CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

The birth of a child is heralded with joy and celebration in most African societies since children are regarded as the most precious gifts from the Almighty God. Children represent the future generation; thus, they must be properly moulded for their future roles. Parents have the greatest part to play in this moulding process as the first socializing agents of the child (Olusakin, Nwolisa & Babatola, 2010). Most parents have high expectations about their child’s future and exact every effort to raise a responsible, healthy and fulfilled child that would become an achiever later in life. It becomes an antithesis when children are not properly cared for, loved, protected for whatever reasons, especially when the street becomes in all intent and purpose a home for children in our normal caring African setting (Child to Child Network, 2008).

Children found on the streets are usually arrested or taken to correctional centres for rehabilitation, care and protection. The most recurring reasons for leaving home or abscondment are polygamy; parental death or parental psychological imbalance. Incidences of street life also start with child neglect, erroneous accusation of witchcraft or when the financial status of the child’s guardian’s begin to take a downward trend. According to Child to Child Network (2008), children leave home due to various reasons: Poverty, child neglect and parental maltreatment which can be as a result of frustration from parents. For instance
when a father marries many wives and cannot take care of his children, the children may end up living with grandparents. The death of one of the parents and lack of love from the parents, broken homes are also factors, while corporal punishment being used to correct a child’s stubbornness; peer pressure; fear of parents’ reactions (punishment) when children err are other factors. The above assertion was supported by Nwolisa (2010), who asserted that some parents do not play their roles effectively in the upbringing of their children, which has resulted in the society being fraught with all forms and shades of unwholesome attitudes and behaviours. Makinde (2004) however cautions that parental expectations of their children’s behaviour should not be too high and that the home climate should be a good example of a happy marriage which is stress-free and with a minimum level of conflicts.

Children who do not get the proper attention at home devise many ways of survival on the streets which about with them behaviour such as stealing, cheating, gambling, fighting, smoking, engaging in the use of illicit drugs, bus conducting, carrying loads for money, and doing other menial jobs to survive in Lagos State. Lagos State was former Federal Capital of Nigeria and is also the commercial nerve centre of the country, it thus attracts people both far and near which puts immense pressure on the existing social facilities which metamorphoses into various social problems.

Street children live in conditions of severe deprivation and risks of exploitation, sexual abuse, drug abuse, HIV/AIDS, forced labour, physical assault and lack of
education according to Mrs Sara Nyanti who is United Nations Children Fund (UNICEF) Assistant Country Representative and Chief of Lagos B-Field Office.’ According to (Child to Child Network 2008), such children are used by the “senior area boys” who live under the bridges to do forced jobs such as clearing of gutter and packing refuse in the early hours of the morning. They are sometimes used in armed robbery because of their vulnerable nature. The girls among them are sometimes used by “Madams” as bar attendants and commercial sex workers in brothels. As a result, some contact the dreaded Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome (HIV/AIDS). Some end up with unwanted pregnancies while some die attempting to abort such pregnancy. They are abused psychologically, physically and sexually.

According to the UNICEF Desk Officer, Mrs Orji in Ebonyi State opines that African child is still exposed to all forms of abuses including malnutrition, denial of basic education, gender discrimination, inadequate healthcare and forced labour. The irony of the whole scenario is that in spite of this, millions of African children still live in penury and abject poverty as they are continually denied one or more of their rights to survival, good health protection and education. This group of children are termed young offenders or juveniles when eventually rescued or caught by law enforcement agents for wandering on the street, they become government’s “property”. Within 24 hours of being in police custody, they are sent to Juvenile Welfare Homes of the Lagos State Ministry of
Youth, Sports and Social Development at Alakara, in Mushin Local Government Area. With nobody to lay claim to them, they are charged to a magistrate court and are remanded in custody of remand homes with a remand warrant in a remand home for at least three months because they are minors (below the age of 18) pending the time they are united with their parents. If orphans, they stay there pending the time they were adopted by people or they continue living at the homes.

Remand Homes are transit camps for young juvenile offenders whose cases are pending in court. The homes also accommodate lost but found children pending the time they are either reconciled with their parents or committed to approved school for necessary corrective measures. There are two Remand Homes in Lagos State, Boys Remand Home at Oregun in Ikeja and Girls Remand Home at Idi-Araba in Mushin e.g. in the correctional centres there are more male than female inmates as the table below indicates.

Table 1: Distribution of inmates according to Gender

<table>
<thead>
<tr>
<th>YEAR</th>
<th>BOYS</th>
<th>%</th>
<th>GIRLS</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>67</td>
<td>66.3</td>
<td>34</td>
<td>33.7</td>
</tr>
<tr>
<td>2008</td>
<td>75</td>
<td>64.7</td>
<td>41</td>
<td>35.3</td>
</tr>
<tr>
<td>2009</td>
<td>131</td>
<td>72.4</td>
<td>50</td>
<td>27.6</td>
</tr>
</tbody>
</table>

Evidence from the above table showed an increase male in the past year, 2009 with 72.4 % greater than 2008, 35.3% and 2009, 27.6% statistics of the female put together. This showed that the indices that make children leave home are on the increase instead of decrease, especially for the male.

Adolescence, the transition period from childhood to adulthood is a stage that is characterized with emotional instability. Adolescents tend to experience stress, as they get conflicting messages from peers, media, have conflicts within the family and school and with difficulties in establishing self-identity and self-esteem (Bamidele, 2010). The stage is regarded as the period of “storm and stress” and is confronted with a lot of problems emanating from the peculiarity attached to this period between childhood and adulthood (Omoegun, 2004). An assessment of the adolescents showed that in the Special Correctional Centres, they do not have access to formal education like other children. They go to school, when transferred to the Approved School but have the challenge of getting sponsorship for their education. They are saddled with the psychological and social problems of adolescence, its being a time of stress and turmoil places higher stress on adolescents. Remand homes are to provide temporary custody in a stable, safe, fair and warm communal living but unfortunately, most of the adolescents in the homes do not have access to qualitative education like the others and institutionalization impacts negatively on their emotional, psychological and social lives. Some psychosocial problems such as depression, aggression, low self-
esteem and anxiety are evident in their lives. The United Nations Children’s Fund (UNICEF) in Uduchukwu (2003) calls anybody who is below 18 years a child and that is the official position of Nigeria. These adolescents therefore are classified as children since they are below the age of eighteen, and as such, they have basic rights. According to the United Nation (UN) Child Rights emphasizes four basic rights of children which are: The right to life; Survival and development right: these include rights to adequate food, shelter, clean water, formal education, primary health care, leisure and recreation and cultural activities; Protection rights: these include protection from all forms of child abuse, neglect, exploitation and cruelty, war and abuse in the criminal justice system; Participation rights: these include freedom of expression on matters affecting their social, economic, religious, cultural and political life. The right to information and freedom of association. The Lagos State House of Assembly passed the Child Rights Act into Law in 2007. Under the law, the Remand Homes are now called Special Correctional Centres while the Approved Schools are now called Children’s Correctional Centres. The United Nation Convention on the Rights of the Child (1989) for which Nigeria is a signatory, makes it mandatory to provide comprehensive care to all children below 18 years.

The Correctional Centres, have five categories of children; those with criminal cases, those beyond parental control, those for care and protection, those who were rescued by good-spirited individuals and those who were arrested by the government’s taskforce. Children with criminal cases were caught engaging in
criminal acts and because they are minors, after charging them to a court, they are given a Remand Warrant by the Chief Magistrate Court under the Family Case Work Unit in the zone where the incident took place. Such children are kept at the centre until the criminal aspect of their case is concluded before subsequent action will be taken on them. The duration of their stay at the Remand Homes ranges from three months to five years as the case may be. Those who are classified as ‘Beyond Parental Control’ are brought to the centre as a result of their parents’ wilful plea to the court mentioned earlier for antisocial behaviour and if convicted, are remanded in the centre with a remand warrant. This prevailing atmosphere gives rise to questions about what could have been the possible cause of children, youths and even adults’ involvement in antisocial behaviours. Could parents, who are expected to be the custodians of appropriate behaviour in children, be held accountable for such behaviour as a result of laxity and failure in carrying out their parental responsibilities? Parents may in one way or the other contribute to their children’s involvement in antisocial practices according to (Olusakin & Nwolisa, 2010). They usually stay up to five years or more in cases where the parents could not be located or the child having no clue about his/her place.

Care and Protection children/cases are lost but found children; some are those whose parents cannot adequately cater for them or whose parents are lunatics. They are housed there until there are changes in their circumstances before being re-united with their parents.
Rescued Children are children rescued by good spirited individuals from roaming the streets with no clear knowledge of their homes and the Police Task force, for hawking at odd hours or in dangerous places, sleeping under the bridges or roaming the street during school hours. They are brought in by the Police with a paper called Police Extract to the centre from where they will be taken to court by a social welfare officer known as the Probation Officer.

The adolescents in the remand homes experience diverse psychological and social problems while institutionalized such as feelings of rejection, abandonment, low self-esteem, underachievement, depression, anxiety about the future. Olusakin & Ubangha (1996) confirmed that Nigerian prisons are characterized by filthy environment, congestion, poor feeding practices, diseases, survival of the fittest syndrome and dehumanizing tendencies of warders. Oral interviews conducted by the researcher confirmed the above facts and the lack of some amenities in their facilities. The children also decried the lack of freedom to go home to their relations at will.

The problems of adolescents in correctional centres could be as a result of abandonment as a child (Anwuri, 2007). For the individual, the realization that he had been given away or left unattended to is devastating in adolescence stage. An overwhelming sense of rejection can overtake him (Weiner and Kupermintz 2001). If an adolescent has not been equipped psychologically for this experience, he can be exposed to emotional and psychological problems which
affect his interpersonal relationships. This may lead to development of psychosocial problems such as feeling sad, feeling critical of others, feeling lonely and feeling overly concerned about things (Weiner and Kupermintz, 2001). Oral interviews conducted with the directors of some selected orphanages by Anwuri (2007) highlighted low self-esteem, anxiety and fear of the future, aggression, depression, loneliness, lack of self confidence, guilt as some of the psychological problems being experienced by such boys and girls.

One of the most important social contexts for the development and expression of self-esteem is the family. This is because the family’s major function is the socialization and care of the children (Gorbert & Kruzek, 2008). Therefore, taking away a child from his/her family could cause psychological problem.

A child without psychosocial problems is indeed an asset to the society, given the ravaging menace of anti-social behaviours, especially in recent times. Osarenren, Ubangha and Oke (2008) identified the role of the family in the socialization and care of children as pivotal especially in the development and expression of self-esteem. Positive self-esteem indeed is crucial in a child that must live to conform to societal norms or standards. Previous researches had dealt extensively with the psychosocial problems of adolescents in orphanages and beggars in destitute homes but in the opinion of the researcher, not much had been done on adolescents in correctional centres (Anwuri, 2007; Ahime, 2007). The family and society are supposed to assist adolescents in overcoming some of the crises that
are inherent in this stage of development. The Nigerian society can hardly play this stabilizing role because of the deteriorating state of education, alarming rate of unemployment, galloping inflation, near collapse of social amenities among other ills plaguing the nation at this time. These affect the overall well being of Nigerian adolescents negatively by exacerbating feelings of depression, aggression, social maladjustment, low self-esteem and unassertiveness among others (Bamidele, 2010).

Anwuri (2007) used Cognitive Behaviour therapy in assisting adolescents in orphanages while Ahime (2007) helped to alleviate the psychosocial problems of beggars using the social learning theory. The adolescent must be assisted to get on the right track by conforming and adapting to the collective norms and value systems of the society. To some extent, the adolescents are aware that crime threatens social peace which inevitably leads to loss of personal freedom that is highly valued. Besides, law and order are guaranteed if the society or even the individual is assured that the law would take its course by depriving the offender of his/her liberty.

The society would be a better place to live in when the remanded adolescents are properly trained using cognitive restructuring and modelling in shaping their lives while in the centres to avoid the cases of recidivism. This is because, it has been observed and researches have shown that the crimes committed in the society are carried out by children between the ages of fifteen and twenty-five.
The adolescents would begin to have a better view of themselves while in the centres and that upon their release, they would successfully pursue a career of interest and not be taunted by the experiences they went through before and during remand at the centres. The adolescents would also be used by government and other stakeholders as models and agents of positive change to other adolescents in schools and communities on how to be good and responsible citizens to themselves, their families and society at large.

Moreover, the majority of juvenile offenders released into the community unskilled, uneducated, and more hardened as adult criminals are likely to return to criminal activities and recidivism. In the face of these multifarious problems, it was observed that in Nigeria intervention strategies used for offenders; especially juvenile offenders have always focused on adjustment after release.

1.2 Statement of the Problem
The number of adolescents found on the streets of Nigeria and Lagos in particular has reached an alarming rate which present serious problems and threats to life. This had led to an upsurge in the number of juvenile offenders in correctional centres in Lagos. The attendant psychological and social problems experienced when adolescents are remanded are of great concern to government and other stakeholders. It is sad that a good number of adolescents who are supposed to be potential leaders are being remanded in correctional centres when they should be in schools or learning useful life skills.
During adolescence, a broad range of emotional and cognitive changes occur that may render adolescence a crucial time for the development of adaptive or maladaptive beliefs, or philosophies, about emotions (Hunter, Katz, Shortt, Davis, Leve, Allen & Sheeber, 2010). Also, these adolescents encounter serious hardships ranging from verbal harassment to hunger, lack of privacy, separation from parents and loved ones and general poor medical care. These young offenders are consequently left in a state of physical and psychological trauma. The emotional, mental, social and psychological distresses caused by these influence the cognitive impression of these inmates, which could possibly lead to serious health problems (Ditto, 1999). According to Aitken (1993), children in institutions for offenders are in persistent confusion, conflict or uncertainty about future plans, parental authority, family relationships and past history. A good number of them experience some forms of psychological and social problems which include aggression, anxiety, depression and low self-esteem among others. Loner (1999) posits that children living outside their homes face difficulties such as depression, low self-esteem, feelings of shame and embarrassment, anxiety, under-achievement, low motivation, and low energy. The atmosphere inside these institutions is hostile and unsavoury for a serious regime of character reformation and such constitute potential perils to the peace and security of society. The adolescents are traumatized to the extent that they suffer a life-long stigma on being released which is compounded by societal attitude towards them resulting in recidivism. According to Moneke (2008), there is no gainsaying the
fact that all our correctional centres, prisons and police cells are lacking in the ingredients that are conducive for the education, reformation and general welfare of young offenders.

It has been established that the roles of the correctional institution in the modern era which are to reform, rehabilitate and reintegrate (3Rs) the juvenile offender, have unfortunately been eroded due to poor implementation of the reform programme. Overly negative interpretation of life events among adolescents in correctional centres, may be as a result of parental deprivation (Anwuri, 2007). The dehumanizing circumstances they are confronted with during incarceration eventually heighten their problems of adjustment in life. This condition often leads to the development of emotional, social, psychological, and mental problems. These include depression, aggression, low self-esteem, unassertiveness and social maladjustments among others (Aneke, 2009).

The management of juvenile offenders is essential because a nation that neglects the reformative needs of juvenile offenders, and fails to equip such persons with adequate education and skills that will make them useful again, is really sitting on a keg of gunpowder, in that the adolescents may in future begin to create problems for the nation.
1.3 Theoretical Framework

This study was based on Cognitive Behaviour Theory and Social Learning Theory.

Cognitive Behaviour Theory

The Cognitive Behaviour Theory was propounded by Beck in 1976. The theory states that people’s feelings are influenced by what they think or how they view life events. Cognitive behaviour theory stresses that the way individuals feel or behave is largely determined by their appraisal of events. It is not people’s experiences or situations that make them angry, depressed or anxious but the way they process the information and think about those experiences (Felham and Horton, 2000). According to them, human beings have cognition—we can think, we can process information coming in through our five senses and make interpretations, inferences and evaluations about such information. In this way, people interact with their environment. These cognitions are linked to feelings, behaviour and physiology. Beck (1976) outlined five ways in which individuals may distort reality. These are:

1. Personalization- blaming oneself for an occurrence out of one’s control.
2. Polarized thinking – interpreting everything in all-or-nothing terms.
3. Selective abstraction - paying attention to a detail while ignoring the context.
5. Over-generalization- drawing a sweeping conclusion from a single instance.
The theory stated that people are emotionally disturbed as a result of their faulty labelling of situations and wrong attributions. In other words, the way people think about a situation, their knowledge, expectation and feeling influence how they behave. Emotional disturbances are not the result of the external events but are caused by our irrational thinking, wrong labelling and accompanying internal defeating verbalization or self “talks” (Okoli, 2002; Olayinka, 2001; Nwadinigwe and Makinde, 1997). As long as one continues to think and verbalize illogically, one will continue to reinforce one’s emotional disturbance or illogical behaviour.

Automatic thoughts: In cognitive behaviour model of counselling, self-defeating beliefs are also known as automatic thoughts so called because they occur very quickly or spontaneously and may appear to be both plausible and realistic to the person (Nwadinigwe & Longe, 2008). They are in form of images or pictures and are also considered as thinking errors because they lead to distortion of reality. Thus, they are known as cognitive distortions (Szymanska & Palmer, 2000; Schroeder, 2002). Cognitive Schema: According to Evans, Kincade, Marbely & Seem (2005), schema is an underlying beliefs and rules of life usually learnt from an individual’s early development. It helps to make sense of the world and about other people. As children grow they develop schema for gender which help them to develop gender identity and formulate an appropriate gender role (Hunter & Forden, 2002). Gender schema is therefore a cognitive structure. The entrenched schema could however interfere with the individual’s self beliefs and success aspirations.
This theory is very useful in this study because the researcher used it to help to explain or manage the emotional disturbances (aggression, depression, test anxiety, etc) of adolescents by changing their irrational beliefs. These adolescents may feel sad, inferior, anxious, rejected, unloved, and stressed due to the effect of living outside their homes. The therapist’s duty is vital in order to change the adolescents’ cognition, emotions and behaviour.

**Social Learning Theory**

The social learning theory proposed by Bandura in 1977 holds that a person’s learning and social experiences coupled with his values and expectations determine behaviour. Social learning theory views individuals in terms of such processes as perceiving, thinking and expecting. Social learning theory has its root in the behaviourist notion of human behaviour as being determined by learning, particularly as shaped by reinforcement in the form of rewards or punishment. Bandura (1977) stated that:

*Learning would be exceedingly laborious, not to mention hazardous, if people had to rely solely on the effects of their own actions to inform them what to do.*

*Fortunately, most human behaviour is learned observationally through modelling: from observing others, one forms an idea of how new behaviours are performed, and on later occasions this coded information serves as a guide for action.*
Social learning theory explains human behaviour in terms of continuous reciprocal interaction between cognitive, behavioural, an environmental influences. The social learning theory proposed by Bandura has become perhaps the most influential theory of learning and development (Cherry, 2004). While rooted in many of the basic concepts of traditional learning theory, Bandura believed that direct reinforcement could not account for all types of learning. His theory added a social element, arguing that people can learn new information and behaviours by watching other people. Known as observational learning (modelling) this type of learning would be used to explain a wide variety of behaviours.

**Basic Social Learning Concepts**

1. People can learn through observation

**Observational Learning**

In his famous “Bobo doll” studies, Bandura demonstrated that children learn and imitate behaviours they have observed in other people. The children in Bandura’s studies observed an adult acting violently towards a Bobo doll. When the children were later allowed to play with the Bobo doll, they began to imitate the aggressive actions they had previously observed.

Bandura identified three basic models of observational learning:

1. A live model, which involves an actual individual demonstrating or acting out behaviour.
2. A verbal instructional model, which involves descriptions and explanations of behaviour.

3. A symbolic model, which involves real or fictional characters displaying behaviours in books, films, television programs, or online media. Mental states are important to learning

**Intrinsic Reinforcement**

Bandura noted that external, environmental reinforcement was not the only factor to influence learning and behaviour. He described intrinsic reinforcement as a form of internal reward, such as pride, satisfaction, and a sense of accomplishment. This emphasis on internal thoughts and cognitions helps connect learning theories to cognitive developmental theories. While many textbooks place social learning theory with behavioural theories, Bandura himself describes his approach as a ‘social cognitive theory’. Learning does not necessarily lead to a change in behaviour. While behaviourists believed that learning led to a permanent change in behaviour, observational learning demonstrates that people can learn new information without demonstrating new behaviours. The two main methods of intervention in social learning theory are modelling and changing perceived self-efficacy.

1. **Modelling**: This is similar to imitation. Through observing appropriate models, people learn to acquire skills and strategies. This means that we observe other people, the consequences of their behaviours and imitate their actions to
receive similar rewards. People imitate what they appreciate. Modelling can accelerate behaviour modification and be used wherever possible to establish new responses. Bandura (1963) suggests that modelling procedures and operant conditioning should be used together. Modelling helps to develop new responses and reinforcement serves to maintain the new responses.

The Modelling Process

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

- **Attention:** Attention, including modelled events (distinctiveness, affective valence, complexity, prevalence, functional value) and observer characteristics (sensory capacities, arousal level, perceptual set, past reinforcement).

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

- **Retention:** Retention, including symbolic coding, cognitive organization, symbolic rehearsal, motor rehearsal).
The ability to store information is also an important part of the learning process. Retention can be affected by a number of factors, but the ability to pull up information later and act on it is vital to observational learning.

- **Reproduction:** Motor Reproduction, including physical capabilities, self-observation of reproduction, accuracy of feedback.

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

- **Motivation:** Motivation, including external, vicarious and self-reinforcement.

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

2. **Changing Perceived Self-efficacy:** Self-efficacy refers to people’s judgment of their capabilities to organize and execute courses of action required to attain designated types of performances (Bandura, 1986). It is important to note that the knowledge and skills that people possess will play critical roles in
what they choose to do and not to do. According to Bandura (1986), a person’s attitudes, abilities, and cognitive skills comprise what is known as the self-system. The system plays a major role in how we perceive situations and how we behave in response to different situations. Self-efficacy plays an essential part of this self-system (Cherry, 2004). According to Bandura (1995) self-efficacy is “the belief in one’s capabilities to organize and execute the courses of action required to manage prospective situations” In other words, self-efficacy is a person’s belief in his or her ability to succeed in a particular situation. Bandura described these beliefs as determinants of how people think, behave, and feel (Bandura, 1994). Since Bandura published his seminal 1977 paper, “Self-Efficacy: Towards a Unifying Theory of Behavioural Change,” the subject has become one of the most studied topics in psychology. Why has self-efficacy become such an important topic among psychologists and educators? As Bandura and other researchers have demonstrated, self-efficacy can have an impact on everything from psychological states to behaviour to motivation (Cherry, 2004). It is important to note that the knowledge and skills that people possess will play critical roles in what they choose to do and not to do.

Research has established (Cherry, 2004) that self-efficacy beliefs and behaviour changes and outcomes are highly correlated and that self-efficacy is an excellent predictor of behaviour. In psychology and education, self-efficacy has proven to be a more consistent predictor of behavioural outcomes than have any other
motivational constraints, Bandura, 1986; Pajares, 1996; Graham & Weiner, 1996; Bandura, 1997 and Pajares, 2000. In some cases, unrealistically low self-efficacy perceptions, not the lack of capability or skill, may in part be responsible for avoidance of certain courses and careers. Individuals who lack confidence in skills they possess are not likely to engage in tasks in which those skills are required, and they will more quickly give up in the face of difficulty. This might be as a result of low level of self-efficacy. Such individuals might resort to anti-social behaviour and take to crime and delinquency.

The Role of Self-Efficacy

Virtually all people can identify goals they want to accomplish, things they would like to change, and things they would like to achieve. However, most people also realize that putting these plans into action is not quite so simple. Bandura and others have found that an individual's self-efficacy plays a major role in how goals, tasks, and challenges are approached (Cherry, 2004).

People with a strong sense of self-efficacy:

- View challenging problems as tasks to be mastered.
- Develop deeper interest in the activities in which they participate.
- Form a stronger sense of commitment to their interests and activities.
- Recover quickly from setbacks and disappointments.
People with a weak sense of self-efficacy:

- Avoid challenging tasks.
- Believe that difficult tasks and situations are beyond their capabilities.
- Focus on personal failings and negative outcomes.
- Quickly lose confidence in personal abilities (Bandura, 1994).

Sources of Self-Efficacy

How does self-efficacy develop? These beliefs begin to form in early childhood as children deal with a wide variety of experiences, tasks, and situations. However, the growth of self-efficacy does not end during youth, but continues to evolve throughout life as people acquire new skills, experiences, and understanding (Bandura, 1992).

According to Bandura, there are four major sources of self-efficacy.

1. Mastery Experiences

“The most effective way of developing a strong sense of efficacy is through mastery experiences, “(Bandura, 1994). Performing a task successfully strengthens our sense of self-efficacy. However, failing to adequately deal with a task or challenge can undermine and weaken self-efficacy.
2. **Social Modelling**

Witnessing other people successfully completing a task is another important source of self-efficacy. According to Bandura,(1994) “Seeing people similar to oneself succeed by sustained effort raises observers’ beliefs that they too possess the capabilities and master comparable activities to succeed ”.

3. **Social Persuasion**

Bandura also asserted that people could be persuaded to believe that they have the skills and capabilities to succeed (Cherry, 2004). Consider a time when someone said something positive and encouraging that helped you achieve a goal. Getting verbal encouragement from others helps people overcome self-doubt and instead focus on giving their best effort to the task at hand.

4. **Psychological Responses**

Our own responses and emotional reactions to situations also play an important role in self-efficacy. Moods, emotional states, physical reactions, and stress levels can all impact how a person feels about their personal abilities in a particular situation. A person who becomes extremely nervous before speaking in public may develop a weak sense of self-efficacy in these situations. However, Bandura (1994) also notes “it is not the sheer intensity of emotional and physical reactions that is important but rather how they are perceived and interpreted”. By learning how to minimize stress and elevate mood when facing difficult or challenging tasks, people can improve their sense of self-efficacy.
The theory sees certain behaviour as being learned unconsciously or consciously through socialization. Social learning theory emphasizes the ability to reproduce the action, attitude and behaviours of a model. The theory also assumes that what has been learned can also be unlearned through modelling. The theses of Bandura are relevant and will provide a proper modelling for the study. As inmates who are exposed to appropriate models as they observe and imitate them and their behaviour reinforced, they are likely to adopt a more positive outlook to life.

This theory is very useful in this study because adolescents can be made to model their lives after a successful person in the society they know and the wrong perception they previously had about themselves will begin to give way to more self-confident people.

1.4 Purpose of the Study

This study is designed to assess and manage the psychosocial problems of the remanded adolescents in correctional centres in Lagos State, using Cognitive Restructuring of Cognitive Behaviour Theory (CBT) and Modelling - an intervention strategy of Social Learning Theory (SLT) as counselling interventions to help alleviate such psychosocial problems and to reintegrate well adjusted and responsible individuals into the society upon their release from the centres.

Specifically, the study sought to:
1. Determine the effectiveness of treatment strategies in alleviating participants’ aggressiveness.

2. Investigate the effectiveness of the treatment strategies on participants’ anxiety levels.

3. Evaluate the effectiveness of the treatment strategies on participants’ depression levels.

4. Investigate the effectiveness of the treatment strategies on participants’ self-esteem.

5. Determine if there is gender difference in the effectiveness of the treatment strategies.

1.5 Research Questions

Five research questions guided this study:

1. Do treatment strategies reduce participants’ aggressiveness?

2. Are treatment strategies effective in reducing participants’ anxiety levels?

3. Do treatment strategies enhance adolescents’ depression?

4. Are treatment strategies effective in enhancing adolescents’ self-esteem?

5. Are there gender differences in the assessment measures due to treatment strategies?
1.6 Research Hypotheses

The following null hypotheses were tested in this study:

1. There is no significant difference in the post-test scores in aggressiveness among participants in the three experimental groups (Cognitive Behaviour Therapy, Social Learning Therapy and Control).

2. There is no significant difference in the post-test scores in anxiety among participants in the three experimental groups.

3. There is no significant difference in the post-test scores in depression among participants in the three experimental groups.

4. There is no significant difference in the post-test scores in self-esteem among participants in the three experimental groups.

5. There is no significant gender difference in the post-test scores in the dependent measures (aggressiveness, anxiety, depression and self-esteem).

1.7 Scope / Delimitation of the Study

This study was limited to two special correctional centres in Lagos State which are Special Correctional Centre for Boys located at Oregun, Ikeja, and Special Correctional Centre for Girls at Idi-Araba, Mushin owned and managed by Lagos State government. This study covered only some of the psychosocial problems experienced by adolescents in correctional centres. These are aggression, anxiety, depression and self-esteem.
1.8 Significance of the Study

This study will be of immense benefit in that it will provide information to the policy makers in the Federal Ministry of Youth Development, Ministries of Youth, Sports and Social Development, Women Affairs, Labour, Employment agencies and Non-governmental organizations on how best to address the psychosocial problems of children in correctional centres. It would also help in supporting the youth in the society to be gainfully employed upon their release from the centres thereby curbing incidences of youth restiveness and violence. It would also help in identifying youths who would be vibrant agents of change in the nation and using them as role models to other youths. There also should be less school drop-outs as a result of hopelessness as a result of remand at the centres. Children willing to go back to school and those that opt for vocational training will be helped and adequately equipped to carry on and be useful to themselves and the society at large. People will realize the need to foster these children or take up sponsorship of their education to any level. A youth could even be appointed as a minister to oversee the Federal Ministry of Youth Development because they are in a better position to know issues as they affect their wellbeing.

It will be of immense help to the participants themselves in managing their problems effectively during remand and learning how best to face life after institutionalization. The adolescents would begin to have a better view of themselves and the willpower to be useful to themselves and the society at large.
because according to Mahata Gandhi...strength does not come from physical capacity. It comes from an indomitable will.

This study will be of immense benefit to religious organizations on the need to enforce a proper pre-marriage counselling to intending couples and the need to be committed to their marital obligations towards their families in order to curb the incidents of broken homes. Sanctions would be put in place for couples to ensure that children’s rights are respected and children properly cared for thereby curbing the social implications of having street children in the society.

This study would also be of immense benefit to government officials on the need to provide good governance which would help reduce the rate of poverty in the society by creating adequate jobs to the teeming youths because as the saying goes...an idle mind is a devil’s workshop. Poverty has been fingered to be the cause of all child abandonment and deprivation which leads to anti-social behaviour among adolescents.

It will provide counselling psychologists with empirical data on the profiles of children in correctional centres in Lagos State.

Finally, it will provide an understanding of the effectiveness of cognitive behaviour therapy and social learning therapy and their relevance in the treatment of psychosocial problems.
1.9 Operational Definition of Terms

In order for readers to follow this study, the following terms used in this study are operationally defined here:

**Correctional Centres**

These are homes or institutions where juvenile offenders or children below 18 years who have committed crime are kept. Those found wandering or brought by their parents for anti-social offences are also kept there pending when they are released to their families. In this study, correctional centres are places juvenile offenders are kept for anti-social behaviours. Also orphans who need care and protection, lost but found children are also sheltered at such institutions as Special Correctional Centre for Boys at Oregun, Ikeja and at Special Correctional Centre Idi-Araba for the Girls at Mushin all in Lagos State.

**Adolescent**

An adolescent is a young person who has not reached full maturity. An adolescent is one who is going through the period of physical transition between childhood and adulthood. He is found between two worlds: childhood and adulthood. He is undergoing revolt and internal turmoil. However, he needs to know his or her limits and to accept guidance. In this study adolescents refer to male and female participants who are between the ages of ten and twenty-four.
Psychosocial Problems

The term psychosocial underscores the close relationship between the psychological and social effects of any traumatic situation, the one type of effect continually influencing the other. Psychological effects mean those experiences, which affect emotions, behaviours, thoughts, memory and learning ability and how a situation may be perceived and understood. Social effects relate to how the diverse experiences of war or other disasters alter people’s relationship with one another, since such experiences change people. Social effects may also be extended to include an economic dimension. For the purpose of this study, psychosocial problems are behavioural, emotional and social problems, and they include, aggression, anxiety, depression and self-esteem.

Aggression - This is a feeling that manifests itself in a desire to hit out at something or someone else. In this study aggression refers to hostile behaviour as measured by Verbal Aggressiveness Scale (VAS).

Anxiety - This is an anticipatory emotion. It refers to abnormal apprehension, fear, uneasiness or self-doubt that stems from the anticipation of danger. Appraisals of helplessness are a fundamental component of anxiety. In this study anxiety refers to feelings of apprehension and fear measured by Social Anxiety Thoughts Questionnaire (SAT).

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**Depression** - This is a condition, which immerses its sufferers in a world of self-blame, confusion, and hopelessness. It leads to persistent feelings of worthlessness and inability to feel pleasure or take interest in life. It can be caused by overly negative interpretation of events. For the purpose of this study, it refers to persistent feelings of hopelessness as measured by Automatic Thoughts Questionnaire (ATQ).

**Self-Esteem** - This refers to a low sense of self-regard. It is in consequence of individuals comparing themselves with others and making negative self-evaluations. In this study it refers to scores in Index of self-esteem (ISE).

**Treatment Strategies** - These are the techniques used in the treatment stages. One treatment group was exposed to (Cognitive Restructuring) based on Cognitive behaviour theory while the second group received (Modelling) as defined in Social learning theory. In this study, the treatment strategies are cognitive restructuring and modelling.
CHAPTER TWO

LITERATURE REVIEW

Review of related literature, which enabled and overview of work done in the area of psychosocial problems of adolescents in correctional centres is organized under the following headings:

2.1 The adolescent
2.2 The adolescence stage
2.3 Historical development of social work and correctional Centres in Europe and America
2.4 Historical development of social work and correctional centres across Africa
2.5 Historical development of social work and correctional centres in Nigeria
2.6 Historical development of social work and correctional centres in Lagos State
2.7 Establishment of juvenile courts and its role in Lagos State
2.8 Rights of the child across Africa
2.9 Rights of the child in Nigeria
2.10 Children in conflict with the law
2.11 Parents ‘socialization of children and effects of deprivation
2.12 Psychosocial problems of children raised in correctional centres
2.13 Cognitive Behaviour Theory
2.14 Aggression
2.15 Cognitive Behaviour Therapy and Aggression
2.16 Research findings on Cognitive Behaviour Therapy
2.17 Cognitive Behaviour Therapy and Anxiety
2.18 Cognitive Therapy and Depression
2.19 Cognitive Therapy and Low Self-Esteem
2.20 Review of Empirical Studies on Social Learning Theory
2.21 Contemporary views
2.22 Appraisal of the reviewed literature

2.1 The Adolescent

The World Health Organization (1994) views adolescents as youths from the age of ten (10) to nineteen (19) years while Nigerians’ National Adolescent Health Policy (1996) considers them as youths between ages of ten (10) and twenty four (24). The Adolescent years differ in several respects from the previous years of childhood. While the genes inherited from parents still influence thought and behaviour just as in childhood, but inheritance now interacts with the social conditions of the adolescents’ world- with families, peers, friendship, dating, and school experiences. An adolescent has experienced thousands of hours of interactions with parents, peers, and teachers in the past ten to thirteen years of development. Still, new experiences and developmental tasks appear during adolescence. Relationship with parents take a different form, moments with peers become more intimate, and dating occurs for the first time, as does sexual
exploration and possibly intercourse. The adolescents’ thoughts are more abstract and idealistic. Biological changes trigger a heightened interest in body image. Adolescence, then, has both continuity and discontinuity with childhood. (Omoegun, 2001). These show the ambiguous position of adolescents and the enormous challenges that face them. Adolescents tend to experience stress, as they get conflicting messages, have conflicts within the family and school and with difficulties in establishing self-identity and self-esteem (Bamidele, 2010).

2.2 Adolescence Stage

Adolescence is a developmental phase of tremendous significance. It represents a time of enormous changes, at times difficult and confusing for adolescents as they make their way through this transitional period into adulthood. For some teens, this journey can be made smoother by parents and other adults who are understanding, by supportive peers, and a strong inner sense of direction (Coles, 1974).

Adolescence is a period when a young person passes through process of reformation from childhood to adulthood. It is a period when either the privileges of childhood or the freedom of adulthood is rarely accessible to a young person. There is no consensus among authors regarding the inception and ending of this period. Nevertheless, the age ranges from twelve to twenty-one years (Okoye, 2006). Adolescence, the transition period from childhood to adulthood is a stage that is characterized with emotional instability. The stage is regarded as the
period of “storm and stress” and is confronted with a lot of problems emanating from the peculiarity attached to this period between childhood and adulthood (Omoegun, 2004).

Several authors have defined and described the period in terms of new awareness of physiological development that result to changes in social relationship. For instance, Olayinka (1987) defines adolescence as a period of physical, endocrinal and emotional changes in a youth as well as a period of crisis when an adolescent involves himself/herself in sexual experimentation because of new awareness. Way (1995) refers to it as a period of relatively rapid psychological, social and physical development. Freud (1856-1939) believed it to be a period in which sexual urges are reawakened. Osarenren (1996) describes it as a time of biased emotional response due to innovations that probably left the teenagers with ‘trial and error’ method of problem solving. Pipher (1994) likened early adolescence as a ‘hurricane’ that sweeps away majority of girls. Indeed, the adolescence is marked with a number of developmental characteristics, which create disturbances in the minds of the adolescents (Okoye, 2006).

Adolescence is seen as the transition period from childhood to adulthood when the child attains puberty. Adolescence chronologically refers to a period between puberty and adulthood (Osarenren, 1996). Adolescence is a mid-way between two worlds; adulthood and childhood. The adolescent is no longer a child and is not yet an adult. The child looks up to him for help while the adult looks up to
him for greater responsibilities which he has not got the will-power to accomplish satisfactorily. More so, the physiological changes heralding the stage makes the transition period even more challenging (Bamidele, 2010).

Havighust (1975) cited in Omoegun (1995), identified the multifarious problems that adolescents face as a result of physical and psychological changes characterizing adolescence as sex, developmental problems, problem of somatic variation, problem of egocentrism, problem of aggression, anxiety, depression, low self-esteem and antisocial problems among others. Walter, Castille & Springer (1974) as reported in Emeri (2010) perceived adolescence as the period between childhood and adulthood. They maintained that the adolescent lives in two worlds at the same time. He craves independence, but often feels dependent. He resents parental correction but needs parental sympathy and help. He thinks he has much and suddenly finds that he does not know enough to solve his problems. He wishes to control his own life but finds life full of frustrating obstacles. Hence he may be aggressive or rebellious in a day, and cooperative and affectionate the other day.

Olayinka & Omoegun (2001) identifying personality characteristics of the adolescent, predisposing him to abuse, observed that children who have a placid temperament are less likely to be victims of abuse within a family than hyperactive children by virtue of their placidity; they may be less affected by emotional turmoil surrounding them.
In the light of this, various researchers have described the period as: a period of storm and stress, most turbulent, most problematic, turbulent teens and identity crisis among others. Freud (1952) viewed it as a period of heterosexual attachments of interest. Rogers (1981) cited in Osarenren (1996) described adolescence as a process of achieving the attitude needed for effective participant and functioning in the society. The physical changes in the adolescent are accompanied by new and often times, confusing emotional responses, a broadening of social awareness and functioning (Osarenren, 1996). Ausubel & Sullivan (1970) cited in Omoegun (1995) described the period in which new and continuous changes in personality organization are being formulated as transitional phases. During this period, the individual is in the marginal position of having lost an established and accustomed status and of not yet having acquired the new status, towards which the factors impelling developmental changes are driving him.

A full appreciation of adolescence would be incomplete without noting many of the common myths which surround students during this developmental period. Unfortunately, many of these beliefs are negative, they may tend to prejudice our thinking and more seriously, influence the way in which we treat adolescents.

Common Myths about Adolescents-
Adolescents are not quite “normal.” Adolescence is a normal developmental phase; therefore, suggestions of abnormality to the adolescent only serve to intensify his/her self-absorption and fears of the changes he/she is experiencing.

Adolescence is transitional & temporary, and less significant than “real life” – What young people do in the here – and-now is important and determines their current and future needs, their growth, and their self-concept.

Adolescents are basically all alike. Adolescents are the most widely variable group in society. The behaviour of troubled youth should not be generalized to describe all adolescents.

Every adolescent’s growth is uniform and scheduled. There are great differences biologically, socially, emotionally, and intellectually. A physically mature teenager can be emotionally immature and vice-versa.

Adolescents are still children. Teenagers are capable of assuming responsibility, decision-making, and serious thought and conversation.

The Facts

Adolescence is an exhilarating developmental phase of tremendous significance. It can be a stressful period, both for the adolescent and the adult.

Parents’ intentions for their children for happiness, health and safety can often go unrewarded.

Teenagers resent unsolicited attention and advice.
Teenagers strive to appear grown-up, independent, and self-sufficient (Ginott, 1969).

**Developmental Tasks**

The adolescent must work through a number of developmental “tasks” before he/she enters into adulthood. The following highlights the major task areas:

1. **Physical and Sexual Maturity**

   New feelings emerge which have to do with relationships with peers and adults. Sexual maturation is a major, basic, universal task. Its significance is due to the changing expectations from both others and oneself which accompany physical and sexual maturity.

2. **Developing Individuality**

   As adolescents find answers to basic identity questions, their preferences, interests, personalities and self-concept are solidified and tested. There is an increased capacity for logical, rational, complex thought, and most important, the ability to deal with abstract thought.

3. **Increased Responsibility**

   This includes explorations of a purpose in life, reasons for living, and vocational choice. This is accompanied by experimenting with wider circles of society, meeting various kinds of people, and participating in aspects of the adult work world. Youth also need to experiment with their own
strengths and values as responsible people in society. Youth need to be held responsible for their actions and accountable for the impact they have on others, without suffering disastrous consequences when they fail or make mistakes.

4. **Separation and Autonomy**

This is the most difficult for both teens and parents. This is the time when a child is no longer a child, which leads to mixed emotions of joy and fear. Rebellion against authority and against convention is to be expected. As parents, your need is to be needed; as teenagers, their need is not to need you. This conflict is real; it is experienced daily as those you love become independent of you. Teens have a continuing need for adults to set limits as well. Ambivalence may arise out of the desire to achieve independence while being reluctant to give up the physical and emotional security of childhood. It may also come from wanting to try out newly merging powers and skills, while fearing the loneliness that may go with striking out on one’s movement towards healthy separation. The peer group is important, but adults are as well.
5. **Re-evaluating Values**

Adolescents are questioning old values and learning new ones. It often irritates and scares adults although this questioning is normal and necessary.

6. **Outgrowing Types of Egocentrism**

There are two main kinds of “egocentrism” that are typical of adolescents and which must be worked through. The first is the feeling that you are always on stage being looked at, listened to and judged. This is accompanied by self involvement and absorption, most notably, the preoccupation with the body and its physical changes.

The second kind is a type of psychological loneliness in which the adolescent feels, “I am alone”; “No one understands me”. This includes feelings of a kind of immorality/ invincibility in which teenagers believe, e.g., “I will never die, not become pregnant or addicted to drugs,” etc. Teenagers may engage in risk-taking behaviours as symbols of maturity, sophistication, and to defy authority.

Adolescence has no defining age which begins or ends, because of the need to learn a wide variety of skills necessary for earning a living and for the development needed for adult relationships. In order to understand what is required of parents during adolescence, it may help to look at the struggles a child is going through at this time.
EARLY ADOLESCENCE (12-15)

- Sexual Development – early physical development has a positive effect on boys and a negative one on the girls. The reaction and outstanding of the maturation process by peers and adults creates these negative or positive adjustments. One of the prime concerns of early adolescent is, “Am I normal?”; “How acceptable are these changes to others?”

- Academic performance is more complicated and demanding.

- Separation – As loyalties shift from parents to peers, outbursts are frequent, arguments are intense, and differences of opinion can be extreme (sometimes called “rebellion”).

- Lack of objectivity and excessive involvement with themselves makes them inconsiderate of others and difficult to engage in an extensive conversation. They cannot generalize.

- Social world is expanding with more complicated and demanding expectations. The adolescent’s self-worth is being validated.

- Need for autonomy less than in later adolescence. In contrast, in the early, turbulent years, teens need adult leadership and influence in the areas of lifestyle and views.
MIDDLE ADOLESCENCE (15-18)

- Sexuality and the accompanying changes of the teen’s new body image are accepted.

- There is a change in relationship with parents, as the adolescent becomes more separate and differentiated. Feelings of conflict, loneliness and confusion emerge.

- Strong peer bonds as well as crushes occur. Idolization of a public figure may also appear.

- Same-sex identity, such as mode of dress, language, hair, etc. is important. Opposite sex relationships are ambivalent, awkward, and intense.

- Psychologically unprepared for consequences of sexual activity.

LATER ADOLESCENCE (18+)

- Physical growth and development completed.

- Interpersonal relationships more mature and constructive. Less guidance needed from authority figures.

- Experimentation and learning of new roles; preparation for career and relationship.
• More ready to enter into nurturing relationships.

• Full cognitive development attained (Haven, 1977).

2.3 Historical developments of social work and correctional centres in Europe and America

The records of earlier civilized peoples reveal that despite the rigors of the times, a compassion for others - the sick, the old, the handicapped, the poor was prevalent. This was true of Egyptians, Jews, Greeks, Romans and those who adopted Christian teaching. Even before the rise of modern European States, there were social services of a primitive sort provided through the agency of the church. Individual and institutional benevolence, in obedience to religious teachings were manifested through alms to the poor, shelter to the homeless, and care and comfort to the sick. Monasteries and hospitals, the shelter being foundation for the sick, the destitute, and the aged were most prominently identified in the almsgiving and sheltering role. Throughout the Middle Ages the religious guilds and craft associations also undertook to provide shelter and alms. This religious role still persists today, usually supplementing state efforts in bringing care and comfort to the weaker members of the society.

From the earliest immigration to America through the succeeding years, concern has been expressed by members of various religious groups for the welfare of people. This was true of Protestants, and Catholics, of Jews, and of members of
the Society of Friends from the first day they set foot on America soil. Indeed, this was true once these groups settled in the New World because they had had a similar concern in the countries from which they came. In all religious teachings, there is like a commitment, which seeks expression in whatever place and in whatever circumstances the members find themselves. The commitment often finds expression in promoting social welfare through voluntary associations.

2.4 Historical development of social and correctional centres across Africa

In Kenya, street children constitute a large and growing sector of the country’s most disadvantaged children and youth, with high risk of social exclusion. According to the Government of Kenya (GOK)/ UNICEF report (1998,) there were around 150,000 street children in Kenya with close to 60,000 in Nairobi (the capital city) alone. Though it is not very clear how many street children there are in Kenya, the Government estimates in the year 2001 put the figures at 250,000. Majority of these children are aged between 10 and 18 years with a large proportion of boys as compared to girls. The Street children phenomena have continued to be a worrying case in Kenya, especially with the emergence of street families, that is becoming even a security for many. The Society in Kenya, and in many other countries has branded all street children as criminals, due to the criminal, and other anti-social activities they have been involved in for survival such as snatching bags/valuables, using unorthodox means to get money
from innocent members of the public. The children themselves also have a negative perception about themselves and in a way have also “branded themselves criminals”. It is for these reasons that the law enforcers, such as government have attempted even to round up children, put them in homes, but the next opportunity they have of being free, they still end up on the streets.

Undugu Society Kenya (USK) interventions of Street children and Youth at risk. Street Children rehabilitation has remained the core business of the Undugu society for close to 34 years now. During this time, the Organization has gained a wealth of experience, as well as exchanged ideas and experiences with other local and international players in this field. For Undugu, the three decades signifies valuable experience in engaging in one of the most complex social and economic challenges facing urban communities today. Over the years, USK’s street children and youth rehabilitation work has gone through a number of phases as follow: 1970’s – 1995’s – Needs Based Approach where USK provided food, shelter, clothing, counselling, medical care and protection through an institutionalized approach. 1995 – 2005 – Rights Based Approach: The organization continued with the transformed institutionalized rehabilitation, more emphasis on Family Reintegration/ Family Centred Rehabilitation. Services to children such as health care, protection, education and training were seen as rights and not needs. It’s in this era that USK got involved in policy influencing activities, and was active in lobbying for Enactment of the children’s Act and introduction of Free Primary Education for all children. 2006- 2010 – Rights Based
Approach with emphasis on Capacity Building and empowerment, and involvement and participation of children and youth on issues affecting them. Through the years, institutionalized rehabilitation has been used to provide care, protection and a transit “home” to many of the children that USK has integrated with from the streets.

In Uganda, Kampala- South Western region Police officers have asked the Government and the European Union (EU) to construct juvenile remand homes in the region. Kanungu district Police commander Nazarius Mugisha said the rate of crimes committed by juveniles had shot up. Mugisha added that they needed juvenile remand homes to reduce the numbers of young offenders in Police cells. Because of lack of such remand homes, juvenile suspects who are tried in the south-western region have to be transported to Naguru, Mulago and Kisubi remand homes in Kampala. Lubandi (2008) said “In a country like Uganda where there is no enough infrastructures to accommodate prisoners, it is almost a curse to be a juvenile offender or just a criminal suspect at such a young age." As a result, children fail to express themselves in a way that is satisfactory to judges, and are thus thought to be guilty or obstructing justice. The violation of offenders’ rights goes on in the prisons where they are detained in chambers with adult inmates of all criminal backgrounds who may inflict countless abuses upon the children. They are beaten up by adult inmates, sexually abused and exposed to more awful behaviours including sodomy. Both the Prisons Act and the Children Act prohibit the detention of children in same cells or prisons with
adults, whatever the circumstances. Realizing that young offenders need special attention as compared to adult inmates, the Children Act also provides for the establishment of Family and Children’s Courts (FCC), rehabilitation centres and remand homes in every district to handle child offenders. On the contrary there is only one Family and Children’s Court- Mwanga 11 Magistrate Court-and one rehabilitation centre- Kampilingisa National Rehabilitation Centre in this country (Lubandi, 2008). The two are inadequately supported financially and in terms of human resources. They are situated in Kampala, leaving the rest of the country without any child rehabilitation centre. The result is to commit child offenders to prison meant for adults. This does not only limit access to courts but also hinders the administration of justice for them. Section 91 of the Children Act states that “Where a child is not released on bail, the court may make an order remanding or committing him or her in a remand home, situated in the same area as the court making the order”. However instead courts now remand children to adult prison due to inadequate remand homes. Children are made to stay in prisons for longer periods than what is prescribed in the law-the law only mandates the courts to remand a child for not more than six months in cases punishable by death and three months in all other cases, after which the child would be released on bail pending trial. On conviction, a child is supposed to be committed to a rehabilitation centre and not a prison per se. The government must increase investment in child protection by
constructing more detention centres and family and children’s courts to ensure children in conflict with the law access to corrective services.

In Mumbai, according to Mazumdar (2005), the 100-year-old Victorian structure that houses 400-odd children is “definitely not conducive for an overall development of a child”. Lack of basic facilities—insufficient towels, inadequate food—was some of the findings of committee that reviewed 21 child observation centres across the state. Though the centre has taken some remedial measures, the problem of lack of qualified psychiatrists and effective rehabilitation programme is still to be addressed. The Child Welfare Committee that was set up to review the working of seven CAS institutes in the city recommended child guidance clinics to be set up within their premises. But, except for the Dongri home, none of the others has set up the clinic.

“Even at the Dongri clinic, the psychiatrist and psychologist come only once in a week,” says Anjali Gokarn, member of the Child Welfare Committee. There is also a strong need for group counselling and parental counselling. “The children have multiple problems and counselling must involve a therapeutic approach. The current approach is to solve problems. Some children also have serious psychological problems and need professional help,” says Gokarn. While the Dongri home has 77 staff members (administrative included), most other remand homes are plagued by a shortage of staff. There are also reports of administrative clerks being promoted as probationary officers, who act as councillors. Changing times require changed training programmes. Rehabilitation
programmes like sowing, cooking and other traditional vocational training programmes, have become redundant. "Instead of teaching these children skills, the need is to prepare them for the real world. Vocational training should also acknowledge the changing needs of today’s society- of various languages for example," says Mazumdar.

2.5 Historical development of social welfare and correctional centres in Nigeria (1870 Present Day)

Social welfare services as we know it in Nigeria, are fragmented and in an uncoordinated state. But since 1920’s, there has been growing awareness to help people in need, particularly the poor, the aged and difficult children. So voluntary services in Nigeria have been related to juvenile delinquency, abandoned or neglected children, matrimonial disputes etc. The Federal Government and State Governments have no clear policy on social welfare services. The truth is that the colonial experience brought along its trail, an increased rate of urbanization and industrialization both processes which combined to undermine the extended family system which previously ensured the provision of social services in many traditional societies. The missionaries activities especially in the furtherance of education as an instrument of social change and a pre-requisite to religious conversion, further jettisoned the traditional values on which the traditional social services were built.
The Colonial Welfare Service organized in 1942 focused upon the establishment of boys clubs in order to prevent delinquency among young migrants. Subsequently however, statutory child welfare services began with Native Children Custody and Reformation Ordinance of 1944, and the Children and Young Persons Act of 1948. The 1940s saw the development of policies with respect to children while the 1950s and 60s saw the extension of these policies to the area of adoption, foster care and marriage counselling. Remand homes (first established in Ibadan for the care of disadvantaged children Boys Approved School, a reformatory in Enugu, and the Boys Borstal in the North were created also in the 1940s. Traditionally, family problems with spouses or children were handled by extended kinship groups and local authorities. For the most part, this practice continued in the rural areas. In urban settings, social services were either absent or rare for family conflict, for abandoned or runaway children, for foster children, or for children under the care of religious instructors. As with many other Third World nations, Nigeria had many social welfare problems that needed attention.

2.6 Historical development of social welfare and correctional centres in Lagos State

The Salvation Army started in 1925 to run what was called “The Boys Industrial Home” at Yaba, Lagos. The Home catered for juveniles who were beyond parental control and were menace to the public. Similarly, the Roman Catholic
Church had a reformatory Institution at Topo Island, Badagry for boys who were unruly and were brought to the institution by their parents for such a period the staff found desirable for juvenile full reformation. The Colony Welfare service started during the latter years of World War II. In common with many countries affected by the war, many social problems were created of which the most serious was the increase in children who were absconding from their homes in Lagos and the interior parts of Nigeria, and were living on the streets and developing delinquent habits. To help such boys, a group of young Nigerians opened the Green Triangle Club. These children usually come to the Club to engage in different activities and whilst there, made friends with adult helpers who tried to influence them to return home and settle down. Many members of the public made financial contributions to help. Some of these children who had no homes in Lagos, or whose parents did not want them to return home because of their delinquent ways, began more or less living in the Club.

At this time, expatriate officers who were due to go to England often found that they had to remain in Lagos for several weeks until a boat arrived. Mr. D. Faulkner, who was then working at the Enugu Boys’ Approved School, was in Lagos awaiting embarkment for England, and together with Green Triangle Club helpers carried out a survey of Juvenile delinquency and submitted it to the Government. The high incidence of Juvenile delinquency and the inadequacy of the methods available for dealing with it were such that the report submitted to
the Government strongly recommended the setting up of a Colony Welfare Service, designed primarily to help delinquent boys.

The Colony Welfare Service was eventually organized in 1942 and concentrated especially on the setting up of Boys’ clubs which would help in preventing delinquency. Boys’ Remand Home was opened at Military Street, Lagos, where boys could be housed, while the reasons for their delinquencies and their home conditions could be studied. Three men and three women were given scholarships for training in social science and administration in 1943 to work in Colony Welfare Service on their return from overseas. At this time, the Salvation Army was responsible for running a Boys’ Reformatory at Yaba, but with the increase in Juvenile delinquency, it soon became apparent that this could not be large enough. The Reformatory was already being largely financed by the Government and it was therefore decided to close this down and open a Boys’ Approved School at Isheri, as part of the Colony Welfare Service. In March, 1945, a group of boys moved to Isheri, and under the supervision of the staff, the school buildings were built of temporary materials. A few years afterwards, buildings of a permanent nature were erected, and there were over 100 boys being trained to become good members of the society, and these boys were taught different trades. Although there have never been as many girl delinquents requiring training as boys, there was a growing need for a place of shelter and protection for girls, so the Salvation Army vacated the premises at Yaba, these were used as a Home for girls and small boys. Such children included those who
had got lost in Lagos or had been sent to work as house-servants and having been ill-treated, had run away. At this time, again as a result of the war, there was a marked increase in Juvenile delinquencies, child prostitution and women Social Welfare Officers were appointed to rescue young girls from brothels, and such girls remained at the Girls’ Home until they could be repatriated to their homes. Returning Nigerian soldiers, who had money saved, spent it on paying dowries for young wives. Many of these young wives had not yet reached puberty, and were sent to Lagos to the soldiers whom they had never seen. Those girls were very unhappy and frequently ran away, and the Native Authorities of the areas from which they came objected to these children who came to be known as “posted” being wives. The Social Welfare Officers persuaded those soldiers, and other men involved to send their wives name until the girls were older. As the services developed, more delinquent girls became known to the Social Welfare Officers, and those who were not too uncontrollable were sent to Approved School which was opened for delinquent girls. The Services also began foster-homes for boys and girls whose delinquency was not deep rooted, but was rather the result of lack of parental care. Many foster-parents have rendered invaluable assistance in training of children.

For many years, the Service had to work under the Native Children (Custody and Reformation) Ordinance, which provided for the cases of children brought before the Courts on criminal charges, but made no provisions for children in need of
care and protection or beyond parental control. In 1948, the Juvenile Court was established. This led to an increase in the work of the Juvenile Court. It was then found that many boys started stealing and absconding from the Home at early age, and to provide training for such boys from the ages of 8 to 11 years, a Junior Boys’ Approved School, called Birrell House, was opened. There was no Native Authority Court in Lagos where matrimonial cases of marriages under the Native Law and Custom could be heard, and therefore Social Welfare Officers were set aside to deal with these matters. In many cases, married couples came to refund dowries, but in some cases, couples were desirous of reconciliation, and here the Social Welfare Officers were able to help such to come together again. Family Welfare Service was started to help reconcile husbands and wives, family matters, including paternity disputes etc. As has been stated, Boys’ Clubs were started at the very beginning, and shortly afterwards, Girls’ Clubs were developed, together with Women’s Club Sports. Community Centres were built and urban community development undertaken. These services were transferred to the Lagos State Ministry of Education on 1st April, 1968 to form the Community Development Division when the twelve States were created by a decree. The Social Welfare Division since 1968, now consist of the following Units:

CASEWORK SERVICES

- Juvenile Welfare Unit, Yaba
- Juvenile Court
- Aftercare Services, Lagos
• Family Welfare Unit, Lagos
• Children’s Unit, Lagos
• Adult Probation
• Adoption Unit
• Juvenile Welfare Units, Ikeja
• Family Welfare Unit, Ikeja
• Aftercare Service, Ikeja
• Social Welfare Divisions- Tarwa Bay Camp.

SOCIAL WELFARE INSTITUTIONS

• Mapara Senior Boys’ Approved School, Isheri
• Isheri Intermediate Boys’ Approved School, Isheri
• Birrell House Junior Boys’ Approved School, Yaba
• Girls’ Approved School, Idi- Araba
• Boys’ Remand Home, Yaba
• Girls’ Remand Home, Idi-Araba
• Children’s Transit Home, Idi-Araba

2.7 Establishment of the Juvenile Court and its role in Lagos State

The Juvenile Court Law was enacted in Lagos in 1913 to cope with the welfare of the children and young offenders. In fact the Lagos Juvenile Court was not officially established until 1948 when trained Nigerian Probation Officers returned
from overseas to serve the Court. Probation Officer has a detailed report containing the general conduct of the juvenile, his home and family background, medical report, his relationship to his family, his school and any other information that can be of use to the court in dealing with the juvenile. The probation officer will therefore investigate into all the aspects of the juvenile’s life. Unlike the Magistrate Courts, the Juvenile Court is not open. It is restricted only to those members of the public who are directly concerned in the cases before the court. The Juvenile Court panel consists of the Magistrate and the Lay Assessor, the Court Registrar and his Assistants, the Police, the Probation Officers, the Juveniles, their parents or guardians and witnesses of the Police. Occasionally Solicitors and Counsel are present to represent the interest of the child or young person. Under the Act only cases involving juvenile who are below the age of 17 are brought to the Court. A “Child is a person under the age of fourteen years and a “ Young Person” means a person who has attained the age of 14 years and is under the age of 17 years. Wide varieties of offences involving juvenile are brought before the Juvenile Court. They include stealing, and attempted stealing, assault, fighting and hawking cases. Children and young person beyond parental control or in need of care and protection also appear before the court. They include cases of abandoned children, of children deprived of adequate care by their parents or guardians, and of those exposed to moral danger, because of the company they keep or their environment. Cases arising from the failure of parents or guardians to pay maintenance allowances are also referred to the
Juvenile Court. The Court usually orders fathers to pay these allowances for the upkeep of their children committed to Approved Schools or fit persons. Some mothers who default on payment, Judgment Pobters Summons are issued against them and such defaulter, are dealt with by the Juvenile Court, and others are referred to Probation Officers at the Social Welfare Division for detailed reports to be written of them. The case is adjourned for at least two weeks, and the child is either released on bail or remanded in one of the Remand Homes.

The occupation of the Juvenile Court is the protection of the welfare of these young ones. The Juvenile Court and the Probation Officers are aware of the fact that they are working towards a common goal that is to correct and reform the offender in order to make him or her a good useful member of the community.

The constitution of juvenile courts has been regulated in section 6 of the law, which states:

*A juvenile court for the purpose of hearing and determination of cases relating to children or young persons shall be constituted by a magistrate sitting with such other persons, if any, as the Chief Justice of the region shall appoint.*

The different states of the Federation have adopted two approaches to the establishment and operations of juvenile courts. In few states (especially Lagos State), a visible structure of juvenile justice administration is on ground. But in most states, such structures are not readily visible. Instead of a permanent juvenile court, magistrates hear cases involving juveniles outside the normal
courtrooms or outside normal court sessions either in the courtrooms or in their chambers. This is to protect the privacy of the young offenders and also to protect him or her from the effects of stigmatization that may result from public trial, in line with Section 6 (2) of CYPA:

A court when hearing charges against children or young persons shall, unless the child or young person is charged jointly with any person not being a child or young person, sit either in a different building or room from that in which the ordinary sittings of the court are held, or on different days or at different times from those at which the ordinary sittings are held.

Nevertheless, in spite of these provisions relating to the constitution of juvenile courts, international standards enshrined in the CRC and other important instruments such as the Standard Minimum Rules for the Administration of Juvenile Justice are not reflected in the Nigerian system of juvenile justice. Gravely concerned about the absence of specialized judges, police and other personal handling cases involving juvenile offenders. (Rule 12 of the UN Standard Minimum Rules provides that: In order to best fulfil their functions, police officers who frequently or exclusively deal with juveniles or who are primarily engaged in the prevention of juvenile crime shall be specially instructed and trained. In large cities, special police units should be established for that purpose)

In Nigeria, female police officers are often deployed to juvenile welfare departments in divisional and police state command headquarters. However, they are not given specialized training, assignment to the unit is reconsidered a general duty posting and officers are frequently transferred in and out of the
unit. Judges frequently switch between trials of adult offenders and juvenile delinquents, are not specialized in the work with children and are thus often not aware of the special vulnerability and needs of children. Section 8 of the CYPA regulates the trial procedure of juvenile courts, including the right of juvenile offenders to due process. The provisions satisfy the requirements of art. 40 of the CRC and section 36 the Nigerian constitution to a very large extent. But notwithstanding these provisions, widespread derogation by the police, judges and parents have been reported.

2.8 Rights of the child across Africa

The Afghanistan Independent Human Rights Commission (AIHRC) was enriched in the Bonn Agreement and established in accordance with a decree by Hamid Karzai, the then President of the Afghanistan Interim Authority. AIHRC works in 5 units (1) Women Rights Unit, (2) Child Rights Unit, (3) Monitoring and Investigation Unit, (4) Transitional Justice Unit and (5) Human Rights Education Unit. The 5-unit work is supported by the Media and Research and Policy Sections.

As mentioned above, the Child Rights Unit (CRU) is one of the AIHRCs fundamental working units and has conducted many activities in order to promote and protect child rights in the country. This Unit conducts its activities by using the following means:
1. Education
2. Research
3. Monitoring and investigation, and
4. Partnerships with other institutions.

In terms of protecting the rights of the child, one of the crucial areas is to give support to and rehabilitate those children who commit acts contrary to the law. Such a protection is necessary because child perpetrators need corrective and rehabilitative services to that the non-reoccurrence of the crime can be guaranteed in the future. Guided by Article 37 of the Convention on the Rights of the Child (CRC), AIHRC has prioritized the issue of monitoring the rights of child delinquents. The Commission undertakes regular observation on Child Correction and Rehabilitation Centres (CCRCs) in the capital Kabul and in the provinces. As a result of the Commission’s work, the situation in CCRCs has seen a relative improvement. In addition, AIHRC has sought to segregate children from adults in the detention places and has tried to promote donor interest in rebuilding CCRCs in war-devastated Afghanistan.

2.9 Rights of the Child in Nigeria

Nigeria is located on the coast of western Africa and has a surface of 923,768 square km. It is Africa’s most populous country with an estimated population of about 120 million, with an annual growth rate of 2.9%. The country consists of over 400 ethno-linguistic groups. The major languages spoken include Yoruba,
Ibo, Fulani, Hausa, Edo, Ibibio, Tiv, Efik, Nupe and Igala. Nigeria is a Federal Republic composed of 36 states and one Federal Capital Territory (Abuja). The states are further subdivided into 774 local government areas. For several years, Nigeria has been criticized for the human rights and children’s rights violations perpetuated on its territory. Nigeria ratified the Convention on the Rights of the Child (thereafter the CRC) on April 16th 1991 and has ratified other international instruments that generally affect the rights of the child. The Child Right’s Act 2003, passed into law in the Federal Capital Territory (Abuja), defines a child as a person who has not attained the age of eighteen years. However, according to Art 2 of Children and Young Persons Act, enacted in Eastern, Western and Northern regions (hereafter referred to as CYPA, a “child” means a person under the age of fourteen, while “a young person” means a person who has attained the age of fourteen years and is under the age of eighteen years” (CRC, 2003). The UN Child Rights perspective emphasizes four basic rights:

- **The right to life.**

- **Survival and development rights:** These include rights to adequate food, shelter, clean water, formal education, primary health care, leisure and recreation and cultural activities.

- **Protection rights:** These include protection from all forms of child abuse, neglect, exploitation and cruelty, war and abuse in the criminal justice system.
• **Participation rights**: These include freedom of expression on matters affecting their social, economic, religious, cultural and political life. The right to information and freedom of association.

Children have also been severely affected by the economic crises faced by the country in 1999, which has led to an increase in the number of children living in poverty or extreme poverty. Among other dangerous consequences, poverty made more children to live and/or work in the street and has increased their vulnerability to trafficking. Moreover, there is a severe lack of financial resources allocated to the protection and promotion of children’s rights. Consequently, mechanisms for protection and promotion of children remain “weak, uncoordinated and not in line with Nigeria’s obligations under the CRC, the African Charter on the Rights and Welfare of the Child and the UN Convention on the Elimination of all Forms of Discrimination Against Women”. According to (William, 2010), Nigeria’s efforts to meet the Millennium Development Goal 4, which is aimed at reducing neonatal deaths by two-thirds in 2015, with the neonatal deaths of 284,000 per annum, it is obvious that Nigeria has not made enough progress on MDG4. The country tops the list of neonatal deaths in Africa followed by Congo with 130,000.
**Policy on Rights of the Child**

The convention on the rights of the child agreed on the following:

1. Every child has the right to life and be allowed to survive and develop.
2. Every child is entitled to a name, family and nationality.
3. Every child is free to belong to an association or assembly according to law.
4. Every child has the right to express opinions and freely communicate them on any issue subject to restrictions under the law.
5. Every child is entitled to protection from any act that interferes with his or her freedom and reputation.
6. Every child is entitled to adequate rest; recreation (leisure and play) according to his or her age and culture.
7. Every child is entitled to good health, protection from illness and proper medical attention for survival, personal growth and development.
8. Every child (male or female) is entitled to receive compulsory basic education and equal opportunity for higher education depending on individual ability.
9. Every child must be protected from indecent and inhuman treatment through sexual exploitation, drug abuse, child labour, maltreatment and neglect.
No child should suffer any discrimination on account of ethnic origin, birth, colour, sex, language, religion, political and social beliefs, status or disability.

Nigeria became a signatory to the Convention on the Rights of the Child (CRC) in 1991, and the African Charter on the Rights and Welfare of the Child in 2001. The Child Right Act (CRA) was first drafted in 1993 and was adopted in 2003. As at the Children’s Day 2007, it has only been enacted into law in 24 states out of the 36 states of the Federation. Findings show that the convention has been incorporated into the national framework by legislative reform, including constitutional amendment in 50 countries (Bissel & Santos, 2006). Nigeria ought to legislate the CRA effectively to curb the violation of child’s right as the right of a child cannot be claimed in states that have not incorporated such acts. The education of the citizenry on human rights generally and child rights specially is quite imperative. The children need to know their rights, so they can become human right conscious. Parents need to know the rights of the child in order to respect them. Law enforcement officers need to know about child rights in order to stop confusing violations with domestic affairs. Government agencies need to know these rights to enable them to differentiate child right from child privileges and charity. Legislators too need to know these rights in order to have a reorientation on the rights of the child. Generally, human rights education will
enable us to build a culture of universality of human rights and will provide the legal atmosphere that Nigeria needs to promote and enforce child rights.

The protection and promotion of the rights of the child secures a future for such a child as well as the nation at large, and the way the right of a child is handled in a country shows what the future holds for such a child and nation. The rights of the Nigerian child is far from being respected as could be seen from the increase in the number of poor beggar children in Nigerian cities, the number of children without basic education, and the number of children in one form of servitude or the other which are on the increase.

The situation is not same with most civilized nations of the world. For instance, in Britain and United States of America, the law stipulates that parents must provide for their children such necessities of life as food, clothing, shelter, education, and medical care. If they cannot or will not, State laws authorize intervention by designated authorities to ensure that children’s needs are met. Children who are physically abused by their parents may be subject of legal action in order to protect the children. Parents’ right to custody of their children may be limited or, in extreme cases terminated because of failure to provide adequate care. Laws require a father to support his minor children if he is able to do so. Failure to provide support may result in civil or criminal proceedings against him. This cannot be said to be true of Nigeria where the rights of the child is being daily trampled upon.
2.10. Children in Conflict with the Law

According to human rights standards, children have the right to separate detention facilities and the punishments that are harmful to child’s physical and psychological health are prohibited. In order to establish juvenile justice has the grave responsibility to finalize juvenile cases in the shortest period of time. The judicial system should put the special necessities of children at the centre of its attention. Juvenile cases should be dealt in a confidential manner. Juvenile offenders have the right to be informed of the charges against them and the decisions that have been taken regarding their cases in the presence of their parents. Considering the nature of the crimes and the personal status of the criminals, the Penal Code has foreseen criminal procedures.

Juvenile delinquents should not be punished in a way that adult ones are. For this reason, the law has predicted the establishment of Especial Juvenile Courts (SJC.s) and the segregation of child offenders from adult ones. As a consequence, our country’s High Judicial Council agreed to form SJC.s in 1970. The courts are more of a disciplinary and rehabilitative nature than a penal one.

CCRCs are required to fulfil a number of conditions. It is overarching law that accused persons should be separated from the convicted ones. In the interim, there are minimum standards for the environment of juvenile detention sites. Juvenile delinquents should have access to a humane situation of living in CCRCs. There should be adequate doctors, psychologists and psychoanalysts to render
24-hour health service to children in juvenile detention places. Handcuffs, chains and other prison prevent instruments should not be used. Moreover, CCRCs should have libraries and recreational facilities. Juvenile detention centres should be very different from prisons and no practice of torture should be allowed in those centres as well as prisons. These detention centres should rehabilitate juvenile delinquents and prepare them for a community reunion. It is essential, therefore, to build CCRCs as part of a series of measures to rehabilitative offenders of child age.

Since children are at a stage growth, CCRCs-based juvenile delinquents should be physically, mentally, psychologically and socially developed. Education and vocational training opportunities should be provided to children in CCRCs. Varies approaches need to be applied to make child offenders to refrain from recommitting crimes in the future. Serious child offenders have to be segregated from those with minor offences. Juvenile delinquents abuse and degrading treatment should be banned.

There are several reasons why child offenders need especial detention facilities, separate from those for adult criminals. Child offenders may learn more dangerous crimes and more sophisticated anti-social techniques if they are detained together with adult offenders. This is substantial reason for the need to have segregated juvenile custody facilities.
In addition, mixed detention places will have negative impacts on juvenile delinquents and will avert their smooth rehabilitation and social reintegration. It is also essential if accused juvenile offenders can stay away with their parents on bail so that they can be kept away from detention places.

**In Nigeria**

Juvenile justice administration in the country is undertaken within and by three core criminal justice institutions—police, courts and prisons. In addition, the social welfare departments of the state and local governments also play important roles in juvenile justice administration. However, for very long, Nigeria laws on juvenile justice have not been reviewed and coordinated to reflect international rules and standards. Despite the recent adoption of the Child Rights Bill 2003, the Children and Young Persons Act (CYPA) and the description of the living conditions of children deprived of liberty will reveal the gap in the juvenile justice administration in Nigeria. Despite the recent adoption of the Child Rights Bill 2003, the CYPA remains the most important legislation in the country dealing with the treatment of juvenile offenders. It was enacted to make provision for the welfare of young persons, the treatment of young offenders and for the establishment of juvenile courts. Section 5 of CYPA enjoins “the Inspector General of Police to make arrangement for preventing so far as practicable, a child or young person (until the age of eighteen) while in custody, from associating with an adult charged with an offence” in line with art 37 © of the CRC.
However, in reality, this provision is not always enforced especially in police cells. Similarly, Nigerian prisons contain a large number of young offenders, who are often not separated from adult inmates (Annual Abstracts of Statistics published by Federal Office of Statistics).

Section 7 deals with the remand or committal to custody of juvenile offenders, and specifies the conditions of custody or remand. It provides that:

A court on remanding or committing for trial a child or young person who is not released on bail, shall instead of committing him to prison, commit him to custody in place of detention provided under this Ordinance and named in the commitment, to be there detained for the period for which he is remanded or until he is thence delivered in due course of law; (2) provided that in case of a young person it shall not be obligatory on the court so to commit him if the court certifies that he is of so unruly a character that he cannot be safely so committed, or that he is of so depraved a character that he is not a fit person to be so detained (emphasis added).

It will appear that the intent of the law is to ensure that young offenders are not detained in prisons, except in exceptional circumstances. However, in reality, inadequate remand centres, approved schools and Borstal institution led to the detention and imprisonment of young offenders in the prisons. Also, the law makes a distinction between the child and young person. For example, the detention of a child in prison is prohibited, while that of a young person is excused under exceptional circumstances.
The place of detention referred to in many sections of CYPA is remand homes, approved institutions including Borstal institutions and prisons. A native or local authority or a local government council with prior approval of competent authority “may establish remand homes and make rules for the management, upkeep and inspection of such homes” (section 15 (1)).

Section 15 (3) provides that:

Where no remand home is conveniently situated a child or young person ordered to be detained in a custody may be in the discretion of the officer or the court, as the case may be, be detained in an approved institution or in a prison: provided that if a child or young person be detained in a prison he shall not be allowed to associate with adult prisoners.

Nigerian authorities to immediately ensure that every child deprived of liberty is separated from adult inmates, in line with art. 37 © of the CRC. Existing specialized institutions for juvenile offenders must be improved and new ones established as a matter of urgency in all states of Nigeria.

Since the ratification of the United Nations Convention on the Rights of the Child (CRC), the AU Charter of the Rights and Welfare of the Child and other relevant international instruments, Nigeria has instituted various legislative and institutional measures at both the Federal and State levels, aimed at addressing various forms of violence against children; some recently enacted legislations include:
- The Child’s Right Act (CRA) 2003
- Trafficking in Persons (Prohibition) Law Enforcement and Administration Act 2003
- Ebonyi State Law No. 010 (2001) on the Abolition of Harmful Traditional Practices Against Children and Women; among others.

The CRA 2003 under Sections 21-40 provides for the protection of children against discriminatory, harmful and exploitative practices. These include the prohibition of child marriage, child betrothal, infliction of skin marks, abduction, forced, exploitative, and hazardous child labour, child hawking, begging for alms, prostitution, unlawful sexual intercourse and other forms of sexual abuse and exploitation prejudicial to the welfare of the child. The CRA further prohibits recruitment of children into the Armed Forces of Nigeria, and importation of harmful publication which portray information on commission of crimes, acts of violence, obscene, immoral and indecent publications which tend to corrupt or deprave a child.

The CRA 2003, provides for the family courts which will operate at the High Court and Magisterial levels, and have been vested with the jurisdiction to hear all cases in which the existence of a legal right, power, duty, liability, privilege, interest, obligation or claim in respect of a child is in issue, or any criminal proceedings relating to any offence committed by a child. (Part 1, No. 13)(2004).

Under the various Criminal and Penal Codes as well as the Children and Young Persons Laws, children in conflict with the law or juvenile offenders are liable to
various forms of punishment ranging from committal to remand homes or Borstal training homes for vocational training, rehabilitation and reformation programmes before release. This depends on the nature and gravity of the offence in question.

2.11 Parents Socialization of Children and the effects of deprivation

Parents play a very fundamental role in the socialization of their children. Socialization includes all of one’s tendencies to establish and maintain relationships with others, to become an accepted member of the society at large, to regulate one’s behaviour according to society’s codes and standards, and generally to get along well with other people. This ensures the integration of the individual into society as a respected participant. Osarenren (1996), posits that children get socialized through their family members and significant others and that it begins early in life and is a lifelong process. The effects of children’s deprivation can have damaging effect on the overall development of the child. Providing stable and nurturing families can bolster the resilience of children in care and ameliorate negative impacts on their developmental outcomes.

Eloise (2005) asserts, “Most of the children found in remand homes were products of broken homes who enjoy little or no protection from their parents ‘as a result they take anything the society offers them, thereby ending up as nuisance to the society. He lamented the situation whereby parents abandoned their children to the mercy of housemaids while the television has become their
referral point instead of their parents. Repeated separation during very early stages of life is a stressful emotional experience, which includes a variety of neuronal and synaptic changes in limb cortical areas that may be related to behavioural alterations (Braun, Kremz, Wetzel, Wagner & Poeggel (2003). According to Hotz (2002), researchers in New Orleans USA reported that parental care makes such a lasting impression on an infant that maternal separation or neglect can profoundly affect the brains biochemistry, with lifelong consequences for growth and mental ability.

Children brought up without being regularly hugged, caressed or stroked, “deprived of the physical reassurance of normal family attention,” have abnormally high level of stress hormones. One psychosocial factor unique to children is that they are developing. Children do not develop in isolation; the family is essential in providing the sense of self-esteem, security and identity that is necessary for the child to successfully learn from and fit into the rest of society. The emotional well-being of children is influenced by the protection and care they received from their families and communities (United Nations High Commissioner for Refugees, 1994). Despite government efforts, labour, political, and other problems plague Nigerian’s educational system. Many children go without any formal education. Parents are often forced to remove children from school for economic reasons. There are credible reports that poor families often sell their daughters into marriage as a means of supplementing their incomes.
(Daley, 2009). The First Lady of Nigeria, Hajija Tuari Yar’dua challenged parents to shape the lives of children as future leaders especially those who have been inflicted with one form of social vice or another at tender age (Okon, 2008).

Maternal deprivation has been operationally defined as the absence of a positive and continuous relationship between infant and mother or mother surrogate (Evoy, 1983). To Bowlby (1951) maternal deprivation is a state of affairs in which the child lacks warm, intimate and continuous relationship with his mother (or permanent mother substitute, which gives rise to later acute conflicts in love relations.

Providing stable and nurturing families can bolster the resilience of children in care and ameliorate negative impacts on their developmental outcomes (Harden, 2004). Protecting and nurturing the young is a universal goal across human cultures. Research confirms the importance of the family unit as the provider of safe, stable and nurturing environments for children. Unquestionably, children who are reared in safe and stable environments have better short and long-term adjustment than children who are exposed to harmful experiences. Children exposed to highly unstable environments are likely to experience developmental difficulties.

Psychosocial problems are the commonest chronic conditions for primary care of children not living with their parents (McInerny, 2001). Homeless children face difficulties such as depression, low self-esteem, feelings of shame and embarrassment. Problems such as anxiety, low motivation, low energy and underachievement are attributable to low self-esteem (Loner 1999; Bien-Aime 1995; Tanksley 1994; Goins and Cesarone, 1993). Many institutionalized children suffer psychological damage, are less sociable and develop poor work adjustment. Children brought up in Correctional Centres also show more personality and behavioural problems (Ahmad and Mohammed 1996, Hodges, Jensen 1987, Skeels and Kirk, 1987 & Smart 2000).

Aitken (1993), describes children in foster care or in institutions as being in “limbo”. This he defined as: “a prolonged period of separation of a child from nurturing parents, a period in which there is persistent confusion or uncertainty about future plans, parental authority, family relationships, and past history.

According to Hotz (2002), children who are maternally deprived are withdrawn, apathetic, slow to learn and prone to chronic illness. Prolonged neglect can warp the brains developing neural circuits so that they produce too much or too little of the hormones that control responses to stress causing permanent changes in the way an organism behaves and responds to the world around it. In infants, high levels stress can impart growth and development of the brain and body. In
animal studies, the presence of the mother ensures that the stress hormones remain at a low level.

The greatest terror a child can have is that he is not loved and rejection is the hell he fears. With rejection comes anger and with anger some kind of crime in revenge for the rejection and with the crime guilt (Evoy, 1983).

To Steinhaur (1991), negative self-image, antisocial behaviour and chronic dependency are long lasting effects of prolonged limbo. Anna Freud, after a study of the problem of child separation (Freud & Burlingame, 1944) concluded that institutionalized children were doomed to fail psychologically as a result of maternal deprivation. This was despite good physical and social care.

A number of the rejected adults recall that physical separations from parents, particularly mothers, had been deeply hurtful to them, irrespective of motive. They had later come to identify this experience as the feeling that they had been rejected. In addition, where prolonged—even if it included periodic visits by the mother—there was a counter-rejection of the mother by the child no matter how reasonable the grounds for the parents absence, it appears that the separation as almost invariably experienced as rejection (Evoy, 1983).

Belsky (2003) reported that aggression, disobedience and assertiveness increased alongside the amount of time in non-maternal care. Evoy (1983) found that rejection was no respecter of creed, sex, social class, intelligence, education or race or any other such consideration. It is a tragic fact in the lives of many.
Disregarding it does not make it go away. It is deeply destructive human experience. Underlying the individual variations in their responses to it, the rejected people reported certain discernible, unwholesome, psychological patterns left in the trail of parental rejection.

According to Eberstadt (2004), institutional care makes children more aggressive. The more time children spent in any non-maternal care arrangement across the first five years of life, the more externalizing problems and conflict they manifested in kindergarten classes. To her, more time in care not only predicted problem behaviour measured on a continuous scale but also predicted at-risk levels of problem behaviour, as well as assertiveness, disobedience and aggression.

The impact of institutional care on children was extensively investigated during World War II. Many English children were separated from their parents and sent to residential nurseries in rural away from the bombings in the cities. Despite relative good living conditions, the separated children suffered from feelings of not being wanted and from being deprived of maternal affection (Freud, Solnit & Goldstein, 1973). There is an immediate emotional and behavioural importance to most children and adolescents of having their parents being there for them (Eberstadt, 2004).
Based on European and United States of American findings, Bowlby (1951) concluded that institutional childcare was in a terrible state. In many cases, the physical care of children was inadequate. According to him, the psychological damage which institutionalized children suffer despite good physical care was even more serious. To him, the cause was disruptive of the special mother-child bond (due to institutionalization) needed for healthy psychological development. According to him, children deprived of maternal contact and affection early in life, were seriously damaged emotionally.

In Mumbai, Ajay Suryawanashi, tortured in a juvenile home, will showcase plight of children like him in his movie Remand Home. Ajay Suryawanashi (24) experienced hell for more than ten years. The boy from Satara lived in a cramped room along with 150 boys and girls in a remand home, was sexually abused, wore unwashed clothes and lived without food for days. Though that nightmare is now over, Suryawanashi wants to replicate it on celluloid. He has produced a film, Remand Home, which will showcase the plight of children living in juvenile homes and the trauma associated with it even when you leave the place. At the Satara remand home, we got food with dirt in it and there were no books to study. I wanted to study, but never got a chance. My friend has completed his Masters, but can’t get a job because he does not have a nation card or any residential proof. He only has a certificate stating the number of years he spent in the remand home. There is an impression among people that kids living in remand homes are thieves. This is what my movie will project explained
Suryawanashi, who now lives in Chembur. Ajay Suryawanashi does not remember how he landed in the remand home. He only knows the police brought him there when he was in Std 1 and had a harrowing experience. Social worker Raju Sontakkle and a film producer came to his rescue. Suryawanashi who now runs a local newspaper in Chembur, has no clue about his family. Another case of condition of young offenders in remand homes was captured by Koen of Innocent Kirungi. Innocent Kirungi was fourteen when he was murdered. Over several years, the young boy had taken to running away from home, living rough on the streets and stealing. In early December 2009, his father, at loss with how to reform his ways and deeply concerned about his son’s well-being, appealed to the local authorities, with whom he decided to take his child to the district remand home in order for him to be rehabilitated. On his second day at Ihungu Remand Home, Innocent was taken with other children to work on the potato plantation of police officer David Abitekaniza. Not accustomed to hard labour, Innocent found himself lagging behind other boys, for which the matron, Rose Mpairwe, ordered them to beat him. They beat him so severely that he was rendered unconscious. Then, on the matron’s orders, they began to bury him alive. Fortunately, several witnesses ran to alert the local authorities, who came to the site and ordered for the boy to be exhumed. He was still alive and was taken back to the remand home. Later that day, Abitekaniza came and threatened the local council leaders, saying that he would arrest them for criminal trespass (after they had come on his property to exhume the boy). The
next day, the children were once again taken to work on Abitekaniza’s property. There Innocent was beaten once again. A girl went to the local council leaders to alert them, but this time they were too afraid to intervene because they feared Abitekaniza. Innocent died hours later due to complications from the beatings.

Ironically, Innocent’s father, Patrick Wandera, originally agreed to refer his son to the remand home as a last resort, for fear that if he continued his rough lifestyle, he would be “killed by errant people on the street”. Instead the very institution Wandera thought would protect his son from harm managed to take his life after only three days.

The rights of the child- Innocent’s story is a horrifying example of the disregard for children’s rights that has prevailed in the Ihungu remand home in Uganda. Indeed, upon investigation, it was revealed that the remand home has been sending children to work on people’s farms since 2005. Some of the authorities at the remand home justified that the boys were doing this work because they required money to buy food or blankets, which they needed at the remand home.

In Innocent’s case, there seems to have been a mistake in referring the child to a remand home. As noted by the probation officer, Mugisha Mugungu Milton, remand homes are only for children who have committed offences, yet Innocent was not in conflict with the law. The children’s Act of 1997 outlines very clearly the steps that are to be taken in a case like Innocent’s. On the application of a
probation officer or an authorized person, a family and children’s court can make a “care order” whereby the child is sent to an “approved home” which “shall provide substitute family care for a child until such a time as the parents of the child are able to provide adequate care to meet his or her needs”.

Innocent’s father has however showed himself exceptionally motivated in bringing his son’s story into the public eye. The Platform for Labour Action (PLA) responded to Mr. Wandera’s call over the son’s untimely death, they also organized and are now spear-heading a coalition of NGOs including Defence for Children and the African Network for the Prevention and Protection against Child Abuse and Neglect (ANPPCAN), who are prepared to advocate for better conditions in all remand homes in the country. At its own expense, PLA took a trip up to Masindi for a fact-finding mission so as to clarify the details and circumstances of Innocent’s death. PLA is now suing police officer Abitekaniza, the owner of the land on which the boys were working, as well as the matron and the several other local authorities involved in the case.

PLA’s Anita Marie Kiddu, legal officer, explained that the case caught their attention because it involved child labour, a crime that PLA has a mandate to fight against. She stated: “we are trying to sensitize people to stop using child labour”. In this specific case, she reminded us that “even if they are inmates they are still children” and thus they are still protected by laws against child labour. “Indeed, “she added, “what happened here is tantamount to forced labour, as the children were inmates and had no choice over their actions”. Had the children
not been working on the farm, Innocent would not have been beaten, and perhaps would still be alive. Kiddu hopes this case will act as a deterrent against others using children for exploitative labour and will set a precedent for future cases. “It will be a huge step we have taken and something in place which will deter others”. For Wandera, “my son died like Jesus Christ, he died on behalf of many children in remand homes”. He believes that his son’s death can be useful if it instigates a closer look at remand homes, and in particular, remand homes at the district level, and their disrespect of children’s basic rights. At Innocent’s funeral, Wandera noted that several families came out to testify of having lost their own children at the remand home and having been told by officials that their sons had escaped. Had Innocent’s first hasty burial not been spotted by passer-bys and his body not exhumed, perhaps he too would have been officially recorded as having “escaped”. This begs the question; How many other cases like Innocent’s are unknown? How many other children have been forced to work, beaten or even killed while living in an institution meant to protect them?

Mackey gave an insight of what happens in Scottish care homes. Former Glasgow borstal at the centre of the latest child abuse scandal. On the eve of a watershed government report explaining why children in Scottish care homes from 1950s until the 1990s were allowed to be sexually abused, the Sunday Herald has uncovered yet another disturbing scandal. It centres on the sexual assault of children that lasted for decades in government-run Scottish remand homes and assessment centres- the country equivalent of borstals. Although children were
abused at a number of borstal –type institutions in Scotland, the worst site appears to be a former Glasgow borstal called Larchgrove. The details are coming to light just as the Scottish Executive is preparing to publish the Historical Abuse Review, which is meant to draw a line under a series of shocking revelations about sex abuse in care homes run by independent organizations such as the Catholic Church and charities such as Quarriers.

Des- not his real name – was put in Larchgrove 27 years ago as a boy. He was detained for playing truant from school to avoid bullying. “I was in there between 1978 and 1979,” he told Sunday Herald. “The sexual and physical abuse was terrible. This was perpetrated both by staff- although not all of them- and also people who did not work there. “I complained at the time, ran away and was dragged back screaming. Nothing was ever done. I still wake up screaming, sweat running off me, because of the abuse I suffered.” Des said he ended up a heroin addict through using drugs to “block out all the pain and abuse I suffered there”. He’s now been clean for six years and is happily married. He was the first of many people spoken to by the Sunday Herald who confirmed the routine of abuse of children at Larchgrove. Reg McKay, a former director of social work who is now a best-selling crime writer, said he was aware of the abuse of children at Larchgrove from the beginning of his career. McKay was the social worker for three teenage boys who were locked up in Larchgrove. In 1976 they told him that they had witnessed other suffering from sexual abuse at the hands of both males and female staff. “There children were not bad boys,” said McKay. “There
were deeply disturbed – from dysfunctional homes. They had some very serious personal problems and were at risk of turning to offending or falling into drug misuse. One boy told McKay that the most dangerous time in Larchgrove was just after lights-out when the boys were put to bed. The boys were housed in small dorms holding six to eight beds. Staff would sometimes call boys from their beds. Often this was for valid reasons, such as administering medicine, but at other times it was simply to abuse them.’

McKay says that on some occasions female staff took the children from their beds to be abused. The women provided the children with a false sense of security, ensuring that they did not panic or scream on their way to be abused. The women were “either standing by or taking part” in acts of abuse, McKay added. “I knew this was happening back then as I heard the allegations personally,” said McKay. The children trusted me and had no reason to lie. When I reported the allegations to management, I expected a full investigation to take place for the sake of the boys who were being abused. It was our duty to protect these children and we clearly failed them. I went on to report what I was being told up the chain of command. I raised the allegations with senior members of social work staff. As far as I know there were at least three internal investigations, but nothing happened. There were no sackings, no charges- nothing. To be blunt, many of the homes where children were kept in those days were worse than something out of Oliver Twist. I can even remember staff taking money from children. These were children who had nothing in the first place. McKay says that
he recalls the same allegations resurfacing about Larchgrove in the 1980s. Allegations of child sex abuse were being made against many similar institutions at the time. As far as I know, nothing was done about these claims either. McKay says that some managers “hated” him for reporting allegations of abuse and demanding investigations. Many social workers found themselves in the same position: raising concerns and allegations with management then having no power to ensure the right action was taken he added. It was bloody frustrating—especially when you or a colleague went back to the same institution a year or two later and heard similar allegations. Later, as McKay’s career as a social worker progressed, he led two investigations into allegations of sexual abuse at Kerelaw—another institution for detaining children who had broken the law. Glasgow City Council also ran this facility for vulnerable children. Kerelaw closed last year amid allegations of abuse. Glasglow City Council admitted that 40 of its employees had been alleged to have been involved in the sexual or physical abuse of children at the home. The council also said that some of those suspected of abusing children at Kerelaw were still working with children in care.

At the end of his investigations into abuse allegations at Kerelaw in the 1980s, McKay recommended that the claims be passed to the police immediately and that those accused of assaulting children be suspended with no pay. Once again, nothing happened, he said. And once again, I have no idea why. Frank Doherty, founder of the Scottish organization In Care Abuse Survivors (Incas), was sent to Larchgrove for 28 days in the late 1950s. He’d previously been in the notorious
Smyllum orphanage in Lanarkshire where many children were abused. He used two words to sum up his memories of Larchgrove: “Getting battered.” Dorherty was sent to Larchgrove for “petty criminality”, he said. The physical abuse he suffered at Smyllum had left him a mental wreck so he was in no state to withstand the violence at Larchgrove. Going into Larchgrove after being in Smyllum set me back years as I’d already been battered and tortured. Larchgrove was just another smyllum. I saw regular physical violence in Larchgrove and I was often on the receiving end of it.

Tommy “TC” Campbell was another child inmate at Larchgrove. He knew boys who were abused and spoke of warders trying—but failing—to sexually abuse him. Campbell was wrongly jailed for life for the death of six members of one family in a firebug attack during Glasgow’s infamous “ice cream wars”. He was jailed in 1984 and his conviction was not quashed until 20 years later. Campbell has always admitted that he was a tearaway as a teenager. He ended up in Larchgrove borstal in the mid-1960s aged 14 for truanting, trespassing and stealing eight pence. Everything was brutal. The staff was just like screws, he said. They thought nothing about giving you a wallop (a heavy powerful hit). There were also a few child molesters among them. It was common for boys who misbehaved to have their trousers pulled down before being beaten with a cane on their backsides. Campbell says he knew of a number of boys who were sexually abused. He also named one warder who preyed on the weakest boys in the borstal (a type of prison for young criminals). The warder would single out
bed-wetters and other vulnerable children, believing they were less likely to inform or resist. They will target the weak ones, he said. They would not go for the boys who were rebels or who were tougher lads as they would not stand for it. They would go for the ones with no mum and dad—the ones who were in there for care and protection. It was a terrifying place. You will see boys in total terror—crying and withdrawn.

Campbell said that at the beginning of his time in Larchgrove there were attempts made to sexually abuse him. Three different warders tried it with me, he said but they realized very rapidly that I was not one to try it with. Campbell later butted a warden for physically assaulting him. The whole place was mentally and psychologically oppressive. We were starving all the time—there were fights over a slice of bread. Campbell says that the children were even fed tins of pet food. It was like Colditz. Boys were always plotting ways of escaping, although you would be badly beaten for trying. Many boys were deliberately disruptive because they hoped they would be transferred to an adult jail and get away from the abuse at Larchgrove. Tom Shaw, who is heading up an independent review of historic abuse for the Scottish government, said his report—due out shortly—investigated the flaws in the care system that allowed paedophiles (people sexually attracted to children) to abuse them.

In Uganda, Milbrant and Pepperdine law alumnus Ray Boucher, along with Associate Dean Jim Gash and alumnus David Barrett, spent time with the children at the remand home as part of an operation they called Project Masindi. Their
mission was to gather the details surrounding the children’s’ cases and summarize them in a series of reports, hoping to facilitate the scheduling of trial dates for the children. Because of their work, many of the children have already had their hearings and been released from the remand homes. The children were charged with a number of different crimes, ranging from petty theft to statutory rape to murder. When Milbrandt, Gash, Boucher and Barrett began to evaluate the evidence against the prisoners, however, it was clear that many of them were innocent. In Uganda, one accusation is enough to warrant an arrest. Because the country’s criminal justice system does not have the court staff or resources to keep up with its number of cases, prisoners will often wait for years before they get a hearing. All you have to do is to be accused of something, and you rot for a long time. Gash said. In U.S., you are out (of jail) that night. You get a lawyer, and you get probation. There, you just sit. On the first day, the magistrate judge asked the boys if any of them spoke English. Only two, a pair of 16-year-old brothers named Henry and Joseph, raised their hands. They were assigned to be interpreters. My assumptions were that everybody (at the remand home) spoke English, said Jim Gash, associate dean for student life at the School of Law. “So the initial reaction was ‘We have a bigger job ahead of us than we thought’.

Henry and Joseph had been at the remand home for 20 months when Gash and Barrett interviewed them. They were accused of beating a man to death, although the police report revealed they had been in school at the time of the
murder. It was also clear from the interviews that these boys were extraordinarily gifted, Gash said. Prior to their arrest, they had attended an advanced school with scholarships from the Ugandan government. In December, the female police officer who monitored the remand home was arrested, which left the children without any adult supervision. The local government put Henry in charge, giving him a cell phone, a set of keys and instructions to lock himself and the other kids in each day. He became the leader of the remand home, dutifully carrying out his responsibilities while making sure the other children were safe. “It was otherworldly,” Gash said. If the kids tried to flee, Milbrandt explained, they would be killed by nearby villagers, who would see them as escaped prisoners first and children second. That’s the mob justice mentality out in the bush-criminals do not last very long, Milbrandt said.

The group also interviewed a 17-year-old girl named Scovia, who had been at the remand home for five months because she was charged with murdering her two-week-old baby. With Henry interpreting, Scovia claimed her baby girl had died of natural causes. During the interview, Scovia spoke in quiet tones and would often have to be asked to repeat herself, Gash said. She appeared to be sad, hopeless and still in mourning. She kept saying, “I did not kill my baby, I love my baby.”

The court file confirmed she was telling the truth. Shortly after she became pregnant, Scovia moved in with her grandmother, who was an alcoholic. On the night she gave birth, Scovia was alone at the house. She sat on the ground,
cradling her newborn baby for several hours before her grandmother returned home and cut the umbilical cord. Scovia named the baby Kirabo, which means “gift.” Kirabo began to vomit soon after she was born, so Scovia asked her grandmother for money to take her baby to the hospital. Her grandmother refused, saying the vomiting was normal and that Kirabo would be fine. Two weeks later, while the grandmother was out drinking, Kirabo died. The grandmother told the police that Scovia murdered her baby. She did not kill her baby, Gash said. That was clear from our conversation, and even clearer from the court file. There was not any reason to believe this baby died from anything other than being a sick two-week-old that was not getting medical attention.

Not all the children were innocent, however, and some confessed they had committed the crimes they were charged with. But many of them had been at the remand home for longer than the sentences of their alleged crimes. One boy, for example had served six months for stealing $40 and a tin of bubblegum.

Boucher said the prisoners were initially distrustful, but “by the end, they were smiling, and you knew that they were beginning to trust somebody for the first time in months, if not years”, Boucher said.

Orphans and vulnerable children often suffer from severe psychosocial problems. These children may be increasingly disadvantaged although not intentionally, because older guardian are less able to provide disciple and adequate socialization or even to address the basic needs like food, clothing, shelter and
health care, all of which have got psychosocial impact on them. Psychosocial disturbances among orphans have the potential of affecting their outlook towards the whole concept of life if no effective interventions are put in place.

A number of cases were recorded in the literature of young children who when forced to acknowledge unmistakable parental rejection, manifested psychotic or even autistic behaviour. The rejected usually managed somehow to delay the clear open recognition finally occurred, it was both a surprising and exceedingly painful experience---in fact some reported it as catastrophic. A substantial number of the rejected reported that after they had finally recognized their rejection for years, they unknowingly employed one or more psychological devices to protect themselves from the unlovely realization that they had been rejected.

Many adolescents who are under very difficult situation in life and others who suffer permanent developmental delays or disruptions exhibit resiliency. Resilience embraces the ability of a child to deal more effectively with stress and pressure, to cope with everyday challenges to bounce back from disappointments, adversity and trauma to develop clear and realistic goals to solve problems to relate comfortably to others and to treat oneself and others with respect.

Investigations show that child offenders in Kabul centre have complained because they are having the same food every day. Child offenders may face
nutrition problems in these cases. Children are at a stage of physical development and the food they have in CCRCs should contain calories for the smooth physical growth. It is, therefore, essential that the total allocated money per child offender should completely be spent.

It is very important to detain child delinquents in CCRCs with consideration to the nature of the crimes they have committed. Minor juvenile delinquents should be separated from those with serious and repeated offences. Many child offenders with different crimes including theft, murder, adultery, and sodomy and traffic mishaps have been detained at the same CCRCs, something that can have negative psychological impacts on minor child offenders. There is a situation in some CCRCs that not only rehabilitates child offenders but also lead them to commit more serious crimes.

The non-existence of forensic medicine in the provinces is a fundamental problem. Juvenile delinquents are sent to the detention centres so that their age can be established. This causes a delay in the judicial procedure and can put negative effects on the child offenders. The non-existence of experienced teachers and tutors is one of the reasons why juvenile delinquents are not rehabilitated in a good manner. CCRCs teachers do not have the qualifications required for juvenile offender rehabilitation. Juvenile offenders from two different age groups (child offenders and adolescent ones) are held at the same detention places and the authorize say that the co-detention is because of lack of accommodation for the delinquents. The lack of recreational facilities is causing
CCRCs a big difficulty. Some provincial CCRCs use handcuffs and chains after the arrest of the child offenders. In Baghlan, Chains are used to rehabilitate juvenile criminals. In addition, investigations indicate that child offenders are humiliated in Kabul CCRC by professors at the dormitory.

2.13 Cognitive Behaviour Therapy

This is a combination of treatment procedures aimed at identifying and modifying faulty thought processes, attitudes and attributions, and problem behaviours (Barlow and Durand, 1999). It is a blend of two very effective kinds of psychotherapy- Cognitive Therapy and Behaviour Therapy. The combination provides one with very powerful tools for stopping symptoms and getting one’s life on a more satisfying track. Cognitive Behaviour Therapy is based on the belief that the only access to our moods and emotions are the cognitive and behavioural routes (Bush, 2006). It is a form of psychotherapy that emphasizes the important role of thinking in how we feel and what we do.

Cognitive behaviour therapists teach that it is our thinking that causes us to feel and act the way we do. Therefore, if we are experiencing unwanted feelings and behaviours, it is important to identify the thinking that is causing the feelings/behaviours and to learn how to replace this thinking with thoughts that lead to more desirable reactions. There are several approaches to cognitive behavioural therapy, including Rational Emotive Therapy and Behaviour Therapy. For this
study, cognitive behaviour therapy is known as a blend of cognitive and behaviour therapies. The cognitive part of the therapy refers to thinking or learning and it is the part of therapy that can be “taught” to the person in need of behaviour modification. The person then needs to take what has been taught, practice it at home, and through repetition, get that new “learning i.e. understanding” down into the mind over and over again so that it becomes automatic or habitual. This is essentially the same as school or college learning. The student is taught some new information or skills, and then they learn. When they learn them (through repetition), this affects the memory processes (and physiologically the brain’s neural pathways) which allows the student to begin thinking, acting, and feeling differently. This takes persistence, practice, and patience, but when a person sticks with this therapy, and does not give up, noticeable progress begins to occur.

The behavioural component of CBT involves participation in an active, structured therapy group, consisting of people with clinical social anxiety. In the behavioural group, people voluntarily engage in practical activities that are mildly anxiety-causing, and proceed in a flexible, steady, scheduled manner. By moving forward in this manner, step by step, and through the use of repetition, the anxiety felt in social situations is gradually reduced.

Meek (2008) alleges that the hallmark of CBT is an intense focus on thought processes and belief systems. The overall goals of the approach are to help
people identify problematic beliefs and thought patterns, which are often irrational or unrealistic, and replace them with more rational and realistic views.

**Characteristics of Cognitive Behaviour Therapy**

1. Cognitive Behaviour Therapy is considered among the fastest in terms of result obtained. What enables Cognitive Behaviour Therapy to be brief are its highly instructional nature and the fact that it makes use of homework assignments.

2. Cognitive Behavioural Therapy is based on the scientific fact that our thoughts cause our feelings and behaviours, not external things, like people, situations, and events. The benefit of this fact is that we can change the way we think to feel/act better if the situation does not change.

3. Cognitive Behavioural therapists believe that it is important to have a good, trusting relationship, but that is not enough. To them, clients change when they learn to think differently; therefore, cognitive behaviour therapy therapists focus on teaching rational self-counselling skills.

4. Cognitive Behaviour Therapy is a collaboration effort between the therapist and the client. Cognitive behaviour therapists seek to learn what their clients want out of life (their goals) and then help them achieve those goals. The therapist’s role is to listen, teach and encourage while client’s role is to express concerns, learn, and implement that learning.

5. Cognitive Behaviour Therapy is associated with stoic philosophy. It teaches the benefits of feeling, at worst, calm when confronted with undesirable
situations. It also emphasizes the fact that we have our undesirable situations. It also emphasizes the fact that we have our undesirable situations whether we are upset about them or not. If we are upset about our problems, we have two problems- the problem, and our upset about it.

6. Cognitive Behaviour Therapy uses the Socratic Method. The cognitive behaviour therapist wants to gain a very good understanding of their clients’ concerns. That’s why they often ask questions. They also encourage their clients to ask questions of themselves, like “how do I really know that those people are laughing at me?” Could they be laughing about something else?”

7. Cognitive Behaviour Therapy is structured and directive. The cognitive behaviour therapists have a specific agenda for each session. Specific techniques/concepts are taught during each session. The therapy focuses on helping the client achieve the goals they have set. Cognitive Behaviour Therapy is directive but the therapists do not tell their clients what to do- rather teach their clients how to do.

8. Cognitive Behaviour Therapy is based on an educational model. It is based on the scientifically supported assumption that most emotional and behavioural reactions are learned. Therefore, the goal of therapy is to help clients unlearn unwanted reactions and to learn a new way of reacting. The educational emphasis of Cognitive Behaviour Therapy has an additional benefit-it leads to long-term results. When people understand how and why
they are doing well, they can continue doing what they are doing to make themselves well.

9. Cognitive Behaviour Therapy and techniques rely on the inductive method. The inductive method encourages us to look at our thoughts as being hypotheses that can be questioned and tested. If we find that our hypotheses are incorrect (because we have new information), then we can change our thinking to be in line with how the situation really is.

10. Homework is a central feature of Cognitive Behaviour Therapy. Goal achievement (if obtained) could take a very long time if all a person does is to think about the techniques and topics taught for one hour per week. For effectiveness, cognitive behaviour therapists assign reading assignments and encourage their clients to practice the techniques learned (Omrod, 1999).

Cognitive Behaviour Therapy is a present centred and forward looking therapy. It involves the use of cognitive and behavioural strategies. These two strategies taken together create a balanced approach to understanding and treating common life-problem.

Cognitive Behaviour Therapy CBT is a combination or “pulling together” of any and all methods, strategies, and techniques that work to help people successfully overcome their particular emotional problems. Some psychologists use the phrase, cognitive – behaviour therapy and others simply call this approach cognitive therapy. In practice, both cognitive and behavioural techniques are used together. Once upon a time, behaviour therapy did not pay attention to
cognitions, such as perceptions, evaluations or expectations. Behaviour therapy only studied behaviour that could be observed and measured. But, psychology is a science, studying human thoughts, emotions and behaviour. Scientific research has found that perceptions, expectations, values, attitudes, personal evaluations of self and others, fears, desires, etc. are all human experiences that affect behaviour. Also, our behaviour, and the behaviour of others, affect all of those cognitive experiences as well.

The cognitive part of the therapy refers to thinking or learning and is the part of therapy that can be “taught” to the person. The person then needs to take what has been taught practice it at home, and through means of repetition, get that new “learning” down into the brain over and over again so that it becomes automatic or habitual. This is essentially the same as school or college learning. You are taught some new information or skills, and then you learn them. When you learn them well enough (through repetition), this affects your memory processes (and physiologically your brain’s neural pathways) and allows you to begin thinking, acting, and feeling differently. This takes persistence, practice, and patience, but when a person sticks with this therapy, and does not give up, noticeable progress begins to occur.

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Meek (2008) alleges that the hallmark of CBT is an intense focus on thought processes and belief systems. The overall goals of the approach are to help people identify problematic beliefs and thought patterns, which are often irrational or unrealistic, and replace them with a more rational and realistic views. This is generally accomplished in a supportive environment that can often feel like a classroom, with the treatment professional assigning homework, highlighting concepts, and helping the client through a path of self-discovery and change. CBT is most often associated with Aaron Beck and Albert Ellis, who have slightly different views on treatment.

**Cognitive Distortions**

Typically, one of the first tasks of the client is to learn to identify certain types of problematic thoughts called “cognitive distortions”. These are systematic ways that people can twist and distort information coming in from the environment that can significantly increase anxiety and reduce coping resources. Theoretically, if a person is able to identify when he/she is using these, and able to replace them with a more realistic view, then anxiety is reduced.
Schemas

A schema is another important concept in CBT. Essentially, a schema is a network of information that dictates how people think about things and interpret the world. There are schemas for everything: computer, freedom, anxiety, and self. Longer term work in CBT is focused on changing schema, which are at the core of one’s belief system. An important part of this process is identifying “automatic thoughts”, which are thoughts that occur instantly when thinking about something. For example, if someone had significant anxiety around public speaking, simply thinking about it can trigger “embarrassment”, “fear”, or “failure” or a previous experience. Working to change automatic thoughts and creating more accurate and positive networks of information can take a significant amount of time, but often result in long term reductions in anxiety.

Research Support

Finally, one of the main reasons CBT has become so popular is because of how much research has demonstrated its effectiveness. There are a large number of well constructed experiments that have shown it to be highly useful in treating depression and anxiety disorders, including GAD. The key factors for it to be useful are buying in to the belief that it will help, completing relevant assignments, and a willingness to confront uncomfortable thoughts. Although many CBT techniques can be difficult to do at first, for most people the remission of GAD is well worth the struggle (Beck, 1995).
The cognitive part of the therapy refers to thinking or learning and it is the part of therapy that can be “taught” to the person in need of behaviour modification. The person then needs to take what has been taught, practice it at home, and through repetition, get that new “learning i.e. understanding” down into the mind over and over again so that it becomes automatic or habitual. This is essentially the same as school or college learning. The student is taught some new information or skills, and then they learn. When they learn them (through repetition), this affects the memory processes (and physiologically the brain’s neural pathways) which allows the student to begin thinking, acting, and feeling differently. This takes persistence, practice, and patience, but when a person sticks with this therapy, and does not give up, noticeable progress begins to occur.

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2.14 Aggression

There is little doubt that aggression was an adaptive behaviour for many of our ancient ancestors who lived in small groups. Male used aggression to gain access to female, food, shelter, and other resources. Female used aggression to defend their offspring and gain resources for them. Thus, the most aggressive individuals in our evolutionary past were at one time the ones were most likely to pass on their genes to subsequent generations. As humans became more social, however, aggression towards others in the social group on which one’s survival depended became less adaptive and prosocial genes became common.

Aggression today, in fact, seems maladaptive and destructive. Aggressive breeds aggressive, and seems to cause more problems than it solves. Even if it works in the short run, it fails in the long run. Most social psychologists today are interested in understanding why people become aggressive, what factors influence aggression, and how to reduce it.

Aggression Defined

The scientific study of aggressive behaviour was hampered for years because of different understandings of the word “aggression.” Aggressive toddlers are generally considered bad. However, in sports and in business, the term “aggressive” is frequently given a position connotation as a trait to be admired. Consequently, one of the first steps scientists had to undertake was to define aggressive behaviour clearly as a negative social behaviour.
In social psychology, the term aggression is generally defined as any behaviour that is intended to harm another person who does not want to be harmed (e.g. Baron & Richardson, 1994). Aggression is an external behaviour that you can see. For example, you can see a person shoot, stab, hit, slap, or curse someone. Aggression is not a thought inside someone’s brain, such as mentally rehearsing a murder. Note also that aggression is a social behaviour—it involves at least two people. In addition, aggression is intended to hurt. Aggression is not accidental, such as when a drunk driver accidentally runs over a child on a tricycle. In addition, not all intentional behaviours that hurt others are aggressive behaviour. For example, a dentist might intentionally give a patient a shot of Novacain (and the shot hurts!), but the goal is to help rather than hurt the patient.

**Different forms of Aggression**

It is useful to distinguish between forms and functions of aggression. By *forms* we mean how the aggressive act is expressed such as physical versus verbal, direct versus indirect, and active versus passive (Buss, 1961). *Physical aggression* involves harming others physically (e.g., hitting, kicking, stabbing, or, shooting them). *Verbal aggression* involves harming others with words (e.g., yelling, screaming, swearing, name calling). *Relational aggression* (also called *social aggression*) is defined as intentionally harming another person’s social relationships, feelings of acceptance, or inclusion within a group (e.g., Crick & Grotpeter, 1995). Some examples of relational aggression include saying bad things about people behind their backs, withdrawing affection to get what you
want, excluding others from your circle of friends, and giving someone the “silent
treatment.” Recent research shows that social pain may even linger longer than
physical pain (Chen, Williams, Fitness, & Newton, 2008). Participants in these
studies recalled an event that caused social pain (e.g., betrayal by a person very
close to them) and an event that caused physical pain. They rated how intense
the initial pain had been and how intense it was as they relived it. The initial
levels of social and physical pain did not differ, but relieved pain was more
intense for social pain than for physical pain. Social pain also impaired cognitive
performance more than physical pain did.

The different forms of aggression can be expressed directly or indirectly
(Lagerspetz, Brorkovist, & Peltonen, 1988). With direct aggression, the victim is
physically present. With indirect aggression, the victim is absent. For example,
physical aggression can be direct (e.g., hitting a person in the face) or indirect
(e.g., destroying another person’s property when he or she isn’t looking). Likewise, verbal aggression can be direct (e.g., screaming in a person’s face) or
indirect (e.g., spreading rumours behind a person’s back).

In displaced aggression, a substitute aggression target is use (e.g., Marcus-
Newhall, Pedersen, Carlson, & Miller, 2000). The substitute target is innocent of
any wrongdoing and just happens to be in wrong place at the wrong time. For
example, a man is berated by his boss at work but does not retaliate. When he
gets home, he yells at his daughter instead. Sometimes the substitute target is
not entirely innocent, but has committed a minor or trivial offense, called
triggered displaced aggression (Pedersen, Gonzales, & Miller, 2000). For example, the man berated by his boss might yell at his daughter because she forgot to clean her room. Triggered displaced aggression is especially likely to occur when the aggressor ruminates about the initial offence (Bushman, Bonacci, Pedersen, Vasquez, & Miller, 2005) and when the aggressor does not like the substitute target, such as when the target is an out-group member or has a personality flaw (e.g., Pederson, Bushman, Vasquez, & Miller, 2008).

People displace aggression for two reasons. First, directly aggressing against the source of provocation may be unfeasible because the source is unavailable (e.g., the provoker has left the area), or because the source is an intangible entity (e.g., hot temperature). Second, fear of retaliation or punishment from the provoker may inhibit direct aggression. For example, the employee who was reprimanded by his boss may be reluctant to retaliate because he does not want to lose his job.

The form of aggression may be active or passive. With active aggression, the aggressor responds in a hurtful manner (e.g., hitting, swearing). With passive aggression, the aggressor fails to respond in a helpful manner. For example, the aggressor might “forget” to deliver an important message to the person. Direct and active forms of aggression can be quite risky, leading to injury or even death. Thus, most people prefer to use indirect and passive forms of aggression instead.
Emergence of Gender Differences

Gender differences in aggression are very noticeable by the preschool years, with boys showing higher levels of physical aggression than girls (Loeber & Hay, 1997). However, many preschool girls are physically aggressive, and they show levels of verbal and indirect aggression similar to or greater than boys (Crick & Grotpeter, 1995; Rys & Bear, 1997). In later elementary grades and in adolescence, gender differences in indirect and physical aggression increase. Indirect aggression becomes much greater for girls than boys; physical aggression becomes much greater for boys than girls; and verbal aggression is about the same for girls and boys (Crick & Grotpeter, 1995; Lagerspetz, Bjorkqvist & Peltonen, 1988; Vaillancourt, 2005). These gender differences culminate in dramatic differences in violent behaviour in young adulthood, reflected by large gender differences in murder rates. Nevertheless, this should not lead one to believe those females are never physically aggressive. Female do display physical aggression in social interactions, particularly when they are provoked by other females (Collins, Quigley, & Leonard, 2007). When it comes to heterosexual domestic partners, women are slightly more likely than men to use physical aggression against their partners (e.g. Archer, 2000; Straus, 1997). However, men are more likely than women to inflict serious injuries and death on their partners. Laboratory studies with college students often yield higher aggression by men, but provocation apparently has a greater effect on
aggression than do biological sex. Sex differences in aggression practically disappear under high provocation (Bettencourt & Miller, 1996).

Developmental research suggests that many gender differences in aggression result both from nature and nurture. Innate factors have led to substantial evolutionary theorizing about the reasons for gender differences in aggression (Archer & Conte, 2005; Buss & Shackelford, 1997b; Campbell, 1999; Geary, 1998).

**Aggression in Children and Adolescents**

Aggression in children and adolescents is a serious problem and is associated with various psychiatric disorders, not just conduct and oppositional defiant disorders, but in fact, most psychiatric disorders. Currently, while a growing base of data supports an important role for pharmacologic treatments in managing aggression, studies have also shown that psychosocial therapy in conjunction with medication may be more effective in treating aggression than medication alone in many patients. According to recently published treatment guidelines on the management of aggression, psychosocial approaches should always be implemented first, with pharmacotherapy added later if necessary. This article details the risk factors and protective factors associated with aggression in children and adolescents, describes the evidence base for the use of psychosocial therapy for the management of aggression, and discusses various psychosocial therapy approaches that may be effective in treating aggressive children and adolescents.
2.15 Cognitive Behaviour Therapy and Aggression

Lochman (1985) conducted a research on the effectiveness of Cognitive Behaviour Therapy using a group of four to six participants. In the study, forty-five to sixty minutes’ sessions were held weekly for twelve weeks. Participants were divided into four groups: Cognitive Behaviour Therapy to provide anger-coping skills, goal setting, combinations of 1 & 2 above and control. The sample consisted of 76 boys whose ages range from 9-12 years. Fifty three percent of the sample was African-Americans. They were drawn from 8 schools and screened for aggressive behaviour. The results of the study showed that Cognitive Behaviour Therapy evidenced a reduction in aggressive behaviour of the boys above goal setting group or the control. However, the group treated with a combination of Cognitive Behaviour Therapy and goal setting showed greater gains than any of the boys in the other groups.

Follow-up analysis was conducted on a sub-sample of 32 boys. Aggressive boys who completed the cognitive behaviour therapy programme of anger-control and combination group of cognitive behaviour therapy and goal setting were found to have lower aggressive tendencies, high levels of self-esteem and stronger problem-solving skills than those who either did not complete the programme or belong to the other groups: goal setting and untreated control group. Outcome based on repeated measures using ANOVA and later ANCOVA to co-vary pre-test scores revealed that treatment effects were greatest for the combined condition (Lochman, 1985). Beck and Fernandez (1998) reviewed 50 outcome studies on
anger/aggression covering a total of 1640 participants many of who were in programmes for violent offenders. They found a mean weighted effect size of 0.70 for CBT versus untreated controls. The average CBT participants did better than 76% of untreated participants on reduction of anger.

Lochman and Lampron (1988) found Cognitive Behaviour Therapy effective for aggressive boys in 10 to 12 years age range. A goal setting component was added to the cognitive behavioural interventions. Aggression in children and adolescents is a serious problem and is associated with various psychiatric disorders, not just conduct and oppositional defiant disorders, but in fact, most psychiatric disorders. Currently, while a growing base of data supports an important role for pharmacologic treatments in managing aggression, studies have also shown that psychosocial therapy in conjunction with medication may be more effective in treating aggression than medication alone in many patients. According to recently published treatment guidelines on the management of aggression, psychosocial approaches should always be implemented first, with pharmacotherapy added later if necessary. This article details the risk factors and protective factors associated with aggression in children and adolescents, describes the evidence base for the use of psychosocial therapy for the management of aggression, and discusses various psychosocial therapy approaches that may be effective in treating aggressive children and adolescents.
Aggressive behaviour is often a reflection of inability to regulate emotional reactions to stimuli that are anger inducing. This behaviour pattern is very stable and a risk marker for variety of poor adolescents outcomes (such as delinquency, conduct disorder, substance abuse, poor peer relations and school failure or dropout (Lochman, 1985).

According to Evoy (1983), aggression in the rejected was a qualitatively distinct, feeling-response of heightened displeasure. It is usually stimulated by the experience of perceived injustice, humiliation or some other personal hurt or frustration. It carried with it an inclination to lash out damagingly against someone or something. Children who are aggressive often demonstrate a variety of social cognitive deficits or distortions that contribute to their lack of social competence (Anwuri, 2007). Their cognitive problem-solving skills are also impaired when they are emotionally aroused (Lochman, 1985). The case of a teenager Ime Sunday typifies aggressive behaviour: “Teenager Stabs Colleague To Death Over ₦200”

The Lagos Police Command has arrested a teenager, Ime Sunday, for allegedly stabbing his colleague, Asuquo Effiong to death. Sunday reportedly inflicted a serious injury on Effiong in his hand with a broken bottle during a disagreement over ₦200 naira. The Calabar, Cross River State-born suspect aged 16 years said that trouble started when he lent Effiong ₦200 to give a customer as his balance for the drinks he bought from the deceased. He explained that his bid to recover the sum led to the disagreement which claimed Effiong’s life. Both of them were bar attendants at a restaurant located at Kirikiri Prisons Barracks,
Kirikiri, Lagos. The Lagos command’s Public Relations Officer, Mr. Frank Mba confirmed that Sunday was arrested by policemen attached to Kirikiri Police Station following a report made by the restaurant’s manager. He said the case had been transferred to the State Criminal Investigation Department, Panti Street, Yaba, for further investigation. The Punch, Wednesday, March 3, 2010, Pg.5.

A person has a problem with anger if his frequent reaction to stress or frustration is to yell, hit, throw or break things, or his temper negatively affect his intimate relationships, family, life, work or friends and acquaintances. Aggression and other conduct problems are considered to be under controlled meaning the individual has not developed sufficient strategies for self-regulation of their behaviour, affect and cognition.

**Frustration-Aggression Theory**

This theory as formulated by Berkowitz (1989) states that any kind of noxious experience produces instigation to impulsive aggression. Frustration is one type of noxious experience. Frustration, which is interference with goal response is necessary and sufficient for aggression. A study by Toldos (2005) examined the construct validity of Direct and Indirect Aggression Scales (DIAS) in 653 adolescents aged 14-17 in four Spanish High Schools. The paper also examined sex and age differences in aggression. The factor structure of scales was assessed using exploratory factor analysis. Varimax rotation was used. With a factorial structure of three factors: physical aggression, verbal aggression and indirect aggression. The result showed that compared with girls, boys reported a
more frequent use of physical and verbal aggression. However for indirect aggression, no differences were found between boys and girls. A specific examination of sex differences on individual items of the DIAS showed that boys used physical, verbal and indirect aggression more often than girls. The findings also indicated that, as expected, adolescents in lower courses (14-15 years old) rated higher in all types of violence than adolescents in higher courses (16-17 years old). Also they found that boys used physical and verbal aggression more often than girls did in all age groups studied (Toldos, 2005).

What kind of rearing conditions create aggressive children?

In the light of the characterization of the bullies as having an aggressive reaction pattern—that is, they display aggressive behaviour in many different situations—it becomes important to examine the question: what kind of rearing or other conditions during childhood are conducive to the development of an aggressive reaction pattern?

Very briefly, four factors have been found to be particularly important (based chiefly on research with boys (Olweus, 1980). First, the basic emotional attitude of parents, mainly that the primary caretaker (usually the mother), toward the boy is very important, maybe in particular the emotional attitude during his earlier years. A negative basic, characterized by lack of warmth and involvement, clearly increases the risk that the boy will later become aggressive and hostile towards others.
A second important factor is the extent to which the primary caretaker has been permissive and allowed aggressive behaviour on the part of the child. If the caretaker is generally permissive and “tolerant” without setting clear limits to aggressive behaviour towards peers, siblings, and adults, the child’s level of aggression is likely to increase. We can summarize these results by stating too little love and care and too much “freedom” in childhood conditions that strongly contribute to the development of an aggressive reaction pattern.

A third factor that has been found to raise the child’s level of aggression is the parents’ use of “power-assertive” child-rearing methods such as physical punishment and violent emotional outburst. This finding supports the notion that “violence begets violence”. It is important to set clear limits to and impose certain rules on a child’s behaviour, but it should not be done with the use of physical punishment and the like.

Finally, the temperament of the child also plays a part in the development of an aggressive reaction pattern. A child with an active and “hot-headed temperament is more likely to develop into an aggressive youngster than is a child with an ordinary or quieter temperament. The effect of this factor is smaller than those of the first two conditions mentioned above.

There are main trends. In individual cases other factors may have been central and the casual pattern may appear partly different. None the less, these results in combination with other research on childhood conditions, give rise to the
following important conclusion: Love and involvement from the persons (s) who rears the child, well-defined limits on which behaviour are permitted and which are not, and use of non-physical methods of child-rearing create harmonious and independent children.

This conclusion is likely to hold true for both boys and girls, and the factors described are important for both younger and older children. As children become teenagers, it is also essential that the parents try to supervise the child’s activities outside school reasonably well, and to monitor what he/she does and who his/her friends are Patterson; 1982. Patterson & Stouthamer-Loeber 1984. Most unwanted activities including bullying and antisocial or criminal behaviour tend to take place when the parents do not know what the child is doing, or when they or other adults are absent. Some research indicates that when parental conflicts are handled in privacy by the parents, there are fewer negative effects than when they are enacted in front of the child. The socioeconomic conditions of the family, including level of income, length of parental education, and standard of housing are one such factor.

2.16. Research Findings on Cognitive Behaviour Therapy

CBT is a combination or “pulling together” of any and all methods, strategies, and techniques that work to help people successfully overcome their particular emotional problems. The cognitive part of the therapy refers to thinking or learning and it is the part of therapy that can be “taught” to the person in need
of behaviour modification. The person then needs to take what has been taught, practice it at home, and through repetition, get that new “learning i.e. understanding” down into the mind over and over again so that it becomes automatic or habitual. This is essentially the same as school or college learning. The student is taught some new information or skills, and then they learn. When they learn them (through repetition), this affects the memory processes (and physiologically the brain’s neural pathways) which allows the student to begin thinking, acting, and feeling differently. This takes persistence, practice, and patience, but when a person sticks with this therapy, and does not give up, noticeable progress begins to occur.

The behavioural component of CBT involves participation in an active, structured therapy group, consisting of people with clinical social anxiety. In the behavioural group, people voluntarily engage in practical activities that are mildly anxiety-causing, and proceed in a flexible, steady, scheduled manner. By moving forward in this manner, step by step, and through the use of repetition, the anxiety felt in social situations is gradually reduced.

Meek (2008) alleges that the hallmark of CBT is an intense focus on thought processes and belief systems. The overall goals of the approach are to help people identify problematic beliefs and thought patterns, which are often irrational or unrealistic, and replace them with more rational and realistic views
2.17 Cognitive Behaviour Therapy and Anxiety

Durham and Allan (1993) examined the efficacy of some techniques in treating anxiety. Techniques used were Cognitive behavioural therapies, relaxation, biofeedback and nondirective therapy. Fourteen (14) studies using Hamilton Anxiety Scale (HAS) and State-Trait Anxiety Inventory (STAI-T) were examined. The percentage of improvement in post-treatment varies, rather markedly across studies. For all treatments combined, there was a 54% reduction for somatic symptoms on the HAS (range across studies 20-76%) and a 25% reduction in general tendency to worry on STAI-T (range 6-50%). The effect of threat of failure and threat of shock on the state anxiety reactions of subjects differing in levels of trait anxiety were investigated. Consistent with the worry-emotionality distinction, worry scores were aroused only in the failure – threat situation while emotionality scores tended to be elevated only in the shock- threat condition. Contrary to predictions derived from Spielberger’s State-Trait anxiety theory. A – state scores were higher for the high A-trait subjects than for low A-trait subjects in all treatment and control groups. The relationship between A-trait and worry scores was not supported. (Morris and Liebert, 1973).

Cognitive –Behaviour Therapy is a form of treatment that has repeatedly been shown to be among the most effective in reducing or eliminating Anxiety Disorders. The Cognitive –Behaviour therapy provided at the anxiety disorder clinic involves three components that are critical to overcoming anxiety: Education, Thought Challenging and Exposure and Response Prevention.
Education

“You can’t fix what you don’t understand”. This adage is completely true when it comes to anxiety disorders. This is why it is essential for treatment to have a good component that explains what anxiety is all about and how it is treated. Education itself won’t get rid of an anxiety disorder- it’s not quite that powerful- but makes the other techniques work (Norton, 2010). Education serves several purposes:

- reduces stigma
- letting clients know they are not alone
- providing hope
- providing correct information about danger and threat
- helping you understand what the treatment will involve
- give solid reasons for why they need to do things like exposure and thought challenging.

Many years back, famous psychologist named Jerome Frank recognized that all forms of therapy must have certain features to be effective. One of these is providing the client with a rationale for how treatment will work. Education does this.

Thought Challenging

Our minds are wonderful things. They take in massive amounts of information about the world, try to make sense of the information based on our past
experiences, beliefs, and biases, and then create an appropriate emotional state based on the information. Usually our minds are accurate in interpreting the information and selecting the appropriate emotional response, but not always. Consider a scary movie. We are not in any real danger while watching the movie, but emotionally we respond as if we were in danger. Likewise, I can recall many times where I was in some danger but did not realize it- and therefore did not respond fearfully writes Frank.

With anxiety disorders, this type of mismatch is happening. The mind interprets something as dangerous or threatening, when in fact it is either not dangerous or not nearly as dangerous as the person believes. When the mind interprets something as dangerous or threatening, it creates the emotional response of fear/anxiety. Thought challenging is a process of systematically and logically challenging the danger thoughts, helping the client learn to re-evaluate the actual amount of danger or threat.

Thought challenging is really a three-step process:

1. The first step involves identifying these danger thoughts that flash into the mind. Psychologists call these “automatic thoughts” because they seem to come to mind immediately when a person encounters something he or she fears. One good strategy is to immediately ask oneself “what was I thinking?” as soon as you notice your anxiety increase.

2. Once someone becomes good at identifying their automatic thoughts, we then focus on trying to teach them to challenge the logic of that thought
through a variety of methods. Most commonly we have clients ask themselves various questions designed to challenge the accuracy of a thought.

3. Finally, when the inaccurate thought has been broken apart and shown to be inaccurate, we replace it with a thought that is a more accurate reflection of the actual amount of danger, if any.

**Exposure and Response Prevention**

Education sets the stage; relaxation feels great, thought challenging is very useful, but exposure is the magic bullet for treating anxiety. It is the most powerful component of treatment. In fact the U.S. Surgeon General recently agreed that “a critical element of therapy is to increase exposure to the stimuli or situations that provoke anxiety”. Unfortunately, it is by definition the most anxiety provoking part of treatment. As the name suggests, exposure involves exposing yourself to things that cause your anxiety to rise. Depending on the specific fears, this may involve certain animals or objects such as heights or germs, certain situations such as talking to authority figures, certain body sensations such as racing heart or shortness of breath, certain thoughts such as worries or memories. These are several explanations for how exposure therapy works.
1. First, much of what we learn in life comes from things being paired together, such as public speaking and having people laugh at you or seeing a dog and getting bitten. Much of what we unlearn, on the other hand, comes from un-pairing two things. With anxiety disorders, this means un-pairing the fear trigger (e.g., public speaking) from the expected outcome (people laughing).

2. The second way that exposure works is through habituation. The more often we are exposed to something, be it good, bad, or otherwise, the less of an emotional reaction we will have. We get used to things; that’s just human nature.

3. Finally, exposure works by giving the people new correct information about the things they thought were threatening. This is the “A-hah…it wasn’t as dangerous as I expected” principle. Our therapists understand that this usually is very scary, which is why we don’t expect (or want) our clients to tackle the scariest things first. Instead we start with something that will cause only mild to moderate anxiety. Once our client has success in overcoming their fear to that situation, we move to something slightly harder and so forth. Very often, a therapist and client will sit down before doing exposure to create a “Hierarchy of Fears”, which is an ordered list of thing that cause different amounts of anxiety, as well as the different variations that make them more or less anxiety provoking. This hierarchy then serves as a road map for treatment.
Anxiety disorders all involve the tendency to engage in preventive or defensive actions to protect oneself. This can involve trying to avoid certain things, situations, activities or even thoughts. It can involve escaping from things when they come up unexpectedly. It can involve doing, saying, or thinking things that make you feel safer. It can involve carrying something with you. These safety behaviour all share the common purpose of making you feel safer, and they have to go. Exposure helps you learn that something is not as dangerous or threatening as you expected. If you use safety behaviours in exposure, you give the anxiety an escape hatch. Instead of learning “the bad thing didn’t happen because this isn’t as dangerous as I expected”, safety behaviours cause your mind to say “the bad thing did not happen because I did -------------. If I hadn’t, the bad thing would have happened” (Norton, 2010).

Psychologist Richard posits that overcoming anxiety disorder in therapy focuses on three main areas: cognitive, behavioural and emotional.

1.  **Cognitive (thinking / belief processes)**

Here we learn new methods and ways to change our old thinking patterns and habits. If we’re always thinking and expecting the worst, then we will continue to suffer. We train or condition our minds to think and respond differently than we have in the past. Or think of it this way—if we can be conditioned to think and feel negatively, then we can be reconditioned to think healthfully.
We have dozens of specific methods and techniques that we use—and you only need to find several methods that work well for you. We usually start CBT (cognitive-behavioural therapy) at this stage.

Some effective techniques are:

Slow-talk/slow walk/slowing down

Stopping automatic negative thinking (ANTs)

The acceptance paradox: how we keep the fires burning and how to put them out

Rational and helpful self-statements that can become permanent and “automatic”

Continuing to move our self-statements up

Whose voice are you listening to, anyhow? Do we have to listen and believe all those old lies?

The determination factor: becoming more focused and determined

Focusing: What are you paying attention to?

Later, it’s important we address: perfectionism, anger, frustration, setbacks, and our view of the world.

2. Behavioural (what we do)

The behavioural aspect of therapy is the part where we actually put everything into place in everyday, real-life situations where we are bothered by anxiety and depression. This area is always handled at the same time or after cognitive
therapy, because we need a strong foundation of cognitive and emotional skills/strategies so that we can begin living and acting differently before we confront real-life challenges. This stage is essential for people with some of the anxiety problems (such as social anxiety disorder) and serves as a powerful adjunct to individual treatment for others).

**Emotional (relaxation/peaceful/strength and power strategies)**

It is important to have some type of relaxation or “de-stress” strategy that is accessible whenever we need it. In this area, calmness and peace are the goals. The more your brain is quiet and relaxed, the easier therapeutic information can get into it and be processed. This is simply another way to let the therapy reach your brain and gently sink in. Our focus is on peace and calmness here. We do not focus on decreasing anxiety by using these methods. Why? As peace and calmness become a little stronger, they tend to “crowd” out the anxieties and fears we have.

**2.18. Cognitive behaviour therapy for depression**

Depression is a common problem worldwide and can have severe consequences such as poor psychosocial adjustments (Coryell, 1993), poor quality of life, and suicide (Kendel, 1991). Longitudinal studies have shown that depression prevalence rates increase in early adolescence (Cole, 2002) and decrease through middle and late adolescence (Needham, 2008). As depression can have severe consequences, it is important to examine its antecedents. In adolescence,
parental influences are important predictors of depressive feelings. Both parental support and parental depression are found to be related to depression in their offspring (for meta-analyses see Kane & Garber, 2004; McLeod, 2007). Next to these environmental influences, interest has shifted towards examining the genetic factors underlying depression. So far, molecular genetic studies on depression have almost solely focused on adult depression.

Ample research has demonstrated that the experience of depressive symptoms among adolescents is both widespread and problematic. A 2004 report on the health and well-being of adolescents stated that 21-36% of 12-16 year-old males and females report “feeling depressed” (Boyce, 2006). Depressive symptoms in adolescence have been linked to increased risk for suicide, suicide attempts, recurrent depressive episodes, psychiatric and medical hospitalizations, and risk-taking behaviour, as well as general maladjustment in adulthood (Nansel, 2001; Weissman, 1999). Clearly, adolescence represents a unique period of vulnerability to depressive symptoms. A better understanding of the mechanism that lead to increase or decrease in symptoms is needed.

Psychological treatment of depression (psychotherapy) can assist the depressed individual in several ways. First, supportive counselling helps ease the pain of depression, and addresses the feelings of hopelessness that accompany depression. Second, cognitive therapy changes the pessimistic ideas, unrealistic expectations, and overly critical self-evaluations that create depression and sustain it. Cognitive therapy helps the depressed person recognize which life
problems are critical, and which are minor. It also helps him /her to develop positive life goals, and a more positive self-assessment. Third, problem solving therapy changes the areas of the person’s life that are creating significant stress, and contributing to depression. This may require behavioural therapy to develop better coping skills, or Interpersonal therapy, to assist in solving relationship problems.

At first glance, this may seem like several different therapies being used to treat depression. However, all these interventions are used as part of cognitive treatment approach. Some psychologists use the phrase, cognitive-behavioural therapy and others simply call this approach, cognitive therapy. In practice, both cognitive and behavioural techniques are used together.

Modern cognitive behaviour therapy (CBT) was developed independently by two separate individuals; Aaron Beck, a psychiatrist, and Albert Ellis, a clinical psychologist. Both Beck and Ellis began working on their versions of the therapy in and around the late 1950s and early 60s. Both versions of the therapy are founded on the single basic idea that cognition, in the form of thoughts and preconceived judgments, precedes and determines people’s emotional responses. In other words, what people think about an event that has occurred determines how they will feel about that event. Depression happens because people develop a disposition to view situations and circumstances in habitually negative and biased ways, leading them to habitually experience negative feelings and emotions as a result (Nemade, Reiss & Dombbeck, 2007).
**Theory of depression according to CT**

One etiological theory of depression is the Aaron Beck cognitive theory of depression. His theory is regarded as the most verified psychological theory of depression. His theory states that depressed people think the way they do because their thinking is biased towards negative interpretations. According to this theory, depressed people acquire a negative schema of the world in childhood and adolescence. (Children and adolescents who suffer from depression acquire this negative schema earlier.) Depressed people acquire such schemas through the loss of a parent, rejection of peers, criticism from teachers or parents, the depressive attitude of a parent and other negative events. When the person with such schemas encounters a situation that resembles in some way, even remotely, the conditions in which the original schema was learned, the negative schemas of the person are activated (Davidson & Neale, 2001).

Beck also included a negative triad in his theory. A negative triad is made up of the negative schemas and cognitive biases of the person. Beck theorized that depressed individuals make negative evaluations of themselves, the world and the future. Depressed people, according to this theory, have views such as “I never do a good job,” and “things will never get better”. A negative schema helps give rise to the cognitive bias, and the cognitive bias helps fuel the negative schema. This is the negative triad. Also, Beck proposed that depressed people often have the following cognitive biases arbitrary inference, selective abstraction, overgeneralization, magnification and minimization. These cognitive
biases are quick to make negative, generalized, and personal inferences of the self, thus fuelling the negative schema (Davidson & Neale, 2001).

**Hopelessness Theory of depression**

Another cognitive theory of depression is the hopelessness theory of depression. This is the latest theory of the helpless/hopeless theories of depression, stating that hopelessness depression is caused by a state of hopelessness. A state of hopelessness develops when the person believes that no good outcomes are possible, only negative ones. The person also feels that he or she has no ability to change the situation to allow for a positive outcome. Stressors (negative life events) are thought to interact with a diathesis (in this case, a predisposing factor to depression) to create a sense of hopelessness (Davidson & Neale, 2001).

Some proposed diathesis are attributing negative events to stable and global factors, low-self-esteem, and a tendency to believe that negative life events will have severe negative consequences. Such diatheses increase the possibility that a person will experience hopelessness depression.

**Attributional style**

An approach to depression based upon attribution theory in social psychology is related to the concept of attributional style. First advanced by Lyn Abramson and her colleagues in 1978, this approach argues that depressives have a typical
attributional style— they tend to attribute negative events in their lives to stable and global characteristics of themselves (Abramson, Seligman & Teasdale, 1978). This theory is sometimes known as a revised version of learned helplessness theory.

In 1989, this theory was challenged by Hopelessness theory (Abramson et al, 1978). This theory emphasized attributions to global and stable factors, rather than, as in the original model, internal attributions. Hopelessness theory also emphasizes that beliefs about the consequences of events, and rated importance of events, may be at least as important as causal attributions in understanding why some people react to negative events with clinical depression.

**CBT with children and adolescents**

The use of CBT has been extended to children and adolescents with good results. It is often used to treat depression, anxiety disorders, and symptoms related to trauma and Post Traumatic Stress Disorders. Significant work has been done in this area by Mark Reinecke and his colleagues at Northwestern University in the Clinical Psychology program in Chicago. Paula Barrett and her colleagues have also validated CBT as effective in a group setting for the treatment of youth and child anxiety using the Friends Program she authored. This CBT program has been recognized as best practice for the treatment of anxiety in children by the World Health Organization. Combining the Biofeedback method with the CBT process is very effective. CBT has been used with children and adolescents to
treat a variety of conditions with good success (Philip, 2005, Reinecke, Mark, 2003).

CBT is also used as a treatment modality for children who have experienced Complex Post Traumatic Stress Disorder, chronic maltreatment, and Traumatic Stress Disorder. It would be one component of treatment for children with C-PTSD, along with a variety of other components, which are discussed in the Complex Post Traumatic Stress Disorder article.

**Therapeutic methodologies**

The particular therapeutic techniques vary within the different approaches of CBT according to the particular kind of problem issues, but commonly may include keeping a diary of significant events and associated feelings, thoughts and behaviours, questioning and testing cognitions, assumptions, evaluations and beliefs that might be unhelpful and unrealistic, gradually facing activities which may have been avoided, and trying out new ways of behaving and reacting. Relaxation, mindfulness and distraction techniques are also commonly included. Cognitive behavioural therapy is often used in conjunction with mood stabilizing medications to treat conditions like bipolar disorder. Its application in treating schizophrenia along with medications and family therapy is recognized by the NICE guidelines within the British NHS.
Cognitive behavioural therapy generally is not an overnight process. Even after patients have learned to recognize when and where their mental processes go awry, it can take months of effort to replace a dysfunctional cognitive-affective-behavioural process or habit with a more reasonable and adaptive one.

More specifically, CBT therapies suggest that depression is caused by a combination of an unhelpful dysfunctional thought process and by maladaptive behaviours motivated by that thought process. Because these dysfunctional thoughts and behaviours are learned, people with depression can also learn new, more adaptive skills that raise their mood and increase their ability to cope with daily hassles and stressors. Another basic idea behind CBT is that if a person changes his/ her thoughts and behaviours, a positive change in mood will follow.

The cognitive aspect of CBT involves learning to identify distorted patterns of thinking and forming judgments. These maladaptive thought patterns are also known as negative or maladaptive schemas, or core beliefs. Core beliefs are fundamental assumptions people have made that influence how they view the world and themselves. People get so used to thinking in these core ways that they stop noticing them or questioning them. Simply put, core beliefs are the unquestioned background themes that govern depressed people’s perceptions. For example, a depressed person might think “I am unloved” or “I am inadequate and inferior” and because these beliefs are unquestioned, they are acted upon as though they are real and true.
Core beliefs serve as a filter through which people see the world. Core beliefs influence the development of "intermediate beliefs", which are related attitudes, rules and assumptions that follow from core beliefs. When depressed people’s core beliefs are negative and unrealistic, they lead people to experience predominantly negative and unrealistic thoughts. Following along the example stated above, a depressed person might develop the attitude that, “It’s terrible to be unloved”. Similarly, the intermediate belief might include the following rule, “I must please everyone” and an assumption to the effect that, “If I please everyone then people will love me”. Intermediate beliefs can influence people’s view of a particular situation by generating “automatic thoughts,” the actual thoughts or images that people experience flitting through their minds. Automatic thoughts are evaluative cognitions which occur in response to a particular situation. They are spontaneous (hence, the term automatic), rather than the result of deliberate extended thinking or the logical reasoning that occurs when someone concentrates.

Automatic thoughts occur effortlessly, more or less all the time. Most of the time we are unaware that they are occurring, not because they are unconscious sorts of things but rather because we’re so used to them that we don’t notice them anymore. Automatic thoughts influence emotions and behaviours and can provoke physiological responses. To continue the above example, if a friend of a depressed person does not return a phone call, a depressed person might think, “He is not calling me back because he hates me”. It may never occur to her to
generate alternative and less irrational explanations for the lack of a callback such as, He must be really busy today.” Because the automatic thought “he hates me” is allowed to stand unchallenged, the depressed. Though every patient’s automatic thoughts are unique, there are also clear patterns of depressive automatic thoughts that from are common across many depressed people’s minds. Some common patterns of negative and irrational automatic thoughts include:

Catastrophizing - always anticipating the worst possible outcome to occur (e.g., expecting to be criticized or fired when the boss calls).

Filtering-exaggerating the negative and minimizing the positive aspects of an experience (e.g., focusing on all the extra work that went into promotion rather than on how nice it is to have promotion).

Personalizing- automatically accepting blame when something bad occurs even when you had nothing to do with the cause of the negative event (e.g., He didn’t return my phone call because I am a terrible friend or a boring person; I caused him to not to call.)

(Over) Generalizing- viewing isolated troubling events as evidence that all following events will become troubled (e.g., having one bad day means that the entire week is ruined).

Polarizing-viewing situations in black or white (all bad or all good) terms rather than looking for the shades of gray (e.g.,” I missed two questions on my
examination, therefore I am stupid”, instead of “I need to study harder next time, but hey- I did pretty good anyway!”).

Emotionalizing-allowing feelings about an event to override logical evaluation of the events that occurred during the event (e.g., I feel so stupid that it is obvious that I am a stupid person). (Nemade et al, 2007).

Dysfunctional beliefs are thinking habits that people learn which happen to be irrational and not based on reality (e.g., on objective, unbiased observation). Because such beliefs are not linked to reality very well, they tend to appear rather distorted when compared with reality. Distorted though they may be, dysfunctional beliefs are all people typically have to help them make sense out of the events that happen to them. Snap judgments are made (called Cognitive Appraisals) based on the assumptions present within dysfunctional beliefs, and those judgments end up being, not surprisingly, biased and irrational. People look to their appraisals of stressful situations to know how to react, and when they do, they see that situations look simply awful (worse than it really would appear if some reality testing were to occur). They react to that false or exaggerated sense of awfulness, and correspondingly experience depressive symptoms.

2.19 Cognitive Behaviour Therapy and Low Self-Esteem

Self-esteem is a pivoted variable. Positive and resilient self-image, as opposed to negative or mutable self-esteem, is considered a crucial resource for resisting the negative implications for the self that are the frequent accompaniments of
personal changes and other stressful experiences (Turner and Roszell, 1994). Self-esteem buffers emotional consequences of stressors and significantly reduces psychological symptoms (Thoits, 1995). Low self-esteem is a common, disabling, and distressing problem that has been shown to be involved in the etiology and maintenance of a range of Axis 1 disorders. Hence, it is a priority to develop effective treatments for low self-esteem. A cognitive-behavioural conceptualization of low self-esteem has been proposed and a cognitive-behaviour treatment (CBT) program described.

Low self-esteem is linked to problems such as dissatisfaction, physical health problems, depression, substance abuse, suicidal behaviour, and aggressive behaviour (Crocker & Wolfe, 2001; Trzensniewski, 2003). As yet there has been no systematic evaluation of this treatment with routine clinical populations (McManus, Waite & Shafran, 2009). The current case report describes the assessment, formulation, and treatment of a patient with low self-esteem, depression, and anxiety symptoms. At the end of treatment (12 sessions over 6 months), and at 1-yr follow up, the treatment showed large effect sizes on measures of depression, anxiety, and self-esteem. The patient no longer met diagnostic criteria for any psychiatric disorder, and showed reliable and clinically significant change on all measures. As far as we are aware, there are no other published case studies of CBT for low self-esteem that report pre and post-treatment evaluations, or follow-up data. Hence, this case provides an initial contribution to the evidence base for the efficacy of CBT for low self-esteem. As such, low self-
esteem represents a vulnerability factor that substantially increases the risk for negative outcomes (Turner & Lloyd 1999; Turner & Roszell, 1994). Research suggests that self-esteem destabilizes during adolescence, such that there is a drop in self-esteem in early adolescence and a recovery between mid- and late-adolescence (Baldwin & Hoffman, 2002; Block & Robins 1993; Quatman & Watson 2001; Trzensniewski, 2003). This is attributed to pubertal changes, shifts in roles and responsibilities, shifts in personal identity as adolescents try to find somewhere to “fit in” as well as variation in support from family and friends (Greene & Way, 2005; Quatman & Watson 2001; Trzensniewski, 2003). Self-concept, which refers to one’s description of one-self and appraisals of competencies within various domains, is a critical element to one’s overall evaluation of personal worth (Eccles, 1989; Findlay & Bowker, 2009). For example, research conducted by Shapka & Keating (2005) noted that changes in various domains of self-competence, including physical, social and scholastic domains, contributed to changes in general self-worth. As adolescents mature, their self-concept stabilizes and its various components become more integrated (Cole, 2001; Young & Mroczek, 2003). By young adulthood, there is stabilization in physical and social change, which also contributes to the stabilization of self-esteem (Baldwin & Hoffman, 2002).

However, further research is needed to confirm the efficacy of CBT for low self-esteem and to compare its efficacy and effectiveness to alternative treatment, including diagnosis-specific CBT protocols.
When opening up a dictionary of psychology there are many terms which are interchangeable with the term low self esteem. A poor self image in the literature has the simple meaning that the picture in a person’s mind’s eye of how they view their physical attributes (body self image) their success in mastering their environment (success, competence, intelligence) and their overall self worth is distorted by the picture they hold of themselves.

Self image is often described as a circus mirror which dramatically twists size and shape into ungainly proportions which in no way resemble how a person actually appears. This self perception of how we view ourselves, our perception of how others see us, and the thoughts and beliefs we have about ourselves, our world, and our future, affect three areas:

1. Self respect
2. Self-worth and
3. Self acceptance.

The self esteem quotient is the distance between how we see our ideal self in contrast to our real self. The greater the distance between the ideal and the real self, the lower the self esteem. The smaller the gap between the two the higher their self-esteem quotient. When clients hold negative beliefs about themselves, which keep them from achieving the goals they set by being critical, punishing, and negatively evaluating their abilities, this leads to poor self-esteem.
When the opinions we have about ourselves and our evaluation of self worth is negative this correlates highly with low self esteem. In the assessment phase of CBT client and therapist collaboratively draw up a problem list of the things they want to competently and effectively master as a result of treatment. These problems may be in the areas of :-

- Assertiveness
- Boundary setting
- Stress problems
- Relationship issues
- Problems at work
- Financial problems
- Health issues
- Age-related problems
- Sexual problems
- Identity issues
- Body image
- Poor self efficacy.

In all of these areas clients have self-doubts about their ability to competently and effectively master their diverse life. CBT teaches clients to improve to improve their self esteem by first recognizing the relationship between their thoughts, feelings, and behaviour (what to do). By teaching clients to first identify these negative automatic thoughts, identifying the underlying errors in
their thinking and challenging them by rewriting the thoughts in a more alternative and balanced way, thoughts become hypothesis to test rather than truths to be indiscriminately taken on board and acted upon. Examples of negative thoughts:

- I am not good enough
- I am stupid
- I am ugly
- I am inferior
- I am fine
- I am unlovable
- I am weak / vulnerable
- I am a bad person
- I am a failure
- I hate myself.

CBT believes that it is not what we experience but how we interpret it that determines how we are. An information processing model where changing our interpretation of ourselves, the world, the future, changes how you as a person feel about themselves.

CBT provides an individualized programme using, relaxation, imagery, and behavioural experiments, standard CBT for negative belief change, and core belief work for early life problems which, if left untreated, can lead to relapse. Warren, McClellan and Ponzoha (1988) conducted a research on the effectiveness of Cognitive Behaviour Therapy and found out that the therapy was
effective in treating low self-esteem and related emotional problems. They concluded that methods used should include skill training.

2.20 Review of Empirical Studies Behavioural Theories: Social Learning Therapy

Social learning theory has its root in the behaviourist notion of human behaviour as being determined by learning, particularly as shaped by reinforcement in the form of rewards or punishment. Social learning theory or SLT is the theory that stipulates that people learn new behaviour through overt reinforcement or punishment, or via observational learning of social factors in their environment. If people observe positive, desired outcomes in the observed behaviour, then they are more likely to model, imitate, and adopt the behaviour themselves. The first major theory of social learning, that of Rotter (1954), argued that cognition, in form of expectation, is a crucial factor in social learning. In his influential 1954 book; *Social Learning and Clinical Psychology*, Rotter claimed that behaviour is determined by two major types of “expectancy”: the expected outcome of a behaviour and the value a person places on that outcome. He emphasizes perceptual processes in the acquisition of behaviour. (Ahimie, 2007).

According to Rotter, children who have frequently been praised for doing well in school expect praise when they do well. If praise has acquired positive value, children will try to do well in order to obtain it. On the other hand, a child that is frequently criticized by his teachers at school, his parents at home, and his
playmates outside of his home and school, will come to expect criticism for whatever he does. The child would probably become unable to discriminate between situations in which he is likely to receive praise and those in which he is likely to receive criticism. Under these conditions, he would tend to develop personality characteristics in keeping with his generalized expectancy of criticism.

In Applications of a Social Learning Theory of Personality (1972), Rotter, in collaboration with June Chance and Jerry Phares, described a general theory of personality variables based on the ways that different individuals habitually think about their experiences. One of the major variables was I-E, which distinguished “internals”, who think of themselves as controlling events, from “externals”, who view events as largely outside their control. Correlations have since been found between I-E orientations and a variety of behaviours, ranging from job performance to attitudes towards one’s health. Social Learning Theory is derived from the work of Cornell Montgomery (1843-1904) which proposed that social learning occurred through four main stages of imitation:

- close contact
- imitation of superiors
- understanding of concepts
- role model behaviour

It consists of three parts observing, imitating, and reinforcements. Rotter moved away from theories based on psychosis and behaviourism, and developed learning theory. In social learning and clinical psychology, Rotter’s (1954)
suggests that the effect of behaviour has an impact on the motivation of people to engage in that specific behaviour. People wish to avoid negative consequences, while desiring positive results or effects. If one expects a positive outcome from a behaviour, or thinks there is a high probability of a positive outcome, then they will be more likely to engage in that behaviour. The behaviour is reinforced, with positive outcomes, leading a person to repeat the behaviour. This social learning theory suggests that behaviour is influenced by these environmental factors or stimulus, and not psychological factors alone.

Bandura (1977) expanded on Rotter’s idea, as well as earlier work by Miller & Dollard (1941), and is related to social learning theories of Vygostky and Lave. This theory incorporates aspects of behavioural and cognitive learning. Behavioural learning assumes that people’s environment (surroundings) cause people to behave in certain ways. Cognitive learning presumes that psychological factors are important for influencing how one behaves. Social learning suggests a combination of environmental (social) and psychological factors influence behaviour. Social learning theory outlines three requirements for people to learn and model behaviour which include attention: retention (remembering what one observed), reproduction (ability to reproduce the behaviour), and motivation (good reason) to want to adopt the behaviour.
Social Learning Theory and Criminology

The Social learning theory is the behaviour theory most relevant to criminology. Akers and Burgess (1966) developed social learning theory to explain deviancy by combining variables which encouraged delinquency (e.g. the social pressure from delinquent peers) with variables that discouraged delinquency (e.g. the parental response to discovering delinquency in their children).

The Social Learning Perspective: Social Learning Model

This perspective developed by Bandura (1977) and Mischel (1973) sees learning as not simply being the result of classical and operant conditioning but as being influenced by observational learning. Observational learning takes place when people learn from observing the actions of others and the consequences of those actions. People also learn to inhibit or disinhibit their actions through observing other people. According to Ahimie (2007), reinforcement according to this model depends on cognitive processes, namely those of anticipation and expectation. People anticipate and expect reinforcement. Therefore reinforcement is dependent on cognition. Bandura introduced the concept of vicarious reinforcement, where people think about and anticipate the outcomes of observed behaviours prior to imitating those behaviours. Bandura and Mischel see behaviour, cognition and the environment as interconnected and as influencing each other. This three-factor interaction is called reciprocal determinism. This means that people’s behaviours influence their environment.
Their environment influences their behaviours. Their cognitions influence and are influenced by their behaviours and their environment. Therefore behaviour is seen as being the result of a plurality of causes and interactions (Ahimie, 2007).

The aims of social learning intervention are to increase both cognitive and behavioural competencies. The two interventions are modelling and changing perceived self-efficacy.

**Modelling** - Modelling has the following characteristics. It is structured in steps and stages

- It incorporates feedbacks
- It has to be clear and easily understood
- People rehearse until satisfactory levels of competence are reached.

Modelling can serve various functions example, inhibiting or disinhibiting performance and in facilitating appropriate or inappropriate responses. Through observing appropriate models, people do learn to acquire skills and strategies. Models also convey a message or success if individuals follow a demonstrated sequence of actions. Students can learn through cognitive modelling or direct instruction. Cognitive modelling requires teachers to verbalize their problem-solving procedures. Teachers demonstrate the desired behaviours to students and the students imitate the behaviours until they reach a satisfactory level of competence. Teachers should also comment on the demonstration while delivering it. In addition, teachers may need to reinforce the students’ efforts.
Students should be encouraged to use positive self-statements in order to increase motivation. Peer modelling can also be effective when students observe other students mastering problems. To be effective the model should possess the following characteristics, that is, be realistic, convey trust, be convincing and have sufficient status in the eyes of students.

**Social Learning Theory and Aggression**

The social learning theory is the theory most relevant to criminology. Bandura believed that aggression is learned through a process called behaviour modelling. He believed that individuals do not actually inherit violent tendencies, but they modelled them after three principles (Bandura, 1976). He argued that individuals, especially children learn aggressive responses from observing others, either personally or through the media and environment. He stated that many individuals believed that aggression will produce reinforcements (Isom, 1998). These reinforcements can formulate into reduction of tension, gaining financial rewards, or gaining the praise of others or building self-esteem (Siegel, 1992).

Many studies have shown that both children and adults may behave more aggressive after having observed someone else, a “model,” acting aggressively. The effect will be stronger if the observer has a positive evaluation of the model, for example, perceives him/her as tough, fearless, and strong. These results can of course apply to a bully/victim situation- with the bully (ies) acting as model. Those who are most strongly influenced by such model effects are probably
students who themselves somewhat insecure and dependent (passive bullies, henchmen who do not have a natural status among their peers, and who would like to assert themselves. The term “social contagion” has been used for this type of effect (Olweus, 2003).

Another and closely related mechanism is the weakening of the control or inhibitions against aggressive tendencies. The main principle here is that seeing a model getting “rewarded” for aggressive tends to decrease the observer’s own “inhibitions” (i.e., ordinary blocks and controls) against being aggressive. Conversely, negative consequences for the model often activate and strengthen inhibitory tendencies in the observer. In the Bobo doll experiment, the children imitated the aggression of the adults because of the reward gained. Bandura was interested in child development. If aggression was diagnosed early in children, Bandura believe that children would reframe from being adult criminals. He argued that aggression in children is influenced by the reinforcements of family members, the media, and the environment. He believed that aggression reinforced by family members was the most prominent source of behaviour modelling. He reports that children use the same aggressive tactics that their parents illustrate when dealing with others.

Extensive international research indicates that children and adolescents who view a lot of violence on TV, video, and movies often become more aggressive and have less empathy with victims of aggression. Hereditary factors may also
contribute to the development of an aggressive or anxious reaction pattern, for instance, through the temperament of the child (Olweus, 2003).

Among the bullying-or aggression-generating factors, poor childhood conditions in general and certain forms of child –rearing and family problems in particular, are important. A less satisfactory upbringing implies among others things that the child gets too little love, care and supervision, and that the child’s caretakers do not set clear limits to the child’s behaviour. Family problems can include conflict-filled interpersonal relationships between the parents, divorce, psychiatric illness, alcohol problems etc. In order to control aggression, Bandura stated that problem should be diagnosed and treated during one’s childhood. We should not be subjecting people to treatments and then, some years later, trying to figure out what effects they have. We should test treatments before we embark on widespread applications (Evans, 1989). Children learn to act aggressive when they model their behaviour after violent acts of adults, especially family members. For example, the boy who witness his father repeatedly strike his mother will more than likely become an abusive parent and husband (Siegel, 1992). Bandura believed that aggression must explain three aspects. First, how aggressive patterns of behaviour are developed; second, what provokes people to behave aggressively, and third, what determines whether they are going to continue to resort to an aggressive behaviour pattern on future occasions (Evans, 1989). In this experiment, he had children witness a model aggressively attacking a plastic clown called the Bobo doll. Their children would watch a video
where a model would aggressively hit a doll and “the model pummels it on the head with a mallet, hurls it down, sits on it and punches it on the nose repeatedly, kick it across the room, flings it in the air, and bombards it with ball...” (Bandura, 1973). After the video, the children were placed in a room with attractive toys, but they could not touch them. The process of retention had occurred. Therefore, the children became angry and frustrated. Then the children were led to another room where they were identical toys used in the Bobo video. The motivation phase was in occurrence. Bandura and many other researchers founded that 88% of the children imitated the aggressive behaviour. Eight months later, 40% of the same children reproduce the violent behaviour observed in the Bobo experiment.

Observational learning is also known as imitation or modelling. In this process, learning occurs when individuals observe and imitate others’ behaviour. There are four components processes influenced by the observer’s behaviour following exposure to models. These components include: attention, retention, motor reproduction and motivation (Bandura, 1977).

Attention is the first component of observational learning. Individuals cannot learn much by observation unless they perceive and attend to the significant features of the modelled behaviour. For example, children must attend to what the aggressor is doing and saying in order to reproduce the model’s behaviour.
(Allen & Santrock, 1993). In the Bobo doll experiment, the children witnessed the Bobo doll being verbally/ or physically abused by live models and filmed models.

Retention is the next component. In order to reproduce the modelled behaviour, the individuals must code the information into long-term memory. Therefore, the information will be retrieval. For example, a simple verbal description of what the model performed would be a known as retention (Allen & Santrock, 1993). Memory is an important cognitive process that helps the observer code and retrieve information. In the Bobo doll experiment, the children imitated the aggression they witnessed in the video. They aggressively hit the Bobo doll because it was coded and stored in their memory.

Motor reproduction is another process in observational learning. The observer must be able to reproduce the model’s behaviour. The observer must learn and possess the physical capabilities of the modelled behaviour. An example of motor reproduction would be to be able to learn how ski or ride a bike. Once a behaviour is learned through attention and retention, the observer must possess the physical capabilities to produce the aggressive act. The children had the physical capabilities of hitting and pummelling the doll to the ground.

Motivation or reinforcements is the final process in observational learning. In this process, the observer expects to receive positive reinforcements for the modelled behaviour. In the Bobo doll experiment, the children witnessed the adults being rewarded for their aggression. Therefore, they performed the same act to achieve the rewards. For example, most children, most children witnessed
violence on television being rewarded by the media. Historically, bank robbers were heroes. Many people were highly upset about the death of Bonnie and Clyde. When individuals, especially children witness this type of media, they attend, code, retrieve, possess the motor capabilities and perform the modelled behaviour because of the positive reinforcement determined by the media (Bootzin, Bowers & Crocker, 1991). The Bobo doll experiment helped Bandura to theorize that "As children continue to age, the experience still affected their personality, turning them into violent adults.

Environmental experiences

Environmental experiences is second influence of the social learning of violence in children. Bandura reported that individuals that live in high crime rates areas are likely to act violently than those who dwell in low-crime areas (Bandura, 1976). This assumption is similar to Shaw and Mckay’s theory of social disorganization. They believed that a neighbourhood surrounded by culture conflict, decay and insufficient social organizations was a major cause of criminality (Bartollas, 1990). The environment in which one exists has for long been ‘accused’ creating the ‘right’ conditions for criminal and violent behaviours. Researchers agree that there is an environmental component that needs to be examined, such as family, peers as well as social learning theory (Aneke, 2009). The family environment is critical to the upbringing of a child and if problems exist, then the child is most likely to suffer the consequences. In confirmation, it
has been proved that, Attention Deficit Hyperactivity Disorder (ADHD) influences antisocial or criminal behaviour. The investigation was carried out by the diagnosis of a child with ADHD (Morley & Hall, 2003; Schmitz, 2003). They also carried out a research on the relationship between family environment and child behaviour which correlates a child’s well being with a positive and caring parent-child relationship; a stimulating home environment and consistent disciplinary techniques (Schmitz, 2003) Families with poor communication and weak family bonds have been shown to have a correlation with children’s development of aggressive/criminal behaviour (Garnefski & Okma, 1996). These researchers specifically identified poverty, education, parenting practices and family structure as family risk factors. They also attributed other factors like unemployment, illiteracy, affluence, greed, and inequality in society, poverty, urbanization and a host of other factors, as responsible for crimes in the society. Another indicator of future antisocial or aggressive behaviour is that of abused or neglected childhood. A statistics shows that children are at 50% greater risk of engaging in criminal acts and aggressive behaviours if they were neglected or abused (Holmes, Slaughter & Kashani, 2001).

Age of the individual is an additional research finding, in the debate between genetic and environmental influences on antisocial or aggressive behaviour. Research seems to be consistency in recognizing that heredity influences adult behaviour more than environmental influences, but for children and adolescents, the environment is the most significant factor influencing their behaviour (Rhee &
Waldman, 2002). As adults, we have the ability to choose the environment in which to live and will either positively or negatively reinforce our personality traits, such as aggressiveness. However, children and adolescents are limited to the extent of choosing an environment, which accounts for the greater influence of environmental factors in childhood behaviours.

Another significant factor in the development of antisocial or delinquent behaviour in adolescence is peer groups. A boy the researcher met at the correctional centre confessed that he was brought to the centre by policemen. According to him, he came from Bayelsa State for a Christian program in Lagos with his grandmother. While at the program that lasted for days, he made friends with a fellow boy and soon he was introduced into the act of pick-pocketing of handsets of worshippers. One day, they were caught but the friend escaped and because he was new in Lagos, he was thoroughly beaten up and handed over to the security operatives who handed him over to the police. Being a minor, he was brought to the correctional centre with a police extract and remanded. Granefski and Okma (1996) stated that there is a correlation between the involvements in an antisocial or delinquent peer group and problem behaviour. One of the primary causes as to why this occurs can be traced back to aggressive behaviour in young children. When children are in preschool and show aggressive tendencies towards their peers, they will likely to be deemed as outcasts. This creates poor peer relationships and relegates those children to be with children who share similar behaviours. A relationship like this would most likely continue
into adolescence and may even further into adulthood. The similar tendencies of these individuals create an environment in which they influence one another and push the problems towards criminal or violent behaviour (Holmes, Slaughter & Kashani, 2001).

Social learning theory has been cited as a way to explain how the environment can influence a child’s behaviour. Using this theory to explain the aggressive or antisocial behaviour of a child means that a child observes aggressive behaviour between parents, siblings or both. As a result, the children believe that this aggressive behaviour is normal and therefore can use it themselves because they do not see the harm in acting similar to their parents (Millers & Carey, 1997). As stated earlier, interaction between family members and disciplinary techniques are influential in creating antisocial behaviour. Using the social learning theory these two factors are also critical in the development of aggression. Children who are raised in an aggressive family environment would most likely be susceptible to experiencing a lack of parental monitoring, permissiveness or inconsistency in punishment, parental rejection and aggression. The exposure to such high levels of aggression and other environmental factors greatly influences and reinforces a child’s behaviour. A significant point that should be known however is the fact that other researchers have supported the notion that genetics do influence levels of aggression, which stands in opposition to social learning theory (Miles & Carey, 1997).
Bandura believed television was a source of behaviour modelling. Today, films and television shows illustrate violence graphically. Violence is often expressed as an acceptable behaviour, especially for heroes who have never been punished. Since aggression is a prominent feature of many shows, children who have a high degree of exposure to the media may exhibit a relatively high incidence of hostility themselves in imitation of the aggression they had witnessed (Berkowitz, 1962). For example, David Phillips reported homicide rates increased tremendously after a heavy weight championship fight (Cloward & Ohlin, 1960). There have been a number of deaths linked to violence on television. For example, John Hinckley attempted to assassinate President Ronald Reagan after he watched the movie “Taxi Driver” fifteen times. In the movie “Born Innocent,” a girl was raped with a bottle by four other girls. In 1974, a similar incident happened to a California’s girl. The girls who raped her testified in court that they had witnessed the same scene in ‘Born innocent.’ In addition, Ronald Zamora brutally killed an elderly woman and pleaded the insanity defense. His attorney argued that Zamora’s was addicted to the violence on television. As a result, he could not differentiate between reality and fantasy. However, Zamora was found guilty because the jury did not believe his defense (Siegel, 1992).

2.21 Contemporary views

Today, many social learning theorists have indicated that crime is a product of learning the values and aggressive behaviours linked with criminality. Skyes cited by Ozo-Eson (2004) opined that in a developing world such as Nigeria, social
instability result from political instability, which breeds anarchy, a situation that encourages lawlessness and disorder. Others see crime as a consequence of revolt against what appears to be injustice in society, whereby the rich continue to exploit the poor. It is the resistance against such exploitation; it is argued that results in criminal behaviour. Skyes, concluded that crime in a capitalist system such as Nigeria, must be traced to the socio-economic arrangement. He further concluded that ‘crime is a result of class oppression and antagonism because of class conflicts.’ The argument that environment factors are responsible for criminal behaviour is rooted in the assertion that crime is a social fact; therefore, it needs social explanation. Sutherland developed the differential association theory that suggests that individuals learn criminal behaviour while in their adolescence from family members and peers (Sutherland, 1939). In ‘Deviant Behaviour’: A Social Learning Approach,’ Akers believed individuals learned aggressive acts through operant condition (Akers, 1977). In this process, the aggression was acquired through direct conditioning and modelling others’ actions. He believed that positive rewards and the avoidance of punishment reinforced aggression (Akers, 1977).William Benson found that adolescents that watched excessive amounts of television during their childhood became adult criminals. They committed crimes, such as rape and assault, ‘at a rate 49% higher than teenage boys who had watched below average quantities of television violence (Centerwall, 1993). Also, Bandura’s theory has made the public and political affairs realize that violence does cause aggression in children.
He has spoken at a number of political conferences concerning the Bobo doll experiment and the effects television has on children. Several political candidates have indicated that violence on television does cause aggression.

**Changing Perceived Self-efficacy**

According to Ahimie (2007), individuals may experience low levels of self-efficacy. This means they feel unable to perform desired behaviours thinking they do not have the necessary resources or skills. The aim of this intervention would be to increase students’ self-efficacy i.e., feeling that they have or can acquire the skills and resources necessary to achieve the desired targets. Changing self-efficacy could be achieved through modelling, self-instructional statements, self-reinforcement and attribution retraining.

**2.22 Appraisal of reviewed literature**

The adolescence stage is viewed by various researchers as very vital in the life of a child and should therefore be handled with utmost care in order to turn out well adjusted adults. Adolescents are basically all-alike. Adolescents are the most widely variable group in society. The behaviour of troubled youth should not be generalized to describe all adolescents.

Records of earlier civilized people reveal that despite the rigours of the times, a compassion for others—the sick, the old, the handicapped, the poor and help for
the troubled youth was prevalent. It has been expressed by members of various religious groups, government, non-governmental agencies and individuals.

Children in conflict with the law also has succour where the antisocial behaviour could be reformed, rehabilitated and reintegrated back into the society as responsible and useful individuals to themselves and society at large. They should not be put into prison with adult offenders. There is also need for such places to be homely in order to achieve the aim of being correctional centres.

The four variables studied which are aggression, anxiety, depression and low self-esteem according to various researchers could be effectively managed among the inmates of the correctional centres using the combined therapies of cognitive restructuring and modelling. Families with poor communication and weak family bonds have been shown to have a correlation with children’s development of aggressive/criminal behaviour (Garnefski & Okma, 1996). These researchers specifically identified poverty, education, parenting practices and family structure as family risk factors. They also attributed other factors like unemployment, illiteracy, affluence, greed and inequality in society, poverty, urbanization and a host of other factors, as responsible for crimes in the society.

Another indicator of future antisocial or aggressive behaviour is that of abused or neglected childhood. A statistics shows that children are at 50% greater risk of engaging in criminal acts and aggressive behaviour if they were neglected or abused (Holmes, Slaughter & Kashani, 2001).
CHAPTER THREE

METHODOLOGY

This chapter discussed the following sub-topics: the research design, area of study, population, sample and sampling techniques. In addition, the pilot study, instrumentation, validation of instrument, procedure for data collection, treatment procedures and data analyses were presented.

3.1 Research Design

The study utilized survey and quasi-experimental designs. This research utilized 2 x 3 pretest-posttest control group design. The research design comprised three groups (two treatment groups and one control group). The effect of regression is minimized since the groups are made up of equivalent participants (Ilogu, 2005). One treatment group was exposed to (Cognitive Restructuring) based on Cognitive behaviour theory while the second group received the (Modelling) as defined in Social learning theory. The third group served as the waiting-list control. The researcher went back and treated the control group with both cognitive restructuring and modelling because the two treatments were equally effective. The dependent variables were aggression, anxiety, depression and low self-esteem.

The research design is diagrammatically represented below:

\[ O_1 \rightarrow X_1 \rightarrow O_2 \]
\[ O_3 \rightarrow X_2 \rightarrow O_4 \]
\[ O_5 \rightarrow C \rightarrow O_6 \]
Where:

\[ X_1 \text{ represents treatment 1—(Cognitive Restructuring)} \]
\[ X_2 \text{ represents treatment 2—(modelling).} \]
\[ C \text{ represents control group} \]
\[ O_1, O_3 \text{ and } O_5 \text{ represent pre-test scores} \]
\[ O_2, O_4 \text{ and } O_6 \text{ represent post-test scores.} \]

Since the study was interested in the effect of more than two independent variables at the same time, the \( 2 \times 3 \) pretest-posttest control group design was employed. The 2 represented the gender (male and female) while the 3 represented the 3 experimental conditions (2 treatment and 1 control group).

### 3.2 Area of Study

This study was carried out in Lagos State. Lagos State is in the south-western part of Nigeria. She is bounded by Ogun State in the East and North, adjoins Atlantic Ocean in the south while she is bounded on the west by the Republic of Benin. Lagos was the former capital of Nigeria and is still the commercial nerve centre of the country. The state is densely populated, and in her modern form, the state is a socio-cultural melting pot that has attracted a cross-section of Nigerians from all over the Federation as well as non-Nigerians from other African countries and the rest of the world. The peculiar nature of Lagos State as the trade hub of the country have continued to attract an influx of people from both far and near into the metropolis. This has put immense pressure on the
existing social facilities, thereby metamorphosing into various social problems. The state has a population of about nine million. The UN estimates that at her present state will be the third largest mega city in the world by 2015 after Tokyo in Japan and Mumbai in India (National Population Commission 2006 in Ojikutu, 2009).

3.3 Population

The target population for this study comprised 233 adolescents in the four correctional centres in Lagos State. The ages of the children under study are between 10 and 24 years.

3.4 Sample and Sampling Procedure

The sample of this study consisted of all adolescents in the two Special Correctional Centres in Lagos State. At the time of the study, the boys were 122 while the girls were 67 in Oregun and Idi-Araba respectively. The number in the Centres varied across the years because of increase or decrease in the number of inmates due to either being restored to their parents or influx to the centres. Cluster-sampling method was adopted and samples were selected in the three groups using the hat and draw method. Cluster-sampling was used in geographically distributed or demarcated areas where each cluster possessed some elements that had characteristics of interest. According to Best & Khan
(1989), it is impracticable to use the simple random sampling technique when the geographic distribution of the individuals is not widely scattered.

The total number who participated in the pre-test, treatment and post-test were 50 girls and 104 boys. This was because some participants whose cases were pending in court were released; some went to court on some days and could not participate fully in the treatment sessions. Some were indisposed making them unable to complete the whole treatment package. Below is the table showing the distribution of participants used for the study by centre and gender.

<table>
<thead>
<tr>
<th>Correctional centres</th>
<th>Boys</th>
<th>Girls</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oregun, Ikeja</td>
<td>104</td>
<td>0</td>
<td>104</td>
</tr>
<tr>
<td>Idi-Araba, Mushin</td>
<td>0</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>104</strong></td>
<td><strong>50</strong></td>
<td><strong>154</strong></td>
</tr>
</tbody>
</table>

3.5 Research Instruments

Four instruments were used to obtain relevant data for this study. They are Verbal Aggressiveness Scale (VAS) (Infante and Wigley 11, 1986); Social Anxiety Thoughts Questionnaire (SATQ) (Hartman, 1984); Automatic Thoughts Questionnaire (ATQ) (Hollon and Kendell 1980) and Index of Self-Esteem (ISE) (Hudson, 1982).
The instruments were adopted in their original form while a word “picnic” was adapted to “party” so that it be culture-fair to Nigerian environment and for the respondents’ easy understanding.

**Verbal Aggressiveness Scale (VAS)**

This is a 20-item scale inventory designed by Infante and Wigley (1986) to measure verbal aggressiveness as a trait that predisposes people to attack the self-concept of others instead of or in addition to their positions on topics of communication. It’s main focus is interpersonal. VAS has good internal consistency with an alpha coefficient of 0.81 and a test-retest reliability coefficient of 0.82. It has fairly good concurrent validity correlating at moderate levels with five other trait measures. For this study, a test-retest reliability of 0.73 was obtained after three weeks interval.

Infante and Wigley (1986) used a five-point scale inventory. The following instructions for administration are provided in the VAS text form:

The respondents were asked to read each of the statements carefully and tick the appropriate number which indicates how often each statement is true for them personally (see Appendix 2).
Social Anxiety Thoughts Questionnaire

This is a 21-item inventory developed by Hartman (1984) to measure the frequency of cognitions that accompany social distress or anxiety. This inventory has an excellent internal consistency with an alpha co-efficient of 0.95 and a mean of 42.3. It has fairly good concurrent validity showing significant correlations with Social Avoidance and Distress Scale and the Fear of Negative Evaluation Scale measures. For this study, a test-retest reliability co-efficient of 0.70 was obtained after three weeks interval at the pilot stage.

Hartman (1984) used a five-point scale. The following instructions for administration are provided in the SATQ text form:

The respondents were asked to read each of the statements carefully and tick the appropriate number which indicates how often each statement is true for them personally (see Appendix 3).

Automatic Thoughts Questionnaire

This is a 30-item instrument designed by Kendall and Hollon (1980) to measure the frequency of automatic negative statements about the self. The ATQ covers four aspects of these automatic thoughts:

Personal maladjustment and desire for change (PMDC); Negative self-concepts and negative expectations (NSNE); Low self-esteem (LSE) and Helplessness.

The instrument has an excellent internal consistency with an alpha coefficient of 0.97. It has a good concurrent validity, correlating with two measures of
depression, the Beck Depression Inventory and the Minnesota Multiphasic Personality Inventory (MMPI). For this study, a test-retest reliability co-efficient of 0.67 was obtained after three weeks interval at the pilot stage.

Hollon and Kendell (1980) used a five-point scale. The following instructions for administration are provided in the ATQ text form:
The respondents were asked to read each of the statements carefully and tick the appropriate number which indicates how often each statement is true for them personally (see Appendix 4).

**Index of Self-Esteem**

This is a 25-item instrument designed by Hudson (1982) to measure the degree of severity or magnitude of a problem the individual has with self-esteem. Self-esteem is the self-perceived and self-evaluative component of self-concept. Problems with self-esteem are often central to social and psychological difficulties that most adolescents experience. The ISE has an excellent internal consistency with a mean alpha co-efficient of 0.93. It has a test-retest correlation of 0.92. It correlates well with measures such as depression, happiness, sense of identity and score on the Generalized Contentment Scale. In this study, test-retest reliability co-efficient of 0.82 was obtained after three weeks interval at the pilot stage. Hudson (1982) provided the original psychometric properties for American samples, while Onighaiye (1996) provided the properties for Nigerian samples.

Hudson (1982) used a five-point scale. The following instructions for administration are provided in the ISE text form:
The respondents were asked to read each of the statements carefully and tick the appropriate number which indicates how often each statement is true for them personally (see Appendix 5).

### 3.6 Reliability and Validity Determinations of the Instruments

A pilot study was carried out to determine the reliability of the research instruments. For this purpose, thirty-four adolescents; 22 from Children’s Correctional Centres for Boys at Sabo, Yaba, and 12 girls at Idi-Araba, Mushin (not at the same place where the main study took place) were used. To determine the stability of the test, the test-retest method was employed. The interval between the first and second administration was three weeks. The correlation between the two sets of scores of the instruments was determined using Pearson’s Product Moment Correlation method. The results of the correlation are given below:

#### Table 3: Test-Retest Reliability Estimates of The Instruments Used

<table>
<thead>
<tr>
<th>Instruments</th>
<th>Number of Participants</th>
<th>Mean Score</th>
<th>Standard Deviation</th>
<th>Correlation Co-efficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verbal Aggressiveness</td>
<td>34</td>
<td>55.09</td>
<td>5.50</td>
<td>0.73</td>
</tr>
<tr>
<td>Social Anxiety Thoughts Questionnaire</td>
<td>34</td>
<td>48.71</td>
<td>11.44</td>
<td>0.70</td>
</tr>
<tr>
<td>Automatic Thoughts Questionnaire</td>
<td>34</td>
<td>60.5</td>
<td>12.74</td>
<td>0.67</td>
</tr>
<tr>
<td>Index of Self-Esteem</td>
<td>34</td>
<td>57.79</td>
<td>11.94</td>
<td>0.82</td>
</tr>
</tbody>
</table>
From the above table, it can be seen that the reliability of VAS, SATQ, ATQ, and ISE were 0.73, 0.70, 0.67 and 0.82 respectively. The instruments were therefore found reliable enough for the study.

### 3.7 Procedure for Data Collection

#### Permission

A letter of introduction was obtained from the Head of Department of Educational Foundations, University of Lagos, Akoka. With this letter, the researcher applied for the use of Correctional Centres in Lagos and permission was granted by the Permanent Secretary in the Ministry of Youth, Sports and Social Development, Alausa, Ikeja, Lagos State.

#### Recruitment and Training of Research Assistants

Three research assistants were employed and trained by the researcher for effective data collection. These assistants were trained to assist in translating the questionnaire to those adolescents who were not literate in English; for easy administration of questionnaires and on how to tick the responses for each item on the instruments. The research assistant for the female was a Master’s Degree student on Industrial Attachment to the Centre from Ladoke Akintola University of Technology. The researcher worked closely with her to achieve the desired result. Two research assistants were obtained for the boys who were graduates and social workers, who were employees of Lagos State Government attached to the Centres. They were very fluent in the use of English Language and at least
one other Nigerian Language (Igbo, Yoruba, Igbira, Hausa, Edo, Ijaw and Efik). There were two training sessions of two hours each for the research assistants, which lasted for a period of one week. The training sessions took place in the office of the Principals of both schools located within the Centres. The Principals recommended the staff to assist for the exercise after the researcher explained the motive of the research work. They were adequately remunerated for their efforts. The research assistants were informed of the objectives and duration of the study. The researcher worked closely with the assistants to avoid mistakes. However, scoring the instruments was done by the researcher.

**Administration of Instruments**

The pre-assessment instruments were initially administered to 122 boys and 67 girls of Boys’ Special Correctional Centre at Oregun, Ikeja and Girls’ Idi-Araba in Mushin both in Lagos State. Thereafter, only 104 boys and 50 girls took part in the treatment and completed the post-test. This development was as a result of being released from the centres by the court because most of them had been going to court before the commencement of the research work. As soon as their cases were settled and application for their release were sought, the court reverses their remand warrant and they were released to their parents or guardians, thus they leave the centres. The research was carried out over a period of eight weeks. One week each was used for pre-test and post-test, while the actual period for the treatment lasted for 6 weeks.
3.8 Procedure for Treatment

This study was carried out in three phases.

**Phase 1:** Pre-treatment assessment;

**Phase 2:** Treatments

**Phase 3:** Post treatment assessment.

**Phase 1: Pre – treatment**

One week before the actual treatment, the researcher administered the Verbal Aggressiveness Scale (VAS), Social Anxiety Thoughts Questionnaire (SATQ), Automatic Thoughts Questionnaire (ATQ) and Index of Self-Esteem (ISE) to the participants in the three experimental groups.

**Phase 2: Treatments**

**Treatment** - There were three experimental groups (two treatment and one control group). The participants were assigned randomly to the groups. The control group did not receive any treatment during the study but the researcher went back and administered both cognitive restructuring based on cognitive theory and modelling based on social learning theory because the two were equally effective. The treatment lasted for six weeks with sessions of one hour per week. The treatment for both male and female was carried out simultaneously in their separate centres. The whole sample took part in three experimental groups that were carried out in each of the centres. Both centres
had CBT, SLT and Control groups each. The separate scores were got and paired against the instruments and compared.

**Detailed Treatment Procedure**

In phase 2, there are three groups divided into two main groups and one control group. Group 1 is the Cognitive Behaviour Therapy group and the treatment procedure is in six layers. Group 2 is the Social Learning Therapy. The procedure in this group is divided into six sessions. Finally Group 3 is the control group (Waiting List).

**Cognitive Behaviour Therapy (Cognitive Restructuring)**

The rationale for the treatment was to help participants develop better ways of perceiving or thinking about problems as a means of alleviating the problem symptoms. The treatment lasted for six weeks with a session of one hour per week. CBT techniques used were based on the procedures suggested by Meichebaum (1997) and Mckay, Davis and Fanning (1997).

**Session 1**

The researcher established rapport by introducing herself and calling on the participants to do likewise. The participants were acquainted with the rationale, procedures and benefits of the training. The need for confidentiality was stressed and participants were told that they should feel free to ask questions. Progressive relaxation training was taught. Participants were told that every session would begin with five minutes of exercises. The therapist told participants that the more
the brain is relaxed and quiet, the easier therapeutic information can get into it and be processed.

Specific instructions for Progressive Relaxation

1. Tense the muscles and hold for five seconds.
2. Feel the tension. Notice it carefully.
3. Now release. Let the tension slide away, all way.
4. Notice the pleasant warmth of relaxation.

Repeat the sequence with the same muscle group for at least three times for each muscles group.
5. Tense all the muscles together and hold for five seconds.
6. Feel the tension, notice it carefully, then release.
7. Let all tension slide away.

Identification of the problems: The exact events, thoughts, emotions, moods and actions that cause trouble were identified. Specific circumstances under which they occurred and the consequences (both immediate and delayed) were identified.

Session 2

The session was devoted to anger management through imagination. Progressive relaxation exercises. The participants were led through some relaxation techniques. “Relaxation training will equip the participants with the skills to cope with the tensions that precipitate the emitting of negative self statements and
interfere with performance. It is based on the premise that incompatible responses cannot occur at the same time. The participants were trained to progressively tense and relax various muscle groups and to acquire skills of deep breathing."

Specific Instructions for Deep Breathing Exercises

1. Take a deep breath. Say softly to yourself, “relax”, you breath out slowly.
2. Continue this exercise for about five minutes.
3. Remain totally relaxed.

Culled from: “Self-Directed Behaviour: Self Modification for Personal Adjustment” (Watson and Tharp, 1985). Identification of the problems: The exact events, thoughts, emotions, moods and actions that cause trouble were identified. Specific circumstances under which they occurred and the consequences (both immediate and delayed) were identified.

Instruct the participants to practice the relaxation exercises on their own after the training session.

Development of anger hierarchy: Participants were given blank sheets of paper. They were told to write down as many anger situations as they knew or could think of. They were told to think of a full range of provocations, from minor irritations to things that will make them blow their tops (make them very, very angry). They were told to write down as many as twenty or thirty situations. When they could not get as much, they were told to break the ones they had written down. When this was completed, they were then told to write on a new
sheet of paper a hierarchy of the situations starting with the least source of anger to the one that made them angriest.

The participants were taught to develop coping thoughts by first visualizing the scene and making it as real as possible. They were told to notice what they saw, heard, and what they felt physically. Then they were told to listen to their trigger thoughts. Did they blame others for what happened? Did they see their behaviour as wrong or bad? Those whose thoughts fell in the category of blame were taught some suggested coping responses to control anger:

- I may not like it, but they are doing the best they can.
- I’m not helpless. I can take care of myself in this situation.
- Blaming just upsets me. There’s no point in getting mad.
  Don’t assume the worst or jump to conclusions.

For those who felt that others broke the rules of standards of reasonable behaviour, some coping thoughts were given:

- Forget what people should do or not do; they only upset me.
- People do what they want to do.
- No one is wrong. We just have different needs.
- People change only when they want to.
- No one is bad; people do the best they can.

They were told that if one have difficulty remembering relaxation and coping thoughts during a provocative situation, one should visualize and practice coping later so if similar situation occurs again, one would be able to handle it.
Assignment:

Practice relaxation and other anger coping skills in real life.

Session 3

(A) The goal of this session was to help the participants on how to correctly see life events without joining issues with things that happened to them which caused emotions to rise unnecessarily. Relaxation exercise: Participants took some exercises to relax their brains.

(B) Participants were told that events do not have emotional content. It is one’s interpretations of an event that causes emotions. Change the thoughts and the feeling will change.

Participants were taught the eight limited thinking patterns- filtering, polarized thinking, overgeneralization, mind reading, “catastrophizing”, magnifying, personalization and “shoulds”.

1. Filtering focusing on the negative and filtering out the positive. Example: Your father says your result is okay but you need to improve in Mathematics where you scored 39%. You then get depressed focusing on only the area for improvement and filtering out the praise.

2. Polarized thinking: Seeing everything as awful or great, good or bad with no middle ground. Example: If I am not perfect then I am a failure.

Solution: think in percentage (%).
3. Overgeneralization: (Exaggeration). This involves making sweeping statements based on scanty evidence. Example: Low marks in a test means I can never do well.

4. Mind-Reading: Assuming you know what others are thinking. Example: She looked at me that way because she is jealous of me.
   Solution: Find evidence for conclusions. Find alternative interpretation.

5. Catastrophizing: Assuming the worst will happen. This leads to anxiety.
   Solution: Make an honest assessment of the situation.

   Solution: Get things in proportion, no need to magnify.

7. Personalization: Comparing yourself to others. Assuming the reactions of others always relate to you.
   Example: This girl is better person than I.
   Solution: We all have strong and weak points.

   Solution: Make flexible rules, values are personal.

**Activity:** Participants were asked to answer the questions below;

What patterns describe the following?
1. I could have enjoyed the picnic, but the chicken was burnt (filtering).

2. He is always smiling, but I know he doesn't like me (mind reading).

3. This subject is too difficult for me to understand, I can never pass the examination (magnifying).

4. Many of my classmates are more intelligent than I am (personalization).

**Session 4**

This session was devoted to anxiety control.

**Step 1:** Relaxation exercise – To prepare the brain for new skills, participants were told to devote some minutes every day for relaxation exercises. This should be done about five times a day or more at less regular intervals. The exercise could be done anywhere as it takes only few moments at a time. They were told that frequent relaxing moments would keep their overall level of physical stress under control. In this session, the training in coping in the imagery was introduced. Before then, the review of the activities which took place in the previous sessions were done. To commence training in coping with anxiety in the imagery, the researcher first explained the rationale for coping in the imagery. In this session, the training in coping in the imagery is introduced. Below is an excerpt of an explanation of the rationale for training in coping with anxiety provoking situations in the imagery?

“Today, we are going to learn how to cope with tensions and apprehensions associate with worry, first by gradual exposure in the imagery, and thereafter
how to transfer the acquired skill to worry situation. If a person is able to cope effectively with anxiety by imagining being exposed to graded series of the anxiety evoking scenes in a completely relaxed state, he can transfer the acquired coping skills to real life anxiety situations. To commence the coping in the imagery proper, first instruct the participants to progressively tense and relax the various muscle groups followed by practice in deep breathing paired with a cue word “relax” at each exhalation. After the participants had achieved a reasonable state of relaxation, ask them to close their eyes and imagine becoming anxious at the introduction of the first item in the anxiety/worry group hierarchy and then to attempt to cope with the anxiety of practicing deep breathing accompanied by emission of appropriate positive self statements and self instructions. Repeat this procedure until all the participants can successfully practice coping with the anxiety evoking scenes in the imagery.

**Step 2:** Risk management. Participants were told that no one could escape risk in life. The trick is to know which risks to avoid, which ones to prepare for and which risks one should not worry about. They are told that most anxious moments are as a result of overestimation due to either experience or belief. People who suffer from anxiety tend to engage in catastrophic thinking. Participants were taught to fill risk assessment form. They will be told to fill assessment form each time they are confronted by a significant worry.
Step 3: Worry exposures: Participants were told to expose themselves to minor worries first, experiencing them for about thirty minutes at a time. When minor worries no longer cause painful anxiety, then they could move on to more distressing worries. They will be told that gradually they would learn to take on major worries with little or no anxiety. The result of this method is different from what participants would get if they just worry on their own, which is if they engage in unstructured worry. They will be told that structured worry exposure would help them concentrate worrying time and therefore clear their minds of worry during the rest of the day.

Step 4: Worry behaviour prevention. Participants will be told to take one worry situation and stop the behaviour that leads to worry by replacing it with another. Example: If you avoid people because of fear of rejection, resolve to say a greeting to any one you sit next to in a bus or stand beside at a bus stop. Some will respond and some will not. You will notice that you will survive both situations.

Assignment:
Participants were told to practice worry control techniques at home on their own as they were taught in step 3.
Session 5
Participants were led through some minutes of progressive relaxation training using the procedures outline by Watson and Tharp (1985). Behaviour activation was introduced. The strategy was to get participants up and moving so that they could experience more of the good things in life that they had been missing. The goal of this session was to overcome depression by restoring contact with the normal rewards of everyday world. The researcher and participants developed lists of activities that were either pleasurable in themselves or that gave them greater control of themselves and their environment.

Activity: Participants identified activities with potentials for pleasure or mastery, and initiated or increased participation in them.

Assignment:
Participants were told to keep record of practice of new behaviour outside training session as were taught in step 5.

Session 6
A) Relaxation exercises: Participants were led through some minutes of relaxation exercises to calm them and prepare them for the session’s activities.

B) Participants were taught stress management through acceptance and commitment therapy, which is a part of Cognitive Behaviour Therapy.
They were encouraged to be less disturbed by events, thoughts, memories, mental images, fantasies and bodily sensation. They should not let these interfere with living by identified personal values. Participants were taught to embrace the principle embodied in the well-known serenity prayer: Grant me the serenity to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the difference.

**Assignment**

Participants were told to practice the new behaviour outside training sessions beginning from the easy ones to the most difficult ones. Participants were encouraged to ask any question of concern. This session was devoted to group discussion. The difficulties participants encountered in the course of their out of training activities and assignments were brought forward and discussed. Successes achieved thus far were also discussed.

There was a summary of the coping skills learnt in the course of therapy. The researcher urged the participants to continue to practice the skills that were learnt during training in all situations anywhere and anytime.

**Group 2: Social Learning Therapy (Modelling)**

This treatment assumes that people learn by observing others. People observe and imitate the real-life behaviour of people around them. An individual may know how to do something but refrain from acting until he expects the behaviour
to be rewarded. The focus here is on modelling. The aim of this treatment is to encourage participants to listen to and observe real life models (people who engage in one trade/vocation or the other), the consequences of their actions (how they get paid for services rendered). The participants will be asked if they are willing to imitate the actions of the models in order to receive similar rewards. The treatment is also aimed at counselling participants who believe that things are tougher than they really are and that they have or if they are willing, they can acquire skills and resources that are necessary to achieve the desired targets.

**Session 1**

The researcher established rapport by introducing herself and calling on the participants to do likewise. The participants were acquainted with the rationale, procedures and benefits of the training. The need for confidentiality was stressed and participants were told that they should feel free to ask any questions or express concern at any time during therapy. To further enhance the mutuality in the group, the members nominated a captain and assistant.

**Session 2**

Discussion with participants. The researcher asked the participants to mention their areas of vocational/job interest, the skills they think they possess or are willing to learn. The researcher took note of all their contributions. They were made to feel free to ask questions or make contributions.
Session 3

The researcher introduced modelling to them, people who have independently achieved success in their vocation. Their stories were told and participants were encouraged to model their lives after them. Emmanuel Adebayor, a Nigerian that plays football in Togo and Ramson Nouah a Nollywood actor for the boys. For the girls, Genevieve Nnaji (an actress) and Prof. Dora Akunyili (former Director – General of National Food, Drug Administration and Control (NAFDAC) and former Minister of Information and Communication were introduced. Questions and answers were entertained.

Session 4

The researcher asked the participants to introduce two models again in their area of greatest interest. They did and the researcher asked them to list out what were the main attractions they had for the models. General discussions followed.

Session 5

The researcher asked the participants questions on what they have learnt from the models and the impact they made on their lives. Questions were entertained from the participants by the researcher too.
**Session 6**

Further discussion with participants on the outcome of counselling sessions and encouragement from the researcher that their willingness to turn new leaves was the first step to actualizing their dreams towards independent life. The end of the sessions and appreciation day for both the participants and research assistants and the researcher. Awards were given to best behaved and others who excelled in different areas. Every participant received a gift and group photographs with the staff were taken only as the management do not allow photographs of the inmates of both centres.

**Waiting-List Control**

Participants in the waiting-list control (WLC) group did not receive any treatment; rather they were told that owing to time constraints, their own training sessions would be arranged at a later date. By saying this, the researcher intended to ascertain the extent to which mere promise of future treatment would engender treatment effects on aggression, anxiety, depression and self-esteem. Nevertheless, the participants in this group took part in all pre-test and post-test assessments (Okoli, 1998).

**Phase 3: Post Treatment Assessment**

A week after the treatment, the instruments (VAS, SATQ, ATQ and ISE) were re-administered to the three groups to evaluate the treatment effect of counselling on the psychosocial problems using the same procedure.
3.9 Method of Data Analysis

The data collected from the various centres were analyzed using both descriptive and inferential statistics. Descriptive statistics was used to show the means, mean differences, standard deviations, and percentages for pre and post treatment measures. 2 X 3 ANCOVA was used to test all, for the while the fisher’s protected t-test was used for the post-hoc comparisons. All hypotheses were tested at 0.05 level of significance
CHAPTER FOUR

RESULTS

This chapter presents the results obtained from the various statistical analyses carried out in the study. Results of the survey done were presented below. Five null hypotheses were formulated to guide the study. The hypotheses were tested with Analysis of Covariance (ANCOVA). Mean scores, standard deviations and percentages were used as the descriptive statistics. All hypotheses were tested at 0.05 level of significance.

Fisher’s Protected t-test Multiple comparisons were carried out to determine which pair of the groups show true difference especially when there is a significant treatment effect. The acceptance or rejection of the hypotheses were provided with evidences to support them.
Presentation of Descriptive Data

Table 4a: Distribution of Adolescents in Boys Special Correctional Centres in Lagos State by States of the Federation.

<table>
<thead>
<tr>
<th>S/No</th>
<th>State</th>
<th>Number of Boys</th>
<th>S/No</th>
<th>State</th>
<th>Number of Boys</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Abia</td>
<td>1</td>
<td>20</td>
<td>Katsina</td>
<td>0</td>
</tr>
<tr>
<td>2</td>
<td>Adamawa</td>
<td>0</td>
<td>21</td>
<td>Kebbi</td>
<td>0</td>
</tr>
<tr>
<td>3</td>
<td>Akwa-Ibom</td>
<td>3</td>
<td>22</td>
<td>Kogi</td>
<td>2</td>
</tr>
<tr>
<td>4</td>
<td>Anambra</td>
<td>4</td>
<td>23</td>
<td>Kwara</td>
<td>5</td>
</tr>
<tr>
<td>5</td>
<td>Bauchi</td>
<td>0</td>
<td>24</td>
<td>Lagos</td>
<td>4</td>
</tr>
<tr>
<td>6</td>
<td>Bayelsa</td>
<td>2</td>
<td>25</td>
<td>Nasarawa</td>
<td>0</td>
</tr>
<tr>
<td>7</td>
<td>Benue</td>
<td>2</td>
<td>26</td>
<td>Niger</td>
<td>0</td>
</tr>
<tr>
<td>8</td>
<td>Borno</td>
<td>0</td>
<td>27</td>
<td>Ogun</td>
<td>28</td>
</tr>
<tr>
<td>9</td>
<td>Cross-River</td>
<td>4</td>
<td>28</td>
<td>Ondo</td>
<td>7</td>
</tr>
<tr>
<td>10</td>
<td>Delta</td>
<td>5</td>
<td>29</td>
<td>Ogun</td>
<td>5</td>
</tr>
<tr>
<td>11</td>
<td>Ebonyi</td>
<td>3</td>
<td>30</td>
<td>Oyo</td>
<td>15</td>
</tr>
<tr>
<td>12</td>
<td>Edo</td>
<td>1</td>
<td>31</td>
<td>Plateau</td>
<td>0</td>
</tr>
<tr>
<td>13</td>
<td>Ekiti</td>
<td>0</td>
<td>32</td>
<td>Rivers</td>
<td>0</td>
</tr>
<tr>
<td>14</td>
<td>Enugu</td>
<td>1</td>
<td>33</td>
<td>Sokoto</td>
<td>0</td>
</tr>
<tr>
<td>15</td>
<td>Gombe</td>
<td>0</td>
<td>34</td>
<td>Taraba</td>
<td>0</td>
</tr>
<tr>
<td>16</td>
<td>Imo</td>
<td>4</td>
<td>35</td>
<td>Yobe</td>
<td>0</td>
</tr>
<tr>
<td>17</td>
<td>Jigawa</td>
<td>0</td>
<td>36</td>
<td>Zamfara</td>
<td>0</td>
</tr>
<tr>
<td>18</td>
<td>Kaduna</td>
<td>0</td>
<td>37</td>
<td>F.C.T.</td>
<td>0</td>
</tr>
<tr>
<td>19</td>
<td>Kano</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Researcher’s Survey

There are also non-Nigerians at the centre as table 4b indicates below:
Table 4b: Distribution of Non-Nigerian Adolescents in the Special Correctional Centre for Boys

<table>
<thead>
<tr>
<th>Country</th>
<th>Ghana</th>
<th>Swiss</th>
<th>Benin Republic</th>
<th>Togo</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>8</td>
</tr>
</tbody>
</table>

Source: Researcher’s Survey

Table 4a & 4b revealed that Ogun, Oyo and Ondo States had the highest number of adolescents in Special Correctional Centre for Boys at Oregun, Lagos State that took part in the study, while states like Adamawa, Borno, Ekiti, Gombe, Jigawa, Kaduna, Kano, Kastina, Kebbi, Nasarawa, Niger, Plateau, Rivers, Sokoto, Taraba, Yobe and Zamfara had no inmates. It also showed that non–Nigerians are at the centre.

Table 5: Inmates Reasons for Being at the Special Correctional Centre for Boys

<table>
<thead>
<tr>
<th>Age per age</th>
<th>Number per age</th>
<th>Criminal Cases</th>
<th>Rescued by people</th>
<th>Arrested by the Taskforce</th>
<th>Care &amp; Protection</th>
<th>Beyond Parental Control</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>11</td>
<td>8</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>5</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>12</td>
<td>15</td>
<td>0</td>
<td>2</td>
<td>4</td>
<td>8</td>
<td>1</td>
<td>15</td>
</tr>
<tr>
<td>13</td>
<td>14</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>7</td>
<td>0</td>
<td>14</td>
</tr>
<tr>
<td>14</td>
<td>14</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>8</td>
<td>2</td>
<td>14</td>
</tr>
<tr>
<td>15</td>
<td>22</td>
<td>6</td>
<td>5</td>
<td>2</td>
<td>6</td>
<td>3</td>
<td>22</td>
</tr>
<tr>
<td>16</td>
<td>20</td>
<td>3</td>
<td>7</td>
<td>5</td>
<td>3</td>
<td>2</td>
<td>20</td>
</tr>
<tr>
<td>17</td>
<td>7</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>18</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>104</td>
<td>16</td>
<td>18</td>
<td>21</td>
<td>40</td>
<td>9</td>
<td>104</td>
</tr>
</tbody>
</table>

Source: Researcher’s Survey
Table 5, revealed that care and protection, taskforce and rescued cases had the highest number of inmates followed by criminal case and beyond parental control. From the above table too, it shows that ages 15 & 16 had the highest number of adolescents in the centre. For Care & Protection, ages 12 to 14 ranked highest. It could also be proven that the highest number of the adolescents in the Special Correctional Centre for Boys at Oregun, Ikeja in Lagos State are there not really for criminal cases but for care and protection according to the above data collected from the centre. This confirmed the assertion by one of them that they are not all criminals.

Table 6a: Distribution of Adolescents in Girls Special Correctional Centres in Lagos State by States of the Federation.

<table>
<thead>
<tr>
<th>S/No</th>
<th>State</th>
<th>Number of Girls</th>
<th>S/No</th>
<th>State</th>
<th>Number of Girls</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Abia</td>
<td>0</td>
<td>20</td>
<td>Katsina</td>
<td>0</td>
</tr>
<tr>
<td>2</td>
<td>Adamawa</td>
<td>0</td>
<td>21</td>
<td>Kebbi</td>
<td>0</td>
</tr>
<tr>
<td>3</td>
<td>Akwa-Ibom</td>
<td>0</td>
<td>22</td>
<td>Kogi</td>
<td>0</td>
</tr>
<tr>
<td>4</td>
<td>Anambra</td>
<td>2</td>
<td>23</td>
<td>Kwara</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td>Bauchi</td>
<td>0</td>
<td>24</td>
<td>Lagos</td>
<td>2</td>
</tr>
<tr>
<td>6</td>
<td>Bayelsa</td>
<td>0</td>
<td>25</td>
<td>Nasarawa</td>
<td>0</td>
</tr>
<tr>
<td>7</td>
<td>Benue</td>
<td>1</td>
<td>26</td>
<td>Niger</td>
<td>0</td>
</tr>
<tr>
<td>8</td>
<td>Borno</td>
<td>1</td>
<td>27</td>
<td>Ogun</td>
<td>6</td>
</tr>
<tr>
<td>9</td>
<td>Cross- River</td>
<td>5</td>
<td>28</td>
<td>Ondo</td>
<td>1</td>
</tr>
<tr>
<td>10</td>
<td>Delta</td>
<td>6</td>
<td>29</td>
<td>Osun</td>
<td>1</td>
</tr>
<tr>
<td>11</td>
<td>Ebonyi</td>
<td>0</td>
<td>30</td>
<td>Oyo</td>
<td>2</td>
</tr>
<tr>
<td>12</td>
<td>Edo</td>
<td>2</td>
<td>31</td>
<td>Plateau</td>
<td>0</td>
</tr>
</tbody>
</table>
There are also non Nigerians at the Special Correctional Centre for Girls as table 6b indicates.

Table 6b: Distribution of Non-Nigerian Adolescents at the Special Correctional Centre for Girls

<table>
<thead>
<tr>
<th></th>
<th>Ghana</th>
<th>Benin Republic</th>
<th>Togo</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>Ekiti</td>
<td>4</td>
<td>32</td>
<td>Rivers</td>
</tr>
<tr>
<td>14</td>
<td>Enugu</td>
<td>0</td>
<td>33</td>
<td>Sokoto</td>
</tr>
<tr>
<td>15</td>
<td>Gombe</td>
<td>0</td>
<td>34</td>
<td>Taraba</td>
</tr>
<tr>
<td>16</td>
<td>Imo</td>
<td>4</td>
<td>35</td>
<td>Yobe</td>
</tr>
<tr>
<td>17</td>
<td>Jigawa</td>
<td>0</td>
<td>36</td>
<td>Zamfara</td>
</tr>
<tr>
<td>18</td>
<td>Kaduna</td>
<td>0</td>
<td>37</td>
<td>F.C.T.</td>
</tr>
<tr>
<td>19</td>
<td>Kano</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

Table 6a & 6b: revealed that Ogun, Delta and Cross-River States had the highest number of adolescents in Special Correctional Centre for girls at Idi-Araba, Lagos State that took part in the study, while states like Benue, Borno and Osun had one each. Adamawa, Ebonyi, Enugu, Gombe, Jigawa, Kaduna, Kano, Kastina, Kebbi, Nasarawa, Niger, Plateau, Sokoto, Taraba, Yobe and Zamfara had no inmates. There are also non-Nigerians at the centre too.
## Table 7: Inmates Reasons for Being at the Special Correctional Centre for Girls

<table>
<thead>
<tr>
<th>Age</th>
<th>Number per age</th>
<th>Criminal Cases</th>
<th>Rescued by people</th>
<th>Arrested by the Taskforce</th>
<th>Care &amp; Protection</th>
<th>Beyond Parental Control</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>11</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>12</td>
<td>4</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>13</td>
<td>6</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>14</td>
<td>7</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>7</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>15</td>
<td>11</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>6</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>16</td>
<td>11</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>6</td>
<td>0</td>
<td>11</td>
</tr>
<tr>
<td>17</td>
<td>7</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>6</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>18</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>50</td>
<td>1</td>
<td>1</td>
<td>-11</td>
<td>3</td>
<td>34</td>
<td>1</td>
<td>50</td>
</tr>
</tbody>
</table>

**Source:** Researcher's Survey

*Table 7* revealed that Care & Protection, Rescued and Taskforce had the highest numbers while Criminal Case and Beyond Parental Control had the lowest numbers. From the above table too, it shows that ages 15 & 16 had the highest number of adolescents in the centre. For Care & Protection, between ages 14 to 17 ranked highest. It could also be proven that the highest number of the adolescents in the Special Correctional Centre for girls at Idi-Araba, Mushin in Lagos State are there not really for criminal cases but for Care and Protection according to the above data collected from the centre. This confirmed the assertion by one of them that they are not all criminals.
Testing of Hypotheses

**Hypothesis 1:** There is no significant difference in the post-test scores in aggressiveness among participants in the three experimental groups Cognitive Behaviour Therapy, Social Learning Therapy and Control.

Table 8 presents the means and standard deviations for the pre-test and post-test scores for Verbal Aggressiveness Scale (VAS) for the three experimental groups. Table 9 presents the Analysis of Covariance summary data on the effects of gender and experimental conditions on the post-test in VAS using the pre-test scores as covariate which also explains table 8. Table 10 presents Fisher’s Protected t-test comparison of the treatment strategies on post-test verbal aggressiveness.

**Table 8: Means and Standard Deviation, of Pre-test and Post-test Means on Verbal Aggressiveness Scale (VAS) for Adolescents Based on Gender and treatment strategies and control group.**

<table>
<thead>
<tr>
<th>Experimental Groups</th>
<th>Gender</th>
<th>N</th>
<th>Pre-test Mean</th>
<th>S.D.</th>
<th>Post-test Mean</th>
<th>S.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive Behaviour Therapy</td>
<td>Male</td>
<td>40</td>
<td>62.55</td>
<td>16.74</td>
<td>49.13</td>
<td>10.92</td>
</tr>
<tr>
<td>(Cognitive Restructuring)</td>
<td>Female</td>
<td>14</td>
<td>60.29</td>
<td>12.52</td>
<td>48.14</td>
<td>8.56</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>54</td>
<td>61.96</td>
<td>15.67</td>
<td>48.87</td>
<td>10.23</td>
</tr>
<tr>
<td>Social Learning Therapy( Modelling)</td>
<td>Male</td>
<td>35</td>
<td>66.66</td>
<td>12.20</td>
<td>54.80</td>
<td>10.40</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>18</td>
<td>58.17</td>
<td>7.28</td>
<td>43.39</td>
<td>9.44</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>53</td>
<td>63.77</td>
<td>11.45</td>
<td>50.92</td>
<td>11.38</td>
</tr>
<tr>
<td>Control Group</td>
<td>Male</td>
<td>29</td>
<td>56.21</td>
<td>8.55</td>
<td>63.79</td>
<td>9.47</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>18</td>
<td>55.94</td>
<td>9.32</td>
<td>63.61</td>
<td>10.37</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>47</td>
<td>56.11</td>
<td>8.76</td>
<td>63.72</td>
<td>9.71</td>
</tr>
</tbody>
</table>
Table 9: $2 \times 3$ Analysis of Covariance (ANCOVA) Summary Data for Post-test Scores on Verbal Aggressiveness Scale (VAS) Using the Pre-test Scores on VAS as Covariate

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of squares</th>
<th>Degree of freedom</th>
<th>Mean of squares</th>
<th>F-value</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main effects</td>
<td>7068.125</td>
<td>4</td>
<td>1767.031</td>
<td>17.31</td>
<td>*</td>
</tr>
<tr>
<td>Experimental Group</td>
<td>6116.746</td>
<td>2</td>
<td>3058.373</td>
<td>29.96</td>
<td>*</td>
</tr>
<tr>
<td>Gender</td>
<td>693.719</td>
<td>1</td>
<td>693.719</td>
<td>6.79</td>
<td>*</td>
</tr>
<tr>
<td>Covariates (Pre-VAS)</td>
<td>49.020</td>
<td>1</td>
<td>49.020</td>
<td>.480</td>
<td>n.s.</td>
</tr>
<tr>
<td>Exp. Vs Group &amp; Gender</td>
<td>978.211</td>
<td>2</td>
<td>489.106</td>
<td>4.79</td>
<td>*</td>
</tr>
<tr>
<td>Residual</td>
<td>15008.787</td>
<td>147</td>
<td>102.101</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>23055.123</td>
<td>153</td>
<td>150.687</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Significant, P < 0.05 level, n.s not significance
F critical (1, 147) = 3.92
F critical (2, 147) = 3.06

Table 9 showed that there is a significant difference in the post-test scores in Verbal Aggressiveness Scale (VAS) among the three groups (F=29.96, p<0.05). Null hypothesis for hypothesis one is therefore rejected. Also, there is a significant difference in the post-test scores in VAS due to gender difference of the participants (F=6.79, p<0.05). Female had a mean difference of 5.59 while male had 7.04. It worked better for the female. In the same vein, the interaction of gender and experimental conditions recorded significant effect on the VAS score (F=4.79, p<0.05). This means that whatever treatment effects evidenced
by the experimental groups was with regards to their gender composition. This therefore did not support hypotheses five.

Because the above ANCOVA table reveals that there is significant difference across the experimental groups, it becomes very important to find out the most effective of the counselling strategies. This led to the use of fisher’s protected t-test. The result of the post-hoc analysis is in Table 10 below:

**Table 10: Multiple comparisons using fisher’s protected t-test\**

**dependent variable: Post-test aggressiveness.**

<table>
<thead>
<tr>
<th>Experimental Conditions</th>
<th>CBT n=54</th>
<th>SLT n=53</th>
<th>CG n=47</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive Behaviour Therapy</td>
<td>48.87a</td>
<td>-1.04</td>
<td>-7.35*</td>
</tr>
<tr>
<td>Social Learning Therapy</td>
<td>-2.05</td>
<td>50.92</td>
<td>-6.34*</td>
</tr>
<tr>
<td>Control Group</td>
<td>-14.85</td>
<td>-12.80</td>
<td>63.72</td>
</tr>
</tbody>
</table>

a = Group means are in the diagonal; differences in group means are below the diagonal while protected t-test are above the diagonal.

*Significant at 0.05.

The pair-wise comparison in table 10 shows that participants exposed to CBT do not significantly differ in aggressiveness from those exposed to SLT (t=-1.04, df=105; critical t=2.00; p>0.05). However, participants exposed to CBT significantly manifested less aggressive behaviour than the control group (t=-7.35, df=99; critical t=2.00; p< 0.05). Similarly, participants exposed to SLT significantly have less aggressive behaviour than those in the control group (t=-6.34, df=98; critical t=2.00; p< 0.05).
This indicates that both treatments were efficacious in reducing participants’ aggressiveness. Hypothesis one which states that treatment strategies do not significantly reduce participants’ aggressiveness is therefore rejected.

There is a significant difference in the post-test scores in Verbal Aggressiveness Scale (VAS) among participants in the three experimental groups;

There is a significant difference in the post-test scores in VAS due to gender difference.

**Hypothesis 2:** There is no significant difference in the post-test scores in anxiety among participants in the three experimental groups.

Table 11 presents the means and standard deviation, pre-test and post-test of gender in the three experimental groups. Table 12 presents the summary data of Analysis of Covariance (ANCOVA) on the effects of gender and experimental conditions on the post-test score in SATQ using the pre-test scores as covariate. Table 13 presents Fisher’s Protected t-test comparison of the treatment strategies on post-test anxiety levels.
Table 11: Means and Standard Deviation of Pre-test and Post-test on Social Anxiety Thoughts Questionnaire (SATQ) for Adolescents Based on Gender and treatment strategies and control group.

<table>
<thead>
<tr>
<th>Experimental Groups</th>
<th>Gender</th>
<th>N</th>
<th>Pre-test Mean</th>
<th>S.D.</th>
<th>Post-test Mean</th>
<th>S.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive Behaviour Therapy (Cognitive Restructuring)</td>
<td>Male</td>
<td>40</td>
<td>69.08</td>
<td>10.91</td>
<td>47.83</td>
<td>7.84</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>14</td>
<td>69.79</td>
<td>7.77</td>
<td>34.50</td>
<td>11.02</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>54</td>
<td>69.26</td>
<td>10.12</td>
<td>44.37</td>
<td>10.48</td>
</tr>
<tr>
<td>Social Learning Therapy (Modelling)</td>
<td>Male</td>
<td>35</td>
<td>65.37</td>
<td>13.03</td>
<td>51.94</td>
<td>13.13</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>18</td>
<td>65.61</td>
<td>10.62</td>
<td>41.00</td>
<td>11.23</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>53</td>
<td>65.45</td>
<td>12.16</td>
<td>48.23</td>
<td>13.47</td>
</tr>
<tr>
<td>Control Group</td>
<td>Male</td>
<td>29</td>
<td>54.76</td>
<td>11.45</td>
<td>56.76</td>
<td>11.16</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>18</td>
<td>53.61</td>
<td>7.14</td>
<td>55.89</td>
<td>10.47</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>47</td>
<td>54.32</td>
<td>9.95</td>
<td>56.43</td>
<td>10.79</td>
</tr>
</tbody>
</table>

Table 12: 2 x 3 Analysis of Covariance (ANCOVA) Summary Data for Post-test Scores on Social Anxiety Thoughts Questionnaire (SATQ) Using the Pre-test Scores on SATQ as Covariate

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of squares</th>
<th>Degree of freedom</th>
<th>Mean of squares</th>
<th>F-value</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main effects</td>
<td>6164.738</td>
<td>4</td>
<td>1541.184</td>
<td>13.16</td>
<td>*</td>
</tr>
<tr>
<td>Experimental Group</td>
<td>3831.814</td>
<td>2</td>
<td>1915.907</td>
<td>16.36</td>
<td>*</td>
</tr>
<tr>
<td>Gender</td>
<td>2312.050</td>
<td>1</td>
<td>2312.050</td>
<td>19.74</td>
<td>*</td>
</tr>
<tr>
<td>Covariates (Pre-SATQ)</td>
<td>90.856</td>
<td>1</td>
<td>90.856</td>
<td>.776</td>
<td>n.s</td>
</tr>
<tr>
<td>Exp. Vs Group &amp; Gender</td>
<td>979.237</td>
<td>2</td>
<td>489.619</td>
<td>4.18</td>
<td>*</td>
</tr>
<tr>
<td>Residual</td>
<td>17220.181</td>
<td>147</td>
<td>117.144</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>24364.156</td>
<td>153</td>
<td>159.243</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Significant at 0.05 level  n.s. = not significant

F critical (1, 147) =3.92
F critical (2, 147) = 3.06
Table 12, showed that there was a significant difference in the post-test scores in Social Anxiety Thought Questionnaire (SATQ) among the three groups (F=16.36, p<0.05). Null hypothesis for hypothesis two was therefore rejected. Also, there was a significant difference in the post-test scores in SATQ due to gender difference of the participants (F=19.74, p<0.05). In the same vein, the interaction of gender and experimental conditions recorded significant effect on the SATQ score (F=4.18, p<0.05). This means that whatever treatment effects evidenced by the experimental groups was with regards to their gender composition. This therefore rejected hypotheses five, which showed that there was a significant gender difference and in interaction effects of gender and experimental groups. The female benefitted more than the male with a mean of 69.79 and 69.08 in CBT and 65.61 and 65.37 in SLT.

Because the above ANCOVA table reveals that there is significant difference across the experimental groups, it becomes very important to find out the better of the counselling strategies. This led to the use of fisher’s protected t-test. The result of the post-hoc analysis is in table 13 below:

Table 13: Multiple comparisons using fisher’s protected t-test dependent variable: Post-test anxiety.

<table>
<thead>
<tr>
<th>Experimental Conditions</th>
<th>CBT n=54</th>
<th>SLT n=53</th>
<th>CG n=47</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive Behaviour Therapy</td>
<td>44.37a</td>
<td>-1.83</td>
<td>-5.58*</td>
</tr>
<tr>
<td>Social Learning Therapy</td>
<td>-3.86</td>
<td>48.23</td>
<td>-3.80*</td>
</tr>
<tr>
<td>Control Group</td>
<td>-12.06</td>
<td>-8.20</td>
<td>56.43</td>
</tr>
</tbody>
</table>
a =Group means are in the diagonal; differences in group means are below the diagonal while protected t-test are above the diagonal.

*Significant at 0.05.

The pair-wise comparison in table 13 shows that participants exposed to CBT do not significantly differ in anxiety levels from those exposed to SLT (t=-1.83, df=105; critical t=2.00; p>0.05). However, participants exposed to CBT significantly manifested less anxiety level than the control group (t=-5.58, df=99; critical t=2.00; p<0.05). Similarly, participants exposed to SLT significantly had less anxiety level than those in the control group (t=-3.80, df=98; critical t=2.00; p< 0.05). This indicates that both treatments were efficacious in reducing participants’ anxiety. Hypothesis two which states that treatment strategies do not significantly reduce participants’ anxiety was therefore rejected. There was a significant difference in the post-test scores in Social Anxiety Thought Questionnaire (SATQ) among participants in the three experimental groups. There was a significant difference in the post-test scores in SATQ due to gender.
**Hypothesis 3:** There is no significant difference in the post-test scores in depression among participants in the three experimental groups.

**Table 14:** Means and Standard Deviation of Pre-test and Post-test on Automatic Thoughts Questionnaire (ATQ) for Adolescents Based on Gender and treatment strategies and control group.

<table>
<thead>
<tr>
<th>Experimental Groups</th>
<th>Gender</th>
<th>N</th>
<th>Pre-test Mean</th>
<th>S.D.</th>
<th>Post-test Mean</th>
<th>S.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive Behaviour Therapy (Cognitive Restructuring)</td>
<td>Male</td>
<td>40</td>
<td>70.90</td>
<td>9.34</td>
<td>53.33</td>
<td>9.39</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>14</td>
<td>65.29</td>
<td>5.14</td>
<td>47.50</td>
<td>10.13</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>54</td>
<td>69.44</td>
<td>1.25</td>
<td>51.81</td>
<td>9.83</td>
</tr>
<tr>
<td>Social Learning Therapy (Modelling)</td>
<td>Male</td>
<td>35</td>
<td>77.66</td>
<td>21.19</td>
<td>59.43</td>
<td>17.69</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>18</td>
<td>77.28</td>
<td>18.42</td>
<td>52.61</td>
<td>13.69</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>53</td>
<td>77.53</td>
<td>20.11</td>
<td>57.11</td>
<td>16.63</td>
</tr>
<tr>
<td>Control Group</td>
<td>Male</td>
<td>29</td>
<td>78.17</td>
<td>8.72</td>
<td>80.31</td>
<td>12.53</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>18</td>
<td>72.61</td>
<td>19.40</td>
<td>81.44</td>
<td>18.39</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>47</td>
<td>76.04</td>
<td>13.89</td>
<td>80.74</td>
<td>14.86</td>
</tr>
</tbody>
</table>

**Table 15:** 2 x 3 Analysis of Covariance (ANCOVA) Summary Data for Post-test Scores on Automatic Thoughts Questionnaire Adolescents Based on Gender and Experimental Group

<table>
<thead>
<tr>
<th>Source of variation</th>
<th>Sum of squares</th>
<th>Degree of freedom</th>
<th>Mean of squares</th>
<th>F-value</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main effects</td>
<td>29993.304</td>
<td>4</td>
<td>7498.326</td>
<td>49.19</td>
<td>*</td>
</tr>
<tr>
<td>Experimental Group</td>
<td>20869.025</td>
<td>2</td>
<td>10434.512</td>
<td>68.45</td>
<td>*</td>
</tr>
<tr>
<td>Gender</td>
<td>177.798</td>
<td>1</td>
<td>177.798</td>
<td>1.17</td>
<td>n.s</td>
</tr>
<tr>
<td>Covariates (Pre-ATQ)</td>
<td>6147.757</td>
<td>1</td>
<td>6147.757</td>
<td>40.33</td>
<td>*</td>
</tr>
<tr>
<td>Exp. Vs Group &amp; Gender</td>
<td>607.523</td>
<td>2</td>
<td>303.762</td>
<td>1.99</td>
<td>n.s</td>
</tr>
<tr>
<td>Residual</td>
<td>22409.511</td>
<td>147</td>
<td>152.446</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>53010.338</td>
<td>153</td>
<td>346.473</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Significant  at 0.05 level n.s. = not significant

F critical (1, 147) = 3.92
F critical (2, 147) = 3.06
Table 15, showed there is a significant difference in the post-test scores in Automatic Thought Questionnaire (ATQ) among the three groups (F=68.45, \( p<0.05 \)). Null hypothesis of hypothesis three is therefore rejected. There is no significant difference in the post-test scores in ATQ due to gender difference of the participants (F=1.17). In the same vein, the interaction of gender and experimental conditions recorded no significant effect on the ATQ score (F=1.99). This means that whatever treatment effects evidenced by the experimental groups was not with regards to their gender composition. Thus hypothesis 5 is hereby accepted. The male showed better improvement in CBT with mean of 70.90 and the female with 65.29 and in SLT with a mean of 77.66 and 77.28 for the female.

Because the above ANCOVA table revealed that there is significant difference across the experimental groups, it becomes very important to find out the better counselling strategies. This led to the use of fisher’s protected t-test. The result of the post-hoc analysis is in table 16 below:

Table 16: Multiple comparisons using fisher’s protected t-test

dependent variable: Post-test depression.

<table>
<thead>
<tr>
<th>Experimental Conditions</th>
<th>CBT n=54</th>
<th>SLT n =53</th>
<th>CG n=47</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive Behaviour Therapy</td>
<td>51.81a</td>
<td>-2.20*</td>
<td>-11.71*</td>
</tr>
<tr>
<td>Social Learning Therapy</td>
<td>-5.30</td>
<td>57.11</td>
<td>-9.57*</td>
</tr>
<tr>
<td>Control Group</td>
<td>-28.93</td>
<td>-23.63</td>
<td>80.74</td>
</tr>
</tbody>
</table>
a = Group means are in the diagonal; differences in group means are below the diagonal while protected t-test are above the diagonal.
*Significant at 0.05.

The pair-wise comparison in table 16 shows that participants exposed to CBT significantly differ in depression from those exposed to SLT (t=-2.20, df=105; critical t=2.00; p <0.05). However, participants exposed to CBT significantly manifested less depression than the control group (t=-11.71, df=99; critical t=2.00; p< 0.05). Similarly, participants exposed to SLT significantly had less depression than those in the control group (t=-9.57, df=98; critical t=2.00; p< 0.05). Indicative of the fact that social learning therapy was a better treatment than cognitive behaviour therapy. Hypothesis three which states that treatment strategies do not significantly reduce participants’ depression was therefore rejected. There was a significant difference in the post-test scores in Automatic Thought Questionnaire (ATQ) among participants in the three experimental groups. There was no significant difference in the post-test scores in SATQ due to gender difference. Therefore, hypothesis five was hereby accepted.
Hypothesis 4: There is no significant difference in the post-test scores in self-esteem among participants in the three experimental groups.

Table 17: Means and Standard Deviation of Pre-test and Post-test on Index of Self-Esteem (ISE) for Adolescents Based on Gender, treatment strategies and control group

<table>
<thead>
<tr>
<th>Experimental Groups</th>
<th>Gender</th>
<th>N</th>
<th>Pre-test</th>
<th>Post-test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Mean</td>
<td>S.D.</td>
</tr>
<tr>
<td>Cognitive Behaviour</td>
<td>Male</td>
<td>40</td>
<td>77.68</td>
<td>8.89</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>14</td>
<td>81.00</td>
<td>7.95</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>54</td>
<td>78.54</td>
<td>8.70</td>
</tr>
<tr>
<td>Social Learning Therapy (Modelling)</td>
<td>Male</td>
<td>35</td>
<td>76.77</td>
<td>8.25</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>18</td>
<td>82.44</td>
<td>10.00</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>53</td>
<td>78.70</td>
<td>9.20</td>
</tr>
<tr>
<td>Control Group</td>
<td>Male</td>
<td>29</td>
<td>87.55</td>
<td>8.92</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>18</td>
<td>83.67</td>
<td>11.11</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>47</td>
<td>86.06</td>
<td>10.11</td>
</tr>
</tbody>
</table>

*Higher scores on the self-esteem measure are indicative of low self-esteem.
Table 18: 2 x 3 Analysis of Covariance (ANCOVA) Summary Data for Post-test Scores on Index of Self-esteem (ISE) Using the Pre-test Scores on ISE as Covariate

<table>
<thead>
<tr>
<th>Source of variation</th>
<th>Sum of squares</th>
<th>Degree of freedom</th>
<th>Mean of squares</th>
<th>F-value</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main effects</td>
<td>46998.896</td>
<td>4</td>
<td>11749.724</td>
<td>194.17</td>
<td>*</td>
</tr>
<tr>
<td>Experimental Group</td>
<td>37943.662</td>
<td>2</td>
<td>18971.831</td>
<td>313.52</td>
<td>*</td>
</tr>
<tr>
<td>Gender</td>
<td>16.753</td>
<td>1</td>
<td>16.753</td>
<td>.277</td>
<td>n.s.</td>
</tr>
<tr>
<td>Covariates (Pre ISE)</td>
<td>977.550</td>
<td>1</td>
<td>977.550</td>
<td>16.16</td>
<td>*</td>
</tr>
<tr>
<td>Exp. Group &amp; Gender</td>
<td>275.326</td>
<td>2</td>
<td>137.663</td>
<td>2.27</td>
<td>n.s.</td>
</tr>
<tr>
<td>Residual</td>
<td>8895.389</td>
<td>147</td>
<td>60.513</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>56169.610</td>
<td>153</td>
<td>367.122</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Significant at 0.05 level  n.s. = not significant

F critical (1, 147) = 3.92
F critical (2, 147) = 3.06

Table 18, showed that there is a significant difference in the post-test scores in Index of Self-Esteem (ISE) among the three groups (F=313.52, p<0.05). Null hypothesis for hypothesis four is therefore rejected. There is no significant difference in the post-test scores in ISE due to gender difference of the participants (F= 2.77). In the same vein, the interaction of gender and experimental conditions recorded no significant effect on the ISE score (F=2.27). This means that whatever treatment effects evidenced by the experimental groups was not with regards to their gender composition. Thus hypothesis five is accepted. The male improved more with a mean of 77.68 and female with 81.00
in CBT. In SLT the male with mean of 76.77 and female with a mean of 82.44. Higher mean indicates lower self-esteem.

Because the above ANCOVA table reveals that there is significant difference across the experimental groups, it becomes very important to find out the most effective of the counselling strategies. This led to the use of fisher’s protected-test. The result of the post-hoc analysis is in table 19 below:

**Table 19: Multiple comparisons using fisher’s protected t-test**

**dependent variable: Post-test self-esteem.**

<table>
<thead>
<tr>
<th>Experimental Conditions</th>
<th>CBT n=54</th>
<th>SLT  n=53</th>
<th>CG n=47</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive Behaviour Therapy</td>
<td>59.78a</td>
<td>12.30*</td>
<td>-15.54*</td>
</tr>
<tr>
<td>Social Learning Therapy</td>
<td>18.7</td>
<td>41.08</td>
<td>-27.53*</td>
</tr>
<tr>
<td>Control Group</td>
<td>-24.24</td>
<td>-42.94</td>
<td>84.02</td>
</tr>
</tbody>
</table>

*a =Group means are in the diagonal; differences in group means are below the diagonal while protected t-test are above the diagonal.

*Significant at 0.05.

The pair-wise comparison in table 19 shows that participants exposed to CBT significantly differed in self-esteem from those exposed to SLT (t=12.30, df=105; critical t=2.00; p<0.05). However, participants exposed to CBT significantly manifested less low self-esteem than the control group (t=-15.54, df=99; critical t=2.00; p < 0.05). Similarly, participants exposed to SLT significantly have less low self-esteem than those in the control group (t=-27.53, df=98; critical t=2.00;
p< 0.05). Indicative of the fact that social learning therapy was a better treatment than cognitive behaviour therapy though both of them worked. Hypothesis four which states that treatment strategies do not significantly reduce participants’ self-esteem was therefore rejected. There was a significant difference in the post-test scores in Index of Self-Esteem (ISE) among participants in the three experimental groups. There was no significant difference in the post-test scores in ISE due to gender difference. Therefore, hypothesis five was hereby accepted.

**Summary of findings**

1. Cognitive Behaviour Therapy and Social Learning Therapy were both efficacious in alleviating aggression in both male and female adolescents in correctional centres.

2. The level of anxiety among the participants reduced using both the Cognitive Behaviour Therapy and the Social Learning Therapy.

3. Social Learning Therapy was more effective in the management of depression among both male and female adolescents in the correctional centres.

4. Low self esteem was significantly reduced by Social Learning Therapy among the participants in the correctional centres better than the cognitive behaviour therapy.

5. There was significant gender difference with the groups in dependent measures of aggression and anxiety but no significant gender difference was noticed in depression and self-esteem measures.
6. The number of males in correctional centres in Lagos State is twice the number of females for the past three years, 2007-2010.

7. Adolescents from the south-west top the list of all the inmates in the correctional centres.

8. Poverty, polygamy and parental neglect and hostile home environment were found to be factors that made the adolescents leave home for the streets.
CHAPTER FIVE

DISCUSSION OF FINDINGS, IMPLICATIONS, RECOMMENDATIONS, SUGGESTIONS FOR FURTHER RESEARCH

This chapter presents the discussion of the result of the statistical analysis reported in chapter four and offers possible interpretations of the findings. The discussion of findings would either affirm or negate some of the research findings earlier reviewed. Implications of the findings, study, recommendations of the study, suggestions for further research, conclusion and contributions to knowledge.

5.1 Discussion of Findings

This section presents a discussion of the results of the five tested null hypotheses.

**Hypothesis one** states that there is no significant difference in the post-test scores in aggressiveness among participants in the three experimental groups Cognitive Behaviour Therapy, Social Learning Therapy and Control.

The results of statistical analysis of hypothesis one presented in tables 8, 9, & 10 provided evidence that Cognitive behaviour Therapy and Social Learning Therapy were found to be equally good treatments in alleviating aggressiveness in adolescents. Verbal Aggressiveness Scale was used to ascertain whether the treatment method Cognitive Behaviour Therapy would evidence comparable treatment effects on aggression as would Social Learning Therapy. Both
treatments had significant positive influence on aggression of all participants both males and females, compared to the control group.

The findings of this study concerning the efficacy of the experimental conditions on Verbal Aggressiveness Scale (VAS) confirmed partially the research findings of Lochman (1985), that Cognitive Behaviour Therapy was effective in treatment of aggressive adolescents. Based on his study of 76 boys ranging 9-12, he had concluded that the group treated using Cognitive Behaviour Therapy evidenced a reduction in aggressive behaviour.

The study also supported Lochman & Lampron (1988) who found Cognitive Behaviour Therapy an effective therapy for aggressive boys in 10-12 age range. It is also consistent with Beck & Fernandez (1998) who reviewed 50 outcome studies on aggression covering a total 1640 participants and found that Cognitive Behaviour Therapy participants did better than 76% of untreated participants. Social Learning was found to be equally efficacious in ameliorating aggressiveness in adolescents. This is in line with the claim of Bandura (1963) that "Through observing appropriate models, people learn to acquire skills and strategies and people imitate what they appreciate. Modelling can accelerate behaviour modification and should be used wherever possible to establish new responses. Modelling helps to develop new responses and reinforcement serves to maintain the new responses."
The relative effectiveness of both cognitive restructuring and modelling in alleviating aggressiveness in both male and female participants could be due to the fact that when real life models of which they identified themselves were discussed, they found out that if those people could become great in life, they too could equally achieve greatness if they could look beyond where they are now and focus their attention on what they would like to become in the future. The way they previously see themselves and their situations gradually began to give way to more self-confident people. It is important to note that the knowledge and skills that people possess will play critical roles in what they choose to do and not to do. Cognitive Behaviour Therapy (CBT) and Social Learning Therapy are efficacious in the group management of psychosocial problems. Treatment effects were significant at 0.05 levels.

**Hypothesis two** states that there is no significant difference in the post-test scores in anxiety among participants in three experimental groups. The result of hypothesis two as indicated in tables 11, 12, & 12 showed that Cognitive behaviour therapy and Social learning therapy were found to be equally efficacious in alleviating adolescents’ anxiety. Social Anxiety Thoughts was used to find out if the treatment method Cognitive Behaviour Therapy would evidence comparable effects on anxiety, as would Social Learning Therapy. There was significant difference in the post-test scores on anxiety of participants in the three experimental groups. Cognitive Behaviour Therapy and Social Learning
Therapy showed to be efficacious in reduction of anxiety levels of participants than those who received placebo treatment. The reason for this could be because both therapies used behavioural techniques, which are effective in reducing anxiety.

The findings supported Heimberg, Dorge & Hope (1990), and Mattick & Peter (1988) who stated based on their research findings that Cognitive Behaviour Therapy was effective in treatment of anxiety. Cognitive Behaviour Therapy evidenced positive change on the dependent measures because it is a therapy that encourages the development of valuable coping and emotional management skills (Bush, 2006A). This is consistent with Burns (2000) that described the therapy as a fast-acting technology of mood modification and behaviour therapy, which encourages people not to give in to their compulsive urge to fight, show of anger or anxiety.

The finding supported Kendell, Flannery-Schroeder, Panichelli-Mindell, Southam-Gerow, Henin and Warman (1997) on the outcome of their research on 94 children who were diagnosed with general anxiety disorder and social phobia and counselled using Cognitive Behaviour Therapy. Based on teacher rating, 70% of the treated children were functioning normally for one year. The findings of this research are also in support of Albaro and Barlow (1996) who treated adolescents with social anxiety using group Cognitive Behaviour Therapy. They suggested that socially phobic adolescents could attain relatively normal
functioning in school and other social settings. Their suggestion was on preliminary results of their research.

The findings is consistent with that of Beck & Stanley (1997), Mattick & Peter (1997), Durham & Allen (1993), Durham & Turvey (1987) and Butler, Fernnell, Robson & Gelder (1991) who concluded that Cognitive Behaviour Theory was very effective in treatment of anxiety. CBT was better in the treatment of anxiety for the males who had higher levels of anxiety due to the much pressure on their future. Female showed lower trace of anxiety. This confirmed (Anwuri, 2007) that CBT had great impact on treatment of anxiety and (Ahime, 2007) also confirmed this. These findings were not in support of Shea, Pilkonin, Beckham, Collins, Elkin, Sotsky, & Docherty (1982), who suggested that there is no significant advantage of Cognitive Behaviour Therapy over other interventions. Hope, Heimberg & Bruch (1995) also stated that Cognitive Behaviour Therapy only evidenced 30% gain in anxiety reduction as against 70% of those treated with exposure. This finding contradicts Okoli (1995) who found that treatment involving cognitive-behavioural techniques as well as behavioural procedures had significant treatment effect on anxiety among senior secondary school students. Although anxiety irrespective of the types arouses unpleasant emotions that are threats to our well being (Onyejiaku, 1991) yet may vary in their severity. Okoli (1995) concentrated on test anxiety which could result from lack of achievement in school subjects or fear of failure.
The efficacy of both cognitive behaviour therapy and social learning therapy in reducing anxiety could be as result of participants personal decision to rise above their present circumstances by changing the way they perceive themselves before the study and by engaging in positive self-talk after the sessions. The previous situations that make them anxious were therefore seen as nothing with the new knowledge they had about people and situations. The assignments given to them on how to counter fearful or anxious situations must have been well practiced at their leisure time.

**Hypothesis three** states that there is no significant difference in the post-test scores in depression among the three experimental groups. The results of the findings are presented in tables 14, 15, & 16 showed that Social Learning Therapy evidenced significant improvement for the treatment of adolescents’ depression more than the cognitive behaviour therapy. Automatic Thought Questionnaire was used ascertain whether the treatment methods Cognitive Behaviour Therapy would evidence comparable treatment effects on depression, as would Social Learning Therapy. Both treatment groups had significant reduction in participants’ depression level when compared to the participants who received placebo treatment. The treatments have equal effect on depression of all the participants both male and female. However, male showed higher levels of depression than female because from the mean scores of both, males were higher in their manifestation of depression than the females.
This may be due to male having issues of taking responsibility of fending for themselves, their wives and children and their hope of ever achieving that in considering their present predicament. Social Learning was found to be equally efficacious in ameliorating aggressiveness in adolescents. This is in line with the claim of Bandura (1963) that “through observing appropriate models, people learn to acquire skills and strategies and people imitate what they appreciate. Modelling can accelerate behaviour modification and should be used wherever possible to establish new responses. Modelling helps to develop new responses and reinforcement serves to maintain the new responses.

It is important to note that the knowledge and skills that people posses will play critical roles in what they choose to do and not to do. Cognitive Behaviour therapy had significantly lower levels of depression than those treated with medication. This study also partially supported the findings of Elkin, Gibbons, Shea, Sotsky, Watkins, Pilkons & Hedeker, (1995), that Cognitive Behaviour Therapy was superior to no-treatment or placebo controls for depressive, anxious and somatic disorders in children.

One possible reason for this is that cognitive component of intervention programme focuses on changing the maladaptive thinking style of the depressed person and the behavioural component focuses on increasing positive activities and behaviours that are likely to increase the amount of social and response-contingent reinforcement available to the depressed child or adolescent (Robbins, 1993).
Psychological treatment of depression (psychotherapy) can assist the depressed individual in several ways. First, supportive counselling helps ease the pain of depression, and addresses the feelings of hopelessness that accompany depression. Second, cognitive therapy changes the pessimistic ideas, unrealistic expectations, and overly critical self-evaluations that create depression and sustain it. Cognitive therapy helps the depressed person recognize which life problems are critical, and which are minor. It also helps him/her to develop positive life goals, and a more positive self-assessment. Third, problem solving therapy changes the areas of the person’s life that are creating significant stress, and contributing to depression. This may require behavioural therapy to develop better coping skills, or Interpersonal therapy, to assist in solving relationship problems. The finding also lends support to the findings of Payne & Blanchard (1995) that behavioural therapy effectively improves psychological measures on depression more than intervention with operant based procedures. Depression is a deep rooted emotional problem that demands awakening of the unconscious minds of the clients for them to face the reality of the antecedent.

**Hypothesis four** states that there is no significant difference in the post-test scores in self-esteem among participants in the three experimental groups.

The statistical analysis as presented in tables 17, 18 & 19 proved that Social learning therapy was very effective in the improvement of low self-esteem although treatment both treatments helped adolescents self-esteem. This finding
was in line with Anwuri 2007 & Ahime that confirmed that social learning therapy significantly improved self-esteem. Aneke (2009) in the studies carried out among female prisoners in Lagos state also confirmed the efficacy of social learning therapy in improving self-esteem of the women thereby enhancing their overall self-image and self-confidence. It was also found out that children who live with people other than their own parents are saddled with low self-esteem among others. The assertion was supported by (Anwuri, 2007; Ahime 2007; Aneke 2009 & Bamidele 2010. The treatment on the self-esteem of the participants in this study proves that psychotherapy is effective in enhancing self-esteem of adolescents who suffer from depressed mood, anxiety, social and interpersonal problems as suggested by Chan & Lee (1993). The positive response of the participants to the treatment supported the finding of Engel (1959) that most adolescents succeed in maintaining a sense of continuity in spite of turbulent experiences they have encountered. The improvement of the of the participants’ self-esteem in the study also confirm the findings of Hendel (1980) that adolescents who score high on neuroticism scales and low on adjustment scales are more likely to report significant amount of perceived self-image.

Female showed higher levels of problems of self-esteem than male because from the mean scores of both, females were higher in their manifestation of problems of self-esteem than the male. This may be due to the fact that female are psychologically affected by what they hear more than what they see. They are
emotional and work with feeling, while the males are logical and work with reason. The female get their sense of worth by verbal approval from the opposite sex. They may feel that they are worthless as most of them attested to the researcher.

A feeling that stemmed from the fact that because they are remanded, they felt that people seeing them in correctional centres will look at them as being irresponsible. It was also found out that children who live with people other than their own parents are saddled with low self-esteem among others. This assertion was supported by (Anwuri 2007; Ahimie 2007; Aneke 2009 and Bamidele 2010). The treatment on the self-esteem of the participants in this study proves that psychotherapy is effective in enhancing self-esteem of adolescents who suffer from depressed mood, anxiety, social and interpersonal problems as suggested by Chan & Lee (1993). The positive response of the participants to the treatment supported the finding of Engel (1959) that most adolescents succeed in maintaining a sense of continuity in spite of turbulent experiences they have encountered.

The improvement of the participants’ self-esteem in the study also confirm the findings of Hendel (1980) that adolescents who sore high on neuroticism scales and low on adjustment scales are more likely to report significant amount of perceived self-change. The way one sees oneself goes a long way in determining personal development. With debilitating self-esteem, positive and strong self can
hardly be formed because of the fragility of the self at the face of difficult situations (Okoye, 2006).

**Hypothesis five** states that there is no gender difference in the post-test scores in the dependent measures (aggressiveness, anxiety, depression and self-esteem). The statistical results as provided in tables 8 to 19 showed that there was significant gender difference in the dependent measures of aggressiveness and anxiety of the participants post-test scores but in the dependent measures of depression and self-esteem, gender difference was not significant. This evidence was supported by Loeber & Hay (1997) which stated that gender differences in aggression are very noticeable by the preschool years, with boys showing higher levels of physical aggression than girls. However, many preschools girls are physically aggressive, and they show levels of verbal and indirect aggression similar to or greater than boys (Crick & Gropeter, 1995; Rys & Bear, 1997). In later elementary grades and in adolescence, gender differences in indirect and physical aggression increase. Indirect aggression becomes much greater for girls than boys; physical aggression becomes much greater for boys than girls; and verbal aggression is about the same for girls and boys (Crick & Gropeter, 1995; Lagerspetz et al., 1988; Vallancourt, 2005). These gender differences culminate in dramatic differences in violent behaviour in young adulthood, reflected by large gender differences in murder rates. Nevertheless, this should not lead one to believe that females are never physically aggressive. Females do display
physical aggression in social interactions, particularly when they are provoked by other females (Collins, Quinley, & Leonard, 2007). When it comes to heterosexual domestic partners, women are slightly more likely than men to use physical aggression against their partners (e.g., Archer, 2000; Straus, 1997). However men are more likely than women to inflict serious injuries and death on their partners.

Focusing on the possible existence of sex differences in the various forms of aggression, a study by Bjokqvist and his colleagues (1992) investigated boys’ and girls’ (aged 8-15 years) use of different forms of aggressive behaviour. Using the Direct/Indirect Aggression Scale (DIAS), their data suggest, that while boys exceed girls on standard measure of direct physical and verbal aggression, the sex differences is reversed when a measure of indirect aggression is used. Thus, while boys employ more direct aggression than girls (in conflict behaviour), girls use more indirect aggression than boys. Other researchers have also confirmed this sex difference in the exhibition of aggression behaviour among adolescent males and females (Tapper & Boulton, 2004). Crick & Gropeter (1995) found evidence to suggest that girls use more relational aggression than boys whilst boys use more overt aggression than girls. According to Amedahe & Owusu-Banahene (2007), found that in Ghanaians high school campuses, both sexes would initially employ a verbal assault or verbal aggression, female adolescent students’ verbal aggression is much less likely to escalate to physical aggression, unless the situation really demands it, such as for self-defense.
Okoli (1995), contradicted the above findings. He found that no significant difference in the prevalence of test anxiety among senior secondary school two students. However, the female students seemed to have had slightly higher level of debilitating anxiety, learning mathematics anxiety, mathematics evaluation anxiety, worry and emotionality.

Female participants showed higher levels of problems of self-esteem than male because from the mean scores of both, females were higher in their manifestation of problems of self-esteem than the male. This may be due to the fact that female are psychologically affected by what they hear more than what they see. They are emotional and work with feeling, while the males are logical and work with reason. The female get their sense of worth by verbal approval from the opposite sex. They may feel that they are worthless as most of them attested to the researcher. A feeling that stemmed from the fact that because they are remanded, they felt that people seeing them in correctional centres will look at them as being irresponsible. It was also found out that children who live with people other than their own parents are saddled with low self-esteem among others. This assertion was supported by (Anwuri 2007; Ahimie 2007; Aneke 2009 and Bamidele 2010).

In addition, male showed higher levels of depression than females because from the mean score of both, male were higher in their manifestation of depression than the females. This may be due to male having issues of taking responsibility
of fending for themselves, their wives and children and their hope of ever achieving that in considering their present predicament.

Hostile families are likely to have children fraught with psychosocial problems as proved by the study. This was supported by Makinde (2004) who cautions that parental expectations should not be too high and that the home climate should be a good example of a happy marriage which is stress-free and with a minimum level of conflicts.

Adolescents from the south-west top the list of all the inmates in the correctional centres. This may be as a result of Lagos State being a south-west state and being surrounded by Ogun, Ondo and Oyo being in the same geo-political zones of Nigeria. This could be as a result of distance decay theory which states that interaction between two locales decline as the distance between increases. Once the distance is outside of two locales activity space their interactions begin to decrease. Distance decay is a geographical term which describes the effect of distance on cultural or spatial interactions (Wikipedia, 2011).

5.2 Implications for Counselling

- Counsellors and other care givers in correctional centres should teach relaxation techniques to children and adolescents in their care. During relaxation training sessions, one would discover that one’s racing thought would start to show, and one’s feeling of fear and anxiety will ease considerably. When one’s body is completely relaxed, it would be impossible to feel fear or anxiety (McKay, Davis & Fanning, 1997). When
the body is relaxed, the alpha between the brain wave frequency, which is associated with a state of calm well being, increases (Benson, 1975).

- Counsellors and Caregivers should note the fact that the children and adolescents in their care should be treated with love and helped to build a high self-esteem. Low self-esteem might lead to a depressed, irritable or aggressive mood. This is because the person who has a low self-esteem uses aggressive and depressed moods as cover-up. He would be unable to form meaningful relationships (McKay, Davis & Fanning, 1997). It therefore follows that if adolescents assisted to build a high self-esteem, then the likely onset of depression, aggression and anxiety would be minimal.

- The findings that cognitive-restructuring treatment had more positive significant effect on psychological measures imply that people with traumatic experiences will benefit more from combined therapeutic procedures involving cognitive and behavioural orientations than treatment procedures involving only behavioural backgrounds. Consequently, school counsellors should not adhere to a particular theoretical orientation but should incorporate other necessary theoretical models to achieve maximum result.

- Adolescents in correctional centres should be given coping resources (counselling) as they are used to deal with life demands.
• Counsellors need to counsel parents on how to cope with problems of adolescents using modelling. They need appropriate parenting skills and psycho educational strategies to assist their children especially at the critical stage of transition from childhood to adulthood known as the adolescence stage. Parents should ensure that a child is adequately taken good care of by providing the basic needs of the child to avoid resorting to anti-social behaviour as a result of deprivation, neglect and abandonment and thereby taking to the street.

• Counsellors should be at the forefront of the re-education process for parents on how to maintain very close and cordial relationship with their children as these will help to develop good self-image and good confidence.

• Counsellors should start creating awareness of the implications and consequences of involvement in criminal activities by adolescents through radio and television programmes, jingles, NGOs and some community programmes.

• Counsellors should counsel parents to desist from giving out their children to relatives or strangers as house helps or baby-sitters in order to be sent to school. People could support poor parents by sponsoring their children to school without necessarily taking them away from their parents. This
was found to heighten low self-image as they carry the stigma of being second-class citizens in their new homes.

5.3 Recommendations

Based on the findings of this study, the following recommendations were made:

1. Policy should be enacted as a bill or act that could be signed into law at the Federal, State and Local Government levels on the need to have functional correctional centres across the country.

2. The infrastructures in the correctional centres should be made homely and adequate for the corrective measures to be really achieved in order to serve the purposes they are put in place in the first place.

3. Adolescents in correctional centres should be given avenues to express themselves in sporting activities, academic competitions and social engagement. That way they will be able to relax and therefore have less need to exhibit depressive or aggressive tendencies.

4. Adolescents should be respected. This would be a boost on their self-esteem. They should be corrected in a loving way. If a child’s ego is deflated, he is likely to have a low self-concept, which in effect would mean low self-esteem. An adolescent, who has a high self-esteem, would not likely exhibit inappropriate behaviours such as aggression, anxiety, depression, and drug addiction.
5. Government at all levels should provide the basic necessities of life for the citizenry in order to reduce extreme poverty which is the cause of most anti-social and deviant behaviour among the adolescents and creation of jobs for the teeming population.

8. Education to some extent should be made free to ensure that no parents gives out his wards to people to help send them to school who turn these vulnerable ones to slaves and some to prostitution to make up for the “education” they are so given.

9. Cognitive Behaviour Therapy and Social Learning Therapy should be used to counsel adolescents in correctional centres on continual basis.

10. Periodically, these group of children, lost but found children should be screened on National Television Authority Network News, so that people will get to know them and contact made to reconcile them back to their families.

11. Comfortable members of the society should be encouraged to help these children by sponsoring their education because if they are not adequately educated or given vocational training while in the correctional centres, upon their release, the tendency of falling back to crime is very high. This is because as the saying goes, “an idle mind is the devil’s workshop”.


5.4 Suggestions for Further Research

The following suggestions are made as a result of the findings emanating from this research study.

1. The replication of this study in other correctional centres in other states of the country other than Lagos State.

2. The study dealt on the treatment of some psychosocial problems of adolescents in correctional centres in Lagos State using Cognitive Behaviour Therapy and Social Learning Therapy. Other psychological and social problems could still be investigated.

3. The replication of this study with younger children in correctional centres. This might be a pointer to when the effect of parental deprivation, neglect and abandonment of correctional centres experience really begin to manifest in children.

4. The investigation of treatment effects over a period of time.

5. The study might be carried out using other counselling methods.

6. The result of the present study showed differences in the efficacy of cognitive behaviour therapy and social learning therapy. Further research is needed to clarify the mechanisms through which the two counselling methods achieved such almost uniform effects.
5.5 Contributions to knowledge

1. The study demonstrated the efficacy of treatment strategies in alleviating aggressiveness in adolescents. Based on this, the study has demonstrated the need for the adoption of Cognitive Behaviour Therapy in assisting adolescents cope/overcome their problem of adjustment at the correctional centres.

2. Cognitive Behaviour Therapy and Social Learning Therapy reduced anxiety among adolescents in correctional centres is a breakthrough. In addition, it has shed light on the fact that intervention strategies vary with ailments or different psychosocial problems.

3. Social Learning Therapy proved very efficacious in reducing depression in adolescents in correctional centres more than the Cognitive Behaviour Therapy. This should be of immense concern to researchers and counsellors.

4. Social learning therapy proved highly effective in the treatment of low self-esteem. These finding would be of immense help to researchers.

5. The study has shown that institutionalized adolescents differ from adolescents who live with their parents. This difference is due to parental deprivation of adolescents in correctional centres. This should be of great concern to academics and others interested in the welfare of children and adolescents.

6. Adequate infrastructure is vital in the adjustment of remanded adolescents because a conducive and healthy environment a complementary to other strategies employed in the management of some psychosocial problems of adolescents in remand homes.
REFERENCES


APPENDIX 1

QUESTIONNAIRE

PART ONE

Name..................................................................................................................
Sex....................................................................................................................
Age...................................................................................................................
School.............................................................................................................
Date..................................................................................................................

PART TWO

In this part, read each statement carefully and indicate your opinion by putting a tick (v) in one of the five choices provided.
APPENDIX 2

VERBAL AGGRESSIVE SCALE

Developed by D.A., & Infante & C.J. Wigley 111 (1986)

This survey is concerned with how we try to get people to comply with our wishes. Indicate how often each statement is true for you personally when you try to influence other person, by ticking on the appropriate box.

The number stands for;

1 = Never
2 = Rarely
3 = Sometimes
4 = Often
5 = Always

<table>
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<tr>
<th>S/N</th>
<th>Statement</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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<tbody>
<tr>
<td>1.</td>
<td>I am careful to avoid attacking individual’s intelligence when I attack their ideas</td>
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<td>2.</td>
<td>When individuals are very stubborn, I use insults to soften the stubbornness</td>
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<td>3.</td>
<td>I try very much to avoid others feel bad about themselves when I try to influence them</td>
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<td>4.</td>
<td>When people refuse to do an important task without good reason I tell them they are unreasonable</td>
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<td>5.</td>
<td>When others do things I regard as stupid, I try to be extremely gentle with them</td>
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<td>6.</td>
<td>If individuals I’m trying to influence really deserve it, I attack their character</td>
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<td>7.</td>
<td>When people behave in ways that are in very poor state, I insult them in order to shock them into proper behaviour</td>
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<td>8.</td>
<td>I try to make people feel good about themselves even when their ideas are stupid</td>
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<td>9.</td>
<td>When people simply will not bulge on matter of importance, I lose my temper and rather say strong things to them</td>
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<td>Item</td>
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<td>10.</td>
<td>When people criticize my shortcomings, I take it in good humour and do not try to get back at them</td>
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<td>11.</td>
<td>When individuals insult me, I get a lot of pleasure out of really telling them off</td>
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<td>12.</td>
<td>When I dislike individuals greatly, I try not to show it in what I say or how I say it</td>
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<td>13.</td>
<td>I like poking fun at people who do things that are very stupid in order to stimulate their intelligence</td>
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<td>14.</td>
<td>When I attack people’s ideas, I try not to damage their self-concept</td>
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<td>15.</td>
<td>When I try to influence people, I make a great effort not to offend them</td>
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<td>16.</td>
<td>When people do things that are mean or cruel, I attack their character in order to correct their behaviour</td>
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<td>17.</td>
<td>I refuse to participate in arguments when they involve personal attacks</td>
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<td>18.</td>
<td>When nothing seems to work in trying to influence others, I yell and scream in order to get some movement from them</td>
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<td>19.</td>
<td>When I am not able to refute other’s positions, I try to make them feel defensive in order to weaken their positions</td>
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<td>20.</td>
<td>When an argument shifts to personal attacks, I try very hard to change the subject.</td>
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The participants were expected to shade one of these five in response to an item. Two scoring techniques namely the **direct** and **reverse** scoring were used. The items corresponding to the direct items are 2, 4, 6, 7, 9, 11, 13, 16, 18 & 19. In the direct scoring technique, a participant is given the score corresponding to the number shaded on the five-point scale. Thereafter, the total scores of the participant for the ten items was summed up (added together) to form the total score for the session.
The items corresponding to the reverse questions are 1,3,5,8,10,12,14,15,17 & 20. In the reverse scoring technique, the scale was reversed as:

5 = Always
4 = Often
3 = Sometimes
2 = Rarely
1 = Never

Similar to the direct scoring technique, the participant is awarded the score corresponding to the option chosen. The total score of the participant was obtained by adding together scores relating to the shaded item.
APPENDIX 3

SOCIAL ANXIETY THOUGHTS QUESTIONNAIRE

Developed by Kendell and Hollon (1980)

Listed below are a variety of thoughts that pop into people’s heads in situations that involve being with other people or talking to them. Please read each thought and indicate how frequently, if at all, the thought occurred to you over the last week.

The number stands for;

1 = Never
2 = Rarely
3 = Sometimes
4 = Often
5 = Always

<table>
<thead>
<tr>
<th>S/N</th>
<th>Thought</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
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<tbody>
<tr>
<td>1.</td>
<td>I feel tense and uncertain</td>
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<td>2.</td>
<td>I don’t know what to say</td>
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<td>3.</td>
<td>May be I sound stupid</td>
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<td>4.</td>
<td>I am perspiring</td>
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<td>5.</td>
<td>What would I say first?</td>
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<td>6.</td>
<td>Can they tell I am nervous?</td>
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<td>7.</td>
<td>I feel afraid</td>
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<td>8.</td>
<td>I wish I could just be myself</td>
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<td>9.</td>
<td>What are they thinking of me?</td>
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<td>10.</td>
<td>I feel shaky</td>
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<td>11.</td>
<td>I’m not pronouncing well</td>
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<td>12.</td>
<td>Will others notice my anxiety?</td>
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</tr>
<tr>
<td>13.</td>
<td>I feel defenceless</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>14.</td>
<td>I will freeze up</td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>15.</td>
<td>Now they know am nervous</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>16.</td>
<td>I don’t like being in this situation</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>17.</td>
<td>I am inadequate</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>18.</td>
<td>Does my anxiety show?</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>19.</td>
<td>I feel tense in my stomach</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>20.</td>
<td>Others will not understand me</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>21.</td>
<td>What do they think of me?</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
The respondents were asked to read each of the statements carefully and tick the appropriate number which indicates how often each statement is true for them personally.

There is only direct scoring of the items in SATQ. Add together the values of the numbers ticked in relevant items. For example, if the items 1,2,3,4,5,6,7,8 the numbers are ticked 4,5,1,3,2,5,3,4, respectively, the score for the 8 items is 4+5+1+3+2+5+3+4=27.
APPENDIX 4

AUTOMATIC THOUGHTS QUESTIONNAIRE

Developed by Hartman (1984)

Listed below are a variety of thoughts that pop into people’s heads. Please read each thought and indicate how frequently the thought occurred to you over the last week. Please read each item carefully and fill in the blanks with the appropriate number, using the following scale:
1 = Never
2 = Rarely
3 = Sometimes
4 = Often
5 = Always

<table>
<thead>
<tr>
<th>S/N</th>
<th>Thought</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I feel I am up against the world</td>
</tr>
<tr>
<td>2</td>
<td>I’m no good</td>
</tr>
<tr>
<td>3</td>
<td>Why can’t I ever succeed</td>
</tr>
<tr>
<td>4</td>
<td>No one understands me</td>
</tr>
<tr>
<td>5</td>
<td>I’ve let people down</td>
</tr>
<tr>
<td>6</td>
<td>I don’t think I can go on</td>
</tr>
<tr>
<td>7</td>
<td>I wish I were a better person</td>
</tr>
<tr>
<td>8</td>
<td>I’m so weak</td>
</tr>
<tr>
<td>9</td>
<td>My life’s not going the way I want it to</td>
</tr>
<tr>
<td>10</td>
<td>I’m so disappointed in myself</td>
</tr>
<tr>
<td>11</td>
<td>Nothing feels good anymore</td>
</tr>
<tr>
<td>12</td>
<td>I can’t stand this anymore</td>
</tr>
<tr>
<td>13</td>
<td>I can’t get started</td>
</tr>
<tr>
<td>14</td>
<td>What’s wrong with me?</td>
</tr>
<tr>
<td>15</td>
<td>I wish I were somewhere else</td>
</tr>
<tr>
<td>16</td>
<td>I can’t get things together</td>
</tr>
<tr>
<td>17</td>
<td>I hate myself</td>
</tr>
<tr>
<td>18</td>
<td>I am worthless</td>
</tr>
<tr>
<td>19</td>
<td>I wish I could just disappear</td>
</tr>
<tr>
<td>20</td>
<td>What’s the matter with me?</td>
</tr>
<tr>
<td>21</td>
<td>I’m a loser</td>
</tr>
<tr>
<td>22</td>
<td>My life is a mess</td>
</tr>
<tr>
<td>23</td>
<td>I’m a failure</td>
</tr>
<tr>
<td>24</td>
<td>I’ll never make it</td>
</tr>
<tr>
<td>25</td>
<td>I feel so helpless</td>
</tr>
<tr>
<td>26</td>
<td>Something has to change</td>
</tr>
<tr>
<td>27</td>
<td>There must be something wrong with me</td>
</tr>
<tr>
<td>28</td>
<td>My future is bleak</td>
</tr>
<tr>
<td>29</td>
<td>It’s just not worth it</td>
</tr>
<tr>
<td>30</td>
<td>I can’t finish anything</td>
</tr>
</tbody>
</table>
The respondents were asked to read each of the statements carefully and tick the appropriate number which indicates how often each statement is true for them personally.

There is only direct scoring of the items in SATQ. Add together the values of the numbers ticked in relevant items. For example, if the items 1,2,3,4,5,6,7,8 the numbers are ticked 4,5,1,3,2,5,3,4, respectively, the score for the 8 items is 4+5+1+3+2+5+3+4=27.
APPENDIX 5
INDEX OF SELF-ESTEEM

Developed by W.W. Hudson (1982)

This questionnaire is designed to measure how you see yourself. It is not a test, so there is no right or wrong answer. Please answer each item as carefully and accurately as you can by ticking the box that is most appropriate.

1 = Never
2 = Rarely
3 = Sometimes
4 = Often
5 = Always

<table>
<thead>
<tr>
<th>S/N</th>
<th>Question</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I feel that people will not like me if they really knew me well</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>I feel that others get along better than I do</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>I feel that I am a beautiful/handsome person</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>When I am with other people, I feel they are glad I am with them</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>I feel that people really like to talk with me</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>6</td>
<td>I feel that I have enough ability to do something</td>
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</tr>
<tr>
<td>7</td>
<td>I think I make others admire me</td>
<td></td>
<td></td>
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<tr>
<td>8</td>
<td>I feel that I need more power to trust myself</td>
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</tr>
<tr>
<td>9</td>
<td>When I am with strangers, I am very nervous</td>
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</tr>
<tr>
<td>10</td>
<td>I think that I am a dull person</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>I feel ugly</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>I feel that others have more fun than I do</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>I feel that I make people feel tired of me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>I think my friends find me interesting</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>I think I make people laugh</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>I feel self-conscious when I am with strangers</td>
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<td></td>
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</tr>
<tr>
<td>17</td>
<td>I feel I would have made it, if I were like other people.</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>18</td>
<td>I feel that people enjoy me when am with them</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>19</td>
<td>I feel rejected by men/women in party</td>
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<td></td>
</tr>
<tr>
<td>20</td>
<td>I feel I get pushed around more than others</td>
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</tr>
<tr>
<td>21</td>
<td>I think I am a nice person</td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>I feel that people really like me very much</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>I feel that I am a likeable person</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>I am afraid I will appear foolish to others</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>My friends think very highly of me</td>
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</tr>
</tbody>
</table>
The participants are expected to shade one of these five in response to an item. Two scoring techniques namely the **direct** and **reverse** scoring were used. The items corresponding to the direct questions are 1,2,8,9,10,11,12,13,16,17,19,20 & 24. In the direct scoring technique, a participant is given the score corresponding to the number shaded on the five-point scale. Thereafter, the total scores of the participant for the thirteen questions were aggregated (added together) to form the total score for the session.

The items corresponding to the reverse questions are 3,4,5,6,7,14,15,18,21,22,23,25. In the reverse scoring technique, the scale was reversed as:

- 5 = Always
- 4 = Often
- 3 = Sometimes
- 2 = Rarely
- 1 = Never

Thereafter, score in number 25 is subtracted from the overall score to obtain the participant’s ISE score. Scores higher than the norm are indicative of low self-esteem.
APPENDIX 6

PROGRESSIVE RELAXATION TRAINING

Relaxation Instructions

<table>
<thead>
<tr>
<th>Muscle Groups</th>
<th>Tension Exercises</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The dominant hand</td>
<td>Make a tight fist</td>
</tr>
<tr>
<td>2. The other hand</td>
<td>Make a tight fist</td>
</tr>
<tr>
<td>3. The dominant arm</td>
<td>Curl your arm up, tighten the bicep</td>
</tr>
<tr>
<td>4. The other arm</td>
<td>Curl your arm up, tighten the bicep</td>
</tr>
<tr>
<td>5. Upper face and scalp</td>
<td>Raise eyebrows as high as possible</td>
</tr>
<tr>
<td>6. Centre face</td>
<td>Squint eyes and wrinkle nose.</td>
</tr>
<tr>
<td>7. Lower face</td>
<td>Smile in a false, exaggerated way, Clenched teeth</td>
</tr>
<tr>
<td>8. Neck</td>
<td>(a) Pull head slightly forward, then relax.</td>
</tr>
<tr>
<td></td>
<td>(b) Pull head slightly back, then relax.</td>
</tr>
<tr>
<td>9. Chest and shoulders</td>
<td>(a) Pull shoulders back till the blades almost touch, then relax.</td>
</tr>
<tr>
<td></td>
<td>(b) Pull shoulders forward all the way, then relax.</td>
</tr>
</tbody>
</table>
10. Abdomen - Make abdomen tight and hard
11. Buttocks - Tighten together
12. Upper right leg - Stretch leg out from you tensing both upper and lower muscles
13. Upper left leg - both upper and lower muscles
14. Lower right leg - Pull toes up towards you.
15. Lower left leg - Pull toes up towards you.
16. Right foot - Curl toes down and away from you.
17. Left foot - Curl toes down and away from you.

**Specific instructions for Progressive Relaxation**

1. Tense the muscles and hold for five seconds.

2. Feel the tension. Notice it carefully.

3. Now release. Let the tension slide away, all way.

4. Notice the pleasant warmth of relaxation.
Repeat the sequence with the same muscle group for at least three times for each muscles group.

5. Tense all the muscles together and hold for five seconds.

6. Feel the tension, notice it carefully, then release.

7. Let all tension slide away.


**Specific Instructions for Deep Breathing Exercises**

1. Take a deep breath. Say softly to yourself, “relax”, you breathe out slowly.

2. Continue this exercise for about five minutes.

3. Remain totally relaxed.