THE UNIVERSITY OF HULL

Intervention to Alleviate Shyness:

Social Skills Training and Brief Counselling

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By

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IN THE NAME OF ALLAH,
MOST GRACIOUS, MOST MERCIFUL

To My Husband

For his unconditional love and full support

Preface

During my work as a lecturer and counsellor at King Abdulaziz University I noticed that many students suffered from shyness, a problem that affected them in many aspects of their lives.

Shy people don't usually seek help because of the their shyness, they are afraid of embarrassment. Yet they cannot avoid interacting with others, and being shy is a problem they face every day, at home, in school, in any situation involving other people. Even answering the phone can be a big problem for some.

I became very concerned when I noticed that one of my brighter students was getting low marks due to her inability to participate in class, even though she had all the relevant knowledge and was probably the best student in the class.

One of the things that drew my attention to the extent of the problem was when another student of mine withdrew from college and studied computer science in a private organisation so as, she told me, to work from home and avoid communicating with other people. When I asked her what about marriage and children, she started to cry and told me many painful incidents that had happened to her regarding this matter.

I chose this subject for my research because I wanted to understand shyness better in order to help others overcome their shyness and interact normally with others. As humans we are in need of healthy contacts with others, even in the smallest circle of people.

My main concern in my research is those students who believe that their shyness is the cause of many of their problems, and who are willing to try to overcome it.

I pray that Allah, Almighty may render my work beneficial and helpful.

Acknowledgment

All praise to Allah Almighty who gave me the understanding, strength, and determination to pursue this task, and also for the enormous support of all the people around me. He overwhelms me with His benevolence and I am eternally grateful and thankful to Him.

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Thanks to my dearest friend, Nesmah Alkhateeb. If I used all the ink and paper in the world I could not thank her enough. I am forever in her debt. Special thanks to

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I wish also to thank King AbdulAziz University for this opportunity and I hope my work proves to be beneficial to the students, the university, and the community in general. My thanks to all those helped me; in the University of Hull; Jude Irving, Kay Littlefield, Linda Baldwin, Linda Randerson, Sandi Redhead, Roxane Gervais, and Trevor Cook; their help, advice, care, and concern is much appreciated

Thanks to Dr Cheek, and Dr Al-Ansari who supplied free invaluable material, and my sincere thanks to all students who participated in my study for their commitment and their willingness to share their experiences.

Finally, all praise to Allah. May He accept my humble effort. And peace and blessings be upon His Messenger, Muhammad.

Abstract

The aim of this study was to investigate the effectiveness of a Social Skills Training programme (based on Bandura's social learning theory) and Brief Counselling (using Egan model) to alleviate shyness.

The aetiology of shyness is examined together with its relationship to other constructs such as social anxiety and social phobia. For many, shyness is a major social problem. This is particularly true of female university students in Saudi Arabia. This was confirmed by the survey in a sample of 1000 female students, and by the development of a standardised (Arabic) shyness scale, which was given to another sample of 706.

From this population a sample of 80 (scoring 1sd above mean) were divided into 6 groups who received either (i) Social Skills Training (two groups), (ii) Brief Counselling, (iii) Study Skills Training, and (iv) No training (waiting list control, two groups). Both the Social Skills and Brief Counselling were effective in reducing shyness although there was a similar beneficial effect for study skills. However in a 6-week follow-up test the Social Skills training and Brief Counselling groups showed that significant gains had been made and maintained in comparison with both controls.

While overall Social Skills Training is more effective and economic, an intervention involving both Social Skills Training and Brief Counselling is recommended. The study demonstrated that sever shyness can be alleviated by short-term intervention.

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Chapter One: Introduction

When I know I have to meet someone new, I get sick to my stomach and usually blush a lot and find it hard to even say "hello." The more people notice this, the shyer I become until I feel like running away!

S.H.Y
7/8/00

1.1. Importance of the study

Among many challenges facing today's societies is the increasing incidence of emotional and behavioural problems experienced by children, adolescents and adults. Anxiety, depression, aggressiveness, shyness etc., all interfere with the way people live their lives, having a negative impact on their health, social life, and personal development. These negative impacts not only affect the person's life but they also have negative consequences on society in general. Although there is an agreement on the seriousness of these problems, little attention has been paid to shyness.

According to Crawford and Taylor (1997) shyness is a powerful and limiting emotion that can lead to many physical illnesses. As people's minds are a part of their bodies, any emotion could affect their health. Crises and confrontations are life-changing experiences that empower people to grow. The shy person will avoid confrontations or situations where he/she has to face others for fear of how he/she might be perceived by others, whereas the non-shy person is not afraid to be open about his/her emotions, to show his/her vulnerability and to fail or to be rejected. What makes life harder for the shy person is that sometimes society does not acknowledge shyness as a problem.

Many researchers such as Zimbardo (1977), Jones et al., (1985), Jones et al., (1981), Izard (1991), and Asendorpf (2000) emphasise that shyness encourages social isolation and thereby limits the availability of social support. Also, shyness is an important personal contributor to loneliness. Significant correlation between shyness and loneliness in high school and college students has been reported (Abu Rasain, 1988).

1.2. Aim and questions of the study

The aim of this study is to propose, implement and evaluate two kinds of interventions for shyness: a Social Skills Training Programme, and Brief Counselling.

The research plan is divided into four phases: first, a descriptive survey designed to determine the extent of the problem; second, a standardization of an instrument to measure shyness; third, structured interviews to assess the problematic aspects of shyness; and finally, the intervention to alleviate shyness, using the Social Skills Training programme, and Brief Counselling using Egan's Model.

The researcher addresses the following questions:

1. Can shyness be alleviated by training?
2. Which is the most effective intervention, Social Skills Training or Brief Counselling?

Two main hypotheses were formulated for this study:

1. There will be significant differences in the level of shyness between those who participate in the social skills training programme or brief counselling compared with those who participate in the Study Skills

Training Programme (control group) and the other waiting list control groups that do not receive any training.

2. There will be a difference in the level of shyness between those who participate in the Study Skills Programme compared with the control groups receiving no training.

1.3. Context of the research

This study took place in Saudi Arabia. It is necessary to understand some history of this country in order to appreciate the significance of the work.

The Kingdom of Saudi Arabia is the largest country in the Middle East. It occupies four-fifths of the Arabian Peninsula. On the west it is bordered by the Red Sea and on the east by the Arabian Gulf. To the south there are borders with Yemen and the Sultanate of Oman. To the east lie the United Arab Emirates, Qatar, and the Island State of Bahrain. In the north it has borders with Kuwait, Iraq, and Jordan. It is at the crossroads of three continents: Europe, Asia, and Africa.

Saudi Arabia has been described as a great, sandy desert. Winds are extremely harsh during the spring and early summer months, resulting in eroding windswept plains alternating with rolling sand dunes (http://www.saudinf.com/main/a2.htm). Most of the country is desert. The eastern part is a plateau that begins with the great Nafud desert in the north, continues along the Arabian Gulf, and culminates in the world's largest sand desert, the Rub Al-Khali in the south. To the west is the Central Province, the heartland of the peninsula, which is known for its spectacular escarpments, gravel and sand

deserts. The capital city, Riyadh is located in this area. A chain of mountains in the west runs parallel to the Red Sea. The western region contains the holy cities of Makkah and Madinah, the port city of Jeddah and the summer capitol of Taif (SAIC, 1996) (Appendix D). The country's area is estimated to be some 2,331,000 sq. km (900,000 sq. miles). According to the 1999 census, the Kingdom's population is 21.4 million, of whom 50.4% are male and 49.6% female. Currently, it is estimated that more than half the Saudi population is under the age of 20 (http://www.saudinf.com/main/a4.htm). There are some minority groups mainly in the Holy Cities of Makkah and Madinah and coastal cities, such as Jeddah and Dammam; these groups come from other Islamic countries, mainly from Africa and Asia (Al-Badr, 1967; Pesce, 1977).

Saudi Arabia is well known in the world as a rich country because of the petroleum which accounts for 85 percent of the national income, but there are various economic resources, like agricultural and mineral products. The Saudi economic system is based on free enterprise. Thus, everybody is entitled to ownership of anything short of the national resources, such as the mineral mines and the oil wells, which are owned and operated by the government (Anon, 1996). As far as economic activities are concerned, government policies, put forward in a series of five-years development plans since the 1960s have encouraged diversification. This has led to success both in terms of economic growth and in terms of a progressive reduction of dependence on oil (Algosaibi and Turki, 2000; Hain, 2000).

Islam is the official religion and its tenets are enshrined as law. Saudi Arabia occupies a special place in the Islamic world as the birthplace and heartland of Islam. One of the

influences of the Islamic religion is the strong role of family systems in all aspects of the personal and social life of Saudi people. Norms and values of relationships between family members are taught at an early age, and are expected to be followed. Among these values is respect for elders and, in particular, for parents. Respect can, in many cases, extend to the extent of absolute obedience. The social behaviour of the individual in the wider community is mainly an expression of his/her family pattern (Al Orini, 2001).

Although Saudi Arabia has been experiencing vast and rapid economic, social, and demographic changes, which have affected every Saudi regardless of sex, age, background, and occupation, the family members tend to be close to each other and involved in each other's affairs. However, the process of social change can be an important factor affecting people's mental health, sometimes in a negative way. This is because the process requires a transformation in the pattern of individuals' mode of living, in order to cope with the new demands that are brought about in their environment (Abu-Rasain, 1998).

1.3.1. Jeddah

Jeddah, where the research was done is located on the eastern shore of the Red Sea, it is the largest city in Saudi Arabia's Western Province. It has grown from humble origins about 2500 years ago (AD647) as a tiny fishing settlement to one of the biggest cities in the Middle East. Today it hums, glitters and resounds with industry, technology and cosmopolitan human life. But as a city it has successfully managed to combine the dignity and traditions of the past with the dynamism of the modern business world.

Jeddah in Arabic means seashore, but the school of thought, which prefers Jeddah or grandmother, is given credence by the tradition that Eve's tomb is located within the city. Jeddah is the Kingdom's principal port, the original gateway to Makkah and Madinah for pilgrims arriving by ship, or by plane. It welcomes 97% of all pilgrims arriving by sea and 98% of those arriving by air (http://www.arab.net)

1.3.2. Education in Saudi Arabia

When the Kingdom of Saudi Arabia was founded, education was not accessible to everyone but was limited to individual instruction at religious classes held in mosques in urban areas. Saudi Arabia now has a nation-wide educational system that provides free education from pre-school to university for all citizens.

The 1970s coincided with two 5-year National Development Plans (1970-1975 and 1975-1980), focused on the modernisation of Saudi Arabia, based on developing the required human resources through education and building a comprehensive economic infrastructure. This period witnessed enormous increases in school facilities and numbers, as well as efforts to improve the quality of education, which continued in the 1980s in order to achieve the ultimate objective of meeting workforce demands. Another important development in this period was the establishment in 1980 of a separate organisation for technical education and vocational training, to oversee secondary level institutions. These were intended to meet the country's needs for qualified technical manpower.

Saudi Arabia boasts over 17,500 educational institutions spread throughout the country. The general education system consists of four levels: kindergarten, six years of primary

school and three years each of intermediate and high school. Students are provided with free education, books and health services. Education is open to every citizen, although it is not compulsory after the primary stage (Zaid, 1990). In the Universities, all students receive a monthly allowance for studying. The length of study depends on the major subject chosen; for example, it is four years in Arts and Humanities, five years in Dentistry, and seven years in Medicine.

Education has a pivotal role in Saudi society. Two characteristics of Saudi education are particularly worthy of note: Firstly, the importance of Islamic Studies: religious studies are integrated into the curriculum at all levels, as a way of life for the present and future and a very important source of Saudi education. Secondly, separate male and female education: Equal but strictly separate schools for male and female students are maintained throughout the educational system. In general, students are taught by separate teaching staffs of the same gender. However, so far, both sexes study the same curriculum, except for home economics (girls only) and physical education (boys only) (The S.A. Cultural Mission, 1991; Al-Saloom, 1995). Because of this strict segregation, the present study has had to be confined to female students.

1.3.3. King Abdul Aziz University (KAAU) (Women's section)

The study took place in the Women's Campus of King Abdul Aziz University (KAAU) The idea of establishing the university's women's campus and providing Saudi women with an equal opportunity of receiving a formal university education was an integral part of the University's administrative policy since its early foundation as a private institution in 1966. It started with evening classes in Dar-Alarbia School, until 1971 when the complex that currently houses the women's campus was completed. In that

same year KAAU officially became a government institution. Within three decades, the women's campus developed into a full-fledged professional institution of remarkable structure encompassing several schools, vice-deanships, research centres, administration offices and supporting services. At present, it houses more than twenty buildings, including a Central Library, Bookstore, Recreation Centres, Auditoriums, English Language Centre, Information Centre, Xerox Centre, Bank, Post office, and a mosque. In addition, there is a women's complex adjoined to the University Hospital and King Fahad Research Centre, which houses the school of Medicine and Dentistry. The University has six Faculties in Jeddah: Economics and Administration, Arts and Humanities, Science, Medicine and Allied Health, Home Economics, Dentistry. A branch in the city of Al-Madinah has two faculties, Education and Science, and there is a Community College in the city of Tabuk. KAAU also provides a General Diploma in Education. There are five support services: Admission and Registration, Library Affairs, Community Services, Students' Affairs, Students' Affairs for Housing and Nutrition (Concise information Catalogue, 1419,1420H. 1999,2000).

The present study is very pertinent to the development of guidance and counselling within the University. Services run by "Students' Affairs" are currently very limited and deal with specific problems, such as smoking, which is judged to be a socially undesirable behaviour. Those offering guidance and counselling have no formal training or qualifications, but nevertheless through their experience and motivation to help and support students they do a "good job". Also, some staff from the Psychology, Sociology, and Islamic Studies Departments provide advice to students who seek them in their offices, or those referred to them by the Vice-dean of the Women's Section or Vice- dean of Students' Affairs.

Students who come to the university find themselves in a totally different environment from school. They have more freedom in the way they dress than before, and they have the choice whether to attend classes or not. At the same time, they mix with other students who are from different classes of society. In many ways, it is a different world, a world they have to adjust to one way or another. In this environment, shy students may find themselves in many new situations which may result in them overcoming their shyness, albeit with difficulty, remaining as they are, or developing more problems.

The structure and function of the university is the same as any institution in the society, it may either help them in fulfilling their needs or may create new problems by stimulating further tension and frustration (Abu-Rasain, 1998). Success in education and work depends upon knowledge and development of one's potential. Education and society must provide young people with systematic experiences to help them understand and develop their abilities, interests and skills, achieve career awareness and make wise educational and vocational decisions.

Social changes, modern technology and plurality in value systems make society appear too complex and unpredictable to adolescents and young adults to provide them with a stable frame of reference. Psychological distress among Saudi young people is increasing due to intergenerational conflicts that have resulted from social and economic change (Al-Gazlan, 1990), and also the influence of the media and the use of the Internet. One should not forget the effects of the 11th of September and what is happening in Palestine. Therefore, there is an urgent need to provide these young people with a wide range of psychological services in order to help them to deal with stress that has been brought about by the shift in the social patterns and demands, not to

mention the personal problems within themselves. Providing individual and group counselling, and skills training are as important as providing classes and degrees.

1.4. Shyness in the Arabic language

The Arabic word for Shyness is "Khajal". Another word "Haya'" is sometimes used as a synonym to shyness, yet there is a big distinction between them. Scholars define Haya' as "One's rejection of all that is not good", " A character that prompts one to abandon all that is bad, immoral, and wrong." (Alkhalfi, 2002). The Prophet, peace be upon him said "Haya' leads only to what is good" Al Bukhari (855). But shyness in general means, in Arabic, social shyness, where one is unable to say or to do things in the presence of others. It is considered a vice, a hindrance. Shyness may also include "Haya'" which means one's shyness or bashfulness about saying or doing anything that is considered bad or wrong. "Haya'" is considered a virtue, a good characteristic (trait) because it prevents a person from doing any wrong, while shyness is considered a vice, a bad characteristic (trait) because it makes a person feel inferior to others or prevents him/her from doing or saying what he/she feels right in the presence of others. If a person had no Haya' he/she would do anything and not care for other's feelings or opinions. Many Arabs do not consider shyness as a problem because they confuse it with "Haya'", which is desirable because it is a sign of the pure intention inside one's heart and it indicates the extent of one's good manners and Values (Al Ghazaly, 1973).

1.5. Some related studies within the Saudi Arabian context

As far as the researcher knows, there have been three studies concerning shyness in Saudi Arabia. One is a Master thesis by Albakr (1986) to study the relationship between shyness and academic achievement in male students at King Saud University.

Significant correlations were found between: shyness and field of study, and economic status, and parental treatment. There was no significant correlation between shyness and academic achievement.

The other two studies were by Shuqair (1991, 1992). The first one was on the effect of shyness on performance in an educational practical course. The second was on the relationship between shyness, as a personality factor and volunteer working during the Gulf crisis. Both studies were applied in the Education College for women. Shuquar found that students who score high on a shyness scale are distant from society, more introverted, find it hard to express themselves or talk in front of others, and if they talk they fail to get the attention of others, and they feel anxious and inferior so they prefer to be isolated from the society. However, working as a teacher requires courage and confidence in dealing with teaching situations, so shy teachers face many difficulties in doing their jobs. Unfortunately, the results of these studies were not presented in a manner from which conclusions can be clearly drawn.

Chapter Two: Shyness: A conceptual framework

His soul is full of love and longing, but the world knows it not;
the iron mask of shyness is riveted before his face, and beneath is never seen;
genial words and greetings are ever rising to his lips,
but they die away in unheard whispers before the steel clamps.

Campbell
1896

2.1. Overview

Shyness in ordinary language is the term most often used to label feelings of anxiety and inhibition in social situations. It is a remarkably common experience. Less than 10% of respondents to a cross-cultural survey reported that they had never felt shy (Zimbardo, 1977). Despite the apparent simplicity of the concept and its pervasiveness in everyday life, scientific investigation of shyness shows it to be a complex topic.

Many words and terms have been used to describe shyness, including social phobia, social anxiety, avoidant personality disorder, dating anxiety, heterosocial anxiety. Some researchers use the terms shyness and social anxiety interchangeably when they mention either of them (Glass and Shea,1986; Berent and Lemley,1994; Butler, 1999).

This chapter will deal with: the fundamental issues in the conceptualisation of shyness, the developmental perspective, the construct of shyness, and other related issues.

2.2. Definition

The Oxford Compact English Dictionary (2000) defined shy as "nervous or timid in the company of other people" (p1065). But this definition is limited for two reasons: It is over inclusive, as the meaning overlaps the concept of shyness. And it is not specific enough to define shyness.

According to the Longman Dictionary of the English Language (1991) a shy person is:

- easily alarmed; timid
- tending to avoid a person or thing; distrustful
- wary of committing him/herself; circumspect; reluctant
- uneasy and timid in the company of others; bashful, reserved (p.1497).

According to dictionary usage, the term shy refers to being uncomfortable in the presence of and avoiding contact with other people. The research by Zimbardo (1977) follows this definition and equates shyness with a type of people phobia: "to be shy is to be afraid of people, especially people who for some reason are emotionally threatening".

Rapee (1998) defined a shy person as being nervous or worried about what other people are thinking of him. Shyness usually also involves being frightened of and avoiding activities or situations where one might become the centre of people's attention. Shyness can refer to particular situations ("I get shy when I have to speak in front of people"), or to a certain person across situations ("He is generally such a shy person").

Multiple definitions of shyness have appeared in the literature. Lewinsky (1941) defined shyness as a "state of hyper-inhibition through fear, shame and mistrust, directed partly against the environment, partly against the subject's own impulses, mainly aggression and sexuality." (p.13). Pilkonis (1977a) defined shyness as a "tendency to avoid social interaction and to fail to participate appropriately in social situations."(p.585). Buss (1980) conceptualised shyness as one form of social anxiety, along with audience anxiety, embarrassment, and shame, with shyness and audience anxiety being most similar in terms of determinants and reactions.

Cheek and Buss (1981) looked at shyness as a psychological syndrome that includes both the subjective experience of anxiety in social situations and awkward or inhibited social behaviour. McCroskey with Richmond (1982) (cited in Daly, McCroskey, Ayres, Hopf & Aryes, 1997) defined shyness as "the tendency to be timid, reserved, and most specifically, talkless." Jones and Russell (1982) looked at shyness as a global, unitary construct without regard to its relation to other forms of social anxiety. Buss (1984) defined shyness "as discomfort, inhibition, and awkwardness in social situations, especially with people who are not familiar."

The narrowest definition of shyness been given by McCroskey and Beatty (1986) " a strictly behavioural tendency that is essentially equivalent to a quietness-versus-talkativeness dimension." Jones, Briggs, and Smith (1986, p629) defined shyness as "discomfort and inhibition in the presence of others."

Cheek, Carpentieri, Smith, Rierdan, and Koff (1986,p105) defined shyness as a "tendency to be tense, worried, and awkward during social interactions with strangers,

casual acquaintances, and persons in positions of authority." Leary (1986,36) defined shyness as "a psychological syndrome characterized by social anxiety and interpersonal inhibition that results from the prospect or presence of interpersonal evaluation."

Van der Molen (1990) put forward two definitions, a basic definition and a working definition. His basic definition was based on the view that the individual is the most reliable expert on his/her own shyness; what others had to say about it is based on enquiries or (fallible) observations of behaviour. To define the concept he chose the noun "shyness", not the phrase "shy behaviour", for "shyness" offers the scope to regard the problem primarily as a concept of experience and only secondarily as a concept of behaviour. Even when a person's behaviour is not remarkable, he or she still can feel shy. On this basis he suggested that individuals can safely be called shy if:

(1) they consider themselves (to a certain degree) shy, and

(2) enquiry and/or observation of behaviour proves that in certain kinds of social situations they habitually have to contend with

   a) feelings of tension, "diffidence", "feeling inhibited",

   b) behavioural problems (not knowing how to behave in social situations or not daring to do what they really think they ought to do, particularly not daring to speak freely), and

   c) negative thoughts about themselves. (Van der Molen,1990, p258)

The working definition was intended as a starting point for training or therapy objectives and the evaluation problems closely interwoven with these objectives. He said that someone suffers from shyness when it frequently is the case that he or she does not know how to cope with social situations.

The aspects of shyness are

1. Experience: fear, tension, lack of self-confidence
2. Knowledge: not knowing how to behave
3. Skills: not capable of executing the adequate behaviour
4. Cognitions: irrational thoughts before and during attendance at social situations; negative self-evaluations afterwards
5. Physical aspects: sweating, trembling, blushing, and so forth
6. Avoidance behaviour: not daring to execute (adequate) behaviour. (Van der Molen,1990, p268)

According to Buss (1997, p109) "Shyness is discomfort when confronted with others in a give-and-take social situation. Normally expected social behaviour is diminished, as may be seen in inhibited speech and gestures, little facial expression, and reluctance to become involved in conversation."

Crozier (2000a, p2) admits that shyness is not a precise term. "It refers to feeling awkward or uncertain in social situations. It is associated with self-consciousness, excessive monitoring of behaviour and over-rehearsal of potential utterances. The shy person feels anxious and often (though not invariably) appears anxious to others. Shyness takes the form of hesitation in making spontaneous utterances, reluctance to express opinions and in making responses to the overtures of others that reduce the likelihood of further interaction."

Henderson and Zimbardo (2000) defined shyness experientially as discomfort and/or inhibition in interpersonal situations that interferes with pursuing one's interpersonal or

professional goals. It is a form of excessive self-focus, a preoccupation with one's thoughts, feelings and physical reactions. It may vary from mild social awkwardness to totally inhibiting social phobia.

Subsequently, Henderson and Zimbardo (2001) took a different approach to deal with the definition of shyness, which is not far from that of Van der Molen (1990). They define chronic shyness in terms of the individual's goals because they wish to leave the definition in the hands of the person whose experience they are describing. They do this because they want to promote from the outset the idea that people can learn to define themselves in ways that either inhibit or promote social experimentation and constructive change. As social psychologists, they are well aware of the power of self-labelling, and they claim that chronically shy individuals generally lack a belief in their ability to achieve social goals. They believe, however, that it is possible for such people to develop a sense of self-efficacy that will allow them to reappraise situations initially perceived as threatening to be challenging and manageable. As social psychologists, they are also sceptical about the use of external standards for defining shyness. Research in social psychology emphasises the power of situational influence on behaviour. For instance, socio-economic status and cultural influences constrain what people are able to do, and those people who appear to be higher functioning due to higher status may be under-achieving in relation to their peer group. All in all, they feel that the individual's self-appraisal of shyness has greater value in treatment than any externally imposed judgement (Henderson and Zimbardo, 2001).

Although no widely shared conceptualisation of shyness has been reached yet, many appear to agree on at least four clarifications of the lay concept of shyness (Asendorpf, 1987a).

First, the transient affective state of situational shyness should be clearly distinguished from the trait of dispositional shyness, that is, individual differences in situational shyness that are rather stable over time and across a wide variety of social situations (Russell, Cutrona, & Jones, 1986). Second, situational shyness, similar to all affective states, should be conceived of as a syndrome encompassing experiential and overt-behavioural processes that are often, but not always, consistent with each other (Leary, 1986). Third, situational shyness occurs only in social situations and always involves an elevated level of anxiety that refers to certain aspects of current or future interactions; this anxiety component distinguishes situational shyness from simple non-involvement in interaction and dispositional shyness from introversion (Cheek & Buss 1981, Jones, Briggs, & Smith, 1986; Leary, 1986). Fourth, situational shyness often involves not only anxiety but also positive affect such as interest (Izard & Hyson, 1986).

With some exceptions, most existing conceptualizations of shyness according to Leary (1986) can be classified, roughly, into three categories. Although the definitions in each category are not identical, they share common characteristic that distinguish them from definitions in other categories.

First: Several writers have viewed shyness as a subjective experience characterized by apprehension and nervousness in interpersonal encounters (e.g., Buss, 1980; Leary and

Schlenker, 1981; Zimbardo, 1977). This conceptualization is reflected in everyday language when someone speaks of "feeling shy." Defined in this way, shyness may be regarded as a particular form of social anxiety (Buss, 1980; Leary, 1983a).

Second: Some writers define shyness in terms of inhibition, reticence, or social avoidance. For example, Pilkonis (1977b, p596) defines shyness as "a tendency to avoid social interactions and to fail to participate appropriately" in them. In common usage, people sometimes describe themselves or others as "acting shy" when they behave in an inhibited or hesitant manner.

Third: Some definitions identify shyness as a psychological syndrome that includes both subjective social anxiety and inhibited social behaviour (e.g., Cheek & Buss, 1981; Crozier, 1979a; Jones & Russell, 1982). Although social anxiety and interpersonal inhibition can occur independently, there is a low to moderate positive correlation between them (Leary, 1983a, Leary, 1986). Also under this category, shyness can be identified as constructed in behaviour systems. A systems approach emphasizes the patterning or organization of behaviours (Crozier, 2000a).

However, even if there is an agreement to define shyness as the simultaneous occurrence of social inhibition and anxiety, there is still the difficulty of producing a definition that precisely characterizes the construct so as to distinguish it from other instances of anxious inhibition that most people would not call shyness. None of the existing definitions of shyness is much help in this respect, as they generally fail to distinguish shyness from non-social discomfort and lack of responsivity that may occur in social settings (Leary, 1986).

2.2.1. Components of shyness

There is considerable agreement among clinical, psychometric, experimental, and observational studies concerning the typical reactions of shy people during social interactions: global feelings of tension, specific physiological symptoms, painful self-consciousness, worry about being evaluated negatively by others, awkwardness, inhibition, and reticence (Briggs, Cheek, & Jones, 1986). However, the disagreement among definitions of shyness centre on deciding which reactions typify the concept and should be considered the core characteristics that identify the shy person.

The best way to organize this list of typical shyness symptoms is to employ the standard tripartite division of experience into three components: affect, cognition, and observable behaviour. This trichotomy of feeling, thinking, and acting has a long history in psychology (Breckler, 1984). Buss (1984) has advocated the formal elaboration of a three-component model of shyness. Jones, Briggs, and Smith (1986), however, conducted a factor analysis of 88 shyness items from five personality scales and concluded that "there are persuasive reasons to suspect that a single dimension underlies the construct of shyness" (p638). This is quite consistent with the factor analytic work of Cheek & Buss (1981, p 332) and Cheek & Melchior (1985), which indicates only one major factor in shyness items. Nevertheless, research described later, employing a variety of methods other than factor analysis, persuaded them to continue to hold their previously stated preference for the three-component rather than the unidimensional conceptualisation of shyness (Cheek & Briggs, 1990; Cheek & Melchior, 1990).

The first category of shyness symptoms includes global feelings of emotional arousal and specific physiological complaints, such as upset stomach, pounding heart, sweating,

or blushing These reactions define the somatic anxiety component of shyness. Several surveys of high school and college students indicate that from 40 to 60 percent of shy students experience difficulties with multiple symptoms in this category (Cheek, Melchior, 1985; Fatis, 1983; Ishiyama, 1984). In a study that employed content coding of free descriptions by shy women, 38 percent of them volunteered at least one somatic anxiety symptom when describing why they considered themselves shy (Cheek, Watson, 1989). The somatic component is clearly an important aspect of shyness, but these results also help to clarify why it has been relatively easy for researchers to identify a subtype of socially anxious individuals who are not troubled by somatic arousal symptoms (e.g., McEwan & Davins, 1983; Turner & Beidel, 1985).

The second, cognitive component of shyness is acute public self-consciousness, self-deprecating thoughts, and worries about being evaluated negatively by others. The argument for distinguishing the somatic and cognitive components of shyness is based on the general distinction between somatic anxiety and psychic anxiety (Buss,1962; Schalling,1975) which continues to receive empirical support (Deffenbacher & Hazaleus, 1985; Fox & Houston, 1983). Between 60 and 90 percent of shy students identified various cognitive symptoms as part of their shyness (Cheek & Melchior, 1985; Fatis, 1983; Ishiyama, 1984). However, only 44 percent of the shy adults in Cheek and Watson's (1989) study described specific cognitive symptoms. Although this figure is unusual (Turner & Beidel, 1985), even among men and women clinically diagnosed as socially phobic, there is a meaningful amount of variability in public self-consciousness and other cognitive symptoms of anxiety (Hope & Heimberg, 1988).

The third concerns the social competence of shy people. The relative absence of normally expected social responsiveness defines the quietness and withdrawal typical of shy people (Buss, 1984). Nonverbal aspects of the behavioural component of shyness include awkward body language and gaze aversion. About two-thirds of the shy respondents in the studies described previously reported behavioural symptoms of shyness. Similarly, the results of several laboratory experiments indicate that most, but not all, shy people show observable deficits in social skills (e.g., Cheek & Buss, 1981; Curran, Wallander, & Fischetti, 1980; Halford & Foddy, 1982; Paulhus & Morgan, 1977).

All three components of shyness are important, but none is a universal aspect of the experience of shy people. Evidence that supports the three-component model suggests that shyness as a global or nomothetic trait should be conceptualised as a personality syndrome that involves varying degrees of these three types of reactions (Cheek & Melchior, 1990). Such evidence validates Buss's (1984) theoretical argument that it is reasonable to infer shyness when symptoms of at least one of the three components are experienced as a problem in a social context, as well as his contention that "it makes little sense to suggest that any one of the components represents shyness to the exclusion of the other two".

From the perspective of the three-components syndrome model, dispositional shyness is defined as "the tendency to feel tense, worried, or awkward during social interactions, especially with unfamiliar people" (Cheek & Briggs, 1990). Although the focus of this definition is on the reactions that occur during face-to-face encounters, it should be noted that feelings of shyness often are experienced when anticipating or imagining

social interactions (Buss, 1980; Leary, 1986). It should also be clear that discomfort or inhibition of social behaviour due to fatigue, illness, moodiness, or unusual circumstances, such as the threat of physical harm, are excluded from the definition of shyness (Buss, 1980; Jones, Briggs, & Smith, 1986).

2.2.2. Being shy

Regardless of their relative positions in experiencing the somatic, cognitive, and behavioural components of shyness, shy people have one obvious thing in common: They think of themselves as being shy. Rather than being a trivial observation, this may be a crucial insight for understanding the psychology of shyness. Shy people seem to have broad commonalities at the metacognitive level of psychological functioning. Metacognition is defined as "higher-order cognitive processing that involves awareness of one's current psychological state of overt behaviour" (Flavell, 1979). This distinctive self-concept processing of shy people suggests that maladaptive metacognition is the unifying theme in the experience of shyness during adulthood (Cheek & Melchior, 1990).

Viewed at this higher level of metacognitive functioning, shyness may be conceptualised as "the tendency to become anxiously self-preoccupied about social interactions" (Crozier, 1979b, 1982). As Hartman (1986) put it, shy people become "preoccupied with metacognition; thoughts about their physiological arousal, ongoing performance, and others' perceptions of them as socially incompetent, inappropriately nervous, or psychological inadequate" (p269). Because this tendency represents only one specific aspect of metacognition, Cheek and Melchior (1990) referred to the shy person's metacognitive processing of self-relevant social cognitions as meta-self-consciousness (Dissanayake, 1988).

The pervasiveness of the self-concept processes summarized in Box (1) suggests that the cognitive component is the predominant aspect of adult shyness. That is, shy people's cognition regarding their somatic anxiety symptoms and degree of social skill may be more consequential than their objectively assessed levels of tension or awkwardness (Cheek & Melchior, 1990). The metacognitive model of shyness implies that, in addition to help for their specific shyness symptoms, therapy for shy adults should include cognitive approaches that address self-concept disturbances and anxious self- preoccupation (Alden & Cappe, 1986).

Box 1 Summary of Shy People's Cognitive and Metacognitive Tendencies.

Unlike those who are not shy, dispositionally shy people tend to:

1. **Perceive that a social interaction will be explicitly evaluative.**
2. **Expect that their behaviour will be inadequate and that they will be evaluated negatively.**
3. **Hold "irrational beliefs" about how good their social performance should be and how much approval they should get from others.**
4. **Think about "who does this situation want me to be?" rather than "how can I be me in this situation?"**
5. **Adopt a strategy of trying to get along rather than trying to get ahead.**
6. **Become anxiously self-preoccupied and not pay enough attention to others.**
7. **Judge themselves more negatively than others judge them.**
8. **Blame themselves for social failures and attribute successes to external factors.**
9. **Accept negative feedback and resist or reject positive feedback.**
10. **Remember negative self-relevant information and experiences.**

From Cheek and Melchior (1990, p68)

According to Henderson and Zimbardo (2000) shyness reactions can occur at any or all of the following levels: cognitive, affective, physiological and behavioural (Table 1). It

may be triggered by a wide variety of arousal cues such as authorities, strangers, and one to one opposite sex interactions.

Table 1 Symptoms of Shyness

Behaviour	Physiological	Cognitive	Affective
Inhibition and passivity	Accelerated heart rate	Negative thoughts about the self, the situation, and others	Embarrassment and painful self-consciousness
Gaze aversion	Dry mouth	Fear of negative evaluation and looking foolish to others	Shame
Avoidance of feared situations	Trembling of shaking	Worry and rumination, perfectionism	Low self-esteem
Low speaking voice	Sweating	Self-blaming attributions, particularly after social interaction	Dejection and sadness
Little body movement or expression or excessive nodding or smiling	Feeling faint or dizzy, butterflies in stomach or nausea	Negative beliefs about the self(weak) and others (powerful),often out of awareness	Loneliness
Speech dysfluencies	Experiencing the situation or oneself as unreal or removed	Negative biases in the self-concept, e.g.," I am socially inadequate, unlovable, unattractive."	Depression
Nervous behaviours, such as touching one's hair or face	Fear of losing control, going crazy, or having a heart attack	A belief that there is a "correct" protocol that the shy person must guess, rather than mutual definitions of social situations	Anxiety

Henderson and Zimbardo (2000, p3)

2.2.3. Types of shyness

A related issue has to do with whether shyness is conceptualized as the basic unit of analysis, as is typically the case, or whether it is divided into components or types. For example, Baldwin (1894) made a distinction between "primary", or "organic" bashfulness, seen in infants, young children and animals, and "true bashfulness", which appears in humans only after the age of 3. This type of shyness involves "reflection upon the self and the action of self and represents the child's direct application of what

he knows of persons to his own inner life". Eysenck (1956) distinguished between two types of shyness: Introverted shyness (a preference to be alone but with the ability to function effectively in company if necessary) and Neurotic shyness (a feeling of being troubled about being self-conscious, experiencing feelings of loneliness, troubled with feelings of inferiority and self-conscious with superiors, worrying over humiliating experiences).

Pilkonis (1977a) distinguished between two major types of shy people: those persons who are privately shy and focus on internal events (discomfort, physiological arousal, fear of negative evaluation) in describing their shyness, and those persons who are publicly shy and regard their behavioural deficiencies (failures to respond, inappropriate or awkward responses) as more critical aspects of their shyness.

Public shyness, is relatively easy to recognize. Shy people appear to be nervous in social situations, they are often reluctant to speak or make eye contact, and they frequently succeed in making those around them anxious also. In addition, they are usually willing to report that they are unhappy with themselves and their social presentations (Pilkonis, 1986).

Bowlby (1969, 1973, 1977, 1980) is the best known proponent of attachment theory and its implications for psychopathology. His portrait of "anxiously attached" individuals bears a strong resemblance to Pilkonis's (1986) everyday stereotypes of shy people. Shy people are insecure about relationships with others, inhibited in attempting to establish them, and often excessively dependent and clinging once a bond is formed. They have serious doubts about the stability of any relationship, anticipating that

rejection and loss are inevitable. They assume that they are worth little in the eyes of others. Bowlby has described the kinds of "pathogenic parenting" that such persons have sometimes received and that promote fears of loss, separation, and abandonment.

If one accepts that such different phenotypes are the expression of a similar genotypic disturbance, then several consequences follow. First, in assessing shyness, it is also necessary to determine the extent to which these other tendencies also exist, as a measure of the breadth and severity of attachment problems. Second, shy people are often attracted to those who appear, at first, to be socially confident and self-reliant or those who promise to take care of them in some way. Such relationships can be painful and disappointing when the original perception of the partner changes. One often leaves such relationships wondering what went wrong. An understanding of the nature of compulsive self-reliance and compulsive care giving makes it possible to appreciate that one's partner may also have been struggling with problems of intimacy and attachment and that neither person had the emotional resources to allow the relationship to grow. Third, to the extent that all these patterns are similar etiologically and dynamically, one can predict that they will respond to the same treatments. Although there is only anecdotal evidence in this regard, it is plausible that a particularly effective psychotherapy group might consist not only of shy people, but also patients with other chronic difficulties in attachment. Such a group would allow all participants to recognize the covert similarities that underlie their apparent differences (Pilkonis, 1986).

Leary (1982, 1984) defined social anxiety generally in terms of its subjective, internal manifestation, thereby distinguishing it from any overt behaviour manifestations with which it may be associated. Buss (1980,1984, 1986) distinguished between what is

called early developing or fearful shyness which starts during the first year of life and seems to be caused by temperamental qualities of wariness and emotionality based on a genetic predisposition, and late developing or self-consciousness shyness which first appears after age five, when the cognitive self-concept has already begun to develop.

In another approach to the distinction between types of shyness, Gough and Thorne (1986) distinguished between three types of shyness: positive, negative and balanced. Positive shyness means relatively desired and wanted attributes that are considered as indicators of shyness, such as cautions, modesty, self-control, and tact, and also undesirable and unwanted attributes that are not considered as indicators of shyness, like arrogance, and boastfulness. Negative shyness means the relatively undesirable and unwanted attributes that are considered as indicators of shyness, such as anxiety, fearfulness, nervousness, and silence, and also favoured and wanted attributes that are not considered as indicators of shyness, like aggressiveness, forcefulness, and talkativeness. Balanced shyness means the relatively favoured and wanted attributes that are considered as indicators of shyness, such as quietness, sensitivity, timidity, and desirable and wanted attributes that are not considered as indicators of shyness, like self-confidence, and being outgoing.

From their attachment study Krasnoperova & Cheek (1995) formed four groups (shy-secure, shy-dismissive [conflicted], shy-preoccupied [dependent], and shy-fearful [withdrawn]) based on scores on an index of moving toward others and an index of moving away from others. They also conducted a replication study with a larger sample of male and female participants. Their first study (1995) revealed differences between the dependent and withdrawn subtypes of shyness on measures of attachment, affiliative

needs, emotionality, and loneliness. The shy-secure group differed from the other groups on shyness, attachment, self-consciousness, and loneliness. The shy-conflicted group differed from the other groups on ratings of secure and fearful-avoidant attachment and on the need for attention. The second study (1999) demonstrated that shy-dependent participants had higher affiliative needs and were less lonely than were shy-withdrawn participants. Participants who were low on both dependency and withdrawal (the secure group) were less shy, had lower affiliative needs, and were less lonely and less depressed than participants who were high on dependency, withdrawal, or both. Finally, participants who were high on both dependency and withdrawal (the conflicted group) were more shy, less securely attached, and had higher affiliative needs and lower self-esteem than the other shy participants. They were also more depressed and more lonely than the other shy participants.

There is considerable overlap in the result of the two studies. The results of comparisons between shy-dependent and shy-withdrawn participants and between shy-secure participants and all other shy participants are highly consistent across the two studies. A discrepancy in the results of the two studies, however, occurs in comparisons between shy-conflicted participants and all other shy participants. The second study demonstrated many more differences than the first study, including differences in the important outcomes of depression and loneliness. One possible reason for the larger number of significant results in the second study is its greater statistical power due to a larger sample size. Another reason is that the sample used in the second study was more diverse. It included both men and women; it was more ethnically diverse, and it consisted of students from a large state university rather than from a small and selected women's college.

The four-group subtypes of shyness approach appears to be superior on both empirical and theoretical grounds to Cheek and Buss's (1981) two-group classification of shy individuals into shy-sociable and shy-unsociable. First, it permits identification of a relatively better adjusted, more psychologically secure shy group. Second, using measures of both dependency and withdrawal allows a more precise classification of what used to be called the shy-sociable and the shy-unsociable groups. Third, the four-group approach separates out the conflicted shy group, whose members are high on both dependency and withdrawal. This group may present more difficult and complex treatment issues, because conflicted shy people need help in two areas simultaneously: how not to be too passively dependent on others and how not to be too disconnected from others.

The dependent subtype of shyness represents only one of the various possible dependent interpersonal styles. Similarly, the withdrawn subtype of shyness is only one of the various possible avoidant interpersonal styles. In particular, it is not the same as Bartholomew and Horowitz's (1991) dismissing-avoidant style, because a dismissing-avoidant person has a positive self-concept, whereas a shy person generally does not have a positive self-concept (Cheek & Melchior, 1990). There was no significant difference between shy-withdrawn and shy-dependent groups on self-esteem in either of Cheek, & Krasnoperova's two studies (Krasnoperova, & Cheek, 1995, 1999).

Schmidt & Fox (1999) examine the developmental course and outcomes of different types of shyness beyond early childhood. The correlates and outcomes associated with childhood shyness are comparable to those seen in adults. For example, extremely shy

adults are known to have more problems regulating negative emotion and are more likely to suffer from problems of poor self-concept and depression than their non-shy counterparts.

Using a design identical to that reported by Cheek and Buss (1981), Schmidt & Fox, 1994) examined whether one could distinguish different types of shyness on multiple psychophysiological measures. They found a significant Shyness × Sociability interaction on two separate autonomic measures (mean heart rate and heart rate variability) just prior to an anticipated novel social encounter. High shy/high sociable participants exhibited a significantly faster and more stable heart rate than those in the other three groups.

There is also evidence to suggest that the pattern of resting frontal absolute EEG power distinguishes different types of adults' shyness. Schmidt (1999) found that adults who self-reported high shyness and high sociability (i.e., conflicted) and adults who self-reported high shyness and low sociability (i.e., avoidant) both exhibit greater relative right frontal EEG activity, which was a function of less power in the right lead than in the left frontal lead. High shy/high sociable participants exhibited significantly less power (i.e., more activity) in the left frontal lead than participants in the high shy/low sociable group. These data suggest that shyness and sociability are distinguishable on a neurophysiological level and that each trait may be subserved by distinct neurophysiological systems. These data also suggest that there are different types of shyness, each of which is distinguishable on behavioural, central, and autonomic measures during resting and socially stressful conditions. (Schmidt & Fox, 1999).

Kerr's (2000) results support these patterns, to some degree. There were no relations between early shyness and any of the variables that tapped quality of relationships, either with friends, with partner, or in the realm of sexuality. In contrast, adolescent-developing shyness was a negative predictor of nearly all measures of the frequency and the quality of interactions with friends and partners, and in the realm of sexuality. Concerning psychological well being, early –developing shyness was clearly less problematic than later-developing shyness for males, but the same was not true for females. The results for males supported the hypothesis in that early-developing shyness was related to less anxiety, more feelings of control, fewer depressive symptoms, and more positive affect in adulthood. However, for all of these measures there were significant sex differences, and the results for females, although not strong, went in the opposite direction. In addition, for females, early developing shyness was linked to lower self-esteem in adulthood. For both sexes, however, adolescent-developing shyness was linked to more depressed mood, lower self-esteem, poorer attitudes about one's appearance, lower life satisfaction, and less positive affect. There is little evidence that any form of shyness is related to later occupational or economic circumstances.

The results show that shyness can have very different implications for men and women. One possible explanation for this is that the mechanism through which early-developing shyness could result in positive adjustment might not work for females because they are expected to be more social than males. It is difficult to say how much of these results are dependent upon culture. Cultural differences in the acceptance of shyness can be quite extreme and can have radically different implications for social experiences of shy people.

Crozier's (1999) study was based on extended interviews with 21 adults, median age 40 years, age range 24-59 years, predominantly women and all studying in a British university. They were not selected for shyness but were interviewed with the primary goal of understanding the role, if any, that shyness had played in their adjustment, as mature adults, to student life. The interviews were tape-recorded and transcribed, and responses to specific questions were subjected to content analysis. The first stage in the analysis was to identify all mentions of situations that elicited shyness and to categorize these in terms of the causes of fearful and self-conscious forms of shyness. These causes were identified on the basis of the account provided by Buss (1986). Fearful shyness is, in general, caused by new situations, intrusions into situations, being evaluated by others, and speaking in front of others. New situations were categorized into three groups: (1) novel situations, such as going to college for the first time; (2) meeting a single new person, such as going on a first date; and (3) meeting more than one new person, for example, in teaching with strangers, going to an informal social gathering, or joining a new class. Speaking in front of others was divided into two categories: (1) making a presentation, as in public speaking or giving a paper in class; and (2) speaking in front of others, for example, expressing a point at a meeting. A further category dealt with being evaluated by others. There were no instances that fitted the social intrusion category among the protocols.

Self-conscious shyness is caused by being looked at by others or being the focus of attention; being different from others; interacting with an authority figure or someone of different status; attending formal occasions; and being concerned with what other people think of oneself. These situations formed five categories for self-conscious

shyness. A final category was formed for situations that did not fit into either category of fearful or self-conscious shyness.

Eighty-eight situations could be classified as fearful and 48 as self-conscious. This tendency for more fearful than self-conscious references was statistically reliable. The single largest category related to meeting people for the first time and interacting with strangers; this accounts for more than one in four of all shyness-eliciting situations, and at least one instance of this category was mentioned by 16 out of the 21 respondents. There was a range of contexts for these social encounters: meeting people for the first time, meeting co-workers or friends of a spouse, conversing with people one does not know, introducing oneself to other parents at a child's school, joining a new class, going into a bar, or joining a group who are seated together in a restaurant.

Speaking in front of others accounted for 27 percent of fearful shy situations. Among this sample of student participants, presenting a paper to a group of other students was the most feared situation. Speaking up in front of others was not, however, restricted to public speaking and included answering questions in class and expressing a point of view at meetings.

The most common causes of self-conscious shyness were being looked at or being the focus of attention (arriving late at a lecture or crossing a room where others are seated); interacting with an authority figure (professor or boss) or a high status person (e.g., someone with a "posh" accent); being aware one is different from the other people (e.g., feeling an outsider, being from a different social background, feeling older or less qualified than other students).

Finally, a small number of situations could not easily be categorized. These included attending an interview (without further elaboration), being assertive (returning an item of clothing to a department store), and using the telephone.

In the second stage of the analysis, the protocols were searched for words and short phrases that described responses to these situations. The categories were based on theoretical grounds, drawing on the characteristic responses of fearful and self-conscious shyness according to Buss (1986) and also reflecting common shyness responses as identified in previous shyness research (e.g., Zimbardo et al., 1974).

2.3. Trait and State shyness

In lay psychology, "shyness" denotes both an emotional state, which everybody may experience in certain situations, and a trait that influences behaviours across situations and time. "State shyness" and "trait shyness" are related, though quite different concepts as results obtained for one of them cannot be generalised to the other. "State shyness" refers to intra-individual differences, and "trait shyness" refers to inter-individual differences (Asendorpf, 1990a; Briggs, 1985).

It is useful to distinguish between these two types of characteristics: traits and states. Traits are those relatively stable and enduring characteristics of people that make them predictable; that make them the person they are. States, on the other hand, are more changeable. They are concerned with how people are feeling or performing at this particular moment, rather than how they generally feel or typically perform. For example, the worry one feels about some specific events represents a state, while his/her

tendency to worry about things in general is a manifestation of a trait. Everyone shows state variations in how sociable he/she feels from time to time, sometimes more, sometimes less. In addition, there are also trait variations between people in that some people tend to be generally more sociable than others. Another way to looking at this, is to see the trait as the underlying potential to act, think or feel in certain ways, while the state is the current realization of that characteristic. The state will be determined partly by the trait itself and partly by situational factors. While Shyness may be chronic and dispositional, serving as a personality trait that is central in one's self-definition, situational shyness involves experiencing the symptoms of shyness in specific social performance situations but not incorporating it into one's self-concept (Henderson and Zimbardo, 2000).

Shyness may be conceptualized as either an emotional response to certain social situations or as a relatively enduring personality disposition, and there is evidence to support the utility of both conceptualizations (Briggs, Cheek, and Jones, 1986). As an emotional state, shyness is transitory, situation bound, and may be experienced from time to time by virtually anyone. For example, Izard and Hyson (1986) have argued that the emotion of shyness, although disruptive, is nevertheless functional as it signals the potential for social loss. As a personality disposition, shyness influences behaviours across situations and time (Briggs, 1985). Research has shown that shyness occupies an important position in the universe of trait descriptive terms, and also that shyness or social anxiety is a major component of the pattern of responses to most multifactor personality inventories, often subsuming the largest proportion of the common variance in item responses (Howarth, 1980).

Russell, Cutrona, and Jones, (1986) developed the Shyness Situations Measure (SSM) in order to determine the kinds of situations that contribute to the experience of shyness. The results from their study of 136 college students indicated that the immediate experience of shyness is determined by properties of the person and by properties of the situation. In general, trait and situational factors appear to be more or less equally important in producing shyness, when both factors are assessed in a systematic and comparable fashion.

In contrast to the general acceptance of the inter-actionist perspective by personality and social psychologists, Russell, Cutrona, and Jones, (1986) failed to find any evidence of statistical interactions between individual differences and situational factors in determining shyness. Results presented by Jones and Russell (1984) indicated that previous findings of person-situation interactions might have been an artifact of the methodology used to test for these effects. In addition, results regarding cross-situational consistency in shyness indicated some utility in assessing self-perceived consistency. However, in contrast to expectations, highly variable subjects were not more responsive to characteristics of the situation. Instead, results suggested that consistent subjects are generally more predictable in their shyness-related responses, both from dispositional and situational measures. Concerning the experience of shyness, these findings indicated that a strictly trait or situational approach to the psychological state of shyness is limited, in that the experience of shyness is clearly a function of both the person and the situation.

Buss (1980,1986) has argued that the situations leading to shyness may be categorized as involving (a) novelty, (b) the presence of others, and (c) certain actions of others.

Buss argued that shyness may occur in conjunction with the novelty of unfamiliar physical surroundings (attending classes at a new school), social novelty (meeting strangers), and role novelty (assuming a new position within an organization). The presence of others, according to Buss, elicits shyness by virtue of formality (a wedding ceremony), high status (meeting important or famous people), and conspicuousness (being the only person who thought it was a costume party). Finally, shyness may be the result of certain actions on the part of others, including excessive attention (being stared at), insufficient attention (being ignored by your spouse at a party), and intrusiveness (being asked personal questions in public). Buss suggested that the combination of formality and meeting a stranger of high status lead to particularly intense shyness.

These speculations have received some empirical verification, especially with respect to novelty and the presence of others (Jones and Russell, 1984; Russell et al., 1986). Situations in which one is the focus of attention (e.g., giving a speech) strangers have been found to be particularly powerful elicitors of shyness among both college students and elementary school children (Zimbardo, 1977; Zimbardo and Radl, 1981). Also Izard and his colleagues (Izard, 1972; Izard and Hyson, 1986) have found that situations that elicit shyness as opposed to other emotions also elicit higher tension and, paradoxically, higher pleasantness. In fact, the pleasure associated with shyness situations is greater than that of any of the other negative emotions. Other researchers have provided important information about shyness as a state experience, for example, Leary's work on the self-presentational aspects of shyness (Leary 1983b). However, shyness has traditionally been thought of as an enduring personal characteristic. Most of the empirical work has approached shyness from the trait perspective, beginning with

the early work of Cattell (1947) and Guilford (1959). By taking a trait orientation they assume that the discomfort and inhibition one experiences in the presence of others reflects an enduring tendency or predisposition, and not simply a reaction to some specific and temporary feature of the situation. "Shyness as a trait is the propensity to respond with heightened anxiety, self-consciousness, and reticence in a variety of social contexts; a person high in the trait of shyness will experience greater arousal than a person low in shyness independent of the level of the interpersonal threat in the situation." (Jones, Briggs and Smith,1986, p630).

Briggs (1988) in his article, "Shyness: Introversion or neuroticism?" also focused on the trait of shyness, which according to him is similar to other negative emotional traits in that it involves a complex mixture of behavioural, affective, somatic, and cognitive elements. McDougall (1963) extended Baldwin's (1894) analysis (primary or organic bashfulness and true bashfulness) to explain the development of individual differences in the trait shyness, and he suggested a third stage of development in which the intensification of self-consciousness at the onset of puberty interacts with the development of self-regarding sentiment to shape shyness and modesty as qualities of adult character and conduct.

Shyness fulfils two key criteria in the definition of a temperament: "inherited personality traits present in early childhood" (Buss & Plomin, 1984, p.84). Therefore it may seem puzzling that Kagan (1994) has concluded that "most adults who say they are shy do not belong to the temperamental category favouring this quality" (p.42). The solution to this puzzle may depend on the time at which shyness first becomes a salient characteristic for a particular individual (Box 2).

Box 2 Ages and stages in the development of shyness

Age	Stage
0	Temperamental "organic" bashfulness (Baldwin,1894)
	Early developing shyness (Buss, 1980; Kagan & Rezink,1986)
4	"true" bashfulness with simpler form of self-reflection (Baldwin, 1894)
	first appearance of self-conscious shyness (Buss, 1986)
8	prepuberty intensification of self-consciousness (McDougall, 1963)
	increased use of social comparison in self-evaluation (Harter,1986)
14	peak of adolescent self-consciousness, higher for females than males
	(Elkind & Bowen, 1979; Simmons & Rosenberg, 1975; Zimbardo,1977)

Cheek & Krasnoperova (1999, p 226)

It is claimed that shyness is the personality trait with the strongest genetic component (Plomin & Daniels, 1986), yet it is also a trait that involves pervasive and consequential disturbances in conscious self-concept processes.

Cheek and Krasnoperova (1999) argue that innate tendencies are the fundamental postulates for understanding social behaviour, not because they can explain behaviour directly but because they enter into the complex transactional processes of personality development and current self-interpretation (Cheek 1985; Cheek & Hogan 1983).

Personality traits exist at different levels of biological, emotional, cognitive, interpersonal, and cultural functioning (Barkow, 1980). Because humans are complex, self-constructing living systems, no narrow approach to the psychology of shyness, whether based on genetic, physiology, learning, emotion, self-esteem, psychodynamics, self-attention, self-efficacy, or self-presentation, can succeed by itself (Cheek & Briggs, 1990).

2.4. Theoretical explanations of shyness

Theories of shyness can be discussed from three viewpoints that are not totally separated from each other:

1- Theories of emotion that focused on the relationship between bodily changes and mental activity.

2- Theories of anxiety from the three major psychological approaches; the psychodynamic, the humanistic and the cognitive-behavioural.

3- Theories that draw distinctions between different kinds of shyness.

2.4.1. Theories of emotion

Shyness is one of the ten basic emotions identified by the differential emotions theorists (Stanley and Burrows, 2001).

2.4.1.1. The James-Lange theory

The James-Lange theory postulated that emotions are made up of bodily changes and a mental event or feeling. To James (1884) and Lange (1885) the prototypic human emotions such as fear, grief, love and rage were based on bodily involvement "I saw the bear, I ran, I was afraid". One does not run because he/she is afraid; rather, he/she becomes afraid because he/she runs (Westen, 1999). The James-Lange theory proposes that emotional experience is the result, rather than the cause (Gross and McIlveen, 1998). The theory states that reflexes/responses precede emotions and the brain interprets these patterns of responding as emotion (i.e. the cognitive labelling of specific physiological responses). The response may involve heart-rate elevation, respiratory changes, perspiration, facial expressions, and reflex stances. Van Toller (1979) (cited in

King, 2001) asks the pertinent question, "what if the person froze with fear?" a question James overlooked (King, 2001).

Cannon (1927-1929) challenged this theory. He argues that in an emotional situation the thalamus first gets the sensory information, then it simultaneously sends signals to the autonomic nervous system starting an action (running) and to the cerebral cortex where the emotion is realized (consciousness) (Bernstein et al., 1997).

2.4.1.2. Cannon and Bard theory

Cannon (1927,1929) and Bard (1934) noted that autonomic responses are typically slow, occurring about one to two seconds after presentation of a stimulus. In contrast, emotional responses are immediate and often precede both autonomic reactions and behaviours such as running. They argued, further, that many different emotional states are linked to the same visceral responses, so that arousal is too generalised to translate directly into discrete emotional experiences. For instance, muscle tension and quickened heart rate accompany sexual arousal, fear, and rage, which people experience as very different emotional states (Westen, 1999).

Much modern research on emotion has focused on the interplay between bodily changes and feeling states. Arnold (1960) argued that mental evaluations of events determine emotional response, including bodily changes and feelings. Part of this determination involves evaluation of sensations: feelings are based partly on interpretation of events and partly on interpretation of bodily changes.

Evidence for James Lang theory is the different emotions that are associated with different physical responses. While Cannon-Bard theory evidence is that people with spinal cord damage experience a full range of emotion without feedback from

periphoral responses (Bernstein, et al., (1997). On the surface the difference between the James-Lange and Cannon approaches is that James and Lange, believe that specific bodily changes are associated with specific emotions, while Cannon believe that bodily changes are fairly similar from situation to situation, and that the most important aspect of emotion is the way in which these changes are interpreted (Baum, 1994).

2.4.1.3. Schachter and Singer theory

Schachter and Singer's (1962) two-factor theory of emotion sees emotion as based on both physiological changes and cognitive interpretations of the environment To experience an emotion, the arousal must be interpreted in an emotional way. Schachter (1964) assumes that the same physiological changes underlie all emotions and that it is the meaning attributed to them that generates different emotions.

Evidence for Schachter-Singer is that the excitation generated by physical activity can be transfered to increase emotional intensity (Bernstein, 1997).

One criticism of Schachter's theory is that many emotions are triggered spontaneously, and do not apparently arise from interpreting and labelling unexplained arousal. The possibility that some stimuli elicit emotions before there is opportunity to cognitively assess physiological change has been addressed by Lazarus (1982). He argues that some cognitive processing is an essential pre-requisite for the experience of emotion, and that sometimes this occurs in a conscious, rational and deliberate way. He claims that emotional responses such as fear may not involve conscious appraisal, but do involve primitive evaluative perception. He agrees that reflex emotional responses do not involve cognitive appraisal (Gross and McIlveen, 1998).

The subjective experience of an emotion refers to what the emotion feels like to the individual. People differ tremendously in emotional intensity. The extent to which people experience shyness differs across situation, age, gender, culture, experiences, etc.

2.4.2. Theories of anxiety

Shyness is a form of anxiety that has been studied by almost every theory. The aim of this section is to give a sense of rather than an in depth exploration of theories.

2.4.2.1. Psychodynamic Approach:

Psychodynamic models look at early life experiences as the source of anxiety. Anxiety is a state of tension that motivates people to do something. It develops out of a conflict between the id, ego, and superego over control of the available psychic energy. Its function is to warn of impending danger.

There are three kinds of anxiety: reality, neurotic, and moral. Reality anxiety is the fear of danger from the external world, and the level of such anxiety is proportionate to the degree of real threat. Neurotic and moral anxieties are evoked by threats to the "balance of power" within the person. They signal to the ego that unless appropriate measures are taken, the danger may increase until the ego is overthrown. Neurotic anxiety is the fear that the instincts will get out of hand and cause one to do something for which one will be punished. Moral anxiety is the fear of one's own conscience. People with a well-developed conscience tend to feel guilty when they do something contrary to their moral code. When the ego cannot control anxiety by rational and direct methods, it relies on unrealistic ones, namely, ego-defence behaviour (Corey, 1996).

Freud proposed that phobias, in general, arise out of traumatic experiences that occur in infancy or early childhood and drive disturbing fears and aggressive or sexual wishes into the unconscious. He suggested that the resulting unconscious conflict over these prohibited wishes can come into awareness in the form of anxiety when certain situations awaken earlier feelings.

The idea that social anxiety is a manifestation of conflict, conscious or unconscious, is consistent with some of the typical ambivalent behaviours shown by an anxious person entering a feared social situation. For example, if a shy person is going to say something to a group of people he or she does not know, he or she tends to stand up, then sit down, and stand up again, playing nervously with her hands, before ultimately going ahead. In social interactions, a person with social anxiety may intermittently smile and make eye contact, but then turn his or her gaze away prematurely and look down. Often these are not well-thought-out, conscious decisions.

The recognition of unconscious influences on social fears also suggests one way to understand why some people feel embarrassment even when the social attention they receive is quite neutral. For example, the embarrassment some people experience when being introduced during a meeting often seems to have no conscious rationale. It is not clear, however, whether such automatic reactions suggest the presence of underlying conflicts that are due to inborn sensitivities to scrutiny, or have other causes.

In contrast to Freud, Jung maintains that humans are not merely shaped by past events but also progress beyond their past. Part of the nature of humans is to be constantly developing, growing, and moving toward a balanced and complete level of

development. For Jung, personality is determined both by who and what one has been and also by the person one hopes to become. He divided psychic energy into: extrovert and introvert, which are present in everyone to varying degrees. Extroversion is motivated from the outside and is directed by external, objective factors and relationships. Introversion is motivated from within and directed by inner, subjective factors (Storr,1983).

Modern psychoanalytic theories have considered some social anxiety to be a manifestation of narcissism. In the person whose anxiety fits this model, self-esteem is dependent on constant praise from others and on feelings of superiority and fantasies of being envied by others, rather than on a less grandiose but more stable inner sense of self-worth. This jerry-rigged self-esteem is vulnerable to collapse at the first sign of criticism or mediocrity. In fact many persons with narcissistic difficulties spend most of their lives at the lower levels of the self-esteem roller coaster. Such unstable self-esteem may result from a child's insecure attachment to parents who were extremely critical or whose love was conditional upon the child meeting the parents' needs.

Although Freud and his heirs revolutionised the field of psychology, and although psychoanalytic thinking has stimulated tremendous intellectual ferment, the importance of this thinking to understanding and resolving most social anxiety problems remains uncertain. Elements of psychoanalytic theory seem relevant to understanding some forms of social anxiety in some people, but in general they seem less specifically helpful in treatment than the simpler but more testable hypotheses of cognitive-behavioural schools (Schneier and Welkowitz,1996).

2.4.2.2. The Humanistic Approach

Although the humanistic approach does not focus specifically on childhood experience as a source of unearthing repressed material, it does acknowledge that many aspects of false self are formed by the individual's need to fit into family and society. Rogers (1969) regarded the human as having a deep need for "affiliation and communication with others"; he postulated that to become fully socialized, people first need to be fully themselves. Through the process of socialization and what Rogers termed "conditions of worth" (the self-concept of the child formed by parental and social values), the potential to grow to be a "fully functioning" unique person is quashed. In an attempt to satisfy the need for positive regard, the child learns to please others, understanding primarily what aspects of character and self-expression are acceptable to the parents. Alterations are made and those "sides" of the self that are unapproved or rejected outright are gradually replaced by behaviour, as expressions of personality, that elicits approval (Milne, 1999).

The self-concept is how people learn to define themselves to meet the criteria required for them to be loved and valued. A "fully functioning" person would demonstrate congruence between their inner world of feelings and sensations and outer expression, evident in words and behaviour. The congruent person has a strong self-concept, is able to be open, honest with him/herself and others, and to live spontaneously.

According to Rogers (1970) individuals usually behave according to the expectations of others rather than spontaneously. If a person starts to react to the world in a spontaneous way, and is more often disapproved by the parents or significant others, he/she may feel lonely in his/her relationships with others. Another problem arises

when the self which has found acceptance, and a sense of being valued by significant others, first parents, then other social groups, friends, a partner, etc. is incongruent with the "authentic self". A state of incongruence has established itself within the individual's self-concept when feelings of inner experiencing are at odds with the self that is presented to the external world. A common example of this is the sensitive boy who, from a very early age, internalises parental disapproval of any display of emotion. He experiences parental disapproval and rejection when he cries or shows affection or dependency, and yet he senses that he is met with enthusiastic approval when he is "being brave", keeping emotions in, being independent and self-contained. Such a person can crave a closeness with others all his life but dare not show emotion or dependence on another. At the primary stage of his functioning, when he required unconditional love from his parents, he was given acceptance and love if he met with their requirements of him (Milne, 1999). If people believe that they will be rejected by others because their behaviour does not accord rigidly to the accepted social norms they may suffer from shyness (Rook, 1984).

2.4.2.3. Cognitive-behaviour approach

Behavioural psychology explains the impossibly complex development of human social anxiety by breaking anxiety down into discrete behaviours. Behavioural models, which try to predict such behaviours, have the advantage of lending themselves to scientific testing. These models put aside the black box of human consciousness and start with the premise that what people do is the key to understanding their problems. This behavioural approach forms the foundation for cognitive-behavioural models that have recently gained prominence in explaining and treating social phobia.

No long after Pavlov trained dogs to salivate to the sounds of a metronome by pairing the sounds with the presentation of meat, others began to apply his method of learning by association to study fears. The case of little Albert is a famous early behavioural experiment on development of fear. This way of picking up a fear is known as classical conditioning, and it can explain a wide range of fears including social fears. Maha who was not social but had always been confident about the way she dressed, once being unhappy went to a party without paying much attention to her appearance. When she went to the party her best friend said to her, " What's wrong with you, you look awful in this dress". Following this painful humiliation, Maha discovered that just the thought of going out produced an automatic response of panic.

Once they are paired with a particular situation, intense fears can be incredibly persistent, even when pairing is irrational. Social fears in particular seem easy to acquire but difficult to shed. For Maha, the unexpected harshness of the criticism she received was especially traumatic, forging a strong link between going to parties and feelings of extreme anxiety. Half of all people with social phobia recall a traumatic event that seemed to set off their problem. These traumatic events usually involve an experience of humiliation in social situation, such as being laughed at. In many people with social fears, however, no such traumatic trigger can be identified. Instead, the fears seem to have crept into a person's life gradually. A variation of the classical conditioning theory, operant conditioning, explains these fears as the culmination of a long series of small negative experiences rather than response to a single traumatic event. Beginning in the late 1920s and early1930s, Skinner refined the principle of operant conditioning. This form of learning involves the use of rewards and reinforcements to shape behaviour. Skinner believed that all behaviours, including

fearful responses, have been shaped in predictable ways by the consequences of behaviour. If a rat receives an electric shock (a punishment) when visiting one part of the cage, it is more likely to avoid that part of the cage in the future. If the rat receives a food pellet (a reward) when visiting another part of a cage, it will visit there again. People respond to operant conditioning as well. If they grow up receiving praise and rewards from their parents, teachers, and friends for particular social behaviours, such as giving public presentations, they are more likely to be comfortable speaking up in front of others. If they receive frequent criticism (a punishing consequence) for the way they talk, they are more likely to develop fear and to shy away from formal speaking.

While the notion that people's previous experience of rewards and punishments influences the likelihood of their current social behaviours may seem obvious, this idea often runs counter to how most people think. People tend to identify a feeling or an event that occurred just prior to a particular behaviour as its critical "cause." Maha would say "I did not go to the party because I was nervous," rather than "I did not go to the party because I have a history of experiencing relief of anxiety when I did not go." In the latter view, it is the reward of relief that influences Maha's behaviour. So what is the point of these fine distinctions?

While classical conditioning models ask the socially anxious person to recall early traumatic events that triggered social fear and avoidance, the operant model asks what may seem quite strange at first: "What consequences, positive or negative, do I experience by entering and leaving social situations?" Although the consequences Maha thought about the most were feeling humiliated and putting herself down for

failing at looking good, the little-noticed consequence of short-term relief from anxiety was also driving her unwanted behaviour. For Maha, relief was spelled E-S-C-A-P-E. Maha's avoidance relieved her unpleasant anxiety symptoms and prevented her from possibly having to endure critical looks or comments from others. Rather than emphasising the influence of complex emotional experiences like fear and anxiety, classical and operant conditioning models emphasise the influence of specific problem behaviours.

The same conditioning models provide a basis for methods to change unwanted behaviour. So, for example, the often-criticised child might become more eager to raise her hand if her teacher were to praise the parts of her answers that are acceptable. By focusing on specific behaviour, these models skirt the inscrutable complexity of the internal workings of the mind and the brain.

Those who believe that in order to understand people, thoughts and feelings need more attention, have challenged the simplicity of behavioural models. "Cognitivists" point out that all the praise in the world will not erase a social fear if the fearful person rejects the praise and clings to irrational fears of embarrassment.

The cognitive model deals with how people's thoughts influence what they feel. This model suggests that a tendency to dwell on negative thoughts, which are often inaccurate or untrue, is a cause of negative emotional responses. So when Maha goes to the party and find herself thinking" I do not look good," her emotions change quickly from a state of confidence to fear, helplessness, and eventually depression. For some people, these negative thoughts may be part of a pervasive pessimistic view of how well

they do in social situations, a person with such a negative "cognitive style" might think "Social events always make me nervous" or "I can never think of anything to say when I'm asked to give my opinion on any matter." For others, negative thoughts about social situations occur only sporadically and often unexpectedly. Even skilled speakers who ordinarily enjoy the spotlight may have negative thoughts before a performance such as " They won't like this speech" or "I could fumble and forget what I was about to say." These thoughts are immediately followed by tension and anxiety, but they typically dissipate after the first minute or two of the speech.

Whether constant or sporadic, fearful thoughts often appear to arise in an automatic fashion. This automatic thought is often set off by a particular trigger situation. The negative thought also carries the power of any other punishing consequence, like being laughed at by friends, only this time, the punishment comes from within. Even if nothing bad actually happens, a preoccupation with negative ideas can be toxic, producing increased fear of situation that is not dangerous.

People with social anxiety report that their particular feared situations trigger a wide variety of self-critical thoughts. Often these thoughts build on one another. A new teacher feared that her hands might tremble noticeably as she writes on the board. Her chain of thoughts quickly multiplied from this original idea to the idea that students would laugh at her and they would not respect her as a teacher. Then everyone in the department would know, so she could not do this specific job any more. What started as a fleeting negative thought about one unlikely event became a torrent of increasingly negative thoughts. The whole process took only a few seconds and ended with the teacher experiencing her most catastrophic fears with an accompanying surge

of anxious feelings. So why do people care so much about some social situations but not others? According to the self-presentation theory of social anxiety (Schlenker & Leary, 1982), concerns about one's public impressions lie at the heart of social anxiety and, hence, shyness. As long as people are either oblivious to the impression they are making on others (i.e., they are not self-aware whatsoever) or they are self-aware but believe that they are making the kinds of impression they desire to make, they should not feel socially anxious. However, when people are motivated to make desired impressions on others but do not think that they will successfully do so, they will feel anxious and may display the behavioural characteristics of shyness, such as inhibition and reticence. According to the self-presentation theory, anything that increases the individual's motivation to make a desired impression or lowers the likelihood that the person will expect to make the impression will heighten social anxiety (Leary, 2001). But Leary (2001) noted that not all failures to make desired impressions result in social anxiety. People often realize that they are making an impression on others that differs from how they would like to be seen, yet they do not feel socially anxious.

Socially fearful people often think inaccurately about the future in three general ways. First, they set unrealistic goals for themselves and assume that any achievement short of their goals will be failure. Second, they overestimate the likelihood that a failure will occur. Third, they exaggerate the severity of the negative consequences of such a failure.

Ellis (1962) argued that most emotional problems are linked to core categories of negative thoughts or presumptions about the world. He boiled down these thinking errors to several types of thoughts, such as "I must be perfect" or "I must be loved by

everyone." The problem with holding on to such absolute ideas, of course, is that they are impossible to obtain. The person who always "must" do this, or "must" do that, will certainly fail to achieve his/her goals.

But just as the purely behavioural theory had some deficiencies, so does the purely cognitive theory. If these thoughts are so out of line, why are they not proven wrong by experience? People normally learn from their mistakes. Why do these mistakes go on and on? In recent years, researchers have addressed these questions by a synthesis of cognitive and behavioural theories and their respective therapies. While combined cognitive and behavioural therapies were originally used to treat for depression, similar techniques have now been developed for social anxiety (Schneier and Welkowitz,1996).

Cognitive-behavioural models combine both thinking and doing aspects of social anxiety. They recognise the influence of thinking patterns on social behaviour-irrational fears of public speaking obviously will lead to an avoidance of public speaking. Less obviously, they recognise the influence of behaviour pattern on fearful thinking. Avoidance of public speaking prevents the phobic person from having the positive experiences necessary to disprove their worst fears, so it ends up reinforcing the very same fears. A therapy approach that attacks problematic thoughts and behaviours simultaneously can have synergistic benefits. Just as positive experiences can build confidence, negative experiences can increase fears. People with social fears often recall uncomfortable or even frightening experiences at certain social events.

While cognitive-behavioural models have the advantage of both looking into the mind and observing behaviour, they historically did not directly examine the additional factor of sensations people experience in their bodies. The three-system model proposed by Lang (1993) provides an important link between thinking, doing, and physical sensations. Cognitive, behavioural, and psychological factors all combine to create that overwhelming emotion called anxiety. These factors can operate in different combinations and in different directions.

Some people who are prone to miscalculating the risk of social catastrophes may also tend to be more aware of bodily sensations such as their own rapid heartbeat. Additionally, they may overestimate the likelihood that others will notice a symptom such as blushing or sweating and overestimate the likelihood that others will react negatively if they do notice the symptom. When a disturbing physical symptom, such as blushing, gets relieved by avoidance behaviour, such as cutting short a conversation, the symptom relief may act as a powerful reward that encourages future avoidance.

By breaking down anxiety into its component parts, the three-system model is useful for designing programmes for change. It is far easier to direct treatments to these particular components than to an amorphous overall experience of anxiety. So cognitive techniques can be used to correct negative ways of thinking, exposure therapy to deal with avoidance, and specific relaxation techniques or sometimes medication to calm physiological symptoms.

The thinking, feeling, and doing model both helps explain why people are feeling anxious at any particular moment and provides a guide for treatment. But the model

alone does not explain where these thoughts, feelings, and behaviours develop (Schneier and Welkowitz 1996).

The majority of investigations of cognition have been focused on the causal attribution approach, which explains people's behaviour in terms of causal conditions or how people account for their behaviours (Hewstone, 1983, Glassman, 1995). Attributional analysis of shyness can be explained on three dimensions: the first is locus of causality (internal or personal versus external or situational). The second is stability (stable or constant versus variable or changeable over time). The last dimension is controllability, which concerns whether or not people perceive themselves as having control over the factors that caused their behaviour. Therefore, individuals who feel shy may attribute their shyness to either themselves (for example, I cannot have a friend because I am too shy), or to an external situation (for example, I cannot have a friend because in my school it is hard to find a friend) (Peplau & Perlaman, 1982). Internal variable or changeable attributions for shyness lead to active attempts to change the personal situation as the person maintains the hope that he/she can alter the undesired situation. On the other hand, stable attribution should lead individuals to expect that the social isolation cannot be altered. Anderson et al. (1983) found that lonely college students tended to explain their social failure through their lack of personal abilities, rather than the lack of effort or use of ineffective strategies. Such people do not look for opportunities of making social contact, and this leads to the persistence of loneliness (Abu-Rassain,1998).

The variety of theories that have been reviewed reflects the complexity of social psychology. Social behaviour has multiple influences. Any particular social experience

is simultaneously a result of early interactions with parents, history of being reinforced and punished for particular social actions, the opportunities to hone social skills, and the way one thinks and feels about different social situations. All these factors interact with genes, passed down from preceding generations, in developing one's social self (Schneier and Welkowitz,1996).

2.4.3. Theories of shyness

Three theorists are notable for having drawn distinctions between different kinds of shyness. Buss (1980,1986) distinguishes between early appearing fearful shyness and late appearing self-conscious shyness. Lewis (1995) distinguishes between shyness which arises in the first year and is entirely avoidant and negative, and two forms of embarrassment which arise later, one born of self-exposure, and the other one born of self-evaluation. And Asendorpf (1993), basing his distinctions on Gray's physiological analysis of the causes of inhibition, separates inhibition to adult strangers which arises early in development, from inhibition to reinforcement arising later in development. This paints a developmental picture very similar to Lewis's distinction between exposure and evaluation, and is in essence similar to Buss's distinction between fearful and self-consciousness shyness (Reddy, 2001).

2.4.3.1. Buss' theory of Shyness

Buss (1980,1986, 1997) distinguishes between two kinds of shyness: fearful shyness and self-consciousness shyness.

Fearful shyness or anxious shyness starts in the latter part of the first year of life. Sometimes called stranger anxiety, the reaction occurs mainly when unfamiliar people,

usually adults, confront the infant. The typical response is wariness, retreat, and the seeking of comfort in the security of mother's arms; more intense reactions include a cry-face or the crying and shrinking back that characterize fear. Of course, adults vary considerably in physique and personality, so whether the infant is fearful may depend on who the stranger is, although Smith and Sloboda (1986) find from their research that variations in the adult have no impact on infants' anxiety.

Fearful shyness occurs not only among human infants but also among young of most mammalian species. Its adaptive value, if there is any, is that the presence of strangers (especially adults), even members of one's own species, may be associated with danger.

Fearful shyness tends to wane as children mature. They gradually achieve better motor control, become less emotional, and habituate to social novelty. After many repetitions, non-threatening strangers are no longer unfamiliar and therefore do not evoke fear. Also, children gradually develop the instrumental means for coping with potential threats. Therefore most leave behind their anxious shyness. For a minority of children, however, fearful shyness persists. It is characterized less by the crying and escape attempts of children and more by the inhibition of speech and behaviour interactions that are typical of adult shyness.

Fearful shyness is different from other fear reactions in its being a social anxiety. Thus it involves being upset about social interactions or being frightened when being with others. It is different from such nonsocial fears as the fear of flying, of snakes, or of height. The distinction lies not in the reaction which in physiological terms involves activation of the sympathetic division of the autonomic nervous system but in the

immediate cause of the reaction. Thus, one can distinguish two kinds of evaluation anxiety. The first occurs in a testing situation, in which one's competence in particular subject matter or skill is assessed, usually by the paper-and-pencil format. If there is worry and disorganization in this context, it is nonsocial evaluation anxiety. The second kind of evaluation anxiety occurs on a first date, when one first meets prospective in-laws, or when one is giving a public speech. In these contexts, whether general competence is being assessed, one's self or person is being evaluated; this is social evaluation anxiety. In brief, fearful shyness is construed as a social anxiety. (Buss, 1986).

The major cause of fearful shyness is social novelty. Adults meet strangers on the job, at party, dinner, or similar social occasion where physical fear is not the issue. Rather, the cause of shyness is unfamiliarity. People are not sure what to say or how to behave. They do not know what to expect or what the stranger expects of them. Some topics of conversation may be explosive, so they step carefully in the minefield of potentially taboo topics. Can they latch on to a topic of conversation that is interesting but not offensive? The result may be apprehension and inhibited social behaviour.

Unfamiliar social settings may also cause shyness. For many people, change is a way of life. In the military, men and women are transferred from one post to another every several years; employees are shifted from one city to another when jobs in a different locale beckon. Families move to different dwellings, and children change schools. Most people can remember the trepidation of the first day at high school or college. Everyone seems to know everyone else, and no one is interested in getting to know someone new. There is a feeling of being out of place. Little in one's experience prepares a person for this situation. So the person who is unsure how to behave remains

on the fringe of any social group, watches, listens, and says little until receiving some cues from the others. This person is socially anxious.

Adults may move from one social role to another. A man or woman may be promoted to supervisor. Divorce and widowhood have their own changed role expectations, and for those who remarry and have stepchildren, the role of a stepparent is new and offers its own perils. The stepchildren must deal with a comparable novelty in how they relate to the new parent. When there is novelty in a stranger, a social setting, or a social role, there is an initial conflict between the motives of security and exploration. In each instance, the way to deal with unfamiliarity is to explore the new environment and start coping with it.

As people, roles, and settings become familiar, the person becomes more secure. Instrumental social behaviour occurs as the person explores the social environment and responds more freely. For most people, the initial anxious shyness wanes and then disappears, but a minority may remain chronically shy.

Fearful shyness is not merely stranger anxiety, for it may be caused by two other conditions. The first is intrusiveness. Even when the other person is moderately familiar, if he or she approaches too quickly or moves in too close, the infant may be frightened. A similar reaction may occur in older children and adults, for each of us has a personal spatial zone that we prefer not to be penetrated by most people. Intrusiveness can be not only spatial but also psychological. The other person may disclose intensely personal information or ask for a similar disclosure. Either way, most older children

and adults find this excessive intimacy aversive and perhaps even threatening, and they react by becoming inhibited and seeking to escape from the situation.

The other cause of fearful shyness is social evaluation. Once past infancy, children are exposed to social evaluation, which increases in frequency with passing years. For adults, the appraisal occurs in situations that may be aligned along a continuum from explicit to implicit. The more explicit is the evaluation the greater the probability of shy behaviour. Thus in a job interview, many people are stiff and inhibited; some freeze and have difficulty in speaking normally.

Among the major criteria of social appraisal are attractiveness, friendliness, social skills, and conformity to local social rules of comportment. When people are rejected or realize that they have failed a social test, they become worried and socially cautious. Such wariness and inhibition make it harder to cope with evaluation-laden situations, for the rejected ones are unlikely to be friendly and therefore may be seen as cold and distant. The fact of social evaluation has led some psychologists to offer self-presentation as a cause of shy behaviour (Schlenker & Leary, 1982). They assume that there is explicit or implicit evaluation in social situations, and that people inevitably strive to sustain a favourable impression on others. People may worry about their ability to convey a proper impression. Fearing negative evaluation, they become socially inhibited.

The enduring causes of fearful shyness are assumed to be specific to anxious shyness. They do not apply to self-conscious shyness because they involve inheritance, occur too early in life, or involve events known to affect only anxiety.

The inheritance of shyness has been established by over a dozen twin studies, all with positive findings (Plomin & Daniels, 1986; Matheny, 1989). Shyness may also derive from two temperaments, which are inherited tendencies that appear during infancy, fear and sociability.

Several kinds of learning may lead to shyness. Some children are raised in rural isolation, their main social contacts being those that occur in school. Such insularity means that such children rarely see strangers. Unable to habituate, they maintain their fear of strangers and remain anxiously shy. As with any chronic fear, the trait of anxious shyness can be acquired through traumatic avoidance conditioning. A child may be treated roughly by strangers or sharply rejected by peers. It may require only a single bad experience for the child to acquire a lasting tendency to avoid social novelty. "Once bitten, twice shy."

Self-conscious shyness represents extreme awareness of oneself as a social object (Buss, 1980). It is a feeling of psychological nakedness, as though one were completely exposed to others. When this feeling is especially intense a private act is suddenly made public, for example the outcome is often embarrassment, the extreme endpoint of shyness (Buss, 1986). It often leads to blushing, but one can experience keen public self-awareness without embarrassment. However, embarrassment is always accompanied by acute self-awareness. Thus embarrassment is a major component of self-conscious shyness, but the two are not equivalent (Buss, 1997).

Embarrassment is usually characterized by blushing, though at times people report feeling embarrassed when they are not blushing. Nevertheless, blushing may be regarded as the hallmark of embarrassment. Only humans blush, because they are aware of themselves as social objects. Such public self-awareness appears to be a universal feature of socialization training. Children are taught that others are observing them, scrutinizing their appearance, manners, and other social behavior. After several years of such training, children develop the requisite social awareness and may be as aware of their own observable aspects as are those around them. This tendency to focus on oneself as a social object is not present in infants because they lack not only socialization training but also the necessary cognitive ability, which is present only in older children and adults.

The immediate cause of self-conscious shyness is, conspicuousness, which is considered the most important cause. Most people dislike to be stared at, for such close observation makes them feel naked and vulnerable. When children are taught to become aware of themselves as social objects, their parents and other caretakers tend mainly to correct mistakes. Thus public self-awareness can easily become associated with criticism. When people stare at someone, he/she wonders what he/she has done wrong to become so conspicuous. Such discomfort is intensified when some aspect of oneself (clothes, manners, or a secret crush) is held up to ridicule. Teasing often leads to embarrassment and shyness. People tease others with nicknames long ago abandoned as childish, or about physical features such as baldness or being overweight or underweight. They may ridicule another's name, clothes, or speech accent. Children, not having been taught consideration for others, may be especially vicious in their teasing, but it does not stop at the end of childhood. A girl may be teased about being

too thin or a boy about having a squeaky voice. A male adolescent may reveal a friend's crush on a girl or reveal to his friend that a girl has a similar crush. Such ridicule is designed to embarrass others; the hostility typically justified as just another example of humour. But even well meaning social behaviour can cause embarrassment. An example is over-praise. This is evidently a case of too much of a good thing, that is, compliments causing mild distress. One explanation is that over praise inevitably involves being made conspicuous. Thus, when a person receives a letter announcing the winning of a prestigious award, there is no embarrassment. But when praised effusively by another, especially when others are present, there is embarrassment. For example, in her son's presence, a mother brags about her son's accomplishment to neighbours. A more familiar example to psychologists is being lauded excessively as part of an introduction to a speech. Too little attention is also aversive. If one is shunned by others, who for whatever reason, adventitious or deliberate, will not talk to him/her, this exclusion is likely to make him/her feel conspicuous and therefore self-consciously shy.

Another reason for conspicuousness is being demonstrably different from others. One might be the only woman in a gym full of men or the only man in a sewing class. Being so obviously different calls so much attention to oneself that it may inhibit social behaviour. That is the time to keep quiet and not draw any attention to oneself.

Conspicuousness also derives from breaches of privacy, in which private functions or body parts are made public. Virtually all societies teach their children bodily modesty, and in many societies, eliminative functions and sexual behaviour are supposed to be unseen and unheard. In addition, there are thoughts, feelings, and ambitions that are personal and private; when they are disclosed inadvertently or suggested by teasing, most people become self-consciously shy, often to the extent of embarrassment.

People may feel conspicuous when the social context is public and therefore when one is open to scrutiny or made aware of how uniquely different he or she is. Both characteristics mark formal situations, which are not only public but emphasize the status of the participants; the person of subordinate status is often acutely reminded of his/her lesser status, and many people are inhibited and disorganized when they are in the presence of Nobel Prize winners, governors, and others of great status. Formal contexts also involve more social rules, more specific rules, and more inflexible rules. Thus a man is likely to feel conspicuous and embarrassed when wearing a business suit to a dinner at which all the other men are wearing tuxedos.

The enduring causes of self-conscious shyness is when ridicule and teasing are used excessively in socializing children, the outcome is likely to be a person high in self-conscious shyness. One result of the socialization of children is the association between conspicuousness and embarrassment. When parents, teachers, and peers single out a child for particular attention, typically, it is because he/she has done something wrong, for example, violated a taboo about privacy, demonstrated conceit, or had a childish outburst of emotion. The punishment is often teasing, and ridicule, causing embarrassment. After many repetitions, a close link is forged between conspicuousness and embarrassment.

Perry & Buss (1990) found that public self-consciousness correlates (-0.21) with self-esteem, which suggests that among people who are concerned about themselves as social objects there is a (weak) tendency to have a negative self-image. Beyond this relationship, there is a rational basis for assuming that low self-esteem and self-

conscious shyness are connected. Those with low self-esteem tend to be more susceptible to any kind of negative social reaction, which means that laughter and ridicule will be especially potent causes of embarrassment. People with low self-esteem are more likely to believe that others will regard them as foolish and clumsy, even in the absence of teasing or other negative social reactions.

Another enduring cause of self-conscious shyness is an obvious problem with physical appearance, such as facial scarring, crossed eyes, or features so plain as to approach ugliness. Obese people are made keenly aware of bodily grossness, if not by others then by their own mirrors. The effect may lie not in appearance but in behaviour. Thus, stuttering children are often mercilessly teased by playmates, and adult stutterers are acutely aware that their listeners are impatiently waiting for them to get the words out.

Finally, some people never acquire the social skills that make it easy and pleasurable to deal with others. Some people do not know how to ask another person to come to their home for a cup of coffee to just talk. Similarly, some adolescents do not know how to ask for a date or what to talk about when on a date. Most adults are expected to have acquired these skills: how to listen and seem attentive, maintain eye contact without staring, offer or receive a compliment, gain the floor, direct attention away from oneself, put someone at ease, introduce someone, deal with a rebuff, or acknowledge making a mistake. There are minimal rules to etiquette that everyone is more or less expected to know. A lack of these social skills and the various defects mentioned earlier may also contribute to low self-esteem, which can further intensify self-conscious shyness.

When comparing fearful shyness and self-consciousness shyness, one finds that fearful shyness differs from other fears in its source, which is other people. It is similar to other fears in the nature of the reaction to the frightening stimulus. The reaction involves one or more of three components: (a) a motor component, which consists of attempts to shrink back, to escape, or to avoid the situation; (b) a physiological component, which involves activation of the sympathetic division of the autonomic nervous system and therefore a potentially intense state of bodily arousal; and (c) a cognitive component, which consists of concern over past fearful situations and apprehension about future social situations.

Self-conscious shyness does not involve fearfulness but feelings of being awkward, foolish, and vulnerable. The three possible components of the reaction are: (a) a motor component, which consists mainly of fumbling, disorganization, and inhibition of social behavior; (b) a physiological component, which is present only in embarrassment and then only when the parasympathetic division is activated in blushing; and (c) a cognitive component, which is acute awareness of oneself as a social object. Fearful shyness requires no special, advanced sense of self and therefore can occur when there is only a primitive, sensory self: in mammals and in human infants. Self-conscious shyness involves public-awareness, which requires an advanced, cognitive self, and it is therefore present only in older human children and adults. Though fearful shyness may start during the first year of life, it may not begin until later. Two of its immediate causes, novelty and intrusion, may occur any time in life, starting in infancy. Social evaluation, however, does not commence until the child is several years old.

The causes of self-conscious shyness have no impact until the fourth or fifth year of life, by definition. Thereafter, they begin to have an impact in the developmental sequence listed in Table (2). The earliest cause is being the focus of attention, but it may take a few more years before children become sensitive to being uniquely different from others. Breaches of privacy become important later in childhood, when teasing is most important and reaches a peak in adolescence, when teenagers develop an acute sense of privacy. The impact of formal situations awaits the completion of socialization and is ordinarily an important cause of self-conscious shyness starting in adolescence.

Table 2 Fearful versus Self-conscious Shyness

	Fearful	Self-conscious
Emotion	fear, distress	embarrassment
Autonomic reactivity	sympathetic	parasympathetic
Present in	mammals, human infants	human: older children and adults
First appearance	first year	fourth-fifth year
Immediate causes	Strangers, novel setting novel social role, evaluation poor self-presentation	Conspicuousness, breach of privacy, Teasing, ridicule Overpraise, foolish actions
Enduring causes	heredity, chronic (low) sociability (low) self-esteem isolation avoidance conditioning	socialization public self-consciousness history of teasing, ridicule (low) self-esteem negative appearance poor social skills

Buss,1986 (p43) Buss, 1997 (p121)

2.4.3.2. Lewis' theory of shyness

Lewis (1995) distinguishes between shyness that arises in the first year and is entirely avoidant and negative, and two forms of embarrassment which arise later, one born of self-exposure, and the other born of self-evaluation. He suggested that shyness late in the first year of life is fearful and elicited by novel situations and persons, and pointed out that the natural cues to fear are age-related, or dependent on development or maturational processes. Fear of strangers cannot occur in the first few months of life, simply because the child has not developed a perceptual-cognitive capacity to

discriminate familiar from unfamiliar faces. This ability emerges between roughly six and nine months of age, and it is during this period that observers report occasional fear of strangers in infants (Izard, 1977).

Lewis, Sullivan, Stranger, and Weiss (1989) studied children's response to a mirror to determine the age of onset of self-recognition and its role in the experience of shame. Shyness was defined on the basis of the following behaviours: a staring, attentive look characterized by a neutral or sober facial expression, accompanied by sudden inhibition of ongoing vocal or other behaviour and followed by gaze aversion. No infants showed self-recognition on the mirror test until 15 to 18 months of age (Izard, 1991).

Lewis (2001) suggested that there may be two types of embarrassment: exposure and evaluation, each having different developmental timing and being supported by different cognitive processes.

Embarrassment elicited by exposure appears to be more similar to shyness than to shame. In certain situations of exposure, people become embarrassed. This type of embarrassment is not related to negative evaluation, as in shame. The best example is being complimented. Another example of this type of embarrassment can be seen in people's reaction to their public display. When people observe someone looking at them, they are apt to become self-conscious, to look away, and to touch or adjust their bodies. Observed people look either pleased or frightened. One should realize that the exposure does not have to be about the physical presence but can extend to the secret part of the self. The experience of embarrassment may be caused not by negative self-evaluation, but by simple public exposure. Exposure alone does not produce the embarrassment; looking for a negative evaluation to explain why one is embarrassed

may be the cause. For example, a person who arrives early for a meeting may attract attention. This situation may promote a negative self-evaluation: "I should have waited outside until the time of the meeting".

The other type of embarrassment is related to negative self-evaluation and to shame. The difference in intensity between embarrassment and shame may be due to the nature of the failed standard. People have different standards, some of which are more important than others to their identity. Violation of these less important standards is likely to elicit a less intense form of shame. For example, failure at driving a car may be embarrassing rather than shaming, if driving is less related to the core self. On the other hand, failure at driving a car may be shaming, if it is a core capacity. In these examples, there appear to be some association between embarrassment and shame. Perhaps there is another important differentiating cause for embarrassment versus shame. Evaluative embarrassment (like exposure-embarrassment) always needs a socially present audience. Shame does not. Thus, evaluative embarrassment would only be a milder form of shame, but may need to take place in public.

Exposure-embarrassment occurs at the point when the idea of "self" exists and is utilized in social exchanges. For some children, social exchanges, where they become the centre of another's attention and they are aware of the other's attention toward them, produces embarrassment. This capacity, unlike evaluative embarrassment, emerges in the second year of life (Lewis, 2001).

Children differ in the degree of "exposure-embarrassment" that they exhibit, some show extreme forms, while others show hardly any. Those showing extreme forms have been

called shy or inhibited. Lewis (2001) argued that individual differences in this form of embarrassment are less likely to be a function of the types of child rearing they have experienced than of temperament-like variables. They are more like biological than learning differences and may be related to how well children can regulate their emotional arousal.

"Evaluative-embarrassment" requires considerable cognition since it is based on an evaluation ability of the child in regard to how he/she behaves relative to a standard. The cognitions involved here require that the child has a standard and can apply that standard to his/her own behaviour. Such cognitions are seen only after 24-30 months of age. Individual differences in evaluative embarrassment are dependent first and foremost on child-rearing practices. These include the type of standards, how they are taught and enforced by the parents. They also include the same simple cognition seen in the other type of embarrassment, that is, a self-concept. Evaluative embarrassment also requires cognitions about others' awareness of oneself. While it is similar to shame in many ways, it differs in that it is a less intense negative emotion, since it does not involve the attribution of a damaged self and takes place in a social context, something that the emotion of shame does not require.

2.4.3.3. Asendorpf's theory of shyness

Asendorpf (1990a) and Asendorpf & Meier (1993) has suggested that different types of shyness emerge as a result of differences in social approach and social avoidance motivational tendencies. According to Asendropf (1990b), social reticence (shyness) emerges from an approach-avoidance conflict. Socially reticent children wish to engage in play with their peers but cannot seem to enter the social playgroup successfully. This

is contrasted with another type of shy child whom Asendropf describes as avoidant. This type of child is high on avoidance and low on approach behaviour. There appear to be different developmental outcomes associated with each of these types of children. Children who experience an approach-avoidant conflict tend to be described as socially reticent and to experience a high degree of anxiety in socially evaluative situations (Fox et al., 1995). Children who are high-avoidant/low-approach are often described as socially withdrawn and, in some instances, depressed (Rubin et al., 1995).

According to Asendorpf (1993) acute state shyness is the final common pathway for two different kinds of inhibitory processes: inhibition towards the unfamiliar, and inhibition due to fear of being ignored or rejected by others. This view is consistent with Gray's (1982, 1987) physiological model of inhibition where inhibition is aroused by novel stimuli and by conditioned cues for frustrative non-reward and punishment. By taking this view, he separates inhibition to adult strangers which arises early in development, from inhibition towards reinforcement arising later in development, painting a developmental picture very similar to Lewis's distinction between exposure and evaluation, and in essence similar to Buss's distinction between fearful and self-consciousness.

Gray's Model of Behavioural Inhibition (1971,1982), a biologically based model of temperament, mostly developed from the results of animal research, includes three constructs that are very relevant to a discussion of behavioural inhibition and shyness in childhood. Gray has identified two orthogonal temperamental dimensions of behavioural inhibition (anxiety) and behavioural activation (impulsivity). Increasing levels of proneness to anxiety, or behavioural inhibition, identified at the physiological

level with the action of the septal-hipocampal system, are seen in Gray's theory to reflect the person's sensitivity to novelty, to signals of non-reward and punishment, and to innate fear stimuli (Rothbart & Mauro, 1990).

Increasing levels of behavioural activation, or impulsivity, on the other hand, identified at the physiological level with the medial forebrain bundle, are seen to reflect higher proneness to respond to signals of reward or non-punishment. An additional temperamental variable, neuroticism, or proneness to distress, is seen to be a function of the operation of the arousal due to both activation and inhibition.

In situations where the child's responses have resulted solely in reward, individual differences in approach will depend upon the strength of the behavioural activation system (BAS). In situations where a child's responses have resulted solely in punishment, or when there is a new or fear-inducing stimulus, individual differences will depend upon the strength of the behavioural inhibition system (BIS). In situations where children's approach responses have been alternately rewarded and punished or where both aspects of reward and punishment are present, as in the child's meeting of a stranger, whether an approach will occur will be a function of the operation of both the BAS and the BIS. Thus, children with low activating tendencies may be unlikely to show rapid approach, even when they are not very susceptible to behavioural inhibition. On the other hand, children who are high on both activation and inhibition tendencies would be expected to show rapid approach under circumstances of familiarity and non-threat, but they might be highly inhibited under conditions of punishment, novelty, or threat. These children would be expected to be especially variable in their behaviour, depending upon conditions of novelty-familiarity, challenge, or punishment. Gray's

model allows for the important possibility that children can have both approach and inhibition tendencies.

Research by Schaffer and his colleagues (1972), Rothbart and Mauro (1990) suggested that approach tendencies are clearly present by 6 months of age, but that there will be increasing development of a behavioural inhibition system during the last half of the first year of life. Thus, Schaffer (1974) argues that the important change occurring in the third quarter of the first year of life is not the onset of avoidance responses in young children, but rather the onset of inhibition of children's approach responses.

Schaffer and his colleagues (Schaffer, Greenwood, & Perry, 1972) conducted a longitudinal study in which 20 children were observed monthly from 6 to 12 months in their responses to unfamiliar stimuli. Even at 6 months, children showed by their looking times that they could differentiate between novel and familiar objects. However, at 6 months, the infants approached unfamiliar objects "impulsively and immediately" (Schaffer, 1974,p.14). At 8 months and beyond, however, latency to reach and grasp was clearly influenced by familiarity. Infants now showed hesitations, sometimes but not always accompanied by distress and/or avoidance. When these older infants made contact with the subject, it was likely to be done cautiously.

In a longitudinal study, Rothbart and Mauro (1990) found that some children approach objects much more rapidly than others, a sign of individual differences in behavioural activation or Gray's BAS. Individual differences in latency to approach high-intensity stimuli (Gray's BIS) do not show relative stability across this age period. Rothbart and Mauro also suggest that individual differences in approach as assessed under conditions

unlikely to elicit behavioural inhibition (safe and familiar circumstances) can be observed both before and after the developmental onset of behavioural inhibition and they show stability from 6½ months.

When this perspective on state shyness is applied to interindividual differences in trait shyness, the enduring tendency to react with state shyness more than others, one might expect two different types of chronically shy people. Temperamentally shy people have a low threshold or a steeper response gradient for behavioural inhibition for physiological reasons and therefore become more easily or more intensely shy in both unfamiliar and social-evaluative situations. Experientially shy people have often experienced social neglect or rejection in the past and therefore have higher expectations of being ignored or rejected by others, including strangers and unfamiliar groups. In both cases, a stable disposition of reacting in a shy manner to both unfamiliar and evaluative situations results (Asendorpf, 2000).

Rubin and Asendorpf (1993) distinguished social withdrawal from social isolation and from sociometric measures of neglect (children who receive few peer nominations, positive or negative) or rejection (children who receive negative nominations, e.g. are disliked). They regarded shyness and inhibition as distinct forms of withdrawal: "Shyness is one form of social withdrawal that is motivated by social evaluative concerns, primarily in novel settings. Inhibition is a form of withdrawal characterized by social aloneness or withdrawal in novel settings"(p14).

Crozier (2000a) recognized that there are problems with these definitions. People who describe themselves as shy or who obtain high scores on a trait measure of shyness

might not be withdrawn in behaviour. Carducci (2000a) identifies "extraverted" and sociable coping strategies that can be adapted by shy people. Also there is ambivalence in shyness that is not captured by the notion of withdrawal (Crozier, 2000a).

Buss's (1986) theory of shyness and Asendorpf's (1990a) conceptualisation are quite similar. Children who are fearfully shy are most likely those who are high in social avoidance and low in social approach motivations. Also, children who are self-consciously shy are most likely those who show high avoidance/high approach motivation. Interestingly, these two types of shyness share properties with two stereotypical fear responses, seen in mammals.

One stereotypical fear response is to flee; this category is similar to fearful shyness or high avoidance/low approach. The other stereotypical fear response is to freeze; this category shares many of the features of the self-consciously shy and high approach/high avoidance category. Children in this latter shy category freeze in their behavioural responses during social encounters, possibly resulting from an approach-avoidance conflict.

Schmidt & Fox (1999) used an approach-avoidance paradigm to account for at least two categories of shyness. They found examples of self-consciously shy people. Such people are characterized by an approach-avoidance conflict. They refer to this group as conflicted. They also found examples of fearfully shy people. Such people are characterized by high avoidance behaviour and low approach behaviour. They refer to this group as avoidant. According to them, these two shy subtypes represent different

temperamental categories, each of which is associated with distinct behavioural correlates and developmental outcomes.

The behavioural properties that characterize the former category are distinguished from the latter category. Children who fall into the category of fearfully shy become flooded with negative emotion in social situations. Rubin and his colleagues (Coplan, Rubin, Fox, Calkins, & Stewart, 1994) found that such children often avoid peers, try to escape from the playroom, and begin to cry and fret during play situations involving unfamiliar peers. This is in contrast with those in the self-consciously shy category, who typically display behaviour indicative of an approach-avoidance conflict. They approach peers during the playgroup but have problems trying to enter the playgroup. Their attempts to enter the playgroup are often thwarted, and they exhibit overt signs of anxiety, such as circling the playgroup and increased frequency of self-manipulation.

Asendorpf (1990) suggests that children in the low approach/low avoidant group display behaviour characterized by ignoring others. Schmidt & Fox (1999) believe that this category-which is often mistakenly labelled as another shyness category-constitutes the early origins of introversion. That is, children in this group apparently are not bothered by having to interact with others; they just do not have a preference (or need) to do so.

All three theorise (Buss, Lewis, and Asendorpf) link the later appearing forms of shyness or embarrassment with the development of the self-consciousness, although they differ somewhat on the age at which they argue self-consciousness develops and on the behavioural criteria they use to describe and detect these various forms of shyness and self-consciousness. They suggest that late in the first year of life, a form of shyness

is present and they agree that this form of shyness is fearful rather than positive, and is elicited by novel situations and persons, while later appearing forms of shyness, akin to embarrassment, can contain more positive elements (Reddy, 2001).

The emotion in anxious shyness is fear, by definition, and the emotion in self-conscious shyness is embarrassment. The physiological reactions in these two emotions are widely believed to be mediated by the two divisions of the autonomic nervous system. Fear; an emergency emotion involving reaction to threat, is mediated by the sympathetic division. Embarrassment which is not a reaction to threat is mediated by the parasympathetic division.

Table (3) shows that all three theories suggest the presece of shyness in the first year of life. While the later appearing of shyness is linked to embarrassment.

Table 3 Theories of Shyness

Theories	Forms of the phenomena	Predicted age of onset in development	Eliciting contexts	Expressive behaviour
Buss (1980,1986)	Two forms of shyness			
	-Early fearful shyness	7 to 9 months (primitive, sensory self)	Novelty, strangers(increased by high tendency to wariness and distress and low sociability)	Shyness: diminution of social behaviour; gaze avoidance; shrinking back or keeping distance; reduced speech; distress, wariness
	-Late (self-consciousness) shyness (public self-awareness, embarrassment)	From 5 years of age (advanced, cognitive self-awareness of self as social object)	Novel contexts; conspicuousness; social roles; over-praise; breaches of privacy; exposure of wrongdoing; ridicule	Embarrassment: tentativeness; blushing; giggling; silly smiles; gaze avoidance
Lewis (1995)	Shyness	Middle of the first year	Strangers, fear	Shyness: reduced sociability: reduction in gaze, vocalizations, smiles and contact
	Two forms of embarrassment:			
	-Exposure -self-evaluation	18 months 3 year	Being observed by others, potential evaluations of performance by others	Embarrassment: smiling gaze aversion, and face/body touching; coy or silly behaviour
Asendorpf (1990-1993)	Two forms of social inhibition			
	-inhibition towards strangers (wariness)	From approximately 8 months, reactions more extended with age, continues to adulthood	Meeting unfamiliar adults (with peers peak at 20 months)	In infancy: clear cut wariness: wary brow with gaze, wary averted gaze, avoidance, cry face or crying. In early childhood: mixture of wariness and sociability; lengthy coy expression of smiling
	-social-evaluative inhibition (evaluative fear)	From 20 months or later; continues into adulthood; strong at adolescence	Anticipation of negative or insufficiently positive evaluation by others (involves perspective talking); embarrassment is a reactive form of the same emotion	With gaze aversion peaks at 3 to 4 years. Embarrassment: blushing, smiles with gaze aversion before apex of the smile ends

Reddy (2001, p81)

A study by Buck, Parke, & Buck, (1970) distanced between fear (anxious shyness) and embarrassment (self-conscious shyness), they divided college men into two experimental groups. The fear group who were told that they were about to receive intensely painful electric shocks and the embarrassment group who were told that they would shortly suck on the following objects: a baby bottle, a breast shield, a pacifier, and two nipples. Then physiological measures were recorded for two minutes, and the experiment ended without any shocks or objects being placed in the mouth. Skin conductance, a measure of physiological arousal, was higher in fear than in embarrassment. Heart rate changed little in fear, but dropped in embarrassment. These results are consistent with fear being sympathetically mediated (high arousal) and embarrassment parasympathetically mediates (low arousal).

But there is another reason for believing that embarrassment is a parasympathetic emotion. When embarrassed, people tend to blush, an engorgement of the capillary bed of the face, which is under the control of the parasympathetic division. Animals and human infants do not blush, presumably because they lack the advanced cognitions and socialization training that would lead to a sense of oneself as a social object. Once this public self is attained in humans by the fourth or fifth year of life, there is a basis for becoming embarrassed and blushing appears.

Blushing and the silly smile that often accompanies it appear to be universal. The different situations that cause embarrassment are sufficiently common in that virtually no one has escaped that burning sensation in the face. It should be added that some people experience a facial temperature rise without the skin reddening (Buss observed this in a pilot research on embarrassment). In one study, almost four fifths of the

subjects reported that a rise in skin temperature characterized their embarrassment reaction, and about half of them mentioned blushing (Edelmann, 1987).

Novelty is an immediate cause of anxious shyness, but in a strange setting or new social role, people sometimes feel conspicuous, which is a cause of self-conscious shyness. Making social mistakes and being teased, which are immediate causes of self-conscious shyness, can also make people anxious about evaluation, which is a cause of anxiety shyness.

Low self-esteem appears on both sides. People low in self-esteem expect to fail, a cause of anxious shyness, but when such people make blunders, they may blame themselves and become embarrassed. And poor social skills, which make people feel self-conscious, may also cause them to fear evaluation, a cause of anxious shyness. Thus the contrasts between anxious shyness and self-consciousness shyness must be interpreted in light of the various overlaps in the causes of the two kinds of shyness. But the similarities between the causes of anxious and self-conscious shyness should not be over-interpreted either, for they are minor compared to the major differences in causes. Perhaps even more important than causes are the crucial differences between the two kinds of shyness: their first appearance during development and their distinctive emotional reactions. It is possible to be socially anxious and embarrassed at the same time. If one considers other emotions, it is possible to find people who are sometimes simultaneously afraid and angry, ashamed and angry, or sexually aroused and afraid. The fact that two emotions can occur at the same time does not deny their distinctiveness. When people are shy, they may be anxious and self-conscious at the same time. It should be added that like other emotions, blends in anxious and self-

conscious shyness are infrequent. Typically, at any given moment when one kind of shyness occurs, the other is usually absent. College women, who identified themselves as being previously shy but not presently shy, were asked when their shyness first occurred (Cheek, Carpentieri, Smith, Rierdan, & Koff, 1986). Roughly four fifths said that their shyness started after the age of 6; the other fifth, before age of 6. Presumably self-conscious shyness, which occurs because of socialization training and a history of teasing, can be more easily overcome than anxious shyness, which has an inherited component and is also caused by insecure attachment in infancy. On these assumptions, one should expect self-consciously shy people to change more than anxiously shy people, which is consistent with the prior percentages.

Another study divided college students into two groups of shy subjects (Bruch, Giordano, & Pearl, 1986). One, called fearful shy, was high in fear and low in public self-consciousness. The other, called self-conscious shy, was low in fear and high in public self-conscious. Most of the fearful shy subjects reported that their shyness started before elementary school, but most of the self-conscious shy subjects reported that their shyness started after they began elementary school. In addition physiological arousal was reported more frequently by the fearfuly shy subjects.

The results of these two studies are consistent with the distinction between the two kinds of shyness, but they depend on retrospective reports. Such research needs to be supplemented by longitudinal research.

One approach suggests that shyness is not a unitary experience but refers to two distinctive experiences, fear and wariness on the one hand and shame and

embarrassment on the other. The trend in psychological research is to emphasize the differences among the self-conscious emotions rather than their similarities. For example, research into embarrassment suggests that embarrassment and shame may be distinct emotions (Keltner & Buswell, 1997; Miller, 1996). Moreover, Miller (1995) has argued that although shyness and embarrassment do share such components as public self-consciousness, they also differ from each other in important respects. For example, embarrassment is typically regarded as a reaction to social predicament that has already arisen, whereas shyness is an anticipation of, and possibly a defensive strategy against, such predicaments. Differences are also argued at the trait level. For example, Miller (1995) reported a factor analysis of a set of scales measuring shyness, embarrassability, self-consciousness, self-esteem, and fear of negative evaluation, among others. Shyness and embarrassability had significant loadings on separate, uncorrelated factors. Shyness was represented, along with low social self-esteem, on a factor that was interpreted by Miller as low social self-confidence; embarrassability shared a common factor with fear of negative evaluation and social sensitivity, a factor interpreted as concern with social evaluation.

A second approach is to suggest a duality within shyness, either that there is a "common final pathway of two different kinds of inhibitory processes" (Asendorpf, 1993, p.266) or that there are two forms of shyness, one related to fear and one related to self-consciousness (Buss, 1984, 1986). Asendorpf argued, and provided empirical support, for the proposition that shyness can be triggered by two different kinds of social situations: those involving the individual interacting with strangers and those which have the potential for evaluation of the individual by others. His theory also included a developmental aspect. He argued that the self in early childhood is not sufficiently

developed to support the kinds of thinking about the self or perspective-taking ability that is characteristic of self-consciousness.

Buss (1984) adopted a stance that opposes the unitary nature of shyness advocated by Asendorpf. Buss proposed two distinct types, fearful shyness and self-conscious shyness. He distinguished between these in terms of immediate causes and affective reaction. Fearful shyness is elicited by novelty and intrusion into a social situation; self-conscious shyness is produced by formal situations and breaches of privacy and is also a result of being scrutinized and being uniquely different. The predominant affective components of the two types are, obviously, fear and self-consciousness. This theory also has a developmental aspect, related to the cognitive demands of self-consciousness. Fearful shyness emerges early in life and is associated with inhibition in new situations, including contact with strangers. This form does not require self-awareness of any degree of complexity, but the later-appearing self-conscious form is associated with heightened awareness of the self as a social object and the capacity to adopt a detached-observer perspective toward the self.

2.5. Causes of shyness

People are not either shy or not shy. Just like height or weight or hair colour, shyness is something on a continuum from not at all shy to extremely shy. People vary in their degree of shyness. Second, shyness is not the same for all people. One person may be terrified of signing a cheque in front of someone and yet be quite happy to give a speech to an audience of 500. To another person, giving a talk, even to ten people, might be the stuff of their worst nightmares, but they may not give a second thought to signing a cheque.

Based on these two points, it seems logical to assume that like height and weight, an individual's basic level of shyness is likely to be partly based on his/her genetic makeup. However, the specifics of an individual's shyness (fears and worries) are very likely to have been shaped by the environment in which he/she grew up.

The most extensive study on genetics and socialization is the Colorado Adoption Project (CAP) carried out by Plomin and his associates (Daniels & Plomin, 1985; Plomin & Defries, 1985). The sample included over 200 infants between ages of 12 and 24 months, from both adoptive and nonadoptive families.

The results from this project indicated that both genetic and socialization variables played a role in the origins of infant shyness. Perhaps the most exciting result found was a significant correlation between biological mothers' shyness and sociability and their infants' shyness at 24 months, a correlation found for both adoptive and non-adoptive families. The finding for adoptive families is especially impressive, since the biological parents' self-reports were filled out before the birth of the children, and the children's ratings were filled out by their adoptive parents over 24 months later. This relationship was found at 24 months, but not at 12 months. The inability to discover a relationship between infant shyness at 12 months and maternal personality may be due to behavioural and emotional developmental changes that occur in the child between the first and second year of life. This finding suggests the presence of a genetic component for shyness in young children, and it also indicates the genetic comparability between infant shyness and low sociability in the adults' self-reports.

For both adoptive and non-adoptive families, parental ratings of infant shyness were also found to be related to mothers' self-report of shyness, low sociability, and introversion, thereby suggesting the influence of shared home environment. Families who score high on sociability are active in cultural events, like to learn new things, and are involved in a number of recreational and social events. This finding is in agreement with an "exposure to novelty" hypothesis put forward by Schaffer (1966) and by Kagan, Kearsley, and Zelazo (1977). The exposure to novelty hypothesis suggests that shy mothers do not expose themselves or their infants to novel situations, thereby reinforcing shy tendencies in the children. This link was found for both adoptive (shared environment only) and non-adoptive (shared biological and environmental factors) families, suggesting that family environment must account for some of the resemblance between parent and infant shyness (Rothbart & Mauro, 1990). The aetiology of shyness would appear to embody a number of contributing factors:

2.5.1. Genetic and Biological Contributions

Current thinking suggests that the origins of shy behaviour may be linked to the dysregulation of some components of the fear system. The amygdala (particularly the central nucleus) is known to play a significant role in the autonomic and behavioural aspects of conditioned fear. The amygdala also appears to be involved in the attentional aspects related to the recognition of changes in negative valenced environmental stimuli. The amygdala is known to be more reactive in defensive rather than nondefensive cats (Adamec, 1991). These behaviours are analogous to those seen in extremely fearful and shy children. Schmidt, Polak, & Spooner (2001) list a number of studies involving human adults that have noted associations between genes that regulate soecific neurochemical systems and complex human traits. These studies provide

evidence that there may be a genetic aetiology underlying some complex human personality traits (Schmidt, Polak, & Spooner, 2001).

Twin studies have demonstrated that shy behaviour and timidity towards unfamiliar people and situations is heritable in children and adults (Matheny, 1989; Plomin, 1986). There have been a number of studies that have begun to examine associations of genes that code for the regulation and transportation of neurotransmitters with complex human traits such as shyness. The theory of a molecular genetic basis for individual differences in temperament/personality was sparked largely by the publication of three papers inferring a molecular genetic basis to complex human traits in adults. Two of these studies demonstrated an allelic association between novelty seeking and a functional polymorphism in the dopamine D4 receptor gene (Benjamin et al., 1996; Ebstein et al., 1996). A third paper noted an allelic association of polymorphism in a gene that codes for the transportation of serotonin (5-HTT) with anxiety-related traits (Schmidt, Polak, & Spooner, 2001).

While these three papers provide an initial view of the role of genes in personality, it is important to note that other studies, for example, Goldman et al. (1996), Jonsson et al. (1997), and Deary et al. (1999), have failed to replicate the DRD4-novelty seeking and serotonin-neuroticism associations in adults.

Although there have been relatively few studies of the molecular genetics of complex human personality traits in children, two studies (LaHoste et al., 1996; Swanson et al., 1998) noted an association of the DRD4 receptor gene with attention deficit hyperactivity disorder (ADHD). Two other very recent studies have noted a similar

association of the DRD4 gene and attention-related problems in normally developing pediatric populations. Association of DRD4 long alleles with less sustained attention in 12-month-old infants (Auerbach, Benjamin, Faroy, Geller, & Ebstein, 2001) and maternal report of attention problems in 4-7 year-old children (Schmidt, Fox, Perez-Edgar, Lu, & Hamer, 2001) have been noted in non-clinical samples.

Kagan and his colleagues (Kagan & Snidman, 1991a,b) have argued that the origins of shyness in some children may be linked to individual differences in early infant reactivity. For example, infants who exhibit a high degree of motor activity and distress in response to the presentation of novel auditory and visual stimuli during the first four months of life exhibit a high degree of behavioural inhibition and shyness during the preschool and early school age years. There is, in addition, evidence to suggest that there may be a genetic aetiology to inhibited behaviour (Dilalla, Kagan, & Reznick, 1994).

Fox (1991) has noted that the pattern of frontal EEG activity distinguishes different types of emotion. Infants exhibit greater relative right frontal EEG activity during the processing of negative emotion (e.g., fear, disgust, sadness) and greater relative left frontal EEG activity during the processing of positive emotions (e.g., happiness, joy, interest). Several studies have noted similar relationships (Davidson & Rickman, 1999; Schmidt & Trainor, 2001). Furthermore other studies suggest that individual differences in the pattern of resting frontal brain electrical activity (EEG) may reflect a predisposition (i.e., trait) to experience/express positive and negative emotion in infants (Fox, 1991,1994) and adults (Davidson, 1993).

The startle response is a brainstem and forebrain-mediated behavioural effect that occurs in response to the presentation of a sudden and intense stimulus, and its neural circuitry is well mapped (Davis, Hitchcock, & Rosen, 1987). A number of studies have noted relations between startle amplitude and the processing of emotion and individual differences in personality (Lang, Bradley, & Cuthbert, 1990). Furthermore, there are known to be individual differences in the startle response. Adults who score high on trait measures of anxiety (Grillon, Ameli, Foot, & Davis, 1993) and children who are behaviourally inhibited (Snidman & Kagan, 1994) are known to exhibit a heightened baseline startle response.

These sets of behavioural and physiological data suggest that some infants may have a temperamental bias towards shyness in early childhood. These features appear early in the first year of life and remain stable during the first two years of life. They are the same types of behaviours and physiological patterns observed in some inbred strains of highly reactive animals, and appear to have a genetic aetiology.

Two separate studies (Schmidt, 1999; Schmidt & Fox, 1994) examined the behavioural and physiological correlates of shyness in a group of young adults who scored high on self-report measures of trait shyness. They recorded regional brain electrical activity (EEG) and heart rate during baseline conditions and during a socially challenging situation. They found that, compared to their non-shy counterparts, adults reporting a high degree of trait shyness exhibited greater relative baseline right frontal EEG activity and a higher and more stable heart rate in anticipation of a social encounter with an unfamiliar same-sex peer (Schmidt, Polak, & Spooner, 2001).

Schmidt & Tasker (2000) examined the relationships between salivary cortisol, frontal EEG, and temperament in 12-week-old human infants, and found a link between overall frontal EEG responses and salivary cortisol reactivity. These findings suggest that the pattern of overall frontal EEG activity may be an early marker of dysregulation of the adrenocortical system and emotional processes.

In fact, the idea that shyness is rooted in a biological predisposition is as old as the field of psychology. William James (1890) quoted Darwin's discussion of shyness and included it in his list of basic human instincts. Baldwin (1894) also interpreted the emergence of bashfulness during the first year of life as an organic stage in the expression of instinctive emotion.

Drawing on observations from his medical practice, Campbell (1896) claimed that "no fact is more certain than that shyness runs in families" (p.805). Work in behaviour genetics tends to support these early speculations about the contribution of an inherited biological predisposition to the origins of shyness (Plomin & Daniels, 1986).

Although the evidence reviewed provides a strong case for the notion of a biological predisposition to shyness in some people, the information suggests that there is no specific gene that directly determines how shy a person can be. Rather, it seems that there is a gene or genes that control the degree to which people are generally emotional. This is likely to cover an entire range. Most shy people probably fall at the upper end of emotionality. This means that they are likely not only to be shy, but they may also be worried, become depressed, have panic attacks, and so on. However, there is also a positive side. Emotional people are more likely to be kind-hearted, conscientious, and

trustworthy. In other words, the degree of emotionality one has is part of him / her and it has both good and bad aspects to it. It is part of what makes each person unique (Rapee, 1998).

2.5.2. Environmental Contributions

When a person is born with a certain degree of emotionality, what form that emotionality takes will depend on that person's life circumstances. There are probably many things in people's lives that shape the degree and form of their shyness, for example, familial influences and specific experiences.

2.5.2.1. Familial influences:

An important familial influence is mother-infant attachment, through which social competence is developed. A secure attachment allows the infant to develop a sense of trust in the caregiver. The establishment of trust allows the child to explore his or her social world, to develop social skills, and to develop a sense of efficacy in succeeding in a complex social world and foster the development of social competence. The child who is socially competent looks forward to engaging in social situations rather than avoiding them. On the other hand, the child who is characterized by an insecure attachment may not develop the same degree of trust with his or her caregiver. Thus, the insecurely attached child, lacking social skills and social competence, is likely to feel awkward in social situations and may eventually begin to avoid them entirely. Several studies have noted relations between patterns of attachment and differences in social competence during the early and middle school age years (Cohn, 1990; Jacobson & Wille, 1986; Sroufe & Fleeson, 1986).

Parents who provide warmth and support and set clear expectations have socially competent and sociable children; parents who are distant and rejecting, on the other hand, tend to have children who are characterized as shy and socially withdrawn (Schmidt, Polak, & Spooner, 2001). Frequently people are moulded and shaped by their family pattern of behaviour. If the parents are highly critical, a child may very quickly learn to criticize his/her self and will focus on his/her self as an imperfect being, not worthy of being loved (Crawford, & Taylor, 1997).

A number of studies have noted important relations between maternal beliefs about parenting and child-rearing and children's social development. For example, Burgess, Rubin, Cheah, & Nelson (2001) and Mills & Rubin (1993) have noted that maternal beliefs about modes of learning social skills, reactive strategies, attributions, and emotions contribute to social development. Mills and Rubin (1993) have also noted, among other things, that mothers of socially withdrawn children were less tolerant of unskilled social behaviour than other mothers, were more angry, disappointed, guilty, and embarrassed when asked about these behaviours and were more inclined to blame them on traits residing within their children. There is well-documented evidence that the mother's personality influences the child's social development. Mothers who are depressed are known to display less positive affect and often have reduced levels of stimulation when interacting with their infants (Cohn, Matias, Tronick, Connell, & Lyons-Ruth, 1986; Cohn & Tronick, 1989; Field, 1986; Field et al., 1988).

In an extensive study, Engfer (1993) noted a consistent relationship between maternal personality and childhood shyness during the first six years of life, particularly for girls.

The literature reviewed above provides compelling evidence for the role of parental, familial, and extra-familial relationships in influencing early childhood social and emotional development.

Shy adults report that their parents were more controlling and protective of them than do non-shy people. These reports have been supported by studies that have directly observed the parents of shy and non-shy children. Parents of shy children do tend to be more controlling than parents of non-shy children. It is important to point out that the relationship is not necessarily uni-directional. In other words, it cannot be said that it was because a child's parents were over-controlling that the child was shy. Research studies suggest that the most likely pattern is a complex and circular one. That is, a loving parent will most likely respond to an emotional, anxious child by trying to help in whatever way he/she can. Emotionality has a genetic component, so it is very likely that the parent or parents are also somewhat anxious. It is hardly surprising, then, that their help will involve trying to take over, in other words, overprotecting the child. In turn, this will give the child the message that he/she is not competent to handle things himself. As a result, the child will become more dependent, thus increasing the amount of help asked for, and therefore the amount of help the parent gives (Rapee, 1998).

2.5.2.2. Specific experiences

In addition to the broad messages obtained from parents, there may also have been some more specific experiences a person has gone through that taught him/her to act in a shy way. First, many shy people also have somewhat shy parents. If this is so, then it may be that they have learnt a lot about shyness by watching and copying their parents

during their formative years. Second, many shy people have specific life experiences which have potential to direct their later behaviour (Rapee,1998).

It has been shown that even in the womb, babies may be sensitive to the 'hearings of parents exchanges' (Crawford & Taylor, 1997). Therefore, unwanted children and those who are subjected to parents arguing whilst in the womb may have an awareness of parents' negative feelings from an early age. The anxiety of children who are surrounded by shouting and battling could remain in their "subconscious" for life.

In addition, children who are taken from their mothers at birth or delivered by Caesarean birth may also suffer from feelings of isolation and alienation. Encased inside an incubator, the babies cannot receive any comfort or succour from their mothers. These children may well spend the rest of their lives unable to understand why they cannot get close to people and have feelings of alienation and loneliness (Crawford & Taylor, 1997).

People may suffer a childhood humiliation that will remain with them, condition their behaviour, and colour their responses. There are many ways in which a person can be humiliated and the shock can stay in one's mind for life' in a manner akin to Post-Traumatic Stress Disorder.

Trauma comes in many forms and results in a subconscious conditioning that translates into unexplained behaviour and self-sabotage for the rest of one life. The shock, grief and confusion, which usually arise from traumatic events, often programme people subconsciously to avoid further pain. Avoidance action is frequently quite

inappropriate to situations that people have to face later in life, such as having to cope without sufficient support, e.g. if parents were ill or absent, or died.

Put-downs may be experienced from other children, teachers, parents, friends, work colleagues, family members, etc. Whatever the source, they constantly erode a person's self-esteem and self-image. The effects of bullying may stay with a person for the rest of her or his life. Bullying can make a person fearful of social and work situations. It may inhibit people's studies, work, and social life; fear of intimidation can destroy people's self-esteem.

2.5.3. A Diathesis-Stress Model of Shyness

Schmidt, et al. (2001) propose an interactionist model (the Diathesis-Stress Model of Shyness) that encompasses both biological and environmental contributions in an attempt to understand the origins of shyness in some people.

The comparative and human evidence about *genetic/biological and environmental* contributions to shyness raises the possibility that there are both genetic/biological and environmental contributions to shyness. These independent projects highlight the importance of considering the interplay of biology and environment in understanding the development of shyness. This is further underscored by the findings that not all temperamentally reactive infants, nor all insecurely attached infants, develop shyness, suggesting that it is most likely produced by an interplay of both biology and environment.

Along with Kagan (1994), Schmidt, et al. (2001) speculates that there may be a subset of infants who are born with a biological push towards shyness. This biological predispostion is linked to genetic variation in neurochemical and physiological systems involved in the regulation of fear and the fear system. There is a large and growing literature suggesting that there is a genetic contribution to complex human traits such as shyness.

The genes that code for the regulation of serotonin may play an important role in the regulation and dysregulation of some components of the fear system. This claim is based on recent studies that have noted an allelic association of a short allele of the serotonin transporter gene with adults' neuroticism, and the determination of neonatal temperament. The presence of this genetic polymorphism may contribute to a reduced efficiency of serotonin promotion and a reduced serotonin expression. Serotonin has been implicated as a major neurotransmitter involved in anxiety and withdrawal because of its effects on regulation mood and emotional states (Westenberg et al., 1996).

The action of this reduced serotonin expression may be particularly evident in the forebrain limbic and frontal cortex where there are dense concentrations of serotonin receptors. The reduction of serotonin may play an important role in regulating the amygdala and the hypothalamic-pituitary-adrenal (HPA) system; that is, serotonin may serve to inhibit (or regulate) the action of amygdaloid firing and activation of the hypothalamic system. Without the regulating effects of serotonin, the amygdala and the HPA system become overactive in some individuals with this serotonin genetic polymorphism. The overactive amygdala stimulates the HPA system and the release of increased cortisol.

Cortisol is known to facilitate fear-related behaviours and responses in animals and humans, including heightened CRH startle responses and freezing behaviour in rats. Moreover, exogenous administration of synthetic cortisol is known to produce increase in right frontal EEG activity (a marker of stress) and anxious mood in healthy human adults. Adults with agitated depression (i.e., comorbidity of depression and anxiety) are known to exhibit elevated endo-genous cortisol levels (Gold, Goodwin, & Chrousos, 1988).

The overactive amygdala and dysregulated HPA system perhaps leads to the increased activity noted on resting psychophysiological and neuroendocrine measures that index forebrain and frontal cortical functioning, components of the fear system. As noted above, the startle response, autonomic, and frontal EEG measures are all known to be sensitive to the manipulation of cortisol. Thus, it may not be a coincidence that temperamentally shy children are characterized by elevated basal cortisol levels, high and stable resting heart rate, exaggerated baseline startle, and greater relative resting right frontal EEG activity. It is possible that dysregulation of the HPA system triggered by an overactive amygdala serves to maintain the pattern of resting physiological activity in temperamentally shy children. The genetic variation of neurochemical and physiological system, in this case, the regulation of serotonin, may contribute to greater relative resting right frontal EEG activity, a high and stable resting heart rate, exaggerated baseline startle responses, and elevated morning basal cortisol levels. In short, these baseline measures may be indexing different components (levels) of a dysregulated fear system at rest. It is possible that increased cortisol due to dysregulation of the HPA system brought about by a genetic vulnerability in the

serotonergic system continues to "prime" the amygdala and its related components of the fear system.

The amygdala is known to be involved in the appraisal of emotional valence and intensity. Now that it is dysregulated and maintained by cortisol, the temperamentally shy child becomes hypervigilant and appraises all environmental stimuli as threatening. The continual priming of the fear system serves to "kindle" the brain circuits regulating normal fear responses, reducing its sensitivity and lowering its threshold for stimulation in response to environmental stimuli (Rosen & Schulkin, 1998).

It may, however, not be enough to have a genetic/biological bias towards shyness. Environmental stressors are also needed, which might include familial and extra-familial relationships. For example, maternal insensitivity or rejection by peers may be significant environmental influences that contribute to the development of shyness in some children who already have a biological predisposition towards it.

When the person with a genetic diathesis towards a dysregulated fear system meets social stress, the diathesis is manifested on multiple behavioural and physiological levels. For example, there may be an increase in focus on the self, increase in behavioural anxiety, increase in right, but not left, frontal brain activity, increase in heart rate, and an increase in adrenocortical activity. Frontal lobe functioning may become dysregulated and person may exhibit less cognitive control over regulating his or her emotions and behaviour in response to stress. The inability to regulate the experience of negative emotion, reflected in an increase in right frontal EEG and heart

rate, and adrenocortical reactivity during stress may then lead to an increased expression of anxious behaviour and social withdrawal.

It is possible that exposure to social situations may be too stressful for people with this genetic diathesis, and their only coping strategies may involve avoiding social interactions altogether. It is known, however, that engaging in social interactions is imperative to the development of early social skills and social competence. Now the person's adaptive coping strategies soon become maladaptive, possibly leading him/her down a path towards social withdrawal, social isolation, and perhaps even depression.

It is important to point out that this model is not strictly unidirectional, as there is a complex relationship between biology and environment. For example, children's temperament influences maternal practices and attitudes; children seek out environments that are compatible with their temperaments. There are many children who present with features that would be described as "biological predispositions" but who do not develop shyness. These children may be protected by environmental factors such as warm and sensitive caregiving. There are, in addition, many instances where children without biological correlates predictive of shyness develop shyness. However, research also shows that some people who were not so previously, have become shy in adulthood usually due to experiences of rejection, conditions that lower self-esteem, and fears of failure in social domains (Henderson & Zimbardo, 2000).

2.6. Individual Differences

While everybody may agree on what it feels like to be shy, there are still variations in the experience of shyness. For some it is the reserved manner of the introvert, for others, a kind of modesty or diffidence. It can shade from bashfulness through timidity to a chronic fear of people. Shyness is an attribute that spans a wide behavioural-emotional continuum.

At one end of the scale are those people who choose a shy demeanour because they feel more comfortable with things, ideas or their work than they do with other people. They are not particularly apprehensive about being with people or about joining the crowd when necessary; they would simply rather be alone.

The middle ground of shyness consists of those people whose lack of self-confidence, inadequate social skills, and easily triggered embarrassment produce reluctance to approach people. This form of shyness is represented by people who are unable to ask for a date, a favour, or better service.

At the other extreme, shyness becomes a form of imprisonment in which the person plays both the role of guard, who constantly enforces restrictive rules, and the role of prisoner, who uncomfortably follows them and thus earns the contempt of the guard. The guard knows the prisoner wants to engage in the given behaviour and usually knows how to do so; consequently, his/her shyness is obviously not a question of lack of motivation or lack of ability. The issue is one of imposing rules that limit the prisoner's freedom to act spontaneously. Under some conditions, what was originally just gauche behaviour may develop into pathology of total withdrawal and a life of

excruciating loneliness. Isolation from people is both a significant contributor to, and a consequence of, many forms of psychopathology (Zimbardo, Pilkonis, & Norwood, 1975).

Individuals who are shy, lonely, and socially anxious differ from individuals who are not shy in their affect, behaviour, and thoughts. Behaviours that may interfere with the development of social skills or with their use include cognitive-verbal (e.g., negative thoughts, inadequate role-taking), overt (aggressive reactions, impulsive behaviour), and physiological-emotional (e.g., anger, anxiety, depression or fear) Gresham (1988). Almost all shy people fear rejection, being shy, and not knowing how to start a conversation. As with lonely individuals, there is an absence of social responsiveness to others (Mattaini & Thyer, 1996).

The behavioural aspects of shyness involve inhibited, reticent, and withdrawn social behaviours. In extreme instances, behavioural withdrawal may be total, as when a person avoids a social event altogether. In other cases, people may withdraw partially by participating only minimally in difficult social encounters. When shy, people talk less than they otherwise do, and they may display other evidence of disaffiliation such as gaze aversion, a closed body position, and other social distancing behaviours (Leary 2001). Shyness is often associated with physiological arousal, such as blushing, rapid heartbeat, and dry mouth, as well as a variety of negative thoughts, such as worrying that one is doing poorly.

Shy men do not interpret interpersonal cues as accurately as socially comfortable men, and they are more likely than are non-shy people to expect rejection from others. Shy men rate others more negatively (as less friendly), expect to be rated negatively by

others, and rate themselves as less friendly than do their non-shy counterparts. Shy people speak for less time, take longer to respond to others' comments, allow more uncomfortable silences to occur, and exhibit less tendency to interrupt when compared with non-shy individuals (Gambrill, 1996).

Research into individual differences in social anxiety as a trait has been stimulated by a trait conception of shyness. Studies have shown that the various scales that have been produced to measure shyness are intercorrelated to a substantial degree and seem to be measuring a common factor (Crozier & Alden, 2001a). For example, Briggs and Smith (1986) carried out an analysis of five scales and reported correlations between them that ranged from 0.70 to 0.86, with a mean correlation of 0.77. Shyness is correlated with, but separate from, the "Big Five" traits of extraversion and neuroticism (Briggs, 1988). Notwithstanding this unidimensional structure, Cheek and his colleagues (Cheek & Briggs, 1990; Cheek & Krasnoperova, 1999) have set out a model of shyness that postulates three components, somatic anxiety, cognitive, and social competence components. All three are regarded as important elements of shyness. All need to be present in any one individual, with variation in the emphasis assigned to each in any one person's shyness.

The involvement of the self in social anxiety implies that variation in self-related processes is a factor in individual differences in shyness and social anxiety. There is considerable evidence to support this thesis. Leary (2001) argues that self-awareness is necessary because shyness is a consequence of thinking about oneself, and particularly oneself in relation to others, in specific ways. Shyness also involves thinking specifically about how one is perceived and evaluated by other people; and thinking

about oneself from others' perspectives is a central feature of the human self. At the same time, shyness is affected by the self-relevant cognitions that people hold their self-concepts, self-attributions, relational schemas, and so on.

Shyness may be regarded as both a state and a trait. On one hand, the degree to which an individual feels and acts shyly changes as a function of the interpersonal context. Sometimes a person may not be shy at all, whereas at other times he/she may be quite shy. Thus, shyness fluctuates over situations, reflecting its state like nature. On the other hand, people clearly differ in how shy they generally are. Some people are rarely if ever shy; other individuals are shy most of the time.

Shyness is related to public self-consciousness, so that people who routinely envision what others are thinking of them experience more shyness than do people who are heedless of their public images (Miller, 2001). Bruch (2001) reviews evidence for individual differences in self-efficacy beliefs and attributions. Shy individuals perceive that they have less ability than do the less shy and there is a larger discrepancy between their perceptions of their capabilities and their perceptions of others' expectations for their performance. The appraisal problem that occurs for a shy person, therefore, is not that they believe that others hold impossible standards, or that shy persons hold perfectionistic self-standards. The problem is that the shy person's perception results in a discrepancy between perceived ability and perceived standards, resulting in low self-efficacy beliefs for social interaction. These beliefs are resistant to feedback indicating successful performance; indeed, success may only raise the expectations of others as these are perceived by shy people, and serve to make the shy person even more pessimistic.

Baldwin and Fergusson (2001, p237) explain individual differences in terms of "the relational schemas that have been built up through the individual's experience of social relationships and the attitudes to them of significant others such as their primary caregivers". They consider that anxious individuals may have experienced a history within the family of interactions that fosters an exaggerated sense of self as a social object being evaluated against high standards for acceptance, coupled with few opportunities for expressive communication and the kind of social interactions that might hone social skills, modify misconceptions and temper social pressures.

Individual differences in behaviour may also reflect self-processes. There is one line of argument to suggest that socially anxious people lack the social skills needed for effective social interaction (for example, the social skills therapy movement) with the implication that reticence and keeping in the background are produced by skill deficits (Crozier & Alden, 2001b).

Bruch (2001) reviewed research into social skills deficits. Shy people speak for less time and make shorter utterances. They also interject more agreements and acknowledgement of what the other has said and exhibit fewer dominant and assertive speech acts. Shyness is correlated with less accuracy at decoding nonverbal cues. Shy people tend to be less skilful in turn-taking in conversation, verbal fluency, introducing topics for conversation, and in expressiveness. Miller (2001) suggests that differences in skill serve to distinguish shyness from embarrassability; whereas people with good social skills are unlikely to be shy, they are not immune from embarrassment; on the other hand, those prone to embarrassment are more sensitive to social norms and values.

There is evidence of consistent individual differences in shyness. The fears of shy people do not seem to extend beyond social situations, whereas it seems to be their fears about these rather than any lack of motivation to be sociable that leads to avoidance of interaction. A significant proportion of the variance in shyness is due to situational variance, and those situations that are novel or that imply the evaluation of the individual are most likely to elicit shyness (Crozier, 1986).

Schmidt & Fox (1999) presented evidence to explain different categories of shy children and adults. They argued that individual differences emerge out of the underlying motivation tendencies of approach-avoidance (Asendorpf, 1990). They suggested that these motivational distinctions might be used as a framework to understand behavioural and physiological distinctions among different types of shyness. These different types may have distinct aetiologies and most probably manifest themselves in alternate ways, both behaviourally and physiologically. After reviewing Buss's (1986) theory of shyness and Asendorpf's (1990) conceptualisation, Schmidt & Fox presented an approach-avoidance paradigm that they used to account for at least two categories of shyness. One category was self-consciously shy people, who are characterized by an approach-avoidance conflict. They referred to this group as conflicted. The second category was fearfully shy people, who are characterized by high avoidance behaviour and low approach behaviour. They referred to this group as avoidant. They believed that these two shy subtypes represent different temperament categories, each of which is associated with distinct behavioural correlates and developmental outcomes.

Cheek and Buss (1981) used a similar approach-avoidance model to describe different types of adults' shyness. They argued that shyness was not merely low sociability. Shyness and sociability were conceptually orthogonal dimensions of personality. Shyness reflects an anxious preoccupation with the self in the response to real or imagined social interaction and is characterized by active avoidance of social interaction; sociability reflects a preference to be with others and an active approach of social situations. There are at least two types of shy behaviour that are seen across development: an avoidant type and a conflicted type.

Schmidt & Fox (1999) have found that a pattern of resting brain electrical activity indexed off the anterior portion of the scalp reflects a predisposition to experience positive and negative emotion and thus underlies individual differences in personality and affective style. Individuals who exhibit greater relative resting right frontal EEG activity appear to be shy, anxious, or depressed; individuals who exhibit greater relative resting left frontal EEG activity appear to be socially outgoing and extroverted. They found that the pattern of frontal EEG activity predicts children's reaction to social stress. They reviewed the evidence that implicates the frontal cortex and the forebrain amygdala as a possible neyroanatomical circuit that underlies different types of shyness. The pattern of resting frontal brain electrical activity (EEG) may reflect a predisposition to experience positive and negative emotion and may directly index the degree of inhibition of limbic areas involved in emotion. Resting right frontal EEG activity has been routinely linked to negative emotion, withdrawal behaviours, and anxious behavioural profiles, whereas resting left frontal EEG activity has been consistently related to positive emotions, approach behaviours, and socially outgoing behavioural

profiles. Also the dynamic balance in frontal EEG power may be linked to individual differences in personality.

Pilkonis (1977a) distinguished between privately shy and publicly shy college students. The privately shy reported distress, but adequate social skills; the publicly shy reported difficulty with social behaviour and inhibition. Zimbardo described shy extroverts as skilled, but socially anxious, and shy introverts as less skilled and inhibited (Zimbardo, 1977). This distinction influences the choice of treatment techniques. In particular, the privately shy and the shy extroverts may need less work with social skills and more work with maladaptive thinking patterns and autonomic arousal. In contrast, publicly shy patients generally benefit from skill training and techniques to increase emotional awareness and expression.

Henderson & Zimbardo (2001) distinguished chronically shy clients by the presence of additional Axis 1 and 11 disorders. At the Shyness Clinic, 97% of their patients meet criteria for generalized social phobia and 57% meet criteria for at least one addictional Axis 1 disorder. The most frequent Axis 1 disorders are dysthymia (29%) and generalized anxiety disorder (27%).

According to the "Millon Clinical Multi-Axis Inventory (MCMI), a striking 94% meet criteria for at least one additional Axis 11 disorder, most frequently the avoidant (67%), schizoid (35%) and dependent (23%) personality disorders. The Minnesota Multiphasic Personality Inventory (MMPI) further suggests the presence of compulsive (21%) and passive aggressive personality disorder struggle with shame-based emotion and reluctance to take risks without guarantees of acceptance. Those with dependent

personality disorder tend to be submissive, but socially skilled and liked by other group members. Schizoid individuals usually struggle with fears of intimacy and intrusion, and have trouble persisting while relationships deepen. Passive aggressive clients resist treatment efforts and are more likely to alienate others. (Henderson & Zimbardo, 2001).

The only crucial difference between shy personality and non-shy personality is a difference of self-evaluation. The shy person labels him/herself shy and therefore reacts much more sensitively to the kinds of situations that elicit shyness in everyone. The worlds of shy and non-shy people are fairly similar, in other words, in terms of what triggers shyness and in the public behaviours and private events that follow. The real distinction lies, not in any objective experience, but rather in what a person believes is the cause of shyness. The cause of shyness in the minds of dispositionally shy people is nothing other than themselves. It is a trait, an element of personality. In contrast, the non-shy person believes that external events cause shyness, that particular people and situations trigger anxiety and "stage fright" in them-and probably in most others (Zimbardo, Pilkonis, Norwood, 1975).

2.7. Cultural variations

Variations in ecology (physical environment, climate, resources) result in variations in contingencies of reinforcement that result in cultural differences in perceptual selectivity, information-processing strategies, cognitive structures, and habits. The cognitive structures may best be summarized by different elements of subjective culture such as categorizations of experience, associations among the categories, attitudes, beliefs, behavioural intentions (self-instructions about how to behave), norms, roles, and values.

Perceptual selectivity: Cultures differ about whether they pay most attention to what people do or who people are. For example, if a mother beats a child, members of one culture may emphasize the mother-element, and hence justify the action, but members of another culture may emphasize the behaviour (beats)-element and question the action. Collectivist cultures tend to emphasize who the person is and almost always assume that in-group members in authority do the right thing; but out-group authorities are generally viewed with suspicion. Individualistic cultures are more likely to focus on behaviours and hence to question the action. Also, in collective cultures, people are very responsive to norms and roles, and in individualist cultures they are more concerned with personal enjoyment.

In collectivist cultures there is often more differentiation among persons by age, sex, religion, language, race, tribe, or status. Individualistic cultures tend to consider such differences of lesser importance than do collectivist cultures. Most Western cultures are Individualistic. Individualism is most clear in the case of the United States, Britain, Canada, and Australia. South America and East Asia are among the most collectivist regions of the world. However, individualism and collectivism are mediated by other factor than nationality. People who have migrated and children from small families are likely to be individualistic, even if they come from collectivist cultures. People who are very modern (strongly influenced by Western culture), educated, and urban, are likely to be more individualistic than people who are traditional, illiterate, and rural.

In collectivist cultures people are more sensitive to the views of others and conform to in-group norms more reliably than in individualistic cultures. Cultures differ in the extent to which people conform to norms. In "tight" cultures people observe norms

with great care. Japan is an example of a tight culture. People in loose cultures may conform in in-group situations, but there are many of other situations when they do not conform, and the culture is very tolerant of deviation from norms. India and Thailand are examples of cultures that allow considerable deviance from norms. When the applicable norms are few and clear and the culture is homogeneous, tightness is likely. When the applicable norms are numerous and unclear and the culture heterogeneous, looseness is likely.

Information-processing strategies: In some cultures all information must be packaged into a broad framework defined by the culture. The framework may have a religious (for example, Muslim) or political (for example, USSR) basis. Actions are "correct" to the extent that they conform to this ideology. There are "correct" and "incorrect" ways of thinking and processing information. By contrast, in pragmatist cultures (for example, the USA) information is processed with little reference to a broad framework. The framework shifts depending on the nature of the information. What is "relevant" and what "works" are the important criteria, not whether the information "fits" the ideological framework.

Furthermore, when deciding what information to consider, members of some cultures consider all information that is in any way related to the topic (associative cultures), but in other cultures they consider only those elements of information of direct relevance to the solution of a problem (abstractive cultures). In associative cultures (for example, Japan) there is much reliance on paralinguistic cues (posture, eye contact, position of body in relation to other, gestures) to interpret a message. In abstractive cultures (for

example, the West) there is much reliance on definitions of terms, and only the entities that fall within the definition are used in further discussion.

Cognitive structures: There are some cognitive structures, attitudes, norms, and roles, that are specific to particular cultures-situations. This is a vast topic: some key structures can be identified. First, the self-concept is the individual's theory of who he/she is. There is evidence that self-concepts vary. In some collectivist cultures the self is merely a bundle of roles. In individualist cultures, it is an entity total distinct from the in-group. Furthermore, self-esteem, sense of power, and activity vary across cultures. Second, some values are particularly important. Whether human nature is conceived as good or bad and changeable or immutable is an obviously critical dimension. Third, the perspective that humans can master, adapt, or be subjugated to nature is also an important dimension.

Habits: Cultures differ in the habits that most members of the culture exhibit. Habits are related to customs. But more than that, they are characteristic behaviour patterns. For example, in "contact" cultures, people are more likely to touch each other, to look each other in the eye, to orient their bodies so they face each other, to use small interpersonal distances and to speak loudly; in "no-contact" cultures, people speak less and less loudly, touch each other less, do not look each other in the eyes, and use large interpersonal distance. Although there is some tendency for these habits to be interrelated, there are also many exceptions, for example, people who touch but do not make eye contact. In general, it is helpful to consider that many behaviour patterns that appear "abnormal" in one culture may be typical of another (Triandis,1987).

Shyness appears to occur everywhere in the world, but not to the same degree. No one has yet collected information about the forms of shyness present in every single country and culture in the world, but nevertheless some generalisations are starting to emerge. Zimbardo (1977) examined the prevalence of shyness in different cultures (America, Japan, Germany, Taiwan, Israel and Mexico) and in different sub-cultures (American Jews, American students and Hawaiians) using the Zimbardo's Stanford Shyness Survey (1977). He reported that shyness was most frequent amongst Japanese and Hawaiian respondents (60%) followed by Taiwanese respondents (55%). Shyness was less frequent among Jewish Americans (24%) followed by Mexicans (39%) and Israelis (31%). Zimbardo explained these differences in shyness as due to different cultural norms and socialization, as well as genetic factors.

According to Henderson & Zimbardo (2000), one explanation for the cultural difference between Japanese and Israelis lies in the way each culture deals with attributing credit for success and blame for failure. In Japan, an individual's performance success is credited externally to parents, grandparents, teachers, coaches, and others, while failure is entirely blamed on the person. The consequence is inhibition about initiating public actions and reticence to take risks as an individual, relying instead on group-shared decisions. In Israel, the situation is entirely reversed. Failure is externally attributed to parents, teachers, coaches, friends, and other sources, while all performance success is credited to the individual's enterprise. The consequence is an action orientation toward always taking risks, since there is nothing to lose by trying and everything to gain. Moreover, the incidence of shyness among Jewish students was considerably lower than among Protestants and Catholics. Only 24 percent of 121 Jewish students described themselves as shy, a proportion about half that of most other subgroups.

Crosscultural comparisons of self-reported shyness among Orientals in Zimbardo et al., (1975) California sample, a University of Hawaii sample, and a University of Tokyo sample reveal a much higher incidence of shyness among traditional Orientals than among Americans from the mainland. In a California sample, the Japanese students did not like being shy; and yet, unlike the Americans, they spontaneously mentioned various positive consequences of shyness. Shyness for the Japanese may create a modest, appealing impression. It can make one appear discreet and introspective, and it can encourage friendships by not intimidating other people. The shy person may also be seen as a good listener.

This comparison of Japanese and American attitudes makes it clear how important a particular culture and its values can be to the prevalence and even the private experience of shyness. Shyness in America, like the even greater shyness of Japan, is a consequence of cultural norms that overemphasize competition, individual success, and personal responsibility for failure. Parents, as the agents of socialization, encourage shyness in their children by adhering to the traditional values of individual achievement, aspiration and social approval as the primary measures of self-worth.

Cultural differences in the acceptance of shyness can be quite extreme and can have radically different implications for the social experiences of shy people. For example, in research with North American children, socially wary children are at risk for being rejected by their peers, becoming lonely and depressed, and feeling badly about their social skills (Boivin, Hymel & Bukowski, 1995; Rubin, Chen and Hymel, 1993) But a number of studies have shown that exactly the opposite is true in China (Chen, Hastings, Rubin, Chen, Cen & Stewart, 1998; Chen, Rubin and Li, 1999). These studies

suggest that Chinese children's socially wary behaviour is valued and encouraged by parents, teachers, and peers and linked to perceptions of oneself as socially competent. Sweden is somewhere in between China and North America in its attitudes about shyness. Shyness is certainly more accepted in Sweden than in North America, because it is more consistent with the culture values of reserve, dignity, and, above all, not thinking of one's self as better than others (Kerr, 2000).

In some cultures, gender differences appear to be absent, suggesting that shyness affects men and women equally. However, culturally there are differences in the ways in which people understand and react to shyness in men and in women. It is generally considered to be a more feminine than masculine trait, and to be more acceptable in women than in men. Shy middle-aged women may remain shy but no longer find that this causes them any problem if they live a rather traditional, family-oriented life, focused on a local, well-known community. But shy men develop, and keep on using more ways of concealing their shyness from others. They learn how to hide behind the "rules of the game", or the structure required by their work or business situations, and to adopt the roles needed for the functions they perform without involving themselves personally (Butler, 1999).

According to Zimbardo's survey, only about 5 % of adults believe they have never been shy at all, and about 80 per cent of people say that they experienced periods of pronounced shyness during childhood and adolescence. It seems that about half the people who are shy when they are young grow out of the problem to a large degree, though a sizeable proportion of them remain shy in some situations. About 40 per cent of adults in America still describe themselves as shy, and in California there is some

recent evidence that this number is slowly increasing. Shyness, it appears, is not dying away, but on the contrary is posing more problems than it used to.

Although the reasons for this increase are not properly understood, there has been speculation about the factors in modern life that could contribute to such a change. For example, it has been suggested that people get less practice nowadays at certain kinds of social interactions than they used to. Many activities that once depended on direct communication with someone else, such as withdrawing money from a bank, filling the car up with petrol, or buying goods from a store, can now be carried out successfully without interacting directly with anyone else. At work, many people spend much of their day, whether they are carrying out complex business transactions or routine, repetitive tasks, face to face with the computer screen rather than another person. Business and social interactions, including making contact with people who have similar interests, or even just chatting, can be conducted using a keyboard, screen and mouse, on the Web or the Net or in cyberspace, with no social content of the kind that helps people to overcome their initial shyness and to develop their confidence when meeting face to face. Such interactions also obey completely different sets of conventions about how to communicate, which require specific skills and knowledge of new "languages". Although these new methods of communication are in some ways extremely successful, there are many things that they do not demand, like being polite or friendly, or sensitive to how someone else is feeling and how their feelings change. They do not require their users to be aware of what might lie behind the communications they receive (Butler, 1999).

The tremendous technological advances society has enjoyed in the latter part of the twentieth century have created numerous new ways to reinforce socially anxious behaviour. Children come home to their televisions, computers, and Nintendo games, with no need to seek each other out for companionship and social experimentation. Adults do their shopping from the Home Shopping Network in their living rooms. This technology is not destructive in and of itself, but when it becomes a substitute for peer relationships and healthy interaction, it can be extremely unhealthy. Teenagers are especially susceptible. On the other hand, technology can become a valuable part of social success. Using the Internet and programmes that help people to communicate with each other may help some to develop a relationship (Berent and Lemley, 1994).

Another cultrally-related factor in shyness may be the social pressure to succeed. The 1980s were a consumer decade in which picture-perfect images on television and in magazines caused many people to cast their lots with either the haves or the have-nots. Pressure to succeed grew to an all-time high. For those who felt they could not measure up, the challenge seemed daunting (Berent & Lemley, 1994).

It is natural to withdraw from situations that people expect will lead to pain. Avoidance, while not necessarily healthy, is logical. Because the negative social experience of a growing number of people has caused them emotional pain and suffering, the number of individuals who choose to avoid socialisation is increasing at an alarming rate. The sometimes-wide distance among family members these days only adds to isolation, and the anonymity of large cities creates a vacuum in which many lonely people co-exist, often leading solitary lives in which they pursue their interests and activities alone (Berent & Lemley, 1994).

2.8. Age trends of shyness

The percentage of people who label themselves as being currently shy shows an important age difference. Lazarus (1982) reported that 38% of the sample of 396 fifth-grade children labelled themselves shy, and noted that this finding is highly similar to the approximately 40% of young adults who said they were shy on the Stanford Shyness Survey (Zimbardo, Pilkonis, & Norwood, 1975). Older adults also report the presence of shyness at about the 40% level, but 54% of seventh and eighth grade students label themselves as shy (Zimbardo 1977). Because these surveys were conducted with relatively large samples, the age trend in labelling oneself shy appears to be well established (Cheek, Carpentieri, Smith, Rierdan, & Koff, 1986).

Kerr (2000) examined the long-term correlates of early and later developing shyness at two different age periods: middle childhood, when the first realization of oneself as a social object is supposed to occur, and adolescence, when issues such as puberty and sexual and romantic relationships are entering the picture. Results show clearly that adolescence is the age at which later developing shyness becomes important for long-term adjustment. Shyness that develops in middle childhood was relatively unimportant in terms of life-course adjustment. He suggested that there are two dimensions on which early-developing fear-based shyness and later-developing self-consciousness shyness differ, which should determine their relations to adult adjustment:

- The extent to which the symptoms are avoidable, and avoiding them is a pleasant experience;
- The extent to which one's interactions with familiar others are affected.

Based on these differences; Kerr suggested that early, fear-based shyness should be linked to adulthood feelings of personal control, happiness, satisfaction with life, and fairly good relationships with others, even though interactions with others might be infrequent. In contrast, later-developing, self-conscious shyness should be linked, in adulthood, to a lack of perceived control, feelings of depression, and both few and poor-quality relationships with others.

Cheek, Carpentieri, Smith, Rierdan, and Koff (1986) referred to two studies. One study, by Simmons & Rosenberg (1973) revealed that a major part of the change in self-consciousness was accounted for by the difference between 12-year-olds still in elementary school (22% classified as highly self-conscious) and those who had started junior high school (41% highly self-conscious). They concluded that the intensification of age trends due to changing schools is a vivid illustration of the way social context can affect individual personality in addition to the physical impact of puberty. This reasoning is consistent with Buss's (1980) conceptualisation of novelty as the most powerful situational cause of shyness.

The second study was conducted as part of Elkind's research and theoretical work on the imaginary audience phenomenon in adolescence. Due to the onset of formal operations in early adolescence, young people become able to think about other people's thoughts, yet they are often unable to distinguish between what is of interest to the self and what is of interest to others (Elkind, 1978). Adolescents begin to understand that many of their own hypotheses are wrong, thus acquiring a new respect for data but also experiencing decreased self-confidence. In addition, the young

adolescent's egocentrism involves becoming concerned with the reactions of others to oneself and imagining that one is the constant focus of everyone's evaluative attention.

One outcome of these cognitive changes may be a type of shyness characterized by anxious self-preoccupation. Age trends in this self-conscious type of shyness were examined in a survey by Elkind & Bowen (1979). The results show that this type of self-conscious shyness peaks in early adolescence around ages 12 to 14, and declines somewhat thereafter. The age trends for girls and boys are similar. Taken together, these two studies suggest that the temporary increase in the percentage of people who label themselves as shy in junior high school (Zimbardo, 1977) may be accounted for by the appearance of self-conscious shyness as defined by Buss (1986).

2.9. Gender differences

The issue of possible sex differences in shyness has been the subject of many studies. Some studies on children, adolescents and adults show that females are somewhat more shy than males (Bem, 1974; Stoppard & Kalin, 1978, Elkind & Bowen, 1979, Porteus, 1979, Friedman, 1980, Lazarus, 1982, Jones & Russell, 1982, Leary, 1983, Al-ansari, 1993). Other studies on adolescents and adults show that males are shyer than females (Watson & Friend, 1969, Pilkonis, 1977b, Jones & Briggs, 1986, Zimbardo, 1977). Also, there have been studies of adolescents and adults that indicate no differences in shyness between females and males (Cheek and Buss, 1981, Jones & Briggs, 1986, Cheek, Carpentieri, Smith, Rirdan, and Koff, 1986). The inconsistency of findings regarding sex differences in shyness in the literature can be explained by differential in socialization, biological and genetic factors.

Gilmartin's (1987) fundamental assumption that "shyness does not force women to remain against their wills in the 'single, never married' category, as it often does with men" (p.5) is flatly contradicted by the data in Wilson's (1958) summary of the records of 500 women who sought counselling because they wanted to marry but were still single. According to Cheek and Melchior (1990) part of the problem in Gilmartin's orientation stems from his reliance on two studies by Pilkonis (1977a, 1977b) which indicated that shyness is much less of a personal and social adjustment problem for women than men (Cheek and Melchior, 1990),

Crozier's data (1984) (cited in Crozier1986) imply that there are sex differences in sociability rather than in shyness. But it would appear that responses to shyness questionnaires reflect situational factors; it is only a minority of items that refer to certain kinds of social encounters that produce sex differences (Crozier, 1986).

Berent and Lemley (1994, p257) stated that about 65 per cent of the calls received from around the country are from men or from parents concerned about their adolescent or adult sons. Their theory is that "society expects more from men, despite recent gains in equality for women. Men are under far more pressure to succeed, both in their careers and in their social lives, than women are. Women can be considered "shy," "demure," "quiet", all stereotypically feminine characteristics and all characteristics that can mask social anxiety, which can perpetuate overprotective and enabling behaviour."

The sex ratio for any problem depends on the sample of people surveyed. According to Rapee (1998) the most common figures are from clinical populations, that is, those people who go to a mental health professional or clinic for treatment. In this group of

people, one usually finds equal numbers of men and women, possibly even slightly more men with social phobia.

On the other hand, when studies of the general population are done, for example, when university students are surveyed with a questionnaire or random people in households are interviewed, one generally finds more women than men who seem to be socially anxious (approximately 60-70 % of women).

Women are somewhat more likely to be shy than men. Because of the social pressure on men to perform and lead (being aggressive at work, being the initiator on a date, and so on), men's lives may be more affected by shyness and so they are more likely to seek help. At the same time, because of changing in the social roles of men and women, one may see more women also coming to the therapist for help (Rapee, 1998).

The pattern of correlation between shyness and dimensions of self-evaluation is much stronger for women. Viewed in conjunction with research on adolescent shyness (Cheek et al., 1986), these findings suggest the interpretation that the burden of shyness as a problem of self-concept disturbance may be greater for females in U.S. culture, whereas behavioural problems related to taking the initiative in social encounters may be more salient for shy males (Cheek& Melchior, 1990).

College men rate shyness as being a more undesirable personality characteristic than do women (Gough & Heilbrun, 1983), and both genders agree that shyness is less socially

desirable for a man than for a women (Bem, 1981). Indeed, rating of both actual and hypothetical individuals show that a shy male is regarded as less likeable than a shy female (Gough & Thorne, 1986; Sigelman, Carr, & Begley, 1986).

Cheek, Carpentieri, Smith, Rierdan, & Koff, (1986) administered a set of personality questionnaires to a sample of 100-ninth-grade students. The questionnaire packet included Cheek's (1983) 13-item revision of the Cheek and Buss (1981) Shyness Scale, the Public Self-Consciousness Scale (Fenigstein et al., 1975), the short form of the Beck Depression Inventory (Beck & Beck, 1972) and Rosenberg's (1979) Self-esteem Scale. There were no significant gender differences for the mean scores on any of the scales. The absence of a difference for shyness may be due to the fact that the Cheek & Buss (1981) Shyness Scale assesses the affective and behavioural, but not the cognitive, self-conscious aspects of shyness. Shyness was found to be significantly correlated with public self-consciousness for girls but not for boys, suggesting that adolescent girls may be somewhat distinct in terms of the relationship between shyness and public self-consciousness. Self-esteem had a substantial negative correlation with shyness in both genders. The relationship between depression and shyness was stronger in the present sample than among college students (Traub, 1983), which may reflect the general increase in self-concept disturbance typically found in early adolescence.

In a survey of 15-year-olds, Porteus (1979) found that although boys and girls were equally concerned about attracting members of the opposite sex, girls were more worried about physical attractiveness, whereas boys reported that shyness was more of a problem for them. Therefore the higher level of self-conscious shyness in adolescent girls may be masking a more severe sex role related problem for the boys. Because the

traditional male role requires initiative in social contacts to a much greater degree than the more passive feminine stereotype, the burden of shyness as a behavioural problem, if not as a disturbance in self-concept, appears to be especially severe for adolescent boys. The original version of the Self-Consciousness Scale shows significant gender differences, with girls reporting greater increases in self-consciousness after age 11 than do boys (Simmons & Rosenberg, 1975).

The results of the Snyder, Smith, Augelli and Ingram (1985) study provide evidence that men but not women use social anxiety symptoms as a self-handicapping strategy. Socially anxious male subjects reported more symptoms in an evaluative situation in which shyness could serve as an excuse for poor performance than in both an evaluative setting in which shyness was precluded as an excuse and a non-evaluative setting. Male subjects who were not socially anxious did not evince this self-protective pattern of symptom reporting. Neither high nor low socially anxious women demonstrated any tendency toward the strategic use of shyness.

Any differences found between females and males should be viewed both in the light of sex roles and with regard to the different types or components of shyness. As Bronson (1966) has pointed out, in terms of social stereotypes, it is more appropriate for girls to be seen as shy than for boys; in fact, the self-descriptive adjective "shy" is scored on the Femininity Scale of the Bem (1981) Sex Role Inventory. Not surprisingly, elementary school teachers nominate girls twice as frequently as boys as being among the five shyest youngsters in their class (Lazarus, 1982).

2.10. Shyness and related constructs

Shyness is closely related to many variables such as social anxiety (some writers, as indicated previously, identified both terms as one), embarrassment, blushing, audience anxiety, shame, blame, guilt, fear, loneliness, social skills deficits, sociability, social phobia, and rudeness. Most involve discomfort in the presence of other people.

2.10.1. Shyness and social anxiety

There are both similarities and differences between shyness and social anxiety. Shyness can range from mild social awkwardness to extreme forms of withdrawal and inhibition that are indistinguishable from social phobia. However, one of the main differences between people who are shy and people who are socially anxious appears to be that, at least for a proportion of people, shyness can be passing phenomenon. It can last for a few months or years in childhood, it can re-emerge during adolescence, or it can continue in an intermittent way, so that, for example, it disappears once the "warm-up" phase in a relationship or interaction is over. Many people who are shy to start with experience little or no social anxiety once they have overcome their initial reticence. Because shyness may appears to involve a sense of shrinking back from social encounters, and of retreating into oneself, the main symptoms of shyness are closely similar to those of social anxiety. They include physical and psychological discomfort, inhibition, excessive self-focus, and being preoccupied with thoughts, feelings and physical reactions. Subjectively, this may translate into a powerful sense of doing things wrong, as if everyone else knew what was required of them and knew how to decode the signals correctly. It can leave people feeling exposed, dreading the next moment, full of nervous tension, unable to forget the thumping heartbeat and the hot, red face. The predominant beliefs of shy people reflect this sense of vulnerability, and

of being (or judged by others to be) inadequate, unlovable or unattractive. The way in which others react to shyness can make a difference to the symptoms too, as the more it appears to bother them, the longer it may last and the worse it may feel. Butler (1999) listed the causes of social anxiety that can be applied to shyness:

- "Biological factors: what people are born with, e.g.: an arousal system that responds quickly, is easily triggered into intense reactions.
- Temperament: being more or less sociable, extrovert, shy.
- Environmental factors: what happens, e.g.: relationship with parents and with the people who cared for the person in childhood. Experience of being evaluated, criticised, praised, appreciated, etc.
- Opportunities for social learning, making friendships, intimacy, etc.
- Ways of coping, by facing up to things or by avoiding them
- Bad and traumatic experiences, e.g.: being bullied, victimised, left out, teased or tormented; being rejected.
- Having to cope without sufficient support, e.g. if parents were ill or absent, or died.
- Difficulties coping with demands or different life stages, e.g.: childhood: learning to interact with other people; stages of shyness. Adolescence: defining an identity, becoming independent, discovering sexuality. Maturity: balancing self-reliance and dependence, control and submission; belonging. Retirement: loss of the working role, or of colleagues
- Stresses that affect relationships with others, e.g.: major moves: new home; friends or family moving away.
- Important changes: a first baby; having to work in a group; managing others.

- Competition: thinking that if you are not a winner, then you must be a loser"(p46).

2.10.2. Shyness and Embarrassment

Several authors have argued that embarrassment and shyness are discrete emotions with a distinctive display even though there are no special facial muscle movements identified with them (e.g., Izard & Hyson, 1986; Keltner, 1995). The single identifying feature common to them is the ambivalent avoidance of communicative contact in some form, for however short a length of time. Izaed and Hyson (1986) suggest that the absence of unique facial movement is itself significant, the particular motivational function of shyness is to avoid rather than signal emotional communication; thus shyness functions to decrease affective interchange. The behavioural signs of ambivalent avoidance described in the literature centre on combinations of, on the one hand, affiliative or interested behaviours such as gaze and smiling with, on the other, gaze aversion, head aversion, hand movements which either obscure key communicative parts of the self, or nervously explore the self, and loss of or disturbances in speech and vocal contact. In the more negative forms of these emotional reactions, such as in shame or painful self-consciousness, these avoidant behaviours are not combined with evident affiliation and interest. In addition to these forms of ambivalent avoidance, there is blushing, which is arguably the most intense expression of ambivalence, but which may paradoxically serve to increase communicative contact (Reddy, 2001).

Shyness and embarrassment are quite distinct. They emerge from recognizable different social antecedents, create different feelings, engender divergent reactions, and elicit

dissimilar responses from others. At the same time embarrassment shares a familial bond with shyness; they are both born of the same fundamental human motivation to be accepted by others. In moderation, neither is necessarily problematic, and both may be dysfunctional when they are extremely low or excessively high (Miller, 2001).

Table 4 Distinguishing embarrassment and Shyness

Characteristic	Embarrassment	Shyness
Antecedent	Disrupted interaction	Normal interaction
Phenomenology	Startled chagrin	Nervous trepidation
Nature of state	Emotion	Mood
Cognitive source	Automatic appraisal	Controlled cognition
Timing	Abrupt and reactive: after predicaments occur	Gradual and anticipatory: before predicaments occur
Duration	Short-lived	Long-lived
Onset of mature form	Early adolescence	Infancy (fearful shyness) or early adolescence (self-conscious shyness)
Behavioural sequelae	Apologetic condition	Inhibited disaffiliation
Interactive result (in moderation)	Sympathy and acceptance	Mild disapproval
Proximal cause	Social-evaluative concern	Social-evaluative concern
Evolutionary verdict	Adaptive	Maladaptive

Miller (2001,p293)

Miller (2001) argues that embarrassment is a reaction to a sudden and unexpected predicament that is usually advantageous and serves valuable social functions. Eembarrassment frequently elicits positive responses from others. Shyness however, is more pervasive and longer lasting, an anticipation of what might go wrong in routine situations and, far from having positive functions, it impairs social life.

He suggests that embarrassment finds expression in blushing and a distinct sequence of facial movements whereas shyness has no unique response pattern (gaze and head aversion, anxious hand movements, etc. are not unique to shyness).

2.10.3. Shyness and Blushing

Blushing is a puzzling phenomenon that is as yet little understood in psychological or physiological terms. It can serve as a useful social signal yet it is uncontrollable. It leaves the person conspicuous when he/she typically least wants to be seen. Although it is regarded as the "hallmark" of embarrassment (Buss, 1980), it does not always occur in this state, while other psychologists argue that it is a characteristic response of shame and shyness, too. Edelmann (2001) provides a detailed review of what is known about blushing. Advances in the measurement of skin colour, facial blood flow and skin temperature are currently facilitating research into the psychophysiology of blushing. A recurrent theme in research is that the blush is a response to self-attention. This attention is often unwanted, and occurs when the person has committed a *faux pas* or is embarrassed in some way. However, people do blush simply when they are conspicuous and also when they are publicly praised, complimented, or thanked. Like other signs of embarrassment, the blush serves useful affiliation functions and people tend to be viewed in a more positive light after they have created a faux pas when they blush (Crozier and Alden, 2001).

2.10.4. Shyness and audience anxiety

Audience anxiety refers to social anxiety that is experienced while speaking or performing in front of a passive group of spectators (Buss, 1980). Shyness pertains specifically to contingent social interactions in which the individual must continually monitor and respond to input and feedback from other people (Cheek & Buss, 1981; Leary, 1983). Although shyness and audience anxiety scales typically correlate, Cheek, Tsang, & Yee (1984) found that audience anxiety scores significantly predicted

performance on public speaking task, whereas shyness scores did not (Cheek & Melchior, 1990).

2.10.5. Shyness and shame, blame and guilt

There is growing interest in shame as a "self-conscious" emotion alongside emotions such as humiliation, shyness, embarrassment, guilt, regret, and remorse. These emotions are regarded as "social" in the sense that they involve a negative evaluation of the self by other people.

Shame is a complex pattern of cognition, behaviours, and physiological reactions. It involves a dual role for the self: The self both evaluates and is the object of evaluation (Tangney, Miller, Flicker, & Barlow, 1996). Furthermore, the experience of shame requires that the person take another perspective on the self and evaluate his/her behaviour as if through the eyes of another (Taylor, 1985). Such accounts are related to notions that shame is a loss of standing or loss of face; thus shame is linked to reputation, honour, and dignity (Crozier, 1999).

According to Izard and Hyson (1986) the distinction between shyness and shame are considerably fuzzier than those between shyness and guilt. Phenomenological descriptions of shame experiences (e.g., Lewis, 1971; Tomkins, 1963) bear several resemblances to shyness, although these theorists have not specifically compared the two emotions. Certain themes run through all these descriptions of shame. Like shyness, the shame experience always involves the self, the concept of self or self-esteem. It involves a heightened awareness of self, or more particularly the aspect of self that is called into question in the shame-eliciting situation. In shame, one tends to

perceive oneself as helpless, inept, emotionally hurt. Self-awareness and self-perceptions momentarily dominate consciousness, interrupting and impeding normal cognitive processes. Still on the theoretical level, Buss (1979) makes some distinctions between the experiences of shame and shyness that are conceptually consistent with differential emotions theory. According to Buss, both of these constructs, along with embarrassment and audience anxiety, form a cluster that may be termed social anxiety. He theorizes that shyness may be distinguished from shame and embarrassment in several ways. Whereas shame is elicited by uncovering or disclosure, shyness is elicited by experiences of novelty or conspicuousness. Anxiety over being evaluated is more closely associated with shyness than with shame: generally, shyness is more future-oriented than shame, focusing on what might happen rather than on what is past. Parasympathetic reactions such as blushing are less commonly associated with shyness than with shame.

Many shy people feel ashamed of themselves for being shy, as if it were their fault, and they were to blame for not having overcome the problem, despite, in most cases, persisting in doing things that they find difficult, and even waging a determined campaign against it. Just like people who are socially anxious, they tend to ignore or discount their successes, and to think of times when things went well for them socially as lucky escapes. They remember, and tend to dwell on, any information that fits with their sense of being awkward or inadequate. Shy people are likely to interpret ambiguous remarks made to them or about them, such as "you seem to be rather quiet", as if they were criticisms, and they remember such remarks better than people who are not shy. They go through life expecting other people to be critical of them, and if they

asked to describe themselves they come up with more negative and fewer positive judgments than other people would (Butler, 1999).

Shyness and guilt have a few commonalities: both are experienced as self-involved or self-focused emotions, and both may have a quality of avoidance of or withdrawal from social situations. However, the differences between these two emotions are more compelling than the similarities. Unlike shyness, guilt is generally the result of the violation of a standard. In guilt one typically feels responsible for physical or psychological harm to someone else. It is as though one feels the hurt one has imposed on the other. Thus, from a motivational perspective guilt is a distressing feeling that may stimulate reparative behaviour, even in toddlers (Zahn-Waxler, Radke-Yarrow & and King, 1979), whereas shyness appears to motivate socially ambivalent or avoidant behaviour (Izard & Hyson, 1986).

Research with the Differential Emotions Scale (DES) offers some evidence of the experiential distinctions between shyness and guilt. In numerous factor analytic studies, the Shyness Scale, consisting of the items "shy", "embarrassed", and "sheepish", was regularly differentiated from the Guilt Scale, consisting of the items "blameworthy", "repentant", and "guilty." In another study, Izard (1972) asked subjects to recall various emotion eliciting situations and then to complete the DES. This procedure resulted in a profile of emotions for each imagined situation. The profile in the shyness situation was quite distinct from that of the guilt situation. In the shyness situation the second highest mean in the emotion profile (after the shyness mean) was interest, whereas the second highest emotion in the guilt situation (after the guilt mean) was fear. The fear mean in the shyness situation was substantially lower than it was in the guilt situation profile.

Thus these data, like those of Mosher and White (1981), show that the interest and fear are the most likely emotions to interact with shyness. Similarly, the most likely emotions to interact with guilt are fear and sadness. Sadness was not present in the shyness-situation profile. The guilt mean was very low in the shyness-situation profile and the shyness mean was very low in the guilt-situation profile.

Bartlett and Izard (1972) asked subjects to recall emotion-eliciting situations and then to rate their feelings on dimensions of pleasantness, self-assurance, impulsiveness, and tension. Despite the fact that the mean for tension was about the same in shyness and guilt, the pleasantness mean in shyness (7.3 on an 18-point scale) was significantly higher than it was in guilt (3.2). Further, shyness had a significantly higher pleasantness mean than any other negative emotion. These findings are consistent with the data of Izard (1972) and Mosher and White (1981) in showing that the discrete emotion of shyness as defined by these investigators is not experienced as completely negative. At the experiential level, shyness apparently has a pleasantness dimension, but, of course, shyness has even stronger negative aspects, as suggested by the magnitude of the mean for tension (14.0), approximately the same as for guilt (13.4) and anger (14.4).

2.10.6. Shyness and Fear

Although most discussions have focused on distinctions between shyness, shame, and guilt, shyness has both logical and empirical associations with fear. Izard and Hyson (1986) argued that shyness is a particular type of fear that is elicited by certain kinds of social situations. The autonomic activity associated with shyness, such as increased heart rate and elevated blood pressure (Buss, 1979), is similar to that identified with fear. Responses observed in self-reported shy people or in shyness-eliciting situations

resemble the behaviours some items used to index mild to moderate fear in social settings (Lewis and Michalson, 1983). The "early appearing shyness" described by Buss (1979) is said to originate in fearful or wary responses to strangers. Subjects recalling shyness situations report substantial feelings of fear, combined with shyness and interest. As already noted, Mosher and White (1981) argued that shyness can be viewed as an oscillation between interest and fear. Clearly, fear is a more toxic emotion than shyness; it also seems less ambiguous in the motivational impact. "Pure" fear stimulates escape; shyness frequently seems to motivate both approach and avoidance tendencies.

2.10.7. Shyness and loneliness

Peplau and Perlman (1982) pointed out that it is difficult to distinguish among behaviour that accompanies loneliness, behaviour that leads to loneliness, and behavioural strategies for coping with loneliness. Shyness, social anxiety, social phobia, and unwanted social isolation may be precursors to loneliness. The negative affective state that characterizes loneliness may increase shyness and social anxiety and encourage social isolation; it is often difficult to be socially outgoing when feeling lonely and alone. Factors related to loneliness include: (a) emotional threats to relationships, such as arguments; (b) social isolation (e.g., being left out); (c) social marginality (being with strangers) or (d) romantic difficulties (Jones, Cavert, Snider, & Bruce, 1985). Loneliness is positively correlated with sensitivity to rejection, measures of shyness, and social anxiety; it is negatively correlated with measures of extroversion and sociability, likeability, confidence, and the skills involved in dating and conflict resolution (Jones, Rose, & Russell, 1990). The greater the interest in being with people (the greater the sociability), the more intense the conflict caused by shyness and social

anxiety may be, and the greater the loneliness that results from ineffective behaviour and less-than-satisfactory social outcomes (Gambrill, 1996).

Behaviours such as a social reticence, behavioural inhibition, shyness, or social isolation clearly are related to poor peer relationships and loneliness. Children who are socially isolated have limited opportunities for interaction and thus do not acquire the social skills necessary to develop friendships. As a result, they feel lonely and isolated, which further limits their interactions with peers and further retards their skill development (Beidel and Turner, 1999).

2.10.8. Shyness and social skills deficits

Shy persons are likely to have social skills deficits because they perform more poorly in social interactions (Twentyman & McFall, 1975). Such skill deficit is likely to develop due to poor parental modelling of effective social skills (Bruch, 1989). However, from another perspective, it can be argued that the poor performance of shy persons is due to the inhibiting effects of anxiety that may interrupt the execution of otherwise effective responses. For example, Hill (1989) found that shy and non-shy participants were relatively similar in their knowledge of appropriate social behaviour, but that shy participants were less likely to employ these responses and did not believe they had the ability to do so effectively (Bruch, 2001).

In addition to differing perspectives, there is also controversy among investigators concerning how to define social skills. Some investigators argue that social skills should be defined at a motor level (e.g., sense of timing) rather than at a molecular level (e.g., eye contact, smile), because the former has a more discernible impact on the

satisfaction interactants experience as well as on judges' ratings of effectiveness (Fischetti, Curran, & Weissberg, 1977). Communication researchers also add another perspective to social skills effectiveness not typically addressed by personality and clinical psychologists. These investigators argue that conversational speech skills are an important aspect of one's social skills repertoire and they have identified some critical differences between shy and non-shy persons (Manning & Ray, 1993).

Bruch (2001) examined selected research studies that have addressed the question of whether shy persons possess social skill deficits. The results from these researches are: (a) shyness was negatively correlated with decoding skill accuracy for interpersonal situations involving kinship, competition, intimacy, and status but not for deception, which showed no correlation; (b) cognitive interference showed little systematic relationship with Interpersonal Perception Task (IPT) domain scores suggesting that a shy person's problem in interpersonal perception may be in part due to inadequate development of certain social information-processing skills; (c) shy, in contrast to non-shy, individuals perceived themselves as less skilful in turn-taking abilities, verbal fluency, and expressiveness (i.e., facial expressions, vocal variety, appropriate volume, and gesturing skills). In terms of communicative adaptability, shy participants perceived themselves as lacking in the ability to ease tension with humour, to show that shy persons may experience difficulties in their social interactions because of inadequate development of certain social information-processing skills.

2.10.9. Shyness and sociability

The trait of sociability, the preference for being with others rather than remaining alone, would seem to overlap shyness considerably, for shy people tend to shrink back from

social interaction. The Factors analysis by Daly, Caughlin & Stafford (1997, pp.109-111), yielded these two sets of items:

Box 3 Sociability and Shyness

Sociability:

(1) Like to be with people.
(2) I welcome the opportunity to mix socially with people.
(3) I prefer working with others rather than alone.
(4) I find people more stimulating than anything else.
(5) I'd be unhappy if I were prevented from making many social contacts.

Shyness:

(1) I am socially somewhat awkward.
(2) I find it hard to talk to strangers.
(3) I feel tense when I'm with people I don't know well.
(4) When conversing, I worry about saying something dumb.
(5) I feel nervous when speaking to someone in authority.
(6) I am often uncomfortable at parties and other social functions,
(7) I feel inhibited in social situations.
(8) I have trouble looking someone right in the eye.
(9) I am more shy with the opposite sex.

From the above list one can see that the sociability items involve a motive, the need to be with others, whereas the shyness items deal with behaviour and feelings when with others. The two measures correlate -0.30, which means that shyness is linked to low sociability. However, the low correlation also suggests that there are sizable minorities who are both shy and sociable or un-shy and unsociable. Furthermore, they relate differently to other personality traits. Fearfulness correlates 0.50 with shyness but -0.90 with sociability; self-esteem correlates -0.51 with shyness but 0.18 with sociability.

Thus, even though shyness and sociability are related, they are best regarded as separate personality traits (Daly, Caughlin, & Stafford, 1997).

2.10.10. Shyness and social phobia

Social phobia is the excessive fear of situations in which a person is exposed to public scrutiny (American Psychiatric Press, 1994). In these situations (e.g., talking to people, giving speeches, eating in front of others etc.), the person fears that he/she will do something to embarrass themselves or will be subjected to negative evaluation. These situations typically cause a panic response in the individual which may include physical symptoms such as heart palpitations, sweating, trembling, nausea, dry mouth, and blushing. As a result, the individual either avoids social situations or endures them with a great deal of discomfort. Social phobia is associated with significant distress, including increased suicidal thoughts, financial problems, reduced work and school performance, impaired social support systems, increased use of psychotropic medication, and increased seeking help from medical and mental health professionals (Chavira, et al., 1999).

From this description, one can easily agree that there is an overlap between social phobia and shyness, but they are not identical constructs . They share many symptoms (Turner, Beidel, and Townsley, 1990). Individuals who are shy cannot be differentiated from individuals with social phobia on the basis of physical symptoms, for example, somatic arousal and heart rate activity. In addition, social skills deficits, avoidance, and cognitive reflecting fear of negative evaluation are found in both groups. Turner, Beidel, and Townsley (1990) examined the relationship between shyness and social phobia on six different dimensions. Somatic responses of both groups were similar

(heart palpitations, sweating, trembling, and blushing), as were the type of negative cognitions (fear of negative evaluation or of doing something humiliating or embarrassing). However, the groups differed with respect to occupational and social functioning behavioural characteristics, age of onset, and course of disorder. Individuals with social phobia were more likely to be occupationally and socially impaired, more likely to avoid social encounters, had an earlier age of onset, and a more chronic course. About 40% of college students described themselves as shy, although a much lower percentage of the general population meets diagnostic criteria for social phobia. According to Chavira et al., (1999) highly shy individuals, specifically those with generalized social phobia, have a greater propensity to exhibit social phobia, than subjects with normative levels of shyness. It is also possible for an individual to be extremely shy but not diagnosable with social phobia.

McWilliams (1995) used the Thought Listing Form and Social Interaction Self-Statement Test to assess cognition among social phobics and nonanxious individuals before, after and during social encounter. The results indicated that moderate fear levels among phobics before the interaction decreased during the social encounter. Shyness levels significantly intensified immediately before the interaction and surpassed fear levels during the interaction. Fear was found to relate to negative thought content before but not during the interaction. Conversely, shyness and shame were significantly related to negative thoughts during but not before the interaction.

Although there was an overlap between the constructs of shyness and social phobia, there were important differences as well. Turner, Beidel, and Townsley (1999) argued that there are multiple pathways to the development of social phobia. One possible

pathway is through genetic transmission. The available evidence from the family study indicates that 16% of the relatives of socially phobic patients meet diagnostic criteria for social phobia (Fyer, Mannuzza, Chapmanm, Liebowitz, & Klein, 1993). It seems that one acquires vulnerability through genetic inheritance and that for the disorder to develop, other factors are necessary.

According to Beidel and Turner (1999), another possible explanation (pathway) for the aetiology of social phobia is that it results from some combination of direct conditioning, observational learning, and information transfer. There is no evidence that those who are considered more vulnerable (due to genetic inheritance) are more susceptible to direct conditioning, observational learning, or information transfer. However, there is a small amount of data to suggest that the offspring of a group of parents with mixed anxiety disorders are more responsive to various types of stimuli than the offspring of parents without anxiety disorders (Turner, Beidel, & Epstein, 1991).

Additional factors also may predispose one to the onset of social phobia or function to help maintain social phobia after it emerges. To illustrate the powerful impact of family interaction style, Barrett et al. (1996) demonstrated how protective parental behaviours may serve to maintain avoidance behaviours in anxious children. Also, findings with behaviourally inhibited children show that even if they initially were inhibited temperamentally, they became less so when their parents deliberately engaged them in social interactions with others. These findings suggest that parental behaviour plays a significant role in the manifestation of social fears, despite one's genetic makeup (Beidel & Turner, 1999).

Box 4 Similarities and Differences Between Social Phobia and Shyness

Characteristics of both groups
(1) Increased physiological (cardiovascular) responses (2) Negative cognitions when in social encounters (3) Behavioural avoidance of social situations (4) Social skills deficits
Characteristics of Social Phobia
(1) Lower prevalence rate in the general population (2) More chronic course of disorder (3) More pervasive functional impairment (4) Later average age of onset

Beidel & Turner (1999b,p205)

Chavira and Stein (1999) study provides empirical evidence to support that an individual who is highly shy is not necessarily pathological. He admits that there is almost an equal probability that an individual will or will not present with a social phobia diagnosis.

2.10.11. Shyness and Rudeness

It is clear that the fear of intruding and of giving offence, or of being rude, has something to do with shyness. Shy people often find it hard to ask questions. Questions are extremely useful socially, but they also run the risk of appearing rude. One of the main ways in which people find out about each other is by asking questions, but the conventions about what is acceptable and what is not vary. In order to develop the manners and the sensitivity that fit with the culture one is in, one has to be sensitive to those conventions. So, during childhood, children learn a large number of social rules, for example about not interrupting, or talking much about themselves, or

upsetting other people, and they also learn that it is wrong, embarrassing and even unacceptable, to do these or similar things. However, as conventions vary, even between people who share the same background but are of different ages, it is always possible to be rude by mistake. Perhaps shy people become over concerned about making mistakes and about their consequences, so that to them social life feels rather like finding their way through a minefield of potentially explosive devices. Perhaps mistakes have too much significance for them, as if being (unintentionally) rude makes them inadequate, or unacceptable, or likely to be rejected. Or perhaps such mistakes did on occasion have dire consequences as they were growing up (Butler, 1999).

Knowing the rules about what is rude and what is not is certainly helpful, but children receive messages that are hard to fit together, such as "look at me when I'm talking to you" and "Don't look at me like that", so knowing the rules is never enough. There are always exceptions, and they often have to be adapted to particular circumstances; shyness makes people uncertain about how to adapt, and makes them feel too inhibited to attempt to do things differently. When this happens, misunderstandings can easily arise. For example, one person thinks, "If he wanted me to know, then he would tell me", and does not ask questions because of not wanting to intrude. But the other person thinks, "She never asks, so she's not interested." Consequently, both of them keep quiet when that is not what either of them really wants.

It is likely that the minefield can be negotiated more easily by learning to be sensitive to other people. Learning to pick up the signals, and learning how to repair the damage when one has done something "wrong", are important tasks, and neither of these can be done so well when feeling self-conscious. The self-awareness and self-focused

attention of shy and social anxious people may make them feel less aware of others and more at risk of giving offence by mistake. But at the same time, feeling shy or socially anxious makes it seem especially important not to be rude or to give offence (Butler, 1999).

2.10.12. Shyness and Illness

There is substantial evidence indicating that biological differences are associated with behavioural inhibition. Shy individuals have a lower threshold for arousal than their non-shy counterparts and thus more frequently experience a state of physiological hyper-reactivity (Kagan, Reznick, & Snidman, 1987, 1988). This entails a hyper-secretion of cortisol that suppresses the immune system and reduces the effectiveness of lymphocytes to combat infection. In addition, stress-induced activation of the sympathetic-adrenomedullary, hypothalamic-pituitary-adrenocortical, and endogenous opiate systems precedes the onset of symptoms related to infection. As a result, behaviourally inhibited or shy individuals may be expected to experience ill health. In support of this notion, some studies have shown a relationship between shyness and allergies. With respect to adults, as early as 1940, Sheldon, Stevens and Tucker noted a higher incident of allergies, skin trouble, chronic fatigue, insomnia, and sensitivity to noise and distractions in ectomophic introverts than in mesomorphic extroverts. More recently, one third of shy college students compared to none of their outgoing counterparts reported hay-fever, and participants with professionally diagnosed hay-fever had higher self-reported shyness scores than those without. With respect to infants and toddlers, mothers of children who were behaviourally inhibited at 21 months retrospectively reported more colic, chronic constipation, and allergies during the first year of life than mothers of comparison children and a higher prevalence of atopic allergies, especially hay-fever and eczema when the children were between ages1 and 3.

Two studies (Boyce et al., 1995, and Chung & Evans, 2000) have investigated the relationship between shyness and illness in school-age children. Boyce et al. (1995) hypothesized that environmental stress and individual reactivity would interact in the prediction of respiratory illness. In their first study of 140 children of 3 to 5 years of age, the children were examined for respiratory illness weekly from January to June at their day-care centres. While neither stress nor individual reactivity predicted illness in themselves, high reactivity children who were in high-stress settings experienced higher rates of respiratory infection than those in low-stress settings. Children with low reactivity showed no higher incidence of illness in high-stress settings. In a second study of 95 5-year-old children, parents completed diary recordings of the frequency of upper and lower respiratory symptoms in the weeks surrounding their child's entry to kindergarten. Stress was assessed via family report of stressful events and family conflict in previous months. Children experienced an average of three respiratory illnesses in the three months following kindergarten entry, but those with high immune reactivity to school entry who experienced a large number of stressful life events had the highest rates of respiratory illness. An unexpected finding in both studies was that respiratory illness was least frequent in highly reactive children in low-stress environments. In both studies, no attempt was made to differentiate between allergies and infectious respiratory problems.

In a study by Chung and Evans (2000) the health of 16 shy and 16 non-shy children from grades 1 and 2 who were matched for age, sex, parental education, family stress, and height/weight ratio was monitored for a period of four weeks in February and March. On twice as many days in the four weeks, shy children versus non-shy children

complained of feeling unwell and their parents observed symptoms of illness in them. There was no difference between shy and non-shy children in the number of days children complained of feeling unwell but their parents did not observe symptoms of illnesses, suggesting that shy children were not more prone to somatization or to complaining of ill health to avoid anxiety-provoking situations. An examination of the individual categories of child complaints and parent observations of ill health revealed statistically significant differences in gastrointestinal illness (nausea, vomiting, diarrhoea, cramps) and fatigue as observed by parents, and in gastrointestinal illness and feeling "off" (loss of appetite, irritable, miserable, trouble sleeping) in the complaints of shy children themselves. In addition, all means were higher in the various categories of ill health with the exception of eye and ear infections observed by parents, which were virtually the same, and headaches as reported by children, which were higher in the non-shy group (Evans, 2001).

The frequency of migraine is also associated with characteristics that distinguish shy or inhibited children. In a study by Bille (1962) (Cited in Evans, 2001), migrainous children, especially girls, rated themselves as more anxious, fearful, tense, and nervous than non-headache children, and parents tended to rate the former group as more anxious, sensitive, apprehensive, tidy, and vulnerable to frustration. Similarly, Kowal and Pritchard (1990) found that children in grades 4-7 who had at least two troublesome headaches a month were rated as more shy-sensitive by their parents but did not rate themselves as more anxious than non-headache controls. These studies collectively show that shy children are likely to be sick more often (Evans, 2001).

2.10.13. Shyness and Interest

Although shyness is a negative emotion, the Differential Emotions Scale (DES) studies of imagined shyness situations show a relatively high level of pleasantness and (specifically) of the positive emotion of interest, presumably social interest. At least among a normal population, then, feelings of shyness do not preclude attraction to others. In fact, one of the distinguishing qualities of shyness may be the conflict between positive and negative social feelings. Observational studies of children in novel social situations frequently show a mixture of social interest and social avoidance or withdrawal (Izard & Hyson 1986). Pilkonis (1977b) found that shy women engaged in more smiling and nodding than any other group, a finding that he attributes to social anxiety but that can also be interpreted as an emotion blend of interest and shyness (Izard and Hyson, 1986).

Quiet students, tend to avoid small classes in favour of large, lecture-type classes in which most of the communication takes the form of the instructor talking to the students and the students simply listening and taking notes. Shy students who select the large, mass-lecture class might be short-changing themselves in terms of in-depth knowledge gain. They may be not taking the opportunity to interact with their peers or their instructor on a one-to-one basis to clarify ideas and gain additional information. Nevertheless, if they were in smaller, interaction-oriented classes, their chances of success would be low because of the amount of interaction required. Classes that required oral reports or speeches are avoided by shy students, but often are attractive to more verbal ones. Similarly with classes that base part of the final grade on class participation.

Once students are enrolled in a class, whether voluntarily or through a requirement, one might assume that the students will simply accept the requirement of high communication and try to do the best they can. Such an assumption is not correct. Shy students often will drop a class with high communication requirements, even if it is a required course. According to Daly, Caughlin, and Stafford (1997) in one study, over 50% of the students with high communication apprehension dropped a required public speaking course during the first three weeks of the course, just before the first speech was due to be presented. Other studies have found that quiet students who remain in courses with high communication requirements are likely to be absent on days when they are scheduled for presentations. This is true not only at the college and high school levels but also at the elementary school level. Highly verbal students, in contrast, are likely to engage in similar behaviours if there is little opportunity for communication in the course. Their attendance in lecture classes is likely to be low; they would rather get the necessary information by reading or talking to other students than by sitting through "boring" lectures. Similarly, research has indicated that highly verbal students do not like automated, individualized instruction in which they are given objectives, reading or viewing assignments, and tests with no opportunity for interaction with a live teacher. They are likely to avoid or withdraw from the class, or, as an alternative if they must have the credit, complete the class in as short a time as is permitted (Daly, Caughlin, and Stafford, 1997).

2.10.14. Shyness and Social Interaction

The most studied aspect of shyness relative to social interaction is the shy person's internal cognitive-perceptual responses prior to, during, and following an interaction. There are four types of cognitive-perceptual variables. These variables are: negative

consistent with the notion that the maladaptive attributional style of shy persons is related to specific negative cognitive and affective reactions experienced in the context of an interaction. Alden's (1987) findings suggest that positive outcomes in social interactions may lack reinforcement value for the shy person.

Self-Appraisal Processes. A third cognitive-perceptual variable that is related with social interaction responses involves self-appraisal processes. Wallace and Alden (1991) found that shy and non-shy persons did not differ in their perceptions of the standards other people held for them. Essentially, their research involved three variables: perceived social standards (i.e., the level of interaction effectiveness expected by others and by oneself), perceived personal ability (i.e., level of social self-efficacy), and type of social feedback (i.e., positive or negative). As perceived social standards are complicated by subjective judgements, Wallace and Alden (1991) developed a "visual scale" rating procedure that presented videotaped interactions of people displaying various degrees of social effectiveness to serve as anchors for social skilfulness. Participants were shown the videotapes and encouraged to watch them as often as necessary before making their ratings of perceived social standards. Consequently, shy persons evidenced a larger discrepancy than non-shy persons between their perception of their own performance capabilities and their perception of others' expectations for their performance. The appraisal problem that occurs for shy persons, therefore, is not that they believe that others hold impossible standards, or that shy persons hold perfectionistic self-standards. The problem is that the shy person's low ability perception results in a discrepancy between perceived ability and the perceived standards of others, resulting in low-efficacy beliefs for social interaction. Wallace and Alden's (1995) results indicated that, following positive feedback, shy men

self-statements, attributional responses, self-appraisal processes, and self-protective social goals. Of specific interest are the types of social interaction that are found for each of these variables. Bruch (2001) reviewed researches that dealt with each variable.

Negative Self-Statements. Self-statement refers to internal speech that is self-referent and accompanies any social or intellectual task. People who score high on measures of shyness or social anxiety consistently report more negative, self-deprecatory thoughts relative to social interaction. Research on social interaction correlates of negative self-statements has focused on a number of variables that theoretically should be associated with self-deprecatory thoughts. One correlate is the amount of subjective anxiety experienced relative to an interaction. Results showed that frequency of negative self-statements was directly correlated with greater amounts of subjective anxiety, suggesting that there is a synchrony between negative cognitive and negative affective responses of shy persons in interactions involving conversation with a stranger. A second correlate consists of other types of cognitive responses that reflect a shy person's attentional concerns during social interaction. Shy persons have a misplaced attentional focus during social interaction, which is likely to interfere with their performance. A third correlate of shy person's negative self-statements is behavioural manifestations of nonverbal anxiety during an interaction. The more negative thoughts reported, the greater the tendency of participants to overestimate the amount of anxious behaviours they manifested relative to judges' objective count of anxious behaviours.

Attributional Responses. A second cognitive-perceptual variable that correlates with social interaction is attributional responses. Bruch and Pearl's (1995) results are

in contrast to non-shy men rated their ability for an upcoming interaction significantly lower than their estimation of the social standards others would hold for them in the upcoming interaction. The same pattern also emerged for shy men who received negative feedback or no feedback. In contrast, non-shy men who received positive feedback or no feedback rated their ability to perform effectively in an upcoming interaction higher than they rated the standards that others would hold for them, while non-shy men who were given negative feedback rated their ability as similar to others' expectations. Finally, the results also showed that shy men rated their ability lower than they rated their own standards for their performance in the interaction regardless of condition, while non-shy men rated their ability similar to their personal standards. Wallace and Alden (1997) suggested that positive feedback about one's social interaction may not be perceived in a manner that facilitates the shy person in modifying his or her negative self-perception. Persons who are highly socially anxious are concerned that others will expect more from them in subsequent interactions.

Self-protective social goals. As people approach and then engage in social interaction, their behaviour presumably is directed by one of two types of interaction goals: gaining approval and avoiding disapproval. Shy persons are primarily motivated to avoid disapproval, and thus adopt self-protective approaches in their interaction. Results from Meleshko and Alden's (1993) study indicated that regardless of disclosure level, shy persons reported engaging in more self-protective and fewer acquisitive response strategies. In contrast, non-shy participants reported just the opposite pattern and this was true regardless of the confederates' degree of intimacy. Bruch, Hamer & Heimberg's (1993) results showed that the self-rated shyness symptoms of "felt nervous", "acted awkward", and "concerned that my partner would be critical"

correlated positively with greater use of self-protective strategies and negatively with use of acquisitive strategies. Negative self-statements also correlated positively with self-protective strategies and negatively with acquisitive strategies. Time spent focusing on self versus partner issues during the conversation was positively correlated with the use of self-protective strategies but uncorrelated with the use of acquisitive strategies. Alden's (1987) comparison of social phobics and non-phobics self-appraisal processes following feedback showed that social phobics reported more self-protective than acquisitive strategies during conversation regardless of whether they received positive or negative feedback. All the three studies are consistent with Arkin's (1981) notion that the basis for a shy person's selection of self-protective over acquisitive strategies is due to his/her preoccupation with avoiding criticism and disapproval because of self-perceived inadequacies (Bruch, 2001).

2.10.15. Shyness and self-esteem

According to the dictionary of Psychology Self-esteem is the degree to which one values oneself (Reber, 1995). Contrary to popular belief, not all shy people suffer from inferiority complexes or low self-esteem. Shy people may eventually develop feelings of inferiority in the area of human relations, but the low self-esteem is the result of shyness, not the cause of it. This is not to say that no shy people suffer from an inferiority complex. But feelings of inferiority or low self-esteem are far from the exclusive domain of shy people. Crozier (1981) found from his study concerning shyness and self-esteem that shyness is independent of both fear of criticism and aspects of the self-concept.

In addressing the causes of shyness in children, Zolten and Long (1997) listed low self-esteem as one. Children who have low opinion of themselves expect other people to feel the same way about them. This belief can lead to shy behaviour.

According to Marina-Lisette's (1999), fearful shy individuals compared to non-shy individuals reported high levels of achievement conflict and low self-esteem. On the other hand, self-conscious shy individuals did not differ from the non-shy group.

2.11. Effects of shyness

Shyness is a universal experience, affecting almost everybody to a greater or lesser extent. Butler (1999) listed the effects of shyness, which are similar to the main effects of social anxiety:

- "Self-consciousness and self-awareness
- Thoughts about being evaluated negatively, and of being judged or criticised
- Beliefs about being inadequate, unlovable or unattractive
- Avoiding and withdrawal; a sense of inward shrinking; not getting involved
- Finding it hard to take the initiative or to be assertive
- Feeling anxious, apprehensive, frustrated or unhappy
- Physical symptoms such as blushing and other signs of nervousness."(pp.25-27)

In addition, shyness can have some indirect effects. For example, when feeling shy, people can become so self-conscious and preoccupied with themselves and their feelings that they are no longer able to pay proper attention to their surroundings or to what they are doing. That is when they cover themselves with confusion by doing something clumsy like knocking over a drink, or stumbling over a step, or bumping into

a chair or table. Shy people are normally no more clumsy than anyone else, but they become so, much to their chagrin, at the worst possible times for them, when they least want to draw attention to themselves and would far prefer to appear less awkward than they feel. It is interesting that shy children suffer fewer disadvantages from their shyness than one might expect. Their self-esteem remains unaffected at first, and so does their ability to form friendships. However, when shyness continues, then the problem appears to interfere more with their lives, so that adults who have always been shy more frequently end up doing jobs that they do not enjoy, or that fail to allow them to take full advantage of their potential, or that earn less money, than people who have succeeded in overcoming their childhood shyness. As a consequence, perhaps, many of them do suffer later on from lowered self-esteem, and a few also from another secondary effect of long-lasting shyness that may be rather surprising. They tend to have more problems with their physical health than might otherwise be expected.

Shyness makes it hard for people to confide in others and talk about their personal problems, or things that many people are sensitive or easily embarrassed about. Therefore they may receive less professional advice than they need, and less support from the people around them when something stressful or distressing happens to them. Having a good support network, and being able to express feelings, whether face to face with someone else or in some other way such as by writing or through music, poetry, or physical activity, for example, helps people to overcome all sorts of problems. Self-expression helps people recover more quickly than keeping things to oneself, and that means that people who are able to do this suffer less from the fatigue that usually goes with persistent stress or distress, and apparently also become less vulnerable to minor illnesses (Butler, 1999).

Shyness is an attractive quality to many people. It can be difficult to get to know someone who is shy, but the difficulty, far from putting people off, can make people interested to know the shy individual more, as if there were a mystery to be solved, and the process of getting to know a shy person held unexpected rewards. The sense of someone gradually warming to the attention they are given, and opening up as they begin to feel more confident, can make the friend who is giving the attention feel that they have won a valued confidence, and it can also make them feel good about themselves, for example for being sensitive and attentive. Shyness is closely related to that much-admired characteristic of the British: reserve, and it can go with a becoming form of modesty that is contrary to some characteristics that are not so universally admired, such as arrogance, loudness, being self-opinionated, pushy or conceited.

There is nothing inherently wrong with shyness, and some people quite consciously take advantage of the fact that it can be a most attractive quality, and use their shyness as means of making people curious about them. Shyness can be an invitation, used to draw people in: a clue that there are hidden qualities to be discovered, or a mystery to be unravelled. People take advantage of their shyness in various ways and may be accused, if they flutter their eyelashes too much, of being manipulative when they do so, though often the intention is not to produce a desired reaction in someone else, so much as to give themselves a helping hand in picking up the social cues or clues in a new or unfamiliar situation. Being shy, and holding back until one feels confident enough to join in, is safer than being bold or uninhibited, especially if a person fears doing the wrong thing socially and need time to get his/her social bearings, so to find out, for

example, who is who and how he/she should react to them, and avoid committing the *faux pas* of sitting in someone else's place.

It is also possible that having too little shyness in one's make-up might be just as bad as having too much. A certain amount of shyness may deter an individual from putting him/herself forward, particularly in situations in which one person finds another attractive, and wants to make this clear, irrespective of whether their attentions are welcomed, or regardless of the appropriateness of doing so at that time or in that place. The ability to turn a social contact into a "real", emotional connection, and, for example, to make people laugh or to tell jokes, is almost universally valued socially; but it is still important to be able to judge what is appropriate. People who do not suffer from shyness at all may not pay attention to such considerations, and say or do some "outrageous" things which can be so embarrassing to people who are shy that they can hardly bear to be near them, or even to watch them on the television. A balance between inhibition and disinhibition may lead to least social difficulty, though it must also be admitted that having disinhibited people around can make for a good party, and that having inhibited ones around can introduce a valuable sensitivity to others, as well as a note of caution that may be so valuable (Butler, 1999).

Interpersonal shyness can be a positive experience. The majority of studies of shyness in infancy and childhood, however, have viewed it as a factor that detracts from early interpersonal and object-related engagements, and deprives the child of exploratory and playful experiences. The general focus, in effect, has been on fearful shyness (Kagan, Reznick, & Snidman, 1988; Kaplan, 1972). However, shyness can result from, and lead

to, positive interpersonal experience. People sometimes turn their eyes away from others not just in fear of anxiety, but even in desired intimacy.

Shyness and related emotions can cause, and be caused by, positive feelings in others as well as in the self. For example, praise, especially excessive praise, has been identified as an elicitor of embarrassment in adults Buss (1978) (cited in Buss, 1980) and even in toddlers (Lewis, Sullivan, Stanger, & Weiss, 1989). Adult embarrassment in certain situations has been shown to lead to an increase in observers' positive feelings towards the embarrassed person (Edelmann, 1982; Miller, 1996; Semin & Manstead, 1982). Bartlett and Izard (1972) showed that shyness has significantly higher self-rated reports of experienced pleasantness than any other "negative" emotion.

These data support the findings of Izard (1972) and Mosher and White (1981), which suggest that although it has a strong negative component as well, shyness is not experienced as completely negative and has both a pleasantness dimension and a high level of social interest and attraction (Izard & Hyson, 1986). Many have drawn a distinction between dispositional or trait shyness on one hand, and situational or state shyness on the other, a distinction which may affect just how positively shyness is experienced. Asendorpf (1985, cited in Asendorpf, 1990) found that shyness and happy mood correlated significantly positively when looking at state shyness within individuals, but correlated significantly negatively when comparing individuals on trait shyness in all situations.

Although William James (1890, p432) saw shyness and related states as "incidental emotions" and "pure hindrances" despite which one gets along, others have argued that

moderate amounts of shyness serve a positive adaptive function in enabling the handling of novel and unpredictable situations and persons (Izard & hyson, 1986) and in inhibiting socially unacceptable behaviour and thus facilitating co-operation in groups Ford (1987) (cited in Cheek & Briggs, 1990). The complete absence of shyness may in fact be argued to be an antisocial characteristic (Cheek & Briggs, 1990). Some expressions of shyness and embarrassment, such as blushing, may serve an appeasing function (Castelfranchi & Poggi, 1990). Miller argues that they are perceived as involuntary (and therefore genuine) acknowledgements of social transgressions, thus functioning to appease and smooth possibly difficult interactions (Miller, 1996). Further, interpersonal shyness may be attractive because it functions as a comment on an interpersonal act by the other. It may be a fundamental marker for a psychologically significant event and reaction, thus both signalling and inviting interest from the other (Reddy, 2001).

The popular conception of shyness is that it is a relatively mild, common and transitory condition. Some shy individuals appear to outgrow their social reticence over time (Zimbardo, Pilkonis, and Norwood, 1975). In a retrospective study using college students selected for their extreme scores on a shyness battery, Bruch, Giordano, and Pearl (1986) examined various characteristics of shyness, including stability. Interestingly, almost half of the currently not-shy group reported feeling shy during their early childhood years. When this group was divided into those who were never shy or those who were previously shy, the latter group had significantly more severe feelings of shyness during junior high school. Thus, for these, students the process of becoming less shy appears to have occurred during high school and college (Beidel and Turner,1999b).

However, exactly how or why this happened remains unclear. Similarly, there are no known features that have been demonstrated to clearly differentiate those with temporary shyness from those who suffer the more chronic pattern. Engfer (1993) examined conditions that increased or decreased shyness between birth and 6.3 years of age. Between these ages, 12 children showed substantial changes in shy behaviour. Six changed from the high-shy to low-shy classification, and six changed in the opposite direction (low to high shyness). Beidel &Turner (1999b) pointed out that there are three important aspects regarding the stability of shyness: First, not all of those who manifest early-onset shyness remain shy. Second, those who are not shy early on can develop shyness in later years. Finally, early-appearing shyness appears to be more predictive of later shyness in males than it does in females. One might speculate that socialization pattern differences between males and females could account for this difference.

Despite gender differences in stability, children who become shyer at 6.3 years were rated by their mothers as having been less soothable, as well as having had more problems with sleeping and eating during infancy. At 8 months, mothers rated them as moody and unhappy, and at 43 months as less socially competent. This latter finding is important because it suggests that shy children who are rated as more socially competent at an early age become less shy, perhaps as a result of their ability to interact appropriately with others.

Long-term prospective studies of identified adult outcomes of preadolescent shyness (Caspi, Elder, and Bem, 1988; Kerr, Lambert, & Bem, 1996; Caspi et al., 1988), the first in the USA and the second in Sweden, indicate that males who are shy as children

marriy later and become fathers at a later age than their non-shy peers. Shy boys also take longer to find an occupation that developes into a stable career.

Among girls, age of marriage and motherhood did not differentiate either the American or Swedish shy samples from their non-shy counterparts. Both American and Swedish women who were shy as children had lower levels of academic achievement than non-shy girls.

The long-term effects for shyness in girls were different but nonetheless evident. Shy girls followed a traditional life path, with marriage and motherhood at the same age as their non-shy peers. They were, however, less likely to work outside the home or to attend college, again indicative of a more traditional female role.

2.12. Summary: The current state of knowledge

Reaching an agreement on a common definition of shyness is difficult, because it has so many facets and can mean quite different thing to different people. So it is important to examine the subjective meaning that shyness has for the individual who suffers from it, as well as for those who identify them as shy. In the same time it is essential to acknowledge that shyness esxists as a continuum ranging from chronically shy person through those who are shy only in some situation to the shy exteroverts, who seem to be outgoing and sociable but may be feeling shy underneath.

The origins of shyness are complex and undoubtedly multiply determined through an interaction of genes, biology, and environment. There are evidences of the genetic/biological contribution to shyness. In the same time there are many significant

environmental influences. It is relevant to consider all aspects when dealing with causes of shyness.

Different theories can be used to explain shyness, three different approaches were discussed in this chapter. Emotional theories, which focused on the relationship between bodily changes and mental activity, anxiety theories; the psychodynamic approach, humanistic approach, and cognitive approach which regard shyness as either personal or situational. And theories that dealt with the distinctions between different kinds of shyness. However, the best and most useful way to consider the experience is through the meaning that an individual gives to his/her social interaction.

Shyness links with other psychiatric disorders such as social anxiety and social phobia because they all involve a level of social discomfort, self-monitoring in the presence of others, and desire to create a certain impression. It is obviously an overlap between shyness and other related states of social anxiety or discomfort. Psychologisits offer a range of very different ideas and theories about how shyness relates to other feelings of social anxiety. For example Buss (1980), who suggests that the common link between them is the feature of self-consciousness. He differentiates between public and private forms of self-awareness (the transient state of observing one's outward appearance and behaviour or personal feelings, respectively) and public and private self-consciousness (the trait or disposition towards feeling self-aware in either of these ways). Buss argues that there are two kinds of social anxiety: that based upon fear and distress about separation from significant others, and that relating to public self-selfawareness and the anticipation of negative evaluation by others. Van der Molen (1990) suggests that there are behavioural, cognitive and emotional components of shyness, including the feelings

of tension, inhibition and diffidence and the problem of not knowing how to act or what to say in certain situations and being unable to interact freely with others for fear of making the wrong impression.

Regardless of the apparent simplicity of the concept and its pervasiveness in everyday life, scientific investigation of shyness shows it to be a complex topic and a very painful feeling for those who suffer from it.

Chapter Three: Measurement and Intervention

I want to live in the world
Not behind some wall
I want to live in the world
Where I will hear if another voice should call
To the prisoner inside me
To the captive of my doubt
Who among his fantasies harbors a dream of breaking out.

L.N.
2002

3.1. Overview

Shyness overlaps other kinds of anxiety, for example, social anxiety, sociability, audience anxiety, and fear of negative evaluation. Many people may consider themselves shy, but are they shy or do they suffer from other kinds of anxiety? To determine a person's condition, two things have to be done. First, an assessment needs to be made with the person and/or his/her parents, teacher, peers, to determine whether he/she suffers from shyness; second, it is necessary to measure how shy he/she is. Then an intervention can be planned. This chapter is divided into two sections: the first section looks at well-known scales to measure shyness, while the second section is concerned with intervention.

3.2. Measurement of Shyness

Human behaviour is the product of at least two interacting factors: characteristic predispositions of the individual (traits), and situational constraints on behaviour at a given time (states). Individual traits are relatively enduring over time, whereas states

are highly variable. Shyness can be measured by self-report, observer rating, or physiological arousal at either a trait or state level. However, the three measurement approaches are not equally useful for all purposes or at all levels. The primary thing to be determined before selecting or constructing a measure is what one wants to measure. The three primary options available are physiological arousal, behavioural disruption, and cognitive comfort or discomfort (McCroskey, 1986).

3.2.1. Physiological measures

If one wishes to measure physiological arousal, the many instruments that record indicants or physiological arousal are the obvious and correct choice. The case for such measures appears strong, at least on the surface. Physiological responses are hard to fake, and the instruments, if handled by competent professionals, are not as subject to such human frailties as demand characteristics and experimenter biases as are other instruments. However, there are many pitfalls in the use of such instruments. Few scientists and even fewer teachers are trained in the appropriate use of the technology involved. This equipment in the hands of the untrained individual is useless and very likely to lead to false knowledge claims that are difficult to identify in research reports. In addition, use of such instruments for screening large numbers of students would seldom be economically or strategically feasible. Finally, many issues are not yet settled, even among the experts, on how such data may be analysed and interpreted.

3.2.2. Behavioural observation

Behavioural observation is probably the most valid and useful approach to measurement. Predispositional and physiological arousal factors are only marginally related to this construct. Thus, whether one is interested in a general trait of shyness or

competence in a specific state setting, observed behaviour is the only indicant with strong face validity. The way people might prefer to behave, and the way they actually behave, often have little relationship to each other, although it would be reasonable to expect to observe at least a modest relationship, if enough observations of each are made.

Behavioural observation is useful for some measurement purposes but it should not regularly be the measure of choice. It has several limitations that may force its rejection for some purposes. It is often, although not always, an intrusive approach to measurement. The observer may, and often does, alter the behaviour being observed. This is particularly true in dyadic and small group communication settings, but can apply to any setting. One method advocated for overcoming this problem is the use of video recording. However, as one who has carefully debriefed subjects who knew they were being videotaped, this is only a "better than nothing" improvement. Intrusion is still there. Secret videotaping, which could overcome this concern, raises serious ethical questions that may make its use inappropriate.

The most difficult problem for the researcher considering the use of behavioural observation is the determination of what behaviour is to be observed. For example, if reticence is the reverse of communication competence, what behaviours shall be taken as evidence of reticence? Field psychologists are far from complete agreement about the nature of so-called "competent" communication. They simply have not yet come to agreement on the set of behaviours that will operationally define this construct. Some believe it will never happen. But it is most useful for assessing states and least useful for assessing traits. This is not inherent in the technology of the method, but is a function of the limitation on the practical application of the method.

Behavioural observation is highly time-consuming and expensive in most instances. It is usually difficult to apply appropriately, even to assess states, because resources typically are more limited than would be desirable. To assess traits requires extensive observation across many settings to generate valid data. Resources are seldom available for such careful observation (McCroskey, 1986).

3.2.3. Self-report

The most widely employed approach to measure shyness is self-report scales. Many people argue that the best way to find out something about someone is simply to ask him /her. McCrosky (1986) said that he could not argue with that logic, except to point out that it is true only if the person knows the answer and if the person is willing to tell the truth.

Self-report measures are most appropriate when they are directed toward matters of affect and/or perception in circumstances in which the respondent has no reason to fear negative consequences from any answer given. They are least useful when they are directed toward matters of fact that may be unknown or unknowable by the respondent. For research involving the constructs of shyness, willingness to communicate, communication apprehension, and self-perceived communication competence, these distinctions are critical to the decision on selection of this type of measure.

The decision to use self-report scales for measuring shyness should be based on two considerations: (a) does the self-report measure have a substantial case for validity compared to observer ratings? And (b) is it practically feasible to use observer ratings as an alternative? (McCrosky, 1986).

3.2.3.1. Shyness Scales

As seen in the previous chapter, Shyness has often been used synonymously with social anxiety. Only a few studies have been published in relation to shyness and social anxiety measures, Pilkonis (1977b) and Harvey (1988). The results of their studies indicated that the shyness and social anxiety scales measure the same construct, which may confirm shyness as a form of social anxiety.

A package of psychometric measures was used at an anxiety disorders clinic that included the Retrospective Self-Report of behavioural inhibition, and the Cheek and Buss Shyness Scale. It was found that behavioural inhibition scale correlated with the shyness scale ($r = 0.48$). When the two subscales of the inhibition scale were correlated with the shyness scale, it was found that the social fears subscale correlated ($r = 0.51$), whereas the non-social fears/illness subscale only correlated ($r = 0.32$). Therefore, those who scored higher on the shyness scale also scored higher on the social fears subscale of the behavioural inhibition scale. This provides some evidence of the relationship between inhibition and anxiety in shyness (Nelson, 2001).

Leary (1991) presented ten popular scales used in research for social anxiety, shyness, and related constructs. He referred to all of them as measures of social anxiety. In addition, he categorized the scales into two groups: (1) those that measure social anxiety as a simply subjective phenomenon; and (2) those that measure social anxiety as both a subjective and a behavioural phenomenon. Although each scale contains very different item content, they correlate moderately to highly with one another (Jones, Briggs, and Smith, 1986; Leary, 1983).

Shyness can be measured using a single scale, for example, the Interaction Anxiousness Scale exceptional psychometric characteristics. They show stability over time as measured by test-retest correlations. Also they provide an important perspective for the study of the construct of shyness. Shyness measures seem to be well balanced in terms of internal consistency and validity; their level of specificity leads to fidelity on the one hand without sacrificing bandwidth on the other. In practical terms, the overall quality of the shyness measures and their considerable overlap implies that the various scales are for the most part interchangeable.

In short, past research of shyness shows that it has many distinctive features, including anxiety and behavioural inhibition. According to Nelson (2001), it has not been shown that shyness can stand alone as a completely unique personality construct. From the few studies that have been conducted the shyness and social anxiety scales correlate highly with each other and it has not yet been shown that they measure different constructs. Thus, shyness may be viewed as a form of social anxiety, or as falling somewhere on a social anxiety continuum. But Jones, Briggs and Smith's (1986) review of one thousand and eighty- seven studies suggests that the shyness measures were valid, reliable, and empirically distinct from measures of related constructs.

Table 5 listes some welknown shyness scales.

Table 5 A Summary of some shyness scales

Name	Author and date	No.of items	Aspects to measure
Interaction Anxiousness Scale	Leary (1983)	15	Affective component of shyness
Social Reticence Scale	Jones and Russell (1982)	22	Cognition and emotion
Shyness Scale	Cheek and Buss (1981)	9	Emotion and behaviour
Shyness Avoidance and Distress Scale Fear of negative Evaluation	Watson and Friend (1969)	28 30	Social evaluation anxiety Evaluation apprehension
McCroskey Shyness Scale	McCroskey, et al (1981)	14	Behaviour
The Personal Report of Communication Apprehension	McCroskey (1970)	24	Emotion and behaviour
Morris Shyness Inventory	Morris (1984)	14	Discomfort in the presence of others
The Adjective Check List for the Shy People:- Shy-Positive Scale Shy-Negative Scale Shy-Balanced Scale	Gough and Thorne (1983)	66 22 22 22	Description of oneself
The Shyness Situation Measure	Jones et al (1985)	20	Level of shyness

3.3. Shyness intervention

Most people cope with their worst social fears in one of two ways: They fight them or they avoid them. Fighters look for opportunities to enter their feared situations. They take public speaking classes, approach people they fear, and hope that practice will lessen their anxiety. Their efforts often succeed. Unfortunately, practice alone does not always make perfect when it comes to conquering social anxiety. When practice leads

to the same old anxiety symptoms again and again, the results are dispiriting. Avoiders try to cut their losses by opting out of their feared situations. They have found that discretion is the greater part of valour. These escape artists manage to hold anxiety at bay until the next time, but at a price of building their lives around avoiding embarrassment. They sacrifice some of the relations they want the most in order to avoid the anxiety that comes with being around people. But they cannot avoid all of the people all of the time. Either way, many people, having been unable to change, come to the erroneous conclusion that they cannot change. Depressed, some let their life aspirations fizzle out, or they rationalise that they never really wanted those social activities anyway. But people with social phobia can make changes and usually do change when they use the right techniques (Schneier and Welkowitz, 1996).

Numerous techniques for treatment of shyness have been developed. Existing treatments generally include exposing the individual to feared situations, anxiety management and/or coping skills training, cognitive restructuring for negative thoughts, communication exercises, relaxation training, and social skills training (Henderson and Zimbardo, 1999). Research has been conducted to test the effectiveness of many of these techniques. No intervention has been found to be useful for every shy individual (Nelson, 2001).

According to Pilkonis (1986) shyness has been treated most frequently with individual therapies. Depending on the underlying model of shyness, the therapies have varied, but they can be characterized broadly as fitting into one of three groups: (a) relaxation and desensitization therapies aimed at alleviating anxiety and disinhibiting behaviours that are a part of the patient's repertoire but that the patient is unable to perform easily;

(b) behavioural therapies designed to enhance social skills that are not yet within the patient's capability; and (c) cognitive therapies aimed at restructuring the patient's negative self-image and expectancies in social situations. "The typical paradigm has been to develop and implement such therapies in individual treatments. When group work has been done, it is usually employed for reasons of efficiency (i.e., it is more cost-effective to teach several individuals together rather than separately)" (Pilkonis, 1986, p375)

There are many causes for shyness. One should try to establish what caused the original pattern of behaviour; is it a humiliation in school or lack of social skills. A shy individual cannot change the past but can change the present and the future. With some, establishing the source of shyness is half the battle. It may help to figure out where the problem started, and start being logical about handling it.

Many people will not admit that there is any problem at all. Breaking through denial is an essential part of beginning to treat any kind of problems. To deny the problem is to enable it to continue. Parents are often actively in denial, even though their child's patterns of social anxiety are striking. Typically, parents of young children or teens will respond in the following way: The mother is sure there is a problem, while the father says simply, "I was shy as a child too, and I grew out of it." Or one parent will not even acknowledge the problem exists at all. The reality, however, is that the child or adolescent is truly suffering from anxiety. The sooner intervention and self-help strategies are put into place, the better the prognosis. Later in life, anxiety can be too old a habit to break, which is a tragedy for all concerned (Pilkonis, 1986, p.256).

3.3.1. Cognitive Therapy

Many researchers have studied the treatment of shyness from a cognitive perspective (Wassmer, 1978; Glass and Shea, 1986; Carducci, 1999; Henderson and Zimbardo, 1999). They believe negative self-evaluation, faulty attributions, disordered thinking, unrealistic expectations, irrational beliefs, and a negative internal dialogue of thoughts and images play an important role in the development of shyness. Their research has attempted to classify shyness as a problem of distorted thinking rather than one of deficient skills. Glass and Shea (1986) worked with several researchers and developed a Shyness Program for shy adults. In their year of study they found that only 10-20% had a deficit in social skills (Amkoff, Glass, McKain, Shea, and Greenberg, 1984; Glass and Furlong, 1984). For the majority of the participants, however, shyness seemed more of a self-confidence issue, involving highly negative self-evaluation and expectations. Thus, cognitive therapy for shyness has been designed to focus specifically on changing such negative self-evaluations (Nelson, 2001).

Cognitive therapists like Glass and Shea (1986) help their clients to understand that their irrational beliefs, expectations, and negative thoughts mediate their maladaptive affective reactions. The focus is directed at modifying clients' distorted, self-defeating, cognitions and replacing them with more adaptive ways of thinking (Goldfired,1979), in order to produce cognitive, behavioural, and affective change. Treatment is generally brief, problem oriented, time limited, directed by the therapist and is based on a collaborative effort between the therapist and client (Beck, Shaw, Rush & Emery, 1979).

Flooding or exposure is the oldest of cognitive behavioural techniques. Exposure therapies are based on the concept that phobic avoidance leads to temporary anxiety relief that serves to reinforce avoidance behaviour. When prolonged exposure to the phobic situation is substituted for avoidance, anxiety reduction ensues within the phobic setting, attenuating the anxiety-avoidance cycle. The roots of the technique lie in the acquisition and extinction of avoidance responses in animals (Solomon, Kamin, & Wynn, 1953) and its primary theoretical underpinning is the extinction of conditioned anxiety. It has been used to reduce fear and anxiety. (Boulougouris & Marks, 1969), (Malleson, 1959). Procedurally, the technique involves forced exposure of a fearful individual to realistic, anxiety-provoking stimuli while not permitting the client to avoid these stimuli. It differs from desensitization, a more commonly used conditioned anxiety technique, by not including a systematic, graded hierarchy of stimuli, and by not having the client engage in an explicit competing activity, such as relaxation (Davison & Wilson, 1972). Although one can imagine the situation, superior results have generally been obtained when in vivo procedures are used by exposing clients to real-life feared objects (Emmelkamp and Wessels, 1975). A number of clinicians assert that the exposure factor is the single most active ingredient common to all behavioural therapy treatments (Boyd and Levis, 1983; Mavissakalian and Michelson, 1983; Meyer, Robertson and Tatlow,1975; Kandel, Ayllon, & Rosenbaum, 1977,).

Most programmes designed to decrease shyness and social anxiety involve exposure to feared situations. There is considerable evidence that exposure to feared situations is a key ingredient in overcoming social anxiety (Barlow, 1988; Marks, 1987). Programmes that emphasize exposure help the client maintain contact with feared cues until anxiety decreases (habituation occurs). Marks (1987) argued that most clients can successfully carry out live self-exposure without a counsellor especially if the exposure is

systematized with the aid of a manual and diary. When investigators compared self-exposure with the aid of a self-help book (Marks, 1978) with treatment by both a psychiatrist and a computer, they found that all groups improved markedly and equally for up to 6 months after follow-up (Ghosh & Marks, 1987). Response-induction aids designed to help clients initiate and complete exposure programmes included keeping a diary to record self-exposure homework and guidance by a manual. The acquired nature of social anxiety, as well as the rationale for exposure, is reviewed in this approach. Other aids included carrying out exposure in small, manageable bits, trying difficult tasks briefly at first, engaging in rather dissociation from the task, varying tasks until fear decreased in response to all relevant cues, and fading out aids as confidence and competence was acquired. Problems that may arise with assignments in real-life setting include the unpredictability of most social situations, the brevity of some social exchanges, and the lack of clear feedback about other people's reactions (Butler, 1985).

In conjunction with their Shyness Program research, Glass and Shea (1986) have run almost a dozen group treatments that were either exclusively cognitive in nature or that involved a combination of cognitive restructuring and social skills training. Their programme, like most other examples of cognitive therapy for social anxiety was carried out in groups format. Methods for helping clients are (a) adopt the cognitive rationale; (b) recognize the irrationality of certain beliefs; (c) become aware of their own thoughts and beliefs; (d) learn to dispute and challenge these negative, unrealistic self-statements and irrational beliefs; (e) begin to analyse faulty logic; and (f) develop facilitative coping self-statements and more rational interpretations or beliefs.

However, as Arnkoff (1981) points out, cognitive therapy need not be restricted to cognitive theories. Behavioural or gestalt methods can, for example, be part of cognitive therapy if such procedures are conceptualized in a cognitive way.

Research in cognitive therapy for shyness has produced conflicting results. Many studies found that cognitive therapy, or a combination of cognitive therapy and social skills training, is more effective than social skills training alone (Elder, Edelstein, and Fremouw, 1981; Glass, Gottman, and Shmurak, 1976; Gormally, Varvil-Weld, Raphael, and Sipps, 1981; Pipes, 1982; Tiegerman and Kassinove, 1977; Omar, 1993).

Glass, Gottman, and Shmurak (1976) randomly assigned 61 male students to one of six groups: response-acquisition training; cognitive self-statement modification training; combined response-acquisition/cognitive-modification training; waiting-list control; enhanced response-acquisition; or enhanced cognitive self-statement modification (the last two groups were added to control for the longer training time of the combined treatment group). Subjects first attended a 90-minute session with other men in their respective treatment groups. The tape presented an introduction to dating problems and gave an example of a typical session for that treatment. Then each subject attended three or four 60-minute training sessions individually with a counsellor. Subjects were assessed using a Dating Behaviour Assessment Test (DBAT). The DBAT consisted of the 11 problem situations included in the first 90-minute session, plus 13 additional non-training situations. After a description of each situation subjects were asked to role-play a response. Responses were rated from 0 to 2 according to specific adequacy criteria for each situation derived from judges' rationales for competency. Phone-call assessment measures were also used. Subjects were asked to call two women and practise getting to know them. Then the women were asked to rate the men on their

skilfulness. Findings were based on a comparison of pre-treatment and post-treatment scores on the DBAT and the number of phone calls. From these results the researchers found significant effects for response acquisition, cognitive self-statement modification and the response-acquisition/cognitive-modification interaction, regardless of length of training. However, subjects trained in cognitive self-statement modification showed significantly better performance in role-play situations for which they were not trained, made significantly more phone calls, and made a significantly better impression on the women than subjects in other groups.

Stravynski, Marks, and Yule (1982) reported contradictory findings. These researchers found that the addition of cognitive therapy did not enhance patient' treatment outcome. The researchers divided 22 subjects into a group of socially anxious patients treated with social skills training solely to a group treated with a combination of social skills training and cognitive therapy. The design of the social skills training group was to provide the subject with instruction, modelling, role rehearsal, and feedback for each social situation. Also, the subjects were required to self-monitor their progress and complete homework assignments relevant to each treatment session. The design of the social skills training and cognitive therapy group included all the techniques of the social skills plus cognitive modification. Subjects in each group participated in eight treatment sessions. Assessment of each subject was based on self-monitoring diaries, self-report questionnaires and by structured clinical interviews. The self-report questionnaires used were the Social Avoidance and Distress Scale, the Fear of Negative Evaluation scale, the Wakefield Depression Inventory, and the Irrational Beliefs test. The results showed that the social skills training group and the cognitive therapy combined with social skills training group both produced improvement to the same extent on all measures (Nelson, 2001).

Schneier and Welkowitz (1996) recognise the influence of thinking patterns on social behaviour-irrational fears of public speaking obviously will lead to an avoidance of public speaking. Less obviously, they recognise the influence of behaviour pattern on fearful thinking. Avoidance of public speaking prevents phobic persons from having the positive experiences necessary to disprove their worst fears, so it ends up reinforcing the very same fears. A therapy approach that attacks problematic thoughts and behaviours simultaneously can have synergistic benefits. Just as positive experiences can build confidence, negative experiences can increase fears. People with social fears often recall uncomfortable or even frightening experiences at certain social events

Wise et al. (1991) developed a systematic assertiveness training programme for adolescents, based on Bandura's social cognitive theory. The programme focused on peer interactions and social responsibility, consisted of six 40-minute semi-weekly sessions. The subjects were 42 sixth-grade students in two comparable social studies classes in a middle school. One class (13 boys and 9 girls) received the assertiveness training, and the other class (12 boys and 8 girls) served as the control group. Assessment of each subject was based on pre-test, post-test and follow-up-test each consisting of 26 questions, one question for each of the learning objectives covered in the assertiveness training. All test questions were multiple-choice, with one correct answer and three incorrect distracters. The pre-test and follow-up were identical, and the post-test was matched question-for-question with these tests in terms of content and difficulty level. Trained students performed significantly better than a control group on the post-test and on the 6-month follow-up (students scored an average of 85% on the post-test and 72% on the follow-up).

Cognitive therapy alone may not be equally effective for all clients, especially those with social skills deficits. Although reducing anxiety and avoidance in social situations using cognitive approach may lead to more frequent interactions and thus a chance to learn new social skills, perhaps some clients would benefit from a more direct approach, teaching them what to do in various social situations.

Thus, social skills training is often incorporated into cognitive therapy. Arnkoff et al. (1984) combined cognitive therapy with behavioural interventions in order to study the effectiveness of each treatment. These researchers conducted three eight-session groups that began with social skills training and then moved on to cognitive restructuring. The programme also included three groups that began with cognitive restructuring and then moved on to social skills training. The researchers found no significant differences in outcome for clients in either group.

In one of the first cognitive therapy outcome studies, Glass et al., (1976) found that self-statement modification, social skills training, and a combined treatment all increased social skills in practised role-play situations, but heterosocially anxious college men who had received the cognitive component demonstrated significantly better performance on untrained situations. Because the cognitive self-statement modification group also made significantly more phone calls during assessment and made better impressions on the women called, cognitive therapy was useful for achieving generalization to new situations.

Gormally et al. (1981) used a similar design, and found cognitive counselling, skills training, and a cognitive/behavioural combination to be equally effective for minimally

dating college men in producing changes on measure of social behaviour, dating, self-confidence, maladaptive thoughts, and irrational beliefs. Cognitive counselling produced the greatest changes on a measure of negative expectancies. Tiegerman and Kassinove (1977) conducted a similar study with socially anxious student volunteers. Although the cognitive-rational therapy was most effective in increasing assertive behaviour, only the assertiveness training and combined treatment proved helpful in reducing social anxiety. In a slightly different type of approach, Schever and Gutsch (1983) investigated the effects of self-administered cognitive therapy (bibliotherapy) for socially anxious college students. Both cognitive and attention-placebo group showed equivalent reductions in shyness, state and trait anxiety, and maladaptive thoughts compared to no-contact controls.

Consideration of individual differences among clients may be an important focus in deciding how best to combine treatment approaches. Thus, Paul's (1967, p.111) famous statement of the outcome question, "What treatment, by whom, is effective for this individual with that specific problem, and under which set of circumstances" is just as important today in considering cognitive therapy for shyness as it was 34 years ago.

One needs to look at each client's cognitive and social skills deficits prior to therapy, as well as at what Glass and Arnkoff (1982) have called the client's predispositions for various methods. One such predisposition might be clients' comfort and familiarity with procedures that are similar to those used in therapy. Some individuals would be highly introspective, regularly examining thoughts and feelings, whereas others would find this new. Others may already be adept at observing others as models, providing self-reinforcement, and believe that "practice makes perfect." Additional

predispositions include clients' expectancies and goals for what will go on in therapy, and their own implicit theory of why they are shy. Those persons with a more cognitive predisposition can be matched to an intervention that would begin with cognitive techniques, making use of the client's preferred style, and then in later stages helped to work in uncomfortable or unfamiliar behavioural modes to learn new competencies. The opposite would be true for the client with a predisposition towards a more behavioural approach (Arnkoff et al., 1984).

Stravynski, Marks, and Yule (1982) examined the contribution of the cognitive component with a sample of socially anxious outpatients. They found that both social skills training and a combination of social skills plus cognitive modification were equally effective in reducing social anxiety and increasing social skill, suggesting that the addition of cognitive modification did not enhance outcome. Contrary to Stravynski et al.'s (1982) findings, Pipes (1982) found that shy male students achieved significantly greater reductions in social anxiety and increases in self-esteem with a combination treatment (anxiety management training and response practice) than with a response practice condition alone or no treatment. Interesting, the shy women in the study appeared to profit less from the combined strategy than did male subjects (Glass & Shea, 1986).

3.3.2. Social Skills Training

Social skills training represents a second related clinical approach for treating social anxiety problems. This approach assumes that shy individuals lack sufficient or appropriate social skills and it includes a variety of specific techniques such as modelling, behaviour rehearsal, shaping, and in vivo practice (Curran, 1979) to change

this state of affairs. The primary change strategy shared by all such techniques is behaviour rehearsal, a procedure in which a client practises new skills and receives feedback in simulated situations (Galassi and Galassi, 1979). The therapist generally instructs the patient about target behaviours and demonstrates them, the patient rehearses the behaviour in role-play with feedback from the therapist, and the patient practises the new behaviours in situations outside the therapy session until goals are achieved. Intervention may be offered individually or in a group setting.

Leary (1983) has suggested that this general skills deficit approach may not explain all instances of shyness, however, because not all individuals with social anxiety possess a skills deficit. Moreover, there are also others who lack such skills but who do not report feeling particularly apprehensive or anxious. Even so, Jones, Hobbs, & Hockenbury (1982) have demonstrated that lonely college students display a particular conversational skill deficit (i.e., giving appropriate partner attention), and that when subjects are subsequently trained to improve this skill, a significant reduction in loneliness occurs. Other studies have also demonstrated that social skills training procedures can improve friendship patterns among socially isolated children (Oden & Asher, 1977), enhance social skills in schizophrenic patients (Finch & Wallace, 1977), and reduce anxiety and/or change the behavior of minimal daters (Twentyman & Zimering, 1979). These techniques differ from flooding and the self-perception technique in that they require a client overtly to practise responses with a model who, in turn, provides the subject with direct, positive and negative feedback concerning the effectiveness of his or her behavior. Additionally, these training techniques are normally carried out with a therapist or other subjects in obviously simulated situations that are under the direct supervision of the therapist (Galassi & Galassi, 1979; Twentyman & Zimering, 1979).

Social skills training has been found to be more effective than relaxation training in enhancing dating skills of clients with developmental disabilities (Mueser, Valenti-Hein, & Yarnold, 1987). Some studies combined social skills training, exposure, and modification of self-statements. Some studies have found an enhanced effect when graduated exposure and social skills training are combined (Cappe and Alden, 1986). Elder, Edelstein, and Fremouw's (1981) treatment-outcome studies and behavioural comparisons of functional and dysfunctional populations do not provide strong support for skill-deficit formulations. Resent research suggests that skills training procedures require modification. When one examines skill training from a clinical perspective, several shortcomings emerge:

First, most published studies assess or teach the behaviours such as eye contact, voice volume, etc., as component skills that is, specific behaviours performed without conscious monitoring, but Trower (1980) emphasizes that social interaction is a fluid ongoing process requiring monitoring, of the other person's behaviour and synchronization of one's own behaviour with that of one's partner. Studies by Trower (1980) and Fischetti, Curran, & Wessberg (1977) suggest that socially dysfunctional individuals either do not monitor the other's behaviour as well as socially skilled individuals, or do not understand how or when to respond so as to maintain the smooth flow of the interaction.

Second, the behaviours commonly taught might also be called discrete, or molecular, in that they involve but one or two aspects of an individual's social behaviour or one or two social situations. The shy, dysfunctional individual is not provided with a global strategy for approaching interactions. The third concern with skills training is that it

conveys the notion that social interactions are performances in which the client should be careful to display "appropriate" behaviours. But one should be more concerned about supportive relationships, which is generally believed to involve factors like sensitivity to others, mutual self-disclosure, and respect.

Finally, during skills training the client is generally asked to make specific changes in his/her behaviour and to monitor and to evaluate those changes, a process that directs the client's attention to the client's own performance. However, self-focused attention and evaluation may be precisely the shy individual's problem. It may be that treatment techniques that involve self-focused attention contribute to, or, at least, are not the most effective means of alleviating, the dysfunctional individual's disruptive self-focus.

Montgomery and Haemmerlie ((1986) suggested that social skills training programmes may succeed not because of reinforcement, modelling, or shaping of behaviour and instructions, but rather because participants are offered appropriate behaviour. Positively biased interactions involve exposure to feared situations as well as vicarious modelling opportunities i.e., watching how others act.

3.3.3. Treatment based on Self-Perception Theory

According to Bem (1967, 1972), people come to know their emotions, attitudes, and other internal states by inferring them from observations of their own behaviour. Bem's theory views the person as forming attitudes, cognitions, and emotional responses in much the same way an external observer might infer the person's attitudes. One knows what one believes or feels based on how one behaves.

Self-perception theory suggests that an increase in approach behaviour and/or a decrease in avoidance behaviour might cause a decrease in perceived anxiety. The traditional approach may assume that an individual does not engage in social interactions because of a lack of requisite skills or because of a negative attitude or emotional state, while self-perception theory suggests that individuals may perceive that they are shy (i.e., do not have social skills and/or have a negative attitude or emotional state) because they do not engage in social interactions (Haemmerlie and Montgomery, 1986).

The decision to use self-perception theory for the treatment of shyness arose when a clinical psychologist found that traditional treatment methods (e.g., supportive therapy, desensitisation, and rational emotive therapy) were not very useful with shy clients. However, in between sessions, homework was given that required clients to engage in different social interactions in the real world. These homework assignments helped many clients become less shy. Thus, the idea was formed that the most direct way of helping shy clients would be to have them talk to several strangers under pleasant, carefully prearranged conditions (Nelson, 2001).

Treatment for shyness based on self-perception theory would simply involve arranging a series of purposefully biased social interactions in which the individuals would appear to themselves to have performed competently as a function of their own behaviour and ability and not as a function of environmental constraints (Haemmerlie and Montgomery, 1986). The goal would be that clients eventually see themselves as adept in social interaction and as not having problem with shyness.

Three studies were conducted to test the effectiveness of self-perception theory in the treatment of shyness (Haemmerlie and Montgomery, 1982, and 1984, Haemmerlie, 1983). In the first study (Haemmerlie & Montgomery, 1982), heterosocially anxious, low-frequency-dating male subjects were not even aware that their anxiety was being treated. Instead they believed themselves to be in a psychology experiment investigating the nature of dyadic interaction processes. A significant reduction in heterosocial anxiety did occur, however, and on a variety of measures, including Rehm & Marston's (1968) Situation Questionnaire, Watson & Friend's (1969) Fear of Negative Evaluation and Social Avoidance and Distress Scales, the State Anxiety Inventory of Speilberger, Gorsuch, & Lushene (1970); the number of conversation initiations by a subject in a conversation period; and the number of personal statements uttered by a subject in a conversation period. Moreover, a follow-up six months later indicated that following the intervention a significant increase in dating frequency had occurred and that the reduced levels of anxiety were fairly permanent.

In the second study (Haemmerli & Montgomery, 1983), the subjects were heterosocially anxious females and expectancy of treatment outcome was manipulated. Again, the intervention (this time with male assistants) produced significant changes on a variety of measures (i.e., the Situation Questionnaire and State Anxiety Inventory, the percentage of conversational silences in a conversation period, and ratings by interaction assistants of the subjects' anxiety level). In addition, the treatment technique was not susceptible to expectancy of therapeutic outcome. In the third study (Haemmerli & Montgomery, 1984), with heterosocially anxious males as subjects, expectancy of treatment outcome was manipulated and the efficacy of the treatment was

compared to an imagined exposure treatment condition. The treatment based on self-perception theory effectively reduced anxiety on a number of measures (e.g., the Situation Questionnaire and State Anxiety Inventory; digit span backwards, a behavioural task). In the imagined exposure treatment, on the other hand, expectancy of outcome did have a significant effect, and the treatment had little impact when subjects did not believe that it would help them (Haemmerli and Montgomery, 1986).

Treatment was highly effective with males and females on a variety of measures. In the first study a 6-month follow-up indicated the effect to be fairly permanent. The treatment appeared to be susceptible to expectancy of treatment outcome effects and it was clearly superior to an imagined exposure treatment technique. Finally, in all three studies, participants found the treatment of interest to be highly enjoyable. None of the subjects expressed suspicion that the interaction assistants had been prompted to be positive towards them. Moreover, even when told of this aspect of the experiment at a later time, it seemed of little interest to them; they had enjoyed the interactions and felt good about having done well in them. Moreover, many spontaneously expressed an interest in participating in future projects of this nature that might be available. Several also indicated an interest (though disallowed) in possible future interactions with particular interaction assistants whom they had met in the various sessions.

Consistent with Bem's theory, these studies suggested that the number of visible external constraints could be a very important ingredient not only with this particular treatment, but also in many other therapeutic interventions. Furthermore, the effect of visible external constraints might be in the direction opposite to that believed to exist by many therapists. Most startling in these three studies was that a reduction of anxiety

occurred in the absence of the therapist or a truly obvious therapeutic agent. Instead, the agent of change was the subject's own behaviour as elicited by a group of minimally trained undergraduates in a setting resembling real life.

The implications of this are twofold. First, a powerful intervention technique was provided when subjects focused on the successful performance of behaviours related to their specific individual problem area. As suggested by Heider (1958), the behaviour engulfed the perceiver's view of the social context in which it occurred. Second, the interesting possibility was raised that when an individual's focus was on their own performance or behaviour, maximally effective results could be obtained if the therapeutic aspects of the treatment package and setting were downplayed. Otherwise, as suggested by Bandura (1977) and Meichenbaum (1977), and consistent with Bem's (1972) theory, success experiences might be attributed to the therapist, the setting, or the treatment package, and this in turn could lessen the overall effectiveness of the intervention (Haemmerli and Montgomery, 1982).

Haemmerli and Montgomery (1986) identified some resemblance of the other clinical methods of treatment. Although self-perception theory represents a departure from the more common treatments techniques known as flooding, social skills training, real life practice, and cognitive therapy, there is some similarity. Flooding may be effective because of the extinction of conditioned anxiety or an avoidance response. Self-perception theorists suggest that any improvement may also be due to the fact that a client's self-perceptions are also altered (Nelson, 2001).

The self-perception approach to helping shy individuals overcome their problem has a number of positive features associated with it. First, it is a relatively inexpensive and easy to administer technique that can be given to a large number of individuals at one time. It does not involve a large amount of therapist time and skill and can be easily administered and monitored by a minimally trained undergraduate assistant. Furthermore, it appears to be a relatively short-term treatment procedure. Lastly, it is consistent with a great deal of previous research in experimental and applied social psychology and appears to include a number of the components found in several of the clinical procedures that have been previously demonstrated to be effective. In fact, from the perspective of self-perception theory, a single explanation might be advanced as to why almost all the procedures surveyed appear to work. Perhaps the technique used is not nearly as important as providing any procedure that systematically helps people to initiate successful behaviour in situations that were previously avoided. Stated more boldly, it is quite likely that nothing succeeds like success, and the perception of that success, in an area where one has previously been unsuccessful.

On the negative side, in some circumstances it may be hard to arrange realistic, natural interactions and to unobtrusively positively bias them. Although Haemmerli and Montgomery (1986) were initially concerned about how the interaction assistants might perform, it turned out that, in fact, a minimum amount of prompting was quite effective in getting them to emit the appropriate positive behaviours that in turn elicited positive, effective interaction behaviours from the subjects. Nevertheless, the careful selection of the research/ therapy assistant and the interaction assistants could be an important factor in the effectiveness of the procedure. Another problem is that, theoretically, the actual mechanism(s) of change in this technique are difficult to tease out. In this regard, it seems that it may be problematic to isolate empirically the in vivo exposure, practice,

and self-observation components of this procedure, given that all occur simultaneously in life.

There is little research concerning the effectiveness of self-perception theory and the treatment of shyness. However, as mentioned earlier, self-perception theorists argue that it is useful for treating shyness because it is inexpensive, easy to administer to a large number of individuals at one time, does not involve a large amount of therapist time or skill and can be administered by a minimally trained clinical assistant (Nelson,2001).

3.3.4. Interpersonal Process Training

After several years of clinical experience, Alden and Cappe (1986) became interested in whether anxiety-generating self-consciousness could be modified by providing shy persons with social strategies that require that they redirect their attention to the person with whom they are interacting. They addressed two major explanations of treatment change: the skills-augmentation position, which suggests that improvement occurs because the client learns new behavioural skills, and the counter-conditioning position, which argues that shyness is due to anxiety and that improvement occurs when this anxicty is in some way neutralized.

The process leading to behavioural inhibition and anxiety involves constant self-observation and evaluation. Researchers hypothesized that anxiety-generating observations could be modified by providing shy individuals with strategies that would help them redirect their attention to the person with whom they are interacting. The treatment strategy developed for interpersonal process training had the following four goals: (a) to increase the client's social monitoring skills; (b) to provide the client with a strategy for developing intimate relationships; (c) to provide the shy client with a social

perspective that recognize the importance of factors such as respect and sensitivity, rather than performance; and (d) to enable the client to focus attention on the other person. The foundation of the treatment involved four skills: active listening, empathic responding, communicating respect for the other's opinion, and self-disclosure which looks like client-centred counselling (Rogers, 1957). During the treatment programme, clients are first taught relaxation techniques first. Second, clients identify specific social situations that are problematic for them and organize them into a hierarchy in terms of the level of fear each situation produces. Third, interaction skills are introduced and discussed. Finally, clients select social situations to encounter in vivo and practise using the social skills.

Alden and Cappe (1986) provide the only published study concerning the effectiveness of interpersonal process training in treating shyness. They randomly assigned 54 clients to one of three conditions: interpersonal process training (IP), graduated exposure (GE), or waiting list control (WL). The GE condition involved all aspects of IP expect for the social skills training. Treatment effectiveness was evaluated using self-reported daily social activities, perceived comfort and skill, The UCLA Loneliness Scale, laboratory social interactions, therapist ratings, clinically significant life changes, subject treatment evaluations, and attentional focus. The researchers found that the subjects who received treatment improved more than the subjects in the WL group. More importantly, subjects in the IP group reported significantly more changes in their daily social activities than did subjects in the GE group. IP subjects reported participating more frequently in social activities, participating in more diverse social activities, and feeling more comfort in and satisfaction with their social encounters than did GE subjects. In a three-month follow-up interview, 82% of the IP subjects reported significant life

changes, such as joining a club or asking someone for a date, as opposed to 40% of the GE subjects. The researchers also assessed change in subject's attentional focus. Therapists rated self and other-focused verbal and nonverbal behaviours in sessions two and eight. Results showed that therapists rated IP subjects as conducting significantly increased other-focused verbal and nonverbal behaviour in comparison to GE subjects. However, when raters who watched videotapes of these sessions compared subjects, no differences were found between IP and GE subjects.

3.3.5. Homeopathy

Homeopathy, combined with some other techniques, creates an intensely dynamic healing process. Each therapy is powerful in its own right, but by integrating the therapies, the healing process is more effective and the shy person can progress more rapidly to a life devoid of irrational fear.

Crawford and Taylor (1997, p.67) define homeopathy as a "complete system of medicine that aims to promote natural health by reinforcing the body's own healing powers." Conventional medicine uses drugs which block the body's own responses to a condition and which suppress the elimination of toxins, disrupting the body's natural balance. Homeopathy, by contrast, works by correcting energy imbalances: minute doses of substances that are similar to the condition are used to 'match' the energy of the illness, thereby stimulating the body on healing energy. It is safe, non-toxic treatment that has no side effects. Improvement is fast, yet gentle, as remedies bring the body into balance.

Homeopathy also treats the patient on an emotional as well as physical level: everyone is unique and, as such, requires an individual remedy. There are many different

methods of prescribing homeopathy: the single-remedy prescribing, complex homeopathy, and the flower remedies. There are many homeopathic remedies such as Aconite, Willow, Sulphur, Thuja, and Hyoscyamus. It is important to put in mind that symptoms of the same ailment are quite often radically different in two different people.

3.3.6. Social Fitness Training

The distinctive feature of Henderson and Zimbardo's (2001) treatment philosophy is the concept of social fitness. "Social Fitness, like physical fitness, is a state of physiological, behavioural, emotional, and mental conditioning that implies adaptive functioning and a sense of well-being."(p.435)

In their social fitness model, they address four domains of shyness: (1) behaviour, which is either inhibited or overactive; (2) physiological arousal, which is manifested in sweating, trembling, and increased heart rate; (3) maladaptive thinking patterns; and (4) negative emotions, such as embarrassment, shame, and guilt. After the initial evaluation is completed, which consists of at least three, and up to six, individual interviews, a 26-week programme of cognitive-behavioural treatment is followed.

The treatment techniques are designed to: increase clients' behavioural activity and fitness and to improve cognitive fitness which may be broken into modules for brief treatment.

Improving behavioural fitness includes 6 modules: (1) self-monitoring (clients practise challenging negative automatic thoughts, including attributions and negative self-beliefs); (2) behavioural fitness homework and self-rewards for workouts (clients set specific goals to enter feared situations and practise new behaviours); (3) telephone calls

(clients practice on the phone and practise forming acquaintances); (4) motivation and compliance with an optimal training schedule (clients do small things every day and tackle one or two bigger challenges each week); (5) interpersonal skill training (clients practise one skill a week, among them self-disclosure, empathic listening, trust building, handling criticism, constructive conflict resolution, and anger management); (6) empathy (clients understand that an inward focus on a painful emotional state tends to have a negative influence on one's perceptions of the self and others).

Improving mental fitness contains attributional and self-concept restructuring to enable clients to recognize the tendency to blame the self in the face of negative social outcomes and to challenge negative self-schemas that operate outside awareness.

3.3.7. Self-help programmes

Self-help programmes involving minimal counsellor contact are ideally suited for individuals who do not have extremely high levels of social anxiety, and who have the skills required to do well in social situations, and who are motivated to carry out recommended procedures. A class format offers a normalizing context for instruction. Analysis of pre-and post-questionnaires completed by men and women who participated in a course called "Taking Charge of Your Social Life," which consisted of 6 weekly 2-hour evening sessions, suggested that this format is effective in decreasing loneliness and shyness (Gambrill, 1993; Gambrill & Richey, 1988).

Weekly homework assignments provided an opportunity to identify and participate in activities of interest that also provided a context to meet people (e.g., volunteer work, a sport, or hobby). Although it is clear that many clients can benefit from a self-exposure

programme involving minimal therapist time, their failure to carry out recommended procedures is a key problem. The success of self-help programmes suggests the role of self-management skills as well as the importance of exposure to feared situations (Gambrill, 1996). There are many books and articles that offer self-help programmes. Examples of these programmes are: the Zimbardo and Radl 90-day Programme, the Berent and Lemley's five-step programme, and Rapee's programme.

3.3.7.1. Zimbardo and Radl 90-day Programme

Zimbardo and Radl (1979) designed a workbook that provided some basic tools to help shy people demolish the constraints shyness imposes on them. The workbook contains seven chapters, each chapter is divided into many exercises that were formatted in order to help the shy person to be active in controlling as much of his/her life as possible.

In chapter (1) the user of the book learns from the information a little about shyness by being an active reader, and from the questionnaire he/she measures his/her level of shyness. In chapter (2) the focus is on the person who is reading the book. The rest of the book contains interesting activities, the user is advised to do at least one every day. Some exercises are easy, some require a lot of work, some are solitary ones, while others force the person to go out into the public arena to confront real people. The book encourages the user to be creative and modify the exercises to make them fit his/her particular circumstances.

3.3.7.2. Berent and Lemley's five-step programme

Berent and Lemley (1994) believe that anxiety does not exist to control people. People exist to control it. Using it properly may heighten one's energy and awareness. They provide 5 steps to achieve that:

1) Identify anxiety symptoms and recognise the way in which they interfere with one's life.
2) Pinpointing stress responses and noting what causes them. Give one the information he/she needs to move on to step 3.

3) Set short and long term social goals. Goal setting is a valuable way of letting one's imagination offer a reward for his/her hard work. Next, learn new skills. Learn stress management and self-awareness.

4) Learn or refine social skills. Good conversation, active listening, an awareness of what behaviour is appropriate, all of these skills will add to the individual's overall social ability and self-empowerment.

5) Expand social network. One should use his/her community's resources to create, expand, or refine his/her social network to best meet one's interactive goals.

3.3.7.3. Rapee's programme

Rapee (1998) in his book "Overcoming Shyness and Social Phobia: A step-by-step Guide offers a clear and accessible steps programme for confronting the fear that inhibit shy and socialy anxious people. He offers 5 important steps:

(1) Have a good understanding of one own thoughts, feelings, and behaviours
(2) Learn to think more realistically
(3) Practise learning to focus attention away from the negatives and more onto the task at hand.

(4) Stop one's avoidance behaviours and begin gently to confront the fear situations

(5) Obtain some clear feedback about the way one comes across to others.

According to him there are three broad types of problems that are common sources of difficulty for many shy people and that might require some special effort if they present problems. These areas are: being unassertive, procrastinating or being perfectionist, and having trouble trusting people.

Becoming assertive: People who are shy often also have difficulty in being assertive. This is often a source of serious distress. Being unassertive can sometimes lead to further anxiety and even depression. Being assertive means being able to express one own needs while at the same time acknowledging the needs of others. An example might be asking a favour of others while at the same time accepting that they have a right to refuse and not feeling hurt or angry if they do. Therefore, being assertive does not necessarily mean that one will get his/her own way. Rather, it means feeling comfortable expressing one's needs and letting others know what one wants, while at the same time recognising that other people also have needs that may be just as pressing. In contrast to being aggressive, it means that sometimes one's own needs must give way to those of other people if theirs are more urgent. In contrast to being unassertive, it means that a person should feel free to express his/her needs and that he/she can often expect his/her needs to be met, or at least to achieve a compromise.

Perfectionism and procrastination: The two P's, perfectionism and procrastination, are a common feature of socially anxious people. Just like unassertiveness, they are simply

another form of social fear. Shy people often say that they become perfectionistic in what they do because they are worried about what others will think of them if they make a mistake. For example, "My boss will think I'm sloppy if I have any spelling errors in my work."

It is easy to see that perfectionism can be thought of simply as a type of social avoidance: avoidance of the possibility of making a mistake or of doing a less-than-perfect job. In order to work efficiently, most people are willing to accept the probability that there are minor problems in their work. Obviously more important or detailed work requires more checking, while less important work requires less checking.

Trouble trusting people: Working on a lack of basic trust is not an easy thing and usually requires a long and slow programme. However the results are well worthwhile. In building trust, it is a good idea to think about where one's original lack of trust comes from. The actual event is not as important as it is to get an understanding of where one's attitudes may have come from and how they have helped to shape one's life (Rapee, 1998).

3.3.8. Traditional psychotherapies

Some people benefit from traditional therapies. These include insight-oriented or psychoanalytic therapy, which focus on uncovering the unconscious roots of a person's fears, and supportive psychotherapy, in which an empathic and encouraging therapist helps the person sort out interpersonal problems. In each of these approaches, the person develops a working relationship with a supportive, accepting therapist, and the very process of establishing such a relationship may be therapeutic in itself.

In insight-oriented therapies, the therapist may play a less active role, allowing the person to make associations between current problems and feelings, childhood experiences, and aspects of the ongoing relationship between patient and therapist. Unconscious feelings that underlie the anxiety symptoms can be accessed, interpreted, and understood. Discovering an explanation for how social fears developed helps relieve excessive self-blame for failings. These therapies may help restore confidence, thereby indirectly helping people to enter their feared situations and to see them as less threatening.

A risk of traditional therapies, however, is that by emphasising the search for the roots of the problem, which may take months or years to uncover, they can inadvertently give patients another reason to postpone exposing themselves to their feared situations. In any therapy, such exposure is ultimately necessary for recovery. Some therapists combine traditional insight-oriented or psychoanalytic approaches with cognitive-behavioural therapy. These therapists believe that developing insight into the underlying causes of social problems can aid in the development of more rational thinking and can encourage exposure to feared situations (Schneier & Welkowitz, 1996).

3.3.9. Relaxation therapies

Relaxation therapies have also been shown to be helpful for reducing some forms of anxiety. According to Joseph Wolpe (1958), a pioneer in the use of relaxation therapies, the opposite of anxiety is relaxed muscles. Put simply, if one's muscles are relaxed, he/she cannot be nervous about anything. One common type of relaxation therapy is called progressive muscle relaxation. Developed in the 1920s by a physician named Jacobson, this method involves systematically tensing and relaxing muscle

groups throughout the body, from the toes to the top of the head. Another type of relaxation therapy focuses on exercises to regulate breathing. It involves concentrating on breathing while repeating certain words or phrases. Although there is an abundance of research showing that relaxation techniques are useful for reducing overall tension and anxiety, only a few studies have applied it directly to social anxiety. These studies suggest that muscle relaxation is most helpful when the technique is actively used during anxiety-producing social situations, as opposed to when it is practiced only at home or in a therapist's office. Many cognitive-behavioural psychologists use it as one of several tools for fighting anxiety and panic. Other related techniques, such as a biofeedback (which involves learning personal control over bodily activities such as heart rate or skin temperature) and meditation,(which can also be helpful). Just as with muscle relaxation techniques, biofeedback and meditation alone will rarely be sufficient to manage social anxiety effectively (Schneier & Welkowitz, 1996)

3.3.10. Alternative therapies

In recent years, people have shown an increased interest in alternatives to mainstream therapies for a variety of physical and psychological problems. While the effectiveness of such therapies for social phobia has been little studied, some alternative therapies are commonly used to alleviate social fears. The Alexander technique is a type of physical therapy and is particularly popular among actors and musicians. This approach is based on the premise that anxieties about performing are linked to problems in physical movement and posture. The goal of the therapy is to relieve anxiety by retraining people to position their bodies in natural ways. While one study showed that musicians using the Alexander technique could reduce blood pressure just prior to a concert performance, adequate scientific studies to prove its effectiveness have yet to be done.

Like the Alexander technique, dance movement therapy is based on the idea that there is a connection between movement and emotions. Dance movement therapists examine how a person moves and analyse the type of "flow" of music movement. "Tension flow" refers to flow that is bound up like a compressed spring and is said to result in high anxiety and social inhibition. Movement is "free-flowing" when muscles are unrestrained, producing a release of tensions and anxiety, and disinhibition. In dance movement therapy, the person seeking help talks about his/her problems while learning to move in new tension-reducing ways.

In psychodrama, one goes onstage with fellow group members surrounding him/her as supporting cast members and with the therapist sitting in the director's chair, barking out commands and suggestions. The term "role-playing" came from this treatment, which was developed by J.L. Moreno in the 1920s. As with cognitive-behavioural group therapy, psychodrama involves rehearsal and acting out fearful situations, but the therapist analyses problems very differently, focusing on early childhood experiences (Schneier & Welkowitz, 1996).

3.3.11. Self-help groups

The power of self-help groups should not be underestimated. According to a recent review of effective psychotherapies by consumer reports, the majority of people attending self-help groups for a variety of problems report being highly satisfied. Self-help groups are not intended to take the place of professional evaluation and therapy, but they can provide valuable opportunities to practise social skills and to share emotional support. Any activity that encourages people to get into social situations may supplement professional therapy by providing an opportunity to put into action new

coping skills. Organisations, such as the Anxiety Disorders Association of America maintain registries of support groups that are geared toward people with anxiety problems. Groups that focus on coping with social anxiety or on developing social skills may be particularly useful. Toastmasters, an international organisation that sponsors public speaking practice groups, can be helpful as a supplement to therapy for public speaking anxiety, and classes on public speaking, acting, or social skills can similarly be useful. The opportunities to practise social skills are endless, ranging from hiking clubs to church activities to political organisations. A sympathetic or supportive friend, or an informal self-help group in the church basement, has helped a good many people shed some anxiety (Schneier & Welkowitz, 1996).

3.3.12. Medication treatments

Little was known about medication treatment for social phobia until the mid 1980s, long after medicines had been shown to be effective treatments for other emotional problems such as depression and panic attacks. In the past decade, study of medication treatments for social phobia has begun to catch up. This research has been stimulated by the growing recognition that social phobia is common, severe, and at least in part biologically based. Another factor has been the development of promising new antianxiety medications. Pharmaceutical manufactures have recently taken notice of this work and recognised that persons with social phobia are potentially a large market for new medications that might prove helpful. They have invested resources into testing the effectiveness of their new medications for persons with social phobia.

The result of this new attention from academic psychiatrists and from drug companies is that controlled trials have shown that several medicines can alleviate the symptoms of

social phobia, and these medicines are now moving into common use. Among the first medications to catch the attention of researchers interested in treatment of anxiety were the beta-adrenergic blockers, commonly known as beta-blockers {e.g.,Inderal, Benzodiazepines}, Selective Serotonin Reuptake Inhibitors (SSRIs) {e.g., Prozac, Zoloft, Paxil and Luvox}, and Monoamine Oxidase Inhibitors (MAOIs) {e.g., Nardil and Parnate} (Schneier & Welkowitz,1996).

SSRI's are now the most popular type of drugs used in treating depression. These antidepressants were found to have fewer side effects than other antidepressants. In 1996, Paxil became the first antidepressant to be approved for the treatment of social anxiety disorder (Koerner, 1999). The extended use of Paxil was welcomed for several reasons. First, it assumed that having an approved medication for this condition would bring recognition to the disorder. Second, treating social anxiety disorder with therapy in addition to medication may provide a more effective treatment plan. Finally, it was thought that using Paxil would give individuals suffering from social disorder additional assistance to meet other treatment goals. The results of recent study by Nelson (2001) indicate that socially anxious and shy participants are more likely to take medication for shyness than any other treatment. Of course, any decision about whether to use a medication must be made in consultation with a physician who has confirmed the diagnosis and considered the medication's safety and benefits for an individual patient.

3.3.13. Rhetoritherapy

Rhetoritherapy originated with Muir (1964), who identified a type of person who appeared to be speech defective but did not fit any diagnostic category. She referred to the problem as "reticence" and noted that it was characterized by reduced speech output.

The earliest definitions of reticence referred to it as a pathology (Phillips, 1968). The condition was later defined as an absence of skill at social speaking, sometimes connected with anxiety, sometimes not (Phillips, 1977).

The decision to be reticent is made in the interest of personal economy. Reticent people tend to avoid situations in which they do not think they can do well. Training enables them to expand the number of situations in which they can participate. The reticent person may have good reason to feel incompetent. But, incompetent or not, it is virtually impossible to perform competently if one does not believe it possible. The reticent person believes there is more to gain by silence than by speech.

The term reticent is relatively neutral. Investigations classify reticence as a self-perceived condition not necessarily discernible by others (Kelly, 1982b; Kelly, Phillips, & McKinney, 1982). In short, there are a great many socially ineffective speakers. Some see themselves as inept and wish assistance. They may or may not be apprehensive about it. Others do not perceive their own inadequacy. A few are not even aware of the importance of skillful communication and still others are apprehensive but are also high quality performers. Rhetoritherapy is a system of training directed at volunteers who see themselves as inept at performing specific social tasks and who wish to become more effective. Their internal emotional states are not relevant to the process of training.

The characteristic sign of reticence is avoidance of particular social situations in which the individual feels most inept. Some social situations can be avoided conveniently. Others, like job interviews and public presentations, cannot be avoided. Rhetoritherapy

is directed at helping individuals achieve competency in the social situations they are most likely to encounter. It is not directed at unusual and particular kinds of social circumstances.

Rhetoritherapy makes no assumptions about emotional states. Trainers are prepared to apply systematic desensitization for mildly apprehensive trainees in order to facilitate training. Trainees who appear to have serious emotional problems are referred to appropriate professionals. However, their performance training can proceed even when they are in therapy.

3.3.14. Brief / Time-limited therapy

Brief counselling refers to any counselling that lasts from one session to approximately twenty sessions. A technical distinction between brief counselling and time-limited counselling is that the former does not specify a limited number of sessions or an ending date, even though it may last only for weeks or months (Dryden & Feltham, 1998)

Long-term therapy or counselling is not widely available through the National Health Service in the UK (or elsewhere), nor do private insurance companies recognise its necessity. Private long-term therapy, particularly of the pure psychoanalytic variety (four or five times a week for several years) is very expensive and totally inaccessible to most people. As Albee (1990) has pointed out, psychotherapy is so labour-intensive, so time-consuming and costly, that its impact on the mental health of the population as a whole is infinitesimal. Add to this the first-hand reports of some former consumers of psychotherapy (see, for example, some of the accounts in Dinnage 1988) and their claims of years wasted in analysis, it may be concluded that the length and cost of

therapy requires serious investigation. Analysts like Malan (1975) and Balint et al. (1972) took up the challenge to reduce the length of therapy. They seemed to agree that "focal" concerns helped to shorten therapy, and that attention to the use of time and judicious exclusion of certain kinds of client material were important factors in achieving change more efficiently. Focal concerns as defined by Balint et al. (1972) (as well as other writers) combine identified limited aims in counselling and identified conflicts in the client's life. The gradual emergence of behavioural and humanistic models of therapy stimulated research into therapeutic outcome and process and encouraged practitioners to experiment with other models and to integrate them into their own work. Many new schools of therapy appeared in recent decades (including Gestalt therapy, primal therapy and transactional analysis), each often claiming to be briefer than previous models. Garfield & Bergin (1986) indicated that various surveys revealed that clients frequently terminated therapy after six, eight or ten sessions. This is what Budman and Gurman (1988) refer to as "brief therapy by default", since clients terminated without notice. Increasingly it seems to be emerging that clients who drop out of counselling "early" may well have obtained all the help they perceive themselves as needing for the time being, within the first few sessions. Many student counselling services report that they see clients on average for only two, three or five sessions, by the client's choice; the service is free and there is no limit set to how many sessions are available to students.

According to Feltham (2000) there was little interest in brief and time-limited counselling or psychotherapy in Britain before the 1990s. However, as demand to improve the general practice has increased, general practitioners (GPs) have been forced to look closely at the service they offer (Hudson-Allez, 1997). By bringing counsellors

into their workplace, GPs can monitor the service that is being provided to their patients. The counselling service being offered is not personal development for the benefit of their patient's psychological well-being; people can pay for that privately if that is what they want. In this case, patients have presented to their GP with a crisis, conflict or confusion in their personal lives, which is causing them emotional and/or physical distress; they are asking the GP for help. The public are becoming more aware of the role of counselling, and when they go to their doctors, what they are often asking for is not medication but someone to talk to. A time-limited service not only offers immediate help when it is needed, it allows for people to choose to move in and out of therapy as they wish (Curtis Jenkins,1996). GPs are offering to their patients the opportunity to deal with the issues that are causing the presenting distress. It is not the role of the practice counsellor to delve into other material that may be lurking in the client's psyche that could be dealt with but is not really relevant to the presenting issue. Once again, it is the prerogative of the client to sort that out at another time, and in another place, should the client so wish. It is also not for the counsellor to insist that the difficulty ought to be dealt with. By limiting the time given for therapy, therefore, the GP and the client stay more in control of the treatment/counselling work, which also helps avoid dependency difficulties. Clients know they have a short time to resolve their problems, and they usually make a conscious effort to make the most of the time they have available (Hudson-Allez, 1997).

Many therapists are against time-limiting therapy, arguing that it is dictated on the ground of cost rather than client need. Of course financial restrictions have something to do with it. GPs are not, however, looking for the cheapest option, but for the one that is the most cost-effective in terms of patient care and outcome. As Cumming (1977)

highlighted, the choice is not about long-term versus short-term therapy, but short-term versus no therapy at all. Clients are entitled to relief from pain, anxiety and depression in the shortest time possible with the least intrusive interventions (Cumming,1988).

Time-limited brief therapy has been well researched (Mynor Wallis & Gath, 1992; Sabin 1992; Cade & O'Hanlon, 1993). It has been proven to be no worse, and no more effective, than long-term therapy. Indeed, according to Malan (1976), the evidence shows that radical techniques of brief focused therapy produce lasting results because they get to the root of the problem. Cade & O'Hanlon (1993) agreed that the more is not necessarily better. Research also demonstrates that some clients do very well with only one session (Talmon, 1990; Budman, Hoyt and Friedman, 1992; Hoyt, 1995). That being the case, if outcome research indicates little difference, then, given financial considerations, it is more cost-effective. For the counsellor, too, TLT can be very satisfying as process and progress are expedited, and dependency issues are usually avoided. In terms of cost to the provider, and cost to the client, TLT is an effective use of scarce resources, and the treatment of choice for 86 % of clients.

A question that might be asked is "Can anything be resolved in such a short space of time?" A six-session contract does not imply six weeks. In most cases, the six sessions together with an initial assessment session may span three to six months. Flexibility in between-session duration has contributed to the success of the therapy. Many clients have no wish to be seen on a weekly basis; that is too disruptive in their lives. Moreover, they say they want more time to think about the session, to practise tasks they have been given, or to wait for an event or anniversary to pass. More distressed clients can be seen weekly or fortnightly for the first two or three sessions. Then, as

their confidence both in themselves and in their counsellor grows, they are content to have longer periods between sessions.

One must not overlook the importance of between-session work, and clients need to be given the time and space to do the work at their own pace. Although several weeks may have elapsed between client-counsellor sessions, the client still feels held, or contained, by the awareness of their forthcoming appointment, and a lot of self-therapy occurs as time progresses. If, however, a crisis does occur and the client may need to see the counsellor urgently, taking cancellation appointments usually means that the client can be seen within a few days at short notice.

The first point to be made is that time-limited therapy is not long-term therapy cut short. It is a very specific way of working that integrates the traditional person-centred (Rogers, 1961, 1980) and cognitive (Beck, 1975, 1987) approaches and incorporates the techniques used in brief therapy (De Shazer, 1985, 1988; O'Hanlon, 1990; Cade & O'Hanlon, 1993) and action (Carkuff, 1987; Egan, 1994) models. Integrative approaches are becoming more common (Corey, 1991) as therapists realise that the approach should fit the person, and not vice versa, as has often been the case in the past.

There is also some evidence that brief therapy is as effective as long-term therapy (Shlien et al. 1962). Taken together, such research indications suggest that the reality is that most counselling and therapy is in fact brief; that clients wish it to be brief; and that its brevity does not detract from its effectiveness. For these reasons, many contemporary counsellors, advocate brief counselling "by design" (Hudson-Allez, 1997).

According to Feltham (2000, p.579) Brief therapies can be understood as falling into three categories:

(1) "Any therapy that is intrinsically concerned with efficiency, pragmatism, parsimony, rapid symptom-amelioration, circumscribed aims, etc. (e.g., behaviour therapy, cognitive therapy, multimodal therapy, rational emotive behaviour therapy, reality therapy, neuro-linguistic programming, etc.)

(2) Therapies designed or intended to be brief but where brevity is not defined and therapy may in fact be open-ended or intermittent (e.g. short-term dynamic psychotherapy, solution-focused brief therapy, focused-expressive sychotherapy, depth-oriented brief therapy, etc.).

(3) Therapies designed to be, and delivered as, time-limited, in other words holding to a pre-designed time limit (e.g. Mann's time-limited psychotherapy (12 sessions) cognitive analytic therapy (16 sessions), Macnab's contextual modular therapy (6 sessions), the 2+1 model', single-session therapy, etc."

3.3.14.1. The Skilled Helper Model

Egan's (1994) fifth edition of The Skilled Helper Model has given counsellors a useful working model of helping which lends itself well to structuring Time-Limited Therapy (TLT) sessions. It is probably the most commonly used model of counselling taught in the UK today, now in its seventh edition, as one of its primary goals is to assist clients to become more effective at managing their own lives. In its most simplified version, the three-stage model has core skills that enhance the counselling process (Hudson-Allez, 1997).

The method starts as one of gentle overview of the presenting problem(s), which are covered in great detail. This establishes trust and encourages the empathic stance of the counsellor. The counsellor then moves on to introducing the cognitive challenges and changes the focus of the sessions away from the problem on to coping strategies or solutions. The skilled helper model has been continuously developed since 1975 by Professor Gerard Egan of Loyola University, Chicago, USA. His earliest published works were about communication skills for helpers, both in groups and in individual encounters. He has a pragmatic approach to "problems in living", believing that psychological explanations are insufficient, and that the impact and opportunities of social settings and systems can be managed through the helping process (Connor, 2000).

The skilled helper model was first published in 1975, as a three-stage framework for helping. The stages were: exploration, understanding and action. The model is integrative and trans-theoretical. It draws from the person-centred ideas of Rogers and Carkhuff. However, the main thrust of the model is cognitive-behavioural, drawing upon such writers as Bandura, Beck, Ellis, Seligman and Strong. The second edition was published in 1982 as a problem-management model or framework for helping. The centrality of goal setting was emphasized and the second stage focused upon goal setting.

By 1986 the third edition showed significant developments, not least in the description of the model for opportunity development as well as problem management. The non-linearity of the model was highlighted, with on-going evaluation of the helping process at the centre of each of the three stages. But there were other significant developments,

particularly in the use of creativity in the second stage of helping so that goal setting was developed from a broad exploration of preferred scenarios. The first stage was called the "Present Scenario" and the steps were: telling the story; focusing; new perspectives. The second stage was called the "Preferred Scenario" and the steps were: new scenarios; critique; choice and commitment. The third stage was called "action-getting the new scenario on line" and the three steps were: brainstorming strategies; formulating a plan; action. In 1990, the fourth edition emerged and with it an increased emphasis on challenging clients early in the helping process so that the chances of clients taking responsibility for action are increased. Egan distinguished between principles and formulas, stating categorically that the model presented principles and not formulas for helping. This distinction led him to talk about the wisdom of helping as against technology of helping. By the fourth edition, an "action arrow" had been added to the model, emphasizing that effective helping requires action from both helper and helped throughout the process, and not just as an outcome. But action must lead to outcomes that are valued by the client.

The fifth edition in 1994 drew attention to the on-going debate about integration and eclecticism. Egan has always claimed that this model is integrative, and he has used the term "systematic eclecticism" to explain the way in which it draws upon theories of counselling and helping. At this stage he also replied to those who misunderstood the linearity of the model and referred to the importance of working with aspects of the shadow-side in both helper and helped, as well as in the helping process (Connor,2000).

The sixth edition was published in 1998, along with a manual of exercises. The book summarized the key questions for each stage: Stage I, Current Scenario: "What's the

present state of affairs?" Stage II, Preferred Scenario: "What do I need/want instead of what I've got?" Stage III, Action Strategies: "How do I get what I need or want?" Behind each stage, the action arrow keeps the ultimate question in mind: "How do I make it happen?" Egan states that answers to this question help clients move from the planning stage to accomplishments.

The seventh edition of Egan' book (2002) with the exercises manual is the most recent. The book contains information on communication skills and an emphasis on hope, optimism, and self-healing. It offers an updated approach to handling client reluctance and resistance. It gives information on using Internet searches for on line helping and allied literature. The manual contains six parts, corresponding to the six major parts of the text. These exercises are meant to help the user translate the concepts in the Skilled Helper into skills that he/she can use (Egan and McGourty, 2002).

Helping can be provided by both formal and informal helpers. There are many situations where those seeking help turn to helpers who may not be fully trained counsellors or psychotherapists, yet these helpers can be trained to use a framework and skills that will increase their effectiveness.

There are two main goals of the helping process. The first is to help clients to "manage their problems in living more effectively and develop unused or underused opportunities more fully". The second is to "help clients become better at helping themselves in their everyday lives" (Egan, 1998; p7,8).

The skilled helper model provides a practical framework for the helping process which may appear to be rational and linear because it is presented in stages, but which is intended to be used flexibly according to the particular needs of the client. Egan has often stated that the model is for the client, not the client for the model. Underlying the helping process are basic communication skills which affect the efficacy of the helper.

Consciously developed listening, responding and challenging skills are important throughout the whole process. The model is integrative and systemic. It is used within a helping relationship characterized by respect and genuineness.

According to Egan (1998) problem situations arise through interactions. Problems can be intrapersonal or interpersonal. They will arise from living within systems and sitting at home, at work, in the community. In this sense, problems are viewed as a reaction to living, rather than as underlying pathology. Lack of ability in problem-solving, lack of confidence, experience or skill to explore possibilities, set realistic goals and develop and implement action plans, deficiency in personal, social and life skills, inability to make the most of the opportunities and resources that are available, are all experiences that may give rise to thoughts, feelings and behaviours which result in the client being blocked, frustrated, guilty, unmotivated or unassertive.

Change occurs through the shared use of the model, which aids the process of decision-making and action. The focus is upon valued outcomes for the client. The steps in decision-making are: initial awareness and clarification of the issue; a sense of urgency about managing the situation; an initial search for solutions; a cost-benefit analysis of the possible solutions; a rational decision, which may not be enough to impel the client

to act; a decision which is based upon both rational and emotional needs and wants, and which is more likely to impel the client to act. These steps do not always occur in logical sequence. Individuals vary in the parts of this process, which they need and want.

The helper should be able to respond to wherever the client is, and wherever the client wishes to go, without preconceived notions about where the client "ought" to be in the change process.

The first stage of the model helps the client to clarify the key issues calling for change. Three steps work towards this exploration: the telling of the story; the identification of blind spots; the focusing upon issues where there will be the leverage to make a difference. The second stage of the model helps clients to determine what they need and want. The focus here is upon developing a preferred scenario. The client is encouraged to engage creatively in imagining the possibilities of a better future. The psychological importance of this key stage in moving towards change cannot be stressed too greatly. Once the clients become clear about what it is that they want and prize, then priorities for change can be worked out, based upon stated wants, needs and values. Hope is engendered through this part of the helping process. The final and most difficult part of this stage helps the client to test his/her own commitment to change and to explore whether specific goals are both realistic and valued. A cost-benefit evaluation is part of this. The hope for change now requires of the client the courage to change.

The third stage of the model helps clients to discover how to get what they need and want by developing strategies for action. The wish for change gets translated into actual accomplishments through brainstorming all the possible strategies for action, then deciding which of these is a best fit for the client in his/her particular circumstances, and finally developing an action plan (Egan, 1998).

Underlying all stages of the model is the requirement for continuous formative actions that entail constant incremental change on the part of the client. This helps the client to turn decisions made through the helping process into action that will help the client to live more effectively by managing a problem or developing an opportunity. Egan reminds the helper that talking about change is not the same as doing it and it is the responsibility of the helper to ensure that the ultimate outcome of change permeates the whole helping process. Action between sessions is a way of evaluating the impact of what has been happening within sessions (Connor, 2000).

In order for the client to be able to change, the helper must communicate the therapeutic qualities of genuineness, respect, and empathy. An effective working alliance needs to be developed. This will be characterized by appropriate levels of support and challenge. Appropriate self-sharing is encouraged, but only if it helps the client to understand his/her own situation more clearly. Immediacy needs to be present in the relationship throughout all stages of the helping process so that the on-going dynamic between helper and helped can be a direct source of learning and change.

In the first stage of the process, support will be essential for the telling of the story. Attending, listening, paraphrasing, reflecting feeling, summarizing, probing and

clarifying are skills that will be needed throughout this process. In addition, empathic challenge will be essential for the identification of blind spots, whether they be inaccuracies or deficiencies in perception of the problem situation, or whether they are to do with the under-utilization of resources and opportunities. Finally, in the first stage, the helper needs the skills of focusing, prioritising and searching for the leverage that will enable the client to move to the second stage of the process.

Creativity and imagination help the client in the second stage to a vision of the preferred scenario. The helper may use a variety of skills and methods to encourage lateral thinking on the part of the client. These may include use of drawing, sculpting or writing. They may also include visualization or brainstorming. The idea is to open possibilities, to encourage the client to think the unthinkable so that within the seeds of a wild idea may be the germ of the realistic possibility. The skill of the helper during the first part of the stage two is to keep accessing valued "wants" and eliminating the effect of limiting "oughts".

The skill of goal setting and checking commitment to a desired goal are required to complete the second stage of the model. The SMART acronym aids in formulating a Specific, Measurable, Achievable, Realistic goal that is stated within a timeframe. Such methods are cost-benefit analysis that can be used to check how painful the cost required to achieve the goal may be, and whether that cost can be outweighed by perceived benefits.

In the third stage the helper needs the skills to brainstorm action strategies and check which are the best fit for the client. Methods such as a force-field analysis can be used

to become aware of factors which may help to hinder the client in using certain strategies to achieve goal. Negative forces can be minimized and positive forces maximized, once they have been identified. Forewarned is forearmed when it comes to problem-solving. Helpers' understanding of the effects of inertia and entropy on clients when they are trying to change can be important aspects of the discussion. Methods such as critical path analysis can be shared with clients as they try to draw up action plans.

Evaluative skills are needed throughout the process, as the helper monitors carefully the progress of the client and encourages the client to use the model for his/her self between sessions. At any point in the process, the client can return to the first stage to "tell the story" of how it has been between the sessions. The skills of being able to go spontaneously with the flow of where the client is and to flexibly apply the model in the service of the client is perhaps the most advanced skill required of a helper. The model is then used with integrity and wisdom, not mechanistically in the way a more inexperienced helper may use it. It is used most effectively when the helper knows it so well that it is used as background, with the client in the foreground and the helper having moved through the stage of conscious competence, now reaches the level of proficiency that is characterized by "unconscious competence."

The skilled helper model is the most widely used counselling model in the world (Egan, 1998). However, it is surprising that there has been so little formal research about it, the only research to the knowledge of the researcher is a comparative study by Harris in 1992. Egan makes reference to research studies in contributing counselling and psychological approaches in each edition of the book and makes explicit the ideas from

which he constantly develops the model. The fact that it has been adopted in so many different cultures indicates that it speaks to some universal understandings of how human beings experience the world and how they may change. In the UK, it is used as a core theoretical model for the training of counsellors (Connor, 1994) and it is used as the basis of mentoring training programmes for doctors throughout the north of England. The use of the model as a framework for stages in the problem-management process has been reported by Reddy (1987) who has focused upon counselling in work settings Connor (1997) (cited in Connor, 2000).

Egan's model is very popular. It is used as a base module in many United Kingdom training courses such as the Catholic Marriage Advice and Counselling Service, Relate, and many College and University Certificate, Diploma and Degree courses. The British Association for Counselling has recognised courses which potentially lead successful candidates to becoming accredited counsellors. Most of these courses teach the Egan Model (Dexter, 1996).

3.4. Group versus individual therapy and other variations

Research is limited in the area of group treatment and shyness. There are persuasive clinical arguments on behalf of the use of group psychotherapy in the treatment of shyness. Krueger (1979) contends that group therapy is the treatment of choice for interpersonal problems like shyness, and according to Pilkonis (1986) there are several reasons to endorse Krueger's position.

First, the in vivo desensitization provided by a group experience is likely to be more powerful than imagine or covert techniques.

Second, group therapy creates a richer and more complex social environment than individual treatments. Although participants may all regard themselves as shy, members of a group will include men and women with different life experiences, social styles, and ethnic and social class backgrounds, thereby providing a variety of models and feedback to each individual. This richer social environment is more likely to promote generalization than are most short-term individual treatments. Also, the group itself is a social situation that is similar to many interpersonal encounters outside treatment, and therefore it may enhance the consolidation of new behaviour in extra-therapeutic settings.

Third, the consensual validation that can occur in a group is more powerful at altering behaviour than those available in individual treatment. Fourth, one of the dangers of individual treatment with shy patients is the inordinate dependency that such patients sometimes develop in a one-to-one relationship. Such a relationship can be beneficial during the course of treatment, but it often leaves patients vulnerable following termination when the therapist is no longer available on a regular basis. The use of group psychotherapy is helpful in minimizing the overly intense attachment that shy persons may develop in individual work (and that cannot be successfully resolved without longer term individual therapy).

Finally, group psychotherapy can be more efficient in terms of time and effort. A typical group of six to eight members, led by two co-therapists, represents a more cost-effective solution than individual therapy to the problem of providing accessible and adequate care for what all investigators agree is a prevalent problem. Of course, the advocates of individual therapy for shyness can marshal alternative arguments about the

advantage of the mode (e.g., the greater tailoring of treatment to specific personal needs, the enhanced respect for the patient's privacy, and the avoidance of negative modelling provided by group members).

Group and individual therapy methods each have certain advantages and disadvantages. One advantage of the group approach is that most group members find it a tremendous relief to learn that other people with social phobia actually exist and even appear normal. Often an immediate bond is formed as members relate to each other's difficulties. Equally important, because the situation of meeting with a group of strangers brings out the fears of social phobic people, the group is a powerful setting in which to work on these exposed fears. Exposures to feared situations-such as giving talk in public or mingling at a party, that can only be imagined in individual therapy, can easily be simulated in the group. Individuals benefit from the feedback about their behaviour that they receive from other group members. Finally, group therapies tend to be less expensive than individual therapy.

There are also some drawbacks to the group approach. For many socially anxious people, the prospect of tackling a problem under the scrutiny of a roomful of strangers has no appeal. For this reason, some people prefer to work individually with a therapist, or to begin therapy on an individual basis and then move on to a group setting once they are more comfortable with the idea. Groups also tend to be more time-consuming, because part of each session focuses on the needs of other group members, and individuals do not get as much direct attention from the therapist as they might in individual therapy. Individual therapy also allows for intermingling into the therapy other personal issues that might be outside the framework of the social phobia group.

Finally, individual cognitive-behavioural treatment is far more available than specialised social phobia therapy groups.

Many variations of cognitive-behavioural therapy, although not as rigorously tested as the specific approaches outlined above, may be equally effective options. Some therapists will use office time to discuss negative thinking styles or general problems in managing social situations and relationships, leaving actual exposure to feared situations to be done on the person's own time, outside of the office. An increasing number of psychiatrists are combining medication treatment with this type of homework-based cognitive-behavioural therapy (Schneier & Welkowitz, 1996).

Contrary to clinical expectations, it is frequently difficult to demonstrate strong comparative outcome differences between psychotherapies (Luborsky, Singer, & Luborsky, 1975; Shapiro & Shapiro, 1982). At the same time, there is good evidence that active treatments (either individual or group) are more beneficial than no treatment or placebo and control treatments (Andrews & Harvey, 1981; Landman & Dawes, 1982; Smith, Glass, & Miller, 1980). As a result, researchers are currently asking more differentiated question: What specific kinds of treatment are most effective with what specific patient groups in achieving which goals?

The literature on shyness is consistent with the broader psychotherapy outcome literature in all these aspects. Different individual therapies have been found to be effective in the treatment of shyness, social anxiety, interpersonal difficulties, and lack of assertiveness (see Arkowitz, 1977; Curran, 1977; Marzillier, 1978; & Twentyman & Zimering, 1979, for relevant reviews). Twentyman and Zimering (1979, p.343) point

out that "studies in the literature are nearly equally divided in presenting treatment individually or in groups" and that conclusions applicable to individual treatments also apply to group interventions; therefore, they assert that "little evidence is present to support the use of one treatment approach over another"

Within the literature on group treatments of shyness and social-skills problems, there are suggestions that more orthodox treatments (either behavioural or cognitive) are more effective than certain alternative treatments, such as sensitivity groups, consciousness raising groups, and bibliotherapy groups (Monti et al., 1979; Monti, Curran, Corriveau, Delancey, & Hagerman, 1980; Wolfe & Fodor, 1977). However, among orthodox group treatments themselves, the similarities in results tend to outweigh the differences.

Linehan, Walker, Bronheim, Haynes, & Yeveroff (1979) have done one of the few direct comparisons of individual versus group training, focusing on the specific problem of assertiveness. Their results supported the position that both active treatments are preferable to no treatment, but they found no substantive differences between them. They pointed out that their study was limited to a small sample of women who received highly structured treatments in both modalities, allowing for minimal individualized work and limiting any emergent group process.

Pilkonis, Imber, Lewis, and Rubinsky (1984) have reported on a psychotherapy-outcome study comparing individual, group, and conjoint therapy that sheds some light on the present issue. Although their patient sample was not preselected for problems with shyness, most patients cited various interpersonal difficulties among the reasons

bringing them to treatment. Pilkonis et al. (1984) found that for patients with more chronic presenting problems, the interpersonal therapies (both group and conjoint treatment) were more beneficial than individual therapy on interpersonal-outcome measures. These measures included the Social Avoidance and Distress Scale (Watson & Friend, 1969), a measure commonly used in studies of shyness and social anxiety, and the Locus of Control of Interpersonal Relationships Scale (Lewis, Cheney, & Dawes, 1977).

Hargreaves, Showstack, Flohr, Brady, and Harris (1974) have reported a finding that is also relevant here. They did not provide treatment-outcome data but did describe the initial acceptability of treatment assignments and the perceived helpfulness of therapy following an initial appointment. Shy patients tended to prefer individual therapy or a daily drop-in group rather than a more traditional group with weekly appointments. Patients for whom shyness was less a problem preferred both of the more usual modalities (individual therapy or a weekly therapy group) over the contact-on-demand group. There has been some discussion in the clinical literature (e.g., Imber, Lewis, & Loiselle, 1979) about the potential value of short-term or contact-on-demand groups for managing extended waiting lists or educating patients about the usual processes occurring in group therapy, and it is interesting to speculate that such techniques may have particular applicability to shy patients. Such approaches may provide shy individuals with greater control over the timing and amount of exposure to a feared interpersonal situation, and such control may enhance their ultimate willingness to persist in a group.

3.5. Current intervention

Carducci, Marion, Lynch, Docsh, & Boley (1997) asked 158 participants to describe what factors contribute to their shyness and how they have to deal with it. The researchers found that the most common used self-selected strategies are:

1. Self-induced extraversion (e.g., forced self to go out and meet people);
2. Self-induced cognitive modification (e.g., self-affirming statements and minimizing perceived threats of social situations);
3. Using self-help books and seminars, seeking professional therapy, and engaging in self-medication (e.g., drinking alcohol or taking drugs).

Pilkonis (1986) characterized the therapies used for shyness into one of three categories: (a) relaxation and desensitisation therapies aimed at alleviating anxiety and inhibiting behaviours; (b) behavioural therapies designed to enhance social skills; and (c) cognitive therapies aimed at restructuring the patient's negative self-image and expectancies in social situations.

Many programmes for treatment of shyness, social anxiety, and other forms of social dysfunction are based on a skills-deficit hypothesis. The dysfunctional individual is assumed to lack the behavioural skills necessary to cope with social situations. Numerous studies show that skills training procedures produce improvements in self-reported and laboratory assessed. However, the mechanism underlying such treatment effects has not been clearly established.

As stated previously treatments programs for shyness include aspects of several different techniques, such as cognitive restructuring, behavioural modification, and

social skills training (Carducci, 1999, 2000; Carducci & Zimbardo, 1995; Henderson and Zimbardo, 1999). Shy individuals need to be aware of their thoughts, feelings, behaviours, and become active in changing them. Some techniques were not to be totally effective for all individuals (e.g., cognitive modification). Upon attempting to use one technique and failing, most shy individuals did not elect to pursue another strategy. These negative outcomes may lead individuals to use self-defeating strategies or self-medicate and eventually give up altogether. This indicates the increasing importance of developing effective treatments for shy individuals.

Clinically oriented investigators have begun to introduce and evaluate treatment strategies designed to alleviate the problematic aspects of shyness (e.g., Kanter & Goldfried, 1979; Lazarus, 1976; Pilkonis, Heape, and Klein, 1980). Although the treatment strategy deemed appropriate to shyness clearly depends on how individual researchers conceptualise shyness as a personal problem, most of the clinically relevant research has focused on behavioural and cognitive-behavioural approaches to teaching social skills (e.g., Alden and Cappe, 1986; Glass and Shea, 1986) Other researchers (e.g., Brodt and Zimbardo, 1981; Haemmerlie and Montgomery, 1982, 1986) have developed techniques that require inducing the shy person to attribute interpersonal anxiety to external distracters and effective performance to themselves. By contrast, Slivken & Buss (1984) conducted a partial replication of Brodt and Zimbardo's experiment with contradictory results.

An important issue is that additional research is needed in order to identify the differences between the pros and cons of each treatment strategy. Clinicians and researchers need to know which treatment will be most effective for which individuals.

In terms of group treatment, the literature suggests that more conventional treatments (such as behavioural or cognitive) are more effective than alternative treatments, such as sensitivity groups, consciousness raising groups and bibliotherapy groups (Monti, Curran, Corriveau, Delancey, and Hagerman, 1980; Monti, Fink, Norman, Curran, Hayes, and Caldwell, 1979;Wolfe & Fodor, 1977). However, among conventional group treatments the similarities in results tend to outweigh the differences. Hargreaves, Showstack, Flohr, Brady, & Harris (1974) collected data regarding acceptability to patient and perceived helpfulness of therapy following an initial appointment. They found that shy patients tended to prefer individual therapy or a daily drop-in or short-term group rather than a more traditional group with weekly appointments. Further research is needed involving short-term group treatment and shyness. Such approaches may provide shy individuals with greater control over the timing and amount of exposure to a feared social situation, and such control may enhance their ultimate willingness to remain in a group setting. While there may be a strong argument for group treatment for shyness, it is still necessary to identify specific patients who will benefit from short-term group therapy. Twentyman & Zimering (1979) pointed out that there is little evidence to support the use of one treatment over another (Nelson, 2001).

The effectiveness of the traditional psychotherapies therapies, unlike the cognitive-behavioural therapies, has not been studied for people with social phobia. Long-term psychotherapies, such as psychoanalytic psychotherapy, are notoriously difficult to assess in a scientifically controlled way. Their effectiveness is supported by relatively weaker evidence of theory and case reports of success (Schneier & Welkowitz, 1996).

One should use considerable judgment in identifying those patients who will benefit from short-term therapy (as opposed to longer treatment, either individual or group) and those patients who present as shy but for whom shyness is only the tip of the psychological iceberg. Numerous criteria have been proposed for the use of short-term psychotherapy in general (Malan, 1976; Mann, 1973; Sifneos, 1972), but the three most important are the presence of a focal, target complaint; some understanding of the psychological nature of the problem; and adequate motivation to work toward psychological changes.

To be suitable for brief treatment, a patient's shyness should be focused on interpersonal anxieties and be relatively circumscribed around this theme. The shyness should not simply be one of a number of neurotic problems or a convenient label for the generalized anxiety that some psychotherapy patients describe. In addition, the overall severity of the patient's problem should be moderate. The shyness should be part of a reasonably intact personality with some positive history of interpersonal and occupational functioning rather than one bit of evidence for a more severe disorder that may include little or no history of interpersonal attachments, severely flawed self-esteem, chronic dysphoria, substance abuse problems, or other signs of more basic "characterological" problems. For such personality disorders, treatment is more likely to be long term and to demand more intensive involvement on the part of the therapist, who will be required to help the patient manage a wide range of intra-and interpersonal difficulties. In these cases, individual therapy may be a prerequisite for group work (Malan, Balfour, Hood, & Shooter, 1976) in order to bring the patient to a level of adaptation and functioning more suited to the give-and-take and frustrations of group therapy.

While cognitive therapy and social skills training may be useful in treating shyness, research continues to produce inconsistent answers as to its effectiveness. Glass and Shea (1986) suggested that further investigation of client variables and client treatment matching will show that these interventions are differentially effective for different individuals.

A general comparison of social skills training and self-perception theory technique shows some overlap in that they both provide an in vivo exposure experience. Yet, social skills training differs from the self-perception therapy in that it includes additional corrective feedback procedures, an aspect that the self-perception theory technique avoids in attempting to create a natural, unstructured conversation session in the absence of the therapist or therapeutic agent. In the realm of conjecture, given that a reduction in shyness was found in the absence of the manipulation of any skill variables, it is possible that the success of these behaviour change therapies may not often be due to the therapy itself, but are also confounded by the fact that the client successfully emits the target behaviour in the first place. Thus, improvement might come more from the client having simply observed that he/she is capable of mastering the behaviour deemed appropriate than from the actual acquisition of skills. This line of reasoning, of course, is similar to Bandura's (1977) notion of self-efficacy.

Social skill training is important, especially for individuals who worry about performing well in a social situation. The training will reduce their anxiety and enable them to concentrate on thoughts and behaviours. It is not surprising that achieving success with all clients is still a dream to be hoped for, rather than a *fait accompli*.

3.6. Conclusion

Shyness can be measured by observer rating, physociological arousal, or self-report at either a trait or state level. The key to select the best measure is what one wants to measure and the purpose behind it.

The literature review of treatments for shyness produced many to take advantage of. The treatments reviewed in this chapter mentioned some of these. However, when shyness is to be treated it is important to clarify the differences specifically in relation to intervention, for example, the thin line between shyness and social phobia can easily be crossed if specific guidelines are not established from the beginning. Also it is very important to consider the suitability of the subject him/herself to this type of the intervention.

The last three chapters dealt with the literature review providing some background information concerning shyness. The remainder of the thesis is concerned with the empirical work carried out by the researcher to test the effectiveness of specific interventions in alleviating shyness among Saudi female students.

Chapter Four: Methodology

The consequences to individuals as well as to society of reticence and anxiety in social situations are great. Such anxiety results in unnecessary distress and lost opportunities and leads to dysfunctional ways of handling these outcomes, including substance abuse. There are losses for society as well.

Gambrill
1996

4.1. Introduction

A quantitative design was employed using pre, post, and follow up testing. Quantitative methodology, operating from a positive philosophy Comte (1830) (cited in Dexter, 1996), seeks to identify a relationship between cause and effect through measuring observable data, quantifying these observations and conducting statistical analyses to verify findings and acknowledge significance. This data is mainly collected with instruments having sound psychometric properties. Traditionally, it has been associated with claims to objectivity and truth (Dexter, 1996).

This chapter outlines the methodology used in this study. It is divided into four sections; section one presents the preliminary survey, section two outlines the procedure of standardising the scale used to measure shyness, section three gives information about the interview, and section four deals with the experiment.

4.2. Section One: The Survey

4.2.1. Aim

The aim of the survey was to determine the extent of the problem of shyness among participating female university students.

4.2.2. Method

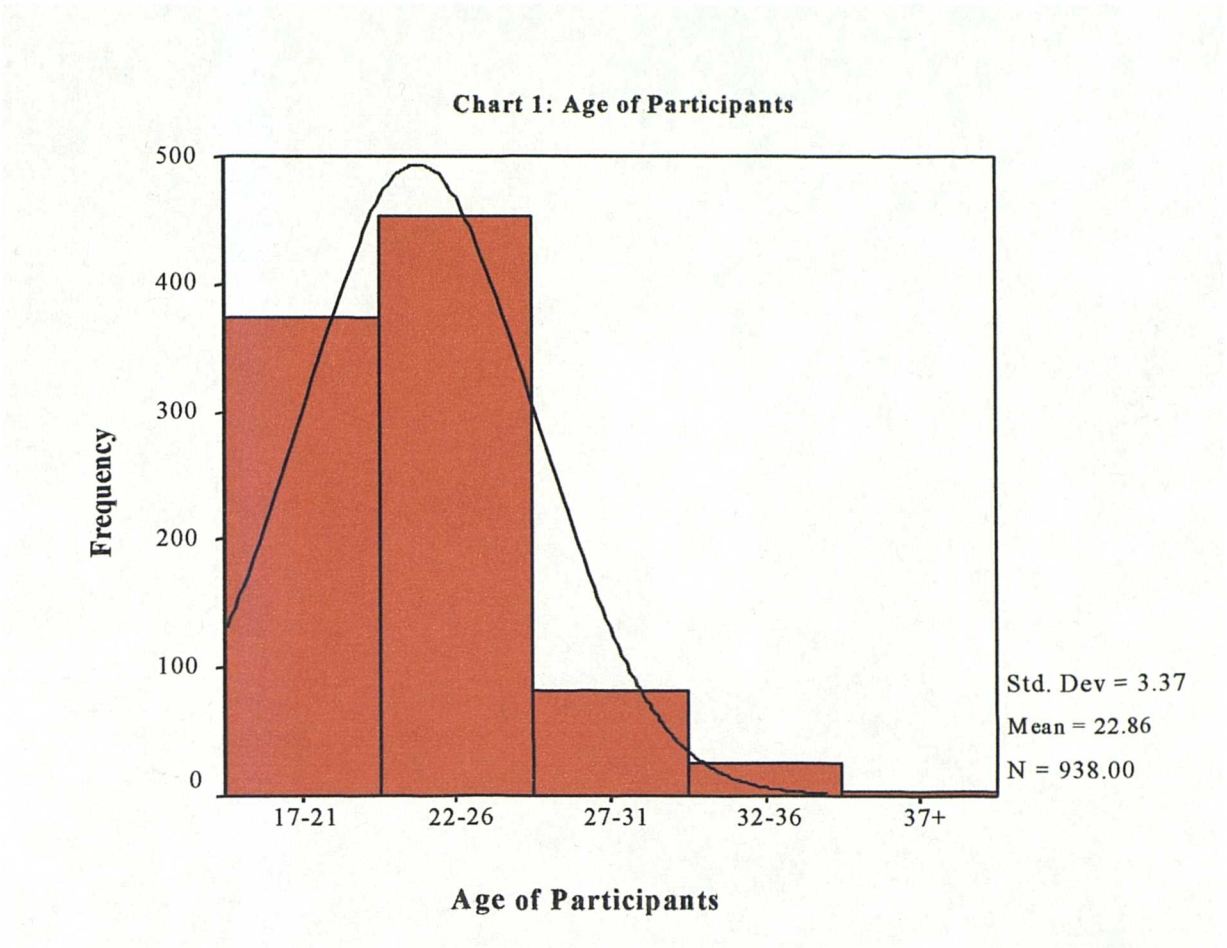
Sample

1200 students from varying years of their study programme and drawn from different disciplines from King Abdul Aziz University in Saudi Arabia were selected. They were approached at the end of their classes and asked to complete the brief questionnaire (Appendix A, Form X). In total 1000 women students completed the questionnaire. This sample represents roughly 6.13% of the total number of university students at the time when the survey was carried out. The responses were anonymous and the participants were not remunerated for taking part in the study.

The data in Table (6) shows the distribution of participants who responded to the survey. The participants were between 17 and 44 years of age, with a mean age of 22.86 years and a SD of 3.37. 6.2% of the respondents did not give their ages.

Table 6 Age of Participants

Age	17-21	22-26	27-31	32-36	37+	Missing	Sub-total
Frequency	374	452	83	25	4	62	1000
Percent	37.4	45.2	8.3	2.5	.4	6.2	100



Instrument

A questionnaire was used as the survey instrument adapted from Stanford Shyness Survey Zimbardo (1977, p177). (Appendix A) It consisted of 5 items. The first item asked the participant's age, and the other 4 items, with yes or no responses, assessed shyness in the participants.

Data Analysis

The data was firstly analysed to obtain measures of central tendency. After the relevant frequencies were obtained for all the variables, a correlation coefficient and chi-square test were used to determine if there was a relationship between responses to questions 1 and 3. SPSS was used for these calculations.

4.2.3. Results

Table (7) shows the frequency and percentage of responses to the four questions asked in the survey.

Table 7 Responses to the Questions

Questions	"n"	Yes%	No%
Do you consider yourself to be a shy person?	1000	69.8	30.2
If yes, have you always been shy?	698	19.4	80.6
Do you consider it a problem for you?	698	36.3	63.7
If the answer to the first question is no, was there ever a prior time in your life when you were shy?*	302	26.2	73.8

From the above it can be seen that the majority of the participants considered themselves to be shy 69.8%, and of these there was a fairly high percentage 36.3 who thought that this constituted a problem, though only 19.4% of them were always have been shy. Of the 30.2% of the participants who did not consider themselves shy, 26.2% said that there had been time in their lives when they were shy.

The correlation coefficient was calculated between responses to all questions Table (8). A significant correlation coefficient was obtained ($r = .497$, $p < .001$) between question (1) {Do you consider yourself to be a shy person?} and question (3) {Do you consider it a problem for you?}.

Table 8 Correlation between the main shyness variables

	S1	S2	S3	S4
Consider self shy (S1)	.097**			
Always consider shy (S2)	-.104**	-.904**		
Shyness always a problem (S3)	-.100**	-.852**	.833**	
Anytime in life (S4)	-.082*	.941**	-.850**	-.802**

** $p<.01$ * $p<.05$

To assess the relationship in more detail a Chi-square test was conducted on the variables. Table (9) shows the relationship between participants who considered themselves shy and those who found it to be a problem. The Chi-square test showed a significant result (χ^2 (df =1)=246.55, ρ<.001)

Table 9 Shyness as a problem for shy people

		Shyness always a problem		Total
Consider self shy		**Yes**	**No**	
Yes		363	335	698
	%Consider self shy	52.0%	48.0%	100.0%
	%Shyness always a problem	100.0%	52.6%	69.8%
	%of total	36.3%	33.5%	69.8%
No	Count		302	302
	%Consider self shy		100.0%	100.0%
	%Shyness always a problem		47.4%	30.2%
	%of total		30.2%	30.2%
Total	Count	363	637	1000
	%Consider self shy	36.3%	63.7%	100.0%
	%Shyness always a problem	100.0%	100.0%	100.0%
	%of total	36.3%	63.7%	100.0%
Chi-square	Pearson Chi-square	Value	Df	Sig.level
		246.558	1	.000

There was a relationship between feeling shy and considering it a problem. Shyness is a problem for Saudi Arabian shy people.

4.3. Section two: Standardizing the Shyness Scale

Once it had been established that shyness was a problem for 36.3% of shy students, the intention was to design a programmes to help students overcome their shyness. In order to assess the effects of these programmes, a measure of shyness was needed. A suitable test to measure shyness is Cheek and Melchior's (1985) shyness scale; it was used here because an Arabic version was available and because it had a high reliability; the original version scale had a reliability of (0,94), and the Arabic version had a reliability of (0,90). Also the content of the scale takes account of the three components of

shyness, which was consistent with the literature review. The scale was standardised for this particular Saudi Arabian sample.

4.3.1. Aim

To standardise the Arabic version of Cheek and Melchior's shyness scale for a female student population in Saudi Arabia and to assess its value as a research instrument.

4.3.2. Method

Instrument

Cheek and Buss (1981) define shyness as discomfort and inhibition in the presence of others. Thus, the Shyness Scale assesses both social anxiety and behavioural inhibition. The original Shyness Scale (Cheek and Buss, 1981) consisted of 9 items, but a 13-item revision (Cheek, 1983) has received increasing use. An intermediate 11-item version has also been used in a few studies.

A 20-item version (Cheek and Melchior, 1985) was translated into Arabic and standardised on a Kuwaiti population by Hamadah and Abdulatif (1995). Items on the scale are answered on a five-point scale (1, very uncharacteristic or untrue, strongly disagrees, 2, uncharacteristic, 3, neutral, 4, characteristic, 5, very characteristic or true, strongly agrees). Scale scores are obtained by reverse scoring six items (5, 7,10,13,19,20) and summing all responses. Scale scores on the 20-item scale run from 20 (lowest shyness) to 100 (highest shyness). The English version is in Appendix (A) and the Arabic version is in Appendix (D).

The same scale was used in the present study, the only changes being to item number 12 to make it more acceptable regarding the Arabic way of writing {I have trouble looking someone right in the eye}, and number 18 to make it more suitable for the Islamic society {I am shyer with members of my family of the opposite sex }. (Appendix D).

Procedure

Cheek and Melchior's Shyness Scale with the statement {I am a shy person} with five other scales; Loneliness, Beck Depression Inventory, Social Reticence Scale, Social Skills Inventory, and Self-Esteem were given to 1000 students. This sample was obtained with the help of some teachers from different disciplines from King Abdul Aziz University in Saudi Arabia. They were asked to spare a half an hour from one of their classes to ask students to participate in answering the scales questions. 1000 students participated but only 706 participants completed all the given scales. Only 80 Participants took the same tests for the second time after 6 weeks.

Reliability:

Table (10) shows the reliability of the scales. Cronbach's α for time one was .68 and for time two .77. A split half reliability coefficient of .70 was obtained for time one and .78 for time two. Test-retest reliability was .69 for a 6-week period. The average measure of intraclass correlation was .69 (lower .65 and upper .72).

Table 10 Reliability of the scales

	Time 1			Time 2		
	N	Alpha (α)	Split half	N	Alpha (α)	Split half
Shyness	706	.68	.70	80	.77	.78
Loneliness	89	.12	.27	43	.37	.36
Depression	74	.87	.81	51	.88	.80
Social Reticence	71	.67	.36	46	.66	.04
Social Skills	19	.79	.83	11	.72	.41
Self-Esteem	97	.37	.51	48	.31	.40

Validity:

Table (11) shows the scores on the Shyness Scale and other used scales. Shyness scale correlated highly with other measures: Beck Depression Inventory .31, Social Reticence Scale .77, and Social Skills Inventory -. 43, self-esteem .29. Scores also correlated at .51 with responses to the statement " I am a shy person." The scale was found to be uncorrelated with loneliness -. 03.

Table 11 Correlations between Shyness scale and other measures

	1	2	3	4	5	6
1. Shyness						
2. Loneliness	-.03 -.22					
3.Depression	.31*** .23	-.28** -.31*				
4.Shyness 2	.50*** .77***	-.14 -.13	.61*** .27			
5.Social Skills	-.28*** -.43***	.01 -.08	-.25* -.03	-.59*** -.57***		
6.Self Esteem	.12 .29*	-.33*** -.48***	.41*** .46***	.39*** .21	-.17 -.00	
7. Shy person	.51*** .37***	-.13 -.19	.23* .05	.30** .31	-.11 -.04	.14 .30*

* p<.05; ** p<.01; *** p<.001 (Time 1 measures are listed first)

There were significant correlations between each statement in the scale and the self-report statement " I am a shy person.", as shown in the following table:

Table 12 The correlation between each statement and "I am a shy person"

No	Item	N	I am shy
1	I feel tense when I am with people I don't know well.	899	.33***
2	I avoid speaking with strangers so as not to say something stupid.	890	.19***
3	I do not converse well with others.	886	.14***
4	I find it difficult to ask other people for help.	882	.27***
5	I feel comfortable at parties and other social functions	885	-.17***
6	When in a group of people, I have trouble thinking of the right thing to say.	893	.22***
7	I feel comfortable even in unusual social functions.	887	-.13***
8	It is hard for me to act naturally when I am meeting new people.	894	.29***
9	I feel shy when I am with people I don't know.	895	.52***
10	I feel confident in my ability to interact with others.	884	-.16***
11	I feel nervous when speaking to someone in authority.	889	.29***
12	I have trouble looking someone right in the eye	893	.29***

13	I initiate conversations with others.	887	-.19***
14	I have doubts about whether other people are willing to be friends with me or to keep company with me.	879	.19***
15	I feel awkward when someone introduces me to new people.	886	.38***
16	I find it hard to talk to strangers.	886	.44***
17	I avoid making new acquaintances for fear that I might not get along well with them.	884	.26***
18	I am shyer with members of the opposite sex of my family.	880	.27***
19	I soon get over my shyness in new social situations.	886	-.24***
20	I feel comfortable in social functions.	897	-.14***

***p<.001

The data collected from the procedure of standardization of the scale gave a strong indication that shyness is a problem that needs attention.

4.4. Section three: The interview

Teachers from different disciplines from King Abdul Aziz University in Saudi Arabia who were not included in either the survey or scale standardisation procedure were asked to give their students the (Appendix A, Form X). One thousand forms were distributed to randomly selected students, asking them if they would like to participate in a skills training programme. If they would like to participate they were asked to give their phone number or any other way to contact them. 300 forms were collected, giving a sample of 275 after deducting those who said "no". These students were called to be interviewed. Most did not respond. Subsequently an advertisement asking students who would be interested to join such a programme to register their names was posted on all the university's main doors and in every building (Appendix A).

All interested students were given the Shyness Scale (Appendix D), and if they scored 65 and above they were interviewed; if not, they were be thanked and told that they would not benefit from the present programmes.

4.4.1.Aim

The aim of the interview was to find out which students felt that being shy was a problem for them. Some shy people like to be shy, not only because they do not consider it a problem but also because they benefit from being a shy person. A minimum score of 65 in the Shyness Scale was used as the criterion entering point to identify a shy person. Then the interviews took place to find out how "shy" students thought and felt about their shyness.

Sample

110 students who scored 65 and above in the Shyness Scale were interviewed.

4.4.2. Method

A ten minute structured interview was conducted with each student. They were asked the same questions, with the same meaning, in the same words. The two criteria for participation in the study are: (a) acknowledgment of shyness, (b) desire to reduce the level of shyness.

The student was welcomed and told the purpose of the interview which was to determine whether she would benefit from programmes being offered or not. She was then asked, " Would you like to tell me a little about yourself?" followed by " Do you consider your shyness a problem for you?" " Would you like to overcome your shyness?" Then she was thanked and told whether she was suitable for the programme. If she was not suitable because she did not consider her shyness a problem, she was thanked and told that the present programmes were not right for her.

80 students were selected for the study.

4.5. Section four: The Experiment

Two approaches were applied: Social Skills Training and Brief Counselling to investigate their effectiveness in alleviating shyness.

4.5.1. Method

Participants

Participants in this study were 80 female students, aged 20 to 24 years (Table 13), with a mean age of 21.9 and a SD of .93. They were selected according to the following criteria:

1. High score (65 and above) in the shyness scale.
2. Feeling that being shy was a problem for them.
3. Having an hour free in their schedule twice a week.

Table 13 Age of participants

Age	Frequency	Percent
20	3	3.8
21	29	36.3
22	23	28.8
23	24	30
24	1	1.3
Total	80	100

The participants were divided into six groups:

1. Social Skills Training group from Psychology Department (SST psy).
2. Social skills Training group from different departments (SST gen).
3. Brief Counselling as individuals using Egan's model (B.Co).
4. Control group from Psychology (Con psy).
5. Control individuals (Con gen).

6. Study skills group (ST).

The distribution of the subject by groups is shown in Table(14).

The reason for having two SST groups was to ensure that the study results were not affected by the nature of the major which students were studying. One SST group included participants from the psychology department, and the other included participants from different departments. Of the three control groups, two did not have any "treatment" and one took the Study Skills Training.

Table 14 Distribution of each group

Experimental groups	No	Control groups	No
Social Skills (psy)	14	Study Skills	13
Social Skills (gen)	16	Control (psy)	14
Brief Counselling	12	Control (gen)	11

Total: 80 participants

To be sure that all groups had more or less the same average rank scores on the pre-test, differences were examined. The outcome is shown in Table (15).

Table 15 Rank of scores in the pre-test

Group	SST (psy)	SST (gen)	B.Co.	ST	Con (Psy)	Con (gen)	Chi-square	Df
Mean Rank	3.09	4.36	3.27	3.50	3.91	2.86	4.973	5

To be significant at 5% level the values of Chi-square should be 11.1 or more (Howitt & Cramer, 1997: 145). Thus, There was no significant difference between the groups, indicating that all had a similar level of shyness at the outset of the experiment.

Design

A correlation method was used to determine the effectiveness of each intervention with controls employed to ensure that the procedure was reliable and valid:

1. All participants were given the same standardised scale.
2. All participants were interviewed to be sure that they believed that being shy was a problem for them.
3. To overcome the problem of being familiar with the test (since it was used three times in a short period of time) a battery of scales with the study scale were given in the pre-test and follow up test.
4. To overcome the issue of maturity and change over time, the follow up test was given to the control groups as well.

Location

A seminar room in the library was chosen to be the place for all sessions. The room was chosen for four reasons:

1) The library building is in the centre of the University, so it was easier for everyone to attend.
2) The room was quiet and far away from classes, so no one would disturb the sessions.
3) The room had all the equipment needed for the programmes.
4) The room was large enough to fit the purpose of the programmes.

Procedure

The participants in the experimental groups and the study skills control group were asked to attend the relevant sessions. Each session lasted for one hour, twice a week.

Each member of the group was given a timetable for the sessions. The control groups were told that their training would be delayed and if they were still interested in taking the programme it would start in 11 weeks time (This course was eventually provided, but the outcomes are not relevant to this study).

4.6. The Social Skills groups

The social skills groups were the experimental groups, which were provided with a Social Skills training programme consisting of ten, one-hour sessions, two sessions a week for a five-week period.

The Social Skills training programme is a learning repertoire based on Albert Bandura's social cognitive theory. The programme includes three repertoire of social skills: conversation skills, assertion skills, and social perception skills.

Conversation skills include three skills: starting a conversation, maintaining a conversation, and ending a conversation. Maintaining a conversation is itself divided into three skills: giving information, asking questions, and listening.

Assertion skills include two main skills, positive and negative assertion. Positive assertion skills or positive feelings include three skills: compliment and praise, affection, and apologies. Negative assertion skills or standing up for oneself include five skills: refusing an unreasonable request, expressing and responding to complaints, requesting new behaviour, negotiating and reaching a compromise, and expressing and responding to anger.

Social perception skills involve two main skills: understanding nonverbal behaviour, and choosing the right time to respond. These skills are included in all the previous skills.

The programme was intended to help the participants to improve their social skills, acquire new social skills, and behave in an appropriate way in everyday social events. The programme provided the participants with ten social skills, divided into ten one-hour sessions twice a week over a five weeks period. Teaching methods were based on five essential techniques: instruction, role-playing, feedback and reinforcement, modelling, and practice.

The present programme took advantages of many existing social skills training programmes putting in mind the culture and nature of the sample (age and gender). {The Shyness Workbook by P. G. Zimbardo & S. L. Radl (1979); The Social Challenge Program, by K. Plummer (1986); The Social Skills Handbook by S. Hutchings, et al., (1999); Skillstreaming the Adolescent by A. P. Goldstein & E. McGinnis (1997); Skills for Living by R. S. Morganett (1990); Group Exercises for enhancing social skills and self-esteem by S. Khalsa (1996 vol,1999, vol 2); Relating Skills by R. N. Jones (1996)}.

4.6.1. General structure of the sessions:

A. The trainer provides clear instructions and rationale for targeting given behaviours within the session.
B. The trainer provides a scenario for role-play. Then the participants play the role in order to find out the response style and shortcomings (weak points).

C. The trainer provides feedback and positive reinforcement. She explains the strong and weak points and emphasises the importance of the nonverbal elements in the interaction between individuals.

D. If the participants are unable to play the role effectively, the trainer models the role, so members of the group can notice how it can be done. At the same time, the trainer gives specific, clear instructions on how to perform the skill.

E. The participants play the role again.

F. The trainer summarises the whole idea of the session.

G. The participants evaluate themselves on an evaluation card, and reinforce themselves, for example by saying " I did a good job", "I am proud of myself."

H. The trainer gives the home assignment, which is to practise the target skill with three different people: a family member, a friend, and an acquaintance, in different situations. Then the participants evaluate their performance on a scale from low to high, and reinforce themselves by saying ,for example, "I did a good job."

All forms used are given in Appendix (C, English; D, Arabic) Full details of each session are given in Appendix B)

Materials

Each participant received a prepared file containing the following material:

Forms

Form A: "The people and situations that make me shy".

Form B: " Things about myself".

Form C: " Record of me" card.

Form D: " Effective Skills Questions".

Form E: " Practice sheet"

Form F: " Homework recording sheet".

Form G: " Pair Interview".

Form H: " My Skills Steps".

Form I: " Final Interview".

Cards

Card A: Timetable schedule.

Card B: Skills Training Record.

Card C: Personal record.

Card D: Session Evaluation Card.

Card E: Face and Eyes Cards.

Card F: Skills Steps Cards.

(Appendix C&D)

A nylon zipper file attached to the main file contained; pencil, pen, and a small mirror.

4.6.2. List of skills:

1) Effective listening.
2) Conversation.
3) Compliment and praise.
4) Affection.
5) Apologies.
6) Refusing an unreasonable request.
7) Expressing and responding to complaints.
8) Requesting new behaviour.

9) Negotiating and reaching a compromise.

10) Expressing and responding to anger.

4.6.2. Sessions

The first session was structured to give participants an introduction to the programme, followed by a "record of me" activity, followed by a definition of the day's skill, " effective listening". The steps for the skill were demonstrated, followed by role-play, then followed by comments and positive reinforcement from the trainer. A pair interview activity was then carried out, after which the trainer gave a summary of the session, and the day's skill was evaluated. The day's assignment was given and the session concluded with the session evaluation.

The same structure was used in all sessions, but instead of the introduction, a review of the previous session took place. In the last session, a post-test was administered.
Timings for all sessions were identical, except for first and last sessions. The following table (16) shows the breakdown of activities for the first two sessions, by way of example.

Table 16 Session one:

Content	Time
Introduction to the programme	10
Record of me activity	10
Lecture about effective listening	5
Role play and modelling	15
Pair interview activity	5
Summary	5
Skill evaluation	3
Home assignment	5
Session evaluation	2

Table 17 Session two:

Content	Time
Review of the last session's home assignment	10
Lecture about conversation skills	10
Role play and modelling	25
Summary	5
Skill evaluation	3
Home assignment	5
Session evaluation	2

Session two (table 17) represents the structure of all following sessions except for the last session, which included the post-test for five minutes, and the conclusion for another five minutes.

A thank you gift and an attendance certificate were given to all participants.

4.6.3. Sessions Objectives:

Each element within the session was intended to serve a particular purpose as follows:

Introduction to the programme:

- To explain the training programme
- To clarify the rule and code of the *group.*

Record of me activity:

- To give the group the opportunity to become familiar with each other
- To produce a relaxed atmosphere.

Lecture about session's topic

- To provide the participants with basic information about the skill.
- To explain and model the skill steps to the participants.

Role-play and modelling:

- To give the participants the opportunity to show how skilled they are.
- To give the participants the chance to learn the skill.
- To give the participants the opportunity to learn from each other.
- To give the trainer the opportunity to give advice and positive reinforcement.
- To give the participants the opportunity to practise the skill.

Pair interviews activity:

- To give the group the opportunity to become more familiar with each other.
- To give the group the opportunity for social interaction.

Summary:

- To sum up what the session has been about.
- To give the group the opportunity to reflect on what the session was about.

Skill evaluation:

- To give each participant the chance to evaluate herself.
- To give each participant the chance to consider what she did.
- To give each participant the chance to reinforce herself.

Home assignment:

- To practise the skill the participants learned in the session.
- To develop participants' competence in the skill they had just learned.
- To enable participants to self evaluate their skills.
- To help participants become more aware of their ability.

Session evaluation:

- To get feedback from the participants.
- To help the trainer to overcome any weakness or deficiency in the session.
- To help the trainer to evaluate the session.
- To help the trainer to do better for the next session.

Review the home assignment

- To find out any difficulty the participants faced and help them to overcome them.
- To find out how far the participants had mastered the skill.
- To give positive reinforcement and to encourage participants to practise more.

The post-test

- To find out if the participants had benefited from the programme
- To compare the result with the pre-test and later with a follow up test.

Conclusion of the programme

- To end the programme.
- To thank the participants
- To give the date for the follow up test.

4.7. The Brief Counselling

Brief counselling using Egan's Model was given to twelve individuals. Each participant had a one-hour session twice a week. The number of sessions was between 4 and 8.

4.7.1. General structure of the sessions:

In the first session, the counsellor established a working relationship with the client and helped the client to manage reluctance and resistance. In the last session the counsellor gave the client the opportunity to review what changes she had made, consider the advantages and the disadvantages of her present behaviour, and develop an action programme for the future. Then a post-test was given to the client. After that the counsellor gave a thank you gift to the client and wished her good luck. The counsellor asked the client to come back after six weeks for the follow up.

From the second session to the session before the last one the counsellor helped the client to help herself to overcome or at least lower the level of her shyness.

All forms used are given in Appendix (C, English; D, Arabic)

Full details of the sessions are given in Appendix (B)

Materials

The counsellor gave the client a file that contained:

Form A: "The people and situations that make me shy".

Form E: " Practice sheet"

Card A: Timetable schedule.

Card D: Session Evaluation Card.

Card F: Skills Steps Cards.

A notebook, and pen.

4.7.2. Sessions

The counsellor helped the client to identify and clarify problem situations by:

- Helping her to tell her story.
- Helping her to challenge herself.
- Helping her work on the relevant aspect.

The counsellor helped the client create a better future by:

- Helping her to develop preferred-scenario possibilities.
- Helping her to identify what she wanted.
- Helping her to commit herself to accomplish what she wanted.

The counsellor helped the client to achieve her goals by:

- Helping her to develop strategies for accomplishing her goals.
- Helping her to choose the strategies that were best for her.
- Helping her to develop action programmes.

4.7.3. Objectives of each stage:

Stage one

a) To reduce the number of negative feelings and emotions.

b) To clarify problem situations.

c) To have new perspectives and change self-limiting and both self-defeating internal behaviours and self-defeating external behaviours.

d) To identify and evaluate incentives.

e) To help participants become more effective decision-makers.

f) To screen problems and opportunities.

g) To work on the right things.

h) To stay focused throughout the helping process.

Stage two

a) To develop a sense of direction by exploring possibilities for a better future.

b) To turn possibilities into a practical programme for change.

c) To set realistic, specific, prudent, flexible, sustainable goals.

d) To establish goals that would make a difference.

Stage three

a) To identify and choose a realistic course of action for achieving goals.

b) To achieve goals.

c) To mobilise needed resources.

d) To learn the life skills needed to cope more effectively.

e) To choose best-fit strategies.

f) To formulate plans for the future.

4.8. The Study Skills Group

The study skills group was a control group that was given the same number of sessions and the same duration as the experimental social skills group. It consisted of ten, one-hour sessions twice a week over a four-week period. The programme provided the students with ten main study skills, one in each session. Each session consisted of two main parts; in the first part, students performed certain exercises, and in the second, they were given information concerning their learning. During the sessions participants were free to converse and interact with each other.

Samples of the exercises are given in Appendix (C, English, D, Arabic)

Full details of each session are given in Appendix (B).

4.8.1. General structure of the sessions:

The first session (table18) was structured to give participants an introduction to the programme. This was followed by exercises on " being a student", followed by fifteen minutes review of the exercises. Then the day's topic, optimal learning, was addressed. The session ended with an evaluation of the day's session.

The same structure was used in all sessions, but instead of the introduction, a review of the previous session took place (table19). In the last session, a post-test was administered. A thank you gift was given to all participants.

All the exercises and information were taken from:

A. The Effective Learning Programme by the Academic Services and Teaching & Learning Support, Hull University.
B. The Study Skills Handbook by S. Cottrell (1999).
C. Secrets for graduating distinctly from university by K. Kably (unpublished).

Arabic exercises provided by Dr. K. Alsaban were added in session three (reading skills). Some adjustments were made to the exercises and information, to suit the Arabic language and culture.

Materials

Each participant received a prepared file containing 10 sections, each section containing different kinds of exercises. It also contained Form A: "The people and situations that make me shy", Card A: Timetable schedule and Card D: Session Evaluation Card. A nylon zipper file attached to the main file contained a pencil, pen, and double ended fibre pens.

The following tables give an idea about the sessions.

Table 18 Session one:

Content	Time
Introduction to the programme.	15
Exercises: Being a student	10
Correcting the exercises.	15
Today's topic (Optimal Learning).	15
Evaluation.	5

Table 19 Session two:

Content	Time
Review the last session.	10
Exercises: Organising yourself	15
Correcting the exercises.	20
Today's topic (How to organise yourself).	10
Evaluation.	5

Session two represented the structure of all following sessions except the last session, which included the post-test for five minutes, and the conclusion for another five minutes.

4.8.2. Session Topics

1. Optimal learning
2. Organisational skills
3. Reading skills
4. Writing skills
5. Making notes
6. Collecting information
7. Recording information
8. Research skills
9. Effective revision
10. Exam strategy.

4.8.3. Sessions Objectives

Introduction to the programme:

- To explain the training programme.
- To clarify the work within the session.

Being a student exercises:

- To formulate the reason for studying at the university.
- To take responsibility for studying at the university.

Correcting the exercises:

- To be sure that the objectives of the exercises were met.
- To clarify any ambiguity in the exercises.

Today's topic " optimal learning"

- To identify the main requirement for successful learning.
- To identify learning styles and methods that can be used during studying.
- To pinpoint the skills which need to be developed.

Evaluation:

- To get feedback from the students.
- To help to overcome any problem for the next session.

Review of the last session

- To answer any questions raised.
- To add more information.

Organising yourself exercises:

- To measure how much structure and planning the student needed in her life.
- To decide how much time to allocate to different life activities.

Today's topic "organising yourself "

- To clarify the importance of being organised.
- To monitor for a week how organised the person could be.

Reading exercises:

- To examine the different purposes that reading can serve.
- To consider the need to make reading an active process.

Today's topic "Reading skills"

- To formulate the reason for quicker and more efficient reading.
- To give an idea about different sorts of speed-reading.

Writing exercises part one:

- To recognise the importance of good writing.
- To choose the most appropriate form of writing for the task.

Today's topic, "writing skills"

- To plan essays, and reports.
- To recognise the importance of careful planning.
- To develop presentation skills.

Writing exercises part two:

- To define the elements of style
- To apply rules of spelling, punctuation, and grammar

Today's topic, "making notes"

- To identify the purpose of making notes.
- To evaluate different techniques for making notes

Collecting information exercises:

- To examine why we need information.
- To identify the available types of resources.

Today's topic, "collecting information"

- To identify the wide range of possible resources.
- To locate and choose the appropriate resources.
- To develop presentation skills.

Recording information exercises:

- To know the reasons for recording information.
- To practise recording information.

Today's topic, "Recording information"

- To explain the importance of recording information about resources.
- To explain different styles of recording information.

Research skills exercises:

- To know what needs to be done before writing an essay, report, or assignment
- To become aware of how to find and select the most relevant information source materials.

Today's topic, "Research skills"

- To learn how to undertake general research skills.
- To learn how to use the library.
- To learn how to find information.

Assessment exercises:

- To identify the purposes of assessment.
- To establish some assessment criteria.

Today's topic, "effective revision"

- To learn how to avoid common pitfalls in revision.
- To develop ideas for approaching the long term and working towards the exams.

Assessment exercises:

- To be prepared for multiple-choice tests.
- To recognise the importance of preparation for exams.

Today's topic "Exam strategy"

- To know the purposes of exams.
- To make adequate preparation for exams.

Post-test.

- To compare the results with the pre-test

Conclusion of the programme:

- To end the programme
- To thank the participants

4.9. Ethical Considerations

The resercher is guided by a code of ethics on conducting research with clients or participants. The present study adhered to the relevant ethical procedures that have been established by the British Psychological Society (1993) and British Association for Counselling (1998). In essence, the psychological well being of participants was regarded as being of utmost importance.

The study recognised the necessity of confidentiality and autonomy of participants. The researcher made it clear that participants were also free to withdraw information and consent given prior, during and after the process of collecting the data.

Chapter Five: Results

The universal human propensity to seek the company of other people and to establish a variety of relationships with them is likely to stem from the fact that human beings need one another for survival.

Leary & Buckley
2000

5.1. Introduction

The aim of this study was to evaluate the effectiveness of Social Skills Training and Brief Counselling. This chapter is concerned with the analysis of the data. It is divided into two sub-sections. The first section reports the results from the data collected before the experiment took place. The second section reports the results of the Shyness Scales.

5.1.1. Section one

The data in Tables 20 to 25 show the distribution of participants who gave background information, replied to the pre-test shyness scale, and completed Form A (Appendix C English, D Arabic) which was given after the interview. It should be noted that the number of the participants was 80.

The distribution of the respondents according to their age is represented in Table (20) Most participants were between 21 and 23 years old, with a mean of 21.9 and SD of .93.

Table 20 Distribution of the participants by age

Age	20	21	22	23	24	Total
SST(psy)		3	7	4		14
SST(gen)		3	3	10		16
B.Co.	1	6	2	2	1	12
ST	2	7	2	2		13
Cont.(psy)		6	6	2		14
Cont.(gen)		4	3	4		11
Total	3	29	23	24	1	80
Percent	**3.75**	**36.25**	**28.75**	**30**	**1.25**	**100**
Mean	**21.9**			**SD**	**.93**	

Table (21) shows the frequency and percentage of the participant's marital status. The majority 78.75% of the participants were single. 13.75% did not respond to this enquiry.

Table 21 Distribution of the participants by status

Status	Frequency	Percent
Single	63	78.75
Married	6	7.5
No answer	11	13.75
Total	**80**	**100**

Table (22) shows the frequency and percentage of responses to the question, " Do you have a shy parent?" The highest number, 83.75%, of the participants said no; only 16.25% said that their mothers were shy.

Table 22 Distribution of the participants' shy parent

Group	Mother	No one
SST(psy)	2	12
SST(gen)	2	14
B.Co.	3	9
ST	1	12
Cont.(psy)	5	9
Cont.(gen)	0	11
Total	**13**	**67**
Percent	**16.25**	**83.75**

Table (23) shows the time when the participants felt shy. The majority, 60%, of the respondents had been shy since their childhood. 13.75% did not respond to this enquiry.

Table 23 Distribution of the participants' time of shyness

Time	Frequency	Percent
Childhood	48	60
Adolescent	18	22.5
Adulthood	3	3.75
No answer	11	13.75
Total	**80**	**100**

Table (24) presents the responses of participants regarding people who made them shy. The majority, 81.25%, of participants said " people in authority", and 45% said "teachers".

Table 24 Distribution of the people who make participants shy

People	Frequency	Percent
People in authority	65	81.25
Teachers	36	45
Men	30	37.5
Friends	24	30
Father	19	23.75
Strangers	19	23.75
Uncle (father's side)	18	22.5
Old people	18	22.5
Brother	11	13.75
All	4	5

Table (25) presents the distribution of participants according to situations that make them shy. All participants said they felt shy in situations where they felt vulnerable, situations requiring assertiveness, situations where they were the focus of attention, before a large group, and situations where they were being evaluated or compared to others.

Table 25 Distribution of the situations that make participants shy

Situations	Frequency	Percent
Situations where I feel vulnerable	80	100
Situations requiring assertiveness	80	100
Situations where I am the focus of the attention, before a large group	80	100
Situations where I am being evaluated or compared to others	80	100
Situations where I am of lower status than others	76	95
One to one interaction with a male person	75	93.75
Situations where I am the focus of attention, before a small group	75	93.75
New interpersonal situations	65	81.25
Small social groups	40	50
Large group	30	37.5
Any social situation	26	32.5
Small, task-oriented groups	13	16.25
One to one interactions with other females	4	5

5.1.2. Section two

Descriptive Analysis of the Scales Means and Standard deviations of the participants scores on the scale used in the study are presented in Table (22) (the raw scores for each participants is given in Appendix A).

Table 26 Mean and standard deviations of the scores in all groups

	Scores					
	Pre-test		Post-test		Follow-up-test	
	Mean	SD	Mean	SD	Mean	SD
SST(psy)	73	7.01	63.43	7.53	62.64	7.45
SST(gen)	71.50	5.75	61.06	8.31	58.44	7.61
B.Co.	73.25	6.77	62.25	7.75	60.73	7.50
ST	71.31	7.47	67.38	8.32	67.50	9.34
Cont.(psy)	70.00	7.04	69.29	7.02	68.36	6.70
Cont(gen)	71.00	4.84	69.27	5.27	67.56	4.25

Chart 1 The distribution of the means

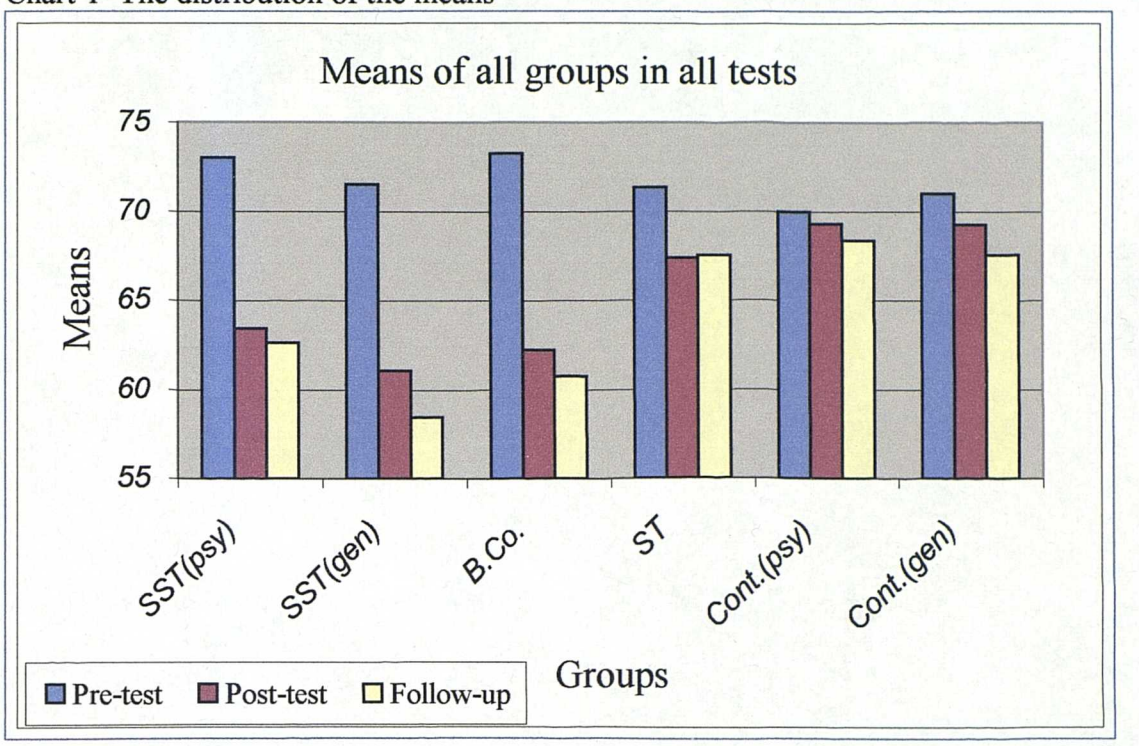


Table (27) shows the Analysis of variance using one –way ANOVA. It indicates no significant difference between the six groups ($p>.05$) for the pre-test scores. It also indicates significant difference between the groups at ($p<.05$) for the post-test and ($p<.01$) for the follow-up-test.

Table 27 The Analysis of variance

	Source of variation	Sum of square	Degree of freedom	Mean square	F-Ratio
Pre-test	Between groups	100.868	5	20.174	.469
	Within groups	3185.019	74	43.041	
	Total	3285.888	79		
Post-test	Between groups	609.339	5	181.268	3.223*
	Within groups	4162.149	74	56.245	
	Total	5068.488	79		
Follow-up-test	Between groups	1098.939	5	219.788	3.978**
	Within groups	3536.432	64	55.257	
	Total	4635.371	69		

*$p<.05$ **$p<.01$

Table (28) shows that there were significant differences (p<.05) between the pre-test and post-test scores for the five groups: SST (psy), SST(gen), B.Co., ST., and Control (gen) groups, but there was no difference between the pre-test and post-test scores for the Control(psy) group. While all groups except the Control (Psy) exhibited significant pre-test-to-post-test change, the differences for the three experimental groups (SST(psy), SST(gen), and B.Co.) were at a higher level of significance (.001) than those for the control groups (ST, Control(gen) (.01, .047).

Table 28 The pre and post-test for all groups

	groups	N	Mean	Std Deviation	t	df	Sig. (2-tailed)
Pre-test Post test	SST (psy)	14 14	73.00 63.43	7.01 7.53	8.017	13	.000
Pre-test Post test	SST (gen)	16 16	71.50 61.06	5.75 8.31	8.523	15	.000
Pre-test Post test	B.Co.	12 12	73.25 62.25	6.77 7.75	7.553	11	.000
Pre-test Post test	ST	13 13	72.08 67.38	7.61 8.32	2.942	12	.012
Pre-test Post test	Con. (psy)	14 14	70.00 69.29	7.04 7.02	.629	13	.540
Pre-test Post test	Con. (gen)	11 11	71.00 69.27	4.84 5.27	2.261	10	.047

Table (29) shows that there were significant differences (p>.05) between the pre-test and follow-up test scores for the three groups SST(psy), SST(gen), and B.Co. However, there were no differences between the pre-test and follow-up-test for ST, con.(psy), and con.(gen).

Table 29 The pre and follow-up-test for all groups

	Groups	N	Mean	Std Deviation	t	df	Sig. (2-tailed)
Pre-test **Follow-up-test**	SST (psy)	11 11	73.27 62.64	7.62 7.45	5.811	10	.000
Pre-test **Follow-up-test**	SST (gen)	16 16	71.50 58.44	5.75 7.61	9.208	15	.000
Pre-test **Follow-up-test**	B.Co.	11 11	73.82 60.73	6.79 7.50	9.686	10	.000
Pre-test **Follow-up-test**	ST	12 12	72.33 67.50	7.89 9.34	1.999	11	.071
Pre-test **Follow-up-test**	Con. (psy)	11 11	70.27 68.36	7.84 6.70	1.040	10	.323
Pre-test **Follow-up-test**	Con. (gen)	9 9	70.44 67.56	4.10 4.25	2.267	8	.053

Table (30) shows that only two groups SST(gen) and B.Co., exhibited significant differences between the post and follow-up test, at $p<.05$. The other four groups had no significant differences.

Table 30 The post and follow-up-test for all groups

	Groups	N	Mean	Std Deviation	t	df	Sig. (2-tailed)
Post-test Follow-up-test	SST (psy)	11 11	63.18 62.64	8.38 7.45	.500	10	.628
Post -test Follow-up-test	SST (gen)	16 16	61.06 58.44	8.31 7.61	2.877	15	.012
Post-test Follow-up-test	B.Co.	11 11	62.45 60.73	8.09 7.50	2.725	10	.021
Post-test Follow-up-test	ST	12 12	67.33 67.50	8.69 9.35	-.071	11	.944
Post-test Follow-up-test	Con. (psy)	11 11	69.36 68.36	7.99 6.70	1.254	10	.239
Post-test Follow-up-test	Con. (gen)	9 9	68.67 67.56	4.50 4.25	.929	8	.380

Table (31) shows that there were significant differences between SST(psy) and con.(psy) and between SST(gen) and con.(gen) at $p<.05$, but there was no significant difference between B.Co. and ST.

Table 31 The comparison between groups in the post-test.

	Groups	N	Mean	Std Deviation	Levene's test for Equality of Variannces		t	df	Sig. (2-tailed)
					F	Sig.			
Post-test	SST (psy) Con. (psy)	14 14	63.43 69.29	7.53 7.02	.670	.421	-2.128	26	.043
Post-test	SST (gen) Con. (gen)	16 11	61.06 69.27	8.31 5.27	4.154	.052	-2.890	25	.008
Post-test	B.Co. ST.	12 13	62.25 67.38	7.75 8.32	.000	.993	-1.593	23	.125

Table (32) shows that there was a significant difference between SST(gen) and con.(gen), at $p<.05$, but there were no significant differences between SST(psy) and Con. (psy), or between and B.Co. and ST, $p>.05$.

Table 32 The comparison between groups in the follow-up-test.

	Groups	N	Mean	Std Deviation	Levene's test for Equality of Variannces		T	df	Sig. (2-tailed)
					F	Sig.			
Follow-up-test	SST (psy) Con. (psy)	11 11	62.64 68.36	7.45 6.70	.445	.512	-1.897	20	.072
Follow-up-test	SST (gen) Con. (gen)	16 9	58.44 67.56	7.61 4.25	5.080	.034	-3.299*	23	.003
Follow-up-test	B.Co. ST.	11 12	60.73 67.50	7.50 9.34	.042	.839	-1.906	21	.070

(* Equal Variances not assumed)

The (psy) and the (gen) groups were combined into one group, so group one is the experimental group made up of SST(psy) and SST(gen); and group two is the control group, comprising Con. (psy) and Con.(gen).

Table (33) shows that there was no significant difference between groups one and two in the pre-test. However there were significant differences between groups one and two in the post-test and the follow-up-test, $p<.05$

Table 33 The comparison between group (1) and (2)

	Group	N	Mean	SD	Levene's test for Equality of variannces		t-test for Equality of Means		
					F	Sig.	t	df	Sig. (2-tailed)
Pre-test	1 2	30 24	72.20 70.46	6.30 6.20	.243	.624	1.017	52	.314
Post-test	1 2	30 24	62.17 69.38	7.91 6.30	3.997	.051	-3.633	52	.001
Follow-up-test	1 2	27 19	60.15 68.16	7.69 5.71	4.502	.040	- 4.053*	43.836	.000

(* Equal Variances not assumed)

Application of One way ANOVA (Table 34) revealed no significant differences between the 6 groups in the pre-test, F=.462 (5,74); $p>.05$. Between the 6 groups in the post-test the overall F test revealed significant differences, F=3.184(5,74); $p<.05$, and there were also significant differences between the 6 groups in the follow-up-test F=3.978(5,74), $p<.05$.

Table 34 The overall One way ANOVA

		Sum of Squares	df	Mean Square	F	Sig.
Pre-test	Between Groups Within groups Total	100.214 3211.173 3311.388	5 74 79	20.043 43.394	.462	.803
Post-test	Between Groups Within groups Total	900.268 4184.732 5085.000	5 74 79	180.054 56.550	3.184	.012
Follow-up-test	Between Groups Within groups Total	1098.939 3536.432 4635.371	5 64 69	219.788 55.257	3.978	.003

Since the overall F test is significant, Post Hoc tests were carried to find out where the significant differences lay, Table (35) shows that there were statistically significant differences between SST(gen) and Con.(psy), and between SST(gen) and the Con.(gen) in the post-test.

Table 35 The post-test : Post Hoc (Tukey HSD)

(I)Groups	(J)Groups	Mean Difference (I-J)	Std. Error	Sig.
SST(psy)	SST(gen) B.Co. ST Con.(psy) Con.(gen)	2.37 1.18 -3.96 -5.86 -5.84	2.75 2.96 2.90 2.84 3.03	.955 .999 .747 .319 .393
SST(gen)	SST(psy) B.Co. ST Con.(psy) Con.(gen)	-2.37 -1.19 -6.32 -8.22* -8.21	2.75 2.87 2.81 2.75 2.95	.955 .998 .227 .043 .071
B.Co.	SST(psy) SST(gen) ST Con.(psy) Con.(gen)	-1.18 1.19 -5.13 -7.04 -7.02	2.96 2.87 3.01 2.96 3.14	.999 .998 .533 .177 .234
ST	SST(psy) SST(gen) B.Co Con.(psy) Con.(gen)	3.96 6.32 5.13 -1.90 -1.89	2.90 2.81 3.01 2.90 3.08	.747 .227 .533 .986 .990
Con.(psy)	SST(psy) SST(gen) B.Co ST Con.(gen)	5.86 8.22* 7.04 1.90 1.30	2.84 2.75 2.96 2.90 3.03	.319 .043 .177 .986 1.000
Con.(gen)	SST(psy) SST(gen) B.Co ST Con.(psy)	5.84 8.21 7.02 1.89 -1.30	3.03 2.95 3.14 3.08 3.03	.393 .071 .234 .990 1.000

A Post Hoc test was also done to find which of the six groups were statistically significantly from each other in the follow-up-test. Table (36) shows that there were significant differences between SST(gen) and ST; between the SST(gen) and Con.(psy); and between SST(gen) and Con.(gen).

Table 36 The follow-up-test: Post-Hoc (Tukey HSD)

(I)Groups	(J)Groups	Mean Difference (I-J)	Std. Error	Sig.
SST(psy)	SST(gen)	4.20	2.91	.701
	B.Co.	1.91	3.17	.991
	ST	-4.86	3.10	.623
	Con.(psy)	-5.73	3.17	.469
	Con.(gen)	-4.92	3.34	.683
SST(gen)	SST(psy)	-4.20	2.91	.701
	B.Co.	-2.29	2.91	.969
	ST	-9.06*	2.84	.025
	Con.(psy)	-9.93*	2.91	.014
	Con.(gen)	-9.12*	3.10	.049
B.Co.	SST(psy)	-1.91	3.17	.991
	SST(gen)	2.29	2.91	.969
	ST	-6.77	3.10	.260
	Con.(psy)	-7.64	3.17	.169
	Con.(gen)	-6.83	3.34	.330
ST	SST(psy)	4.86	3.10	.623
	SST(gen)	9.06*	2.84	.025
	B.Co	6.77	3.10	.260
	Con.(psy)	-.86	3.10	1.000
	Con.(gen)	-5.56	3.28	1.000
Con.(psy)	SST(psy)	5.73	3.17	.469
	SST(gen)	9.93*	2.91	.014
	B.Co	7.64	3.17	.169
	ST	.86	3.10	1.000
	Con.(gen)	.81	3.34	1.000
Con.(gen)	SST(psy)	4.92	3.34	.683
	SST(gen)	9.12*	3.10	.049
	B.Co	6.83	3.34	.330
	ST	5.56	3.28	1.000
	Con.(psy)	-.81	3.34	1.000

The t-test was applied to two groups formed by combining the (psy) and the (gen) groups into one group so group one was the experimental group of the SST(psy) and

SST(gen); and group two was the control group for Con.(psy) and Con.(gen). Table (37) shows that there was no significant differences between group one and two in the pre-test. However, there were significant differences between groups one and two in the post-test and the follow-up-test, $p<.05$

Table 37 the experimental group (1) and the control group (2)

	Group	N	Mean	SD	Levene's Test for Equality of Variances		t-test for Equality of Means		
					F	Sig.	t	df	Sig.
Pre-test	1 2	30 24	72.20 70.46	6.30 6.20	.243	.624	1.017	52	.314
Post-test	1 2	30 24	62.17 69.38	7.91 6.30	3.997	.051	-3.633	52	.001
Follow-up-test	1 2	27 19	60.15 68.16	7.69 5.71	4.502	.040	- 4.053*	43.836	.000

(* Equal Variances not assumed)

One way ANOVA was applied for the 4 groups: group one was the experimental group for SST; group two was the control group for the SST; group 3 was the B.Co.; group 4 was the ST. Table (38) shows that the overall F test for the 4 groups in the pre-test was not significant. However the overall F test for the groups in the post-test and the follow-up-test revealed a significant difference at $p<.05$.

Table 38 The One way ANOVA

		Sum of Squares	df	Mean Square	F	Sig.
Pre-test	Between groups Within groups Total	73.451 3237.937 3311.388	3 76 79	24.484 42.604	.575	.633
Post-test	Between groups Within groups Total	863.744 4221.256 5085.000	3 76 79	287.915 55.543	5.184	.003
Follow-up-test	Between groups Within groups Total	984.487 3650.885 4635.371	3 66 69	328.162 55.316	5.932	.001

Post Hoc tests revealed that in the post-test, there was a significant difference between the Experimental group (SST) and the Control group (SST); Table (39) shows that there was a significant difference between the Control group (SST) and the B.Co. group. As for the Post Hoc, in the follow-up test there were significant differences between the experimental and control groups; there were significant differences between the experimental and ST groups; and finally there were significant differences between the control group and the ST group.

In the post-test the experimental group scored significantly lower than the control group; and the ST group scored significantly lower than the control group. As for the follow-up test, the experimental group scored significantly lower than both the control group and the ST group, while the ST group scored significantly lower than the control group.

Table 39 The Post Hoc Tests (Tukey HSD)

Dependent Variable	(I)group two	(J)group two	Mean Difference (I-J)	Std. Error	Sig.
Pre-test	1	2	1.74	1.79	.764
		3	-1.05	2.23	.965
		4	.27	2.11	.999
	2	1	-1.74	1.79	.764
		3	-2.79	2.31	.623
		4	-1.47	2.20	.908
	3	1	1.05	2.23	.965
		2	2.79	2.31	.623
		4	1.32	2.57	.955
	4	1	-.27	2.11	.999
		2	1.47	2.20	.908
		3	-1.32	2.57	.955
Post-test	1	2	-7.21*	2.04	.004
		3	-8.33	2.55	1.000
		4	-5.19	2.41	.146
	2	1	7.21*	2.04	.004
		3	7.13*	2.63	.041
		4	2.02	2.51	.852
	3	1	8.33	2.55	1.000

		2 4	-7.13* -5.11	2.63 2.93	.041 .310
	4	1 2 3	5.19 -2.02 5.11	2.41 2.51 2.93	.146 .852 .310
Follow-up-test	1	2 3 4	-8.01* -.58 -7.16*	2.23 2.66 2.51	.003 .996 .029
	2	1 3 4	8.01* 7.43* .85	2.23 2.82 2.68	.003 .050 .989
	3	1 2 4	.58 -7.43* -6.58	2.66 2.82 3.05	.996 .050 .145
	4	1 2 3	7.16* -.85 6.58	2.51 2.68 3.05	.029 .989 .145

* $P<.05$

Using the General Linear Model for Repeated Measures, the following Table (40) shows the results for Within-Subjects Factors

Table 40 Within-Subjects Factors (Wilks'Lambda)

Group		N	Mean	SD	Value	F	Hypothesis df	Error df	Sig.
SST (psy)	Pre-test Post-test Follow-up-test	14 14 14	73.00 63.43 62.76	7.01 7.53 6.73	.166	30.036	2	12	.000
SST (gen)	Pre-test Post-test Follow-up-test	16 16 16	71.50 61.06 58.44	5.75 8.31 7.61	.143	41.896	2	14	.000
B.Co	Pre-test Post-test Follow-up-test	12 12 12	73.25 62.25 60.51	6.77 7.75 7.19	.088	52.090	2	10	.000
ST	Pre-test Post-test Follow-up-test	13 13 13	72.08 67.38 67.55	7.61 8.32 8.94	.560	4.313	2	11	.041
Con. (psy)	Pre-test Post-test Follow-up-test	14 14 14	70.00 69.29 68.29	7.04 7.02 5.89	.833	1.207	2	12	.333
Con. (gen)	Pre-test Post-test Follow-up-test	11 11 11	71.00 69.27 68.16	4.87 5.27 5.10	.531	3.974	2	9	.058

Table (41) shows the results of Tests of Within-Subjects Effects.

Table 41 Tests of Within-Subjects Effects

Group	Source	Type 111 Sum of Squares	df	Mean Square	F	Sig.
SST(psy)	Factor 1 Greenhouse-Geisser	918.509	1.514	606.742	46.142	.000
SST(gen)	Factor 1 Greenhouse-Geisser	1527.792	1.636	933.930	65.940	.000
B.Co	Factor 1 Greenhouse-Geisser	1145.534	1.242	922.488	69.847	.000
ST	Factor 1 Greenhouse-Geisser	184.274	1.749	105.374	3.490	.055
Con.(psy)	Factor 1 Greenhouse-Geisser	20.762	1.227	16.919	1.171	.309
Con.(gen)	Factor 1 Greenhouse-Geisser	44.948	1.798	25.003	4.738	.025

Table (42) shows the results of Tests of Within-Subjects Contrasts.

Table 42 Tests of Within-Subjects Contrasts

Group	Source		Typeiii Sum of Squares	df	Mean Square	F	Sig.
SST(psy)	Factor 1 Quadratic	Linear	733.389 185.120	1 1	733.389 185.120	49.469 36.435	.000 .000
SST(gen)	Factor 1 Quadratic	Linear	1365.031 162.760	1 1	1365.031 162.760	84.796 23.016	.000 .000
B.Co	Factor 1 Quadratic	Linear	974.100 171.433	1 1	974.100 171.433	98.753 26.227	.000 .000
ST	Factor 1 Quadratic	Linear	133.114 51.160	1 1	133.114 51.160	4.062 2.554	.067 .136
Con.(psy)	Factor 1 Quadratic	Linear	20.571 .190	1 1	20.571 .190	1.383 .067	.261 .800
Con.(gen)	Factor 1 Quadratic	Linear	44.247 .701	1 1	44.247 .701	7.530 .194	.021 .669

within and between group differences appeared during the post-test and follow-up test. To be more accurate, a percentage of improvement was obtained. The result, as shown in Table (43) revealed that all members of the six groups had decreased in their levels of

shyness, but it was clear that the experimental groups exhibited greater reductions in shyness than the control groups.

Table 43 Percentage of improvement between the pre-test and follow-up-test

Groups	Pre-test (A)	Follow-up-test (B)	Different between A & B	Percentage of improvement
SST (psy)	73	62.64	-10.36	14.20%
SST(gen)	71.50	58.44	-13.06	18.27%
B.Co	73.25	60.73	-12.52	17.09%
ST	72.08	67.50	-4.58	6.35%
Con.(psy)	70.00	68.36	-1.64	2.34%
Con.(gen)	71.00	67.56	-3.44	4.85%

Chapter Six: Discussion

It is easy to perform a good action, but not easy to acquire a settled habit of performing such actions.
Aristotle
335BC

6.1. Introduction

Shyness is very painful. A shy person suffers greatly, it is hard for him/her to start a relationship or join in activities that he/she would love to do. As if this is not enough struggling, people sometimes reject or avoid him/her because he/she is quiet and withdrawn. This painfuly affects his/her life not only socially, but also mentally and physically.

Shyness can be treated; there is no reason for having the pain of being shy. Any effort to overcome the problematic aspects of shyness is worth taking. Shy behaviour can be replaced by more effective behaviour using a variety of different methods.

The aim of this study was to investigate the effectiveness of Social Skills Training and Brief Counselling using the Egan Model to alleviate shyness.

The Social Skills Training programme was designed to meet the therapeutic need of adults (20-24) years old who experience shyness. The aims of the programme were to help participants to improve their social skills and acquire new skills that, it was hoped,

would give them the tools they need to behave in an appropriate way in everyday social events.

Brief Counselling using the Egan model aimed to help participants to help themselves to overcome the problematic aspects of shyness. It was agreed with each participant that the number of sessions would not exceed ten.

6.2. Analyses of the preliminary data

There are three kinds of preliminary data; data from the survey that was conducted to establish the extent and seriousness of shyness among female university students. Data from standardization of the scale, and data from the pre programme interview..

Survey and Scale data.

(A) The findings of the survey to estimate the size and extent of shyness among female university students, were consistent with the findings of other studies (e.g., Zimbardo, Pilkonis, & Norwood, 1975; Watson and Cheek, 1986; Bruch, Rivet, Heimberg, Hunt, McIntosh, 1999) in that, shyness is widespread.

(B) The findings of the standardization of the scale are consistent with the findings of other studies (e.g., Glass & Shea,1986; Crozier, 1979,1981; Kerr, 2000; Asendorpf, 2000) in that the correlation between the chosen scale and other well known scales is high, except that shyness and loneliness were found here to be uncorrelated (*r*-.03). This may be due to the life style and structure of the Saudi family, where girls in many Saudi families are sheltered and protected.

The interview data

(A) The interviews showed that 72.8% of the participants who scored 65 and over on the test admitted that being shy is a problem for them. This finding is exceptionaly high and exceeds the percentage 36.3% of the initial survey. The reason may be because the 110 students who came to register were more aware of their problems. This finding that shyness is a major problem amongst female students in Saudi Arabia demonstrates the importance of finding a way to overcome the problematic aspects of shyness in this population.

(B) Of the 80 students who participated in this study (aged between age 20 and 24), 78.8 % were single, which is a very high percentage in Saudi society where most girls are married by the age of 20. An interesting finding is that only 16.3% had shy mothers while the majority 83.8% did not have shy parents. 60% of them had been shy since childhood and only 3.8% became shy when they entered the university. This indicates that shyness is a trait and that most shy people have had it since childhood. Shyness is precipitated by a wide variety of stimuli, people, and situations. Among the most typical are: authority (people in authority 81%, teacher, 45%, fathers 23.8%, older people 22.5%, men 37.5%, brothers 13.8% uncle 22.5%) one to one 30%, strangers 23.8% (Table 24). These percentages indicate the strong role of authority figures in the shy person's life. Many situations play a part in making people feel shy. There are four situations that all participants agreed on, in which they felt shy: situations when they felt vulnerable, situations requiring assertiveness, situations when they were the focus of attention before a large group, and situations where they were evaluated or compared to others. These contexts descriptions highlight the

inner feelings of the shy individual. Other situations such as those where they were of lower status than others (95%), being the focus of attention before a small group (93.8%), one to one interaction with a male person (93.8%), and new interpersonal situations (81.3%) also caused shyness. So if shy people cannot avoid these situations they may have to face all sorts of anxiety that stem from being shy. If, on the other hand, they avoid them or some of them, they may suffer from being isolated.

6.3. Intervention outcome

The results indicate that shyness can be ameliorated by training, and that although Social Skills Training and Brief Counselling are both effective, Social Skills Training is the more effective. Being a group activity, it is also more economical.

Social Skills Training Programme

The Social Skills Training programme produced positive change in shyness level, not only in the post-test but also in the follow-up-test. The participants were rated as more improved than any other group at both the post-test and follow-up-test. Although the programme was reduced to one hour it still proved to be effective in reducing shyness. The interest of the groups to finish all sessions and practice all skills indicated how beneficial the programme is because from the first session participants acknowledged the improvement in their skills. Participants' changes were noticed not only by the researcher but also by other people who knew them before training. They changed in their looks and attitude. For example, some of them started to change their hair style and clothes, became more relaxed and had positive views for future relationships.

The finding of the investigation regarding the efficacy of the Social Skills Training is consistent with Vaccaro's (1990) findings. Demonstration-plus-participant modelling rather than the traditional videotape encouraged appropriate behaviour. Cooperative enactment between the subjects (a live performance) could have facilitated greater interpersonal understanding because peer familiarity may have generated better acquisition of verbal skills than would unfamiliar performance of symbolic models on videotapes. The positive reinforcement of the behaviour during the training situations and naturalistic settings are important to improve social behaviour. This explanation is supported by many studies (Vaccaro, 1990; Berger & Ross, 1977; Brennan, 1983; Foxx et al., 1986; Hussian, 1984; Kazdin, 1980; Masters et al., 1987).

Brief Counselling

Brief Counselling using the Egan Model was found to produce positive results. It categorically works. All participants scored less in the post-test and follow-up test and behaviour changes were observed. Participants varied in the numbers of sessions they attended, but none of them missed any session, which may indicate that they felt the importance of counselling. The counselling had other positive effects in addition to reducing the level of shyness. Maybe some of the long lasting effects of counselling, were due to other ancillary changes only indirectly related to shyness.

Although the focus was on participants' problems that related to shyness, other aspects were dealt with in a manner that linked with shyness. It was clear that not only the outcomes immediately after the counselling were in favour of positive changes, but also six weeks after the last session. Thus, their greater overall improvement appears to be

related to cognitive and feeling change and may be related to the continued use of coping strategies and different kinds of social skills.

The following Table (44) presents the comparison between the Social Skills Training and Brief Counselling.

Table 44 Social Skills Training and Brief Counselling

Social Skills Training	Brief Counselling
10 sessions, one hour twice a week.	4 to 8 sessions, one hour twice a week.
Specific topics such as conversation skills.	Different topics such as dealing with blushing.
The content of the session was prepared in advance.	The content of the session depends on the client herself.
The trainer controlled the session.	The client shared with the counsellor the responsibility of the session.
Learning new behaviour, by acquiring or developing social skills.	Dealing with feelings, cognition and acquiring new behaviour.
Practice with peers during session and observing others. Then practice outside the sessions.	Practice with counsellor then outside the sessions.
Homework assignments.	Homework assignments.
Specific target for each session.	Each session depends on whatever concerns the client has regarding her shyness.
General.	Personal.
Effect generalized to non-practiced scenes.	Effect generalized to other aspects of personality.

The findings of this study indicate that the full benefits of the Social Skills Training and the Brief Counselling are not entirely apparent at post-testing. Significant improvement occurred during the follow-up period. The homework assignments were a powerful aspect of treatment for both the Social Skills Training and Brief Counselling. Although homework assignments were an important aspect of treatment for both groups, they were more effective with the Social Skills Training group; they practised them and observed others practice during sessions before trying them out in real life, while in the

Brief Counselling, they just practised them with the counsellor before trying them out in real life.

One might combine the two methods to gain the maximum benefit of both. A suggestion is to give one session individually and then group sessions of Social Skills Training and to end up with a final individual session.

Study Skills Training

The Study Skills Training group showed some gain; they scored less in post-test and follow-up-test but the improvement of their scores was not as high as the Social Skills groups and Brief Counselling group. The Study Skills Training group's improvement may be attributed to many influence aspects such as class outcomes, positive reactions from teachers, change in academic level or social status, and the positive reinforcement of social interaction as part of the task. Participants were involved in social exercises and feedback which was given on the task could be taken as personal feedback for them on their own social skills; when they asked a question and got a decent answer they would become less shy in asking again.

Another aspect may have been the presence of the researcher. However this does not explain the Brief Counselling and Social Skills Training result because the same presence was there but the follow-up shows the value of the intervention. It may be that there is some facilitation due to the researcher being an effective communicator which might explain why the Study skills Training group showed some gain, but again, that gain cannot be explained through this factor alone because when tested later the Study Skills group were significantly different from the Social Skills and Brief Counselling

groups. So although this might be a facilitative influence in the first place it is not enough to explain the effectiveness of the other interventions.

From the interviews it appeared that some of the participants were highly motivated to reduce their shyness. Others did not possess sufficient motivation to do so, although they were concerned about other psychological problems. It was surprising that students from the Psychology department were concerned about many more psychological problems; for some, the reason for studying Psychology was to help themselves overcome such problems. This might explain why some participants benefited more than others. Also, these findings do not explain why for the Study Skills group, self-confidence in their study helped them to reduce their shyness, at least in the classroom. The reduced level of shyness for all groups suggests that the interviews and scale assessments may have had a sensitising effect on subjects, leading them to change with or without any intervention.

In comparing each group with itself in both post-test and following-up test there was evidence that both the Social Skills Training programme and Brief Counselling using the Egan Model are effective in reducing shyness. No such differences were found for the control groups.

In light of the present results and earlier findings of long-term benefits (Stake and Pearlman, 1980), it appears that any complete assessment of any new behaviour must include follow-up testing, and any study that does not may underestimate the benefits of training and practicing. (Stake, Deville, Pennell, 1983 p440). It seems likely that the reduction in shyness between post-testing and follow-up resulted from subject's practising their newly learned skills. When the participants used their skills, they would

experience generally positive reactions from others. These positive reactions and the subjects' increasing sense of control in interpersonal situations could obviously lead to more positive self-appraisals of competence.

12.5 % of the subjects were not available for follow-up-testing. However there are two reasons to suppose that the missing subjects are comparable to those who were available for the follow-up-testing. First, the mean pre-test and post-test scores of the subjects tested at follow-up were not significantly different from the scores of subjects not tested at follow-up. Second, a recent test of the relationship between difficulty of follow-up and treatment effects provided evidence that subjects who are more difficult to follow up do not have poorer treatment outcomes (La Porte et al., 1981). It is logical to assume, then, that the untested subjects experienced post-training benefits similar to those of the tested subjects.

This study adds to a growing body of literature that suggests that shyness is a curable problem that may be reduced by short-term, cost-effective, structured group programmes. The efficacy of these and similar interventions, however, raises a number of research questions such as: (1) How do researchers account theoretically for agreement of outcomes when interventions differ significantly in theory and design? (2) How can researchers determine if outcomes can be improved by matching client characteristics to interventions. {For example, is SST a better option for individuals who have low self-esteem?} (3) To what extent can researchers depend on self-reports as a measurement methodology? {For example, data could be collected from relevant others such as parents, peers, teachers, and measures of physiological arousal.}

(4) Can the research findings be generalized to samples other than college students? {for example older community samples and junior high students.} (5) Is it enough to depend on quantitative data to measure change?.

6.4. Consolidation

An attempt is made to integrate the findings of this study with those in the literature. The result is the model shown in Figure 2.

When evaluating the model it should be kept in mind that this model is dealing with trait shyness and the problems it engenders.

The model shows that shyness is one form of social anxiety, and that shy people's main concern is to seek approval from others and avoid disapproval. Three main reasons play a major role in the way they behave in order to get approval from other people and avoid disapproval. These reasons are personality trait deficit, past experience, and social skills.

Within this model there will be contextual variables at work. For example particular situations may demand very specific social skills, like being able to interact with an authority figure. Also there will be interaction, which may have different implication for individuals. For example, for some the cost in personal financial terms of social isolation may be considerable, but by choosing a certain option, social withdrawal may not be a problem.

Social withdrawal may help shy individuals to avoid anxiety but at the same time it limits the opportunity to seek approval. Seeking approval may lead the person to do things he/she does not like. For example, if a person wants to say "no" to his/her best friend which is very hard for many shy individuals, he/she might end up doing things he/she does not want to do; in some situations he/she may regret it later which may result in avoiding similar situations in the future.

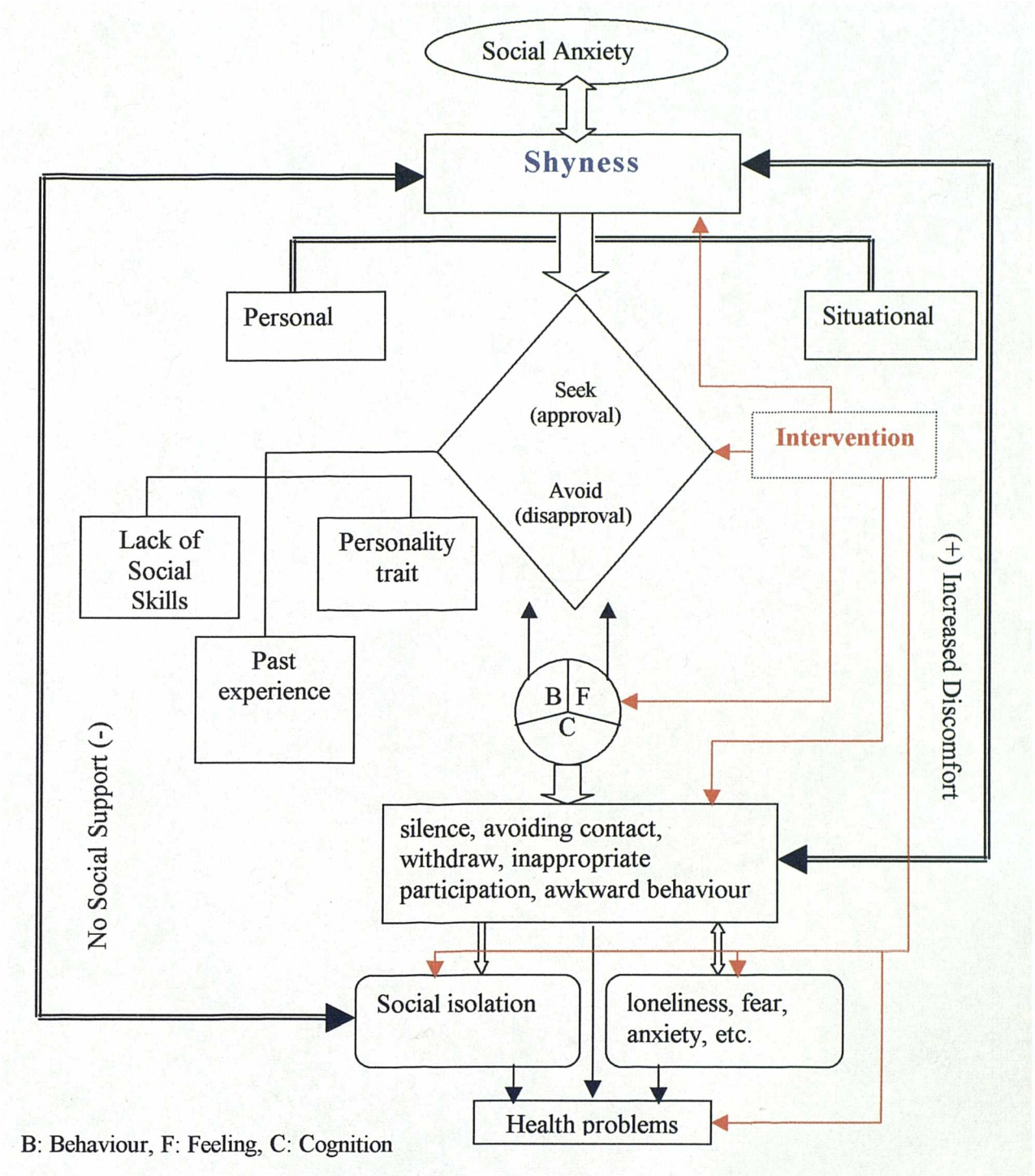
The model emphasises the need to consider behavioural, emotional and cognitive aspects of shyness. These elements, feeling, cognition and behaviour affect and lead each other to build a circle that goes around and forms the component of shyness. If the shy person cannot avoid the situation, or act in a way that is not what he/she wants, his/her feeling of shyness will increase and/or result in negative feelings such as loneliness. Consequently the negative feelings will lead to feelings of discomfort and he/she becomes more shy. In some cases, this will lead to social isolation, and so the problem of being shy will become more severs, because he/she will not have the social support he/she needs to overcome his/her shyness. Lack of a social support network and failure to disclose fully personal or sensitive problems to medical and psychological care givers may create health problems.

This model also demonstrates the complexity of the phenomenon of shyness. The key to this interpretation is the pivotal role of seeking approval and avoiding disapproval. Intervention that deals with behaviour, feelings and cognitive aspects of shyness eventually will lead to positive results. Intervention can be used during childhood, adolescence or adulthood. Both Social Skills Training and brief Counselling can be given to all ages. As with any other problem, the sooner the problem is dealt with the

better the result one gets regarding time and effort and outcome, especially if it is tackled before other problems emerge such as loneliness. Thus, these interventions may be used as precautionary or as therapeutic methods. Most students wait for a problem to escalate to crisis level before accessing any services. The present study emphasizes the importance of group and individual counselling sessions not only during crisis but also before in order to help students increase their self-awareness and promote effective crisis coping, decision-making, and meaningful communication. Each of the interventions can be used alone by itself or as part of the other.

In general, the model provides a historic framework for identifying issues, contexts and costs of shyness.

Figure 2 The Shyness model



6.5. Limitation

The study had a number of possible limitations. There are those associated with the use of self-report measures. Participants may attempt to present themselves in a favourable manner. While this is possible here, it seems unlikely as findings on this measure were consistent with previous research findings.

Only one scale was used. It might have been useful to incorporate other measures related to shyness, such as the Social Reticence Scale. Also, no personal information was collected after the training. It might have been useful to monitor other significant changes in a participant's life.

The fact that this study was done on a female university sample limits its generalization, but not the major value of the research in the Saudi Arabian context.

Chapter Seven: Conclusion & Contribution

"The intent of shyness treatment is not to create perfect social performers. Few people are world class physical athletes, but most can enjoy physical exercise."
Henderson & Zimbardo
2000

7.1. Introduction

Change and transition are part of human development (Fisher and Cooper, 1990); young adults in particular experience a wide range of emotional, behavioural and educational problems, not least shyness.

The acceptance of shyness and the extent to which it is regarded as a problem is influenced by cultural values. Saudi culture values total respect for elderly people, especially parents and people in authority and tends to encourage dependency and loyalty to superiors. Talkative or assertive individuals risk being considered rude. But at the present time the situation is different because the younger generation are opening their eyes to American cultural values that emphasize competition, individual achievement, and freedom of speech and action, a new way of life that makes a shy person's social life more difficult.

Shyness is very common and it can be a big handicap. But people who do not suffer from it look at it as a simple problem that does not require much effort to overcome (how little they know). Research into shyness has shown that it is a complex experience that is elicited by a range of social situations. Because shy people are disinclined to ask

for help, they try to avoid situations where they have to face people, or if they cannot avoid such situations entirely, avoid any kind of interaction, leaving people to think of them as arrogant, boring, or unfriendly. The major problem for shy people is that most of them do not like being shy. Many of them struggle to overcome their shyness. Some succeed; others do not.

At the same time, shy people generally resist information that would challenge their negative self-images by attributing success to external factors, selectively focusing on negative feedback, and doubting the accuracy of positive feedback. According to Arkin et al., (1986) this "vicious cycle" of self-defeating cognitions is exacerbated by the cautious self-presentation style of shy individuals, because playing it safe in social situations deprives them of opportunities for experiencing success and receiving approval from others

Some shy people may even cling to their shyness as an excuse for their inability to cope with social pressures (Snyder & Smith, 1986). But for most it is probably a reflection of a general human tendency to maintain and defend one's self-concept even if it is unrealistic or negative (Epstein, 1973). Breaking the self-perpetuating cycle of shyness is important because shyness is a barrier to personal well-being, social adjustment, and occupational fulfilment (Daly & McCroskey, 1984; Jones et al., 1986; Leary, 1983). The self-concept of the shy person presents a challenge to psychologists who are developing new cognitive therapies to improve existing social skills training and systematic desensitisation treatment programmes for shyness. (Hartman & Blankstein, 1986).

However, any counsellor should addresses two questions; the effect of time on improvement and the stability of the resulting change. This study proved that time is in favour of improvement, but to be more sure of the stability of the change, longitudinal research is needed.

Although part of shyness may be inherited, a major component is a learned behaviour, and therefore learning to change the negative thoughts and feelings is possible. Fortunately there are many techniques that have been proved to be helpful.

The results of this study prove that Social Skills Training Programmes and Brief Counselling are both effective in treating shyness. Although this study was not designed to look at changes in the participants' lives apart from shyness, the data do shed some light on how changes in study skills may be a factor in decreasing the level of shyness. This shows the importance of the teacher's role in helping her students by providing them with skills they need, not only to answer questions in written assignments but also to participate orally in class, and also to reinforce them whenever it is appropriate.

Participants who appeared to be highly motivated to reduce their shyness benefited more than those who seemed not to possess sufficient motivation, or had other problems that they were more concerned about than being shy.

The results of this study are promising enough to encourage counsellors to use either the social skills training programme, brief counselling or a combination of the two. Although the training programme needs to be well prepared with flexibility to cope with different individuals, the cost of both methods is almost the same.

7.2. Contribution of the study

The research findings reinforce the importance of a broad ecological perspective. Families, university and community are crucial sources of feelings of shyness. Therefore, to alleviate shyness, more attention should be paid to these sources.

The study could be contaminated by a failure of distinguishing between shyness and "Haya'". Also it is important to recognize the importance of distinguishing between terms that are related to shyness such as embarrassment, shame, nervousness, self-consciousness and loneliness- that are social terms (in that, like shyness, they have their origins in the lay psychological vocabulary), and those, such as social anxiety, social withdrawal, non–assertiveness and communication apprehension, that are psychological terms (Harris, 1984)

The practical part of the study has contributed in confirming the theoretical expectations that participation in Social Skills Training or in Brief Counselling can lead to positive outcome. The positive results of the Study Skills Training suggested the importance of the teacher's role. In any study, the personality of the trainer, teacher, or counsellor has an impact on outcomes.

Further contributions can also be observed in the successful attempt of the current research to highlight the benefit of counselling. The study should contribute to guidance and counselling programmes not only in the Saudi context but also in other Arab countries where guidance and counselling services are currently being developed or considered.

This study can be seen as the first attempt to use the Egan model in counselling in the university. It also provides two training programmes that are stand alone and can be used to the benefit of future students. (A degree in counselling in King Abul Aziz University is a must.) Qualified counsellors are needed to provide sufficient services to all people (in the university or in other institutions in the Saudi community).

7.3. Suggestions for further research

The findings of the present study suggest that the following topics will benefit from future research:

Nature of shyness

1. The experience of shyness may result from many different causes. This suggests that any research attempts to use a scale to measure the problem should take into account the various causes of shyness. It may be of great importance to distinguish between fearful shyness and self-conscious shyness and identify these in proper intervention programmes.

2. Some shy students do not consider being shy is a problem. Further investigation should find out "why"?

3. There are factors that play a role in changing the level of shyness, such as social status. Therefore, future investigation should be extended to collect information about these factors, not only before the first assessment but also after the last one.

4. Interactions with Family, teachers, and peers were found to affect the level of shyness. Empirical study could investigate the association between styles of family, teacher, and peer interactions and the feeling of shyness.

5. Research comparing men and women not only in the experience of shyness but also in its various causes and other associated psychological and demographic factors, would be highly valuable.

6. Longitudinal research on the effects of time on improvement would give knowledge of the effectiveness of interventions.

Research related to Social Skills Training

1. The programme in the current investigation was conducted with King Abul Aziz female university students. It should be trialed in other universities and schools. A similar programme could also be carried out in the context of male universities and schools.

2. The results of this study indicate the effectiveness of the Social Skills Training programme with shyness. The indications are that the same programme, with some adjustment, could be given to those who have problems other than shyness, such as social phobia and social anxiety.

Research related to Brief Counselling

1. The results of this study indicate the effectiveness of the Brief Counselling using the Egan model. Further research using this method may enhance knowledge of the effectiveness of this method, not only on shyness but also on other psychological problems such as loneliness, depression, and social anxiety.

2. The interest of the participants and their feedback indicated how much they needed a counselling service. Further research on the current counselling provided in Saudi Arabia would be beneficial.

Research related to the Study Skills Training programme.

1. The positive result encourages further research on the relationships between shyness and what takes place inside the classroom.

2. Further research on teacher strategies for coping with shy students should be carried out.

3. The results of this study indicate the effectiveness of the programme. Therefore, the same programme with some adjustment can be given to students in schools.

♦Some suggestions for teachers dealing with shy students should be considered:

a) Use interest inventories to determine the interests of shy students, and use interests as the bases for conversations or learning activities;

b) Help shy students to set social development goals and assist them by providing training in assertiveness, initiating interactions with peers, or other social skills;

c) Make time to talk with them, even if just for a few minutes, and listen carefully and respond specifically to what they tell you;

d) Change the social environment, for example setting them among friendly classmates;

e) Minimize stress or embarrassment, for example do not ask them to give an oral presentation if they are not ready;

f) Engage them in special activities such as organizing a social event;

g) Encourage them to join volunteer groups or recreational organizations inside and outside the university;

h) Involve them frequently in small-group and cooperative interaction with peers;

i) Lead them to communicate by assigning them tasks that require communication;

j) Provide them with information needed to develop social insight (e.g., teasing does not necessarily mean that peers do not like you), suggesting ways for them to initiate productive peer contacts or to respond more effectively to peer initiations.

♦ Honing, 1987; McIntyre, 1989; Thompson & Rudolph, 1992; Brophy, 1996.

7.4. Final Statement

- University students have many concerns; their studies, social life, and future career. Shyness is one concern that has a negative impact on all of these. It interferes with the achievement of personal goals.

- The current research has provided a conceptual framework which helps clarify the concept of shyness and it's relation to other concepts such as social anxiety and social phobia. It also provides background information regarding measurement and treatment of shyness. It examined the causes and the consequences of shyness.

- The results of the study are consistent with the findings of other studies in respect of both the problem and treatment of shyness.

- The results indicate the influence of: family, authority (parents, teachers, etc.) and peers in both creating or solving the problem.

- The findings of the study have positively demonstrated the effectiveness of Social Skills Training and Brief Counselling in alleviating shyness. Shyness can be treated either on an individual or on a group basis.

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Appendix (A)

- ❑ **Survey Questionnaire**
- ❑ **Shyness Scale**
- ❑ **Form X**
- ❑ **Announcement**
- ❑ **Row Scores**
    - **Pre-test scores**
    - **Post-test scores**
    - **Follow-up scores**

Survey Questionnaire

Dear Student

This is a survey about shyness. Fill it carefully and give it back to the person who gave it to you.

Age:

There is no need to write your name.

Put (√) in the right place:-

		Yes	No
1-	Do you consider yourself to be a shy person?	( )	( )
2-	If (Yes), have you always been shy?	( )	( )
3-	Do you consider it a problem for you?	( )	( )
4-	If the answer to the first question is (No), was there ever a prior time in your life when you were shy?	( )	( )

Thank you

Shyness scale

No	Item	Strongly agree	Agree	Not sure	Disagree	Strongly disagree
1	I feel tense when I am with people I don't know well.					
2	I avoid speaking with strangers so as not to say something stupid.					
3	I do not converse well with others.					
4	I find it difficult to ask other people for help.					
5	I feel comfortable at parties and other social functions					
6	When in a group of people, I have trouble thinking of the right thing to say.					
7	I feel comfortable even in unusual social functions.					
8	It is hard for me to act naturally when I am meeting new people.					
9	I feel shy when I am with people I don't know.					
10	I feel confident in my ability to interact with others.					
11	I feel nervous when speaking to someone in authority.					
12	I have trouble looking someone right in the eye					
13	I initiate conversations with others.					
14	I have doubts about whether other people are willing to be friends with me or to keep company with me.					
15	I feel awkward when someone introduces me to new people.					
16	I find it hard to talk to strangers.					
17	I avoid making new acquaintances for fear that I might not get along well with them.					
18	I am shyer with members of my family of the opposite sex.					
19	I soon get over my shyness in new social situations.					
20	I feel comfortable in social functions.					

Form X

Form ( )

Dear Student,

Assalamu alaykum wa rahmatu Allah,

The Psychology Department is organising a Self Development and Skill Improvement Programme in the first semester of the year 1421 H. If you wish to join the programme and benefit in developing yourself and your skills please fill in this form.

Name:	
Registration No.:	
College:	
Major:	
Phone No.	
Comments:	

We wish you success.

Researcher
Lila Al Ghalib

ANNOUNCEMENT

The Psychology Department is pleased to announce that there are some **Self Development** and **Skills Improvement** Programmes on offer. Any student wishing to participate should contact Lila Al Ghalib.

Seminar Room (101), First floor, Library.

Saturday till Wednesday between from 10am and 02 pm.

The raw scores for all groups in the pre-test

	SST(psy)	SST(gen)	B.Co.	ST	Cont(psy)	Cont(gen)
1	67	85	72	88	70	77
2	73	73	75	67	70	68
3	66	66	68	68	66	71
4	67	67	75	85	65	68
5	67	75	75	65	65	80
6	75	68	68	65	75	76
7	85	77	86	69	65	73
8	82	68	65	68	65	65
9	75	69	67	72	65	67
10	68	69	85	77	72	68
11	68	74	75	68	90	68
12	86	70	68	66	70	
13	68	67		69	65	
14	75	68			77	
15		66				
16		82				
Sum	**1022**	**1144**	**879**	**927**	**980**	**781**
No.	**14**	**16**	**12**	**13**	**14**	**11**
Mean	**73**	**71.5**	**73.25**	**71.31**	**70**	**71**

The raw scores for all groups in the post-test

	SST(psy)	SST(gen)	B.Co.	ST	Cont(psy)	Cont(gen)
1	66	73	61	80	67	78
2	69	65	73	54	71	67
3	60	59	55	65	60	68
4	60	60	66	82	63	65
5	55	66	54	65	75	79
6	65	52	52	60	68	69
7	74	69	72	68	65	74
8	75	54	60	66	68	67
9	65	50	60	60	65	65
10	52	53	74	72	70	65
11	55	67	65	66	86	65
12	70	68	55	61	69	
13	54	50		77	63	
14	68	55			80	
15		60				
16		76				
Sum	**888**	**977**	**747**	**876**	**970**	**762**
No.	**14**	**16**	**12**	**13**	**14**	**11**
Mean	**63.43**	**61.06**	**62.25**	**67.38**	**69.28**	**69.27**

The raw scores for all groups in the follow-up test

	SST(psy)	SST(gen)	B.Co.	ST	Cont(psy)	Cont(gen)
1	67	72	56	82	65	72
2	64	63	70	52	70	68
3	xxx	60	55	63	62	68
4	68	62	65	83	60	66
5	52	60	55	78	77	xxx
6	65	48	50	65	65	65
7	72	56	70	xxx	65	75
8	70	50	56	65	xxx	60
9	xxx	50	xxx	65	66	xxx
10	52	52	70	60	xxx	68
11	56	66	66	70	80	66
12	68	66	55	67	xxx	
13	55	48		60	65	
14	xxx	55			77	
15		58				
16		69				
Sum	**689**	**935**	**668**	**810**	**752**	**608**
No.	**11**	**16**	**11**	**12**	**11**	**9**
Mean	**62.64**	**58.44**	**60.73**	**67.5**	**68.36**	**67.56**

xxx: They did not take the test (10 participants).

Appendix (B)

- **Social Skills Training Sessions**
- **Brief Counselling Sessions**
- **Study Skills Training Sessions**

Social Skills Training Sessions

First session: Saturday 07/10/2000.

Assalamo Alaykum Wa Rahmatuallah Wa Barakatuh.
Welcome everybody; I would like to thank you all for your participation in this programme. Before I talk about this programme I would like to introduce my self. My name is Lila Al Ghalib, I am a PhD. student at Hull University in the United Kingdom. My research requires applying different kinds of programmes; your group will take the social skills programme, which is aimed to help you to develop your social skills.

This programme consists of ten, one-hour sessions twice a week, over a five week period. This programme is based on five essential techniques: instruction, role-playing, feedback and reinforcement, modelling, and practice. The first four will be carried out during each session, but the last one " practice" will be your home assignment which you will do in your own time, because as it is known, " practice makes perfect".

Dear students, in order to have a good outcome of this programme we must all cooperate. It is very important that you understand the importance of attending, because each session is dependant on the previous session. So if one of you does not come to any session it will affect not only the present session but also the next session as well because most of the exercises are done in pairs. In another words your absence will have negative effects on the training.

This doesn't mean that you are forced to come. Each one of you has the right to quit at any time, though I hope you won't. If you want to quit please inform us of your reason; it will be considered a gesture of politeness. I would like to inform you that if you stay to the end of the programme you will receive a nice thank you gift.

There are some conditions we must agree upon:

- What we say and do here is confidential and stays in the group.
- Everyone has the right to say no to any activity.

- Each one of you gets time to talk, and when someone is talking, everyone else should listen.
- Everyone must be on time for the session.

Do you have any questions?

OK. In front of each one of you is a file. I want you to keep it with you and bring it to all sessions. This ensures that all your papers are in one place. By doing that you will have a complete file of what you have done in the programme. This file is yours to keep. You can always go back to it in the future if you need it.

There is a diary (notebook); I would like you to use it to write down how you feel and what you think about yourself. You can write it in any way you like. You can use pictures, diagrams, symbols, poems to describe your thoughts and feelings. You can use different coloured pens, underline, highlight. It is better that you record your experiences as soon as possible after the event, and try writing at a regular time each day. You will submit this diary in the last session. All information in your diary will be used only for the purpose of this study. There will be no mention of your name or reference to any events that might reveal your identity. You have the right to delete any information before you submit your diary.

Let's start by answering the first page in your file (Form A). Please hand it to me after you finish.

Now let's answer the second page (Form B). Now choose six of your answers and write them down in the "record of me" card (Card B). Now give your record to the person sitting on your right. Fine, now each one of you should introduce the other person to the rest of the group using her "record of me" card.. Who wants to start?
Ok, now we all know each other's names.

As I told you before, each session you will develop a skill or learn a new one. Today we are going to start with a very important skill that you already have but need to be more skilled in "Effective Listening ".

What do we mean by Effective Listening? In short it is to be involved in what we are hearing. It is the nonverbal communication that indicates that you are paying careful attention to the other person who is talking.

Steps for Effective Listening Skill:

1. Look at the person who is talking.
2. Think about what is being said.
3. Wait for your turn to talk.
4. Say what you want to say.

Now I want you to divide yourselves into two groups, the first group come and sit on right side, the other sit on the left side. Try to remember your partner's name. If you can't remember her name, just ask her.

Now, I want the first group to choose a topic and start to talk about it. The second group should listen to what they are talking about.

That was very good.

Second group, what did you notice about the first group?
I want each of you to mention one thing. I will write your comments on the board.

- They talked in a low voice.
- Only two of them were talking most of the time.
- It seemed that (...) were not interested in the subject.

These are very good notes.

Ok, I know it is a little hard for you because you don't know each other, but let's talk about what happened. First you all did a good job, and I was happy that (...) was not paying attention to what is going on. If you remember, she was the only one who was playing with her pencil and she was not looking at the other person, I told her to do so. So, what happened was that all the rest of the group ignored her, and I could tell that some of you were annoyed with her.

Ok, now the second group will play the role and the first one will observe.
That was very good.

Ok, first group, what do you think?

Again I will write your comments.

- They chose a very interesting topic.
- They all participated.
- When one talked the other talked at the same time.
- They argued about small things and left the big issue.

These are very good notes.

I am glad that you learned from the first group, and all of you got involved in the discussion, but I would like to point out that Effective Listening does not mean that you have to talk but you can use your nonverbal behaviour, such as nodding your head, to indicate that you are listening. Always remember two things; know the best time for your response; and pay attention to the nonverbal behaviour.

Now I want you to be divided into couples, each one of you will interview the other. The form for pair interview is in your file. (Form C).

Now you know more about the other person.
Ok, now let's summarize what we did in this session: -

1. We had a clear idea about the programme.
2. We got acquainted with each other.
3. We trained to be better listeners.

Now it is time to evaluate your skill. Take out the white card from the back of your file (skill evaluation Card A) and write down how well you did in today's skill. Use this card every time you practise any skill, it is a record for you.

Now it is time for your home assignment, which is to practise the skill that you were trained to do in this session with three different groups, family, friends, and

acquaintances. You will use the practice sheet (Form D) to write down what happened with each group. There is a guide to help you in your file (Sheet A). Try to practice as much as you can.

Now please take out the Session evaluation card from your file (Card C), fill it, and hand it to me. I will return it to you next session because you are going to use it each session.

That is it for today. Hope to see you all on Monday; please be on time.

Second session: Monday 09/10/2000

Assalamo Alaykum Wa Rahmatuallah Wa Barakatuh.
Welcome everyone. Please sign your name in the attendance list.
Did you practise the last skill? Lets see how many of you did?
Very good. (then the trainer listened to what every one did and gave them positive reinforcement, such as; that was very good, you should be proud of yourself, and now you know what to do).

Today we are going to learn a really important skill, "Conversation". It can be divided into three parts; starting the conversation, maintaining the conversation, and ending the conversation.

There are general rules in starting and ending a conversation though there might be some differences from situation to situation.

Steps for Conversation Skills:

1. Greet the other person.
2. Make small talk.
3. Decide if the other person is listening.
4. Bring up the main topic.
5. Ask the other person what she/he thinks.
6. Listen to what the other person says.
7. Make a closing remark.

Ok, now I want you to divide yourselves into couples. Choose the one that you did the interview with last session. Each couple will stand in front of us and try to make a short conversation.

(After each act the trainer gave a positive reinforcement and comments). Examples of the comments:

- I want you all to notice the importance of smiling while you are greeting other people.
- Have eye contact with the other person; don't look at the floor while you are talking.
- If you want to end the conversation you should not end it suddenly (unless you are late and in a hurry; if so you should state your reason, for example," I'm sorry but I have a class now, hope to see you later").

Then the trainer asked if anyone wanted to try again, and gave them positive reinforcement).

Always remember two things; know the best time for your response, and pay attention to the nonverbal behaviour. Sometimes people find it very hard to end a conversation, but they may use nonverbal behaviour, such as looking at their watch, or changing their position to indicate that they want to. So if you notice that, you can easily help them by saying, for example, " I think it is getting too late, let's meet again sometime".

As you all noticed, maintaining a conversation is not an easy task. If you want the conversation to continue, you must be a good listener, and have different kinds of knowledge to share with the other person. The more you read the more information you have, and you must know how and what questions to ask. Asking questions serves a number of functions, such as:

1. Obtaining information.
2. Communicating with others.
3. Arousing interest and curiosity.
4. Assessing the extent of the respondent's knowledge.

Now let's summarize what we did in this session: -

1. We reviewed the last session.
2. We trained to make conversation.
3. We had more information regarding the conversation skills.

Now take out the white card from the back of your file (Card A) and write down how well you did in today's skill. Use this card every time you practise any skill. It is a record for you. You can have another card if you need, just ask.

Now it is time for your home assignment, which is to practise the skill that you were trained to do in this session with three different people, a family member, a friend, and an acquaintance. You will use the practice sheet (Form D1) to write down what happened with each one. You have more time to practise, because I will not see you till Saturday, so practice as much as you can.

Now please take out the Session evaluation card (Card C) and fill it in then hand it to me. I will return it to you next session.

That is it for today. Hope to see you all on Saturday; please be on time.

Third session: Saturday 14/10/2000

Assalamo Alaykum Wa Rahmatuallah Wa Barakatuh.
Welcome everyone. Did you have a nice weekend?

Please sign your name in the attendance list.
Did you practise the skills we tooked at in the last two sessions?
Very good. (then the trainer listened to what every one did and gave them positive reinforcement).

Today we are going to look at one of the Assertion Skills. Assertion Skills can be divided into two main skills; positive assertions or positive feelings, and negative assertions or standing up for yourself.

Positive assertions include three skills: Compliment and Praise, Affection, and Apology. Negative assertions include five skills; Refusing Unreasonable Requests, Expressing and Responding to Complaints, Requesting New Behaviour, Negotiating and Reaching a Compromise, and Expressing and Responding to Anger.

Today's skill is Compliment and Praise. To be able to mix with others and have a relationship with them we need to be able to compliment them on their dress, taste, etc. and to praise them on their achievements, morals, etc. This can be done not only using words, but also with the face and the voice.

Please take out your mirrors. I want each one of you to say something good about a person, but in your heart you don't mean it. Look at your face!

If you want the other person to feel that you are friendly and sincere, you must show it both verbally and nonverbally.

Likewise when somebody says something good about you, you should thank him/her, and show her/him that you appreciate their compliment.

Steps for Compliment and Praise Skills :

1. Decide what is it that you want to compliment about the other person.
2. Decide how to give the compliment (consider the wording and ways to keep the other person and yourself from feeling embarrassed).
3. Choose the right time and place to say it.
4. Give the compliment.

Ok, who wants to try?

(After the participants finished, the trainer gave them positive reinforcement).

Ok, now I want you to do it again with somebody else and I want you to pretend that you don't know each other very well; say, you have just met once or twice in the cafeteria, but you don't really know each other.

That was very good. But remember what we did last session, first you have to greet the other person, you don't just go to her and tell her that you like her hair style. So, let's try again. Remember how to react to the compliments, smile and say thank you but don't try to return the compliment unless you really mean it.

Now let's summarise what we did in this session:

1. We reviewed the last session.
2. We trained to be better in giving and accepting compliments and praise.

Now take out the white card from the back of your file (Card A) and write down how well you did in today's skill. Use this card every time you practise any skill. It is a record for you.

Now it is time for your home assignment, which is to practise the skill that you were trained to do in this session with three different people, a family member, a friend, and an acquaintance. You will use the practice sheet (Form D1) to write down what happened with each one.

Now please take out the session evaluation card (Card C). Fill it in and hand it to me. I will return it to you next session.

That is it for today. Hope to see you all on Monday; please be on time.

Fourth session: Monday 16/10/2000

Assalamo Alaykum Wa Rahmatuallah Wa Barakatuh.
Welcome everyone. Isn't it cold today?
Please sign your name in the attendance list.

Did you practise the skills we looked at in the last sessions?
Very good (the trainer listened to what everyone did and gave them positive reinforcement).
Remember that the more you practise the better you get. And don't forget the importance of nonverbal behaviour and how and when to respond.

Today we are going to learn the second positive assertation skill, which is Affection. Expressing affection is associated with romantic relationships, but what we are going to learn in this session is that affection and caring can be expressed toward a wide variety of persons.

Steps for expressing Affection Skill:

1. Decide if you have good feelings about the other person.
2. Decide if the other person would like to know about your feelings.
3. Choose the best way to express your feelings.
4. Choose the best time and place to express your feelings.
5. Express your feelings in a friendly way.

Ok, who wants to try first?

Can you think of something to say?

Let's say that you want to express positive feelings towards your brother after he stood beside you when you had financial problems.
That is good but you didn't really seem sincere, let's try again. Look at his face and show an expression that you really appreciate what he did for you.

That is much better, who wants to try?
(then the trainer asked if anyone wanted to try again with different subjects and different people, and then gave positive reinforcement).

It is very important to know other people's moods before you talk to them.
Here are some pictures; try to find out the feelings of each one.
That is very good.

Ok, now let's summarise what we did in this session:

1. We reviewed the last session.
2. We trained to be better in expressing affection.
3. We trained to be better in understanding other people emotions.

Now take out the white card from the back of your file (Card A) and write down how well you did in today's skill. Use this card every time you practise any skill.

Your home assignment is to practise the skill that you were trained to do in this session with three different people, a family member, a friend, and an acquaintance. You will use the practice sheet (Form D1) to write down what happened with each one.

Now please take out the session evaluation card (Card C). Fill it in and hand it to me. I will return it to you next session.

That is it for today. Hope to see you all on Saturday; please be on time.

Fifth session: Saturday 21/10/200

Assalamo Alaykum Wa Rahmatuallah Wa Barakatuh.
Welcome everyone. Good to see you. How was your weekend? Hope you have enjoyed it, I did not. My mother was not feeling well, but now she is better.
Please sign your name in the attendance list.
Did you practise the skills we learned in the last sessions?

Very good (the trainer listened to what every one did and gave them positive reinforcement).

Today we are going to learn the third positive assertion skill, which is how to apologize for something you did wrong or to give an excuse for your behaviour.

Steps for Apologizing Skill:

1. Decide if it would be best for you to apologize for something you did, or just give an excuse for it.
2. Think of the different ways you could apologize.
3. Choose the best time and place to apologize.
4. Make your apology.

Who wants to try first? (One apologized to her younger sister for taking her bag without her permission)

Ok, that is not bad, but when you said you were sorry you were smiling. That indicates that you are not sincere in your apology. Let's try again.
Now it is very good. (Then the trainer asked if anyone wanted to try again with different subjects and different people and then gave them positive reinforcement).

Let's summarise what we did in this session:

1. We reviewed the last session.
2. We trained to be better in apologizing.

Now take out the white card from the back of your file (Card A) and write down how well you did in today's skill.

Your home assignment is to practise the skill that you were trained to do in this session with three different people, a family member, a friend, and an acquaintance. You will use the practice sheet (Form D1) to write down what happened with each one.

Now please take out the session evaluation card (Card C). Fill it in and hand it to me. I will return it to you next session.

That is it for today. Hope to see you all on Monday; please be on time.

Sixth session: Monday 23/10/200

Assalamo Alaykum Wa Rahmatuallah Wa Barakatuh.
Welcome everyone. I really appreciate your coming on time.
Please sign your name in the attendance list.
Did you practise the skills we learned in the last sessions?

Very good (then the trainer listened to what everyone did and gave them positive reinforcement).

What if somebody refuses to accept my apology? Try again with a different approach.

You see, sometimes we hurt other people's feelings so deeply that it is hard for them to forgive us just by saying we are sorry. Sometimes we need to make an offer to make up for what happened.

Let's play the role again. One of you will apologize for betraying another's confidence. The other one will not accept easily.

That is very good, you see sometimes giving a small card or a flower, as you did, may emphasize your intention and show how sorry you are.

Today we are going to learn the first negative assertion skill, which is how to refuse an unreasonable request. Sometimes you will find yourself in a situation where you must say "No". For example one of your classmates asks you to put her name with you on an assignment you worked very hard to do. What are you going to do?

Steps for Refusing Unreasonable Request Skill:

1. Look at the person who is talking.
2. Say " NO" in a strong voice.
3. If you feel you need to explain why, then explain.

Who wants to try first?

That is not bad, but when you said "No I can't", you said it in a low voice and it looked as if that you didn't really mean it. Let's try again.
Ok, now it is very good. (Then the trainer asked if anyone wanted to try again with different subjects and different people, and then gave them positive reinforcement).

Let's summarise what we did in this session:

1. We reviewed the last session.
2. We trained to be better in saying no to an unreasonable request.

Now take out the white card from the back of your file (Card A) and write down how well you did in today's skill.

Your home assignment is to practise the skill that you were trained to do in this session with three different people, a family member, a friend, and an acquaintance. You will use the practise sheet (Form D1) to write down what happened with each one.

Now please take out the evaluation card (Card C). Fill it in and hand it to me. I will return it to you next session.

That is it for today. Hope to see you all on Saturday; please be on time.

Seventh session: Saturday 28/10/200

Assalamo Alaykum Wa Rahmatuallah Wa Barakatuh.
Welcome everyone. How was your weekend? Was there any thing special?
Please sign your name in the attendance list.

Did you practise the skills we learned in the last sessions?
Very good (then the trainer listened to what everyone did and gave them positive reinforcement).

Today we are going to learn the second negative assertion skill which is how to make a complaint, and how to respond to one. Sometimes you will find yourself in a situation you don't like. For example you bought an expensive watch but when you went home and put it on it did not work, so you sent it back to the store. Let's say that you did the same thing twice. Now you are mad and want to make a complaint.

Steps for Making a Complaint Skill:

1. Decide what your complaint is.
2. Decide whom to complain to.
3. Tell that person your complaint.
4. Tell that person what you would like done about the problem.
5. Ask how he/she feels about what you have said.

Ok, one of you will be the customer and the other one will be the manager.
That is very good, you were very polite and you explained the problem very well.

Steps for Answering a Complaint:

1. Listen to the complaint.
2. Ask the person to explain anything you don't understand.
3. Tell the person that you understand the complaint.
4. State your ideas about the complaint, accepting the blame if appropriate.
5. Suggest what each of you could do about the complaint.

Who wants to try?

Ok, that's good, but when you talked about the problem you seemed as if you were not sure whose mistake it was. You believe you are right, so act like it.
Let's try again.

Very good. (Then the trainer asked if anyone wanted to try again with different subjects and different people, and then gave them positive reinforcement).

Ok, now let's summarise what we did in this session:

1. We reviewed the last session.
2. We trained to be better in expressing and responding to complaints.

Now take out the white card from the back of your file (Card A) and write down how welld you did in today's skill.

Your home assignment is to practise the skill that you were trained to do in this session with three different people, a family member, a friend, and an acquaintance. You will use the practice sheet (Form D1) to write down what happened with each one.

Now please take out the session evaluation card (Card C). Fill it in and hand it to me.

That is it for today, hope to see you all on Monday, please be on time.

Eighth session: Monday 30/10/200

Assalamo Alaykum Wa Rahmatuallah Wa Barakatuh.
Welcome everyone. How were your exams'? I hope that you all did well.
Please sign your name in the attendance list.

Did you practise the skills we took in the last sessions?
Very good. (Then the trainer listened to what every one did and gave them positive reinforcement).

Today we are going to learn the third negative assertion skill, which is how to ask for a new behaviour. To be yourself and enjoy what you do, you sometimes require that other people change their behaviours. For example, I cannot concentrate on my study if you keep the sound of the radio very high. It is very important to know how to ask other people to change their behaviours for your sake.

Steps for requesting a new behaviour:

1. Ask for the new behaviour from the other person in a nice way.
2. Explain to her/him your reason for asking.
3. If she/he does change her/his behaviour, thank her/him.

Ok, who wants to try? Let's say that you are tired and want to sleep and your sister is watching the television and the volume is very high.
Ok, that is very good. (Then the trainer asked if anyone wanted to try again with different subjects and different people, and then gave them a positive reinforcement).

Let's summarise what we did in this session:

1. We reviewed the last session.
2. We trained to be better in requesting new behaviours.

Now take out the white card from the back of your file (Card A) and write down how well you did in today skill.

Now it is time for your home assignment, which is to practise the skill that you were trained to do in this session with three different people, a family member, a friend, and an acquaintance. You will use the practice sheet (Form D1) to write down what happened with each one.

Now please take out the evaluation card (Card C). Fill it in and hand it to me.

That is it for today. Hope to see you all on Saturday; please be on time.

Ninth session: Monday 4/11/200

Assalamo Alaykum Wa Rahmatuallah Wa Barakatuh.
Welcome everyone. How are you today?
Please sign your name in the attendance list.

Did you practise the skills we learned in the last sessions?
Very good (then the trainer listened to what everyone did and gave positive reinforcement).

Today we are going to learn the fourth negative assertion skill, which is how to negotiate and reach a compromise. Sometimes you feel that you are right about a certain topics while the other person feels that she/he is right about this topic. Neither of you wants to give up. What to do?

Steps for Negotiating and Compromising Skills:

1. Decide if you and the other person are having a difference of opinion.
2. Tell the other person what you think about the problem.
3. Ask the other person what she/he thinks about the problem.
4. Listen openly to her/his answer.
5. Think about why the other person might feel this way.
6. Suggest a compromise.

Who wants to try? Let's say that you want to see a film in channel two, and your brother wants to see the match on channel one!

That was very good. (Then the trainer asked if anyone wanted to try again with different subjects and different people, and then gave them a positive reinforcement).

Ok, now let's summarise what we did in this session:

1. We reviewed the last session.
2. We trained to be better in negotiating and reaching a compromise.

Now take out the white card from the back of your file (Card A) and write down how well you did in today skill.
Your home assignment is to practise the skill that you were trained to do in this session with three different people, a family member, a friend, and an acquaintance. You will use the practice sheet (Form D1) to write down what happened with each one.
Now please take out the session evaluation card (Card C). Fill it in and hand it to me.

That is it for today. Hope to see you all on Monday; please be on time.

Tenth session: Monday 6/11/200

Assalamo Alaykum Wa Rahmatuallah Wa Barakatuh.
Welcome everyone. How are you today.
Please sign your name in the attendance list.

Did you practise the skills we learned in the last sessions?
Very good. (Then the trainer listened to what everyone did and gave them positive reinforcement).

Today we are going to learn the last negative assertion skill, how to express your anger. Every one of us faces some situations and people who make her angry. It is very important to now how to express our anger in a mature way.

Steps for Expressing your Anger:

1. Tell the other person that you are angry with her/him.
2. Tell him why you are angry.
3. Ask her/him to understand your feeling.

4. Ask him to behave in the right way.

Who wants to try? Let's say that your friend told you that the exam was at 8 am instead of 1pm.

That is very good, you explained your reason for being angry in a very polite way, and it is true that your voice was high and you were edgy but that was acceptable.

Now I want somebody else to try, but before that here are the steps to follow in dealing with someone else's anger:

1. Listen to the person who is angry.
2. Try to understand what the angry person is saying and feeling.
3. Decide if you can say or do something to deal with the situation.
4. If you can, deal with the other person's anger.

(then the trainer asked if anyone wanted to try again with different subjects and different people, and then gave them a positive reinforcement.

Always remember the importance of the right time and place and the nonverbal behaviour.

Open your file. At the end, there is a picture of a face and a set of eyes and mouths. Try to find out what each set of eyes mean, and which mouth matches which eyes. Try to understand other people's behaviours because that will help you to deal with them better.

Now let's summarise what we did in this session:

1. We reviewed the last session.
2. We trained to be better in expressing and responding to anger.

Your home assignment is to practise the skill that you were trained to do in this session with three different people, a family member, a friend, and an acquaintance. You will use the practice sheet (Form D1) to write down what happened with each one.

Now take out the white card from the back of your file (Card A) and write down how well you did in today skill

Now please take out the session evaluation card (Card C). Fill it and hand it to me.
As you know this is our last session. I would like to thank you all, and emphasise the importance of practising.

In front of you is a package of cards containing all the steps we took in this programme (Appendix C).
Here is a test that I would like you to do. Please do it now and hand it to me.

This is a thank you gift for your participation, I hope you like it. Please help yourselves to the drinks and cakes.

Don't forget to come back in the first week after your Eid vacation.

Thank you again and have a nice vacation.

The Brief Counselling Sessions

Case one:

Salwa was 21 years old, married for two years with one child. She had been shy as long as she could remember. Her clothes were light coloured and she tied back her hair, wore glasses. When she spoke she did so in a low voice.

Her main problem was her fear of negative evaluation and tendency to avoid social gatherings.

Before any social situation, I plan carefully what I am going to say. But when I am in that situation I don't say anything. I just sit there, not knowing what to say. My level of anxiety increases and I wish I could just go home. What makes it worse is that I know that everyone thinks I am stupid.
I don't go out much, though I would like that very much.

The outcomes of each session:

Session (1): The client talked about how shyness had affected her quality of life since she was a little girl.
(stage 1 step 1)

Sessions (2,3,4,5): The client established new perspectives, saw herself as an active person with a lot of qualities.
(stage 1 step 2&3)

Session (6): The client became more effective in decision making and planning to interact with other people.
(stage 2 step 1,2)

Session (7): The client valued the changes in her relationship with others- e.g. she participated in the class discussion for the first time, and distinguished between what is wanted and what is needed.
(stage 2 step 3)

Session (8): The client developed an action programme including, when and what to do in the future.

(stage 3 step 1,2,3)

The client experienced significant changes.

Case two:

Lila was 21 years old, married with two children. She had been shy since she was twelve years old. Her clothes were light coloured, and she tied back her hair. She sat on the edge of the chair.

In the beginning of the first session the client experienced some difficulty talking about herself.

Her main problem was that she had negative thoughts about herself.

I find it very hard to do or say anything in front of a group of people, no matter how many persons there are. All I think about is that I would say something and everyone would look at me and laugh because I don't know the right thing to say. So I prefer to stay at home with my children. I don't talk much with my husband, though he is very gentle and never criticises me in front of anyone. You can say that I agree with whatever he suggests, I never express my thoughts or feelings.

The outcomes of each session:

Session (1): The client talked about her life and how her father used to treat her. He criticised her behaviour and made fun of her in front of everyone else.

(stage 1 step1)

Sessions (2,3): The client started to see her problem as solvable.

(stage1 step 2)

Session (4): The client became more effective in decision making.

(stage 1 step3, stage 2 step2)

Sessions (5,6): The client distinguished between what she wanted and what she needed.
(stage 2 step1, stage3 step2)

Session (7): The client decided what action was best for her. e.g. she decided to tell her husband her opinion about moving to another apartment.
(stage 3 step2, stage 2 step3)

Session (8): The client developed a future plan.
(stage 3 step3)

The client experienced positive change in her thoughts and promised herself to keep working in the same direction to achieve the stage when she wouldl not have negative thoughts about herself.

Case three:

Munah was 23 years old, engaged to be married in the summer. She was a beautiful girl. Her clothes were dark coloured. She tried to avoid eye contact.

Her main problem was her feeling of embarrassment and painful self-consciousness if anybody complimented her.

When anyone says something nice about my appearance, I feel so embarrassed; my face gets very red which makes things worse. I feel that everyone I know likes to see me like this. I try to control my self, but with no success. I am getting married soon, and I feel that my fiancée is a little annoyed at me because every time he compliments me I behave in a childish way. I hate that.

The outcomes of each session:

Session (1): The client talked about her childhood, living in the family house with all her uncles and aunts, and how hard that was for her. What made it worse was that they treated her mother in a disrespecful way because she was not from the same family. Her grandfather kept telling her that her beauty would bring a lot of problems to the family.
(stage1 step 1,2)

Sessions (2,3): The client moved beyond faulty interpretations, and became more aware of her ability.
(stage 1 step3, stage2 step1,3)

Session (4): The client chose some strategies to overcome her flushing.
(stage 2 step2)

Session (5): The client started to set her own goals.
(stage 3 step1,2)

Session (6): The client made a commitment to herself that she would enjoy her beauty and youth and not be shy about them.
(stage3 step1)

The client experienced significant change in her attitude toward herself.

Case four:

Randa was 24 years old, single. She was always smiling. She was reluctant to disclose herself. She did not talk freely till the third session.

Her main problem was her fear of negative evaluation, even from her youngest sisters.

I feel that most of the people around me are waiting for me to do something wrong so they can judge me. When I talk everyone looks at me, I can hear theire thought,s "come on say it, make a fool of you self". So when I speak I make a fool of myself.

The outcomes of each session:

Session (1): The client talked about her problem and gave examples of situations when she behaved awkwardly.
(stage 1 step3)

Session (2): The client started to believe that she could overcome her problems.
(stage 2 step1)

Session (3): The client started to talk about herself and how she started to be afraid of other people's evaluations. She was an A student until the seventh grade when the head teacher made fun of her in the front yard of the school with everyone watching.
(stage 1 step1,2)

Session (4,5): The client made decisions, and practised different ways of expressing herself in social situations.
(stage 2 step2,3)

Session (6): The client set goals and committed herself to achieving them.
(stage 3 step 1)

Session (7): The client found out the best way to express herself without fear of negative evaluation.
(stage 3 step 2)

Session (8): The client made a timetable of activities to help her achieve her goals.
(stage 3 step 3)

The client experienced significant change in her behaviour and she was eager to achieve her goals.

Case five:

Eman was 21 years old. She started to feel shy when she was 14 but she thought that was normal because of the changes in her body. But when she entered the university she began to feel that she had a big problem. Her clothes were light coloured, she tied back her hair, she wore glasses, and when she spoke you could hardly hear her voice.

Her main problem was lack of confidence and social skills.

When I go anywhere I just stay in the corner of the room praying that no one will talk to me, because I don't know what to say. I can't start a conversation or even answer a question without shaking.

The outcomes of each session:

Session (1): The client talked about herself and admitted that she lacked confidence and social skills.

(stage 1 step 1,2)

Sessions (2,3): The client started to have some confidence in herself.

(stage 1 step 3, stage 2 step1)

Sessions (4,5): The client chose which social skills she needed to practise first.

(stage 2 step 2,3)

Sessions (6): The client started to believe in herself.

(stage 3 step 1)

Session (7): The client chose to change her present life style and started to mix with other people.

(stage 3 step2)

Session (8): The client made a list of activities to do; part of it was to practise social skills, and the other part was to get involved in voluntary charity work.

(stage 3 step 3)

The client experienced significant changes in her social skills, which had positive effects on her self-confidence.

Case six:

Suha was 23 years old. She had been shy as far as she could remember. Her clothes were light coloured, and she used light make up. In the interview she questioned whether the sessions would help her. She said that her main problem was that she could not use the bathroom except her own.

Her main problem was Pee Shyness.

I stay home most of the time but when I went to visit my brother, who lived in another city I had to stay there at least six hours. So when I needed to use the bathroom I made sure that no one would see me. I might spend half an hour or more because I am afraid if I come out someone will see me and laugh.

The outcomes of each session:

Session (1): The client told her story explaining her behaviour, thoughts, and feelings.
(stage 1 step 1,3)

Session (2): The client started to see her problem as solvable.
(stage1 step2)

Session (3): The client chose to take positive steps to overcome her problem.
(stage 2 step 1)

Session (4): The client made changes in her behaviour. e.g. she used her brother's bathroom without feeling anxious about it.
(stage 2 step 2,3)

Session (5): The client became more aware of her abilities.
(stage 3 step 1)

Session (6): The client made a list of the activities that would help her overcome her shyness in other situations.
(stage 3 step 2,3)

The client experienced significant changes in her behaviour and thoughts regarding her main problem and she was determined to do the same with her other problems.

Case seven:

Nedah was 22 years old. She had been shy as long as she could remember. Her clothes were light coloured, she tied back her hair, and when she spoke she had a low voice.

Her main problem was her fear of communicating with other people whom she didn't know or those whom she considered to be in authority.

I can't have conversations with anyone; if anyone talks to me I give yes or no answers and most of the time I just nod my head or move my shoulders. I hate myself. I want to go out with others but I cannot fit in. I don't have any friends. I don't participate in class. I think my teachers think I am stupid.

The outcomes of each session:

Session (1): The client talked about how being overprotected by her parents as an only child affected her social life and made her a shy person.

(stage 1 step 1)

Session (2): The client acknowledged both successes and failures in her life.

(stage 1 step 2)

Session (3,4): The client started to discover and work on issues that would make a difference in her life.

(stage 1 step 3)

Session (5): The client set goals for a better future.

(stage 2 step 1,2)

Session (6): The client committed herself to achieve her goals.

(stage 2 step 3)

Session (7): The client chose the best way to accomplish what she wanted.

(stage 3 step 1,2)

Session (8): The client developed an action programme which would help her get what she wanted.

(stage 3 step 3)

The client experienced changes but she needed to work more on her own in order to reach a better outcome.

Case eight:

Basmah was 22 years old. She had been shy as long as she could remember, but she did not realise it was a problem till she got to the university. Her clothes were light coloured, she tied back her hair, and played with her hands.

Her main problem was feeling very nervous when meeting new people.

I become very nervous when meeting new people. I always avoid situations where new people are present. That is why I don't go out often. And when I go out if anyone I don't know talks to me I freeze up.

The outcomes of each session:

Session (1): The client explained her problem situation and how being shy destroyed any chance of her getting married.
(stage 1 step 1,2)

Sessions (2,3): The client started to work on the right things and discovered her creative resources, which she did not think she had before.
(stage 1 step 3)

Session (4): The client became more effective in making decisions.
(stage 1 step 3)

Session (5): The client distinguished between what she wanted and what she needed.
(stage 2 step 1,2)

Sessions (6): The client committed herself to overcome her shyness.
(stage 2 step3)

Session (7): The client set goals that could be achieved.
(stage 3 step1,2)

Session (8): The client made a plan to help her search for more useful ways of accomplishing goals.
(stage 3 step 3)

The client experienced significant changes in her behaviour and thoughts for the better.

Case nine:

Samira was 21 years old. Her clothes were light coloured, very chic, and she paid attention to every small detail in her appearance. She became shy when she had to change her school in the tenth grade.

Her main problem was fear of negative evaluation.

Being shy had a negative impact on my life; I have a few friends, whom I am afraid to lose because of my shyness. I don't talk and I think that my friends think that I am boring and will soon drop me out. But as much as I want to keep their friendship and have more friends. I am afraid that if I talk they won't like what I say. The truth is, I don't want anyone to make fun of me.

The outcomes of each session:

Session (1): The client talked about how hard it is to be shy.
(stage 1 step 1,2)

Session (2): The client worked on her main problem and she realised the missed opportunities that could have made a substantial difference in her life.
(stage 1 step 3)

Session (3): The client identified the most important issues in her life and decided to take a step toward achieving what she wanted.
(stage 2 step 1,2)

Session (4): The client made a list of many different ways to achieve her goals.
(stage 2 step 3)

Session (5): The client chose specific strategies that best fitted her talents and timetable.
(stage 3 step 1,2)

Session (6): The client made a clear picture of what she was going to do in the future to accomplish more achievements.
(stage 3 step3)

The client experienced significant changes in her behaviour and thoughts for the better.

Case ten:

Nour was 20 years old. Her clothes were light coloured, she was bright, and had a sense of humour that she tried hard to hide.

Her main problem was fear of being in any situation where she did not know anyone.

When I find myself in a place where I do not know anyone, I become nervous and I feel pain in my stomach. I cannot mix with other students in the class, I feel out of place. Because I don't talk to anyone, others think that I am arrogant. I wish someone would start to talk to me and insist. But where can I find someone like that?

The outcomes of each sessions:

Sessions (1,2): The client talked about her life after her mother's death and how it had a negative impact on her social life.

(stage 1 step 1,2)

Session (3): The client established a new perspective and saw things more clearly.

(stage 1 step 3)

Session (4): The client became more effective in decision making and planned to interact with other students in her class.

(stage 1 step3)

Session (5): The client challenged herself and committed herself to taking step after step towards establishing relationships with other people.

(stage2 step 1,2,3)

Session (6): The client developed an action plan for the future.

(stage 3 step 1,2,3)

The client experienced significant changes in her behaviour and thoughts for the better. She was quick to understand how she could develop herself.

Case eleven:

Nisreen was 21 years old. Her clothes were light coloured, She had a beautiful smile, and an expressive face. She had just got engaged, and she asked if she could benefit from this programme in two weeks because she was going away on a two-week honeymoon.

Her main problem was fear of criticism.

Being less than perfect, I have always been afraid of criticism. So I always say what people want me to say. I am always nice to other people, no matter what I think or feel about them. But now I am going to be married and I want to start my new life in the right way.

The outcomes of each session:

Session (1): The client talked about her problems in detail.
(stage 1 step 1,2,3)

Session (2): The client became more effective in decision making.
(stage 1 step 3)

Session (3): The client distinguished between what she wanted and what she needed.
(stage 2 step 1,2,3)

Session (4): The client developed strategies for accomplishing her goals.
(stage 3 step 1,2,3)

The client experienced significant changes in her behaviour and thoughts for the better. She was highly motivated to do so.

Case twelve:

Alia was 21 years old, with a petite figure. Her clothes were light coloured. She had been an "A" student all her life. She cames from a large family; 15 brothers and 9 sisters. She was number 19.

Her main problem was fear of rejection.

I don't know anyone in the classes I am taking, no one is interested in me, that is why I avoid social gatherings. I know that people reject me even if they don't say it to my face.

The outcomes of each sessions:

Session (1): The client talked about her problems since she joined the university and tried to explain other people's behaviours towards her.
(stage 1 step1,2)

Session (2,3): The client started to develop hope that she could adjust to the life of the university without losing her sense of self-respect.
(stage 1 step3)

Session (4): The client recognised that there were many different ways to achieve her goals.
(stage 2 step 1,2,3)

Session (5): The client chose the action strategies that best fitted her resources, style, and timetable.
(stage 3 step 1,2)

Session (6): The client made a future plan and committed herself to achieving her goals.
(stage 3 step 3)

The client experienced significant changes in her behaviour and thoughts.

Study skills Sessions

First session: Saturday 7/10/2000

Assalamo Alaykum Wa Rahmatullah Wa Barakatu.
Welcome everyone; I would like to thank you all for your participation in this programme. Before I talk about the programme I would like to introduce myself. My name is Lila Al Ghalib; I am a PhD. Student at Hull University in the United Kingdom. My research requires applying different kinds of programmes; your group will take the Study Skills programme, which is aimed to help you to study better. This programme contains ten sessions; two sessions each week, each will last for one hour. In each session you will do some exercises, then I will correct them with you. After that I will give you some information about learning which will help you learn better than you do now. At the end of each session, you will evaluate the session on a scale from five to one. This evaluation will help me do better next time, so please be honest.

Dear students, in order to have a good outcome of this programme you should attend all sessions. But this doesn't mean that you are forced to do so. Each one of you has the right to quit at any time, though I hope that will not happen.

I would like to inform you that if you stay to the end of the programme you would receive a nice thank you gift.

Do you have any questions?
Q: What if I miss one session?
It is ok, but try to come to me before the next one to take the missed session's exercises and do them at home so you will not be left out for the next session.

Now, in front of each one of you is a file. I want you to keep it with you and bring it to all sessions. This ensures that all your paper in one place. By doing that you will have a complete file of what you have done by the end of the programme. This file is yours to keep. You can always go back to it in the future if you need it.

Ok, let's start by answering the first page in your file (Form B); when you finish it please hand it to me.

Now start answering the rest of the questions in your file.
Ok, did you finish all the exercises? If you did not, it is ok, you can do it while we are correcting them or later at home.

Now after we have gone through all the exercises, it is time to give some information concerning your learning techniques.

Learning is easier when circumstances are favourable in the following ways:[♦] -

1) *When you are in a physical state to learn.*
    a. *You can't learn easily if you are tired, stressed, hungry, dehydrated or on a high sugar diet.*
    b. *A glass of plain water several times a day helps neural activity in the brain, and gives the body energy. Other drinks do not have the same effect. If you tire easily when studying, or if your thinking is muddled, drink some water.*
    c. *Foods such as cereal-based products (rice, oats and wheat), that release natural sugars slowly help balance your energies.*
    d. *Stress may put you into `survival mode`, diverting your energies away from your brain to your muscles. We learn best when relaxed, interested and motivated.*
2) *When you believe you can learn.*
    - *Believe in your intelligence.*
    - *Believe you have the right to learn.*
    - *Create a positive state of mind for learning.*
3) *When the medium suits you.*
    - *Rewrite, draw, act, tape or sculpt new information so that it is easier to absorb whatever suits you best.*
    - *Experiment with different layouts, colours, fonts, and page sizes.*

♦ Cottrell, 1999: 47, 211.

- *Personalise information to make it your own.*

4) *When information is organised.*
   - *Organise information so that your brain can structure it. Some people prefer to organise information as pattern notes or other images. Combining pattern notes, concept pyramids and pictures can give you a greet boots to your powers of recall.*

5) *When you use the 5 strategies.*
   - *Be creative, reflective, effectively organised, active and highly motivated.*

6) *When you use your whole brain.*
   - *Take full advantage of your brain. Use both the left and the right sides of your brain ,the triune brain, and all your senses to encode information.*

7) *When the five study skills components are in place You need:*
   - *self-awareness*
   - *awareness of what is required of you*
   - *methods and strategies*
   - *confidence and permission*
   - *familiarity, practice and habit.*

8) *When you enjoy what you learn. Make sure:*
   - *that it has meaning for you*
   - *that you really care about the outcome, attracted to success like a bee to honey*
   - *that you are fully engaged in what you are learning.*

9) *When you work with othes.*

Now, in the end of your file there is an evaluation card for the session, please fill it now and hand it to me. I will return it to you next session. You are going to do that for each session.

That is it for today. Hope to see you all on Monday. Please be on time.

Second session: Monday 9/10/2000

Assalamo Alaykum Wa Rahmatullah Wa Barakatu.
Welcome everyone. Please sign your name in the attendance list.
Do you have any questions regarding what we did in the last session?
Q: How can I know which method is better for my study?

Go to page 3 in your file. These are some methods that you can use. Think about what you are taking this semester and see which are the methods that apply to your subject.

You will find most of your learning falls into five main categories[♦]*:*

1. *Facts: (for example, the names of the kings of Saudi Arabia). Facts are easier to remember if you can relate them to something. Try using rhymes, mnemonics, flashcards, and notes posted around the room to help you remember facts.*
2. *Rules and formulae: (for example, grammar, mathematical and scientific formulae). It can be difficult to remember rules and formulae if you don't know how to apply them. To help you remember rules, practice solving problems, working through them on your own and then checking the answers given by the book or someone who knows how.*
3. *Concepst: (for example, the ideas of gravity or weight and mass). Concepts can be hard to grasp at first. Only with familiarity and preferably with application do they begin to make sense. Read several sources and then try to rewrite the ideas in your own words or try to explain the concept to someone else.*
4. *Skills: (for example, taking good notes). Gaining skills requires repeated use. Sometimes you have to learn in stages, and then build on the stages to create the whole, for example, writing words, then sentences, then paragraphs, then a whole essay.*
5. *Feeling and attitudes: (for example, enthusiasm, caring, disliking). These are often inseparable from skills, concept, and even facts. They may be seen as either strengths or weaknesses, and they may influence your perception of yourself and of your learning without your realising it. It is always useful to*

♦Effective Learning Programme. (Pp.27-28) Unite (1) Session (1).

explore feelings, and attitudes in order to confront any problems they may cause or congratulate yourself on successes, which may be due to particular attitude.

Ok, now do the exercises in your file.
Ok, did you finish all the exercises? If you didn't, it is ok, you can do it while we are correcting them or later at home.

Now after we have gone through all the exercises, it is time to give some information on how to organise yourself.

Organising yourself will help you to work efficiently and to enjoy yourself. It will give you a more relaxed life, allowing you to finish tasks, find things and get your work done. It will also help you to avoid stress.

Planning for daily life will enable you to do what you want and need to do, and enjoy yourself in the extra time you liberate by being more efficient.

Before you plan, you need to know what you want to do and when. Begin by looking at the time that is already committed and that you cannot reallocate. Depending on your circumstances this can include time spent:

- *In formal learning such as lectures and classes.*
- *At home with your family.*

The remainder of your time you need to split between studying on your own exercises, relaxing, eating, sleeping and doing routine things such as shopping, cooking and laundry.

Before you start to plan your time around your formal commitments, think about what you do best at different times of the day. If you study best in the mornings, it would be unwise to allocate all your mornings to exercise. Some things will have to be at certain times of day. If you go to a volunteer job on Saturday evening, for example, this is a commitment you have to play around.

This is a timetable for a week. Take it with you, fill in everything you do during the day for a week and then see how organised you were!

Now, fill in the evaluation card the same way you did last session and hand it to me.
That is it for today. Hope to see you all on Saturday. Please be on time.

Third session: Saturday 14/10/2000

Assalamo Alaykum Wa Rahmatullah Wa Barakatu.
Welcome everyone. Please sign your name in the attendance list.
Do you have any questions regarding what we did in the last session?
Q: How can I organise my time? I tried during the weekend but I failed.

Look for the time patterns that suit you. You may prefer to work in short spells of twenty minutes, or find you are increasingly engrossed by study as day progresses. As far as possible, schedule study activities to suit your own time patterns. For example, if you begin slowly, schedule short activities, such as brain storming ideas, early in the day. You may find it easier to write at night when it is quiet or it may suit you to write in the morning when you feel more alert[♦].

Give yourself manageable short-term goals. Set yourself mini-goals, so that you have a sense of achievement.

- *Break large assignmenst, such as writing a report, into smaller tasks: `Read course notes`, `Find resource material`, etc.*
- *Break each of these sections into smaller tasks: `Make notes on pp.20-40 of Business Management`.*
- *Set a realistic time allowance for each mini-goal: `Make notes on pages 25-45: 20 minutes`.*
- *Give yourself a start time, and stick to it.*
- *Set a target end-time. However, if you have not finished, keep going until you have.*

♦ Cottrell,1999:136.

Mini-goals work best when they are:-

1. *Integrated : clearly linked to a larger plan, such as your essay, project or your overall motivation for the course.*
2. *Manageable and realistic: set yourself achievable goals.*
3. *Specific: so you know precisely what you are going to tackle.*
4. *Measurable: such as a set number of pages to read, or a report section to write.*
5. *Flexible: plan "empty" spaces into your timetable for emergencies, and be prepared to change things round if necessary.*

Ok, now do the exercises in your file.

Ok, did you finish all the exercises? If not , it is ok, you can do it while we are correcting them or later at home.

Now after we have gone through the exercises, it is time to give you today information. It is about reading skills.

Open the book, go to page 5, read the first paragraph. How do your eyes move to take in the text? And how long do you think you take to read each line of the text?

You can make yourself a quicker and more efficient reader. Three of the most effective strategies are[♦]*:*

1) Eliminating skipping back over words.
2) Increasing the size of the fixation to take in more words.
3) Consciously reducing the amount of time of each fixation.

Eliminating skipping back: Skipping back can be either deliberate (e.g. to have a second go at something you did not understand first time) or can be unconscious. We are worried that we need to go back over something to understand it properly, whereas in reality we would understand the text perfectly well if we carried on.

♦ The Effective Learning program. (P. 63,66) Unite (2) Section (4).

Both forms of skipping back can be reduced by making a conscious effort to keep your eyes on a fixed path. Words or phrases that do need to be reconsidered can be noted or intelligently guessed, or marked up and looked up later.

Increasing the size of fixations: you now know that our eyes move in a series of jumps or fixations when we read. Slow readers are only taking in one word at a time. They bounce from one word to the next, which is not only a lengthy process, but makes it harder to take in the whole picture, i.e. to understand the meaning of the words taken together. Try in your own reading to create clusters, which will help you read fast, Learning to read in clusters of words will take practice.

Reducing the time for fixations: Each fixation that the eye makes can take between 0.25 and 1.5 seconds. You can make a conscious effort to speed up the time taken over each fixation, bringing it as close to the minimum as possible.

There are other sorts of speed-reading, including the techniques of skimming or scanning, where you achieve speed by not reading every word or even every paragraph. Being able to read quickly is one side of the coin; understanding and absorbing the text is equally, if not more important.

Now, fill in the evaluation card the same way you did last session and hand it to me.
That is it for today, hope to see you all on Monday, please be on time.

Fourth session: Monday 16/10/2000

Assalamo Alaykum Wa Rahmatullah Wa Barakatu.
Welcome every one. Please sign your name in the attendance list.
Do you have any questions regarding what we did in the last session?
Q: Are there other ways to improve the speed and efficiency of my reading?
You need to develop different methods of reading to suit your purposes, and to treat each book or article appropriately[♦].

♦ The Effective Learning Programme. P76 Unit 2. Section 2.

There are other techniques than the ones we talked about in the last session, called` speed-reading` but more properly refer to the ability to find useful information and can more accurately be called `speed-searching`. Theses techniques include:

- *Browsing*
- *Skimming*
- *Scanning*
- *Speed-reading*

Browsing is something we generally think of as a casual activity, but can actually be a highly skilful and productive activity. You may browse through a single book in a library or bookshop, looking for something that will interest you or be of use. Typically, you look at the signposts of the book(title page, table of contents, and so on) and then read odd snippets here and there to get a feel for it. You may read whole pages occasionally, or just sentences.

Skimming involves looking quickly through a whole book, article or chapter and picking out a few main words or sentences that stand out. You don't read every work, but glance along the lines to find the important bits.

Scanning is similar to skimming. Again, you look quickly through a book or chunk of text, but this time you are scanning the text for something specific. You stop if you find a word or sentence that seems to relate to what you are interested in. You look down each page, but probably pay more attention to the headings, tables, illustrations and charts than to the main text because they can be a good indication of what the text is about.

Speed-reading comes in several guises. Its objective is to let you cover a lot of material quickly, though not particularly thoroughly. For example, reading only the main words in each sentence and looking at only a central column of words on each

Ok, now do the exercises in your file.

Ok, did you finish all the exercises? If not, it is ok, you can do it while we are correcting them or later at home.

Now after we have gone through the exercises, it is time to give you today information. It is about writing skill.

Remember that like any other skill, the best way to learn to write well is to practise. In this case, you need to read as well as to write. Reading increases your understanding of how the language works. The more widely you read, the more you will become aware of how other people use words[♦].

Pay attention to your reactions to anything you read, from newspaper articles to weighty academic tomes. If you find your mind drifting away, try to determine why by asking yourself:

- *Are there too many long words?*
- *Is the structure unclear or illogical?*
- *Is the subject matter boring?*

If, on the other hand, you find yourself drawn into what you are reading, ask yourself:

- *What is it about the way this is written which makes me want to read on?*
- *Is it written particularly cleverly?*
- *If it is clear and easy to understand, what makes it that way?*

You will need a current dictionary at all times, and will find a thesaurus almost as essential.

Le 'ts now talk about how to present your work?
A great deal of time and effort is likely to go into your essays, report and assignments. You now need to give some thought to how the finished product will look. It is important to present your work clearly in order to help your readers understand what you have written. Part of this presentation will be the visual appearance of your work, but there are a number of academic conventions which you will expected to follow.

***Appearance:** Your reader's first impression of your work will be influenced by its appearance. An attractively essay or assignment indicates to your reader that you*

[♦] The Effective Learning Programme.(P49. Pp52-55.P57) Unit (4) Section (2)

have taken the extra time and trouble necessary to produce clear and attractive work; it also shows respect for anyone reading your work.

- ✓ *Use a typewriter or word processor to produce the final version of your work.*
- ✓ *Double space between lines of writing or typing.*
- ✓ *Provide space for comments.*
- ✓ *Use A4 paper.*
- ✓ *Prepare a list of contents.*
- ✓ *Make sure all the pages are firmly bound together.*
- ✓ *Keep a photocopy of work you hand in.*
- ✓ *Follow any specific instructions about layout or presentation for individual pieces of work.*
- ✓ *Proofread carefully to pick up small mistakes and typographical errors.*

If you are using a word processor, you can set up a standard format to ensure that all your work is consistent.

***Quotations**: You will almost certainly use quotations in your written work. They are useful to:*

- *Express an idea in a different way.*
- *Illustrate a point.*
- *Convey the flavour of work of literature.*
- *Enlarge on your own ideas.*

Quotations are one way of acknowledging someone else's work. They also help to substantiate your studies by demonstrating that you have read widely and considered the work of other people. Quotations must be presented so that the reader can easily distinguish someone else's words from yours. Put inverted commas around the quoted words and always quote accurately.

***References:** Whenever you draw directly on someone else's work, you will need to refer to the author and the work. It is important to acknowledge the original author as the source of your ideas.*

Always work on improving your spelling, grammar, and punctuation.

Assignments lie at the centre of your work at university and so it is important not to regard them as something separate from the rest of your studies. It is through your work on assignments that you consolidate what you have learned. It also offer an opportunity for you to make your own assessments and interpretations and to relate what you have learned to the rest of your studies. Analysing the task, careful planning, following instructions, and thinking about your audience, together with the writing and presentation skills you have, should ensure that your assignments are of the highest quality[♦].

Now, fill in the evaluation card the same way you did last session and hand it to me.
That is it for today. Hope to see you all on Saturday. Please be on time

Fifth session: Saturday 21/10/2000

Assalamo Alaykum Wa Rahmatullah Wa Barakatu.
Welcome everyone. Please sign your name in the attendance list.
Do you have any questions regarding what we did in the last session?

Q: Sometimes it is very hard for me to finish what I am writing. Is there a way to overcome this problem?

There are some activities that can help you to overcome writing blocks. Choose what you think would be most useful for you. These activities are[♦]*:*

- *Scribble. Scribble ideas fast, in any order- whatever comes into your mind- then rearrange what you have written and rewrite it.*
- *' It's only a draft'. Think of each piece of writing as something you will develop through several drafts. As it's just a draft, it doesn't have to be good- it's just something to work on.*
- *Write in pencil. This will remind you that your draft is rough one- mistakes are allowed!*
- *Write on loose paper- not in a book. If you don't like what you have written, you can throw it away. Alternatively, you can cut it up and rearrange it.*

[♦] The Effective Learning Programme. (P77)Unit (4) Section (3)

- *Ignore mistakes in early drafts. Don't worry about minor corrections, such as spellings- you can sort those out in the final draft.*
- *' For your eyes only' Remind yourself that nobody but you needs to see early drafts. Handwriting, untidiness and mistakes don't matter at this stage.*
- *Experiment. Try different starting methods, such as brainstorming, talking with others.*
- *Start anywhere. Write things in any order that suits you- you can rearrange them later. For example, it may be easier to write the introduction last.*
- *Mark the paper. If blank paper puts you off, make any mark or doodle on it so that it's not blank.*
- *Write by talking. If you find it hard to express yourself in writing, say it out loud and record yourself. Then copy this out and redraft it.*
- *Take one step at a time. Break the task into manageable steps.*
- *Use the computer. If you use a computer it is easy to change what you have written.*
- *Brainstorming on the computer. Brainstorm headings an ideas, typing them quickly on the computer screen. Print them and cut them out. Rearrange them on a large piece of paper, until you have the order you want.*
- *Use specialist software. Use computer package such as Inspiration, which allows you to brainstorm and organise ideas both as patterns and as linear notes.*
- *Rest and relax. If your mind goes blank, you may be tired or stressed.*

Ok, now do the exercises in your file.
Ok, did you finish all the exercises? If not , it is ok, you can do it while we are correcting them or later at home.

Now after we have gone through the exercises, it is time to give you today information. It is about making notes.

Making notes can offer several important benefits[♦]*:*

- *To provide a record or summary of important information.*
- *To aid concentration.*
- *To stimulate your own ideas and creativity.*

Notes can take lots of different forms- they can be more or less detailed, they can be written on to a book or text or on to separate paper, they can be written in one colour or several colours, they can be odd words or phrases or complete sentences.

The form your notes take will depend on several factors:

- *What is your own personal style or preference.*
- *How detailed you want your notes on a particular text to be.*
- *Whether the text is your own, someone else's, borrowed from the library or a photocopy.*

First: notes you make away from the text, i.e. on separate paper.
In broad terms notes may take one of three broad forms:

1) *Prose summaries.*
2) *Key word outlines.*
3) *Diagrammatic notes.*

Prose summaries. As the name suggests, these are notes written in straight prose, and represent a condensed version of the original.

Key word outlines.. Theses use single words or brief phrases to capture the main ideas of the text. These notes are generally set out as lists and often use numbering, indentation, headings and sub-headings to organise the information.

Diagrammatic notes. These are described by all sorts of names, such as: patterned notes, spray diagrams, spider charts, mind maps, or brain patterns.

♦ The Effective Learning Programme. (P3,5,6,12,14,15) Unit (3) Section (1)

Diagrammatic notes use key words and phrases, but aim to show the connection between ideas in graphical form. Generally, the main theme of the topic is written in the centre of the page; lines radiating from the centre describe different aspects or branches of the topic. There may be further lines showing sub-sub-topics, while arrows may be used to link up connected parts of the diagram.

Second: notes you make on books.
It is an excellent thing to write on books- provided, of course, that the book is yours. There are several reasons :

- *It helps make reading an active process, rather than a passive one.*
- *It encourages you to be critical (in the positive sense), rather than accept unquestioningly the author's words.*
- *You are paying the author the compliment of engaging with his/her text.*

There are several ways of using the written source to make notes.
Underlining: *it is one of the most popular ways of noting important points. The principle is a sound one: you emphasise the important points by making them stand out against their background. However, there are number of potential drawbacks to this method of note-making.*

- *Underlining a point is less likely to reinforce it in your mind than writing out the key words yourself somewhere else.*
- *It is all too easy to underline far too much and lose the really important details. Any more than one third of a paragraph is too much.*
- *If you underline too little, you may miss important details and have to reread the text to locate them.*
- *Underlining can become an automatic process, done by the hand with the brain disengaged.*
- *It is absolutely unacceptable to mark books that belong to someone else.*

As well as the amount of the text you underline, it is also important to think about how you underline. Two good principles are:

1) *Do not underline complete sentences as this involve you in too much rereading later on.*

2) *Do underline compete thoughts that will make sense when you come back to them.*

Use different sorts of underlining to present different types of note, such as:

- *Single underline for key points.*
- *Wavy underline for queries.*
- *Double underline for a particularly vital point.*
- *Dotted underline for some other purpose e.g. a cross reference.*

Use different coloured pens for different sorts of notes:

- *Using one or more highlighter pens instead of underlining.*
- *Drawing a box around `signpost` points, such as headings.*

Now, fill in the evaluation card the same way you did last session and hand it to me.
That is it for today. Hope to see you all on Monday. Please be on time

Sixth session: Monday 23/10/2000

Assalamo Alaykum Wa Rahmatullah Wa Barakatu.
Welcome everyone. Please sign your name in the attendance list.
Do you have any questions regarding what we did in the last session?
Q: Is making notes a useful activity? Why make notes at all?

It is useful in many ways:

A. *It is a Useful record*
   1. *of important points for future use*
   2. *of where the information comes from*
B. *Helps writing*
   1. *helps ideas flow*
   2. *helps planning- you can see what information you have*
   3. *assists organisation- you can rearrange and renumber notes in a different order*
   4. *helps you get started*
C. *Helps understanding*
   1. *if you focus on selecting information to note*
   2. *if you think through where everything fits*

D. *Helps memory*
    1. *summing things up briefly helps long term memory*
    2. *the act of writing helps motor memory*
    3. *pattern notes can be more memorable visually*

E. *Helps exam revision*
    1. *material is well organised*
    2. *more information is already in memory.* (Cottrell,1999,p117)

Ok, now do the exercises in your file.
Ok, did you finish all the exercises? If not , it is ok, you can do it while we are correcting them or later at home.

Now after we have gone through the exercises, it is time to give you today information. It is about collecting information.

If you are clear in your mind what it is you are aiming to achieve in your studies, it is easier to find the resources to help you to meet your learning goal. There are different sorts of learning resources. They are divided into five categories:-

1. *Text- based resources (published) such as books, magazines, and journals.*
2. *Text- based resources (unpublished) such as theses, notices and posters.*
3. *Non-text- based resources such as computer programs, the internet, and audio-visual aids.*
4. *Group sessions such as demonstrations, lectures, and practice sessions*
5. *People such as members of staff you can talk to, and students working in different subject areas.*

In reality, of course, you are unlikely to use every resource available, as some will be more appropriate to particular subjects and learning tasks than others.
The connections you make between resources and learning tasks should be based on what will help you achieve your learning aims.
You may on occasions have found it difficult to assess how a particular resource could help you; e.g. if you have never used it before or known little about it.

When you are given an assignment or any learning task to do, it is worth investing sufficient time at the start planning how you are going to tackle the task and what sorts of resources you are going to use before you begin, It is rarely a good idea to go straight off to the library and grab the first book you find on the subject you are covering- you may find something extremely useful, but you may just as easily choose something inappropriate or unhelpful.

Your main aim in choosing resources should be to identify those that will help you meet your learning goals. The sorts of resources you choose may include any or all of the following:

1	*Resources that give you an overview of a topic, or suggest a selection of topics or areas you may want to work on*	*e.g. bibliographies, reading lists, other finding aids*
2	*Resources that give you more detailed information about a topic*	*e.g. text books, general subject texts, commentaries*
3	*Resources or tools that will let you explore an area or topic for yourself and reach your own conclusions*	*e.g. primary sources, experiments, lab work, tests*
4	*Resources that will help you judge the value or significance of information you have gathered*	*e.g. people(yourself, lecturers, other students), analytical programs on the computer, work of criticism or analysis*
5	*Tools that will help you with the presentation of your work*	*e.g. word processor, video/audio*

The Effective Learning Programme.(P14,18) Unit (2) Section (2)

Now, fill in the evaluation card the same way you did last session and hand it to me.
That is it for today. Hope to see you all on Saturday. Please be on time

Seventh session: Saturday 28/10/2000

Assalamo Alaykum Wa Rahmatullah Wa Barakatu.
Welcome everyone. Please sign your name in the attendance list.
Do you have any questions regarding what we did in the last session?

Q: What primary sources mean?

In many areas, you will be faced with two types of sources of information[♦]*:*

1. *primary sources, and*
2. *secondary sources.*

Primary sources are original material or the closest you can get to original material.

Examples are:

- *first-hand accounts of historical events*
- *samples, specimens, slides, objects, photographs*
- *original literary sources(poems, plays, novels)*
- *experiments you carry out yourself*
- *experiences with people whose native language you are learning*
- *examination of and conversation with patients.*

Secondary sources involve someone else's interpretation, they include:

- *works of criticism*
- *history text books*
- *accounts of experiments other have conducted*
- *notes someone else has written about patients.*

Ok, now do the exercises in your file.

Ok, did you finish all the exercises? If not, it is ok, you can do it while we are correcting them or later at home.

Now after we went threw the exercises, it is time to give you today information. It is about recording information.

Recording information about resources is very important to you because of these reasons:

- *you may want to find and use the book or article or other resource again*
- *you may need to create a bibliography*
- *you may need to refer to information in the publication in a reference or footnote*

♦ The effective Learning Programme. (P25) Unite (2) Section (2)

- *you may intend to carry on and do further research in the future.*

Many people have good intentions of keeping a well-ordered set of records, but in fact they let things slip and don't maintain their records as well as they should. In this case, you may find that you quickly end up with lots of bits of scrap paper with incomplete references scrawled on them. In this case, you won't be able to find what you need, and will waste a lot of time duplicating work you have already done in researching the literature relevant to an area of your study.
It is easy to keep clear records on index cards of the books and articles you refer to or any you come across which you think may be useful.
Information to note includes:

For a book	*For an article*
the author's name	*author of the article*
the title of the book	*title of the article*
the publisher	*name of the journal or title of the book(plus editor) if it is a collection of articles*
place of publication	*volume, number and year of publication of journal/book*
year of publication	*page numbers of the article within the journal/book*

The Effective Learning Programme. (P77-79) Unit (3) Section (4)

Whatever the resource, there are also other useful pieces of information you could record about it:

- *the library catalogue reference- you will save yourself time looking in the catalogue if you need to refer to the book again later*
- *a few notes on the content of the book or article to remind you what was useful about the resource*
- *a key word identifying the topic(s) covered by the publication.*

The most popular way of keeping this bibliographic information has been the use of index cards kept in an index box. Using one card for each resource, you can record all the information you want to and then file the card in whatever way is most appropriate for you, whether that is subject area, title, or author's name.
With the advent of new technologies, it is perfectly feasible to keep these records on a computer database.

More details were shown using the overhead projector. (from Cottrell 1999 p121).

Now, fill in the evaluation card the same way you did last session and hand it to me.
That is it for today. Hope to see you all on Monday. Please be on time

Eighth session: Monday 30/10/2000

Assalamo Alaykum Wa Rahmatullah Wa Barakatu.
Welcome everyone. Please sign your name in the attendance list.
Do you have any questions regarding what we did in the last session?
Q: What is the conventional way of writing references?

Conventions in writing references[♦]*:*

- *Don't number the items.*
- *Begin each source on a new line.*
- *List alphabetically, by author's surname.*
- *If you use more than one work by a given author and published in the same year, label these a, b ,c...(1999a,1999b,1999c,...) in the text and in the `references`.*
- *Put information in the same order(author, date, title, location of publisher, publisher).*
- *Underline the title of the book or journal or use italics, if available.*
- *Use ' single ' quotation marks for the title of an article within a journal.*

Ok, now do the exercises in your file.
Ok, did you finish all the exercises? If not, it is ok, you can do it while we are correcting them or later at home.

Now after we have gone through the exercises, it is time to give you today's information. It is about research skills.

♦ Cottrell,1999, p125

In Higher Education you will often be told to use you own ideas and express your opinions. This means giving not just `commonsense` answers but your informed opinions, based on knowledge of recent or important texts for your subject area. You are expected to show a deeper understanding of the subject and to use more precise information than the average person in the street.

Before launching into research for an essay, report or other assignment, make sure you know what is required.

- *Read carefully through the assignment guidelines.*
- *What should your work look or sound like when it is finished?*
- *Consider why this particular assignment was set. Is it one that is always set on your course? Or is it topical, related to resent research which has brought the issue into the news? If the latter, make sure you read the relevant recent articles or book.*
- *Identify the marking criteria. Display them where you can see them.*
- *How many words are you expected to write? Scale your research to fit your word limit.*
- *Check how many books or articles you are expected to use. You will not need to read the whole of each book.*
- *How much time is there to do the research? Break the assignment into parts and set yourself mini-goals with specific deadlines.*

There are many more items and facilities than just books in the library. Visit the library early on and see the range of services available.

Finding books in the library:

- *Fiction is arranged in alphabetical order by authors' surnames.*
- *Reference books are arranged by subject. Each subject is given a number, which is shown on the spine of the book.*
- *All the books on a given subject are together on the shelves.*
- *You can find a book's reference number by looking it up in the library catalogue.*
- *For a computerised catalogue, you type in a request and the details appear on screen.*

It helps to find books if you already know the author's surname and initials or the title of the book.

Finding journals or periodicals in the library:
Journals or periodicals usually contain the latest research for your subject, as well as book reviews. Most journal articles have a short `abstract` at the beginning which tells you what the articles are about. Browsing through the abstracts and reviews helps to keep you up to date with the subject. You will be expected to refer to articles in most assignments.

Journals are published at regular intervals during the year. They are collected into numbered volumes, usually one for each tear. To find a journal article you need to know, the title of the journal, the year it was published and its volume number, or the name and initials of the author of the article, and the title of the article.

Finding indexes and abstracts:
Indexes and abstracts are separate publications which give brief details of journal articles, including who wrote what and where to find it. Sometimes reading the abstracts will be sufficient for your assignment; at other times you will need to read the original article also.
In the indexes, you can search by subject heading and by keywords for all the articles on a given subject. They are updated regularly and are well worth using.
Finding electronic information:

An increasing amount of information is being published electronically. This includes anything from mail-order catalogues to academic journals. Electronic information is usually located at an address or site, such as World Wide Web (www). Site used nationally and internationally are on a network such as the Internet.

To locate information on the internet, you type in the address at which it is stored. This will consist of short abbreviations. Spaces, dots, dashes, oblique strokes and letters must be typed in very precisely.

Now, fill in the evaluation card the same way you did last session and hand it to me.
That is it for today. Hope to see you all on Saturday. Please be on time

Ninth session: Saturday 4/11/2000
Assalamo Alaykum Wa Rahmatullah Wa Barakatu.
Welcome everyone. Please sign your name in the attendance list.
Do you have any questions regarding what we did in the last session
Q; Is there any procedure to help me write good essays?

Until you develop your own method of writing essays and other assignments, you may find this seve-n poins procedure helpful[♦]*:*

1. *Clarify the task. Before you start research, make sure you know what you are looking for.*
    - *Examine the title and course notes very carefully. What exactly is required? Ask your teacher early on if you are unsure.*
    - *Write one line to sum up your basic opinion or argument. Adapt it as you proceed.*
    - *Brainstorm or make pattern notes to record what you know.*
    - *What do you need to read or find out?*
2. *Collect and record information. Get the information you need, but be focused.*
    - *Be selective, you can't use everything.*
    - *Write a set of questions to guide your research, and look for the answers.*
    - *Check the word limit to see how much information you can use for each point.*
    - *Keep a notebook nearby to jot down ideas*
    - *Use any relevant material: factual information, ideas, theories, opinions, and experience.*
    - *Use any available sources of information including, books, articles, official reports, surveys, lecture notes, television, newspapers, etc.*

[♦] Cottrell,1999: Pp140-141136.

- *Keep asking yourself: `Do I need the information?` `How will I use this information?`*
- *Record information as you go along.*

3. *Organise and plan. Organise your work as you go along.*
   - *Make a big chart to link ideas and details.*
   - *Make a rough outline plan early on, you can refine it as you go along.*
   - *Keep checking what you are doing. Careful planning helps to prevent repetition, clarifies your thinking, and helps you organise you material.*
4. *Reflect and evaluate. When you have gathered the information, think about where you have got to .*
   - *What have you discovered?*
   - *Has your viewpoint changed?*
   - *Have you clarified your argument?*
   - *Have you enough evidence/ examples?*
5. *Write on outline plan and first draft. Now structure your writing.*
   - *Refine your plan. Work out the order to introduce your ideas, using pattern notes or headings and points.*
   - *Work out how many words you can write on each point. What must you leave out?*
   - *Write a first draft. Write quickly: it is only a draft.*
6. *Work on your first draft. Develop your first draft. You may need to do this several times, improving the assignment with each version. Leave time between drafts for your ideas to simmer.*
   - *Rewrite your early draft.*
   - *Organise the writing into paragraphs.*
   - *Make sure your argument is clear to readers.*
   - *Check that you have include evidence and examples to support your points.*
7. *Write out your references.*
   - *Final drafts. Edit and check your final draft.*
   - *Read it aloud to check that it is clearly written.*
   - *Keep redrafting until you are happy with the text.*

Ok, now do the exercises in your file.

Ok, did you finish all the exercises? If not, it is ok, you can do it while we are correcting them or later at home.

Now after we have gone through all the exercises, it is time to give you today information. It is about effective revision.

Revision is a way of pulling your understanding together in preparation for the exam. You can include and plan for revision from the beginning of the course. Here are some examples:

- *When planning and reading for a part of the course, write alternative essay title on separate pages. Jot brief notes, or page references to material, under each title.*
- *Make your notes readable, attractive and visually compelling as you go through the course. This builds the memory.*
- *If possible, start to over-learn names, dates and key details from index cards at odd moments early in the term. Even when you forget them, they will be easier to learn a second time round.*
- *Begin intense revision about four weeks before the exam.*
- *Read the sections on `exams` well before the exam.*

To avoid reading through notes over and over again:

- *Use creative and interactive strategies. This keeps your mind alert, and helps integrate information.*
- *Instead of just reading, read in order to find out. The best way to do this is to look for material related to possible exam answers. Ask about past exam papers for your course, and invent your own questions.*
- *Discussing past exam questions with friends makes this process more interesting.*
- *Time yourself writing some essays without looking at your notes. This not only shows you which areas need more work but helps to increase your handwriting speed and your ability to think and write under pressure.*

To avoid writing notes out over and over again:

- *This can be a good strategy if you can learn through `motor memory`. Working to different essay plans keeps the information fresh and develops your thinking about the subject.*
- *Some people find that rewriting notes interferes with visual recall of their original set of notes. For them, it is preferable to develop one good complete set of notes, plus a series of index cards.*
- *Reduce information to a series of memory triggers. Reduce a set of triggers to one key word or image.*

To avoid finding ways of putting off revision:

- *Make a revision timetable, which leaves empty spaces to cater for real emergencies. Do a spell of revision before each `urgent task`.*
- *Use watching television or other distractions as a reward, put them in your timetable.*
- *Try revising with other students, or involve others in your revision.*

To avoid `I can't force myself back to study.`:

- *Check your motivation.*
- *Rather than `forcing` yourself, encourage and entice yourself to study through short-term goals, challenges, creativity, and company.*
- *Check that your timetable has sufficient breaks for rest.*

To avoid `I start to panic, I feel I'm never going to get through it all or remember it.`

- *Work with positive-minded people.*
- *Work steadily to small goals.*
- *Speak to a professional counsellor at the university.*

To avoid `I can't cope with the boredom of it. I start to daydream or wonder why I am bothering.`

- *Work in a lot of shorter spells.*
- *Boredom suggests that you are not using a variety of interactive learning techniques, nor your creativity.*

- *Look for ways of introducing variety into your study sessions.*
- *Look for unusual angles on the material you have, or images that sum up the material. Think of ways in which seemingly unrelated material could be linked. Invent an essay or a test for yourself.*

To avoid `I have too many responsibilities to make revision practicable.`

- *Make use of short spells of time, on cars, waiting for visitors, and the like.*
- *Break the work into small pieces. Always carry some work with you.*
- *Carry an exam question in your head and scribble down ideas in odd moments.*

Writing out essays and learning them off by heart is time-consuming and counter-productive, it is unlikely that the identical question will come up in your exam. It is better to spend time reflecting on, and practising, a range of answers, so that you over-learn the material. You will then be able to work with it flexible during exam, selecting exactly what you need for the exactly title given.

It is important to keep checking back what you have learnt, and to reduce you material to shorter, key memory triggers. Keep asking yourself: `How can I use what I have learnt to answer other questions that might come up?`

And remember that over-learning takes time, use spare moments well.

Now, fill in the evaluation card the same way you did last session and hand it to me. That is it for today. Hope to see you all on Monday. Please be on time

Tenth session: Monday 6/11/2000

Assalamo Alaykum Wa Rahmatullah Wa Barakatu.
Welcome everyone. Please sign your name in the attendance list.
Do you have any questions regarding what we did in the last session?
Q: How can I know which revision strategies are the best for me? And why I should not stick to the one I knew?

You can see that effective revision requires skill, planning, commitment, having some awareness of how you learn and remember, and finding what methods work best for you. Even if you have already found a way, or ways, of revising which work for you, a different approach is sometimes necessary at another time and for a different subject[♦].

Comparing your strategies with other people's can be quiet revealing: you may discover that you have had a relatively systematic approach to revising or a more haphazard technique. Wha ever you have done in the past, the best ways to revise are those which are active. Revision should never be simply a passive process in which you hope to absorb enough knowledge to pass the exams.

Ok, now do the exercises in your file.

Ok, did you finish all the exercises? If not, it is ok, you can do it while we are correcting them or later at home.

Now after we habe gone through all the exercises, it is time to give you today's information. It is about exams.

The prospect of examination can be extremely stressful, whether you have performed well or badly in the past. You may even feel resentful that it is a waste of your time, or that you know the material but cannot show your knowledge under exam conditions. Understanding the reasons for exams can be an advantage to you, and knowing you, and knowing you have some control over the process, can help to create the positive mindset needed for a successful exam experience.

The main purpose of exams is for lecturers to check that you have understood the work covered on the course and that the work which demonstrates this is entirely your own. Preparing for exams involves a high release of energy and unusual degree of focus, which produces a very intense kind of learning. That focus and intensity are not easy to reproduce under any other conditions.

♦ The effective learning programme P99 Unit 5 Section 5

Advance preparation for the exam[♦]*:*

1) Find out basic information

- *How many exams will you have?*
- *When are the exams?*
- *How will you be assessed?*
- *Are many mock exams provided?*
- *Where you can get past papers?*

2) Find out the `exam instructions`

Familiarise yourself with the instructions written on exam papers: these can be difficult to understand if you read them for the first time under the stress of the exam itself. They usually tell you about where to write your name and exam number, and how many questions you have to answer.

3) Practice

Like most things, exam performance improves with practice. Attend any mock exams provided, even if you feel you are not at all ready, the experience is important. If no mocks are provided, arrange you own with friends or by yourself.

- *Pick out an old exam paper or make up your own questions.*
- *Arrange the seating so that you cannot see each other's papers.*
- *Write the answers within a set time limit, work alone, in silence.*
- *Afterwards, discuss your answers with each other.*

4) The week before

- *Drink plenty of water in the week before the exam so that you are not dehydrated.*
- *Build in movement and exercise so that you work off excess adrenaline.*
- *Work daily on relaxation, so that your thinking remains clear and focused. You will still feel some nervous energy, which is useful for exams.*
- *Move towards learning master sheets and checking your learning. Find ways of keeping up interest and motivation.*
- *Plan for emergencies. If possible, arrange for childcare or other support from the day before the exam, so that you are free for final revision.*

♦ Cottrell, 1999 Pp222,224

- *Avoid people who may make you feel unsure of yourself, those who are super-confident, and those who panic!*
- *Visit the exam room and get the feel of it.*

5) *The night before*

- *Check over any exam details you have.*
- *Prepare what you will need, pens, ruler, your identity card, and so on.*
- *Avoid people who panic.*
- *Have a snack and a hot, relaxing bath before bed. Leave plenty of time to sleep.*

6) *The day of the exam*

- *Eat well before the exam, to keep up your stamina. Slow-releasing carbohydrates, such as bread and cereals, are best.*
- *Leave plenty of time for the journey in case of delays.*
- *Plan to arrive at the exam room as it opens: it may take time to find your sea*

7) *In the exam*

- *Orientate yourself.*
- *Find a positive, calm, focused state of mind.*
- *Check that you have been given the right exam paper.*
- *Read the instructions slowly, at least twice.*
- *Fill out personal details as required.*
- *Read the whole paper. Always check both sides, even if you think one side is blank.*
- *Divide your time equally among questions that carry the same marks. Jot down the times you will begin each question.*
- *Read each question through at least twice.*
- *Work out what is expected, in general, for each question. Which part of the course does it refer to? Towards which issues is the question directing you?*
- *If a question sounds like one you have done before, check the wording very carefully before you select it. A slight difference in wording might require a very different answer.*

- *Tick all questions you could attempt. Tick twice the ones you could answer best. Don't rush this, it's vital that you choose the questions that will do you justice.*
- *For the questions you select, highlight key words in the title. Notice how many parts there are to the question. Read questions through again very slowly to make sure you have not misread any key words. At this stage you may realise that a question is not what you thought, and may need to select a different one.*
- *At any time, jot down ideas you have about any of your selected questions on a separate sheet. Note the relevant question number beside each idea.*

Now I am going to give the last test, please complete it and after you finish hand it to me.
Now answer the last page in your file and leave it in front of you, I will collect it later.

As you know, this is our last session. I would like to thank you for your participation in this programme.

In front of you is a thank you gift. I hope you like it. Please help yourselves to the drinks and biscuits.

Don't forget to come back the first week after the Eid vacation.
Thank you again and have a nice vacation.

Appendix (C)

- ❑ **Form B**
- ❑ **Record of me**
- ❑ **Card A Record of my homework:**
- ❑ **Sheet A D1 Home assignment**
- ❑ **Skill Sheet**
- ❑ **Self Recording**
- ❑ **Pair interview**
- ❑ **Final Interview (1)**
- ❑ **Final Interview (2)**
- ❑ **Skills Cards**
- ❑ **Ways of Learning**
- ❑ **What I have Learned recently**
- ❑ **Preferences and Practice**
- ❑ **Study Skills Rating**
- ❑ **Card C Session evaluation Card**

Put (√) in any of the following: -

Types Of people who make me feel shy:

( ) Father.

( ) Mother.

( ) Brother.

( ) Sister.

( ) Other male relatives.

( ) Other female relatives.

( ) Friends.

( ) Strangers.

( ) Teachers.

( ) Elderly people.

( ) Famous people.

( ) Others. Who ?

Situations and activities that make me feel shy:

( ) Any social situations.

( ) Large group.

( ) Small, task- oriented groups.

( ) Small social groups

( ) One to one interactions with other female.

( ) One to one interactions with a male person.

( ) Situation where I am vulnerable.

( ) Situation where I am of lower status than others.

( ) Situation requiring assertiveness.

( ) Situation where I am the focus of the attention, before a large group.
( ) Situation where I am focus of the attention, before a small group.

( ) Situation where I am Being evaluated or compared with others.

( ) New interpersonal situation.

( ) Others. What?

Record of me

Choose six categories from the following list and create a record of your self. (One of the categories must be what I hope to accomplish in-this group)

1) My name
2) My favourite subject
3) My favourite place to go with my family
4) My best friend
5) Month of birth
6) My favourite colour
7) Best vacation ever

Record of my homework:

Skills	I tried it with….	The subject was….	Notes

Homework ( )

Date: **Name:**

Before

The skill I will do: ( )

The people I will practice this skill with.

(A member of family, a Friend, and an acquaintance)

After

The length of time I spent with each of them.

( ) ( ) ( )

What happened {in one or two sentences}?

First person

Second person

Third person

This line on the next scale shows my skill's level.

Low High

Skill Sheet

Name: **Date**:

Skill:----------

Skill steps: ----------

Notes:

Self-Recording

Name: **Date**:

Each time you use any of the skills you had in this programme write down when and how well you did:

Skills	When?	How well did you do? Excellent, good, fair, poor

Pair Interview

Name: **Date:** **Time:**

Find things that your partner likes to do.

1)

2)

3)

According to your partner, what is the best thing she did in the last month?

_____

_____

_____

According to your partner, what is the worst thing she did in the last month?

_____

_____

Find out at least one thing that your partner likes about herself.

_____

_____

What are two personal problems that your partner would like to solve, or tow things she would like to change?

1)

2)

What are the most important things in your partner's life?

_____

_____

Find out what makes your partner nervous.

When does your partner get mad?

When does your partner get embarrassed?

Name:

Time:

Notes:

Final Interview

Name: **Date**: **Time**:

1. Did your partner enjoy the programme?

   a lot a little not at all

2. Your partner's most enjoyable experience in the programme was:

   _____

3. Your partner worst experience in the programme was:

   _____

4. Your partner thinks that the group would have been better if:

   _____

   _____

5. The programme dealt with some of the things that were important to your partner.

   True False

6. What will your partner remember most about the programme?

   _____

7. How much did your partner learned about herself?

   She learned a lot She learned a little She learned nothing

8. Write your partner's final comment

   _____

   _____

Name: Time:

Final Interview

Name: **Date**: **Time**:

1. Your partner wanted to have more information about.....

---

2. Your partner will recommend this programme to her friends?

yes no

3. Your partner feels that this programme changed her way of thinking about herself.

True False

4. Your partner thinks that the group would have been better if:

---

5. What will your partner remember most about the programme?

---

6. Your partner's most enjoyable experience in the programme was:

---

7. Your partner worst experience in the programme:

---

8. Write your partner's final comment.

Name: **Time**

Skills Cards

Listening skills:

1. **Look at the person who is talking.**
2. **Think about what is being said.**
3. **Wait your turn to talk.**
4. **Say what you want to say.**

Conversation skills:

1. **Greet the other person.**
2. **Make small talk.**
3. **Decide if the other person is listening.**
4. **Bring up the main topic.**
5. **Ask the other person what he/she thinks.**
6. **Listen to what the other person says.**
7. **Say what you think.**
8. **Making a closing remark.**

Compliment and praise:

1. **Decide what you want to compliment about the other person.**
2. **Decide how to give the compliment.**
3. **Choose the right time and place to say it.**
4. **Give the compliment.**

Expressing affection

1. **Decide if you have good feelings about the other person.**
2. **Decide if the other person would like to know about your feelings.**
3. **Choose the best way to express your feelings.**
4. **Choose the best time and place to express your feelings.**
5. **Express your feelings in a friendly way.**

Apologies:

1. **Decide if it would be best for you to apologize for something you did.**
2. **Think of the different ways you could apologize.**
3. **Choose the best time and place to apologize.**
4. **Make your apology.**

Refusing an unreasonable request:

1. **Look at the person who is talking.**
2. **Say " NO" in a strong voice.**
3. **If you feel you need to explain why, then explain.**

Complaints Skill:

1. **Decide what your complaint is.**
2. **Decide whom to complain to.**
3. **Tell that person your complaint.**
4. **Tell that person what you would like done about the problem.**
5. **Ask how he/she feels about what you have said.**

Requesting new behaviour:

1. **Ask for the new behaviour from the other person in a nice way.**
2. **Explain to her/him your reason for asking.**
3. **If she/he does change her/his behaviour, thank her/him.**

Negotiating and Compromising Skills:

1. **Decide if you and the other person are having a difference of opinion.**
2. **Tell the other person what you think about the problem.**
3. **Ask the other person what she/he thinks about the problem.**
4. **Listen openly to her/his answer.**
5. **Think about why the other person might feel this way.**
6. **Suggest a compromise.**

Expressing your Anger:

1. **Tell the other person that you are angry with her/him.**
2. **Tell him why you are angry.**
3. **Ask her/him to understand your feeling.**
4. **Ask him to do the right behaviour.**

Ways of learning

Here is a list of methods suggested by other learners. Place a cross (x) beside any of these which you have used successfully and a tick (√) next to any which you would like to try.

- ☐ Memorising
- ☐ Reading about something
- ☐ Listening to someone talking or explaining, including lectures
- ☐ Trial and error
- ☐ Following instinct
- ☐ Watching a demonstration
- ☐ Research and experimentation
- ☐ Asking questions of other people
- ☐ Using audio-visual material
- ☐ Using open learning materials
- ☐ Using computer-assisted learning materials (CAL)
- ☐ Applying previous knowledge
- ☐ Using skills such as reasoning, deduction, extrapolation, prediction
- ☐ Discussion with others.

What I've learned recently

Think of three things you have learned recently. For each, identify the facts, rules, concepts and skills involved.

1_____

_____

2_____

_____

3_____

_____

Preferences and practice

Tick (√) the sentence of the following pairs that most closely matches your own preference or practice:

1A I like to research a topic thoroughly before I start to think about a conclusion. ☐

1B I tend to make up my mind about something and then look for material to support my point of view. ☐

2A I like to read a lot on a subject before I make a judgement. ☐

2B I am afraid that if I read too much I may be swayed by persuasive arguments without judging for myself. ☐

3A If I am set a task, I like to get stuck in straightaway. ☐

3B I like to plan my approach to a task and then think a little about it before I start work on it in earnest. ☐

4A I can decide quickly if I agree with new material. ☐

4B I have to think awhile before deciding whether I can agree with new ideas. ☐

5A I like to have a proper plan; I like reading lists and organised timetables. ☐

5B I take a free and easy approach to my work and learn best when I feel unrestricted. ☐

6A I like to know exactly how each topic and task fits into the syllabus and then plan a route through the material. ☐

6B I like to follow my interests, going off at a tangent if I get excited by something new. ☐

7A The idea of a learning agreement appeals strongly to me as I feel it will give me direction and a sense of purpose. ☐

7B A learning agreement seems restrictive to me as it conflicts with the sense of exploration and excitement I associate with learning. ☐

8A I like to concentrate on one skill or topic until I have grasped it. ☐

8B I like to tackle lots of things at once and split my time according to my inclination. ☐

9A I like to use skills I have already learned and feel confident with. ☐

9B I like the challenge of gaining new skills. ☐

10A I like to learn on my own. ☐

10B I prefer to learn with others. ☐

Study skills rating

Look at this list of study skills and tick (√) the box showing whether you think you are good at it, has some skill in it, have little skill in it or need to develop the skill.

	I am good at this	I have some skill in this	I have little skill in this	I need to develop this skill
Writing essays				
Reading critically				
Taking notes				
Speed-reading				
Computer-assisted learning				
Practical work				
Giving seminar papers				
Defending my opinion				
Discussion				
Seeing all angles of an issue				
Asking questions				
Tackling problems				
Group work				
Managing a team				
Managing a project				
Planning my time				
Making decisions				

Sessions Evaluation Card

Evaluate the content listed in the table below from (1) to (5)

5 = Excellent, 4 = Good, 3 = Average, 2 = Poor, 1 = Very poor

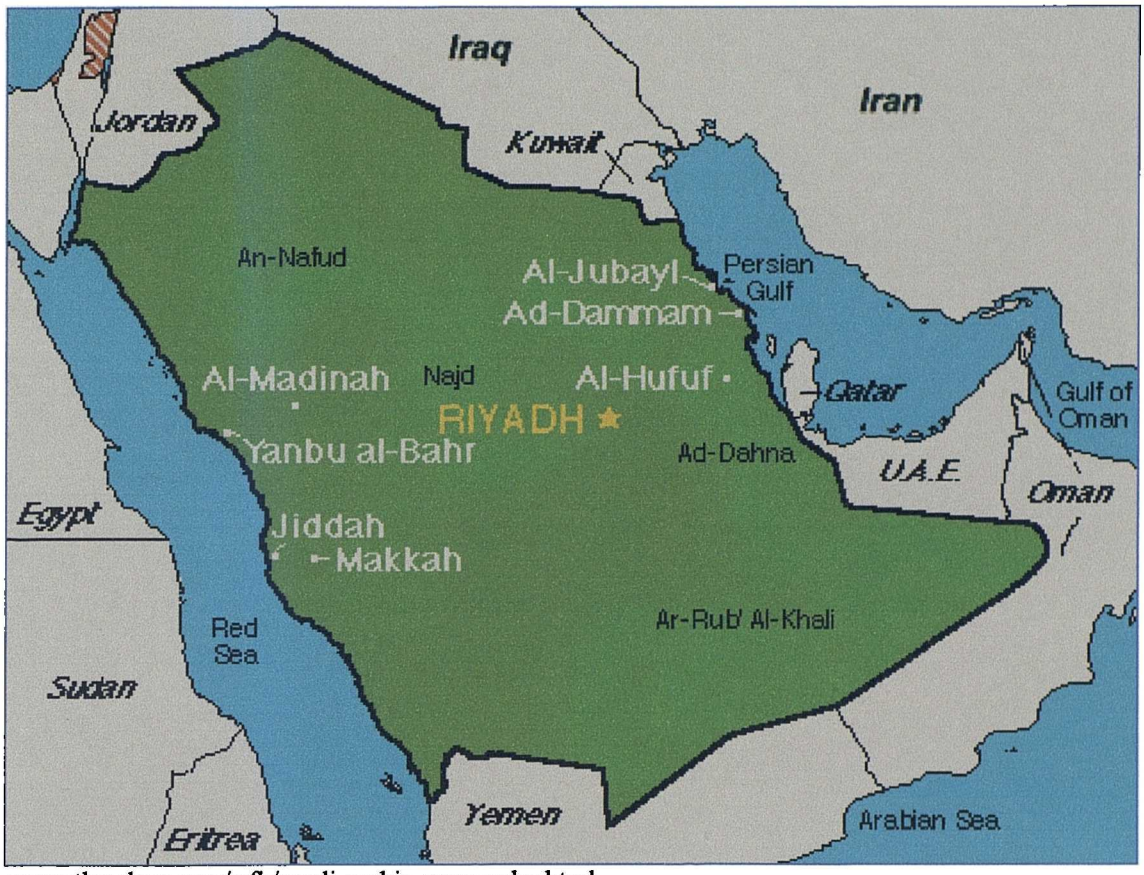
Sessions	First	Second	Third	Fourth	Fifth	Sixth	Seventh	Eight	Ten
Meeting									
Presentation									
Content									
Exercises									
Time									
Benefit									

Appendix (D)

The Arabic Version

- ❑ **Map of Saudia Arabia**
- ❑ **The Programme Cover Sheet**
- ❑ **Survey**
- ❑ **Scales Used in The Standrisation of the select scale**
- ❑ **Shyness Scale**
- ❑ **Form B**
- ❑ ***Announcement***
- ❑ **First Meeting Session**
- ❑ **Form B**
- ❑ **Sheet A**
- ❑ **Pair Interview**
- ❑ **Record of Me**
- ❑ **Card of the Record of Me**
- ❑ **Listening Skills**
- ❑ **Card A**
- ❑ **Skills Steps**
- ❑ **Final Interview (1)**
- ❑ **Final Interview (1)**
- ❑ **Personal Record**
- ❑ **Ways of Learning**
- ❑ **What I have Learned Recently**
- ❑ **Preferences and Practice**
- ❑ **Study Skills Rating**
- ❑ **Card C Session evaluation Card**
- ❑ **The certificate**
- ❑ **Picture of the Meeting Room**

Kingdom of Saudi Arabia



www.theodora.com/wfb/saudi-arabia-geography.html

THE UNIVERSITY OF HULL

برنامج تنمية المهارات

Skills Training Programme

إعداد ليلى جابر آل غالب

عزيزتي الطالبة:

السلام عليكم ورحمة الله وبركاته،

هذا مسح عن الخجل الاجتماعي، فضلا املئي الاستمارة ثم أعيديها . (لا داعي لذكر الاسم)

ملحوظة: الخجل الاجتماعي يختلف عن الحياء .

العمر:

ضعي إشارة (√) في المكان المناسب .

	نعم	لا
١. هل تعتبرين نفسك إنسانة خجولة؟	( )	( )
٢. إذا كانت الإجابة(نعم) ، فهل كنت دائما خجولة؟	( )	( )
٣. هل يسبب هذا الخجل مشكلة (عائقا) لك؟	( )	( )
٤. إذا كانت الإجابة على السؤال الأول (لا) فهل هناك فترة في حياتك كنت فيها خجولة؟	( )	( )

جزاك الله خيرا

أختي الطالبة:

السلام عليكم ورحمة الله وبركاته ...

هذه مجموعة من المقاييس النفسية، نرجو منك الإجابة عليها بكل صدق. جميع المعلومات سوف تستخدم لغرض البحث العلمي فقط.

شاكرة ومقدرة تعاونك

الباحثة

اختياري

الاســـم :

رقم التسجيل :

الرقم	العبارة	تنطبق تمامًا	تنطبق	تنطبق أحيانًا	نادرًا ما تنطبق	لا تنطبق إطلاقًا
١	أشعر بالتوتر عندما أكون مع أناس لا أعرفهم جيدً.					
٢	تواجهني صعوبات كثيرة عند مقابلة أو مجالسة الناس.					
٣	أتجنب الحديث مع الغرباء خشية أن أقول شيئًا يدل على الغباء.					
٤	نادراً ما يكون لدي شعور (ميل) أن أنعزل عن الآخرين.					
٥	أعتقد أن غالبية من يعرفوني يقولون عني أنني لست صديقا حميما					
٦	نادراً ما أحتفظ بهدوئي عندما أكون مع مجموعة من الأفراد ، وعلى الأخص عندما أريد أن أقول شيئاً ما.					
٧	إنني غير لبق أثناء الحديث مع الآخرين.					
٨	يصعب علي تكوين أصدقاء جدد.					
٩	أجد صعوبة في طلب المساعدة من الآخرين.					
١١	اشعر بالراحة في الحفلات أو اللقاءات الاجتماعية.					
١٢	يعتقد معظم الأفراد أنني شخص متفتح وودود.					
١٣	عندما أكون وسط جماعة أجد صعوبة في التفكير في مواضيع مناسبة للحديث.					
١٤	أواجه صعوبة نحو حدوث اتصال مؤثر وفعال بالآخرين .					
١٥	أشعر بالراحة حتى في المواقف الاجتماعية غير المألوفة.					
١٦	من الصعب علي أن أتصرف بشكل طبيعي عندما أقابل أناسًا لأول مرة .					
١٧	أشعر بالخجل عندما أكون بين أشخاص لا أعرفهم.					
١٨	أستطيع أن أعبر عن آرائي للآخرين بفاعلية.					
١٩	أشعر بالثقة في قدرتي على التعامل مع الآخرين.					
٢٠	أشعر بالتوتر عندما أكون مع شخص في مركز السلطة.					
٢١	أجد صعوبة في التعبير عن رأيي أمام الآخرين.					
٢٢	أجد صعوبة في النظر في عين شخص ما مباشرة.					
٢٣	أبادر بالحديث مع الآخرين.					
٢٤	من الصعب علي أن أحدد ما أقوله في الجماعة.					
٢٥	لدي شكوك في رغبة الآخرين في مصاحبتي أو مجاراتي.					
٢٦	كثيراً ما أشعر بالعزلة عن الآخرين.					
٢٦	أشعر بارتباك عندما يقدمني أحد لأناس جدد.					
٢٧	يعتقد كثير ممن يعرفونني أنني شخص متكبر وثقيل الظل بسبب عدم توددي معهم.					
٢٨	أجد صعوبة في التحدث إلى الغرباء.					
٢٩	أجد صعوبة في تأكيد ذاتي حتى عندما تتاح لي الفرصة أو عندما أريد ذلك.					
٣٠	أواجه صعوبات بسيطة عند مقابلة أو مجالسة أناس جدد (لا أعرفهم من قبل) .					
٣١	أتجنب الاختلاط بمعارف جدد خشية عدم الانسجام معهم.					
٣٢	عادة أحدد ما أقوله عندما أكون مع الجماعة .					
٣٣	أشعر بالخجل عند مقابلة الذكور من عائلتي.					
٣٤	من السهل علي تكوين أصدقاء جدد.					
٣٥	عادة أكون هادئاً ومسترخياً في الجماعة ، وعلى الأخص عندما أريد أن أقول شيئاً ما.					
٣٦	سرعان ما تزول عني مشاعر الخجل في المواقف الاجتماعية الجديدة.					

٣٧	أجد صعوبة قليلة في تأكيد ذاتي ، وخصوصاً عندما تتاح لي الفرصة أو عندما أريد ذلك.					
٣٨	أشعر بالارتياح في اللقاءات الاجتماعية.					
٣٩	أنا شخص خجول.					
٤٠	عادة يكون إتصالي بالآخرين مؤثراً وفعالاً.					
٤١	الواضح لي أن المحيطين يعتقدون أنني صديقاً لهم .					

الرقم	العبارة	لا إطلاقا	نعم نادرًا	نعم أحيانًا	نعم دائمًا
١	هل تشعرين أنك منسجمة مع من حولك من الناس؟				
٢	هل تشعرين أنك محتاجة لأصدقاء؟				
٣	هل تشعرين أنه لا يوجد من تلجئين إليه من الناس؟				
٤	هل يغلب عليك الشعور بالوحدة؟				
٥	هل تشعرين بأنك جزء من مجموعة من الأصدقاء؟				
٦	هل تشعرين أنك تشتركين في كثير من الأشياء مع الناس المحيطين بك؟				
٧	هل تشعرين بأنك لم تعودي قريبة من أي شخص؟				
٨	هل تشعرين بأن اهتماماتك وأفكارك لا يشاركك فيها أحد؟				
٩	هل تشعرين بالود والصداقة مع الآخرين؟				
١٠	هل تشعرين بأن الآخرين يهملونك؟				
١١	هل تشعرين بأنك قريبة من الناس؟				
١٢	هل تشعرين بأن علاقتك بالآخرين ليس لها قيمة؟				
١٣	هل تشعرين بأنه لا يوجد شخص يفهمك جيدًا ؟				
١٤	هل تشعرين بأنك منعزلة عن الآخرين؟				
١٥	هل تشعرين بأنك تستطيعين أن تعثري على الأصدقاء عندما تحتاجين إليهم؟				
١٦	هل تشعرين أنه يوجد أناس يفهمونك جيدًا؟				
١٧	هل تشعرين بأنك خجولة؟				
١٨	هل تشعرين بأن الناس رغم أنهم حولك إلا أنهم مشغولون عنك؟				
١٩	هل تشعرين بأن هناك أناسًا يمكنك التحدث معهم؟				
٢٠	هل تشعرين بأنه يوجد أناس تستطيعين أن تلجئي إليهم؟				

العبارة	نادراً ما تنطبق	أحياناً ما تنطبق	تنطبق	تنطبق تماماً
١ – تواجهني صعوبات كثيرة عند مقابلة أو مجالسة الناس.				
٢ – نادراً ما يكون لدي شعور (ميل) أن أنعزل عن الآخرين.				
٣ – أجد صعوبة في التعبير عن رأيي أمام الآخرين.				
٤ – عادة أحدد ما أقوله عندما أكون مع الجماعة .				
٥ – أعتقد أن غالبية ممن يعرفوني يقولون عني أنني لست صديقاً حميماً.				
٦ – نادراً ما أحتفظ بهدوئي عندما أكون مع الجماعة من الأفراد ، وعلى الأخص عندما أريد أن أقول شيئاً ما.				
٧ – يصعب علي تكوين أصدقاء جدد.				
٨ – كثيراً ما أشعر بالعزلة عن الآخرين.				
٩ – أجد صعوبة في تأكيد ذاتي حتى عندما تتاح لي الفرصة أو عندما أريد ذلك.				
١٠ – أواجه صعوبات بسيطة عند مقابلة أو مجالسة أناس جدد (لا أعرفهم من قبل) .				
١١ – يعتقد كثير ممن يعرفونني أنني شخص متكبر وثقيل الظل بسبب عدم توددي معهم.				
١٢ – من الصعب علي أن أحدد ما أقوله في الجماعة.				
١٣ – من السهل علي تكوين أصدقاء جدد.				
١٤ – عادة يكون إتصالي بالآخرين مؤثراً وفعالاً.				
١٥ – أستطيع أن أعبر عن آرائي للآخرين بفاعلية.				
١٦ – عادة أكون هادئاً ومسترخياً في الجماعة ، وعلى الأخص عندما أريد أن أقول شيئاً ما.				
١٧ – الواضح لي أن المحيطين يعتقدون أنني صديقاً لهم .				
١٨ – أجد صعوبة قليلة في تأكيد ذاتي ، وخصوصاً عندما تتاح لي الفرصة أو عندما أريد ذلك.				
١٩ – أواجه صعوبة نحو حدوث اتصال مؤثر وفعال بالآخرين .				
٢٠ – يعتقد معظم الأفراد أنني شخص متفتح وودود.				

رقم التسجيل :

التاريخ : التخصص:

الحالة الاجتماعية: العمر:

فيما يلي قائمة من العبارات تصف مشاعر الناس واتجاهاتهم نحو أنفسهم . المطلوب منك أن تقرا كل عبارة وتحددي مدي انطباق هذه العبارة عليك بوضع علامة (/) في المربع المناسب.

الرقم	العبارة	تنطبق تماما	تنطبق	تنطبق أحيانا	نادرا ما تنطبق	لا تنطبق إطلاقا
١	أشعر بالتوتر عندما أكون مع أناس لا اعرفهم جيدا					
٢	أتجنب الحديث مع الغرباء خشية أن أقول شيئا يدل على الغباء					
٣	إنني غير لبق أثناء الحديث مع الآخرين					
٤	أجد صعوبة في طلب المساعدة من الآخرين					
٥	اشعر بالراحة في الحفلات أو اللقاءات الاجتماعية					
٦	عندما أكون وسط جماعة أجد صعوبة في التفكير في مواضيع مناسبة للحديث					
٧	أشعر بالراحة حتى في المواقف الاجتماعية غير المألوفة					
٨	من الصعب علي أن أتصرف بشكل طبيعي عندما أقابل أناسا لأول مرة					
٩	أشعر بالخجل عندما أكون بين أشخاص لا أعرفهم					
١٠	أشعر بالثقة في قدرتي على التعامل مع الآخرين					
١١	أشعر بالتوتر عندما أكون مع شخص في مركز السلطة					
١٢	أجد صعوبة في النظر في عين شخص ما مباشرة					
١٣	أبادر بالحديث مع الآخرين					
١٤	لدى شكوك في رغبة الآخرين في مصاحبتي أو مجاراتي					
١٥	أشعر بارتباك عندما يقدمني أحد لأناس جدد					
١٦	أجد صعوبة في التحدث إلى الغرباء					
١٧	أتجنب الاختلاط بمعارف جدد خشية عدم الانسجام معهم					
١٨	أشعر بالخجل عند مقابلة الذكور من عائلتي					
١٩	سرعان ما تزول عني مشاعر الخجل في المواقف الاجتماعية الجديدة					
٢٠	أشعر بالارتياح في اللقاءات الاجتماعية					
٢١	أنا شخص خجول					

رقم النموذج ( )

عزيزتي الطالبة،

السلام عليكم ورحمة الله وبركاته،

ينظم قسم علم النفس برنامجا لتطوير الذات وتنمية المهارات ينفذ خلال الفصل الدراسي الأول ١٤٢١فاذا رغبت في الالتحاق بالبرنامج والاستفادة منه في تطوير ذاتك وتنمية مهاراتك فالرجاء تعبئة البيانات المرفقة:

الاسم:	
رقم التسجيل:	
الكلية:	
التخصص:	
التلفون:	
ملاحظات:	

تمنياتي لك بالتوفيق

الباحثة

أ. ليلى جابر آل غالب

إعلان

يسر قسم علم النفس أن يعلن عن بعض برامج تطوير الذات وتنمية المهارات. فعلي الطالبة التي ترغب في المشاركة الاتصال بـالأستاذة ليلى آل غالب.

غرفة الحلقة العلمية (١٠١)، الدور الأول، المكتبة المركزية

من السبت إلى الأربعاء من الساعة العاشرة صباحا إلى الثانية ظهرا

بسم الله الرحمن الرحيم

الجلسة : الأولى (١٠ إلى ١١ ومن ١١ إلى ١٢) السبت ٧ أكتوبر

السلام عليكن ورحمة الله وبركاته، ارحب بكن جميعا و أشكركن علي حضوركن .

قبل ما أتحدث معكن عن البرنامج أحب أن أعرفكن على نفسي، أنا ليلي آل غالب طالبة مبتعثة من قبل جامعة الملك عبد العزيز للحصول على درجة الدكتوراه في علم النفس الإرشادي من جامعة "هل" بالمملكة المتحدة، والبحث الذي أقوم به يقتضي أن أطبق بعض البرامج الارشاديه.

مجموعتكم هذه سوف تأخذ إحدى هذه البرامج وهو برنامج للتدريب علي المهارات الاجتماعية بغرض مساعدتكن على التغلب على مشكلة الخجل الاجتماعي لديكن.

البرنامج عبارة عن "١٠ " جلسات سوف نتقابل مرتين في الأسبوع لمدة خمسة أسابيع مدة كل جلسة ساعة .

يقوم هذا البرنامج على خمسة فنيات أساسية هي : إعطاء التعليمات، لعب الدور، التغذية المرتدة، النمذجة، والممارسة.

بالنسبة للفنيات الأربع الأولى سوف يتم تطبيقها داخل الجلسة أما بالنسبة للأخير وهى الممارسة فسوف يتم تطبيقها خارج الجلسة.

طبعا كما تعرفن فان أي مهارة إذا لم يتم ممارستها فلن يتم تعلمها، لذ فهناك في نهاية كل جلسة واجبا منزليا لابد من التدريب عليه.

خلال الجلسات سوف نتعاون جميعا من أجل إنجاح البرنامج ومن أجل ذلك لا بد أن يكون واضحا لديكن أهمية الحضور وعدم التغيب لان كل جلسة تعتمد على التي قبلها وتعد للتي تليها، لذا فعدم حضور جلسة من الجلسات قد يؤثر سلبا على الفائدة المرجوة من هذه الجلسات ليس فقط على التي تتغيب وانما أيضا على بقية المجموعة، حيث أن معظم التدريبات تستلزم إعدادا زوجية.

ليس معنى ذلك أن حضوركن إلزاميا بمعنى الفرض عليكن فكل واحدة منكن لديها الحرية الكاملة في عدم الاستمرار في البرنامج ولكن أرجو أن لا يحدث ذلك. هذا وسوف يكون هناك جوائز للآتي يستمرون لنهاية البرنامج .

أود أن اطلب منكن طلبا وهو انه في حالة رغبتكن في الانسحاب من البرنامج أن يتم إبلاغي بذلك مع توضيح السبب أو الأسباب أن أمكن.

هذا وسوف نحدد في آخر جلسة موعد آخر نتقابل فيه إن شاء الله لمناقشة أي أمور استجدت معكن ولقياس مدى التحسن الذي طرأ عليكن.

هنالك بعض الأمور التي لا بد أن نتفق عليها وهى :-

أولا : كل ما نقوله وما نسمعه يبقى داخل القاعة بمعنى آخر لا بد من الاحتفاظ بسرية أي موضوعات سوف يتم مناقشتها .أما بالنسبة للبحث فلن يكون هناك ذكر لأي معلومة تدل على شخصية أيا منكن .

ثانيا : كل واحدة منكن لها الحرية في تطبيق التدريب أو الاعتذار عنه.

ثالثا : كل واحدة منكن سوف يكون لها وقت للتحدث وعندما تتحدث فعلى الجميع الاستماع وعدم المقاطعة.

رابعا : على الجميع الالتزام بمواعيد الجلسات.

هل لدى إحداكن أي استفسار ؟

حسنا أمام كل واحدة منكن ملف خاص بها أرجو أن تحتفظن به وأن تحرصن على إحضاره معكن في كل جلسة وذلك لوضع أي أوراق بداخله بحيث يصبح لدى كل واحدة منكن في نهاية البرنامج ملف كامل لما تم إنجازه .

سوف تجدين في جيب الملف بطاقتين الأولى باللون الأخضر(نموذج ٣) والثانية باللون الأبيض (نموذج ٤) ، سوف تكتبين فيهما المعلومات المطلوبة في الخانات المخصصة لذلك وذلك بعد الانتهاء من كل تدريب.

في الجيب الشفاف يوجد بطاقة تقييم الجلسة (نموذج ٥) ففي نهاية كل جلسة عليك تقييمها في المتغيرات المعطاة على مدرج من " ٥ " إلى " ١ " .

أيضا يوجد دفتر مذكرات أرجو منكن استخدامه لكتابة كل ما تشعرن به، يمكنكم الكتابة بأي شكل ترغبن(بمعنى يمكنكم استخدام الألوان، الرسومات، الشعر ، قصاصات، الجرائد،٠٠٠٠ الخ. كل المعلومات التي سوف تكون في المذكرة لن يتم استخدامها إلا لغرض البحث ومع ذلك ففي نهاية البرنامج من حق كل واحدة منكن أن تحذف ما ترغب في حذفه.

الآن لنتعرف على بعضنا البعض، كل واحدة منكن تعرف على نفسها وتعطينا فكرة بسيطة عنها مثال لو أحببت أن أعرفكن على نفسي " أنا ليلي آل غالب محاضرة في قسم علم النفس وأحضر للدكتوراه متزوجه ولدى ثلاثة أولاد؛ هناك قائمه في ملفك في الصفحة الأولى بعد الغلاف (نموذج ١) ، أرجو أن تضعي إشارة ( ) عند الخانة التي تنطبق عليك.

الآن سوف أعطى كل واحدة منكن قائمه تحتوى على بعض الفقرات (نموذج ٢) أرجو الإجابة عليها. بعد ذلك اختاري ستة إجابات على أن تكون الفقرة الثانية عشر من ضمن اختياراتك ، اكتبي في كل خانه من الخانات الموجودة في القرص الذي أمامك إجاباتك الستة.

(نموذج ٣) الآن كل واحدة منكن تعطى قرصها ، بعد أن تكتب اسمها في الخانة المعدة لذلك ، إلى زميلتها ، كل واحدة منكن سوف تقوم بالتعريف بزميلتها بناء على ما هو موجود في قرصها.

لنلخص الآن ما تم اكتسابه في هذه الجلسة :

أخذنا فكرة عن البرنامج

تعرفنا على بعضنا البعض

الآن وقد تم التعارف بيننا نحن بأذن الله مستعدات لبدء البرنامج .

في المرة القادمة سوف نتدرب على مهارة من المهارات المعدة لهذا البرنامج ،

ضعي إشارة (✓) أمام الفقرات التي تنطبق عليك:

الناس الذين يجعلونني أشعر بالخجل:

الوالد	☐	الوالدة	☐
الإخوان	☐	الأخوات	☐
الأعمام	☐	العمات	☐
الأخوال	☐	الخالات	☐
الصديقات	☐	الغرباء	☐
الأساتذة	☐	كبار السن	☐
آخرين			

مواقف وأنشطة تجعلني أشعر بالخجل :

أي موقف اجتماعي	☐
وجودي بين جماعة كبيرة	☐
وجودي بين جماعة عمل صغيرة	☐
وجودي بين جماعة اجتماعية صغيرة	☐
عند اللقاء مع شخص لأول مرة	☐
مواقف أشعر فيها بالضعف	☐
مواقف أكون فيها في موضع أقل من الأخريات	☐
مواقف تحتاج إلى سلوك توكيدي	☐
مواقف أكون فيها في محور الاهتمام مع مجموعة كبيرة	☐
مواقف أكون فيها في محور الاهتمام مع مجموعة صغيرة	☐
مواقف اجتماعية جديدة	☐
مواقف أكون فيها عرضة للنقد أو المقارنة	☐
أخرى	

التدريب ( )

الاسم : التاريخ :

قبل

المهارة التي سوف أمارسها:

المجموعة التي سوف أمارس هذه المهارة معها :

عائلتي ، (من) ؟
صديقاتي ، (من) ؟
غرباء ، (من) ؟

بعد

المدة الزمنية التي قضيتها مع كل مجموعة:

( ) ( ) ( ) ( )

ماذا حدث (في جملة أو جملتين) ؟

المجموعة الأولى :

المجموعة الثانية :

المجموعة الثالثة :

هذا الخط يوضح مستواي في هذه المهارة .....

عالي منخفض

التدريب ( )

الاسم : التاريخ :

قبل

المهارة التي سوف أمارسها:

الأشخاص الذين سوف أمارس هذه المهارة معهم :

فرد من العائلة :

صديقة :

غريبة :

بعد

المدة الزمنية التي قضيتها مع كل شخص:

( ) ( ) ( )

ماذا حدث (في جملة أو جملتين) ؟

الشخص الأول :

الشخص الثاني :

الشخص الثالث :

هذا الخط يوضح مستواي في هذه المهارة .....

عالي منخفض

المقابلة الثنائية

الاسم : التاريخ : الوقت

اعرفي أشياء تحب زميلتك أن تقوم بها :

بناء علي رأى زميلتك ، ما هو أفضل شئ عملته خلال الشهر الماضي ؟

بناء علي رأى زميلتك ، ما هو أسوء شئ عملته خلال الشهر الماضي ؟

اعرفي ما هي الصفات التي تحبها زميلتك في نفسها ؟

اعرفي مشكلتين شخصية ترغب زميلتك في حلهما، أو صفتين ترغب في تغييرهما:

ما هو أهم شئ في حياة زميلتك؟

اعرفي ماذا يجعل زميلتك متوترة :

اعرفي متى تغضب :

اعرفي متى تشعر بالحرج :

الاسم :

الوقت :

أجيبي على الفقرات التالية ، ثم اختاري (٦) فقرات منها وصممي سجل عن نفسك ، على أن تكون الفقرة (١٢) من ضمن اختياراتك .

١- موضوعي المفضل

٢- أفضل مكان أذهب إليه مع عائلتي

٣- أقرب صديقة إلي

٤- الشهر الذي ولدت فيه

٥- لونى المفضل

٦- أفضل إجازة استمتعت بها

٧- رياضة أحبها

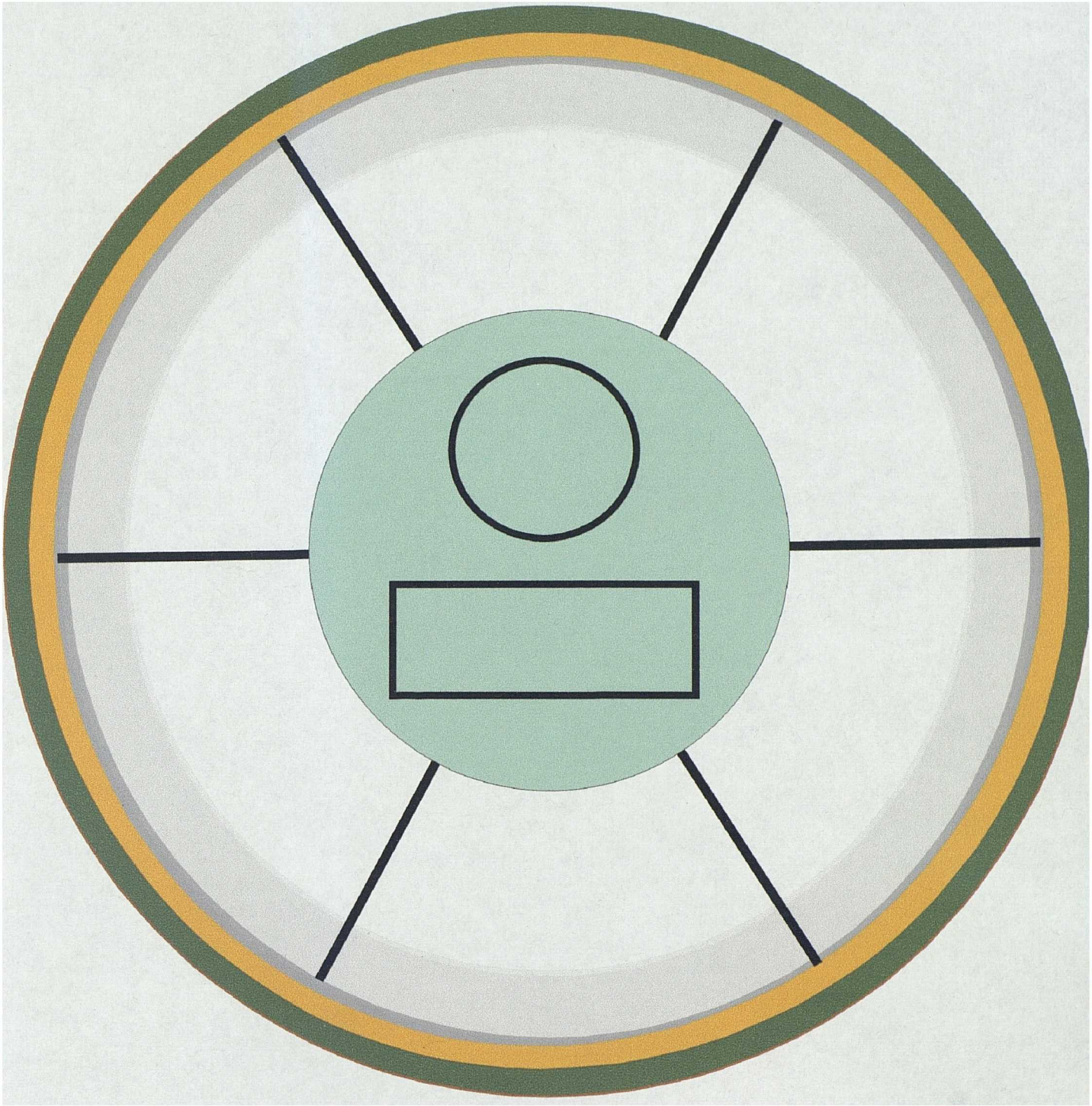
٨- طعامي المفضل

٩- برنامجي المفضل

١٠- مكان ولادتي

١١- مطعمي المفضل

١٢- ما أتمني أن أحققه من هذا البرنامج



المهارة : (الاستماع)

اجلسي مع عائلتك (اختاري الوقت الذي يكون فيه معظم أفراد العائلة موجودين)، استمعي لما يقولون، ثم اكتبي ما لاحظته عن نفسك، وعن كل واحد منهم ثم أجيبي على الأسئلة التالية :

١. هل استمعت لما كانوا يقولونه؟

٢. هل تفهمت وجهة نظرهم ؟

٣. هل حاولت تصحيح أي معلومات ؟

٤. هل سألت عن تفاصيل أكثر تخص الموضوع؟

٥. هل لاحظت سلوكهم غير اللفظي؟

افعلي الشيء نفسه مع صديقاتك،

افعلي الشيء نفسه مع أناس لا تعرفينهم.

على سبيل المثال : الجلوس مع مجموعة من الطالبات (أكثر من اثنتين) في الكافتيريا، البنك، أو في مبنى النشاط .

تسجيل التدريبات

المهارة	مارستها مع	الموضوع عن	ملاحظات

الاسم : التاريخ :

المهارة:

خطوات المهارة :

ملاحظات:

المقابلة الأخيرة

الاسم : التاريخ : الوقت

ترغب زميلتك في معرفة المزيد من المعلومات عن .....

سوف تقترح هذا البرنامج على زميلاتها.

نعم ☐ لا ☐

تشعر أن هذا البرنامج غير من طريقة تفكيرها في نفسها.

صح ☐ خطأ ☐

تعتقد أن هذا البرنامج كان بالإمكان أن يكون أفضل لو.....

ما الذي تتذكره عن البرنامج؟

أكثر تجربة ممتعة مرت بها أثناء البرنامج؟

أسوء تجربة مرت بها أثناء البرنامج؟

تعليق زميلتك على البرنامج.....

الاسم : الوقت :

ملاحظاتك عن المقابلة

المقابلة الأخيرة

الاسم : التاريخ : الوقت

هل استمتعت زميلتك بالبرنامج؟

كثيرا ☐ قليلا ☐ لم تستمتع ☐

أكثر تجربة ممتعة مرت بها زميلتك خلال البرنامج...

أسوء خبرة مرت بها زميلتك خلال البرنامج....

تعامل البرنامج مع أمور مهمة بالنسبة لزميلتك؟

صح ☐ خطأ ☐

ما الذي سوف تتذكره زميلتك عن البرنامج؟

تعليق زميلتك على البرنامج.....

الاسم : الوقت:

ملاحظات:

التسجيل الشخصي

الاسم : التاريخ :

في كل مرة تستخدمين فيها أيا من المهارات التي تم التدريب عليها في البرنامج ، اكتبي في الجدول التالي وقت ممارستك لها ، و إلى أي مدى كانت تلك الممارسة جيدة .

المهارة	وقت الممارسة	إلي أي مدى كانت ممارستك للمهارة جيدة	ملاحظات

طرق التعلم.

هذه قائمة بطرق التعلم إقترحت من قبل متعلمين آخرين. ضعي إشارة (x) بجانب كل واحدة قمت باستخدامها بنجاح. وإشارة (✓)بجانب كل واحدة ترغبين في محاولة استخدامها.

☐ الحفظ.

☐ القراءة عن موضوع ما.

☐ الإستماع لشخص يتكلم أو يشرح ، بما في ذلك المحاضرات.

☐ المحاولة والخطأ.

☐ متابعة الحدس (الغريزة).

☐ الملاحظة.

☐ البحث والتجريب.

☐ طرح الأسئلة على الآخرين.

☐ استخدام الوسائل السمعية/ البصرية

☐ استخدام الوسائل المعينة على التعلم.

☐ استخدام الوسائل المعينة على التعلم بالكمبيوتر.

☐ تطبيق معرفة سابقة.

☐ استخدام مهارات مثل التفسير، الإستنتاج، الإستنباط، التنبؤ .

☐ المناقشة مع الآخرين.

ماذا تعلمت لاحقا (قريبا)

فكري في ثلاثة (٣) أشياء تعلمتها لاحقا. وضحي الحقائق والقوانين والمفاهيم والمهارات المتعلقة بكل واحدة.

١-

٢-

٣-

التفضيل (الأفضلية) والتدريب

ضعي إشارة (✓) أمام الجملة التي تعتبرينها الأقرب لما تفضلينه أو تدربت عليه من كل جملتين بنفس الرقم.

١/أ . أفضل البحث بجدية في الموضوع قبل البدء في التفكير في الخاتمة.☐
١/ب. أميل إلى اتخاذ وجهة نظر محددة ثم ابحث عن المواد التي تدعم وجهة نظري.☐

٢أ. أحب أن أقرأ كثيرا في موضوع ما قبل أن أحكم بنفسي.☐
٢ب. أخشى إذا ما قرأت كثيرا أن تؤثر على الأراء فلا أحكم بنفسي.☐.

٣أ . إذا أنيطت بي مهمة أفضل أن أبدأبها فورا.☐
٣ب . أفضل أن أخطط لمهمة ما وأفكر بها قليلا قبل أن أبدأ العمل الجاد.☐

٤أ . أستطيع أن أقرر بسرعة إذا وافقت على الفكرة (الموضوع)،أو المادة الجديدة.☐
٤ب . لابد أن أفكر قليلا قبل أن أقرر ما إذا كنت سأوافق على الفكرة (الموضوع)أو المادة الجديدة.☐

٥أ . أفضل أن يكون لدي خطة مناسبة ؛ أحب أن تكون هناك قائمة بما سأقرأه وأن يكون هناك جداول زمنية منظمة.☐
٥ب. أحب أن أتخذ إتجاها حرا وسهلا في عملي وأتعلم أفضل إذا كنت أحس بأنني غير مقيدة.☐

٦أ . أحب أن أعرف ما هو موضع كل موضوع ومهمته ضمن مضمون المادة ثم أعد خطة للسير في المادة.☐
٦ب . أفضل أن أتبع اهتماماتي ؛ أخرج عن خط سيري إذا ما أثار اهتمامي شيء جديد.☐

٧أ . إن فكرة اتفاقية التعلم تستهويني بشدة لأني أشعر أنها سوف تعطيني توجيها وإحساسا بالهدف.☐
٧ب. اتفاقية التعلم بالنسبة لي جامدة لأنها تتعارض مع الأحساس بالإستكشاف والمتعة التي اربطها بالتعلم.☐

٨أ . أفضل التركيز على مهارة واحدة أو موضوع واحد إلى أن أتمكن منه.☐
٨ب . أفضل الخوض في أشياء كثيرة في نفس الوقت وأقسم وقتي بناء على اهتماماتي.☐

٩أ . أفضل استخدام مهارات قد تعلمتها وأشعر بالثقة في استخدامها☐
٩ب. أفضل التحدي في اكتساب مهارات جديدة ☐

١٠أ . أفضل التعلم بمفردي☐
١٠ب. أفضل التعلم مع الآخرين☐

تقييم مهارات التعلم

تمعني في القائمة التالية لمهارات التعلم ثم ضعي إشارة (✓) في الخانة المناسبة التي توضح إذا ما كنت متمكنة من المهارة، لديك بعض المهارة ، لديك قليل من المهارة ، تحتاجين إلى تطوير المهارة.

	أحتاج إلى تطوير المهارة	لدي قليل من المهارة	لدي بعض المهارة	متمكنه من المهارة
كتابة المقالات				
القراءة الناقدة				
تدوين الملاحظات				
القراءة السريعة				
التعلم باستخدام الحاسب				
التدريب العملي				
تقديم أوراق سيمنار				
الدفاع عن وجهة نظري				
المناقشة				
رؤية كل زوايا الموضوع				
طرح الأسئلة				
التعامل مع الصعوبات				
العمل الجماعي				
إدارة فريق				
إدارة مهمة				
تنظيم وقتي				
إتخاذ القرارات				

قيمي محتويات القائمة التالية من (١) إلى (٥)

٥ = ممتاز ؛ ٤ = جيد ؛ ٣ = متوسط ؛ ٢ = ضعيف ؛ ١ = ضعيف جدا

الجلسة	الأولى	الثانية	الثالثة	الرابعة	الخامسة	السادسة	السابعة	الثامنة	التاسعة	العاشرة
اللقاء										
التقديم										
المحتويات										
التمارين										
الوقت										
الفائدة										

برنامج تنمية المهارات

Skills Training Programme

شهادة تميز

مقدمة إلى :

بمناسبة انتهاء فعاليات

برنامج تنمية المهارات

المقام في

جامعة الملك عبد العزيز

قسم الطالبات

خلال الفترة من ١٤٢١/٧/١٣ وحتى ١٤٢١/٨/١٧

تقديرا لمشاركتها والتزامها خلال فترة البرنامج
واهتمامها بتطوير ذاتها وتنمية مهاراتها

مقدمة من :أ. ليلى جابر آل غالب


THE UNIVERSITY OF HULL
برنامج تنمية المهارات
Skills Training Programme
Meeting Room P1


THE UNIVERSITY OF HULL
برنامج تنمية المهارات
Skills Training Programme
Meeting Room P2