further explained thus;

- Goal setting serves as a guide that help individual make decisions about what they want to do and how to go about achieving it.
- It gives meaning and direction to activities.
- It increases individuals' chances of successfully achieving his/her ambitions.
- It enables individuals to prepare and plan appropriately.

Stage V: Obstacles to achieving goals

The researcher explained that sometimes in life, individuals may encounter some difficulties or obstacles which obviously would prevent them from achieving their life goals. Some of the obstacles that could be barriers to achieving life goals include;

- Irrational fear and beliefs
- Negative self statements
- Failure to accurately analyse situations and make rational decisions.

Stage VI: Behavioural homework and daily evaluation

The researcher asked participants to brainstorm on why the above listed activities constitute barriers to achieving goals. The day's session was evaluated by giving the participants the following take home assignments.

1. Explain the terms "goal" and "goal setting"
2. Describe the process of setting and achieving goals.
3. Give 5 reasons why it is important to set goals in relation to public speaking.
4. State 4 barriers to goals achievement.
5. State 2 important goals to set in public speaking anxiety reduction

Session Ten

Topic: Administration of post intervention questionnaires and termination of therapy

Objectives

- To empower the participants with the skill to maintain therapy gain.
- To obtain post intervention data
- To formally terminate therapy
- To appreciate participants.

Stage I: General summary of all sessions

The researcher summarized at the sessions, elicited questions and provided answers and clarifications on issues raised. The researcher taught the participants some strategies to enable them maintain the gains of therapy, thus;

- Avoid environmental stimuli which would provoke fear and anxiety of public speaking.
- Avoid friends or colleagues that discourage rational behaviours
- Create alternative behaviours which are incompatible with fears or anxiety, i.e. joining debating societies, giving talks on public speaking anxiety.
- Encourage friends and colleagues to be assertive.

Stage II: Administration of questionnaires

The researcher administered the Personal Report of Confidence as a Speaker (PRCS) (Paul, 1996) and Assertiveness inventory by Alberti and Emmons (1995) and collected them on completion.

Stage III: Appreciation of participants and formal termination of therapy

The researcher appreciated the participants and commended them for being actively involved in the therapy. They were encouraged to maintain the gains of therapy. Participants were entertained with snacks and soft drinks and the therapy was formally terminated.

APPENDIX 1

UNIVERSITY OF IBADAN, FACULTY OF EDUCATION

DEPARTMENT OF GUIDANCE AND COUNSELLING

Dear student,

Kindly respond to the following items as honest as possible. This questionnaire is purely for research purposes. Any information obtained is highly confidential. Please do not write your NAME or identification number.

Thanks

Akintola Jacob

Section A

Name of School:……..…….

Class**:……..**

Sex: Male ☐ Female ☐

Age: below 10 ☐ 11-14 ☐ 15-18 ☐ 19-22 ☐ 23 and above ☐

Religion: Christian ☐ Muslim ☐ Traditionist ☐ Others specify ☐

Course of study…….....

Nationality:

……

Section B

Instruction:

Kindly respond to the items below by placing an (X) or a tick (√) within each of the bracket please.

Personal report of confidence as a speaker Scale.

S/N	ITEMS	Very Seldom	Seldom	Sometimes	Often	Very Often
1	I face with confidence the prospect of speaking before an audience					
2	I'm not afraid of being before an audience					
3	My mind is fresh when I am before an audience					
4	Although I'm nervous just before standing up, soon I forget my fear and enjoy the experience					
5	I feel relaxed and at ease while I'm speaking					
6	I feel terrified just at the thought of public speaking					
7	I'm afraid and tense all the time I'm speaking in front of a group of people					
8	My pose is forced and unnatural					
9	When I speak in front of an audience, my thoughts get confused and mingled					
10	Although I speak fluently with my friends, I cannot					

	find the right words when I am at the rostrum					
11	As much as I can I try to avoid public speaking					
12	I think I am completely under control when I speak in public					

APPENDIX 2

UNIVERSITY OF IBADAN, FACULTY OF EDUCATION

DEPARTMENT OF GUIDANCE AND COUNSELLING

Dear student,

Kindly respond to the following items as honest as possible. This questionnaire is purely for research purposes. Any information obtained is highly confidential. Please do not write your NAME or identification number. Thanks

Section A

Name of School:

……

Class**:……**

….

Sex: Male ☐ Female ☐

Age: below 10 ☐ 11-14 ☐ 15-18 ☐ 19-22 ☐ 23 and above ☐

Religion: Christian ☐ Muslim ☐ Traditionist ☐ Others specify ☐

Indicate proposed course of study…….....

Nationality: ……

Instruction:

Kindly respond to the items below by placing an (X) or a tick (√) within each of the bracket please

Section B

McCroskey's (1982) Personal Report of Communication Apprehension Scale

S/N	Items	Like me	Very much like me	Unlike me	Very much unlike me
1	I dislike participating in group discussions				
2	Generally, I am comfortable while participating in a group discussion.				
3	I am tense and nervous while participating in group discussions.				
4	I like to get involved in group discussions.				
5	Engaging in a group discussion with new people makes me tense and nervous.				
6	I am calm and relaxed while participating in group discussions.				
7	Generally, I am nervous when I have to participate in a meeting.				
8	Usually I am calm and relaxed while participating in meetings.				
9	I am very calm and relaxed when I am called upon to express an opinion at a meeting.				
10	I am afraid to express myself at meetings.				

11	Communicating at meetings usually makes me uncomfortable.				
12	I am very relaxed when answering questions at a meeting.				
13	While participating in a conversation with a new acquaintance, I feel very nervous.				
14	I have no fear of speaking up in conversations.				
15	Ordinarily I am very tense and nervous in organizations.				
16	Ordinarily I am very calm and relaxed in conversations.				
17	While conversing with a new acquaintance, I feel very relaxed.				
18	I'm afraid to speak up in conversations.				
19	I have no fear of giving a speech.				
20	Certain parts of my body feel very tense and rigid while giving a speech.				
21	I feel relaxed while giving a speech.				
22	My thoughts become confused and jumbled when I am giving a speech.				
23	I face the prospect of giving a speech with confidence.				

24	While giving a speech I get so nervous, I forget facts I really know.				

APPENDIX 3

UNIVERSITY OF IBADAN, FACULTY OF EDUCATION

DEPARTMENT OF GUIDANCE AND COUNSELLING

Dear student,

Kindly respond to the following items as honest as possible. This questionnaire is purely for research purposes. Any information obtained is highly confidential. Please do not write your NAME or identification number. Thanks

Section A

Name of School: …….

Class**:……**

….

Sex: Male ☐ Female ☐

Age: below 10 ☐ 11-14 ☐ 15-18 ☐ 9-22 ☐ 23 and above ☐

Religion: Christian ☐ Muslim ☐ Traditionist ☐ Others specify ☐

Indicate proposed course of study…….....

Nationality: ……

Instruction:

Kindly respond to the items below by placing an (X) or a tick (√) within each of the bracket please

Section B

ALBERT AND EMMONS (1995) ASSERTIVENES INVENTORY

S/N	ITEMS	No/never	Sometimes	Average	Always
1	When a person is highly unfair, do you call it to their attention?				
2	Do you find it difficult to make decisions?				
3	Do you generally express what you feel?				
4	Do you often step in and make decisions for others?				
5	Are you able to refuse requests made by a friend if you do not wish to do what the person				
7	Do you speak out in protest when someone takes your place in line?				
8	Do you often avoid people or situations for fear of embarrassment?				
9	Do you usually have confidence in your own judgment				
10	Are you openly critical of others ideas, opinions, behavior?				
11	When a salesperson makes an effort to sell you something				
13	Are you reluctant to speak up in a discussion or debate?				
14	If a person has borrowed money (or a book, garment, or thing of value) and is overdue in				

	returning it, do you mention it?				
15	Do you usually behave confidence in your own judgment?				
16	Are you reluctant to speak up in a discussion or a debate?				
17	Do you generally express what you feel?				
18	Do you find it difficult to keep eye contact when talking with another person?				
19	Do you speak out in protest when someone takes your place in line?				