UNIVERSITY OF CAPE COAST

EFFECTS OF ASSERTIVENESS TRAINING AND COGNITIVE RESTRUCTURING ON LOW SELF-ESTEEM AND DEPRESSIVE DISORDERS AMONG STUDENTS OF TECHNICAL UNIVERSITIES IN SOUTHERN GHANA

BY

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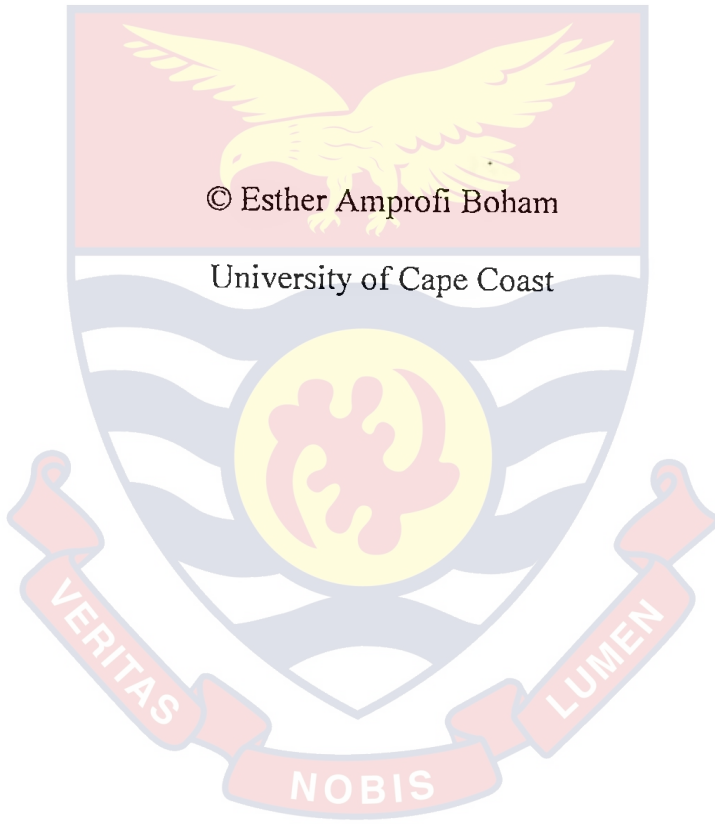

DECLARATION

Candidate's Declaration

I hereby declare that this thesis is the result of my own original research and that no part of it has been presented for another degree in this university or elsewhere.

Candidate's Signature: ..... Date: 15th Oct, 2020

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Supervisors' Declaration

We hereby declare that the preparation and presentation of the thesis were supervised in accordance with the guidelines on supervision of thesis laid down by the University of Cape Coast.

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ABSTRACT

Self-esteem is connected to depression and a wide range of other clinical conditions such as learning disorders, social phobia and hyperactivity disorder. The study sought to ascertain the effects of assertiveness training and cognitive restructuring on low self-esteem and depression levels among technical university students in Ghana. The study was quasi-experimental study. The simple random sampling method was used to select 60 participants for the study. Rosenberg's Self-Esteem (RSE) and Beck Depression Inventory (BDI) Scales were used for the data collection. The Cronbach Alpha for the instruments were 0.77 and 0.72 for RSE and BDI respectively. The statistical tools used for data analysis were frequencies, percentages, one-way analysis of covariance (One-way ANCOVA) and two-way analysis of covariance (Two-way ANCOVA). The results showed that participants who were exposed to assertiveness training and cognitive restructuring recorded better scores in the post-test scores as compared to participants in the control group who were not exposed to any intervention. It was found that significant differences existed between the cognitive restructuring and assertiveness training groups, and the control group. It was concluded that the intervention programmes using cognitive restructuring and assertiveness training were effective in improving participants' self-esteem and reducing their depression levels. It was recommended that counsellors and lecturers of technical universities should be motivated and supported by management of the universities, governments, parents and the larger community to help organize assertiveness training, cognitive restructuring and other related skills for students at all levels who are found to have low self-esteem and depressed.

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DEDICATION

To Jariel Elisha Kwadwo Bempah Amprofi Boham, my grandson

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CHAPTER ONE

INTRODUCTION

Background to the Study

It appears that a great number of young people around the globe, irrespective of their race, colour and economic status battle with issues relating to self-esteem and depression. Self-esteem is said to be key to healthy functioning because it pervades all realms of an individual's life via its effect on perception (Longmore, Manning, Giordano & Rudolph, 2012). Self-esteem is said to be a major key to success in life and the development of positive self-concept and healthy self-esteem is extremely important for good adjustment in society (Sharma & Agarwala, 2015).

Self-esteem is the evaluative and affective dimension of the self-concept, and is considered as equivalent to self-regard, self-estimation and self- worth, according to Harter (1986). Coopersmith (1967) defines self-esteem as the evaluation which the individual makes and customarily maintains with regard to himself: it expresses an attitude of approval and indicates the extent to which an individual believes himself to be capable, significant, successful and worthy. In short, self-esteem is a personal judgement of the worthiness that is expressed in the attitudes the individual holds towards himself. Bednar and Peterson (1995) define self-esteem as the subjective and enduring sense of realistic self-approval, it reflects how the

individual views and values the self at the most fundamental levels of psychological experiencing.

Self-esteem has been found to be the most dominant and powerful predictor of happiness and that positive or high self-esteem, internal standards and aspirations actively seem to contribute to 'well-being' while low self-esteem leads to maladjustment (Furnham and Cheng, 2000; Garmezy 1984; Glick & Zigler, 1992). Positive self-esteem is a protective factor against developing mental health problems (Mulligan, 2011). It has been associated with a number of important life's outcomes including psychological adjustment, academic success, physical, health and relationship satisfaction (Kernis, 2006). Self-esteem affects our trust in others, our relationships, and our work – nearly every part of our lives and it is believed that positive self-esteem gives us the strength and flexibility to take charge of our lives and grow from our mistakes without the fear of rejection (Rosenberg, 1989).

People with high self-esteem seem to be protected from feeling distressed from negative events by experiencing lesser threat to their sense of self and by having the ability to be more resilient. High self-esteem has also been reported to result in more active and effective coping and in increased motivation in the face of stress (Pasha & Munaf, 2013). Rosenberg (1989) sees a person of high self-esteem as an individual, who respects himself, considers himself worthy and not better than others, who recognizes his limitations, and expects to grow and improve. Research has indicated that positive self-esteem is associated with mental well-being, happiness, adjustment, success, academic achievements, and satisfaction (Mulligan, 2011).

Positive Self-esteem is a good quality according to Rosenberg (1989) and those who have it are presumed to be psychologically happy and healthy (Heatherton & Wyland, 2003). High self-esteem is seen as a ticket for those who have it to make good choices about themselves in terms of decisions that affect them. Students need to have good self-esteem to help them hold their heads high and feel proud of their accomplishments and abilities which in turn give them the courage to try new experiences and have respect for themselves. In fact, research has shown that a positive self-esteem is more important to achieve academic success than a high IQ score (Yahaya, Hashim & Rahman, n.d.). Positive or high self-esteem has been found to lead people to achieve greater heights in life. On the contrary, negative or low self-esteem has been correlated with several problematic outcomes (Yahaya et al, n.d.).

Low self-esteem is, having a general negative overall opinion of oneself, judging or evaluating oneself negatively, and placing a general negative value on oneself as a person. These deep-seated, basic, negative beliefs about oneself are often taken as facts or truths about who they are as a person (Lim, Saulsman, & Nathan, 2005). Low self-esteem can be part of a current problem, a result of other problems, or a problem in itself and a risk factor for other problems. It can also have a negative impact on a person in regard to self-criticism and high distress and a negative impact on the lives of individuals covering work, relationships, recreation time, and self-care. Low self-esteem, in particular, comes from a lack of self-acceptance, and frustrated achievement (Sihera, 2015).

Low self-esteem is not an inherited trait or something that appears overnight, but rather, it develops over weeks, months and years of experiences

that cause both children and adults to lose confidence and it is frequently traced to abusive or dysfunctional early years, the effects of which can persist well into adulthood (Rowan, 2014). Rowan reiterates that positive experiences and relationships can raise a person's confidence and allow them to live a happy, successful life. On the contrary, negative experiences and relationships wound many people deeply and cause them to lose hope in themselves and their future (Rowan, 2014). This seems to suggest that our self-esteem is generally shaped by all the experiences and interactions we have as we grow through the various stages across the life span.

Low self-esteem is a debilitating condition that keeps individuals from realizing their full potential (UC Davis Health, n.d.). The feelings of low self-esteem lead to attitudes of hopelessness, uselessness and feelings of scantiness and these attitudes make it difficult for such individuals to build any social relationships and this leads to isolation and loneliness (Nordstrom, Goguen & Hiester, 2014). Studies have demonstrated that low self-esteem is a risk factor for developing mental health problems (Mulligan, 2011).

Low self-esteem correlates with irrationality, blindness to reality, rigidity, fear of the new and unfamiliar, low self-worth, lack of self-confidence, social anxiety, depression, feelings of inadequacy, inappropriate conformity or inappropriate rebelliousness, defensiveness, an overly compliant or controlling behaviour and fear of or hostility toward others (Lim et al., 2005). Low self-esteem people might expect that things would not turn out well for them and might often feel sad, depressed, anxious, guilty, ashamed, frustrated, and angry having difficulty speaking up for themselves and their

needs, avoid challenges and opportunities, or be overly aggressive in their interactions with others (Lim et al., 2005).

Fear and anxiety, according to Get esteem.com (n.d.), are the cornerstones of low self-esteem. The paper explains that those who suffer from low self-esteem experience extreme fear and anxiety frequently which might stem out of the core beliefs they have about themselves. The core beliefs are the fundamental beliefs underlying how individuals think, feel and behave. Core beliefs develop as we grow and lend direction to how we ultimately think, act and feel (Nuekrug,2011). Positive core beliefs lead toward positive way of thinking such as *"I am good"; "I am an achiever".. "I'm loved and competent"* (Austad, 2009, p. 289) Negative core beliefs, on the other hand, lead to dysfunctional ways of living. Beck (2005) proposes that negative core beliefs are of three broad categories namely: helplessness, unlovability and worthlessness. Such individuals may consider themselves as being inadequate, boring and worthless. With the negative thought that there is something innately wrong with themselves, individuals with low self-esteem could likely experience self-esteem attacks (often called panic attacks) anytime they did something they deemed to have been wrong, something they thought others have noticed, and something that confirmed their own feelings of inadequacy, incompetence, being undeserving or unlovable.

YoungMinds, as cited in Coronado (2016) assert that children and young people with low self-esteem display behaviours such as negative self-image, finding it hard to keep friendships, inability to deal with failure, tendency to put themselves down, lack of pride in their achievements, and constantly comparing themselves to peers in negative ways. Such individuals

are more at risk of developing depression, anxiety, self-harming and other mental health problems as they struggle to grow into adulthood and will often find the ups and downs of life in general harder to "get through." The researcher of the current study believed this called for an intervention to help these young people to cope with life's realities and make them functional in the society.

It appears that to develop a people that can function well and contribute meaningfully to their world, the issue of self-esteem needs to be given appropriate attention as it cannot be overlooked as Gupta (2011) puts it:

> Even though self-esteem is something that cannot be touched or seen it is always there following you like your shadow or the reflection in the mirror. Adolescents with lower self-esteem have a lower worth about themselves and think about themselves as nobody. Once this feeling of worthlessness takes power over their body and self-esteem, they start falling in this dark hole with few chances of coming out unless intervened at the right time (p. 14).

Self-esteem is considered vital for psychological health to the extent that some educators have changed course curricula in their attempts to instil children with high self-esteem, based on the belief that positive self-esteem is of cardinal importance, and that many societal ills—such as teenage pregnancy and drug use, violence, academic failure, and crime come as a result of low self-esteem (Heatherton & Wyland, 2003). Records show that the state of California in the United States enacted legislation that encouraged schools to develop self-esteem enhancement programmes, the general idea

being that high self-esteem as Mecca, Smelser, and Vasconcellos (1989) put it, would act like a "social vaccine" that would prevent many of the serious behavioural problems facing the state.

In describing people with low self-esteem, based on empirical research Rosenberg and Owen (2001) state that:

> People with low self-esteem are more troubled by failure and tend to exaggerate events as being negative. For example, they often interpret non-critical comments as critical. They are more likely to experience social anxiety and low levels of interpersonal confidence. This in turn makes social interaction with others difficult as they feel awkward, shy, conspicuous, and unable to adequately express themselves when interacting with others (p. 409).

Substantial evidence shows a link between self-esteem and depression, shyness, loneliness, and alienation and low self-esteem is aversive for those who have it according to Yahaya et al. (n.d.). People with low self-esteem are known to be more prone to depression, both at clinical levels and milder forms and depressed people are more likely to feel worthless, incompetent, and inadequate (Orth & Robins, 2013).

The word "depression" is used to describe a range of moods – from low spirit to a severe problem that interferes with everyday life (Borill, 2000). Depression is a common mental disorder that presents itself with depressed mood, loss of interest or pleasure, decreased energy, feelings of guilt or low self-worth, disturbed sleep or appetite, and poor concentration according to World Health Organization (WHO, 2012). Borill (2000) believes that anyone

can become depressed, emphasising that approximately one person in six experiences depression of some kind in the course of their lifetime and one in 20 experiences clinical depression. At any one time, about one in 10 people will have some symptoms of depression.

According to Borill (2000), depression is a global issue because people from all backgrounds, ages and cultures can experience depression, however, people vary in how they express their difficulties. For instance, while some people use words such as 'sad' or 'low' to describe feeling depressed, others describe their feelings in terms of their body, such as 'a pain in my heart'. It is on record that about two per cent of children under 12 experience depression which rises to about five per cent for teenagers. Also, there is a global worry over the rise in the numbers of young people who attempt suicide, which may be associated with depression, hopelessness, or difficulties in their lives (WHO, 2012). Depression in both women and men is often linked to life changes or to loneliness and about 10 per cent of women are documented to experience post-natal depression in the weeks following childbirth. Social factors which can make people more at risk of becoming depressed include loss of employment, bereavement and problems with relationships (WHO, 2012)

Self-esteem has been such a critical psychological issue over the years that extensive studies have been carried out on the concept globally in the past century measuring various constructs against self-esteem. Self-esteem has been and continues to be one of the most commonly researched concepts in social psychology (Cast & Burke, 2002), Self-esteem is considered to be one of the most popular constructs in psychology and it is used as a predictor

variable, an outcome variable and a mediating variable in research (Brown, Dutton & Cook, 2001).

In the United States, self-esteem has been found to be strongly associated to socially critical behaviours such as academic achievement, teenage pregnancy, and juvenile delinquency among African American adolescents (Madhere, 1991). Madhere (1991) is of the view that because of the persistent and relatively high incidence of these problems among African American adolescents, the issue of identity and self-esteem has preoccupied African American psychologists and educators. Longmore et al. (2012) also found out in their study that, self-esteem and depressive symptoms were associated with risk and resilience and might delay, or conversely, accelerate the pace of adolescents' sexual onset. Their review of cross-sectional findings from the National Longitudinal Study of Adolescent Health revealed that low self-esteem was associated with several problem behaviours including suicide risk and the use of cigarettes, alcohol, and marijuana.

Pasha and Munaf (2013) in a study in Pakistan on the relationship of self-esteem and adjustment in traditional university students based on eight components of self-esteem which included competence, lovability, likability, self-control, personal power, moral self-approval, body appearance, and body functioning, found that the self-esteem variables of competence, lovability, personal power, moral self-approval and body functioning were significantly related to all the areas of adjustment.

In Turkey it was revealed in a research by Ümmet (2014) that educational level of the parents of participants had an effect on the participants' self-esteem. According to the results, the more parent's

especially mother's educational level increased, the more the children's self-esteem increased implying that the increase of the parents' educational level enabled them to be more conscious about how to raise a child. Ummet inferred that educated parents satisfied their children's basic psychological needs with a healthy approach.

In Ghana, some studies have been carried out on self-esteem across the regions over the years which covered various aspects of the human life. For instance, Quarcoo (2013), investigated the factors that determined the self-esteem in the Ghanaian cultural context and using thematic-content analysis, the results indicated that Ghanaians made self-worth judgments through personal evaluations, social comparisons and social appraisals. Further findings showed that, character stood as a core determinant of self-esteem among participants. The study identified seven (7) overarching themes, namely, Character, Identity, Attractiveness, Achievement, Feelings of belongingness, Autonomy and others composed of seventeen sub-themes.

In a study that examined the influence of parental status on depression and self-esteem among adolescents in Ghana, Segbefia (2013) found that adolescents of single-parents had significantly more depression than adolescents of intact-parents. Again, adolescents of intact-parents had significantly higher personal self-esteem and general self-esteem than those of single-parents though there was no significant difference between them on social self-esteem.

Kugbey, Mawulikem and Atefoe (2015) also in a study to examine the influence of parenting styles on adolescents' self-esteem and academic achievement in the Ho Municipality of the Volta Region in Ghana revealed

perceptions about themselves and this has often resulted in withdrawal on the part of the affected students from their peers. Mission Self (2017) reported that individuals who believed that they were not attractive in their appearance tended to feel inferior and this feeling could lead to isolation from active social life, thus making them prone to loneliness and depression. These negative perceptions have been developed over the years through various experiences within the family and social setting such as inadequate supply of their basic needs (such as food, school supplies), physical and verbal abuse by parents, guardians, and other significant persons in their lives including their teachers. There are situations where some parents as well as other significant persons may have certain expectations from their children (sometimes, unrealistic). If a child is not able to fulfil these expectations, he/she gets the feeling of having let down his/her parents and/or the significant others in their lives and this can lead to loss of self-worth (Mission Self, 2017). Parents sometimes make unhealthy or negative comparisons among siblings. Comparisons, according to Healy, as cited in Hatter (2017), tend to erode a child's sense of self-confidence and self-worth because he/she does not get the message that he/she is capable and smart.

Within the school setting, as well as the larger society, some students have experienced pressure and bullying from peers. Peer pressure, according to MisionSelf (2017), can lead to a lot of internal battles within a person especially if the individual does not want to indulge in a particular activity. This might lead to stress and anxiety of standing up to a group which can create a sense of failure in the person. Some students have experienced academic challenges over the period where some students have had a number

of re-sits before making it to the next level or being offered conditional admission. MissionSelf (2017) reports that when people fail after working hard, they treat failure as the ultimate truth and this results in the loss of self-esteem. All the above-mentioned challenges seem to have influenced the self-esteem and depression levels in individuals. The present study sought to determine whether the use of assertiveness training and cognitive restructuring could bring about a change in the self-esteem and depression levels of students.

Assertiveness training programme focuses on helping individuals to improve their self-image, easily express themselves, express their thoughts and ideas appropriately and consequently increase their self-esteem (Eslami, Rabiei, Afzali, Hamidzadeli, & Masondi, 2016). Assertiveness training can be used for people of all ages and from different walks of life, according to Forneris, Danish and Scott (2007). Cognitive restructuring, also known as cognitive reframing, is a technique drawn from cognitive therapy that can help people identify, challenge and alter stress-inducing thought patterns and beliefs (Mills, Reiss & Dombeck, 2008). Cognitive restructuring for lack of confidence generally targets assumptions of lack of ability or about others' judgment, and helps people consider more helpful, realistic ways of thinking about things (CBT Los Angeles, n.d).

Assertiveness training and cognitive restructuring have been used in a number of intervention studies that aimed at improving self-esteem and reducing or alleviating depression symptoms and have proven to be effective. Examples of such studies are Tannous (2015), Keshi, Basavaraiappa and Nik (2013) and Anyaneme, Chiyelu and Nneka (2016). The researcher therefore

sought to ascertain if these cognitive behaviour techniques could affect the self-esteem and depression levels among students of Ghanaian technical universities.

Statement of the Problem

There is a well-established relationship between self-esteem and psychological well-being and there is also a relationship among self-esteem, self-efficacy, ego strength, hardiness, optimism and maladjustment, according to Bernard, Hutchison, Lavin, Pennington; Blascovich and Tomaka, (1996). Individuals who suffer from low self-esteem usually lack fulfilment in life because the feelings of low self-esteem can lead to attitudes of hopelessness, uselessness and feelings of scantiness and students with these attitudes find it difficult to build any social relationships and this in turn leads to isolation and loneliness (Nordstrom, Goguen & Hiester, 2014). Low self-esteem is not only connected to depression but also an associated feature of a wide range of other clinical conditions, such as learning disorders, stuttering, social phobia, and attention deficit/hyperactivity disorder, according to American Psychiatric Association (2000). In a study, Overholser, Adams, Lehnert and Brinkman (1995), found that low self-esteem was closely related to feelings of depression, hopelessness, and suicidal tendencies and, therefore, proposed that assessment of adolescents should include an evaluation of self-esteem. It has also been reported that about 90% of people who kill themselves have depression symptoms, and 47% to 74% of population at risk of suicide is contributed by depression and its other psychiatric disorders (Cavanaugh, Carson, Sharpe et al., cited in Wang, Zhou-Ting & Qian-Ying, 2017). Other research reports suggest that anxiety and depression are the most frequent and impairing mental

symptoms and disorders in college students (Dey in, Leong & Wallbrown, 1987). In the Ghanaian context, low self-esteem has been associated with some social maladaptive behaviours such as armed robbery and suicide/suicide ideations (Baafi as cited in Quarcoo, 2013). Also, low self-esteem and depression are significantly related to suicidal tendencies (Adisa-Attah, Ossom & Lawer, 2016).

In recent times there have been incidents of suicide on the campuses of Ghanaian Universities. For example, a Consumer Science student at University of Ghana, was found dead after she allegedly jumped from the fourth floor of the Akuafo Hall Annex A. (CitiFmonline, 2017). In another incident, a first-year Chemical Engineering student at the Kwame Nkrumah University of Science and Technology (KNUST), allegedly committed suicide over her academic performance because she had failed some of her course papers and could not cope with what she believed was a shame to herself and to the family according to unconfirmed report (CitiFmonline, 2017).

Other reports of alleged suicide incidents have also made the headlines in recent times such as: A first-year student of the Mampong Nursing and Midwifery Training College in the Ashanti Region who committed suicide, allegedly in protest against the course she was offered by the college (Graphic.com.gh, 2017) and a 16-year-old Junior High School female student who allegedly committed suicide at Tafo in the Eastern Region (CitiFmonline, 2017). There were several other reported incidents of suicides including a 27-year-old man who allegedly committed suicide in his mother's room in Kumasi (Abusuafmonline, in GhanaWeb, 2017); a 21-year-old man who committed suicide in Moree in the Central Region (Graphic.com.gh, 2017); a

female police officer who killed herself because of heartbreak (mynewsgh.com, 2017); Electricity Company of Ghana (ECG) Accountant committing suicide using weedicide at Suhum in the Eastern Region, to mention but a few. The headlines suggest that suicidal tendencies in the country is widespread and alarming as well and, therefore, calls for an urgent intervention. The importance of intervention studies cannot be overemphasized. Sowislo and Orth (2013) have also pointed out that depression can be prevented, or reduced by interventions that improve self-esteem.

According to World Health Organization (WHO, 2012) report, over 800,000 people die through suicide every year, and many more attempt suicide globally. The report indicated that suicide occurs throughout the lifespan and is the second leading cause of death among 15-29-year olds globally which implies that many millions of people are affected or experience suicide bereavement every year. WHO has also reported that by the year 2020, depression will be the second leading cause of world disability and by 2030 it is expected to be in the first position and the largest contributor to disease burden. This report suggested that a good number of tertiary students in Ghana were at risk of depressive disorders and suicidal tendencies since majority of them fell within the 15-29-year old bracket. This called for urgent attention to be given to the esteem needs of young people. Again, a study conducted by Asante and Arthur (2015) to examine the prevalence and determinants of depression among university students in Ghana, revealed a 31.1% of mild to moderate depression and 8.1% severe depressive symptoms among a sample of university students. Mulligan (2011) posits that improving self-esteem

might reduce the risk of depression regardless of whether or not the individual is experiencing stressful life events.

. Anecdotal evidence from Cape Coast Technical University and Takoradi Technical University indicated that, a number of technical university students battle with the issue of low self-esteem and some also experience some symptoms of depression.

Since it is established that low self-esteem contributes immensely to depression which also translates into suicide ideations and suicide, there is the need for an intervention to be carried out to find solution to the menace before it gets out of hands. However, it appears not many intervention studies have been carried out in Ghanaian universities on people suffering from low self-esteem and depression. Most of the studies done on self-esteem are descriptive in nature (for example, Dankwah, Afrifa & Sanka, 2017; Kugbey, Mawulikem & Atefoe, 2015; Segbefia, 2013). As far as the researcher is concerned no intervention study has been conducted on students' self-esteem and depression levels in the Ghanaian technical universities.

It was against this background and the gap in the literature that the researcher deemed it timely to conduct an intervention study to explore the effects of assertiveness training and cognitive restructuring techniques on self-esteem and depression levels of technical university students in Ghana.

Purpose of the Study

The purpose of this study was to examine the effects of assertiveness training and cognitive restructuring on the self-esteem and depression levels among technical university students in Ghana. The study specifically sought to:

1. determine the effects of assertiveness training and cognitive restructuring techniques on the self-esteem and depression levels of participants.
2. ascertain whether there is a difference between male and female students in the effect of assertiveness training and cognitive restructuring techniques on self-esteem and depression levels.
3. find out whether there is a difference in the effect of assertiveness training and cognitive restructuring techniques on self-esteem among participants in terms of age.

Hypotheses

1. *Ho* 1: There is no significant effect of a) assertiveness training and b) cognitive restructuring on the self-esteem of technical university students in Southern Ghana.

   HA 1: There is significant effect of a) assertiveness training and b) cognitive restructuring on the self-esteem of students in technical universities in Southern Ghana.
2. *Ho* 2: There is no significant effect of a) assertiveness training and b) cognitive restructuring on the depression levels of students in technical universities in Southern Ghana.

   HA 2: There is significant effect of a) assertiveness training and b) cognitive restructuring on the depression levels of students in technical universities in Southern Ghana.
3. *Ho* 3: There is no significant difference in the effect of a) assertiveness training and b) cognitive restructuring techniques on the self- esteem of male and female students in technical universities in Southern Ghana.

HA 3: There is significant difference in the effect of a) assertiveness training and b) cognitive restructuring techniques on the self-esteem of male and female students in technical universities in Southern Ghana

4. *Ho* 4: There is no significant difference in the effect of a) assertiveness training and b) cognitive restructuring techniques on the depression levels of students in male and female technical universities in Southern Ghana.

   HA 4: There is significant difference in the effect of a) assertiveness training and b) cognitive restructuring techniques on the depression levels of male and female students in technical universities in Southern Ghana.

5. *Ho* 5: There is no significant difference in the effects of a) assertiveness training and b) cognitive restructuring techniques on the self-esteem of students in technical universities in Southern Ghana on the basis of age.

   HA 5: There is significant difference among students in the effects of a) assertiveness training and b) cognitive restructuring techniques on the self-esteem of students in technical universities in Southern Ghana on the basis of age.

6. *Ho* 6: There is no significant difference in the effects of a) assertiveness training and b) cognitive restructuring techniques on the depression levels of students in technical universities in Southern Ghana on the basis of age.

   HA 6: There is significant difference in the effects of a) assertiveness training and b) cognitive restructuring techniques on the depression

level universities in the Central region of Ghana on the basis of age.

7. *Ho* 7: The effects of a) assertiveness training and b) cognitive restructuring on depressive disorders will not be mediated by self-esteem

   HA 7: The effects of a) assertiveness training and b) cognitive restructuring on depressive disorders will be mediated by self-esteem

Significance of the Study

It is envisaged that the findings of the study would contribute to knowledge on self-esteem and depression among technical university students in Ghana. The findings would help establish the effectiveness of the interventions employed in the study in dealing with the issues of self-esteem and depression among young people. The findings would also provide a framework for the development of counselling programme for people suffering from low self-esteem and depression in Ghanaian universities. The intervention package can be used by counsellors when they are dealing with people with low self-esteem or depression. Future researchers embarking on similar studies may also use the results as related literature.

Again, educational institutions that may find the findings useful, and various rehabilitation centres may make use of the findings when dealing with psychosocial problems among young people. Additionally, the results of this study may form the knowledge base for self-esteem and psychosocial functioning studies and also be a clue for studying and understanding other social issues that confront students in their daily lives in technical universities in Ghana.

Delimitations

The study was carried out using students in the technical universities as participants. Students from the traditional universities were not included in the studies. Again, the study would have covered all eight (8) technical universities in Ghana, but due to the scattered locations, and constraints on resources to go to all of them, the researcher purposively selected three of them namely: Accra Technical University (ATU), Cape Coast Technical University (CCTU) and Takoradi Technical University (TTU) for the study. The study was purposely delimited to these three Technical Universities because they are situated in coastal towns which have similar environmental characteristics.

Only second year students of the participating institutions were used for the study, first year and third year students were not included in the sample. The focus of this study was on how exposure to assertiveness training and cognitive restructuring could impact students' self-esteem and depression levels. The study did not look at the effect of the interventions on other areas such as academic achievement.

Limitations

Respondents may feel reluctant in responding to the instrument and as a result may end up providing false responses to the questions. This can affect the validity of responses provided and consequently the conclusion drawn from the study. However, conscious effort was made by the researcher to create a conducive environment by assuring respondents of confidentiality. This was done to make respondents feel comfortable in responding to the

instrument. Despite the limitations, the findings of this study could be generalized.

Definition of Terms

Self-esteem: The value or worth individuals place on themselves.

Low Self-Esteem: Having a score from 0 to 14 on the Rosenberg Self-Esteem Scale.

Depression: A mental disorder which may manifest as a combination of feelings of sadness, loneliness, irritability, worthlessness, hopelessness, agitation, and guilt, accompanied by an array of physical symptoms

Assertiveness: Standing up for personal rights and expressing thoughts, feelings and beliefs without violating others' right.

Cognitive restructuring; Identifying unhelpful patterns of thinking, or untrue assumptions of one's self and learning new, more helpful ways of thinking.

Late adolescents: Students between 17 and 19 years in technical universities in Southern Ghana

Young adults: Students aged 20- 24 years in technical universities

Adult students: Students aged 25 years and above.

Organization of the study

The study is organized into five chapters. Chapter one introduces the study stating the background of the study, statement of the problem, as well as purpose and significance of the study. Also found in the chapter are the hypotheses, delimitations and limitation of the study and operational definition of terms.

Chapter Two deals with the review of related literature which covers conceptual review, theoretical review covering Maslow's Theory of Need,

Roger's Person-Centered Theory and Self-Determination Theory propounded by Deci and Ryan. The chapter also has reviews on previous studies carried out on the effectiveness of assertiveness training and cognitive restructuring in relation to self-esteem and depression. The chapter ends with a summary of the review.

Chapter Three which is the methodology deals with the research design; population, sample and sampling procedure; research instrument; data collection procedure and data analysis.

In Chapter Four, the analysis, presentation and discussion of results are presented. It deals with the overview of analytical procedures; presentation of preliminary data; presentation of main data with discussion of findings.

Chapter Five presents a summary of the research findings, conclusion and recommendations. The chapter concludes with suggestions for further research.

CHAPTER TWO

LITERATURE REVIEW

Introduction

This chapter dealt with the review of literature related to the study. The review mainly focused on the concept and sources of self-esteem, causes of low self-esteem, symptoms, and its effects on various aspects of life across the different stages in the human life. The review also looked at some theories which provided the theoretical base for the study. Some previous studies were reviewed for empirical evidence on the concepts.

Conceptual Review

Concept of self-esteem

Self-esteem is an intrinsic and universal part of human experience and it is a key concept for explaining the "inherent secrets" of human behaviour as a cure for social and individual problems (Ward, 1996). Osborne (1993) also defines self-esteem as a relatively permanent positive or negative feeling about self that may become more or less positives and negatives as individuals encounter and interpret success and failures in their daily lives.

Self-esteem can be viewed as an individual's attitude about him or herself, involving self- evaluation along a positive-negative dimension, that is, how individuals value themselves, and how valuable they think they are to others (Baron & Byrne, 1991). Neil (as cited in Alia & Mohd Hafir, 2009) defines self-esteem as a general feeling of self-worth or self-value. A person

with low self-esteem believes that he or she is worthless or inadequate while a person who has high self-esteem believes otherwise.

Definitions of self-esteem can be categorised into three domains which Brown and Marshall (2010) refer to as the three faces of self-esteem. These are: global self-esteem (trait self-esteem), self-evaluations (domain specific self-esteem) and feelings of worth self-esteem (state self-esteem).

Global self-esteem, also known as trait self-esteem, refers to the overall aggregated opinion of oneself at any one time, on a scale between negative and positive (Harter, 1986). Here, self-esteem is used to refer to a personality variable that represents the way people generally feel about themselves. This form of self-esteem, is called *global* self-esteem or *trait* self-esteem by researchers, as it is relatively enduring across time and situations and it depicts a wide range of outcomes (Brown & Marshall, 2010). It is described as an individual's accumulated lifelong perceptions of social inclusion and exclusion (Leary, Tambor, Terdal & Downs, 1995). Researchers who take a cognitive approach, assume that global self-esteem is a decision people make about their worth as a person (Coopersmith; Crocker & Park; Crocker & Wolfe, as cited in Brown and Marshall, 2010). Other researchers who emphasize emotional processes, define global self-esteem as a feeling of affection for oneself that is not derived from rational, judgmental processes (Brown & Marshall, 2010).

Self-evaluations, also referred to as domain specific self-esteem is where the term self-esteem is used to refer to the way people evaluate their various abilities and attributes. In this instance, the individual might perform well in some attributes but have deficiencies in specific areas. For instance, a

person may be said to have low academic self-esteem because he or she exhibits doubt in his or her academic abilities in school. Another person might place a high value on himself/herself when it comes to social skills and may exhibit it for others to recognize that and respond accordingly. Domain specific self-esteem thus relates to one's self-esteem with regard to a particular area, such as drama, sport, enterprising among others. Self-evaluation that depends on standards of performance, approval or acceptance in order to be maintained is referred to as contingent self-esteem. This is considered a fragile type of high self-esteem since the person only feels good about himself or herself when he or she is able to meet the standards (Jordon & Zeigler-Hill, 2013). To Rogers (1961), self-esteem can become vulnerable when it is based on a conditional criterion. Global self-esteem is theorized to be a global value judgment of the self based on broad issues of competence and ability, while domain specific self-esteem involves the appraisal of one's value in a particular situation or ability (Leary & Baumeister, 2000).

Feelings of self-worth (state self-esteem) is the face of self-esteem where the term self-esteem is used to refer to the way people evaluate their various abilities and attributes. Here, self-esteem is used to refer to self-evaluative emotional reactions to events. An example is when people talk about the fact that certain experiences "threaten self-esteem" or "boost self-esteem." For example, an individual's self-esteem might soar so high after getting a big promotion or receiving a big surprise from a loved one, a boss, or other significant person. On the other hand, a person's self-esteem might also fall so low after a divorce, loss of job or failure in an examination. These self-evaluative emotional reactions are referred to as feelings of self-worth (Brown

& Marshall, 2010). To Thomas (2014), the self-worth is more of an internal feeling about how good one feels about oneself as a person. State self-esteem is a perception of changes in one's level of social inclusion, given a particular setting.

Self-esteem is composed of two distinct dimensions, which are competence and worth (in other words, the sense of personal worth and a sense of personal competence or efficacy) and these are developed over a period of time with multiple experiences (Joshi & Srivastava, 2009). In Maslow's hierarchy of needs, esteem need is placed at the top among the deficiency needs after survival, safety, and love and belongingness needs. The self- esteem need has to do with the reflections of personal worth and accomplishment after which the individual may strive for self-actualization where an individual realises his or her full potential as a person.

In his book *Psychology of Self-Esteem,* Branden (2001), states:

> Self-esteem has two interrelated aspects: it entails a sense of personal efficacy and a sense of personal worth. It is the integrated sum of self-confidence and self-respect. It is the conviction that one is competent to live and worthy of living. Man's need of self-esteem is inherent in his nature. But he is not born with the knowledge of what will satisfy that need, or of the standard by which self-esteem is to be gauged; he must discover it (p. 110).

Commenting on Branden's assertion, Mruk (2013) explains that it is possible to maintain that human beings have a fundamental need to feel worthy but one can only achieve this goal by acting completely when it comes

to decision making especially decisions that involve facing the challenges of living.

The competence dimension (efficacy-based self-esteem) refers to the degree to which people see themselves as capable and efficacious. According to Deci and Ryan; Carver and Scheier; Garcia and Pintrich (as cited in Ümmet, 2015), competence is the ability of making necessary regulations and organisations for reaching the person's goal and having the perception of self-confidence for accomplishing them. Personal competence is achievement, in relation to the other's success, the person's belief of his own success and his psychological state. It is formed by the individual's learning, adaptation and interaction with environment and insofar as the person has that perception, he/she is more likely to be successful.

The worth dimension (worth-based self-esteem) refers to the degree to which individuals feel they are persons to be valued (Joshi & Srivastava, 2009). Self-esteem comes from internal sources, according to Reese (n.d.), and when individuals have a good self-esteem, they feel comfortable with themselves, without depending on others to make them feel good about themselves. A favourable self-esteem as emphasized by Serap (2003) is essential for personal happiness and effective functioning, throughout one's life. One can, therefore, say that self-esteem is a subject that cannot be overlooked in any culture across the life span. This is because how an individual values himself or herself goes a long way to determines how he/she relates to other people and how far he/she can go in this life (PATH, 2002). Muha (1991) is of the view that because self-image and self-esteem contribute immensely to competency and self-worth in childhood and adolescence, low

self-esteem can lead to social problems and school dropout whose consequences can be a concern to both the individual and the society.

People's self-esteem can either be high which is referred to as positive self-esteem or low which is also referred to as negative self-esteem and it is believed that the way people feel about themselves influences their actions toward others and what they accomplish in life. Thus, if individuals believe in themselves and their own abilities, then they are able to work hard, set goals and reach out to achieve what they set out to do (Program for Appropriate Technology in Health (PATH, 2002), Some people are known to base their self-esteem on characteristics such as appearance, altruism, family status, education, tribe/race, personal achievement, intelligence and approval of others (Ghunney, 2005). It has been reported that the beliefs and evaluations people hold about themselves determine who they are, what they can do and what they can become (Mann, Hosman, Schaalma & de Vries, 2004). These beliefs and evaluations are considered as powerful inner influences which provide an internal guiding mechanism that steer and nurture individuals through life, as well as govern their behaviour (Mann, Hosman, Schaalma & de Vries, 2004).

According to Yahaya, Hashim and Rahman (n.d.), self-esteem is a hypothetical construct that includes cognitive, behavioural, and affective components and it represents an aspect of self-cognition that reflects one's perceptions about oneself. These perceptions are formed through the evaluation of one's own personal attributes and the internalization of the evaluations of others. Paxton (2005), believes self-esteem is a cognitive construct as the individual consciously thinks about himself or herself and

considers the discrepancy between his/her ideal self, the person he/she wishes to be, and the perceived self or the realistic appraisal of how he or she sees himself or herself. The affective element refers to the feelings or emotions that the individual has when considering that discrepancy. The behavioural aspects of self-esteem have been found to manifest in such behaviours as assertiveness, resilience, being decisive, and being respectful of others (Paxton, 2005).

Individuals with high self-esteem are known to exhibit the following:

1. They have high self-confidence
2. They place a very high value on themselves
3. They usually believe in themselves
4. They are able to take initiatives
5. They are able to take risk
6. They hold on to their values and personal principles
7. They relate well with other people
8. They are very assertive
9. They are goal-oriented
10. They are confident and yet, respectful
11. They say "No" without feeling guilty
12. They stand for their right without putting others down (Ellis, n.d., Self Help for Life.com, n.d.)

Studies have shown that subjective well-being significantly correlates with high self-esteem, and that self-esteem shares significant variance in both mental well-being and happiness (Mann et al, 2004). Self-esteem has been

known to also play an important role during adolescence as it leads to the construction of a solid and stable personality (Rosenberg, 1989).

Aside being considered as a basic feature of mental health, positive or high self-esteem is seen as a protective factor that contributes to better health and positive social behaviour through its role as a buffer against the impact of negative influences. It is seen to actively promote healthy functioning which is reflected in life's aspects such as achievements, success, satisfaction, and the ability to cope with diseases like cancer and heart disease (Mann et al, 2004). There is also evidence that low self-esteem could lead to a state of apathy, isolation, and passivity. Conversely, high self-esteem is associated with more active lives, a greater control over circumstances, less anxiety and a greater capacity to tolerate internal and external stress (Fertman; Harper: Youngs et al, as cited in Tapia et al, 2007).

Mruk (2013), is also of the view that high self-esteem correlates positively with rationality, realism, intuitiveness, creativity, independence, flexibility, ability to manage change, willingness to admit mistakes, benevolence and cooperation. Research reports have shown that resilient adolescents had higher self-esteem than their non-resilient peers and that they were less likely to initiate a variety of risk behaviours (Mann et al, 2004). Positive self-esteem is considered as a protective factor against substance abuse. Again, it has been found out that optimism, hope and positive self-esteem are determinants of avoiding substance abuse by adolescents, mediated by attitudes, perceived norms and perceived behavioural control (Mann et al, 2004). It can therefore be said that self-esteem plays a vital role in developing healthy personalities.

Rosenberg (1989) posits that individuals with high self-esteem believe that they are people of worth, and thus have a sense of respect for themselves. The traditional description of low self-esteem on the other hand involves an overall low evaluation of the self, persistent feelings of inferiority, a sense of worthlessness, and often, feelings of loneliness and insecurity (Mruk, 2013). Researchers have observed that individuals with higher self-esteem are better able to adapt to challenges and demands, which results in better adjustment to college life as compared to those with lower self-esteem (Betten-court, Charlton, Eubanks, Kernahan & Fuller 1999).

Development of Self-Esteem

According to Bennett (2013), development of our self-esteem begins at the early stages of childhood, and remains a part of our life forever, shaping us toward one direction or another. Our self-esteem is believed to develop and evolve throughout our lives as we build an image of ourselves through our experiences with different people and activities and experiences during our childhood play a particularly large role in the shaping of our basic self-esteem. Cognitive and psychoanalytic theories suggest that early life experiences create beliefs about the self (i.e., self-esteem) that serve as vulnerability factors that interact with subsequent negative life experiences to initiate and maintain depression (Mulligan, 2011).

According to Crocker, Brook and Niiya (2006), the images individuals build of themselves are based on experiences they encounter with different people in their lives across the life span. Thus, there is developed through their interaction and treatment they receive from significant others like family members, teachers, peers and religious leaders.

Several sources have been found to be contribute to the development of self-esteem: these are body image, language ability, feedback from the environment such as significant others, identification with appropriate sex roles and child rearing practices. This is to say that people's self-esteem is shaped by all the things they experience in the environment as they grow up. These sources are thought to be interwoven but some are more important at certain times during the life span.

The development of self-esteem during childhood and adolescence depends on a wide variety of intra-individual and other social factors. However, approval and support, especially from parents and peers, and self-perceived competence in domains of importance are known to be the main determinants of self-esteem (Harter, 1999). Erikson's psychosocial development theory views the mother as the representation of external world as the mother is the person meeting the needs of the infant from birth until one and half years (Ummet, 2015). Feeding the baby when he/she is hungry, changing the diaper when it is dirty, meeting the needs regularly, while doing those actions such as touching her baby, making the baby feel loved, produce a special relationship between mother and child, and this positive relationship between mother and child constructs the base of self-confidence.

According to Yahaya, Hashim and Rahman. (n.d.), people who are motivated will have high esteem, and having it indicates positive self-regard, not egotism. Negative self-esteem is related to many personal and social concerns, such as school failure, depression, social anxiety, violence, substance abuse, and chronic welfare dependency (Yahaya et al. n.d.). Thus, people who grow up in a healthy environment where they were encouraged to

express their opinions will end up having their self-esteem high. Having high self-esteem have found to provide several benefits to those who possess it. Among them are: their ability to feel positive about themselves and life in general, to cope with challenges and negative feedback effectively and relate well with others in the society (Yahaya et al, n.d.; Mayo Clinic, n.d.).

Yahya et al, also believe that the development of self-esteem plays an important role in helping individuals to make adjustment about their self-worth and competence and that the primary contributor to self-esteem changes according to the stages they are in. However, they maintain that true self-worth is developed over a lifetime and most people experience many highs and lows as they journey through life. According to Deci and Ryan (1995), people develop contingent self-esteem when they regulate their behaviour and goals based on interjected standards which come about as they internalize what other people they deem significant approve as standards. This, Deci and Ryan believe can be hard for such individuals as their self-esteem is constantly on the line, trying hard to meet their self-imposed standards, failure of which leads to feelings of shame, incompetence or worthlessness.

Low self-esteem

According to Sihera (2015), low self-esteem comes from a lack of self-acceptance, and frustrated achievement, and characteristically has three main sides. The first is exhibited by the individual who seems to enjoy being the underdog or under-achiever. These individuals usually cling to the negative and are often heard using expressions such as *"I couldn't", "I shouldn't", "I can't", "I have no choice", and "I have to"*. The deep-rooted fear of not being good enough, of losing approval, or the possible consequences triggers a lack

of confidence and low self-esteem, thus preventing some people from changing their actions (Sihera, 2015 p. 2).

With the second type of low self-esteem, the person seems very confident superficially (those over-confident ones), a take-charge type of person, who appears to be much in control, opinionated, keen to do everything, to over-commit themselves, and are often found in leadership positions. Sihera (2015), however asserts that this is usually a mask for low self-esteem because he/she will lack the calmness, competence, and assurance of real confidence. Such people are likely to be tense, serious, anxious, and finicky; eager to please superiors and to impress, but often find it difficult to deal with really confident colleagues. Their low esteem comes to the fore when things go wrong Sihera (2015). This is so because such people are often perfectionists, and therefore find crises difficult to handle, and tend to blame others for their own misfortunes, or poor choices.

Sihera (2015) points out that over-confident people with low self-esteem can be demanding, self-centred, very distrustful of others, and slow to take criticism, instruction, or direction. They are locked in their own narrow world of what they believe is 'right', and dread new experiences, usually going by the book, and resenting innovation. In effect, these persons may be occupying leadership positions without being true leaders. Individuals with this type of low self-esteem will often deny that anything is wrong, because their belief in being more competent than their bosses or subordinates is their main protection.

The third type of people with low self-esteem are referred to as fun seekers, and an individual in this category is always seeking fun and happiness

from others, especially partners and love interests. Sihera (2015) believes that laughter is used as a mask for the low opinion they have of themselves, so everything is done with an emphasis on 'fun' to make them feel worthy - either finding it, or giving it. Sihera (2015) states

> Sensitive and thin-skinned, fun people have very low self-esteem, hiding their anxieties behind a bland mask of cheerful superficiality that tends to grate on others after a time, because they don't know when to stop being happy and playing the fool (p.45)

According to Lim, Saulsman, and Nathan (2005), low self-esteem can have an effect on various aspects of a person. For example, individuals with low self-esteem probably say a lot of negative things about themselves; they might criticise themselves, their actions, and abilities or joke about themselves in a very negative way; they might put themselves down, doubt themselves, or blame themselves when things go wrong. Such individuals might often not recognise their positive qualities but rather focus on what they did not do or the mistakes they made such that when compliments are given to them, they might brush such comments aside.

Sources of low self-esteem

People's self-esteem is generally shaped by all the experiences and interactions they have as they grow through the various stages across the life span. They may not have any control over the happenings around them but such happenings contribute immensely to shape their beliefs, thoughts and feelings. Low self-esteem can emanate from different sources and may manifest in diverse ways. Venzin (2014) is of the opinion that:

> Any negative life event or reaction can cause us to doubt ourselves. We all have times when things do not go as we think they should. The world can feel lonely in trying to find the right resources to help us at these times; everything can be daunting and even confusing. Often, we place too much credibility on the negativity we have around us (p.72).

Lachmann (2013) has outlined about ten (10) areas as possible sources of low self-esteem. These are:

Disapproving Authority Figures,

Uninvolved/Preoccupied Caregivers,

Authority Figures in Conflict

Bullying (with Unsupportive Parents),

Bullying (with Over-Supportive Parents),

Bullying (with Uninvolved Parents,

Academic Challenges Without Caregiver Support

Belief Systems

Society and the Media and

Disapproving authority figures

According to Lachmann, when the authority figures in a child's life tend to criticise him or her for everything he or she does, the individual would grow to believe he or she is not good enough to accomplish anything and this individual may grow to become an adult with a negative self-image. There are instances where individuals are criticized in excess and this can lead to a

situation where the individual would find it difficult to feel confident and comfortable to be himself or herself.

Authority Figures in Conflict

When parents or other caregivers engage in fight on frequent bases in the presence of the children thus making the home environment hostile, they end up modelling negative emotions and unstable family relationship for the children involved. The children will absorb the negative emotions and distrustful situations that have been modelled for them internalizing them as they grow up. When children have been subjected to excessive conflicts between authority figures, it can be overwhelming for them and sometimes they can become disorganized and confused leading to a feeling that they might have contributed to the fights or to a parent's painful circumstance. A child may consider the intense conflicts they experience as extremely threatening, fear driving, and believing he or she might have caused it, the individual can carry this feeling of being "tainted" into adulthood.

Trauma

Physical, sexual, or emotional abuse may be the most striking and overt causes of low self-esteem. When the individual is forced into a physical and emotional position against his or her will, it can put the person in a position whereby he or she will find it difficult to trust themselves or trust others, which profoundly impacts self-esteem. Sometimes the situation can be overwhelming to the extent that the person becomes confused and may even feel like he or she is at fault and carry the blame in addition to the pain that might have already been caused by the abuse. In scenarios, such as rape and physical abuse, so much can be going on within and around the individual at

the same time that can make him or her lose control or become more confused which can make the person feel a sense of nothingness. In an effort to gain control of the circumstances, one may end up internalizing the issue and even convince himself or herself that he or she is the one to blame.

Lachmann (2013) point out that the victim of the abuse may try and find ways to cope with the abuse, to manage the chaos in ways that are unhealthy, and may ultimately view themselves as repulsive and seemingly shameful, among some zillion other feelings. According to Martinez (2016), if individuals who suffered trauma during an important developmental time in their lives (be it physical, emotional, or sexual abuse) do not get help to work through the trauma at an essential point in their lives, the trauma could have a permanent impact on the way these individuals see and feel about themselves. Trauma can make the person feels like either they did something wrong, they were not good enough, or they deserved the abuse.

Uninvolved/preoccupied caregivers

Every child looks up to significant others in their lives for their basic needs. Children want to be acknowledged and accepted and they want their achievement to be recognized. When their primary caregivers such as parents therefore refuse to pay attention to their achievements be it academic or personal by way of reinforcement such as praise or a "high five", the child may interpret that to mean those achievements were not worth noticing; he or she may feel he or she has been forgotten or unimportant as human beings. This negative idea, once conceived can be nurtured until such individuals begin to think nobody cares about their whereabouts and therefore are not accountable to anyone.

Bullying

Bullying can be a major source of low self-esteem according to Lachmann (2013). She argues that if a child has the support of a relatively safe, and responsive family, the individual will have the chance to salvage or redeem his or her self-esteem after being bullied as a child. On the other hand, if the home is seen as an unsafe environment, then added to the outside torture, the individual will be filled with the overwhelming sense of being lost, abandoned and hopelessness will characterise his or her daily life as a child. The individual comes to see himself or herself as so damaged and therefore, considers or sees any friendship as favour extended to her. The individual may also end up with the notion that anyone involved in his or her life must be predating and not be trusted. Lachmann asserts that without a supportive home life, the effects of bullying can be magnified and miserably erode quality of life. From another perspective, over-supportive parents can leave the individual unprepared to face the defective world Lachmann (2013).

Symptoms of low self-esteem

Believing that they are lovable and knowing that they are loved is a basic need of all people according to Get esteem.com (n.d). People with low self-esteem are however anxiously unsure of themselves as to whether they are lovable. As they desperately seek reassurance that they are lovable, individuals with low self-esteem look outside themselves and at the behaviour of those closest to them, to find answers to the question of being lovable. In the event when the person who claims to love them, does not act in ways that they think would indicate this love, low self-esteem sufferers either:

1. try harder to please in order to win the love and attention of the significant other
2. become angry when they feel the significant other is withholding giving them what they need
3. feel they must be deserving of this treatment and conclude that they are indeed, unlovable.

Heatherton and Wyland (2003) reiterate that low self-esteem is likely to result when key figures reject, ignore, demean, or devalue a person. As these individuals continue to search for explanation to their perceived unlovability, the frustration they put themselves through becomes unbearable as finding answers to their questions seems to be somewhat impossible. They however continue to vacillate between depression and anger toward the person from whom they want affirmation (Get esteem.com, n.d.). Get esteem.com (n.d.) points out some signs that often characterise the life of those with low self-esteem.

According to the paper, it has been observed that those with low self-esteem tend to have abusive relationships. This, the paper attributes to the fact that being generally self-focused, hypersensitive, feeling unlovable, defensive and with other consequences of low self-esteem, people with low self-esteem find it difficult to build and maintain a close, honest, mature relationship. They usually find themselves in relationships that are characterised with hurtful feelings, misunderstandings, defensiveness and blaming, unreasonable expectations, poor communication, holding in feelings, and very chaotic. Alcohol Rehab (n.d), is of the view that people with low self-esteem often end

up in abusive relationships and this is because they can inwardly feel like such relationships are all they deserve.

Another observation that has been made is that people with low self-esteem can become defensive when merely being asked for an opinion, for an idea, or merely for their input on a decision. This is attributed to the fact that such people often have some expectation that they might be criticized or their suggestion might receive disapproval, and as such, they do not want to expose themselves for the anticipated criticism or disapproval. When actually criticized, even by someone who loves them, they will often deny the obvious, since they are unable to admit a mistake, poor judgment, or an offense.

Again, those with low self-esteem are overly watchful of the behaviour of others and ever vigilant of what others do and say, they therefore search for clues on how to act, what to wear, what to say and what to do, all because they are constantly anxious and fearful of making a mistake. They also scrutinize the reaction of others, frequently misinterpreting what they see or hear since there are many reasons why people act and react as they do.

Those with low self-esteem have also been associated with the issue of perfectionism and here, Get esteem.com (n.d.) asserts that low self-esteem people often feel so imperfect, so inadequate, and anxiously exert tremendous energy into looking and acting in ways that are acceptable. Their perfectionist tendencies may focus on the need to be the best dressed, the need to have perfect grades; get perfect reviews or else they feel devastated and a failure. Individuals suffering from low self-esteem usually think in terms of two extremes, leaving no room for the in-betweens. It is mostly all or nothing, successful or a failure; to them, anything less than perfection is failure. These

case with domestic gang and teen violence. Spett (2005), points out three components of low self-esteem which need to be identified in every situation in order to help such individuals suffering from low self-esteem. He argues that no one has low self-esteem all the time stressing that one can have severe low self-esteem in certain areas but perfectly confident in another area and therefore emphasizes that low self-esteem is situation specific.

Spett (2005) lists the components of low self-esteem as criticism and compliments; success and failure; skills and skill deficits. He points out that low self-esteem people tend to misinterpret neutral comment as criticism and often fail to recognize compliments, denigrate compliments and/or quickly forget compliments. He also points out that individuals with low self-esteem tend to experience success as neutral events, experience neutral events as failures and experience failures as catastrophies. Again, low self-esteem people usually tend to attribute success to luck, to the ease of the task or to the inadequacy of the competition and never to their own competence. According to Spett (2005), such individuals spend about 90% of their time thinking about the 10% of their lives that is not going well and they view themselves as inferior to others who are better than they are at any task. Spett also points out that low self-esteem causes individuals to avoid situations which may evoke their feelings of low self-esteem and the consequence of this avoidance is that the individuals are further prevented from developing skills which can help them achieve success and self-acceptance.

The issue of low self-esteem seems to affect humans at any stage in life, which is to say that, every stage of development (from childhood to adulthood) has a fair share of the challenges of low self-esteem.

According to Revermann (2014), every child has a general feeling about his or her value and self-worth even though his or her level of self-esteem can vary slightly from day to day because they can have their high days and low days. She believes a child's self-esteem reflects how he or she feels about himself or herself and contributes to how he approaches the world. During the early years of their life, young children largely depend on significant others for their survival and it has been found that children with highly critical parents and teachers can acquire a self-defeating attitude that is carried over later in life (Nairne, 2006). Children who resolve these crises positively learn to trust themselves and their abilities and acquire a strong positive sense of personal identity. Low self-esteem will be reflected in a child's behaviour, body language, approach to life and overall demeanour.

McLeod (2012) reports that self-esteem is generally high in children but some children are unfortunate to experience feelings of low self-esteem and this is due to the fact that children rely on affection from parents and other significant adults to experience their worth. McLeod is of the view that low self-esteem in children tends to be related to physical punishment and withholding of love and affection by parents. Some children only receive positive attention from significant others such as parents and care givers when they act in a certain way. This behaviour from such adults in their lives reinforces to these children that they are only a person of value when they act a certain way such as obtaining good grades on a test or being able to accomplish a chore very well. This makes their acceptance and recognition somehow conditional and because every child wants to be recognized,

children with low self-esteem rely on coping strategies that are counterproductive such as bullying, quitting, cheating, avoiding etc. Although all children will display some of these behaviours at some points in times, low self-esteem is strongly indicated when these behaviours appear with regularity (McLeod, 2012).

According to Yahaya et al (n.d.), children with a healthy sense of self-esteem feel that the important adults in their lives accept them, care about them, and would go out of their way to ensure that they are safe and well. They feel that those adults would be upset if anything happened to them and would miss them if they were separated. They also believe that children with low self-esteem, on the other hand, feel that the important adults and peers in their lives do not accept them, do not care about them very much, and would not go out of their way to ensure their safety and well-being.

Touching on their social life, McLeod (2012) reports that children with low self-esteem can be withdrawn or shy, finding it difficult to have fun. Again, although they may have a wide circle of friends, children suffering from low self-esteem are more likely to yield to group pressure and more vulnerable to being bullied. At school, they avoid trying new things for fear of failure and will give up easily to avoid being ridiculed. Revermann (2014) points out certain behaviours that are usually present in the life of a child who suffers from low self-esteem. These are:

- avoidance behaviour
- low self-confidence
- lack of effort

Avoidance behaviour

Children with low-self-esteem, are not likely to feel comfortable around new people or situations and to this end they may feel awkward and tend to avoid anything unfamiliar. Often, such children are hesitant to take risks or move out of their comfort zones and this type of behaviour, makes them miss valuable social opportunities and situations where they could learn and grow from new experiences.

Low confidence level

The lack of confidence often goes hand in hand with low self-esteem that is, individuals with low self-esteem do not have confidence in themselves. Children with low self-esteem are often seen talking negatively about themselves and their abilities. The evidence of low level of confidence is seen in the individual's body language, such as slumped shoulders, sad facial expression and downcast eyes. He or she may be overly critical of the skills he or she possesses or how he or she looks and may often use pessimistic phrasing about the world in general.

Lack of effort

A child with low self-esteem may view himself or herself as being unskilled or incapable of completing tasks. With this negative view of themselves, whenever they attempt a new activity and fails, they may just give up and walk away whereas a child with a higher level of self-esteem will be confident enough to try again even if the first attempt did fail to work.

Low self-esteem among adolescents

According to Gupta (2011), with the beginning of puberty, physical appearance, body image, and self-esteem become vital to the overall self-

image of an adolescent. These physical and emotional changes could impact critical outcomes on overall self-esteem and developing academic behaviours necessary for academic success among adolescents. McLeod (2012) also asserts that self-esteem continues to decline during adolescence particularly for girls and studies have explained this decline is due to body image and other problems associated with puberty.

The identity the adolescent attains as a consequence of the psychosocial crises preceding and during adolescence influences the rest of the life span (Nairne, 2006). To Erikson (1967), self-esteem is a feeling about the self, which tends to remain constant across life and gives the person a coherent psychological basis for dealing with the demands of social reality (Nairne, 2006). In one in which he cast the notion of identity in terms of self-esteem, Erikson (1968) asserts that self-esteem, confirmed at the end of a major crisis, grows to be a conviction that one is learning effective steps toward a tangible future, that one is developing a defined personality within a social reality which one understands. Elaborating on this assertion, Constantinople (as cited in Nairne, 2006), explains that this self-esteem is the end product of successful resolutions of each crisis; the fewer or the less satisfactory the successful resolutions, the less self-esteem on which to build at this stage of development, and the greater the likelihood of a prolonged sense of identity diffusion, of not being sure of who one is and where one is going.

It has been stressed that adolescents with high self-esteem have better coping resources and are protected against the consequences of stressful life events, those with low self-esteem on the other hand are more vulnerable to stress. Reach Out.com (n.d.) points out that low self-esteem can be particularly

hard for young people as that is the stage in their life when they are exposed to new life events, like starting high school or work, and forming new friendships and relationships. Robins, Trzesniewski, Tracy, Gosling, and Potter (2002) assert that, although boys and girls report similar levels of self-esteem during childhood, a gender gap emerges by adolescence, in that adolescent boys have higher self-esteem than adolescent girls. Girls with low self-esteem appear to be more vulnerable to perceptions of the ideal body image.

Adolescence involves a reduction of emotional wellbeing, since it is a stage of major developmental changes that place the subject in the middle of conflictive situations. For this reason, adolescents may engage in dangerous behaviour, which could constitute attempts to overcome their feelings of handicap and helplessness, intense narcissism and individualization, exclusion and social isolation (Tapia, Barrios & González-Forteza, 2007).

Low Self-Esteem among College Students

From his point of view, Rosenberg (1989) believes that individuals with high self-esteem have a belief that they are people of worth, and thus have a sense of respect for themselves. On the contrary, the traditional description of low self-esteem involves a low overall evaluation of the self, persistent feelings of inferiority, a sense of worthlessness, and often, feelings of loneliness and insecurity (Mruk, 2013). Researchers have therefore proposed that individuals with higher self-esteem are better able to adapt to challenges and demands, resulting in better adjustment to college life when compared to those with lower self-esteem (Bettencourt, Charlton, Eubanks et al, 2005; Kernis, 2003).

A number of studies have indicated that transition to college can be a stressful experience, and may initiate or exacerbate depressive symptoms in emerging adults as students typically face a host of new challenges, as the transition requires adapting to new environments, balancing increased academic loads, and managing social demands rendering them vulnerable to developing depressive symptoms (Rutter & Sroufe; Brougham, Zail, Mendoza, & Miller; Dyson & Renk, cited in Lee et al, 2014). These depressive symptoms have been found to not only impact students during college, as observed in academics, interpersonal relationships, and overall quality of life during college life, but also persist into adulthood according to Rapaport, Clary, Fayyad, and Endicott (2005).

A good self-esteem is seen as an appreciable asset and it has been found that having a higher level of self-esteem allows an individual to possess a higher level of social skills, impressing an employer in the recruitment stage (Davidson, Mueller, Molony & Vodorus, 2012). Findings from research have revealed that higher level of self-esteem positively correlated related with assertive and self-confident career seeking behaviours among young people, indicating that possessing positive levels of self-esteem during job search is likely to help and encourage an individual to get a satisfying career job (Saks & Ashforth, 2002). Davidson et al (2012) predict that those university students with a high self-esteem will directly enter the labour market after graduation. On the contrary, those individual with lower self-esteem will choose an alternative path, like attending more school or taking time off to travel, as it does not seem favourable for them to enter the labour force at that time in their lives.

Gender differences in self-esteem and depression

Over the years, the mindset of many has been that women are more susceptible to self-image issues and therefore relatively more likely to suffer from low self-esteem as compared to men has been. This is however, being challenged as current studies have revealed that many men suffered equally from low self-esteem with the difference between men and women being the source of their low self-esteem and not the degree to which they experienced low self-esteem (Anhalt, 2015).

The study revealed that men looked to social comparisons to fuel their self-image basing a large component of their self-worth on their ability to be the "provider", in comparison with others. Men also compared physical appearance, intelligence, independence, and status with others in their workplace, family, or social group. On the contrary, women relied on reflected appraisals as the source for their self-esteem. This meant that many women relied on how others viewed them for their self-esteem. The reflected appraisal process concludes that people come to think of themselves in the way they believe others think of them (Mead; Cooley; Sullivan as cited in Anhalt, 2015).

Anhalt (2015) pointed out that men with low self-esteem were more likely to engage in negative thought distortions that viewed themselves as coming up short when compared to their male counterparts while women who suffered from low self-esteem were more likely to engage in negative thought patterns of jumping to conclusions, assuming that others were judging them harshly.

Effects of Low Self-Esteem

According to Bos, Muris, Mulkens and Schaalma (2006) self-esteem is a central concept that is related to academic achievement, social functioning and psychopathology of children and adolescents. Research has shown that with respect to academic achievement, children with low self-esteem were less successful at school (Mann, et al, 2006), socially, children with low self-esteem were usually less accepted by their peers (Bos et al, 2006) and low self-esteem was related to child psychopathology, including anxiety, depression, and eating pathology (Beck et al; Muris et al; Harter; Mann et al., as cited in Bos et al, 2006).

According to Al Khatib (2007), when low self-esteem is formed, it affects all aspects of an individual's life especially the relationship with others. Individuals with low self-esteem usually avoid social settings and isolate themselves resulting in having the feelings of loneliness from their lack of confidence. Studies have indicated that low self-esteem in adolescence might be a harbinger for poor longer-term outcomes including likelihood of joblessness, fewer years of post-secondary-education and economic hardships (McClure, Tanski, Kingsbury et al, 2010)

Depression

Depression has been among the most significant public health concern around the globe in recent times according to Ferrari, Charlson, Norman, Patten, Freedman, Murray, Vos and Whiteford (2013). According to Long (2012), depression is a common psychological disorder in adolescents and there is evidence from research that one out of three girls and one out of five boys will have one episode of depression by age 18 and middle to late

adolescence is the average age of the first appearance of depressive symptom. It has been observed that dysfunctional social relations led to stress, anxiety and depression in young people and also one of the problems that limit the efficiency in adolescent and prevents them from developing a healthy character, talent as well as their mental and emotional growth was the inability to establish and maintain constructive relationships (Eslami, Rabiei, Afzali, Hamidzadeli, & Masondi, 2016).

Studies have indicated that depression, sometimes referred to as "clinical depression" or a "depressive disorder "is a mood disorder that causes distressing symptoms that affect how you feel, think, and handle daily activities, such as sleeping, eating, or working (National Institute of Mental Health, n. d). Depression has been found to be more than twice as prevalent in young women than men aged between 14 and 25 years and that from the onset of puberty, puberty, young women are at the greatest risk for major depression and mental disorders across the globe (Albert, 2015). A World Health Organization (WHO) Report (2012) also indicates a rate of 50% higher among females over that of males as far as depression is concerned. It has been found depression can affect one's life in diverse ways. These may include increased fatigue and sleep problems, loss of interest in pleasure, self-worth and hopelessness towards life in general among others (Healthline, 2019). Problems with memory, concentration and attention have been identified as cognitive manifestations of depression. Depressed individuals may experience physical pains and health disorders, low sex drive, loss of concentration, unrealistic irritations and may easily engage in alcohol and drug use (Medical News Today, 2019).

In a study, Kadzin, French, Unis et al. (as cited in Long, 2012), found that depression could lead to a feeling of hopelessness in children which might result in negative expectations towards the future. Bandura (1997) proposed that a sense of powerlessness and futility was created anytime an individual believed success was not possible. According to the American Psychiatric Association (2015), depression can be characterised by feelings of worthlessness, diminished interest or pleasure in daily activities, depressed mood, reduced concentration of focus, lack of motivation and suicidality or thoughts of death.

According to a WHO (2012) report depression is the leading cause of ill health and disability in the world. The report suggested that an estimate of more than 300 million people was living with depression which was an increase of more than 18 percent between 2005 and 2015. In an interview on Class Fm's Executive Breakfast show, Dr Carnita Groves was quoted to have said depression was very prevalent in Ghana and that four or five out of ten people at any given time were suffering from the condition. (Ghanaweb 2017). Mahmoud, Azimi and Zarghami (2014) asserted that stress, low assertiveness, depression and aggressiveness were among the problems prevalent among young university students. Thus, students are considered a vulnerable group for the development of depression and its symptoms and this affect their lives during the critical learning and social development process.

According to Mueen, Khurshid and Hassan (2006), depression was an increasing problem in recent times and that depression along with non-assertiveness was common in males and females. They believed an assertive person had fewer chances to be depressed. People who experience depression

habitually may have a negative philosophy of life, low self-esteem or low assertiveness. Many depressed people are not able to do what they want to do, and they lack the courage to live their own lives according to their own choice. This condition, according to Mueen et al (2006) creates problem for such individuals when they are unable to take the right action at the right time because they will begin to have a negative image of themselves and consider themselves as total failures. Beck (1976) opines that when people are depressed, their thoughts are characterised by significant errors and biases which he referred to as 'information processing errors'. Depressed people tend to remember the bad things that have happened to them in the past rather than the good things that have happened, they also pay attention to negative events rather than positive events in their environment, they make more negative judgements and predictions about the future and interpret their world and new information in more negative ways. Beck (1976) theorised that negative self-statements resulted from maladaptive schemata, that led to biasness in processing information taken from the environment and he believed that through training in cognitive restructuring these negative statements about the self could be corrected

Two types of depression have been identified by Abramson, Seligman and Teasdale (as cited in Long, 2012) as universal helplessness and personal helplessness. These, they believed resulted from a person's belief that outcomes were uncontrollable. Depressed people tend to display more features of helplessness than nondepressed people and individuals with feelings of helplessness usually have low outcome expectation since they believe nothing good may come out of their effort (ScienceDirect, 2020). The feeling of

interact with subsequent negative life experiences to initiate and maintain depression (Mulligan 2011). Mulligan believed that improving self-esteem might reduce the risk of depression regardless of whether or not the individual was experiencing stressful life event. Other studies have recommended that feelings of worthlessness be included in the diagnostic criterion for depression as low self-esteem may be an early symptom of depression (Mulligan, 2011). According to Beck et al (1979), individuals who were at risk of depression sometimes acquired negative cognitive styles including low self-esteem and irrational beliefs as a result of negative experiences. To Robert and Gamble (2001), it is possible that, self-esteem interacts with other risk factors such as negative life event in the prediction of depression. Mulligan (2011) reported that three longitudinal studies revealed that low self-esteem and stressful events were independent risk factors for depression with the researchers suggesting that improving self-esteem might significantly reduce depressive disorders.

Assertiveness Training

Assertiveness is being able to stand up for yourself, making sure your opinions and feelings are considered and not letting other people always get their way. It is not the same as aggressiveness since one can be assertive without being forceful or rude. Instead, it is stating clearly what one expects and insisting that their rights are considered (Williams, 2000). Assertiveness is the ability to communicate opinions, thoughts, needs, and feelings in a direct, honest, and appropriate manner. It involves standing up for your rights in a manner that does not offend others or deny the rights of others. When people are assertive, they have more control over their life and also make it less likely

Assertiveness is believed to be among the most important and essential social skills making a part of the extensive concept of interpersonal and behavioural skills (Rezavat & Nayeri, 2014). Rezavat and Nayeri reiterate that lack of assertiveness coupled with the presence of high anxiety lead to interrupted academic performance, weakened ability and undeveloped talents. Assertiveness is a style of communicating or talking with people about your needs or ideas clearly and directly without being afraid or shy (STIR, n.d.). Assertiveness is standing up for personal rights and expressing thoughts, feelings and beliefs in direct, honest and appropriate ways which do not violate another person's rights (Garner, 2012).

Assertiveness training programmes are designed to improve an individual's assertive beliefs and behaviours, which can help individuals, change how they view themselves and establish self-confidence (Emmanuel, Okreke, & Anayochi, 2015). Studies have indicated that assertiveness training helps to teach an individual on how to assert himself or herself despite the intimidation and pressures coming from other people (Emmanuel et al, 2015). Assertion is a skill that can be learnt and the training is often conducted in groups using modelling, role-play, and rehearsal to practice a new behaviour which makes the individuals become more happy, honest, healthy and less manipulative. It is a way of communicating and behaving with others that helps people to become more confident and develop awareness of themselves.

Assertiveness training is a type of training that increases the awareness of peoples' right, differentiating between non-assertiveness and assertiveness, differentiating passive aggressiveness and aggressiveness, including teaching of both verbal and non-verbal assertiveness skills (Rausepp, as cited in

Anyamene et al, 2016). It is a psychological intervention which helps participants learn to integrate assertive behaviour skills into their daily lives. It deals with attitudes, beliefs, and cognitions about assertiveness as well as specific overt assertive behaviours. Assertiveness training programme which is intended to assist individuals change their self-image, and help them express their thought and ideas easily and appropriately, can be used for people of all walks of life across the life span according to Forneris Danish and Scott (2007).

The assertiveness training programme is a life skill that builds self–confidence, improves social communication and teaches people to stand for their right whilst respecting rights of others and this ultimately increases the amount of their satisfaction and happiness the individual experiences in life (Eslami et al ,2016). It also deals with teaching of personal boundaries and how to avoid manipulation or abuse through fear. The best way to effect a change in people who are unassertive, is to let them realize their rights by standing up for their rights, and by creating awareness of their right to exist (Anyamene et al., 2016).

Cognitive Restructuring Technique

Cognitive restructuring technique (CRT) is cognitive behavioural technique that focuses on changing a person's perceptions and irrational assumptions of self and world (Emmanuel, Okreke, & Anayochi, 2015). Cognitive restructuring was first developed as a part of Cognitive Behavioural Therapy (CBT) for depression (Beck's version) and as a part of Rational Emotive Behavioural Therapy (Ellis' version). Cognitive behavioural therapy (CBT) is considered a great method for helping those suffering from low self-

esteem as it focuses on challenging unhelpful thoughts and finding alternative balanced thoughts that are more accurate (Allied Travel Careers, 2017). This theory believes that man's maladaptive behaviour is hinged on irrational thoughts, beliefs, self-talks or verbalizations. Cognitive behavioural therapy has an assumption that depression can be caused by negative schemas about self, the world and the future created in the early stages of an individual's life due to certain traumatic experiences (Alamdarloo, Khorasani, Najafi et al 2019).

Cognitive restructuring is the therapeutic process of identifying and challenging negative and irrational thoughts referred to as cognitive distortions. Cognitive distortions are irrational thoughts that influence our emotions. Although everyone experiences cognitive distortions to some degree, they can be maladaptive and harmful in their more extreme form (Therapist Aid, n.d.). It is a method of identifying unhelpful patterns of thinking, or untrue assumptions, and learning new, more helpful ways of thinking about difficult situations. Cognitive restructuring, also known as cognitive reframing, is a technique drawn from cognitive therapy that can help people identify, challenge and alter stress-inducing thought patterns and beliefs. (Mills, Reiss & Dombeck, 2008).

This technique teaches us to stop trusting in our automatic tendency to accept the contents of our thoughts as being an accurate assessment of reality. By helping individuals understand the relationship between their thoughts and their actions, they are able to reflect and work towards leading a healthier and more positive lifestyle. In low self-esteem, CBT takes the view that these core beliefs are just opinions, and not facts, that are maintained by unhelpful

thinking or behaviours. Cognitive behavioural therapy focuses on our thinking errors and retrains the brain to think in a more balanced way and it focuses on behaviours to make them more functional (Mayo Clinic, n.d.).

Cognitive restructuring gives people new ways of thinking and talking to themselves about their problems (Emmanuel, Okreke, & Anayochi, 2015). It is a combination of recognizing unhelpful thinking patterns and replacing them with more effective thinking patterns. Cognitive restructuring for low self-esteem often focuses on identifying negative thoughts about oneself, and identifying distorted thinking, such as labelling oneself as a failure due to one skills deficit or negative event (CBT Los Angeles, n.d.). When a person with low self-esteem enters a difficult situations then negative beliefs about the self are activated which in turn generate negative predictions, about what could go wrong, and also generates anxiety and low mood. When an individual's perception of himself or herself is negative it can lead to an overwhelming feeling of low self-worth; "I'm not good enough"; "not interesting enough"; and/or "I am not attractive enough." The cognitive restructuring technique helps us to test each thought we have for accuracy before conclusion is drawn.

The end goal of cognitive restructuring is to enable people to replace stress-inducing thought habits with more accurate and less rigid (and therefore less stress-inducing) thinking habits. In other words, cognitive restructuring helps clients think in reference to reality and facts which tend to help them reformulate their thoughts and beliefs that they have projected onto themselves (Allied Travel Careers, n.d.).

Conceptual Framework of the Study

Miles and Huberman (1994) defined a conceptual framework as a visual or written product, one that "explains, either graphically or in narrative form, the main things to be studied—the key factors, concepts, or variables—and the presumed relationships among them" (p. 18). It is primarily a conception or model of what is out there that a researcher plans to study, and of what is going on with these things and why—a tentative theory of the phenomena that the researcher is investigating.

In this study, from the problem statement, the identified variables are intervention strategies which are made up of "assertiveness training" and "cognitive restructuring" which are the independent variables, and "self-esteem" and "depression" which are the dependent variables. Low self-esteem has been found to be a predictor for symptoms of depression. The cognitive theory of depression hypothesises that the negative schemas that contain dysfunctional beliefs about the self continued to persist in individuals who are vulnerable to depression even after their experiences of depressive episodes (Franck, De Raedt & Hauwer 2008).

The conceptual base of this experimental study base is that self-esteem is a psychological concept which is a function of both cognition and assertiveness. With subjects given well planned and structured interventions using cognitive restructuring and assertiveness training techniques, it is believed that all things being equal, their self-esteem will improve. This will result in its beneficial consequences such as lowering of depressive disorders which will in turn reduce suicidal tendencies; increase students' academic achievement; and increase in general psychosocial functioning.

The narration above is represented diagrammatically in Figure 1 below:

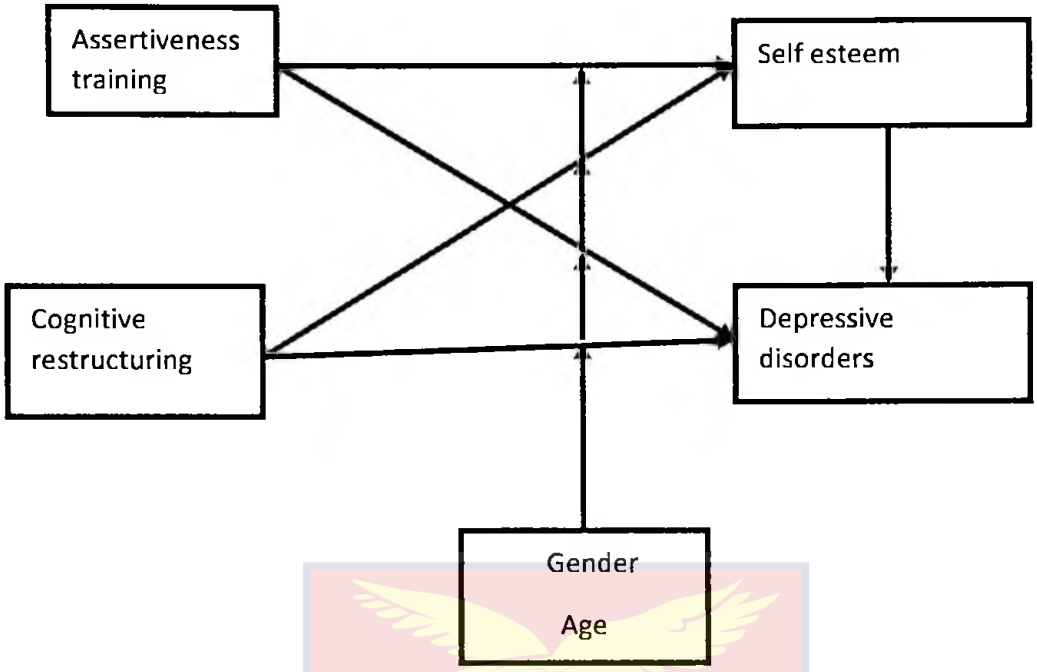

Figure 1: Mode of predictability of assertiveness training and cognitive restructuring on self-esteem and depression

Theoretical Review

The theories that will provide the theoretical framework for the study are Maslow's theory, Rogers' theory and Deci and Ryan's Self Determination Theory. These theories were deemed appropriate to provide the theoretical support to the study because they are all concerned about the innate of the individual to strive towards growth and fulfilment in life. For instance, while Maslow talks about love and belongingness, Rogers emphasizes on unconditional positive regard and the Self-determination theory by Ryan and Deci talks about relatedness. All these factors are about the fact that, significant others contribute to the development of individual's self-esteem.

When individuals grow up in an environment where parents and significant others show unconditional love, the individuals will feel accepted and this will

help them relate well with others which helps develop their self worth. On the other hand, if individual grow up in an environment where criticism abounds and love is based on conditions, they may end up losing their own identity as all they do will be to get approval from the significant others

Maslow's theory

In Abraham Maslow's (1954) hierarchy of human needs, the first four needs on the hierarchy are categorized as deprivation needs; the lack of satisfaction of these needs produces deficiencies that will motivate people to work towards satisfying them. Maslow places esteem needs fourth under the deficiency needs after love and belongingness. The need for love and belongingness is only given attention after the survival and safety needs have been adequately addressed. According to Chauhan (1996) the needs at this level emphasize the basic psychological nature of human beings to identify with the group and associations. These include making intimate relationships with other members of the society, being an accepted member of an organized group and needing a familiar environment as family. Chauhan (1996) complains that the modern developing society with all its material advantages is doing a great harm of disintegrating family and social life of many people. Thus, in big cities, people living in the same building may not even know the next-door neighbour. This makes them feel alone or isolated; they seem not to have social life though there are people around them. He states further that people really have need to escape feelings of loneliness and alienation and give and receive love, affection, and the sense of belonging.

Pietrofesa, Splete and Hoffman (1984) point out that the need to love and be loved includes all forms of affection from friendship to parental love.

They believe that everyone needs to feel loved throughout life and that it is necessary to love someone and to feel loved. They further assert that when individuals are unable to fulfil their need for love they suffer from anxiety, self-blame, depression, anger and possible withdrawal from society. Glasser (as cited in Boham, 2005) also believes that death may result if a person experiences a complete deficit of love early in life. In later life, a complete deficit of love can stimulate sufficient depression to cause suicide or psychosis.

Dacey and Travers (2004) posit that healthy people want to avoid feelings of loneliness and isolation and that people who feel alone or lack any sense of belongingness usually have poor relationships with others. When the need for love and belongingness is adequately met, then the esteem needs would emerge. Maslow (1954) considers esteem needs as deficiency needs in his hierarchy of needs. These are sometimes referred to as ego needs (Chauhan, 1996; Dacey & Travers, 2004) and are divided into two categories namely:

1. Self-esteem, self-respect, self-regard and self-evaluation. This has to do with the desire for strength, achievement, adequacy, mastery and competence, confidence in the face of the world, and independence and freedom. This is considered the higher level of self-esteem.
2. Esteem from others; this has to do with the desire for reputation, status, social success, fame, glory, recognition, attention, importance, dignity and appreciation. This set is also referred to as the lower version of self-esteem needs.

The first is considered as the "higher" form because, unlike the respect of others, once you have self-respect, it is a lot harder to lose. The negative version of these needs is low self-esteem and inferiority complexes.

Maslow (1954), believes that all people in our society have a need or desire for a stable firmly based, usually high evaluation of themselves for self-respect or self-esteem and for the esteem from others.

According to Chauhan (1996) the need of self-evaluation occurs in persons who are comfortably situated and are quite secured in the satisfaction of lower needs. Gelford (as cited in Chauhan, 1996) asserts that feelings of achievement, of competence, and of meeting high standards of excellence in performances are not the concerns of the struggling beginner but the "extra touches" of a comfortable artisan. Chauhan therefore posits that esteem is externally based before it becomes internally based. This is due to the fact that one usually seeks the respect and assurance of others of being a worthwhile person before he or she attains a level of pride in his or her involvement in his or her activities. Norwood (2002) argues that at this level of need, people require a stable, firmly based, high level of self-respect and self-confidence. Gerrow (1992) asserts that once individuals find out that others value them for who they are, they focus on their need to be recognized for their accomplishments. He continues that these needs are social in nature, which implies that people's behaviours are motivated by their awareness of others and their concern for the approval of those others.

Coppersmith (as cited in Chauhan, 1996) has noted that failure to gratify the need for self-respect or reputation from others can produce personality disturbances in the individual, as he or she may develop feelings of

inferiority, worthlessness, of being different from others and being misfit in the society which are clear signs of low self-esteem which can easily induce depression. Maslow therefore believes that sufficient gratification of the esteem needs lessens their dominating force in a person's life and enables him or her to move in the direction of self-actualization. Satisfaction of esteem needs results in feeling of personal worth, self-confidence, psychological strength, capability and a sense of being useful and necessary in the world. Thus, good or high self-esteem brings feelings of competence and confidence and a sense of achievement and individuality whiles thwarting those produces worthlessness, feelings of inferiority, of weakness and of helplessness which in turn give rise to either basic discouragement or else compensatory or neurotic trends.

Assertiveness training and cognitive restructuring will assist individuals to change how they view themselves and establish in them self-acceptance, self-worth and self-confidence. These in turn will give them the strength and courage to move towards self-actualization knowing they are good and have something to offer society.

Rogers' Person-Centered Theory

Carl Rogers' theory is built on a single force of life which he calls the actualizing tendency. Rogers (as cited in Corey, 2009) emphasises the need to create a growth-promoting climate in which individuals can move forward and become what they are capable of becoming. To him for a person to grow he or she needs an environment that provides him or her with three basic needs. These are genuineness (which has to do with openness and self- disclosure)

acceptance (which involves being seen or treated with unconditional positive regard) and empathy (when one is listened to and understood).

Rogers believes that every individual can achieve his or her goals, wishes and desires in life a situation he refers to as self-actualization. According to Rogers actualizing tendency is a built-in motivation present in every individual that propels them to develop their potentials to the fullest extent possible and that all creatures strive to make the best of their existence. The organism has one basic tendency according to Rogers (1961) and that is, striving to actualize, maintain and enhance the experiencing organism. He believes that not all of us can reach actualisation but people who are able to self-actualize, are called fully functioning persons and the actualised person is in touch with the here and now, with his or her subjective experiences and feelings, continuously growing and changing.

The theory is of the view that all humans, as well as other living organisms have an innate need to survive, grow and enhance themselves. According to Thorne (as cited in Corey, 2009), Rogers held the deep conviction that "human beings are essentially forward-moving organisms drawn to the fulfilment of their own creative natures and to the pursuit of truth and social responsiveness" (pg. 169). In view of this, all biological drives are included under actualizing tendency, because they must be satisfied if the organism is to continue its positive development. The actualizing tendency cause people to become more differentiated, more independent and more socially responsible.

Self-concept which is the organized, consistent set of perceptions, thoughts, feelings and beliefs people have about themselves is central to

Rogers' personality theory. According to Rogers, there are two primary sources that influence the development of the self or self- concept and these are childhood experiences and valuation by others. He is of the view that as humans, individuals want to feel experience and behave in ways that are consistent with their self-image, which reflects what they would like to be like, their ideal self. Rogers' view of the self is supported by Erikson (1968) who asserts that individuals are occupied with their self-esteem and self-concept as long as the process of crystallization of identity continues and if this process is not negotiated successfully, the individual remains confused, not knowing who he or she really is. To Erickson, identity problems, such as unclear identity, diffused identity and foreclosure combined with low self-esteem, can be the cause and the core of many mental and social problems. Self-concept is considered a defining characteristic of depression when it low (Manning, 2007)

Components of the self

Rogers put the self-concept into three components. These are the self-worth or self-esteem, self-image and the ideal self. He believes feelings of self-worth are developed in early childhood and are formed from the interactions of the child with the mother and father. The self-image has to do with how we see ourselves, which is important to good psychological health. This includes the influence of our body image on our inner personality. At the surface level people might perceive themselves as good or bad; beautiful or ugly however, the self-image has an effect on how a person thinks, feels and behaves in the world.

The ideal self is the desired person we want to be. It is normally formed as a function of pressures from outside sources such as parents, and significant loved ones. The ideal self contains all those attributes, usually positive, that people aspire to possess (Fiest & Fiest, 1994). This consists of our goals and ambitions in life and it is dynamic, which means it keeps on changing. Thus, the ideal self one has as a child will not be the same in his or her teens, young adult etc. Self-actualization occurs when a person's "ideal self" is congruent with his or her actual behaviour self-image. The closer the self-image and ideal-self are to each other, the more consistent or congruent an individual is and the higher his or her sense of self-worth. A person is said to be in a state of incongruence if some of the totality of his or her experience is unacceptable to him or her and is denied or distorted in the self-image (McLeod, 2014).

Rogers maintains the belief that the main determinant of whether an individual will become self-actualized or not is that individual's childhood experience. He asserts that if the individual experiences conditional positive regard from parents, the individual develops his or her parent's values and conditions of worth and this can lead to incongruence between the self and experience of the individual. If the individual experiences unconditional love and does not develop conditions of worth there is congruence between self and experience and such a person is stable and can strive towards actualisation (McLeod, 2008). According to Rogers (as cited in Patterson 1977), children are influenced by their parents and they strive for their approval by doing things to please them which make them feel more loved and if their effort does not meet with their approval, they feel less loved. This makes them experience

incongruence between self and experience which in turn may lead to psychological maladjustment hindering personal growth towards self-actualisation

Rogers believes that to develop a positive sense of self, the individual must grow up in an environment of unconditional love. When there is an inconsistency between exhibited behaviour and sense of self of the individual, anxiety comes out. However, through assertiveness training and cognitive restructuring the individual can be helped to develop a positive sense of the self which will in turn enhance the self-esteem of the individual.

Self-determination Theory

The self-determination theory is attributed to Edward Deci and Richard Ryan. The theory is basically concerned with human motivation, personality and optimal functioning and focuses on different types of motivation. Self-determination theory (SDT) is a macro theory of human motivation and personality that concerns people's inherent growth tendencies and innate psychological needs. It is concerned with the motivation behind choices people make without external influence and interference. The theory focuses on the degree to which an individual's behaviour is self-motivated and self-determined (Ryan & Deci, 2002; Deci & Ryan, 2012; Ryan & Deci, 2017). Self-determination theory is specifically framed in terms of social and environmental factors that either facilitate or undermine intrinsic motivation. This language reflects the assumption that intrinsic motivation, being an inherent organismic propensity, is catalysed (rather than caused) when individuals are in conditions that are conducive toward its expression.

Self-determination theory claims that people have three innate psychological needs that are considered as universal necessities. These are the need for competence, the need for relatedness and the need for autonomy. The theory also asserts that there are different approaches to motivation and differentiates between different types of motivation. The need for competence refers to the desire to control and master the environment and outcome. Thus, competence is the ability to control the outcome of an activity and experience mastery of that task.

The need for relatedness deals with the universal need or desire to interact with, be connected to and experience caring from other people. Since one's daily activities and functions involve people, human beings always seek the feeling of belongingness. This is in agreement to Maslow need for love and belongingness under his deficiency needs.

The need for autonomy has to do with the urge to be causal agents and to act in harmony with our integrated self, that is, the desire to be an independent agent in one's own life. Autonomy is seen by the Self-determination theory as when an individual takes into consideration his/her own intrinsic processes, have the ability of acting independently and self-approval while deciding. It also means exhibiting strong-willed behaviours and showing self-approval (Ummet, 2015). This is where training in assertiveness and cognitive restructuring is necessary to help the individual to be well integrated into the society by equipping him or her with adequate information on his or her competence and worth thereby gaining the confidence to approve of themselves and make good decisions on their own. A

person can meet this need when he or she is able to lead and control his or her own life and make his or her own decisions.

Autonomous people in general are able to approve their own behaviours and accept the consequence of their actions. According to Ryan and Deci (2000), to be autonomous does not mean to be independent but rather to have a sense of free will when doing something or acting out our own interest and values.

The self-determination theory is all about human motivation: intrinsic and extrinsic motivation. The theory states that man is born with an intrinsic motivation to explore, absorb and master his environment and that true high self-esteem is reputed when there is a balanced between basic psychological needs of competency, relatedness and autonomy (Ryan & Deci, 2004).

Intrinsic is what comes from within, inherently enjoyable, interesting, fulfilling and absorbing. Intrinsic motivation facilitates greater concentration effort, and task completion (e.g. Reading a book from a favourite author as opposed to reading a textbook). Intrinsic motivation is defined by Ryan and Deci (2000) as 'doing of an activity for its inherent satisfactions rather than for some separable consequence'' According to Ryan and Deci (2000), from birth onward, humans, in their healthiest states, are active, inquisitive, curious, and playful creatures, displaying a ubiquitous readiness to learn and explore and they do not require extraneous incentives to do so. This natural motivational tendency is a critical element in cognitive, social, and physical development because it is through acting on one's inherent interests that one grows in knowledge and skills.

Deci and Ryan posit that although, in one sense, intrinsic motivation exists within individuals, in another sense intrinsic motivation exists in the relation between individuals and activities. People are intrinsically motivated for some activities and not others, and not everyone is intrinsically motivated for any particular task. A training in assertiveness and cognitive restructuring will enable the individual to come to terms with the fact that individuals are unique in their ways, having their own set of values and interests which to an extent induce that inner motivation. This means that everybody is good in his or her own peculiar way and this helps to eradicate the cognitive distortion of *All or Nothing* and rather appreciate their own effort.

Empirical Studies

Several studies have been conducted on self-esteem as a construct measuring different variables affecting the human life. Stress, low assertiveness, depression, hostility, and aggressiveness have been found to be among the problems prevalent among young university students (Mahmoudi, Azimi & Zarghami, 2005).

Self-esteem is believed to reflect a person's overall evaluation or appraisal of his or her own worth and competence (Wang, 2013). In a number of studies conducted to establish the association between self-esteem and suicidality, low self-esteem has been found consistently associated with suicidality in adolescents (Lewinsohn et al., as cited in Wild, Flisher, & Lombard, 2004). A study conducted by Yozwiak, Lentzsch-Parcella and Zapolski (2012) revealed that suicide and suicide ideation are concerns on college campuses. Low self-esteem can contribute to negative outcomes such as depression, anxiety, eating disorders, poor social functioning, school drop-

out, and high-risk behaviour (Mulligan 2011). In three studies conducted on Mexican adolescent students, Tapia, Barrios, and Gonzalez-Forteza (2007) found that a greater proportion of female adolescents reported low self-esteem as well as higher suicide ideation and depressive symptoms than their male counterparts.

There is a well-established relationship between depression and suicide ideation, with the literature suggesting that depression is the primary predictor of suicide ideation in college students (Wang, 2013). In a study, Lester (cited in Wang 2013) found depression to be the only predictor of past and current suicidality in a sample of 152 students. It was found that depressive symptoms had the strongest predictive impact on suicide ideation in college students in the United States of American (USA). another study. also revealed strong negative correlations between self-esteem and depression and, on the basis of these results, a caution has been given against treating self-esteem and depression as distinct constructs (Sowislo & Orth, 2013). A study by Adish-Atta, Ossom and Lawer (2016) aimed at examining the relationship between self-esteem, depression and suicidal ideation among the physically disabled in Ghana. Purposive sampling was used to select one Hundred and Eighty (180). Specifically, sixty (60) participants were visually impaired, sixty (60) were hearing impaired and sixty (60) had mobility impairment respectively. Their result revealed that self-esteem and depression related significantly with suicidal ideation. In related studies results have indicated that depression was the main predictor of suicide ideation of Asian adolescents and adults (Chiles et al; Lau et al: Yip et al: Zhang cited in Wang, 2013).

Several studies have indicated that low self-esteem contributed to vulnerability for developing suicide ideation and others have revealed a negative relationship between self-esteem and suicide ideation (Wang, 2013). Among adolescents, low self-esteem has consistently been associated with suicidality and it is often considered as a predictor for symptoms of depression (Wang, 2013). The cognitive theory of depression hypothesized that the negative schemas that contained dysfunctional beliefs about the self, continued to persist in individuals who were vulnerable to depression, even long after their experiences of depressive episode (Franck, De Readt & De Haviwer, 2008).

Studies have also indicated that there is a correlation between low self-esteem and a number of negative outcomes such as depression, social anxiety, low levels of interpersonal confidence and one's increased risk of teenage pregnancy (Silverston & Salsal 2003). McLeod describes those with low self-esteem as people who have difficulty in interacting with others socially as they feel shy, awkward, conspicuous and more likely to experience social anxiety and alcohol and other drugs use.

Effects of Assertiveness Training on Self-Esteem

Several studies have been conducted to explore the effects of assertiveness training on self-esteem. Ozşaker (2013) conducted a study aimed at examining the relationship between assertiveness and self-esteem in adolescents, including both athletes and non-athletes. The participants were adolescents (n=1006) aged 12 to 14 years, residing in Izmir, Turkey. The results showed that there was a significantly stronger relationship between

assertiveness and self-esteem among athletic adolescents compared to the sedentary adolescents.

Kirst (2011) also explored the relationship between assertiveness and the five types of personality (extraversion, neuroticism, openness to experience, agreeableness, and conscientiousness), self-esteem, social anxiety, and shyness. The results revealed direct relationships between assertiveness and self-esteem, extraversion, openness to experience, and conscientiousness, as well as inverse relationships to neuroticism, shyness, and fear of disapproval. No significant relationship was however found between assertiveness and agreeableness.

Lin et al. (2004) evaluated the effect of an assertiveness training programme on nursing and medical students' assertiveness, self-esteem, and interpersonal communication satisfaction. The data were collected before and after training. The results showed that assertiveness and self-esteem of the experimental group were significantly improved in nursing and medical students after assertiveness training, although interpersonal communication satisfaction of the experimental group was not significantly improved after the training programme.

Further, Andrea, Klein, Heuvel and Dijk (2013) in a study, explored the associations between adolescents' assertive behaviour, psychological well-being, and self-esteem. The sample consisted of 1,023 students. Data were analysed using hierarchical linear regression. It was found that assertiveness was associated with psychological wellbeing and self-esteem. Similarly, Gull, Munir Amin and Farooq (2012) in their study explored the relationship among self-esteem, assertiveness and job satisfaction in the personnel working in

banking sector in Lahore city. The sample of the research consisted of 100 respondents (50 male personnel and 50 female personnel) working in different banks in Lahore. Three questionnaires were used to measure the self-esteem, assertiveness and job satisfaction of the employees of various banks. The findings revealed that a significant relationship exists between the employees' self-esteem, assertiveness and job satisfaction.

In addition, Alkhawaldeh (2011) conducted a study which aimed at evaluating the effect of assertiveness training in improving self- esteem and adjustment among victims of bullying students. The sample of the study consisted of 24 participants of the sixth, seventh and eighth grades, in Ail Reda Rekabi school from Amman Second Educational District, in the 2010/2011 academic year. The results of this study showed that assertiveness training programme was effective in improving self- esteem and adjustment among victims of bullying students. The findings of Alkhawaldeh were similar to those of Boket, Bahrami, Kolyaie and Hosseini (2016). They sought to determine the effect of assertiveness skills (AS) training on reduction of verbal victimization of Tabriz high school female students in Iran (Academic year of 2015-16). A sample of 50 students (25 experimental, 25 control) were selected using random clustering sampling. This study was a quasi-experimental design with pre-test, post-test and control group. Data was collected using Iranian Form of Bullying Victimization Scale. In the training, programme, the experimental group attended eight-week 90-minutes sessions (one session per week), but the control group never attended any session. Data was examined using ANCOVA and the results showed that there was a significant difference between pre-test and post-test scores in the experimental group. The findings

therefore suggested that assertiveness training programme decreased students' verbal victimization and improved the self-esteem of the female students.

Moreover, Makinde and Akinteye (2014) investigated the effects of Mentoring and Assertiveness Training on Adolescents' self-esteem in Lagos State secondary schools. A total of 96 adolescents (48 males and 48 females) drawn from three public schools randomly selected from three Education Districts in Lagos State constituted the final sample. The dependent variables for this study were self-esteem and gender. Descriptive survey and quasi-experimental design using the pre-test post-test control group designs were adopted for the study. Two instruments used to generate data for the study were: Adolescents' Personal Data Questionnaire (APDQ) and the Rosenberg Self-Esteem (RSE) Scale. Two research questions were raised and two corresponding hypotheses were formulated to guide the study. The two hypotheses were tested using the one-way Analysis of Covariance (ANCOVA) at 0.05 level of significance. The findings revealed that mentoring and assertiveness training were effective in improving adolescents' self-esteem.

Sert (2003) also investigated the effects of assertiveness training on the assertiveness and self-esteem levels of 5th grade children. The participants of the study were twenty-four students drawn from Ankara University Education Development Foundation Primary School. The experimental design was used in which 2 groups were compared on pre-test and post-test measures by using Assertiveness Inventory and Coopersmith Self-esteem Inventory. Moreover, observations of teachers were collected through the record sheets. The experimental group was given an 8-week training. The results revealed that

there were significant differences between the two groups based on assertiveness scores. In order to explore the effects of assertiveness training on self-esteem levels of children, Analysis of Covariance (ANCOVA) was used. However, there were no significant differences found on self-esteem scores between the two groups. On the other hand, the observations that were collected from the teachers revealed that assertiveness training contributed positively to the children's self-esteem.

Mahmoud and Hamid (2013) carried out a study to ascertain the effectiveness of assertiveness training on self-esteem and academic achievement in adolescent girls at Abba city using the pre-test-post-test experimental approach. The result of their study revealed a significant improvement in the self-esteem levels of participants in the post-test scores. They attributed the improvement in the mean scores of assertiveness, self-esteem and academic achievement after training program to the contents of the training programme which included proper assertive behaviour and clarification and confirmation of the individual's fundamental rights.

In another study, Etodike, Ike and Chukwane, (2017) examined the effectiveness of assertiveness training on self-esteem and academic performance among S.S.3 students is selected secondary schools in rural areas of Amanbra state in Nigeria. A total of 108 students which comprised of 39 males and 69 females with age between 15 and 19 participated in the study. Participants were divided into two groups, control group and experimental group. The result indicated that assertiveness training enhanced the self-esteem score of the experimental group against the control group which recorded no significant change in the post test.

The experimental group also recorded improvement in their academic performance. The researchers therefore recommended that the government through the education board should include practical assertiveness training programmes in the curriculum of all secondary schools so as to enhance the self-esteem of students which will translate into the improvement in academic performance.

Dani (2013) carried out a study on the enhancement of adolescents' self-esteem by intervention module. The results indicated significant difference between the pre-test and the post-test self-esteem mean for the experimental and control group. The results indicated efficacy of the intervention module. The report from the study indicated that self-esteem is the axis of a person's development and therefore enhancing self-esteem can consequently lead to all round growth of an individual's personality. Anyaneme, Chiyelu and Nneka (2016) also carried out a study on effects of assertive training on the low self-esteem of secondary school students in Anambra State. The findings revealed that assertive training had an effect on the low self-esteem of the students by raising or enhancing their self-worth and competence. Their results also showed that, there was no significant difference in the effect of assertive training on low self-esteem of male and female students. The result of the study indicated that assertive training had an effect on the self-esteem of the secondary school students.

The studies reviewed have all pointed out that assertiveness training can improve the self-esteem of individuals. This shows that assertiveness training is important for students particularly those with self-esteem issues.

Cognitive restructuring has been studied in relation to how it affects the self-esteem of individuals. Lawan (2016) examined the effect of cognitive restructuring (CR) and social skills training (SST) counselling techniques on Avoidant Personality Disorder (APD) among Secondary School Students in the Kano Metropolis. The study was a quasi-experimental design involving pre-test-post-test-control group design. The population of the study consisted of second year students of senior secondary schools in Kano Metropolis who exhibited APD. Three all-male and three all-female senior secondary schools, making six schools, were selected in the Kano Metropolis. A sample of 72 respondents from the six schools, twelve from each school, were sampled and put into 3 experimental groups (CR, SST and control group). Each group consists of 12 male and 12 female students. APD test (DSM-5) was used for data collection in the study and each treatment group, either CR or SST, received treatment for twelve (12) consecutive weeks (3 minutes a week) counselling sessions. Seven research questions and seven null hypotheses were formulated and the hypotheses were tested at 0.05 alpha level of significance while standard deviation and t-test for independent sample were used to analyse the data collected. Also, ANOVA was used on the pre-test results to confirm that there was no difference in the level of APD among the groups. The results indicated that Cognitive Restructuring Counselling Technique led to reduction of APD (t=8.086, p=0.000). This improved the level of self-esteem of the students.

Khayat (2017) investigated the effectiveness of cognitive behaviour counselling programme on the self-esteem of a sample of visually impaired

people. The subjects for this research comprised of eight visually impaired female students from the King Abdulaziz University of Jeddah, Saudi Arabia, aged between 18-25. The subjects were chosen for participation in the study and verbally consented to participate in its cognitive behavioural counselling programme after completing the Rosenberg Self-Esteem Scale. At the completion of the counselling programme, the subjects took the Rosenberg Self-Esteem Scale test for a second time, and two months afterwards also took it for a third time. The data obtained from this research was analysed using the Wilcoxon Signed-Rank Test. The results showed several differences for the group in terms of their self-esteem levels. The results emphasize the value of cognitive counselling programmes for helping visually impaired subjects integrate into society by increasing their self-esteem.

Taylor and Montgomery (2007) assessed the efficacy of cognitive therapeutic measures in improving self-esteem among depressed adolescents aged from 13 to 18 years. Randomised controlled trials (RCTs) or quasi-randomised controlled trials was carried out. Two reviewers independently selected papers for inclusion in the review using the following criteria: random allocation, allocation concealment, follow-up and withdrawals, intention-to-treat analysis and blinding of assessors. The study found that there was no statistically significant between-group difference in depressive symptoms at immediate post treatment when cognitive treatments were employed. It was concluded therefore that cognitive treatment appeared to be a potentially effective treatment in improving self-esteem among adolescents aged 13 to 18 years who were suffering from unhealthy low levels of self-esteem.

An intervention study was conducted by Sharma and Agarwala (2015) on self-esteem and collective self-esteem among adolescents in India using pre measures and post measures of self-esteem. Their result proved that the intervention programme given to enhance the self-esteem and collective self-esteem was effective. The study revealed a strong relationship between a person's emotional relations and involvement in social relationships. Sharma and Agarwala (2015) were therefore of the view that parents and teachers could collaborate to provide individualized support by creating an atmosphere that enhances competence and relatedness. This will help young people with low self-esteem and low collective self-esteem through the support of parents, teachers and peers, since enhanced self-esteem supports social skills and makes it easier for young people to have and keep friends.

A study conducted by Liza (2010), found that cognitive restructuring programmes have a positive significant effect on the students' self-esteem indicating that cognitive restructuring technique can tangibly enhance self-esteem. In a study conducted by Addison, Antwi and Avonokadzi (2014), on the impact of cognitive restructuring on students with low self-esteem and academic performance in Dambai College of Education, it was found that repeated fault findings and criticisms of students work led to low self-esteem which affected students' academic performance and that cognitive restructuring significantly enhanced academic performance. One way of changing one's negative self-thought and inappropriate interpretation is through cognitive restructuring. They therefore recommended that cognitive restructuring should form part of parenting education to enable parents to use the techniques in improving the low self-esteem of their children.

Researchers have been interested in the effects of assertiveness training on depression. Fuspita, Susanti and Putri (2018) investigated the influence of assertiveness training against teenage depression among high school students in Kepahiang Regency, Bengkulu, Indonesia. The study used a quasi-experiment approach with pre-test and post-test design and a control group. Eighty (80) students were engaged through simple random sampling. The study found that assertiveness training had a significant effect on the prevalence of depression in the intervention group. Therefore, the study recommended that schools cooperate with health services to increase mental health programmes such as building peer groups, delivering assertiveness training, and teaching stress management to prevent depression in teenagers.

Eslami, Rabiei, Afzali, Hamidizadeh and Masoudi (2016) conducted a study aimed at determining the effectiveness of assertiveness training on the levels of stress, anxiety, and depression of high school students of Isfahan. The quasi-experimental design was adopted for the study. A total of 126 second year high school students were selected using the simple random sampling method and divided into two groups: experimental with 63 participants and control with the same number. Gambill-Richey Assertiveness Scale and Depression Anxiety Stress Scales (DASS-21) were used. Assertiveness training was carried out on the experimental group in 8 sessions after which post-test was carried out on both groups. Statistical tests such as independent t-test, repeated measures ANOVA, Chi-square test, and the Mann-Whitney test were used to interpret and analyse the data. The Chi-square and Mann-Whitney tests did not show significant statistical differences

between the two groups in terms of demographic variables ($P \geq 0.05$). Repeated measures ANOVA showed no significant difference between the mean scores for assertiveness before (100.23 ± 7.37), immediately after (101.57 ± 16.06), and 2 months after (100.77 ± 12.50) the intervention in the control group. However, the same test found a significant difference between the mean score for assertiveness in the experimental group before (101.6 ± 9.1), immediately after (96.47 ± 10.84), and 2 months after (95.41 ± 8.37) implementing the training program ($P = 0.002$). It was concluded from the findings that conducting assertiveness training on high school students decreases their anxiety, stress, and depression. Given that high school years are among the most sensitive stages of one's life plus the fact that they are highly prone to depression, conducting such training programmes was highly recommended.

Rezayat and Nayeri (2014) also explored depression and assertiveness levels and relationship between them in nursing students of Tehran University of Medical Sciences during Autumn and Winter of 2012. The study adopted a cross-sectional correlational approach. The study population consisted of bachelor nursing students before entering the clinical field. The inclusion criterion was lack of any psychological problems. For selecting the samples, convenience sampling method was performed. A significant inverse relationship was found between assertiveness and depression in nursing students.

Mohebi Sharifirad, Shahsiah, Botlani, Matlabi, and Rezaeian (2012) sought to determine the effect of assertiveness training on reducing anxiety levels in pre-college academic students in Gonabad city. In this clinical trial

study, all the pre-college students of Gonabad city were invited to participate and 89 students were divided into experimental and control groups. There were 3 questionnaires, namely Demographic, Academic Anxiety and Assertiveness Rathus questionnaires whose validity and reliability were calculated and approved. The intervention for the experimental group was 5 sessions of assertiveness training using the PRECEDE model and 1 session for parents and teachers to help and support the intervention programme. There was a post-test 8 weeks after the last training session for each group was conducted. The results showed that there was a significant anxiety decrease in the experimental group after the intervention. On one hand, there was a significant increase in decisiveness for both groups, but there was no significant difference between academic anxiety and assertiveness in the control group before and after the intervention. Based on the results, it was concluded that assertiveness training was an effective non-pharmacological method for reducing academic anxiety and it can improve academic performance.

Dhanpal and Paul (2018) investigated the effectiveness of assertive training programme on relieving the academic stress and anxiety, among Nursing Students in a Selected Institute, Bangalore. A quasi experimental study with one group pre-test and post-test design was used to assess the effectiveness of assertive training programme. Simple random sampling was used to collect data from 30 respondents studying in various colleges of nursing in Bangalore. Data was collected by using modified academic stress scale of 5 point and modified Zung's anxiety self-assessment scale of 4 points. Data was analysed using Paired t-test. There was significant reduction of

academic stress ($t = 21.04$, $p < 0.05$) and anxiety ($t = 18.36$, $p < 0.05$) among nursing students after assertiveness training programme. The study findings can thus help in designing assertiveness training programme to improve nursing students' assertive belief and behaviour, which can help the nursing students to change how they viewed themselves and establish self-confidence and avoid anxiety and stress.

Clark, Corbisiero, Procidano, and Grossman (as cited in Sudha, 2016) conducted a study on the usefulness of assertiveness training for elderly psychiatric outpatients. This was done through a quasi-experimental evaluation of a programme at a community geriatric facility with 19 participants aged between 50 and 75 years. Though pre-intervention comparisons between the groups were non-significant, post-test assessment indicated a significant between difference in self-reported assertiveness-($t(17) = 2.69$; $p < .05$).

In another study, Fuspita, Putri and Susanti (2018) investigated the influence of assertiveness training on depression level of high school students in Bengkulu, Indonesia and found that assertiveness training had a significant effect on the prevalence of depression in the intervention group and therefore recommend that institutions should cooperate with health services to increase mental health programme such as building peer groups, delivering assertiveness training and teaching stress management to prevent depression among young people.

In a study Madu (2020) investigated into the effect of cognitive restructuring and assertive therapies in reducing depressive tendencies of students in Colleges of Education in Cross River State of Nigeria. The design

of the study was quasi experimental. The sample consisted 90 out of the students were systematically drawn from 234 students who were experiencing depressive tendencies. Beck`s Depression Inventory (BDI-II) was used to collect the pre-test and post-test data for the study. Cognitive restructuring and assertive therapies were administered on two experimental groups for eight weeks while the control group had discussion on great heroes and heroin and their ideologies. Mean was used in answering the research questions while ANCOVA was used to test the hypotheses at 0.05 level of significance. The result indicated that both cognitive restructuring and assertive therapies had positive effects in reducing students' depressive tendencies. There was no significant difference in the effectiveness of cognitive restructuring and assertive therapy in reducing students` depressive tendencies There was no difference in the reduction of depressive tendency of male and female students in cognitive restructuring and assertive therapies respectively after intervention. It was recommended that Psychologists and Guidance Counsellors be encouraged to use cognitive restructuring and assertive therapies in reducing students` depressive tendencies.

Effects of Cognitive Restructuring on Depression

The effects of cognitive restructuring on depression have been explored in different settings. Alamdarloo, Khorasani and Najafi (2019) investigated the effect of cognitive therapy on reducing depression, anxiety, and stress levels of Iranian males with addiction. The participants included 24 Iranian males with addiction selected through convenience sampling and randomly assigned to the experimental (n = 12) and control (n = 12) groups. The Depression Anxiety and Stress Scale was used as the pre-test, post-test,

and follow-up tests to assess participants' levels of depression, anxiety, and stress. The experimental group received eight sessions of cognitive-behavioural therapy, while the control group did not. The findings of the study showed that cognitive treatment was effective in reducing participants' levels of depression, anxiety, and stress. Thus, the findings indicate that the cognitive therapy reduced the depression, anxiety, and stress of Iranian males with addiction.

David, McMahon, Macavei, and Szentagotai, (2005) in their work elaborated several techniques hypothesized to control mental contamination, tested the efficacy of mental contamination during cognitive restructuring in cognitive-behavioural and rational-emotive therapy, in blocking mental contamination. They adapted and tested in the clinical setting using single case experiment design-multiple baselines across subjects. In their study they found the following three techniques that proved to be effective in both stimulating the assimilation of new adaptive cognitions and in preventing relapses:

1. The global restructuring technique;
2. The rational anticipation technique; and
3. The incompatible information technique.

The implication of the findings is that cognitive restructuring was effective in reducing relapse in depression issues. Mohammed (2017) also investigated the effect of cognitive behavioural treatment program on anxiety level and self-esteem among secondary school students. A Quasi-experimental pre-post non-equivalent group design was used for the study. The study was conducted at El Manial National Language Schools. A convenient sample of thirty (30) secondary school students was selected. The sample was divided

into two groups, fifteen students as the study group and fifteen students as control group. Three tools were used to collect data for the study; a) Personal Data Sheet; b) Hamilton Rating Scale of Anxiety; and c) Self-esteem Inventory. A constructed Cognitive Behavioural Treatment Intervention was developed by the researcher and implemented to the study group in ten sessions that were held twice weekly, and each session ranged from 60 to 90 minutes. The main study findings revealed that, there was a statistically significant difference between study and control groups in the reduction of anxiety level; however, there was no significant change in self-esteem for both groups. The study concluded that, cognitive treatment programme was effective with secondary school students concerning the reduction of the anxiety level.

The study of Asikhia (2014) focused on the effect of cognitive-restructuring therapy on mathematics anxiety in Mathematics among a group of Senior Secondary School Students in Ogun State. A 2 x 2 x 3 pre-test, post-test factorial design (treatment, gender, and study habit) was used in the study. The sample was drawn from Mathematics anxious students who were randomly assigned to one experimental group and one control group. Only the experimental group were treated with cognitive restructuring technique while the control group received a placebo treatment. The participants comprised ninety males and ninety females of high, medium and low levels of study habit. Two validated instruments namely Mathematics Anxiety Rating Scale Revised (MARS-R) by Plake and Parker (1982) and Study Habit Inventory (SHI) by Bakare (1977) were used in generating response from the students. Analysis of Covariance was used to analyse the three hypotheses formulated

and tested at 0.05 level of significance. The results of the study revealed a significant effect of treatment (cognitive-restructuring therapy) on participants' level of Anxiety in mathematics (F-ratio= 5.81, P <0.05). Cognitive restructuring was found to be more effective (× = 40.80) than the control group. It was found that study habit did not affect students' anxiety in mathematics significantly. Based on these findings, it was recommended that counsellors could use cognitive restructuring therapy as a strategy to reduce anxiety in Mathematics among Secondary School Students since it has been identified as effective.

Raising, Creemers, Janssens, and Scholte (2017) sought to identify and describe school-based and community-based prevention programs based on cognitive behavioural therapy with a primary goal of preventing depression, anxiety, or both in adolescents at risk of developing these disorders. The review presented evidence that cognitive therapy-based prevention of depression in groups for high-risk adolescents was effective in the short term. The findings of the meta-analytic review cautiously suggested that depression and anxiety prevention programs based on cognitive therapy might have small effects on mental health of adolescents, although there should be improvements in effects before supporting the implementation of selective and indicated depression and anxiety prevention programs.

Hampel, Graef, Krohn-Grimberghe, and Tlach (2009) evaluated the effects of cognitive-behavioural management training on depressive symptoms for patients with moderate and severe depressive symptoms. A three-factorial design with two between-subjects factor and one within-subjects factor was conducted. The first factor represented the treatment condition, with two

control groups, both participating in a standard rehabilitation programme, and one intervention group. The first control group consisted of patients with no and mild depressive symptoms (CG; $n = 92$) and the second control group of patients with moderate and severe depressive symptoms (CG_{depr}; $n = 52$). The patients assigned to the intervention group had moderate and severe depressive symptoms and took part in the standard rehabilitation programme combined with a cognitive-behavioural management training of depressive symptoms (IG_{depr}; $n = 55$). Depressive symptoms were assessed by the General Depression Scale, being a self-report measure (ADS). The second, quasi-experimental, factor consisted of gender (male, $n = 117$ vs. female, $n = 82$). The third factor involved the within-subjects factor of time of assessment with four sample points; rehabilitation outcomes were evaluated prior to rehabilitation (t_1), immediately after rehabilitation (t_2), 6 months (t_4) and 12 months after rehabilitation (t_5). A follow-up measurement 3 months after discharge (t_3) was also carried out, but was not taken into consideration in the present analyses. In total, 199 participants were included in the study. Although results of the present study have to be interpreted cautiously due to the non-randomized procedure, beneficial short- and mid-term rehabilitation effects on psychological outcome measures of the in-patient standard rehabilitation programme with a cognitive-behavioural management training of depressive symptoms for patients with depressive symptoms were supported.

Gender Difference in Effects of Assertiveness Training

Several decades back, Hollandsworth and Wall (1977) reviewed the literature on sex-related data from self-reported measures of assertion and

found that without exception males reported higher frequencies of assertive behaviour than females. Differential responding for males and females on individual items from the Adult Self Expression Scale was investigated using 4 samples of a total of 294 male and 408 females. Men reported themselves as more assertive than women on items dealing with bosses and supervisors. Men also reported themselves as being more outspoken when stating opinions and as taking the initiative more readily in social contacts with members of the opposite sex. Women, on the other hand, reported themselves as more assertive in expressing love, affection, and compliments, as well as expressing anger to one's parents. These sex differences in assertive behaviour affected assertion-training groups.

In more recent times, Tannous (2015) conducted a study aimed at clarifying the effectiveness of assertiveness training in improving self- esteem among a sample of students with low emotional-behavioural traits. A sample of (42) male and female students were selected from those who possessed the characteristics of low emotional – behavioural traits to respond to the questions in the study. The study sample was divided randomly into two groups, the first one was experimental and consisted of (21) male and female students who received training while the control group consisted of (21) male and female students were not trained. Additionally, two scales were used in the study as follows: Arabized image of Self-esteem Scale, and Emotional-Behavioural Traits Evaluation Scale (BERS-2) after its Arabizing and codification to Jordanian image. The study showed the effectiveness of the training in development of self-esteem to the study sample for the experimental group. It was also shown that there were statistically significant

differences at level of ($\alpha \geq 0.05$) in self-esteem among the members of the study sample due to gender after the training.

A study to test the effectiveness of cognitive behavioural therapy using cognitive restructuring and assertiveness training was carried out by Keshi, Basavarajappa and Nik (2013). Their result showed statistically significant difference in the depression level of the experimental group after the treatment period ($p<0.05$) indicating the efficacy of the CBT techniques in alleviating depression symptoms among high school students. Their results however did not indicate any significant difference regarding the effect of the intervention in terms of gender and age.

In a study, Mueen, Khurshid, and Hassan (2006) aimed at exploring the relationship between depression and self-assertiveness. Sample of the study consisted of 100 people (men = 50, women = 50), who were taken from different offices, houses, and hospitals. For the measurement of depression and self-assertiveness, Urdu translation of Beck Depression Inventory (1996) and scale of self-assertiveness were used. Results indicated highly significant relationship between depression and self-assertiveness. The findings showed that men were more assertive than women. They further showed that low education made a person non-assertive and depressed. Findings further revealed that, men and women could equally be victims of depression in their life. Findings also suggested that married people were more assertive in comparison with unmarried people.

Further, Akbari, Mohamadi and Sadeghi (2012) examined the efficacy of assertiveness training on increasing self-esteem and general self-efficacy of female students. The study method was two experiment groups and control

group with pre-test and post-test. The researcher randomly sampled 40 Anzali (female) students who had lower scores on self-esteem and self-efficacy and were conducted in two groups of 20 people in training programmes. Eight sessions of assertiveness training (90 minutes each) and group practices was provided. Data collected at the end of the training was analysed using multivariable covariance analysis test (MANCOVA). The findings showed that assertiveness training was effective in increasing self-esteem and general self-efficacy of female students. Even though males were not involved in the study of Akbari et al (2012), their findings still have relevance in the current study.

Gentile et al. (2009) conducted a meta-analysis to examine the gender differences in 10 specific domains of self-esteem across 115 studies, including 428 effect sizes and 32,486 individuals. In a mixed-effects analysis, men scored significantly higher than women on physical appearance (d = 0.35), athletic (d = 0.41), personal self (d = 0.28), and self-satisfaction self-esteem (d = 0.33). Women scored higher than men on behavioural conduct (d = 0.17) and moral–ethical self-esteem (d = 0.38) where d stands for the effect size. The gender difference in physical appearance self-esteem was significant only after 1980 and was largest among adults. No significant gender differences appeared in academic, social acceptance, family, and affect self-esteem. The results demonstrated the influence of reflected appraisals on self-esteem. The meta-analysis showed that even after some form of training there still existed gender difference in self-esteem.

Further, Pourjalia and Zarnghasb (2010) explored the relationships between assertiveness on a group of undergraduate students in Shiraz

University. In order to achieve this goal, 120 undergraduate student participants comprising 62 women and 58 men were chosen using random cluster sampling. The measurement tools were General Health Questioner (GHQ), Ratous Assertiveness Questioner (RAS) and Power of Saying No Questioner (self-designed). The data were analysed by Pearsonian coefficient and independent sample t-test. The results revealed that there was a significant relationship between assertiveness and mental health. It was also found that there was no significant difference between the assertiveness of women and men.

Agam, Tamir, and Golan (2015) also explored the impact of gender roles on adolescents' self-esteem and body image, and the influence of prevention programmes on these two factors when delivered in mixed-gender vs. uni-gender groups. They found that boys reported higher self-esteem than girls. Again, boys were more likely to be in situations that encouraged competition, conflict, power, and excitement, whereas girls were more likely to encounter situations of intimacy, self-disclosure, support, and co-rumination.

In addition, the study of Makinde and Akinteye (2014) on the effects of Mentoring and Assertiveness Training on Adolescents' self-esteem in Lagos State Secondary Schools found that the significant effect of assertiveness training on adolescents' self-esteem was not due to gender. Contrasting the study of Makinde and Akinteye, Gull et al. (2012) revealed that gender differences were significant in the self-esteem and assertiveness of the employees' as male personnel scored higher on self-esteem measure than female workers, while female workers were high in the assertiveness.

Parham, Lewis, Fretwell, Irwin, and Schrimsher (2015) investigated the differences in assertiveness as it related to gender, national culture, and ethnicity. The data for the study was collected from 231 undergraduate students majoring in business at one of four academic institutions: three in the USA and one in the Republic of Vietnam. Students completed the 30-item Rathus Assertiveness Schedule. The study found that individuals who were alike in level of education and status demonstrated similar levels of assertiveness, regardless of gender, national culture, or ethnicity. However, differences were seen as the data showed white American males to be the most assertive, with African American females next. White females ranked third, followed by Vietnamese females, concluding with Vietnamese males. The implication of the findings is that gender only caused a difference when studied together with nationality or race.

Dehnavi and Ebrahimi (2016) investigated the effect of assertiveness skills training on aggression dimensions. The research method was the pre-test post-test quasi-experimental design. The population of the study consisted of all high school first grade female students in Qorveh city who were enrolled in the academic years 2013-14. The sample consisted of 30 high school first grade female students who were selected through multi-stage random sampling. Buss and Perry Aggression Questionnaire (1992) was used for the data collection, and univariate ANOVA was used for the data analysis. The results showed that assertiveness skills training is effective on reducing students' physical aggression, verbal aggression, anger and hostility. It was therefore concluded that, assertiveness skills training could be a useful and efficient method for reducing aggression in female students.

The report of three studies conducted in Mexico on adolescent students revealed that a greater proportion of female adolescent reported low self-esteem as well as higher suicide ideation and depressive symptoms than their male counterparts (Wang, 2013).

Gender Difference in Effects of Cognitive Restructuring

Demographic variables such as gender have also been studied in the effects of cognitive restructuring. Cuijpers et al. (2014) conducted an "individual patient data" meta-analysis with the primary data of 1,766 patients from 14 eligible randomized trials comparing cognitive therapy with pharmacotherapy. The researchers examined the extent to which gender moderated or predicted outcome, using the Hamilton Rating Scale for Depression-17-item (HAM-D-17), with mixed effects models. The results showed that despite the high statistical power, there was no indication ($P > 0.05$) that gender moderated outcomes (i.e., no indication that either men or women responded better or worse to cognitive therapy). Gender was neither a nonspecific predictor (indicating whether gender is related to improvement), nor a specific predictor (predicting outcome of cognitive therapy compared to pill placebo). The researchers concluded based on the findings that the lack of predictive relations suggested that gender did not moderate differential response to cognitive therapy versus medication treatment.

In a study, Attila (2018) examined the effect of Beck's cognitive therapy on infertile women who exhibited depressive symptoms in the Cape Coast Metropolitan area in Ghana. A total sample of 29 infertile women took part in the study who were put into experimental and control groups. Participants in the experimental group were exposed to eight weeks pf

treatment using Beck's cognitive therapy and at the end of the eight-week treatment, the infertile women in the experimental group had their depressive symptoms improved as compared to those in the control group. It was therefore concluded that Beck's cognitive therapy was effective in reducing depressive symptoms among infertile women.

Akin-Johnson (2017) in a study investigated the effect of cognitive restructuring on stress factors and academic performance of senior secondary school students in Ogun state in Nigeria. The Quasi-experimental pre-test post-test control group design was used for the study. A total of 161 participants comprising of 84 males and 77 females (students) participants from four senior secondary schools in Ogun state took part in the study. The Mathematic Performance Test (MPT), English Language Achievement Test (ELAT), scale for Assessing Academic Stress (SAAS) and Educational Stress Scale for Adolescents (ESSA) were used to collect the pre-test and post-test for the study. Six hypotheses were formulated to guide the study and the two-way ANCOVA was used to analyze the data at 0.05 significance level.

The study revealed that gender did not significantly influence social and physical stress among participants. The results also revealed no significant effect between experimental conditions and stress level in the post-test scores of academic performance in mathematics among the participants. The result however, indicated a significant effect between experimental conditions and gender in the post-test mean scores in academic stress among participants. It was therefore recommended that cognitive restructuring be used to assist students who have stress in Mathematics and English Language to overcome their stress.

Lawan (2016) also examined the effect of Cognitive Restructuring (CR) and Social Skills Training (SST) Counselling Techniques on Avoidant Personality Disorder (APD) among Secondary School Students in Kano Metropolis. Lawan found that there was a differential effect based on gender in the CR treatment in favour of males (t=014, p=0.006). The study of Asikhia (2014) on the effect of Cognitive-Restructuring training on mathematics anxiety in mathematics among a group of Senior Secondary School Students in Ogun State also revealed that gender affected students' anxiety in mathematics significantly ($P< 0.05$) with male students having more reduction in Mathematics anxiety than female students.

In another study, Zakariyah (2016) investigated the effectiveness of cognitive restructuring technique and solution focused brief counselling on the self-concept of secondary school underachievers in the Illorin metropolis of Nigeria. The pre-test post-test control group quasi experimental design was used for the study. A total of 50 students took part in the study and the ANCOVA was used to analyse the data at 0.05 level of significance. The findings indicated that cognitive restructuring was effective in managing self-concept of secondary school underachievers. The findings however, indicated no significant difference in the effectiveness of cognitive restructuring and solution focused brief counselling in improving the self-concept of male and female secondary school underachievers.

Grubbs Chenney, Fortney, Edlund et al. (2015) aimed at finding out whether gender moderated intervention effects in the Coordinated Anxiety Learning and Management intervention, a 12-month, randomized controlled trial of a collaborative care intervention for anxiety disorders (panic disorder,

generalized anxiety disorder, post-traumatic stress disorder, and social anxiety disorder) in 17 primary care clinics in California, Washington, and Arkansas. The participants (N=1,004) completed measures of symptoms (Brief Symptom Inventory [BSI]) and functioning (mental and physical health components of the 12-Item Short Form [MCS and PCS] and Healthy Days, Restricted Activity Days Scale) at baseline, six, 12, and 18 months. Data on dose, engagement, and beliefs about psychotherapy were collected for patients in the collaborative care group. The study revealed that gender moderated the relationship between cognitive treatment and its outcome on the anxiety and depression measures. Women who received the care showed clinical improvements on the BSI. There were no differences for men who received the care. In the intervention group, women compared with men attended more sessions of psychotherapy, completed more modules of therapy, expressed more commitment, and viewed psychotherapy as more helpful.

The studies reviewed have shown inconsistent findings since in some studies gender difference were found to make significant differences but not so in other studies. This calls for more investigation into the phenomenon.

Age Difference in Effects of Assertiveness Training

Abed, El-Amrosy, and Atia (2015) sought to assess the effect of assertiveness training programme on improving self-esteem of psychiatric nurses. The study was conducted at The Psychiatric and Addiction Treatment Hospital in Mit-Khalf at Menoufia, Egypt. The subjects of the study were 30 nurses and data were collected using Garas, Ahmed and Bader Arabic version of Rosenberg's Global self-esteem scale and Assertive Behaviour Inventory Tool (ABIT). Parametric tests were one a way ANOVA (F test), Paired *t*-test.

A non-parametric test was Mann-Whitney test. The study showed that there was statistically significant difference between measure 1 and 2 intervention programmes regarding assertiveness skills and self-esteem score level of psychiatric nurses; also, there was positive significant correlation between total assertiveness skills and total self-esteem score level and there was positive significant correlation between age and experience and total assertiveness skills. The implication is that age and experience were significant in the effectiveness of assertiveness training programme.

Maddahi, Liyaghat, Samadzadeh, and Keikhayfarzaneh (2011) investigated the effects of a self-assertiveness training program and different parenting styles in female first grade high school students in Tehran. Students were selected from 14 education authorities as designated by the Iranian Ministry of Education. All students had enrolled during the academic year 2008-2009. The sample, using a cluster sampling method consisted of 400 students of whom 50 were selected to take part in the training program. All participants completed the Assertiveness Innovatory (AI) and a 76-item inventory measuring parenting style. Subjects completed the questionnaires twice before and after the training program. Statistical analyses showed that there was a significant difference with "little control and too much love". It was further found that students who scored low on self-assertiveness measures could benefit significantly from self-assertiveness programmes. This was very particular for those who were younger.

Aktop, Özçelik, Kaplan, and Seferoğlu (2015) sought to determine the assertiveness and aggression level of soccer players in different age groups. Participants were 150 amateur soccer players between ages of 14 to 30 years.

anxiety disorder, post-traumatic stress disorder (PTSD), and/or social anxiety disorder. The researchers hypothesised that older adults would show a poorer response to the cognitive interventions than younger adults. The study showed that cognitive interventions were more effective than usual care among younger adults overall and for those with generalised anxiety disorder, panic disorder and social anxiety disorder. Among older adults, the intervention was effective overall and for those with social anxiety disorder and PTSD but not for those with panic disorder or generalised anxiety disorder. These results imply that cognitive interventions for anxiety disorders might not be as effective for older individuals as they might be for younger people.

Karlin, Trockel, Brown, Gordienko, Yesavage, and Taylor (2015) carried out a study which compared the effectiveness of cognitive behavioural therapy (CBT) for depression among older and younger veterans. They categorised participants aged 18-64 as younger veterans and 65 and above as older veterans. Their findings revealed significant and equivalent reductions in depressive symptoms for older and younger individuals. For both groups, there was an average overall reduction of close to 40% in their post-test scores. In addition, they found that CBT yielded significant improvements in overall quality of life for both groups, suggesting that the intervention was equally effective for older and younger patients. They attributed the identical rate of reduction of the depression levels of both groups to the fact that both older and younger age groups might have embraced the intervention with similar levels of acceptability

Johnco, Wuthrich, and Rapee (2014) assessed the impact of cognitive flexibility on cognitive restructuring skill acquisition following group CBT,

and on treatment outcome, along with changes in cognitive flexibility over treatment. Older participants (44 in number) with anxiety and depression completed self-report and neuropsychological tests of cognitive flexibility and a clinical interview at pre-treatment and post-treatment. Qualitative and quantitative measures of cognitive restructuring were completed at post-treatment. Pre-treatment cognitive flexibility was not related to the quality of cognitive restructuring at post-treatment or overall treatment outcome. However, it did predict reduction in subjective units of distress from using cognitive restructuring and therapist ratings of cognitive restructuring ability at post-treatment. Few participants showed changes in cognitive flexibility over treatment. Those with poorer cognitive flexibility did not find cognitive restructuring as useful to alleviate emotional distress as those with better cognitive flexibility. However, those with poorer cognitive flexibility could still benefit from standardised CBT, even if their use of cognitive restructuring is less effective. The implication of the findings was that for older adults, cognitive restructuring reduced distress at the end of treatment, even though this was based on their own cognitive flexibility.

Several other studies have shown that cognitive restructuring work with older adults (Gallagher-Thompson, Steffen, & Thompson, 2010; Laidlaw, 2001). Garber, Frankel, and Herrington (2016) have also showed that when cognitive interventions meet the child's level of development, children's potential as well as their current abilities are likely to be improved. This implies that age plays a role in how effective cognitive restructuring can be.

Self-Esteem as Mediator in the Effect of Assertiveness Training on Depression

Ranjbarkohn and Sajadinejad (2010) investigated the effects of assertiveness training on self-esteem and depression in students of Isfahan University of medical sciences. The study was an experimental study, as pre-test and post-test with a control group, were conducted in the academic year of 2009-2010. Forty students were selected through randomized cluster sampling into case and control groups (10 females and 10 males for each group). The assertiveness training program was used in case group for 8 sessions. The Ellis Pop Esteem Test and Beck Depression Inventory were used to evaluate the variables before and after training. The collected data were analysed using MANCOVA and t tests, at the significant level of 0.05. The study revealed that assertiveness training caused a significant increase in the self-esteem level and decrease in the depression rate in case group (P=0.001 for both) but this effect was not seen in the control group. Based on the findings, the researchers concluded that as self-esteem got improved by assertiveness training, depression reduced.

Hojjat et al. (2016) investigated the effectiveness of group assertiveness training on happiness in rural adolescent females with substance abusing parents. The participants consisted of 57 middle school girls, all living in rural areas and having both parents with substance dependency. The participants were randomly assigned to intervention (n=28) and control (n=29) groups. The data were collected before and six weeks after training in both groups. The intervention group received eight sessions of group assertiveness training. Participants were compared in terms of changes in scores on the

Oxford Happiness Questionnaire and the Gambrills-Richey Assertion Inventory. The total score for happiness changed from 43.68 ±17.62 to 51.57 ±16.35 and assertiveness score changed from 110.33±16.05 to 90.40±12.84. There was a significant difference in pilot-test-post-test change in scores for intervention (7.89±4.13) and control (-2.51±2.64) groups; t (55) =2.15, p = 0.049. These results suggested that intervention really does have an effect on happiness and assertiveness generated self-esteem.

Emmanuel, Okreke, and Anayochi (2015) used a pre-test-post-test, control group quasi-experimental design to investigate the effects of assertiveness training and cognitive restructuring technique on self-esteem of female undergraduate victims of relationship violence in South-West Nigeria with a sample of ninety female undergraduate students who have experienced relationship violence. From their results, the effect of expressed anti-social behaviour such as relationship violence on the developmental well-being of female undergraduate victims could be managed and their self-esteem enhanced with the use of intervention. The results also indicated that the impact of relationship violence on self-esteem was much more on participants in the control group followed by cognitive restructuring and assertiveness training groups respectively. The control group had the highest adjusted post-test mean score (x=33.73) followed by cognitive restructuring group with the adjusted mean score (x=22.21) while the assertiveness training group had the least adjusted post-test mean score (x=21.08). Based on the results, the researchers concluded that self-esteem played a role in how assertiveness affected individuals. They therefore, recommended that psychological intervention programmes should be put in place in universities through their

counselling centres to help undergraduates re-discover their potentials and develop competence to relate intelligently with others.

Other studies have indicated that self-esteem showed positive correlation to assertiveness, self-confident and assured career seeking behaviour implying that self-esteem can mediate the effects of assertiveness training. (Davidson et al, 2012).

Self-Esteem as Mediator in the Effect of Cognitive Restructuring on Depression

Several studies have been conducted on self-esteem as a construct measuring different variables affecting the human life. Stress, low assertiveness, depression, hostility, and aggressiveness have been found to be among the problems prevalent among young university students (Mahmoudi, Azimi & Zarghami, 2014). Baumeister (1990), has pointed out that low self-esteem contributes to vulnerability for developing depression and ultimately suicide ideation. According to him, people develop suicide ideation when they fail to achieve their goals and strongly desire to escape from negative self-attributions of their failure. Watson et al. (as cited in Sowislo and Orth, 2013) also found a strong negative correlation between self-esteem and depression and, on the basis of this result cautioned against treating self-esteem and depression as distinct constructs.

The cognitive theory of depression hypothesizes that the negative schemas that contain dysfunctional beliefs about the self continues to persist in individuals who are vulnerable to depression, even after their experiences of depressive episode (Franck, De Readt & De Haviwer, 2008).

A number of longitudinal studies have shown that low self-esteem prospectively predicts increases over time in anxiety and depression (Mann et al., 2016). Specifically, Mann et al. (2016) found out in their study that self-esteem was negatively related with depression emphasizing that self-esteem could be considered as a protective factor especially in adolescence when individuals go through challenging times. Therefore, the researchers argued that to overcome depression using cognitive restructuring, the self-esteem of individuals can be considered first.

Some studies have also indicated that there is a correlation between low self-esteem and a number of negative outcomes such as depression, social anxiety, low levels of interpersonal confidence and once increased risk of teenage pregnancy (Silverston & Salsal 2003). McLeod (2012) described those with low self-esteem as people who have difficulty in interacting with others socially as they feel shy, awkward, conspicuous and more likely to experience social anxiety, alcohol and other drug use.

In his study, Thomb (2000) found that first year college students with relatively low self-esteem were more likely to exhibit many problems than those with higher self-esteem. Among the problems likely to be exhibited are self-defeating behaviour, poor study habit, poor time management skills, and being in irresponsible relationships. Serap (2003) is of the view that students who feel positive about themselves have fewer sleepless nights and easily cope with pressures of conformity by peers. Such students according to Serap (2003), are also less likely to use drugs and alcohol, they are more persistent at difficult tasks, are happier and more sociable. On the contrary, college students with low self-esteem tend to be unhappy, less sociable and more

likely to use drugs and alcohol and more vulnerable to depression (Serap, 2003)

In a survey conducted with 964 college students, Westefield and Furr (1987) reported depression and suicidal tendencies to be prevalent on college campuses. Again, a survey by the American Psychological Association (APA, 2015) that 36.4% of college students were battling with depression, 21% had severe mental health problems while 40% were battling with mild mental health concerns which were interfering with their daily functioning at college.

Anhalt (2015) also pointed out that men with low self-esteem were more likely to engage in negative thought distortions that made them view themselves as coming up short when compared to their male counterparts while women who suffered from low self-esteem were more likely to engage in negative thought patterns of jumping to conclusions, assuming that others were judging them harshly.

Hayman and Cope (1980) investigated the effectiveness of assertion training on depression using moderately depressed females and the results showed that members in the experimental group were significantly less depressed eight (8) months after treatment indicating the effectiveness of the intervention in alleviating or reducing depression. Zadeh and Lateef (2012) also reported that students who received training in cognitive therapy improved significantly in their depressive disorder and therefore concluded that cognitive restructuring was effective in alleviating depression among students.

Summary of the review

This review has revealed that students in tertiary institutions are confronted with issues that border on their self-esteem and depression levels.

On the basis of gender, the review revealed that men looked to social comparisons to fuel their self-esteem, basing a large component of their self-worth on their ability to be the provider in comparison with others, their intelligence, independence and status with others in their workplace, family or social group. Women on the other hand mostly relied on reflected appraisal as the source of their self-esteem. Thus, many women depended on how others viewed them for their self-esteem. It also brought to light that more female adolescents experienced low self-esteem and higher suicide ideation and depressive symptoms than their male counterparts.

Assertiveness training and cognitive restructuring could assist individuals to change how they viewed themselves and establish in them self-acceptance, self-worth and self-confidence. These in turn would give them the strength and courage to move towards self-actualization as enshrined in Maslow's theory knowing they are good and have something to offer society. The review also indicated that through assertiveness training and cognitive restructuring the individual could be helped to develop a positive sense of the self as asserted by Rogers which in turn enhanced the self-esteem of the individual. Again, it was indicated that a training in assertiveness and cognitive restructuring might enable the individual to come to terms with the fact that individuals were unique in their ways having their own set of values and interests which to an extent induce that inner motivation which is key to Deci and Ryan's Self-Determination Theory.

The literature further revealed that assertiveness training and cognitive restructuring have positive effects in enhancing self-esteem among adolescents in the secondary schools. Again, assertiveness training and cognitive restructuring as interventions have proven to be effective in dealing with issues of low self-esteem and depression among students in the colleges of education, nursing and the traditional universities globally by enhancing academic performance. The literature again revealed that self-esteem has proven to have an influence on the effects of assertiveness training and cognitive restructuring on depression.

The present study sought to fill the gap and establish the effectiveness of assertiveness training and cognitive restructuring treatment programmes on the self-esteem and depression levels among students in the Ghanaian technical universities.

CHAPTER THREE

RESEARCH METHODS

Introduction

In this chapter, methodological procedures of this study are presented. The main topics are the overall research design, the quasi-experimental design, population, sampling procedures, data collection instruments, data collection procedure, and the data analysis procedure of the study.

The aim of the study was to find the effects of assertiveness training and cognitive restructuring techniques on the self-esteem and depression levels of Technical University students in Ghana. It was assumed that an increase in the self-esteem of students would result in a decrease in depression levels to culminate in better psychosocial functioning as consequential effect. This chapter deals with the research design, population, experimental sampling procedure, instrumentation, data collection and data analysis procedures.

Research Design

The focus of the study was on the effect of the interventions (assertiveness training and cognitive restructuring techniques) which were the independent variables on the self-esteem and depression (the dependent variables) levels of students in technical universities in southern Ghana. The experimental design was therefore deemed the most appropriate so that the research hypotheses could be tested to establish cause-effect relationships.

Specifically, the Pre-test - Post-test Control Group Quasi Experimental Design was used for this study.

In an experimental research, the researcher manipulates at least one independent variable, controls other relevant variables and observes the effect on one or more dependent variables. The researcher has total control over the selection and assignment of groups to treatments (Gay, Mills & Airasion, 2009; Sarantakos, 1993). In the most basic form, an experiment consists of the following processes as indicated by Sarantakos, (1993):

1. Establishing and controlling the experiment
2. Measuring the dependent variable
3. Introducing the independent variable
4. Testing the dependent variable
5. Assessing the presence and extent of change in the dependent variable.

Quasi-experimental design

The prefix quasi means resembling and therefore quasi-experimental research is a research that resembles experimental research but is not a true experimental research (Price, Jhangiani & Chiang, 2013). A quasi-experiment is an empirical study used to estimate the causal impact of an intervention on its target population without random assignment. The design shares similarities with the traditional experimental design or randomized controlled trial, but it specifically lacks the element of random assignment to treatment or control. Instead, quasi-experimental designs typically allow the researcher to control the assignment to the treatment condition, but using some criterion other than random assignment for instance, an eligibility cut-off mark (Kowatezyk, n.d).

According to Cook and Campbell (1979), although the independent variable is manipulated, participants are not randomly assigned to conditions or orders of conditions. Price et al (2013) asserts that quasi-experimental research eliminates the directionality problem due to the fact that the independent variable is manipulated before dependent variable is, Quasi-experimental research is often conducted to evaluate the effectiveness of a treatment be it a type of psychotherapy or an educational intervention.

The Pre-test-Post-test design was used for this study. The researcher had two (2) treatment groups and one (1) control group. All participants took a pre-test after which each treatment group was given a different treatment and each group was post-tested at the end of the treatment. Post-test scores on the dependent variable were compared to determine the effectiveness of the treatment.

Control of extraneous variables

Extraneous variables are unwanted factors in a study that, if not accounted for, could negatively affect (i.e. confound) the data subsequently collected. Extraneous variables are factors other than the independent variable that might affect the dependent variable. The validity of an experiment is a direct function of the degree to which extraneous variables are controlled (Gay, Mills, & Airasian, 2009). Extraneous variables are other unwanted independent variables that the researcher may not be interested in but have the tendency to influence the outcome of the experiment such that an outcome cannot be attributed solely to the unique effect of the independent variable(s).

According to Gay, Mills, and Airasian (2009), two types of extraneous variables in need of control are participant variables and environmental

variables. Participant variables include both organismic variables and intervening variables. Organismic variables are characteristics of the participants that cannot be changed, but can be controlled for example, sex of the participants. Intervening variables on the other hand intrude between the independent and dependent variables desiring treatment and cannot be directly observed but can be controlled. Examples are fatigue and anxiety.

To take care of environmental variables exposure to learning materials was made same, same time was used for treatment sessions. Finally, the Analysis of Covariance (ANCOVA) was employed in the data analyses to help cater for the effect of any extraneous variable on the dependent variable as a result of exposure to the pre-test (Gay, Mills & Airasian, 2009; Pallant, 2005). In this study the ANCOVA was used to control for the

Population

The target population for the study was all second (2^{nd}) year Higher National Diploma (HND) students of the Technical Universities in southern Ghana. Table 1 shows the population of students in the Technical Universities in Southern Ghana pursuing HND programmes.

Table 1- *Population of Second Year HND Students in the Technical Universities in Southern Ghana*

Name of Technical University	Student Population
Cape Coast Technical University (CCTU)	1009
Takoradi Technical University (TTU)	2785
Ho Technical University (HTU)	1570
Accra Technical University (ATU)	3245
Total	8609

Source: Existing Data from the various technical universities (2017)

The accessible population however, was all second-year students of the Technical Universities in the coastal regions of Ghana. The technical universities in the coastal regions were considered because the researcher is a counsellor at the Cape Coast Technical University and identified the problem under investigation from anecdotal evidence recorded over a period of ten (10) years at the Cape Coast Technical University Counselling Unit. Since Cape Coast is a coastal city, the researcher deemed it appropriate to select the technical universities in the coastal cities for the study since their environments have similar characteristics to that of Cape Coast. Coastal cities have characteristics such as: a range of smaller suburbs and sub urban centres surrounding the cities, tourist services and an extensive range of edge conditions such as parks, beaches, and waterfront promenades.

The second-year students were deemed appropriate because they have been in the University for at least a year and have gone through a period of struggle or otherwise of some kind of psychosocial adjustments and can respond to self-esteem issues better. The first-year students had just begun the psychosocial adjustment process at the tertiary level of education. The third-year students were too occupied with putting finishing touches to their academic work and would not commit themselves fully to issues that were not strictly academic.

Sampling Procedure

The researcher used a multistage sampling procedure to arrive at the sample for the study. The researcher then used purposeful sampling method to select three technical universities in the coastal regions for the study. The technical universities are divided into three schools namely: School of

Business and Management Studies, School of Applied Sciences and Arts, and School of Engineering. Simple random (lottery) was used to select one (1) school from each of the three institutions for the study. The class sizes of Level 200 of the various departments within the selected schools were obtained from the various institutions. Two hundred (200) students were then randomly selected from the selected school in each participating institution to take part in the pre-test. The two hundred students were selected in order to have a sample large enough to select the participants who have both characteristics of having low self-esteem and at the same time experience depressive disorders. In all, six hundred (600) students took part in the pre-test (baseline survey). Table 2 shows the steps followed to select the institutions, schools, and sample size for the baseline survey.

Table 2- *Multistage Sampling Steps*

Step	Sampling Technique	Purpose
1	Purposeful sampling	This was used to select three (3) technical universities in the coastal regions of Ghana (CCTU, TTU, ATU)
2	Simple random sampling	The lottery method was used to select one (1) school from each technical university
3	Quota sampling	To select sample size from the class size (200 students from each school)

Table 3- *Institutions, Schools and Sample Size for the Baseline Survey*

Institution	School	Population	Sample Size
CCTU	Business & Management Studies	560	200
TTU	Applied Science & Art	934	200
ATU	Business & Management Studies	875	200
TOTAL		2369	600

Source: Existing data from the three institutions (2017)

The scores obtained was used to determine participants who have low self-esteem with depressive disorders were randomly sampled to select sixty (60) participants (20 from each institution). The final sample of 20 participants per group was determined in line with Creswell (2015) who stated that experimental studies should have a minimum of 15 participants. Okobiah (as cited in Awabil, 2013) indicates that a sample of 20 participants is adequate in group counselling. Finally, the three groups (institutions) were randomly assigned to the control group, assertiveness training and cognitive restructuring techniques treatment groups. Table 3 shows the selection of participants for the study.

Table 4- *Selection of Participants for Intervention Stage*

Institution	School	Population size	Initial sample size	Eligible students	Final sample size
CCTU	Business & Management Studies	560	200	32	20
TTU	Applied Science & Arts	934	200	33	20
ATU	Business & Management Studies	875	200	29	20
Total		2369	600	94	60

Data Collection Instruments

Questionnaires were used for the collection of pre-test and post-test data. These were made up of Rosenberg's Self-Esteem (RSE) Scale and Beck Depression Inventory (BDI). The two scales were adopted for use in the collection of pre-test and post-test data. Both scales had been used in Ghana to collect data for studies. For example, Kugbey et al (2015) and Addison (2014) used the RSE Scale for their studies. The BDI was used by Abass, Ziblim and Muntaka (2014) to collect data for their study on depression among infertile women in Ghana and Oppong (2017) lists the BDI among the commonly used tests in Ghana's mental health practice

The RSE Scale is a Ten (10) item self-report measure that pertains to self-worth and self-acceptance on a Four-point Likert-type Scale and was used for the pre-test and post-test. This scale was already developed and used in the area of personality assessments in counselling and psychology and so their

reliability and validity are already ascertained. The Rosenberg Self-Esteem Scale, a widely used self-report instrument for evaluating individual self-esteem, was investigated using item response theory. The original instrument has internal consistency of .77, Coefficient of Reproducibility was at least .90 (Rosenberg, as cited in Statistics Solution, 2018). Scores of the RSE scale were calculated as follows:

For items 1, 2, 4, 6, and 7: Strongly agree= 3, Agree =2, Disagree =1, strongly disagree = 0.

For items 3, 5, 8, 9, and 10 (which are reversed in valence): Strongly Agree= 0, Agree =1; Disagree=2; Strongly Disagree =3,

Scores on the scale range from 0-30. Scores from 25 to 30 indicate high self-esteem, between 15and 25 are within normal range and scores below 15 suggest low self-esteem.

Table 5- *Interpretation of Rosenberg Self-Esteem Scale*

Score range	Interpretation
26-30	High Self-esteem
15-25	Average
0-14	Low self-esteem

The Beck Depression Inventory (BDI), created by Aaron T. Beck (1961), is a 21-question multiple-choice self-report inventory, and it is one of the most widely used psychometric tests for measuring the severity of depression. The Beck Depression Inventory (BDI) was used to measure the depression levels of participants. Beck's study reported a coefficient alpha rating of .92 for outpatients and .93 for college student samples. Each of the

21 items corresponding to a symptom of depression is summed to give a single score for the BDI. There is a four-point scale for each item ranging from 0 to 3. Scoring is achieved by adding the highest ratings for all 21 items. The minimum score is 0 and maximum score is 63. Higher scores indicate greater symptom severity as follows:

Table 6- *Interpretation of Beck Depression Inventory*

Score range	Interpretation
1-10	Normal
11-16	Mild mood disturbance
17-20	Borderline clinical depression
21-30	Moderate depression
31-40	Severe depression
40 and above	Extreme depression

Respondents who scored high on the depression inventory and low on the self-esteem inventory were the ones who qualified to take part in the treatment programme. Specifically, those who scored below 15 on the RSE Scale and also scored between 17 and 30 on the BDI (from borderline clinical to moderate depression) were those who qualified to participate in the treatment programme.

Pilot-testing the Instruments

The Rosenberg's Self-Esteem Scale (RSE) Scale and the Beck Depression Inventory (BDI) were adopted and used in the current study. Pilot testing was done to ascertain its suitability for use in the local setting. This was done at Kumasi Technical University which was selected at random. Sixty

(60) level 200 students were selected randomly from the three afore-mentioned schools in the Kumasi Technical University for the pilot-testing.

Reliability of Instrument

The reliability (internal consistency) of the questionnaire for the main study was estimated using Cronbach co-efficient alpha (cited in Ebel & Frisbie, 1991). The internal consistency of the Rosenberg's Self-Esteem Scale and the BDI was computed using the Cronbach Alpha and the results were 0.77 and 0.72 respectively indicating high reliability level of the items used for the study.

Data Collection Procedures

The researcher personally collected the data with the help of trained research assistants. An ethical clearance approval letter from the Institutional Review Board of the University of Cape Coast was obtained to seek permission from the Registrars of the participating institutions to allow their students to take part in the study (See Appendix I).

During the pre-test (baseline survey), two hundred (200) copies of both the Rosenberg Self-Esteem (RSE) Scale and Beck Depression Inventory (BDI) were administered to participants in each of the participating institutions making a total of 600 copies of each instrument. Based on the pre-test scores, sixty (60) participants (20 from each participating institution) were further sampled to be part of the two experimental groups and one control group. One experimental group (Takoradi Technical University) was exposed to assertiveness training the Cape Coast Technical University group was taken through cognitive restructuring therapy while Accra Technical University was the control group.

A total of ten (10) weeks was used for the data collection exercise. Two (2) weeks were used for the pre-test (baseline survey) and the remaining eight (8) weeks were used for the treatment intervention after which the post-test was administered.

During the pre-test, two hundred (200) copies of both the Rosenberg Self-Esteem (RSE) Scale and Beck Depression Inventory (BDI) were administered in each of the participating institutions. After the Eight-week treatment, the instruments were administered to the participants of the treatment and control groups. In all, 60 copies of the RSE Scale and 60 copies of BDI were administered during the post-test stage.

Intervention Procedure

Each experimental group was taken through an 8-week training each session lasting for 2 hours. The comprehensive session plans for the assertiveness training and cognitive restructuring treatment are found in Appendices F and G, respectively.

Assertiveness Training Sessions

Session 1: Introduction, Welcoming and Orientation

In this session, the researcher, two research assistants and participants introduced themselves and set goals for the entire training programme as well as the rules that govern the programme. Time for sessions was also fixed together.

Session 2: The Concept and Nature of Self-Esteem

Definitions of self-esteem and how it is formed were given. The benefits of having high esteem was also discussed with participants. Some

causes, symptoms and effects of low self-esteem was comprehensively discussed. Take home assignment was given.

Session 3: The concept, nature of Assertiveness and Assertive behaviour

The researcher introduced the concept of assertiveness and described some misconceptions about assertiveness. Participants were taken through discussions on the reasons why individuals become unassertive, effects of not being assertive and the factors that prevent people from being assertive. Smith's Bill of Assertive Rights (Appendix A) was presented to participants. Take home assignment was given.

Session 4: Types of communication Styles

The take home assignment given during Session 2 was processed before the main session. This session focused mainly on the basic ways of interpersonal behaviours sometimes referred to as communication styles. These were aggressiveness, assertiveness, and passiveness. Scenarios were used to help participants to recognize the differences among passive, aggressive and assertive styles of communication and the verbal and non-verbal characteristics of each communication style were introduced. Assertive behaviour was demonstrated in a role-play situation and take home assignment was given.

The participants were asked to identify a number of unhelpful thoughts and then the more assertive counterpart to these thoughts was given. There was a role-play to emphasize the concepts discussed.

Session 5: Sequence of an Effective Assertive Response

A comprehensive explanation on how the inner, unheard dialogue which hinders them from being assertive occurs. These are referred to as

values conflicts. The researcher took participants through the types of assertive behaviour such as objective assertion, subjective assertion and defensive assertion. The non-verbal components of an assertive response such as eye contact and body language were discussed. This exercise was followed by a role-play. Take home assignment was given.

Session 6: Developing Assertive Skills

Participants were taught how to give feedback, the importance of feedback our roles and responsibilities in giving honest and clear feedback to each other. Participants were allowed to role play some scenarios presented. The need for feedback, as well as nonverbal skills and attitudinal and cognitive difficulties revealed by the role-plays were discussed. Homework was given.

Session 7: Assertion Skill Practice: Role-Play- Personal Life Situations

This session was used to help participants to practice more of the learned assertive skills, identify the different types of criticism and why participants may have trouble responding well to criticism.

Session 8: Practice, General Discussions, Evaluation and Post-Test

The researcher summarized the activities of session 1 to 7. There was an open discussion on the entire training. The participants were made to evaluate the training with the use of evaluation forms, the post-test was administered and the training session was terminated.

Cognitive Restructuring Sessions

Treatment intervention consisted of eight 2-hour sessions held weekly

Session 1: Introduction, Welcoming and Orientation

Researcher and research assistants introduced themselves and allowed participants to introduce themselves to one another. Then researcher set goals for the intervention as well as the rules that were to govern the entire training programme with participants.

Session 2: The concept and nature of self-esteem

Definitions of low self-esteem were given, and the symptoms and effects of low self-esteem comprehensively discussed.

Session 3: Concept of Cognitive Restructuring, Basic Irrational Beliefs

A clear definition of cognitive restructuring was also given. Participants were taken through Basic irrational beliefs and the role these beliefs play in their daily lives were also looked at.

Session 4: Some Cognitive Distortions

The distortion of Global Labelling was discussed. This is a situation where individuals generalize one or two qualities into a negative global judgment. These are extreme forms of generalizing and are also referred to as "labelling" and "mislabelling." In this instance instead of describing an error in context of a specific situation an individual may choose to put label on himself or herself. For instance, after trying to accomplish a task about two times without success, an individual may call himself or herself a failure or stupid. The distortion of Selective Abstraction was also discussed. This is a situation where people end up forming conclusions based on an isolated detail of an event. Personalization, the tendency to relate everything around one to oneself was also looked at. In this distortion an individual may tend to think that everything people do or say is some kind of reaction to them. There was a

discussion on Blaming, a distortion where an individual holds other people responsible for his or her pain or take the other tack and blame oneself for every problem.

Session 5: Some Cognitive Distortions (Contd.)

This session focused on four (4) cognitive distortions namely, All-or-nothing thinking, Over-generalization, Mind-reading, and Emotional reasoning. The impact these can have on self-worth and well-being in general was discussed. All-or-nothing thinking is a distortion where situations are viewed in either/or terms. This occurs when individuals see the world in two categories, rather than in a more complex fashion 'Either you are a success or failure' in life.

Overgeneralization is a situation where one holds extreme beliefs on the basis of a single incident and applies them inappropriately to dissimilar events or settings was dealt with. With mind-reading, individuals believe they can discern the thoughts of others without any accompanying evidence. Such people are able to assume how people are feeling toward them. Emotional reasoning is a distortion where individuals assume that their feelings are facts even when the evidence points to the contrary. With emotional reasoning individuals' emotions interact and correlate with their thinking process.

Session 6: Identifying and challenging distorted (unhealthy) thoughts

Researcher assisted participants to identify the unhealthy thoughts discussed which were true with them through questions such as:

1. What was going through your mind when you started to feel this way?
2. What does this situation say about you?

3. What are you thinking about you, other people, or what might happen in the future?
4. What is the worst thing that you think could happen to you?
5. What are you thinking about how other people view you?
6. What are you thinking about other people?

After the identification, participants were taken through the technique of *Putting their thoughts on trial* to challenge the distortions. In this exercise, participants were taught to individually act as a defence attorney, a prosecutor, and a judge on their own cognitive distortions.

Session 7: Behaviour Modification

In this session the participants were taught how to modify their negative self-statements by replacing them with positive self-statements. Participants were encouraged to focus on developing and testing cognitive restructuring techniques to counter self-defeating statements.

Session 8: Practice, General Discussions, Evaluation and Post-test

The final week focused on rehearsal and application of intervention techniques. There was a general discussion on thoughts, feelings and behaviour and how to cope with situations more constructively. The training was evaluated with the use of an evaluation form, post-test was administered and training was terminated.

Data Management Issues

Data management has to do with storage of the data collected in a research. Data management is the process of controlling the information generated during a research project (Thoegersen, 2016). Completed inventories were handled solely by researcher to ensure that information given

out by respondents did not end up in the wrong hands due to the sensitive nature of the study. After ensuring that all ethical issues were considered and addressed appropriately, the completed survey were kept under lock and key to prevent other people from having access to it. The researcher converted the data into softcopy for analysis and the computed data was protected with a password. Respondents were not required to write their names on the instrument, instead, code numbers assigned were used to identify respondents and this anonymity helped to ensure protection of respondents. To maintain the integrity of this study and the University of Cape Coast, the researcher ensured that accurate data were used so that results could be verified and data re-used in future. The result of the study would be made available to the respondent and the general public through publication of the result of the study. After a period of five years for which data had been assigned and programmed, the data will be automatically deleted. Researcher also adhered to other protocols that were recommended by the IRB.

Ethical Issues Considered in the Study

In this study, the researcher, field assistants and participants of the research were protected from any adverse consequences of the study by following laid down rules and procedures of ethics in research. Among the ethical issues that were considered in this study were informed consent, confidentiality, no harm to participants, deception and scientific misconduct. Again, the research proposal together with the instruments went through the Institutional Review Board of the University of Cape Coast for approval and all ethical parameters set were cautiously applied. Respondents were informed about the purpose of the research and what objective it sought to achieve. The

questions were read to them and clarifications were made where needed. Participants were also made aware that they had the right to withdraw from the study at any point in time they wished to.

Data Analysis Procedures

Two main statistical methods were used in data analysis: descriptive statistics, which summarize data from a sample using indices such as the mean, and inferential statistics, which draw conclusions from data that were subject to random variation.

In this study means and standard deviations were used to first describe the data to provide an overview of the results after which inferential statistical analyses were performed to test whether or not the effects of the interventions had been significant. The one-way ANCOVA and Two-way were used to test Hypotheses 1 to 6. ANCOVA is a general linear model that blends analysis of variance and regression. It evaluates whether the means of a dependent variable are equal across levels of a categorical independent variable often called a treatment, while statistically controlling for the effects of other continuous variables that are not of primary interest, known as covariates or nuisance variables (Pallant, 2005).

Hypotheses 1 and 2 were tested using the one-way ANCOVA. The one-way ANCOVA was used to control for possible variance in pre-test scores between groups. The groups were Assertiveness training group, Cognitive restructuring group and Control group.

Hypotheses 3, 4, 5 and 6 were tested using the Two-way Analysis of Covariance (ANCOVA) to help reduce the effects of the pre-test from the post-test performance. In Hypothesis 3 and 4, Two-way between groups

ANCOVA was performed for the gender influence on the groups. Two-way ANCOVA is a test that is performed to compare scores on two independent variables on a dependent variable that is continuous in nature. The dependent variable was the post-test scores of participants on self-esteem (in Hypothesis Three) and depression (in Hypothesis Four). The independent variables were groups and gender. Groups had three levels: control group, assertiveness training group and cognitive restructuring group. Gender had two levels namely male and female.

Hypotheses Five and Six were tested by performing a two-way between groups ANCOVA. The dependent variable was the post-test scores of participants on self-esteem (in Hypothesis 5) and depression. The independent variables were groups and age category. Groups had three levels: control group, assertiveness training group, and cognitive restructuring group. Age was categorised into three levels: 17 – 20 years, 21 – 24 years, and 25 years and above.

ANCOVA was performed to compare the post-test scores of the groups while controlling for the pre-test scores. The use of Analysis of Covariance (ANCOVA) helped cater for the influence of the pre-test on the dependent variable as a result of exposure of the subjects in the study to the pre-intervention data collection instrument. It also helped to adjust for the potential differences that might exist prior to the experiment. That is, the effect of exposure of participants to the pre-intervention data collection instrument on the dependent variable (post-test scores) was controlled (Gay, Mills & Airasian, 2009; Pallant, 2005). Hypothesis seven was tested using PROCESS

procedure for SPSS (Hayes, 2018). This was used to test the mediation role of self-esteem on the effect of the interventions on depression.

CHAPTER FOUR

RESULTS AND DISCUSSION

Introduction

This chapter deals with the presentation and analysis of data. The purpose of the study was to examine the effects of assertiveness training and cognitive restructuring on the self-esteem and depression levels among technical university students in Ghana. The study also looked at the differences between male and female students in the effect of assertiveness training and cognitive restructuring techniques on self-esteem and depression levels. Finally, the study sought to find out the differences in the effect of assertiveness training and cognitive restructuring techniques on self-esteem among participants in terms of age.

The methodology used in this study was the quasi-experimental design. Questionnaires used for the collection of data were Rosenberg's Self-Esteem (RSE) Scale and Beck's Depression Inventory (BDI). The statistical tools used for the analysis were frequencies, percentages, one-way analysis of covariance (ANCOVA) and two-way analysis of covariance (ANCOVA). The tests were conducted for significant differences at a significance level of .05. This chapter consists of two major sections. In the first section, the background data of the participants are presented whilst in the second section the results of the main data are presented.

Background data of participants

The study was carried out in the Cape Coast Technical University, Takoradi Technical University and Accra Technical University with a sample size of 60 participants.

Distribution of Participants by Age

Table 7 presents the age distribution of participants involved in the study.

Table 7- *Distribution of Participants by Age*

Age (Years)	Frequency	Percentage (%)
17-19	14	23.4
20-24	35	58.3
25 and above	11	18.3
Total	60	100.0

Source: Field Survey, (2019)

Table 7 shows that 23.4% were from 17 and 19 years, 58.3% of the participants were from 20 and 24 years whilst 18.3% were 25 years and above. It could be observed that majority of the participants were from 20 and 24 years.

Distribution of Participants by Gender

Table 8 presents the gender distribution of participants involved in the study.

Table 8- *Distribution of Participants by Gender*

Gender	Frequency	Percentage (%)
Male	22	36.7
Female	38	63.3
Total	60	100.0

Source: Field Survey, (2019)

As shown in Table 8, 63.3% of the participants were females whilst 36.7% were males. It can therefore be concluded that majority of the participants were females. This is because at the end of the survey, the results showed that a greater number of females had issues with low self-esteem and depressive symptoms and their number outweighed that of males. In view of that there was the need to select more females than males.

Marital status Distribution of Participants

Table 9 presents the marital status distribution of participants involved in the study.

Table 9- *Marital Status of Participants*

Marital status	Frequency	Percentage (%)
Single	55	91.7
Married	5	8.3
Total	60	100.0

Source: Field Survey, (2019)

The result in Table 9 shows that 91.7% of the participants are single whilst 8.3% are married. It could be observed that a greater proportion of the study participants were single.

Test for Normality and Outliers

This section presents test for normality assumption and outliers in the pre-test and post-test data. Table 10 presents the results of the tests.

Table 10- *Test for Normality and Outliers*

	Control				Cognitive Restructuring				Assertiveness Training			
	Pre-test		Post-test		Pre-test		Post-test		Pre-test		Post-test	
	Dep.	Self-es.	Dep.	Self-es.	Dep.	Self-es.	Dep.	Self-es.	Dep.	Self-es.	Dep.	Self-es.
Mean	22.85	13.40	29.70	13.65	29.70	13.65	6.10	22.85	23.85	13.40	5.15	24.70
Standard deviation	2.28	2.23	4.87	2.66	4.87	2.66	4.79	5.84	2.41	2.23	7.69	2.56
5% Trimmed mean	23.00	13.06	29.61	13.39	29.61	13.39	5.83	23.50	23.78	13.06	3.72	24.89
Median	22.5	13.00	29.50	13.00	29.50	13.00	5.00	23.50	23.00	13.00	3.50	25.00
Shapiro-Wilk Test												
Statistic	.923	.618	.973	.822	.973	.822	.902	.856	.953	.618	.535	.905
Sig.	.115	<.001*	.807	.002*	.807	.002*	.045*	.007*	.411	<.001*	<.001*	.051

Source: Field work (2019); *Significant, $p < .05$; Dep. – Depression; Self-es. – Self-esteem

From Table 10, the mean scores, 5% trimmed mean, and the median for pre-test and post for the control, cognitive restructuring, and assertiveness were approximately the same, with the exception of the post-test depression scores for cognitive restructuring and assertiveness groups which slightly differed. In addition, Shapiro-Wilk's test for normality was performed, and the results suggest that some of the data appeared to have violated the normality assumption ($p < .05$). Further, the normal Q-Q plots for all the data, these suggest the data were normally distributed (see Appendix H).

Preliminary Analyses

Having established the normality of the data, one-way analysis of variance (ANOVA) was performed to compare the pre-test scores the assertiveness training, cognitive restructuring and control groups in terms of depression and self-esteem. Prior to performing the ANOVA test, homogeneity assumption was checked and results indicated that data on both depression ($p = .324$) and self-esteem ($p = .405$) did not violate the homogeneity assumption. Having met the homogeneity of variance assumption, one-way ANOVA was then performed to compare the groups on their pre-test scores. Table 11 presents the results of the ANOVA test.

Table 11- *Results of ANOVA Test for Differences in Pre-test Scores*

Score	Source	Sum of Squares	df	Mean Square	F	Sig.
Depression	Between Groups	547.633	2	273.817	23.673*	.000
	Within Groups	659.300	57	11.567		
	Total	1206.933	59			
Self-esteem	Between Groups	457.833	2	228.917	17.944*	.004
	Within Groups	724.150	57	12.757		
	Total	1181.983	59			

Source: Field work (2019); *Significant, $p < .05$

As presented in Table 11, there is significant difference in the depression pre-test scores of participants among the three groups, $F(2, 57) = 23.67$, $p < .001$. In terms of self-esteem, there is also a significant difference in the pre-test scores of participants among the three groups, $F(2, 57) = 17.94$, $p = .004$. These results imply that the groups were not equal in terms of their pre-test. Therefore, ANCOVA was performed to compare the post-test scores of the groups while controlling for the pre-test scores.

In addition to the normality assumption, homogeneity of regression slopes assumption – a paramount assumption of ANCOVA, was tested. This assumption holds the premise that there should be no interaction between the pre-test scores and conditions. The results of the homogeneity of regression slopes are presented in Table 12.

Table 12- *Results of Homogeneity of Regression Slopes (Self-esteem)*

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	1536.243[a]	5	307.249	21.487	.000
Intercept	255.849	1	255.849	17.893	.000
Condition	94.812	2	47.406	3.315	.044
Pre-test	113.725	1	113.725	7.953	.007
Condition * Pre-test	16.448	2	8.224	.575	.566
Error	772.157	54	14.299		
Total	27278.000	60			
Corrected Total	2308.400	59			

Source: Field work (2019); Dependent Variable: Post-test score for self-esteem

As shown in Table 12, there was no significant interaction between the pre-test scores and the conditions, $F(2, 54) = .58$, $p = .566$. This result implies that the relationship between the pre-test and the post-test scores on self-esteem were the same across the various conditions, hence no violation of homogeneity of regression assumption. Table 13 presents the results of homogeneity of slopes for depression.

Table 13- *Results of Homogeneity of Regression Slopes (Depression)*

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	7867.892[a]	5	1573.578	45.252	.000
Intercept	43.969	1	43.969	1.264	.266
Condition	330.885	2	165.442	4.758	.012
Pre-test	20.922	1	20.922	.602	.441
Condition * Pre-test	100.999	2	50.500	1.452	.243
Error	1877.758	54	34.773		
Total	20925.00	60			
Corrected Total	9745.650	59			

Source: Field work (2019); Dependent Variable: Post-test score for depression

From Table 13, there was no significant interaction between the pre-test scores and the conditions, $F(2, 54) = 1.45$, $p = .243$. The implication of the result is that the relationship between the pre-test scores and post-test scores on depression was the same across the conditions. Based on the results in Tables 12 and 13, the homogeneity of regression slopes assumption has been satisfied, and therefore ANCOVA can be performed.

Hypotheses Testing

This section presents the results of the hypotheses that guided the study.

Hypothesis One

H_0: There is no significant effect of (a) assertiveness training and (b) cognitive restructuring on the self-esteem of technical university students in Southern Ghana.

H_1: There is significant effect of (a) assertiveness training and (b) cognitive restructuring on the self-esteem of technical university students in Southern Ghana.

This hypothesis was formulated to test the effects of assertiveness training and cognitive restructuring on the self-esteem of technical university students. A one-way analysis of covariance (ANCOVA) was conducted. The independent variable was the conditions, and this had three levels: assertiveness training, cognitive restructuring, and control groups. The dependent variable consisted of scores on the self-esteem after the intervention was completed (post-test). Participants' scores on the pre-test of self-esteem were used as the covariate. Table 14 presents the results of the analysis.

Table 14- *ANCOVA of Tests of Between-Subjects Effects Comparing Post-test Scores of Groups on Self-esteem*

Source	Type III Sum of Squares	Df	Mean Square	F	Sig.	Partial Eta Squared
Corrected Model	1519.795[a]	3	506.598	35.974	.000	.658
Intercept	259.456	1	259.456	18.424	.000	.248
Pre-test	118.695	1	118.695	8.429	.005	.131
Condition	1386.155	2	693.078	49.216*	.000	.637
Error	788.605	56	14.082			
Total	27278.000	60				
Corrected Total	2308.400	59				

Source: Field work (2019); *Significant, $p < .05$; Dependent variable: post-test scores on self-esteem

From Table 14, the results indicate a significant difference in the self - esteem post test scores for participants in the assertiveness training group and cognitive restructuring group after controlling for the scores on the self-esteem test administered prior to the intervention, $F(1, 56)= 49.216$, $p < .001$, partial eta squared = .637. The partial eta squared value of .637(63.7%) suggests that the conditions explains the level of self-esteem by 63.7%. A post hoc (Tukey) test was conducted to find out where the differences lie. Table 15 presents the post hoc test.

Table 15- *Pairwise Comparisons of Groups on Self-esteem*

(I) Group	(J) Group	Mean Difference (I-J)	Std. Error	Sig.
Cognitive R.	Assertiveness T.	-2.001	1.188	.098
	Control	9.049*	1.188	.000
Assertiveness T.	Cognitive R.	2.001	1.188	.098
	Control	11.050*	1.187	.000
Control	Cognitive R.	-9.049*	1.188	.000
	Assertiveness T.	-11.050*	1.187	.000

Source: Field work (2019); *Significant, $p < .05$; Dependent variable: post-test scores on self-esteem.

From Table 15, the results showed that there is significant difference between the cognitive restructuring group and the control group and the assertiveness training group and the control group ($p < .001$). Also, there is a significant between mean scores of participants in assertiveness training group and the control group ($p < .001$). In addition, there is no significant difference in the mean scores of participants in assertiveness training group and those in

the cognitive restructuring group (p = .098). Table 16 presents the adjusted mean scores of the groups after the pre-test scores have been controlled.

Table 16- *Adjusted Post-test Scores on Self-esteem*

Groups	Mean	Std. Error
Cognitive Restructuring	22.749[a]	.840
Assertiveness Training	24.750[a]	.839
Control group	13.700[a]	.839

a. Covariates appearing in the model are evaluated at the following values: Pre-test on self-esteem = 13.4833.

From Table 16, cognitive restructuring was effective in enhancing participants' level of self-esteem. Assertiveness training was also effective in enhancing participants' self-esteem. There was, however, no difference in the effectiveness of both therapies. In effect, both cognitive restructuring therapy and assertiveness training therapy equally worked in improving participants' level of self-esteem.

From the results on Hypothesis One, the study has provided evidence which has led to the decision of rejecting the null hypothesis in favour of the alternative hypothesis.

Hypothesis Two

H_0: There is no significant effect of (a) assertiveness training and (b) cognitive restructuring on the depression levels of technical university students in Southern Ghana.

H_1: There is significant effect of (a) assertiveness training and (b) cognitive restructuring on the depression levels of technical university students in Southern Ghana.

This hypothesis tested the effect of assertiveness training and cognitive restructuring on the depression levels of technical university students. A one-way analysis of covariance (ANCOVA) was conducted. The independent variable was the conditions, and this had three levels: assertiveness training, cognitive restructuring, and control groups. The dependent variable consisted of scores on the depression after the intervention was completed (post-test). Participants' scores on the pre-test on depression was used as the covariate. Details of the results are presented in Table 17.

Table 17- *ANCOVA of Tests of Between-Subjects Effects Comparing Post-test Scores of Groups on Depression*

Source	Type III Sum of Squares	Df	Mean Square	F	Sig.	Partial Eta Squared
Corrected Model	7766.892[a]	3	2588.964	73.269	.000	.797
Intercept	67.814	1	67.814	1.919	.171	.033
Pre-test	29.792	1	29.792	.843	.362	.015
Condition	6828.546	2	3414.273	96.626*	.000	.775
Error	1978.758	56	35.335			
Total	20925.000	60				
Corrected Total	9745.650	59				

Source: Field work (2019); *Significant, $p < .05$; Dependent variable: post-test scores on depression

From Table 17, the results indicate a significant difference in the depression post test scores for participants in the assertiveness training group and cognitive restructuring group after controlling for the pre-test scores on the depression, $F(1, 56) = 96.63$, $p < .001$, partial eta squared = .775. The partial eta squared value of 775(77.5%) suggests that the conditions explains

the level of depression by 77.5%. A post hoc (Tukey) test was conducted to find out which pairs of means are statistically different. Table 18 presents the post hoc test.

Table 18- *Pairwise Comparisons of Groups on Depression*

(I) Groups	(J) Groups	Mean Difference (I-J)	Std. Error	Sig.
Cognitive R	Assertiveness T	.567	3.224	1.000
	Control group	-25.300*	2.935	.000
Assertiveness T	Cognitive R	-.567	3.224	1.000
	Control group	-25.867*	2.928	.000
Control group	Cognitive R	25.300*	2.935	.000
	Assertiveness T	25.867*	2.928	.000

Source: Field work (2019); *Significant, $p < .05$; Dependent variable: post-test scores on depression.

From Table 18, it was found that there existed significant difference between cognitive restructuring group and control group and assertiveness training group and control group ($p < .001$). Similarly, significant difference was found in assertiveness training group and control group ($p < .001$). There was no difference when depression scores of participants in the assertiveness training group was compared with those in the cognitive restructuring group ($p = 1.00$). Table 19 presents the adjusted means of the groups.

Table 19- *Adjusted Post-test Scores on Depression*

Groups	Mean	Std. Error
Cognitive Restructuring	5.200[a]	1.651
Assertiveness Training	5.494[a]	1.381
Control group	30.256[a]	1.461

a. Covariates appearing in the model are evaluated at the following values: Pre-test on Depression = 25.4667.

As presented in Table 19, cognitive restructuring therapy was effective in reducing the levels of depression among participants. Assertive training therapy was also effective in reducing the levels of depression among participants. Comparatively, there was no significant difference in the effectiveness of the two therapies. This implies that both therapies were equally effective.

Based on the results on Hypothesis Two, the study has provided evidence which has led to the decision of rejecting the null hypothesis in favour of the alternative hypothesis.

Hypothesis Three

H_0: There is no significant difference in the effect of (a) assertiveness training and (b) cognitive restructuring techniques on the self-esteem of male and female students in technical universities in Southern Ghana.

H_1: There is significant difference in the effect of (a) assertiveness training and (b) cognitive restructuring techniques on the self-esteem of male and female students in the technical universities in Southern Ghana.

The purpose of this hypothesis was to find out the differences in the effects of assertiveness training and cognitive restructuring techniques on the self-esteem of male and female students. Two-way analysis of covariance (ANCOVA) was conducted. The independent variables were the conditions and gender. The conditions had three levels: assertiveness training, cognitive restructuring, and control groups. Gender had two levels: male and female. The dependent variable was post-test scores on self-esteem. Table 20 presents the results of the hypothesis.

Table 20- *ANCOVA of Tests Difference in Assertiveness Training and Cognitive Restructuring in terms of Gender (Self-esteem)*

Source	Type III Sum of Squares	Df	Mean Square	F	Sig.	Partial Eta Squared
Corrected Model	1561.475[a]	6	260.246	18.466	.000	.676
Intercept	247.131	1	247.131	17.536	.000	.249
Pre-test	119.841	1	119.841	8.504	.005	.138
Gender	4.279	1	4.279	.304	.584	.006
Condition	1194.384	2	597.192	42.375	.000	.615
Gender * Condition	31.999	2	15.999	1.135	.329	.041
Error	746.925	53	14.093			
Total	27278.000	60				
Corrected Total	2308.400	59				

Source: Field work (2019) Dependent variable: post-test score on self-esteem

From Table 20, the results show no significant interaction between gender and the conditions in terms of self-esteem after controlling for the pre-test scores on the self-esteem, $F(2, 53) = 1.14$, $p = .329$, partial eta squared = .041. There was also no significant main effect of gender, $F(1, 53) = .304$, $p = .584$, with a small effect size (partial eta squared = .006). The partial eta squared value of .006 (0.6%) suggests that gender explains the levels of depression by 0.6%. These results further suggest that male and female students responded same way to the two types of interventions they received on self-esteem. In other words, gender did not discriminate the effectiveness of the two therapies.

Based on the results, the null hypothesis that "There is no significant difference in the effect of (a) assertiveness training and (b) cognitive restructuring techniques on the self-esteem of male and female students in technical universities in Southern Ghana" was not rejected. This implies that irrespective of participants' gender, cognitive restructuring therapy and assertive training therapies equally work.

Hypothesis Four

H_0: There is no significant difference in the effect of (a) assertiveness training and (b) cognitive restructuring techniques on the depression levels of male and female students in technical universities in Southern Ghana.

H_1: There is significant difference in the effect of (a) assertiveness training and (b) cognitive restructuring techniques on the depression levels of male and female students in technical universities in Southern Ghana.

Research Hypothesis Four sought to determine whether significant differences existed in the effects of assertiveness training and cognitive restructuring techniques on the depression levels of male and female students in technical universities in Southern Ghana. Two-way analysis of covariance was conducted. The independent variables were the conditions and gender. The conditions had three levels: assertiveness training, cognitive restructuring, and control groups. Gender had two levels: male and female. The dependent variable was post-test scores on depression. Table 21 presents the results of the hypothesis.

Table 21- *ANCOVA of Tests Difference in Assertiveness Training and Cognitive Restructuring in terms of Gender (Depression)*

Source	Type III Sum of Squares	Df	Mean Square	F	Sig.	Partial Eta Squared
Corrected Model	8041.261[a]	6	1340.210	41.675	.000	.825
Intercept	83.740	1	83.740	2.604	.113	.047
Pre-test	14.153	1	14.153	.440	.510	.008
Gender	88.304	1	88.304	2.746	.103	.049
Condition	4668.326	2	2334.163	72.584	.000	.733
Gender * Condition	121.331	2	60.666	1.887	.234	.015
Error	1704.389	53	32.158			
Total	20925.000	60				
Corrected Total	9745.650	59				

Source: Field work (2019) Dependent variable: post-test score of depression

From Table 21, the results show no significant main effect of gender, after controlling for the pre-test scores on depression, $F(1, 53) = 1.89$, $p = .234$, partial eta squared = .02. Similarly, there was no significant interaction effect, $F(2, 53) = 2.75$, $p = .103$, partial eta squared = .05. These results imply that gender did not influence the effectiveness of the therapies. This, therefore, suggests that both cognitive restructuring technique and assertiveness training worked equally for males and females.

Based on these results, the null hypothesis was not rejected. It can therefore be said that gender does not discriminate the effectiveness of the use of assertiveness training in reducing level of depression.

Hypothesis Five

H_0: There is no significant difference in the effect of (a) assertiveness training and (b) cognitive restructuring techniques on the self-esteem of students in technical universities in Southern Ghana on the basis of age.

H_1: There is significant difference among students in the effect of (a) assertiveness training and (b) cognitive restructuring techniques on the self-esteem of students in technical universities in Southern Ghana on the basis of age.

The focus of research hypothesis five was to find out whether there were significant differences in the effects of (a) assertiveness training and (b) cognitive restructuring techniques on the self-esteem of students on the basis of age. A two-way analysis of covariance (ANCOVA) was performed. The independent variables were the conditions and gender. The conditions had three levels: assertiveness training, cognitive restructuring, and control groups. Age had three levels: 17 – 19 years, 20 – 24 years, and 25 years and above. The dependent variable was the post-test scores on self-esteem. Table 22 presents the results on the hypothesis.

Table 22- *ANCOVA of Tests Difference in Assertiveness Training and Cognitive Restructuring in terms of Age (Self-esteem)*

Source	Type III Sum of Squares	Df	Mean Square	F	Sig.	Partial Eta Squared
Corrected Model	1529.213[a]	9	169.913	10.903	.000	.662
Intercept	201.846	1	201.846	12.952	.001	.206
Pre-test	98.914	1	98.914	6.347	.015	.113
Age	1.013	2	.506	.032	.968	.001
Condition	794.334	2	397.167	25.486	.000	.505
Age * Condition	9.085	4	2.271	.146	.964	.012
Error	779.187	50	15.584			
Total	27278.000	60				
Corrected Total	2308.400	59				

Source: Field work (2019); Dependent variable: post-test score of self-esteem

As indicated in Table 22, there was no significant interaction effect between age and the conditions, after controlling for the pre-test scores on the self-esteem, $F(4, 50) = .146$, $p = .964$, partial eta squared = .012. The partial eta squared value of .012 (1.2%) suggests that the interaction effect between age and the conditions explains the level of self-esteem by 1.2%. There was also no significant main effect of age, $F(2, 50) = .032$, $p = .968$ with a small effect size (partial eta squared = .001). The partial eta squared value of .001 (0.1%) suggests that the independent variable explains the level of self-esteem by 0.1%. These results suggest that on the basis of age, participants responded same way to the two types of interventions they received on self-esteem. Therefore, the null hypothesis was not rejected.

Hypothesis Six

H_0: There is no significant differences in the effects of (a) assertiveness training and (b) cognitive restructuring techniques on the depression levels of students in technical universities in Southern Ghana on the basis of age.

H_1: There is significant difference in the effect of (a) assertiveness training and (b) cognitive restructuring techniques on the depression levels of students in technical universities in Southern Ghana on the basis of age.

Research hypothesis six sought to find out whether there existed significant differences in the effect of (a) assertiveness training and (b) cognitive restructuring techniques on their depression levels of students in technical universities in Southern Ghana on the basis of age. A two-way analysis of covariance (ANCOVA) was conducted. The independent variables were the conditions and gender. The conditions had three levels: assertiveness training, cognitive restructuring, and control groups. Age had three levels: 17 – 19 years, 20 – 24 years, and 25 years and above. The dependent variable was the post-test scores on depression. Table 23 presents the results for the hypothesis.

Table 23- *ANCOVA of Tests Difference in Assertiveness Training and Cognitive Restructuring in terms of Age (Depression)*

Source	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Corrected Model	7817.569[a]	9	868.619	22.525	.000	.802
Intercept	56.743	1	56.743	1.471	.231	.029
Pre-test	34.087	1	34.087	.884	.352	.017
Age	5.238	2	2.619	.068	.934	.003
Condition	4212.869	2	2106.434	54.625	.000	.686
Age * Condition	42.304	4	10.576	.274	.893	.021
Error	1928.081	50	38.562			
Total	20925.000	60				
Corrected Total	9745.650	59				

Source: Field work (2019) Dependent variable: post-test score of depression

The results in Table 23 indicate no significant interaction between age and the conditions, $F(4, 50) = .274$, $p = .893$ with a small effect size (partial eta squared = .021). The partial eta squared value of .021 (2.1%) suggests that the interaction between age and the conditions explains the level of depression by 2.1%. There was no significant main effect of age, $F(2, 50) = .068$, $p = .934$ with a small effect size (partial eta squared = .003). The partial eta squared value of .003 (0.3%) suggests that the age explains the level of depression by 0.3%. These results imply that on the basis of age, participants responded same to the two types of interventions they received on depression.

Table 23- *ANCOVA of Tests Difference in Assertiveness Training and Cognitive Restructuring in terms of Age (Depression)*

Source	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Corrected Model	7817.569[a]	9	868.619	22.525	.000	.802
Intercept	56.743	1	56.743	1.471	.231	.029
Pre-test	34.087	1	34.087	.884	.352	.017
Age	5.238	2	2.619	.068	.934	.003
Condition	4212.869	2	2106.434	54.625	.000	.686
Age * Condition	42.304	4	10.576	.274	.893	.021
Error	1928.081	50	38.562			
Total	20925.000	60				
Corrected Total	9745.650	59				

Source: Field work (2019) Dependent variable: post-test score of depression

The results in Table 23 indicate no significant interaction between age and the conditions, $F(4, 50) = .274$, $p = .893$ with a small effect size (partial eta squared = .021). The partial eta squared value of .021 (2.1%) suggests that the interaction between age and the conditions explains the level of depression by 2.1%. There was no significant main effect of age, $F(2, 50) = .068$, $p = .934$ with a small effect size (partial eta squared = .003). The partial eta squared value of .003 (0.3%) suggests that the age explains the level of depression by 0.3%. These results imply that on the basis of age, participants responded same to the two types of interventions they received on depression.

Hypothesis Seven

H_0: The effects of a) assertiveness training and b) cognitive restructuring on depressive disorders will not be mediated by self-esteem

H_1: The effects of a) assertiveness training and b) cognitive restructuring on depressive disorders will be mediated by self-esteem

The purpose of research hypothesis seven was to establish whether self-esteem played a mediating role on the effects of (a) assertiveness training and (b) cognitive restructuring on depressive disorders among students. The PROCESS procedure for SPSS (Hayes, 2018) was used to test the mediation role of self-esteem on the effect of the interventions on depression given that the independent variable (X) has three categories (control group, assertiveness training and cognitive restructuring group). The mediator variable (M) was post-test scores on self-esteem. The dependent variable (Y) was post-test scores on depression. Due to the categorical nature of the independent variable, dummy coding of the categories was done, given the following categories (see Table 24).

Table 24- *Coding of Categorical X Variable for Analysis*

Group	X1	X2
Control	0	0
Assertiveness training	1	0
Cognitive restructuring	0	1

From Table 24, the control group was used as the reference group, assertiveness training was (X1) and cognitive restructuring was (X2). Table 25 presents the direct, indirect, and total effects.

Table 25- *Indirect Effect, Direct Effect, and Total Effect*

					Confidence Interval (CI)	
	Effect	SE	*t*	*p*	Lower Limit	Upper Limit
Total effect						
Total effect of X1 on Y	-24.72*	1.89	-13.09	<.001	-28.51	-20.94
Total effect of X2 on Y	-24.67*	2.48	-9.97	<.001	-29.63	-19.71
Direct effect						
Direct effect of X1 on Y	-18.34*	2.87	-6.39	<.001	-24.10	-12.58
Direct effect of X2 on Y	-18.88*	3.11	-6.08	<.001	-25.10	-12.65

Indirect effect	Effect	*BSE*	*BootLLCI*	*BootULCI*
Indirect effect of X1 on Y	-6.38*	3.88	-16.82	-2.10
Indirect effect of X2 on Y	-5.80*	4.06	-16.98	-1.74

*Significant, $p < .05$ level

As indicated in Table 27, analysis of the total, direct and indirect effects indicate that the relative total effect of assertiveness training, b = -24.72, $t(55) = -13.09$, $p < .001$, CI[-28.51, -20.94]; and cognitive restructuring, b = -24.67, $t(55) = -9.97$, $p < .001$, CI[-29.63, -19.71] on depression were both significant. Overall, the effect of the intervention on the level of depression was significant, R^2 change =.69, $F(2, 55) = 95.70$, $p < .001$.

Also, the relative direct effects of both assertiveness training, b = -18.34, $t(54) = -6.39$, $p < .001$, CI[-24.01, -12.58]; and cognitive restructuring, b = -18.88, $t(54) = -6.08$ $p < .001$, CI[-25.10, -12.65] on depression were significant. The overall direct effect of the intervention on the level of depression was significant, R2 change =.14, $F(2, 54) = 22.52$, $p < .001$.

Finally, the relative indirect effects for both interventions assertiveness training, b = -6.38, SE = 3.88, CI[-16.82, -2.10]; and cognitive restructuring, b = -5.80, SE = 4.06, CI[-16.98 -1.74] on depression were significant. The results therefore suggest that self-esteem had significant partial mediation effects on the relationships between the two interventions and level of depression. The null hypothesis was rejected in favour of the alternative hypothesis.

Discussion

The discussion of the findings is done in relation to the following.

1. Effect of (a) assertiveness training and (b) cognitive restructuring on the self-esteem of technical university students in southern Ghana.
2. Effect of (a) assertiveness training and (b) cognitive restructuring on the depression of technical university students in southern Ghana.
3. Differences in the effect of (a) assertiveness training and (b) cognitive restructuring techniques on the self-esteem of male and female students in technical universities in Southern Ghana.
4. Differences in the effect of (a) assertiveness training and (b) cognitive restructuring techniques on the depression levels of male and female students in technical universities in Southern Ghana.
5. Differences in the effects of (a) assertiveness training and (b) cognitive restructuring techniques on the self-esteem of students on the basis of age.
6. Differences in the effects of (a) assertiveness training and (b) cognitive restructuring techniques on the depression and on the basis of age.

7. Mediating role of self-esteem on the effects of (a) assertiveness training and (b) cognitive restructuring on depression levels of students.

Effects of (a) assertiveness training and (b) cognitive restructuring on the self-esteem

The purpose of hypothesis one was to test the effectiveness of (a) assertiveness training and (b) cognitive restructuring techniques on students' self-esteem. The findings of the study indicate that participants in the two intervention groups (assertiveness training and cognitive restructuring) recorded better scores in the post-test scores as compared to the participants in the control group who were not exposed to any intervention. The cognitive restructuring group performed better than the control group with a difference of 9.049. The assertiveness training group also performed significantly better than the control group with a difference of 11.050. The finding implies that the self-esteem of participants of the two experimental groups improved significantly after the intervention programmes. This indicates that the intervention programmes were effective and therefore able to make an impact on the participants. The post-test was administered three (3) weeks after the treatment programme. The post-test scores, therefore, suggest that participants of both treatment groups were able to put into use in their everyday lives, the various skills they acquired in the training. The improvement in the self-esteem and depression levels of participants across treatment groups is consistent with Bandura's assertion that psychological procedures, whatever their form can alter and the level and increase the strength of an individual's self-efficacy. The result confirms the findings by Liza (2010) that cognitive

restructuring programme had a positive significant effect on the students' self esteem and consequently concluded that cognitive restructuring techniques could tangibly enhance self-esteem. The findings also agree with the results of the study by Addison, Antwi and Avonokadzi (2014) that cognitive restructuring enhanced self-esteem which led to the improvement of academic performance.

Furthermore, the findings of the study agree with findings of Anyaneme, Chiyela and Nneka (2016) that assertiveness training had an effect on the low self-esteem of students by raising or enhancing their self-worth and competence. Also, the findings are consistent with the assertion of Mahmoud and Hamid (2013) that assertiveness training led to significant improvement in the self-esteem levels of participant after the training programme. Shimizu, Kubota, Mishima and Nagata (2004) opined in their study that their subjects (hospital nurses) had their self-esteem improved significantly after the assertiveness training programme and therefore concluded that assertiveness training programme had the potential to improve self-esteem.

Similarly, the finding also corroborates the assertion of Ryan and Deci (2004), that human beings in their healthiest state are active, and were ready to learn, explore and master their environment. They also stressed that true self-esteem was imputed when there was a balance between the psychological needs of competency, relatedness and autonomy. During the intervention period participants had the opportunity to interact with their group members and this helped them to develop a sense of belongingness among themselves. Again, since members of the group had similar characteristics, the relationship they developed among themselves helped them to draw strength from one

another as they shared their experiences and expressed their opinion freely in an environment devoid of threat and intimidation which raised their confidence to learn and acquire skills for daily living.

The findings of the study lend support to findings of Ozşaker (2013) who reported a significantly stronger relationship between assertiveness and self-esteem. Lin et al. (2004) also observed that assertiveness helped improve self-esteem level of the experimental group. Sert (2003) observed significant differences between the two groups based on assertiveness scores. Mahmoud and Hamid (2013) revealed a significant improvement in the self-esteem levels of participants in the post-test scores. They attributed the improvement in mean score of assertiveness, self-esteem and academic achievement after training programme to the contents of the training programme which included proper assertive behaviour and clarification and confirmation of the individual's fundamental rights. The findings of the study have generally shown that assertiveness training and cognitive restructuring interventions can improve the self-esteem of individuals. This shows that assertiveness training is important for students particularly those with self-esteem issues.

The finding is also consistent with findings of Emmanuel, Okreke and Anayochi (2015) who reported that cognitive restructuring programmes have a positive significant effect on the students' self-esteem indicating that cognitive restructuring technique can tangibly enhance self-esteem. The findings further lend support to CBT Los Angeles (n.d.) that cognitive restructuring gives people new ways of thinking and talking to themselves about their problems, help them to recognize unhelpful thinking patterns and replace them with more effective thinking patterns. Participants' exposure to the cognitive

restructuring technique helped them to develop a new mind-set abou themselves, thereby enhancing their self-esteem. Likewise, Liza (2010) in he study among high school students found that cognitive restructurin programmes have a positive significant effect on the students' self-esteem She found that cognitive restructuring technique can tangibly enhance self-esteem.

Effect of (a) assertiveness training and (b) cognitive restructuring on depression

Hypothesis two was intended to test the effectiveness of assertiveness training and cognitive restructuring on students' depression levels. The result of the study revealed that significant difference existed between the two intervention groups (cognitive restructuring and assertiveness training groups) and the control group. The findings of the study suggest that the intervention yielded positive impact on the participants who were exposed to the interventions. The reduction in the depression level of the participants who participated in the intervention also suggests that participants would most likely have positive mind-sets toward events in life. This in turn will boost their self confidence level thereby improving upon their depressive symptoms. This finding is consistent with previous findings of Eslami, Rabiei, Afzad, Hamidizadeh and Mashoudi (2016) that assertiveness training programme largely reduced students' stress, anxiety and depression levels. The present finding also agrees with the findings of Fuspita, Putri and Susanti (2018) that assertiveness training had significant effect on the prevalence of depression. The result further confirms the findings of Hayman and Cope (1980) that eight weeks after the treatment programme participants who received training in

assertiveness were significantly less depressed indicating the effectiveness of the intervention in alleviating depression. Chen, Lu, Chang, Chu and Chou (as cited in Emmanuel et al, 2015) also reported that one month after the cognitive restructuring intervention, the depressive symptoms and self-esteem of the experimental group remained slightly but significantly better than those of the control group. Alamdarloo, Khorasani and Najafi (2019) investigated the effect of cognitive therapy on reducing depression and anxiety of Iranian males with addiction. The experimental group received eight sessions of cognitive-behavioural therapy, while the control group did not. The findings of the study showed that cognitive treatment was effective in reducing participants' levels of depression and anxiety.

The findings also corroborate with findings of David, McMahon, Macavei, and Szentagotai (2005) that cognitive restructuring was effective in reducing relapse in depression issues since it helps to block mental contamination, stimulate the assimilation of new adaptive cognitions thereby preventing relapses. The findings of the current study also support that of Mohammed (2017) who in a study using cognitive behavioural treatment programme on the depression level of secondary school students found a statistically significant difference between experimental and control groups in the reduction of depression level. Mohammed (2017) therefore concluded that, cognitive treatment programme was effective among secondary school students concerning the reduction of their depression levels.

The findings again agree with Asikhia (2014) who found cognitive restructuring to be more effective as the experimental group performed better than the control group. He reported a significant effect of treatment

(Cognitive-Restructuring technique) on participants' level of depression (F-ratio= 5.81, P <0.05). It was found that study habit did not affect students' depression level significantly. Based on these findings, it was recommended that counsellors could use cognitive-restructuring treatment as a strategy to reduce anxiety in Mathematics among secondary school students since it has been identified as effective. Rasing, Creemers, Janssens, and Scholte (2017) in a study sought to identify and describe school-based and community-based prevention programmes based on cognitive behavioural therapy with a primary goal of preventing depression in adolescents at risk for developing depressive disorders. The review presented evidence that cognitive therapy-based prevention of depression in groups for high-risk adolescents was effective in the short term. The findings of the review cautiously suggested that depression prevention programmes based on cognitive therapy might have small effects on the mental health of adolescents.

The finding also confirms the report of Hampel, Graef, Krohn-Grimberghe and Tlach (2009) that all patients benefited statistically and clinically significantly from all three treatment conditions in psychological and pain-related outcome measures in the short run. They therefore stated that these treatment modules, which are aimed at improving depressive symptoms deserve serious consideration as an integral component of chronic pain rehabilitation

Differences in the effect of (a) assertiveness training and (b) cognitive restructuring techniques on the self-esteem of male and female students

The purpose of research hypothesis three was to establish whether or not there exists significant difference between male and female students in the

effect of assertiveness training and cognitive restructuring techniques on the self-esteem of male and female students. The study results revealed no significant main effects in the self-esteem post test scores for participants in the assertiveness training group and cognitive restructuring group after controlling for the scores on the self-esteem test administered prior to the intervention. The results also showed that males and females responded in the same way to the two types of interventions they received on self-esteem. The revelation of the current study could be that probably because both male and female participants took both the assertiveness and cognitive restructuring training seriously and this resulted in both male and female participants experiencing the same level of self-esteem. The training on the two interventions would now make students to be proud of themselves and feel useful at all times and also students would henceforth feel that they have a number of good qualities such as the ability to speak confidently without fear of being ridiculed and also to mingle among themselves without any doubt of fear or worry. This finding is consistent with the finding of Tannous (2015) whose study result did not show any statistically significant difference in the effectiveness of assertiveness training programme on self-esteem in relation to gender even though the report indicated that assertiveness training programme was effective in improving self-esteem among students. The finding of the study, however, is at variance with research findings of DuBois, Burk-Braxton, Swenson, Tevendale and Hardesty (2002). Their study revealed a significant difference in the self-esteem scores at post-test when the influence of gender was ascertained. According to them, gender difference has been shown to play important roles in determining routes of adolescent self-esteem.

The findings of the study are inconsistent with findings of Carlson, Uppal and Prosser (2000) who also found a significant gender difference in self-esteem of students. They further indicated that girls regularly experienced sharper declines than boys in their levels of self-esteem. The findings are also at variance with Wild, Flisher, Bhana, and Lombard (2004) whose report indicated that significant gender difference existed in self-esteem with regard to assertiveness training and cognitive restructuring. The current findings are inconsistent with Akbari, Mohamadi and Sadeghi (2012) who reported a significant difference in student self-esteem after assertiveness and cognitive restructuring training when the effect of gender was computed. Michael Schwalbe and Clifford Stables (as cited in Anhalt, 2015) have found that many men suffered equally from low self-esteem. According to the study, the difference between men and women lied in the source of their low self-esteem and not the degree to which they experience low self-esteem.

Furthermore, the findings of the current study are inconsistent with findings of Anhalt (2015) that men looked to social comparisons to fuel their self-image based on a large component of their self-worth on their ability to be the "provider", in comparison with others. Men also compared physical appearance, intelligence, independence, and status with others in their workplace, family, or social group. On the contrary, women relied on reflected appraisals as the source for their self-esteem. This means that many women relied on how others viewed them for their self-esteem. The reflected appraisal process concludes that people come to think of themselves in the way they believe others think of them (Anhalt, 2015). Anhalt (2015) pointed out that men with low self-esteem were more likely to engage in negative thought

distortions that viewed themselves as coming up short when compared to their male counterparts, while women who suffered from low self-esteem were more likely to engage in negative thought patterns of jumping to conclusions, assuming that others were judging them harshly.

Mention should be made that the findings of the study is also at variance with findings of Hamoud, Dayem and Ossman (2011) who reported in their study that students expressing low self-esteem need a combination of intellectual skills, motivational qualities, and social emotional skills to succeed in school. It is necessary for students to be more assertive and have high self-esteem which can help the individual, change how they view themselves and establish self-confidence. Iruloh and Amadi (2008) added that assertive training helps to teach an individual on how to assert himself despite the intimidation and pressures coming from other people.

However, the current findings contradict the findings of Hollandsworth and Wall (1977) who reported that men were more assertive than women upon experiencing cognitive restructuring and assertiveness training. Their finding showed that men failed to deal more on items regarding their bosses and supervisors than women. Men also reported themselves as being more outspoken when stating opinions and in taking initiatives more readily in social contacts with members of the opposite sex. Women, on the other hand, reported themselves as more assertive in expressing love, affection, and compliments, as well as expressing anger to one's parents. These sex differences in assertive behaviour affected assertion-training groups.

Difference in the effect of (a) assertiveness training and (b) cognitive restructuring techniques on the depression levels of male and female students

The focus of research hypothesis four was to establish whether there were any significant differences in the effect of assertiveness training and cognitive restructuring techniques on the depression levels of male and female students. The findings of the study revealed no significant effect in the depression post test scores for participants in the assertiveness training group and cognitive restructuring group after controlling for the scores on the depression test administered prior to the intervention.

The results of the study showed that males and females responded in the same way to the two types of interventions they received on depression. It was found that both males and females appeared to have substantial decrease in their depression levels after participating in the cognitive restructuring and assertiveness training programmes. The findings of the current study suggest that the interventions worked for all participants by decreasing their depression levels. Participants who received the treatment are more likely tend to engage in activities like social gatherings which will make them happy and lively irrespective of their gender. They might also worry less about life issues for the reason that life is full of issues. The reduction in the depression level of participants might bring several positive impacts in their lives such as having positive mind-set about life events or phenomena, being content with what one has and the ability to associate well with other members in the community as well. This finding corroborates with research findings of Emmanuel, Okreke and Anayochi (2015) that cognitive restructuring technique (CRT) focused on

changing a person's perceptions and irrational assumptions of self and world. The treatment received by participants in the current study might have helped them change their line of negative thoughts to positive translating into the reduction of their depressive disorders which is likely to improve their living and social life at large. Cognitive restructuring enables people to replace stress-inducing thought habits with more accurate and less rigid (and therefore less stress-inducing) thinking habits. Allied Travel Careers (n.d.) noted cognitive restructuring technique helps individuals to think in reference to reality and facts which in turn helped them reformulate their thoughts and beliefs that they have projected onto themselves.

The findings lend support to Grubbs Chenney, Fortney, Edlund et al. (2015) whose report indicated that gender moderated the relationship between cognitive treatment and its outcome on the anxiety and depression measures. The findings contradict the findings of Hollandsworth and Wall (1977) who stated in their report that differences in assertive behaviour affected assertion-training groups. The findings also contradict that of Tannous (2015) who found a statistically significant difference in the effect of assertiveness training on males and females. The finding is also at variance with the finding of Lawan (2016) which revealed that gender affected students' anxiety in Mathematics significantly ($P< 0.05$) with male students having more reduction in Mathematics anxiety than female students.

The finding lends support to Mueen et al. (2006) that depression, along with non-assertiveness is common in males and females and that both men and women were equal victims of depression stressing that there was no gender difference in the incidence of depression. The finding also corroborates with

the findings of Madu (2020) who found no significant difference in the reduction of depressive tendency of male and female students in cognitive restructuring and assertive therapies respectively after intervention. Beck (1979) theorized that negative self-statements resulted from maladaptive schemata that has biased processing information taken from the environment and believed that through training in cognitive restructuring these negative statements about the self could be corrected.

However, according to WHO (2012), the treatment given to female students differed and it was observed that there was a rate of 50% higher among females over that of male as far as depression is concerned. WHO (2012) further noted that depression could affect various aspects of a person's life among them being social and family relationships, schoolwork, self-worth and decision-making. It was also observed that men and women can equally be the victims of depression in their life. Tapia, Barrios and Gonzalez-Forteza (as cited in Wang, 2013) also noted that in three studies conducted in Mexico on adolescent students, it was found that a greater proportion of female adolescent reported low self-esteem as well as higher suicide ideation and depressive symptoms than their male counterparts.

Difference among students in the effect of (a) assertiveness training and (b) cognitive restructuring techniques on their self-esteem of students on the basis of age

The focus of research hypothesis five was to find out whether there existed statistically significant difference among students in the effect of (a) assertiveness training and (b) cognitive restructuring techniques on their self-esteem of students on the basis of age. The results from the two-way analysis

of covariance (ANCOVA) showed no significant main effect in the self-esteem post test scores of participants in the two intervention groups after controlling for the scores on the self-esteem test administered prior to the intervention. These results suggested that on the basis of age, participants responded in the same way to the two types of interventions they received on self-esteem. The findings of the study showed that age did not influence participants' responses to the intervention given and that age could not be used to justify participants ability to participate in intervention groups. Irrespective of participant's age, he or she could partake in assertiveness training or cognitive restructuring programme. The findings suggest that probably there were other factors which could influence participants responses to the intervention given. These factors could be participants' education level and physical location. The findings of the current study are consistent with findings of Poutiainen and Holma (2013) and Campbell (2002) who found that there was no significant interaction effect of treatment and age on self-esteem scores of students. The reason for this could be that the relationship between the treatment and age has no effects on the psychological, emotional, physical and sexual well-being of students.

The findings however, contradict the findings of Abed, El-Amrosy and Atia (2015) who reported that there were statistically significant differences between measure 1 and measure 2 intervention programme regarding assertiveness skills on the basis of age. Abed, El-Amrosy and Atia found that the self-esteem score level of psychiatric male had positive significant correlation between total assertiveness skills and total self-esteem score level and there was positive significant correlation between age and total

assertiveness skills. The implication of this finding is that age was a significant factor in the effectiveness of assertiveness training programme. The finding is at variance with Maddahi, Liyaghat, Samadzadeh, and Keikhayfarzaneh (2011) which suggested that younger students who scored low on self-assertiveness measures could benefit significantly from self-assertiveness training programmes. Similarly, the findings of the study are at variance with the findings of Aktop, Özçelik, Kaplan and Seferoğlu (2015) who in a study to determine the effects of assertiveness on individuals in different age groups found that assertiveness had significant effects on different age groups. Follow-up test revealed that juniors had significantly lower assertiveness score than seniors. Their study pointed out that age differences existed in the effects of assertiveness training and therefore advocated developing personalised assertiveness training programmes for people of different ages.

Difference among students in the effect of (a) assertiveness training and (b) cognitive restructuring techniques on their depression levels of students on the basis of age

Research hypothesis six sought to determine whether significant differences existed in the effect of (a) assertiveness training and (b) cognitive restructuring techniques on their depression levels of students on the basis of age. A two-way analysis of covariance (ANCOVA) was conducted at 0.05 level of significance. Preliminary tests of homogeneity of slope and homogeneity of variance were performed to satisfy the assumption of ANCOVA. The results revealed not significant main effect in the depression post test scores for participants in the two intervention groups after controlling

for the scores on the depression test administered prior to the intervention. The results further suggest that on the basis of age, participants responded in the same way to the two types of interventions they received on depression. This revelation suggests that, indeed, age was not a factor for predicting a change in participants depression level after participants had been exposed to an intervention programme. The results probably mean that there could be other factors like participants educational level and home environment which could influence the depression level of participants after an intervention programme. The findings of the study could be attributed to the fact that participants in the study had common features such as the school's physical environment and common instructional procedures and hence the likelihood of the effect of the interventions on their depression level being the same. The findings agree with the finding of Karlin, Trockel, Brown, Gordienko, Yesavage, and Taylor (2015) who in a study that compared the effectiveness of cognitive behavioural therapy (CBT) for depression among older versus younger veterans revealed significant and equivalent reductions in depressive symptoms for both older and younger individuals. For both groups, there was an average overall reduction of close to 40% in their post-test scores. In addition, they found CBT yielded significant improvements in overall quality of life for both groups suggesting that the intervention was equally effective for older and younger patients. In effect, age did not influence the effects of the intervention on depression. The study findings corroborate with findings of Johnco, Wuthrich and Rapee (2014) who assessed the impact of assertiveness training and cognitive restructuring techniques on the depression of participants on the basis of age. The study used 44 depressive participants and

completed self-report and neuropsychological tests of cognitive flexibility and a clinical interview at pre-treatment and post-treatment. Qualitative and quantitative measures of cognitive restructuring were completed at post-treatment. Pre-treatment cognitive flexibility was not related to the quality of cognitive restructuring at post-treatment or overall treatment outcome. The study results did not predict reduction in subjective units of distress from using cognitive restructuring and therapist ratings of cognitive restructuring ability at post-treatment. Few participants showed changes in cognitive flexibility over treatment. Those with poorer cognitive flexibility did not find cognitive restructuring as useful to alleviate emotional distress as those with better cognitive flexibility. However, those with poorer cognitive flexibility could still benefit from standardised CBT, even if their use of cognitive restructuring was less effective. The implication of the findings was that for older adults, cognitive restructuring reduced distress at the end of treatment, even though this was based on their own cognitive flexibility.

Findings however, contradict the report of Wetherell et al. (2013) who in a study examined age differences in outcomes from the Coordinated Anxiety Learning and Management (CALM) study, an effectiveness trial comparing usual care to a computer-assisted collaborative care intervention for primary care patients with panic disorder, generalised anxiety disorder, post-traumatic stress disorder (PTSD), and/or social anxiety disorder. The researchers hypothesised that older adults would show a poorer response to the cognitive interventions than younger adults. The study showed that cognitive interventions were more effective than usual care among younger adults overall and for those with generalised anxiety disorder, panic disorder and

social anxiety disorder. Among older adults, the intervention was effective in the overall for those with social anxiety disorder and PTSD but not for those with panic disorder or generalised anxiety disorder. These results imply that cognitive interventions for anxiety disorders may not be as effective for older individuals as they are for younger people. Generally, it has been found that cognitive restructuring work with older adults (Gallagher-Thompson, Steffen & Thompson, 2010; Laidlaw, 2001; Laidlaw et al., 2003). Garber, Frankel and Herrington (2016) have also showed that when cognitive interventions meet the child's level of development, children's potential as well as their current abilities are likely to be improved. This implies that age plays a role in how effective cognitive restructuring can be.

The mediating role of self-esteem on the effects of assertiveness training and cognitive restructuring on depression level of students

Research hypothesis seven was intended to find out whether self-esteem mediated the effects of assertiveness training and cognitive restructuring on depression level of students. The results of the study indicated that the direct and indirect effect of both assertiveness training and cognitive restructuring were statistically significant because of the *p* value ($p<.001$). The results also showed that assertiveness training was more pronounced in lowering depression as indicated by the t values. The t value of -13.09 for assertiveness training was far less than -2 as compared to the t value of -9.97 cognitive restructuring. The results suggested that self-esteem had significant partial mediation effects on the relationships between the two interventions and level of depression.

The findings of the study agree with Ranjbar Kohan and Sajadinejad (2010) whose report on the effects of assertiveness training on self-esteem and depression in students of Isfahan University of Medical Sciences indicated that assertiveness training caused a significant increase in the self-esteem level and decrease in the depression rate and therefore concluded that as self-esteem got improved, depression reduced. The findings of the study again agree with Watson et al. (as cited in Sowislo and Orth, 2013) who also found a strong negative correlation between self-esteem and depression and, on the basis of this result, cautioned against treating self-esteem and depression as distinct constructs.

The findings further corroborate with that of Mann et al. (2016) who found in their study that self-esteem was negatively related with depression emphasizing that self-esteem could be considered as a protective factor especially in adolescence when individuals go through challenging times. They therefore argued that, to overcome depression using cognitive restructuring, the self-esteem of individuals could be considered first. The findings again support Baumeister (1990), who pointed out that low self-esteem contributed to vulnerability for developing depression and ultimately suicide ideation. This was because according to him, people developed suicide ideation when they failed to achieve their goals and strongly desired to escape from negative self-attributions of their failure implying that high self-esteem would reduce depression and ultimately, suicide ideation. The findings of the present study further agree with Mulligan (2011), who posited that improving self-esteem might reduce the risk of depression regardless of whether or not the individual was experiencing stressful life events. Again, the findings

confirm Sowislo and Orth (2013), who have pointed out that depression could be prevented, or reduced by interventions that improved self-esteem.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Overview of the Study

The study investigated ascertained the effects of assertiveness training and cognitive restructuring on the self-esteem and depression levels among technical university students in Southern Ghana. The study was a quasi-experimental study and focused on the in the effects of assertiveness training and cognitive restructuring techniques on self-esteem and depression levels of male and female students. Again, the study sought to ascertain whether there existed differences in the effect of assertiveness training and cognitive restructuring techniques on self-esteem and depression levels of male and female students.

Three technical universities were used for the study namely Accra Technical university (ATU), Cape Coast Technical University (CCTU) and Takoradi Technical University (TTU). The methodology used in this study was the pre-test post-test quasi-experimental design. Two (2) instruments namely: Rosenberg's Self-Esteem (RSE) Scale and Beck Depression Inventory (BDI) were chosen for the data collection for the study. The simple random sampling method was used to select sixty (60) participants (20 from each institution) for the study after the baseline survey. The statistical tools used for the analysis were frequencies, percentages, one-way analysis of

covariance (ANCOVA) and two-way analysis of covariance (ANCOVA). The tests were conducted for significant differences at a significance level of 0.05.

Summary of Findings

The following are the main findings from the data analysis.

1. It was found that both participants in the two intervention groups (Assertiveness Training and Cognitive Restructuring) recorded better scores in the post-test scores as compared to the participants in the control group who were not exposed to any intervention. Both the cognitive Restructuring and the Assertiveness Training groups performed better than the control group. The finding implied that the self-esteem of participants of the two experimental groups improved significantly after the intervention programme.
2. It was observed that significant difference existed between the two intervention groups (Cognitive Restructuring and Assertiveness Training Groups) and the Control Group. The findings of the study suggested that the intervention yielded positive impact on the participants who were exposed to the interventions. Participants who participated in the intervention had their depression levels reduced.
3. The study results revealed no significant main effects in the self-esteem post test scores for participants in the assertiveness training group and cognitive restructuring group after controlling for the scores on the self-esteem test administered prior to the intervention. The results also showed that males and females responded in the same way to the two types of interventions they received on self-esteem. The revelation of the current study could be that probably both male and

female participants took both the assertiveness and cognitive restructuring training seriously and this resulted in both male and female participants experiencing the same level of self-esteem.

4. The findings of the study revealed no significant main effect in the depression post test scores for participants in the assertiveness training group and cognitive restructuring group after controlling for the scores on the depression test administered prior to the intervention. The results of the study also showed that males and females responded in the same way to the two types of interventions they received on depression. The findings of the current study suggest that the interventions worked for all participants by decreasing their depression levels. The reduction in the depression participants might bring several positive impacts in their lives such as having positive mind-set about life events and worrying less about issues as they equipped with skills to deal with issues constructively.
5. The results from the two-way analysis of covariance (ANCOVA) showed no significant main effect in the self-esteem post test scores for participants in the two intervention groups after controlling for the scores on the self-esteem test administered prior to the intervention. These results further suggest that on the basis of age, participants responded in the same way to the two types of interventions they received on self-esteem.
6. The results revealed no significant main effect in the depression post test scores for participants in the two intervention groups after controlling for the scores on the depression test administered prior to

the intervention. The results further suggest that on the basis of age, participants responded in the same way to the two types of interventions they received on depression. This revelation suggests that, indeed, age was not a factor for predicting a change in participants depression level after an intervention programme has been taken by participants.

7. The results indicated that self-esteem played a mediating role on the effects of assertiveness training and cognitive restructuring on depression levels of students. This suggests that individual students with good self-esteem were likely to live a life devoid of depressive disorders.

Conclusions

Based on the findings, it can be concluded that cognitive restructuring and assertiveness training had positive effects on students' self-esteem as well as reducing depression levels These two interventions can develop in young people good qualities such as the ability to speak confidently without being ridiculed and also to mingle with others without any doubt of fear or worry.

The cognitive restructuring programme had the same positive effect on males in reducing depression levels as it had on females. The age of participants of the treatment group had no influence on the effects of assertiveness training and cognitive restructuring. Self-esteem played a mediating role in the effectiveness of assertiveness training and cognitive restructuring.

Theoretical Implications

The findings suggest that individuals who were exposed to the interventions had a change of mindset on how they viewed themselves prior to the interventions leading to some significant level of self-acceptance and confidence as postulated by Maslow (1954). The findings further suggest that individuals gained some level of stability in their personality. Again, some level of the positive sense of the self was developed as a result of the intervention programmes translating into the enhancement of self-esteem and reduction in depression.

The group counselling sessions offered individuals the opportunity to get connected to other people with similar characteristics and within eight weeks they had built good relationships with one another. This appears to have developed in them a sense of belongingness as pointed out in Maslow's need for love and belongingness, Ryan and Deci's relatedness and Roger's unconditional positive regard. Much openness was expressed by almost all the participants of the intervention groups and was displayed through the sharing of experiences without fear of intimidation or criticism.

General Educational Implications

The Ministry of Education, through its affiliate bodies like the Ghana Education Service (GES), Council for Technical and Vocational Training (COTVET) and Ghana Library Authority (GLA) may need to incorporate in the school curriculum self-esteem enhancement programmes at the various levels of education to build the capacities of individuals right from the onset. Such programmes will build confidence in young people and also help them find their place early in life which can translate into the development of the

positive sense of self-esteem enable them hold themselves high wherever they may find themselves.

There is the need for parents to be educated on the individuality of the child and what each person is capable of based on their interest and values. This will go a long way to avoid the issue of programmes of study being pushed on students against their wish which often tend to impact negatively on their self-image.

Implications for Counselling

1. From the findings it is clear that self-esteem plays a mediating role in the effects of the interventions on depression. This suggests that counsellors need to take students through self-esteem enhancement activities such as assertive skills, how to change their self-talk, how to nurture a positive attitude towards life, self-love among others. Such activities will assist students build and maintain a good self-esteem.
2. Assertiveness training and cognitive restructuring were found to be effective in improving self-esteem as well as reducing depression levels among students of Technical Universities in Southern Ghana. This finding suggests the need for counsellors to consider the use of assertiveness training and cognitive restructuring techniques when dealing with students battling with low self-esteem and/or depression.
3. Counsellors need to organize career workshops for the various faculties and departments to educate students on the employment opportunities and career progressions in their various fields of study. This will result in settling their minds as they could clearly see what the future holds for them.

4. Counsellors in collaboration with the faculties and departments may need to organize career days/Job fairs and invite students from the second cycle institutions within their so that these students could have a fair idea of the technical university set-ups. This may in turn influence their choice of tertiary education thereby reducing the incidence of going to a technical university as a matter of the only option.

Recommendations

In view of the research findings and the conclusions drawn, the following recommendations are made.

1. Since assertiveness training improved students' level of self-esteem, I recommend that management of technical universities should make it mandatory for counsellors to organize assertiveness training for students on regular basis especially freshers who have just come from the senior high schools to technical universities. This would help students see themselves as being good individuals in the society and also feel that they have good qualities and therefore would be able to do things as other people and improve upon their lives.
2. Counsellors and lecturers should be motivated and supported by the governments, school administration, parents and the larger community to help organize assertiveness and cognitive restructuring and other related skills training for students at all levels who may have low self-esteem and show signs of depression.
3. Gender and age should not be considered as significant factors that can influence the effects of intervention programmes which aim at

enhancing self-esteem and reducing depressive disorders since they did not have any significant effect on the effects of the interventions employed in the current study.

4. The self-esteem of individuals having depressive disorders need to be worked on by counsellors/therapists before administering any intervention aimed at reducing depressive disorders since self-esteem plays a mediating role in the effect of the two interventions on depression.

Suggestions for Further Research

The following are suggested for future research.

1. It is suggested that future research be carried out on the relationship between assertiveness training and self-esteem of students in the traditional universities, colleges of Education and Nursing Training Colleges in Ghana.
2. Future research could also be carried out to focus on the effects of assertiveness training and cognitive restructuring on academic performance of students in technical universities.
3. The current study should be conducted in the other remaining technical universities in Ghana so as to have a nationwide representation.

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APPENDICES

APPENDIX A

A BILL OF ASSERTIVE RIGHTS

1. You have the right to judge your own behaviour, thoughts, and emotions, and to take the responsibility for their initiation and consequences upon yourself.
2. You have the right to offer no reasons or excuses for justifying your behaviour.
3. You have the right to judge if you are responsible for finding solutions to other people's problems.
4. You have the right to change your mind.
5. You have the right to make mistakes—and be responsible for them.
6. You have the right to say, "I don't know."
7. You have the right to be independent of the goodwill of others before coping with them.
8. You have the right to be illogical in making decisions.
9. You have the right to say, "I don't understand."
10. You have the right to say, "I don't care."

APPENDIX B

Evaluation Form

Assertiveness Training Workshop

1. Rate how effective the workshop was in helping you to achieve the following goals by circling the appropriate number:

Not Effective Very Effective

Increasing your awareness of assertiveness

1 2 3 4 5

2. Helping you learn to distinguish between assertiveness, aggressiveness and non-assertiveness

1 2 3 4 5

Identifying specific skills, you needed to improve.

1 2 3 4 5

Improving your ability to be effectively assertive

1 2 3 4 5

Other (specify)

1 2 3 4 5

3. Rate how helpful the following components of the workshop were to you:

Not Helpful Very Helpful Information about the basic components of Assertive behaviour

1 2 3 4 5

Discussion of homework assignments

1 2 3 4 5

Role- playing assertive situations

1 2 3 4 5

Other (specify)

1 2 3 4 5

4. How would you rate your overall experience in the program?

Not Negative Very Positive

1 2 3 4 5

5. Regularly did you do the homework assignments?

Not Regularly Very Regularly

1 2 3 4 5

6. Would you recommend the program to a friend?

No___ Not Sure ___ Yes ___

7. How effective was (were) your group leader(s) in helping you to achieve the goal of the program?

Not Effective Very Effective

Leader 1: 1 2 3 4 5

Leader 2: 1 2 3 4 5

8. Rate how sensitive the group leader(s) was (were) to your concerns:

Not Sensitive Very Sensitive

Leader 1: 1 2 3 4 5

Leader 2 1 2 3 4 5

9. How could the program have been improved to meet your needs more effectively?

_____

_____

1. Rate how effective the workshop was in helping you to achieve the following goals by circling the appropriate number:

Not Effective Very Effective

Increasing your awareness of cognitive restructuring

1 2 3 4 5

2. Helping you learn the basic irrational beliefs

1 2 3 4 5

Identifying specific cognitive distortions.

1 2 3 4 5

Improving your ability to challenge distorted thought

1 2 3 4 5

Other (specify)

2 2 3 4 5

3. Rate how helpful the following components of the workshop were to you:

Not Helpful Very Helpful Information on behaviour modification

1 2 3 4 5

Discussion of homework assignments

1 2 3 4 5

The use of the Thought Record Card

1 2 3 4 5

Other (specify)

2 2 3 4 5

4. How would you rate your overall experience in the program?

Not Negative Very Positive

2 2 3 4 5

5. Regularly did you do the homework assignments?

Not Regularly Very Regularly

2 2 3 4 5

6. Would you recommend the program to a friend?

No___ Not Sure ___ Yes ___

7. How effective was (were) your group leader(s) in helping you to achieve the goal of the program?

Not Effective					Very Effective
Leader 1:	1	2	3	4	5
Leader 2:	1	2	3	4	5

8. Rate how sensitive the group leader(s) was (were) to your concerns:

Not Sensitive					Very Sensitive
Leader 1:	1	2	3	4	5
Leader 2	1	2	3	4	5

9. How could the program have been improved to meet your needs more effectively?

_____

_____

APPENDIX C

Thought Record Card

Situation	Thought	Emotion	Behaviour	Alternate Thought

APPENDIX D

UNIVERSITY OF CAPE COAST

COLLEGE OF EDUCATION STUDIES

FACULTY OF EDUCATIONAL FOUNDATIONS

DEPARTMENT OF GUIDANCE AND COUNSELLING

ROSENBERG SELF-ESTEEM SCALE

Name: ----------Programme----------

Age: a. 17-19 [ ] b. 20-24 [ ] c. 25 and above [ ]

Sex: a. Male [ ] b. Female [ ]

Marital Status: a. Single [ ] b. Married [ ]

Instructions: This questionnaire consists of 10 group of statements. Please read each group of statements carefully, and then pick out the one statement in each group that best describes Self-esteem Scale

Please Tick appropriately [√]

	STATEMENT	SA	A	D	SD
1	I feel that I am a person of worth, at least on an equal plane with others.				
2	I feel that I have a number of qualities.				
3.	All in all, I am inclined to feel that I am a failure.				
4.	I am able to do things as well as most other people.				

5.	I feel I do not have much to be proud of.				
6.	I take a positive attitude toward myself.				
7.	On the whole, I am satisfied with myself.				
8.	I wish I could have more respect for myself.				
9.	I certainly feel useless at times.				
10.	At times I think I am no good at all.				

APPENDIX E

UNIVERSITY OF CAPE COAST

COLLEGE OF EDUCATION STUDIES

FACULTY OF EDUCATIONAL FOUNDATIONS

DEPARTMENT OF GUIDANCE AND COUNSELLING

BECK DEPRESSION INVENTORY

Name: ----------Programme----------

Age: a. 17-19 [ ] b. 20-24 [ ] c. 25 and above [ ]

Sex: a. Male [ ] b. Female [ ]

Marital Status: a. Single [ ] b. Married [ ]

Instructions: This questionnaire consists of 21 group of statements. Please read each group of statements carefully, and then pick out the one statement in each group that best describes the way you have feelings during the past two weeks, including today. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than on the statement for any group.

1.

0 I do not feel sad.

1 I feel sad

2 I am sad all the time and I can't snap out of it.

3 I am so sad and unhappy that I can't stand it.

2.

0 I am not particularly discouraged about the future.

1 I feel discouraged about the future.

2 I feel I have nothing to look forward to.

3 I feel the future is hopeless and that things cannot improve.

3.

0 I do not feel like a failure.

1 I feel I have failed more than the average person.

2 As I look back on my life, all I can see is a lot of failures.

3 I feel I am a complete failure as a person.

4.

0 I get as much satisfaction out of things as I used to.

1 I don't enjoy things the way I used to.

2 I don't get real satisfaction out of anything anymore.

3 I am dissatisfied or bored with everything.

5.

0 I don't feel particularly guilty

1 I feel guilty a good part of the time.

2 I feel quite guilty most of the time.

3 I feel guilty all of the time.

6.

0 I don't feel I am being punished.

1 I feel I may be punished.

2 I expect to be punished.

3 I feel I am being punished.

7.

0 I don't feel disappointed in myself.

1 I am disappointed in myself.

2 I am disgusted with myself.

3 I hate myself.

8.

0 I don't feel I am any worse than anybody else.

1 I am critical of myself for my weaknesses or mistakes.

2 I blame myself all the time for my faults.

3 I blame myself for everything bad that happens.

9.

0 I don't have any thoughts of killing myself.

1 I have thoughts of killing myself, but I would not carry them out.

2 I would like to kill myself.

3 I would kill myself if I had the chance.

10.

0 I don't cry any more than usual.

1 I cry more now than I used to.

2 I cry all the time now.

3 I used to be able to cry, but now I can't cry even though I want to.

11.

0 I am no more irritated by things than I ever was.

1 I am slightly more irritated now than usual.

2 I am quite annoyed or irritated a good deal of the time.

3 I feel irritated all the time.

12.

0 I have not lost interest in other people.

1 I am less interested in other people than I used to be.

2 I have lost most of my interest in other people.

3 I have lost all of my interest in other people.

13.

0 I make decisions about as well as I ever could.

1 I put off making decisions more than I used to.

2 I have greater difficulty in making decisions more than I used to.

3 I can't make decisions at all anymore.

14.

0 I don't feel that I look any worse than I used to.

1 I am worried that I am looking old or unattractive.

2 I feel there are permanent changes in my appearance that make me look unattractive

3 I believe that I look ugly.

15.

0 I can work about as well as before.

1 It takes an extra effort to get started at doing something.

2 I have to push myself very hard to do anything.

3 I can't do any work at all.

16.

0 I can sleep as well as usual.

1 I don't sleep as well as I used to.

2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.

3 I wake up several hours earlier than I used to and cannot get back to sleep.

17.

0 I don't get more tired than usual.

1 I get tired more easily than I used to.

2 I get tired from doing almost anything.

3 I am too tired to do anything.

18.

0 My appetite is no worse than usual.

1 My appetite is not as good as it used to be.

2 My appetite is much worse now.

3 I have no appetite at all anymore.

19.

0 I haven't lost much weight, if any, lately.

1 I have lost more than five pounds.

2 I have lost more than ten pounds.

3 I have lost more than fifteen pounds.

20.

0 I am no more worried about my health than usual.

1 I am worried about physical problems like aches, pains, upset stomach,

or constipation.

2 I am very worried about physical problems and it's hard to think of much else.

3 I am so worried about my physical problems that I cannot think of anything else.

21.

0 I have not noticed any recent change in my interest in sex.

1 I am less interested in sex than I used to be.

2 I have almost no interest in sex.

3 I have lost interest in sex completely.

APPENDIX F

Assertiveness Training Sessions

Preamble:

Assertive behaviour promotes quality of life in terms of quality interpersonal relationships, personal power and self-confidence. Assertiveness is an antidote to fear, shyness, anxiety, and other psychosocial challenges.

The main purpose for this training is to empower individual participants by way of enhancing self-esteem thereby promoting their psychosocial functioning.

Session 1: Introduction, welcoming and orientation.

Objectives: The session's aim will be:

1. To introduce self to one another and how participants want to be called during the period of the training.
2. To set goals for the entire training
3. To set rules that will govern the training programme.
4. To form groups within participant and select leaders for the groups

Activities:

In this session, there will be self-introduction of researcher, research assistants and participants.

The goals for the entire training programme will be set by researcher(s) and participants. There will be also be a discussion to determine the ground rules that will govern the programme. The rules will cover areas such as punctuality and regularity, respect and tolerance towards one another, giving and receiving constructive feedback among others.

Three groups will be formed within the treatment group and respective leaders will be elected.

Session 2: The concept and nature of self-esteem

Objectives: The session is to help participants to ascertain and explain the meaning of assertiveness and assertive behaviour

1. Participants to be able to explain the construct of low self-esteem
2. State four (4) causes and four (4) symptoms of low self-esteem
3. Explain in detail the effects of having low self-esteem

Activities:

1. Use an ice breaker to help participants settle for the session
2. Disuses points of information from the previous session that might need clarification.
3. Explain the objectives of the session to participants
4. Show a short video on self-esteem and lead in a discussion to analyse the video.
5. Introduce and explain the self-esteem the source and how self-esteem is formed.

- Self-esteem is an evaluation of our worthiness as individuals, a judgement that we good, valuable people.
- The value one places on him/herself
- It reflects how the individual views and values the self at the most fundamental levels of psychological experience

The way people feel about themselves go a long in to determine how they relates with others and how far they will go in life.

People with high self-esteem are able to make good choices about themselves in terms of decisions that affect them.

- Students ruled to have a good self-esteem to help them hold their heads high and feel proud of their accomplishments and abilities which in turn give them the courage to try new experiences and have respect for themselves.

6. Disuses with participants the issue of low self-esteem and how it affects individuals having it.

- Low self-esteem is having a generally negative opinion of oneself

  Low self-esteem can be part of a current problem, the result of other problems or a problem itself.

- It can be a risk factor for other problems
- Low self-esteem comes from lack of self-acceptance and frustrated achievement.
- Low self-esteem can keep individuals from realizing their full potentials.

  Low self-esteem has effects on various aspects of a person e.g. people with low self-esteem may say a lot of negative things about themselves.

  It makes such people have difficulties in relating to other people.

  People with low self-esteem are more ponied to depression.

7. Allow time for participants to ask questions so that issues discussed will be clarified for the benefit of all.

8. Give Homework assignment and terminate the session.

Homework

a. Identify and write down three human behaviours that depict that the individual exhibiting then has low self-esteem.

b. Make one positive statement about self each day and record it on a chart or in a journal throughout the training period.

Session 3: The concept, nature of Assertiveness and assertive behaviours

Objectives:

1. The aim of this session is to help participants understand and explain what assertiveness means.
2. Enable participants to recognize when they are being assertive.

Activities:

1. Solicit questions and concerns from the previous session

- Discuss with participants any point of information that might need clarification
- Discuss/review homework assignment.

2. Explain the objectives of the session to participants.

b. Solicit from their understanding of being assertive. List their explanations on the board.

3. Define and explain assertiveness and assertive behaviour to participants

Example: Assertiveness is being able to communicate your thoughts and feelings honestly and appropriately in everyday situations. Assertiveness is the ability to communicate opinions, thoughts, needs, and feelings in a direct, honest, and appropriate manner. Assertiveness involves standing up for your rights in a manner that does not offend

others or deny the rights of others. When you are assertive you have more control over your life. You also make it less likely that other people will take advantage of you.

Assertive behaviour is "behaviour which enables a person to act in his own best interests, to stand up for himself without undue anxiety, to express his honest feeling comfortably, or to exercise his own rights without denying the rights of others." (Calberti & Emmons 1974).

Feelings of low self-esteem or self-worth often lead to individuals dealing with other people in an unassertive response. When people are stressed or anxious, they can resort to passive or aggressive behaviour in the expression of their thoughts and feelings. When low self-esteem people are not able assert their rights by clearly stating what they want, they may invite other people to treat them in the same way. Certain job roles such as low status work roles, may be associated with non-assertive behaviour. The experiences people go through growing up can make them learn to respond in a non-assertive way. Some people can also model their behaviour on that of significant others and such learned behaviours can sometimes be difficult to unlearn.

4. Generate from trainees the rights that they have in interpersonal relationships.

Present to participants the Smith's Bill of Assertive Rights (Appendix A) and discuss with them the early childhood beliefs that correspond to each of the principles.

b. Encourage participants to react and respond to any principle(s) in the Bill of Assertive Rights with which they have reservations or disagree. Facilitator should encourage discussion by using active listening techniques to clarify and amplify participants' reactions.

c. Summarize the session and give home work to participants and terminate the session.

Home work

1. Identify which of the principles of the Bill of Assertive Rights you find difficult or impossible to implement.

2. Write up a contract that states the goals you wish to accomplish before the end of the final session of the training. State each goal as specifically as possible and where appropriate, give an example.

Session 4: Types of Communication Styles

Objectives: The aims of this session are:

- To help participants to recognize when they are being assertive.
- To identify faulty beliefs about being assertive.
- To enable participants to distinguish the three (3) styles of communication

Activities:

1. Solicit questions and concerns from the previous sessions. Discuss point of information that might need clarification. Discuss homework
2. Introduce the various types of styles of communication/behaviour and clarify the wrong perception people have about them

b. draw distinctions between assertive behaviour and aggressiveness.

c. explain the differences between non-assertive, aggressive, and assertive behaviour.

Example:

Non-assertive or Passive Style

People with a passive style tend to put the needs of others before their own. , thus, always giving in to what others want. This may be because they do not believe they have the right to assert themselves. They may believe that they are inferior and that their needs are not important enough to make a fuss about. These people tend to believe that they are incompetent, or weak, and thus have difficulty looking after themselves or making their own decisions. With these negative beliefs they often allow other people to make decisions that infringe on their rights as they are mostly afraid to say "no." Their inability to express thoughts and feelings, often leads to resentment and frustration over the fact that their needs are always overlooked. The result may be low self-esteem, depression, anger, and many other emotional or physical complaints.

Aggressive Style

Aggression involves standing up for your rights in a way that is pushy and inappropriate. Aggression offends the rights or feelings of other people. Therefore, people who have an aggressive style believe firmly in their own rights but may not believe that others have equal rights. These people usually have a strong need to compete or prove themselves. Simply put, it is about standing up for your own views and rights but disregarding the views and rights of others. Aggressive individuals are seen to be demanding, hostile,

abrasive, rude and disrespectful. Aggression can often lead to build-up feelings of anger and hostility. An aggressive person feels righteous, superior, deprecatory at the time of action and possibly guilty later.

Assertive Style:

People who are assertive know they have rights but also remember that other people have rights as well. Assertive people care about other people's feelings and therefore phrase their requests or complaints in a polite but firm manner. These people have a sense of `give and take' and are co-operative at times of conflict. An assertive person is one who acts in his/her own best interests, stands up for self, expresses feelings honestly, is in charge of self in interpersonal relations, and chooses for self. The basic message sent from an assertive person is "I'm OK and you're OK." An assertive person is emotionally honest, direct, self-enhancing, and expressive. He/she feels confident, self-respecting at the time of his/her actions as well as later.

. Assertive people try to choose the most appropriate behaviour for the situation. These people have control over their behaviour and have respect for themselves and others.

Explain to participants how being assertive usually involves internal conflict between values of different strength. (Example: A person might wish to return a defective product purchased, but also wants to maintain an image with others as someone who never makes complaints.)

- . Give different scenarios, and let participants respond to them in groups. Example: You go to work each day and enjoy the time to

yourself when you get home after work. Almost every evening neighbour, who stays home all day, pops in for chat. You do not want this to continue. How can you tell your neighbour?

- Your boss comes to you at 4 pm and asks if you would stay late that night to complete an important piece of work for them. You have plans to go out that evening. How would you communicate to him/her? Respond in all three (3) styles

5. Describe how being assertive requires being honest and involves respect for the other person. Discuss each participant's reaction to the distinctions between non-assertive, aggressive, and assertive behaviour
6. Emphasize the point that assertion is a right not an obligation. Whenever we are involved in a situation in which we could be assertive, we face a choice: assert, pull back, or be aggressive. We are not required to be assertive in any situation indicating that there certain situations in which we might find it difficult to be assertive.
7. Discuss some of the faulty beliefs about being assertive such as:

a. Being assertive brings disapproval.

b. It is proud people who give/accept compliments.

c. Others come first and we have to meet the good of others before we meet our own needs.

d. We do not have to express unpleasant feelings.

e. It is wrong to say "no" to others

f. We have to face up any role given to us without challenging the personal cost.

g. We have to justify every statement or argument that we make with supporting reasons.

Assertiveness is not about dominating, resisting or feeling forced to yield to others. It is not about becoming emotional or angry, neither is it about forcing your point of view onto other people. Rather, assertiveness aims at emphasizing the value of clear, calm, frank and often minimal communication as a means of establishing relationships in which everyone knows where they stand and on one feels ill-used.

8. Summarize the session and give homework assignment.

Homework

a. In the course of the week, initiate an interaction with a colleague and try to employ any of the principles of the Bill of Assertive Rights you find difficult or impossible to implement. Record your accomplishment(s).

b. In your interactions with others during the week, look for situations where people exhibit non-assertiveness, aggressiveness and alassertiveness.

Session 5: Sequence of an Effective Assertive Response

Objectives:

- To practice assertive responses.
- To identify inner, unheard dialogues that hinder assertive behaviour
- To identify with some nonverbal assertive behaviours.
- To develop an awareness of the sequence of thoughts and actions involved in making an assertive response
- To explain the key behavioural components of an assertive response

Activities:

1. Solicit questions and concerns from the previous session, process homework and encourage them to share the past week's experiences
2. Explain value conflicts to participants. These are internal conflicts (value clashes) that are often experienced by some people which prevent them from being assertive.
3. Ask participants to describe some problem situations to use in role-play to practice assertive responses later in the training.
4. Describe the ideal chain of events, which, if followed, often leads to clear, honest, effective assertive behaviour as follows:
    - Activating event: that is the situation or event that is causing the person to want to be assertive.
    - Look inside to identify thoughts and feelings – before one releases an assertive response, he or she should "look inside" to become aware of the feelings (anger, hostility, fear, caring, sorrow, defensiveness, etc.) and thoughts (irrational thoughts, "what if's," imagined consequences, etc.) he or she is experiencing.
    - Identify goals in order to "act" instead of "react." After an individual understands the thoughts and feelings that are cascading within, he or she should try to identify some personal goals for being assertive in that particular situation.
    - Achieve one goal at a time.

5. Allow participants to practice the Assertive Response Sequence:

   Ask each participant to imagine a situation in which they would like to be more assertive and mentally project into the situation. Ask each participant to visualize the activating event, become aware of his or her thoughts and feelings, identify the key goal, and formulate a clear assertive response. Have each participant describe his or her assertive response sequence and discuss the process.

6. Take participants through the reasons for being assertive:

   a. Objective Approach Assertion is assertive behaviour utilized in the pursuit of a movement toward an objective goal (e.g., asking for a better condition of service, asking to borrow an object from a friend, getting past rude secretaries or clerks to settle a matter, etc.).

   b. Subjective Approach Assertion is assertive behaviour utilized to approach another person for reasons of interpersonal attraction or any subjective communication to another person (e.g., getting beyond superficial acquaintances to actual friendships, communicating interpersonal feelings, etc.).

   c. Defensive Assertion is assertive behaviour used to maintain one's individual rights and personal dignity: In essence, one is "defending" one's life-space

7. Explain and demonstrate examples of the non-verbal components of an assertive response.

   a. Eye contact – Discuss the use of eye contact to engage another person.

b. Body language – Highlight the importance of effective body posture, use of gestures, and facial expression in communicating messages

Have the participants break into their groups and discuss any topic for about 10 minutes. Tell the participants that at the beginning they are not to make eye contact and are to restrict all body language cues. After about 2 minutes, ask them to slowly make eye contact and begin to bring their body into use in communicating their message. Discuss the activity with them after their interaction. Emphasize that one's body language enhances one's verbal message.

Point out that when you send an assertive message, your nonverbal behaviour is as important as verbal language.

8. Discuss the attitudinal and cognitive guidelines for assertiveness with participants:

a. . Self–Inquire: Stress the importance of looking inward to identify feelings and thoughts before being assertive.

b. Use "I" Statements: "I" statements minimize defensiveness and reduce the likelihood of escalating negative feelings. Contrast the positive outcomes usually associated with "I" statements with the negative, usually non-productive results generated by "you" statements.

c. Be goal-directed: It is critical to know the goal of being assertive in a particular situation so that an individual can focus clearly on goal relevant behaviours and not be distracted by irrelevant information,

attitudes, opinions, etc. Do not attempt to achieve multiple goals in a single assertive response if possible.

d. Assert without long delays: It is best for a person to assert as soon as he or she is aware of both desire and goal. The longer a person delays, the more likely she or he is to not assert or to allow intervening influences to weaken the intended message.

e. Be persistent: Stress the difference between being persistent and insisting on something. Many a time it is necessary to restate and understands what is being communicated.

Ask the participants to form pairs and devise a role-play situation to perform for the group. The role-play should illustrate a specific deficiency, which the group would have to discover the error. Allow question time.

9. Summarize the session and give homework.

1. Observe yourself in front of the mirror for 10 minutes. While observing, be sure to talk in order to provide a clear impression of how you appear to others.

2. In your interactions with others during the week, attempt at least one of the three kinds of assertive responses: (1) defensive assertion, (2) objective approach assertion, and (3) subjective approach assertion.

Session 6: Developing Assertion Skills

Objectives:

1. To begin to increase the participants' level of assertive skills under low threat conditions.

2. To involve all group members in the process of learning to discriminate (feedback role) effective assertive response.
3. To have each group member become involved in communicating (role-play) an effective assertive response.
4. To utilize peer feedback as much as possible to energize skill acquisition.

Activities:

1. Indicate to participants that most of the remaining group time will be devoted to developing and refining assertion skills.
2. Describe the participants' roles and responsibilities in giving honest and clear feedback to each other. Give a brief explanation on how to give feedback.
3. Stress the need for feedback with regard to possible values conflicts (for example, you have a good feedback to give but you do not want the receiver to think you are a critic), as well as nonverbal skills and attitudinal and cognitive difficulties revealed by the role-plays. Emphasize the importance of positive as well as negative feedback

   - Let a participant pick the first situation from the Practice Situations list suggested by participants during Session 5 and ask the person to his or her right to role-play the situation selected.

   - Describes the situation more fully and indicates the goal to be achieved. He or she then instructs the participant to assert as effectively as possible,

   emphasizing the guidelines presented during session 5. Assigned the remaining participants the responsibility of giving feedback.

- initiates the role-play in as realistic a manner as possible, being careful not to "stimulus flood" the participant who is attempting to assert. The role-play should be terminated after 2 to 3 minutes if the person has not been able to be assertive.

- Encouraged first feedback from the individual who role-played, then the other group members, and finally the facilitators.

- The sequence outlined above is repeated until all group members have had a chance to role-play one of the contrived, low threat situations.

4. Summarize session with participants give homework and terminate the session.

Homework Assignments

1. Try to be more assertive in situations you encounter during the week and keep track of situations in which you attempted to be more assertive than before.

2. Ask participants to describe in writing two situations in which you have been unable to be assertive but would like to be. Specify your goals and the imagined consequences of being assertive in each situation.

Session 7: Assertion Skills Practice Role Play – Personal Life Situations

Objectives:

1. To increase the relevance of the role-play experiences by using real life problems.

2. To practice being assertive under higher level anxiety conditions.

4. To continue to identify value and role conflicts that inhibit assertive behaviour.

5. To utilize peer feedback as much as possible to energize skill acquisition.

Activities:

1. Discussion of homework assignments and ask participants to share their successes and failures they encountered during the week as they tried to be assertive
2. Ask the participants to think of one of the life situations in which they would like to be more assertive and then to be able to describe it in enough detail to allow realistic role-playing.

- Let each participant contribute a life situation example to this role play. Ask the participant to identify his or her goal, label what he or she would feel like in the situation and describe the probable behaviour of the person being asserted to.

3. Facilitator takes the role of the person being asserted to and asks for two other participants to each try to give an effective assertive response. Then the participant who originally stated the problem tries to make an assertive response. Allow approximately three minutes for each role-play.
4. Ask the remaining members of the group to give feedback to all three participants involved in the role-play. Emphasize that feedback should center on unearthing values and role conflicts as well as the basic components of good assertive behaviour.

5. Ensure that every participant is participating in giving feedback to others, if necessary, assign specific feedback tasks. for example, assign some participants responsibility for giving feedback about non-verbal behaviour, values conflicts, timing, good directedness, persistence, the Bill of Rights, etc.

6. After the final role-play, provide feedback about overall group progress and offer suggestions for the group when appropriate. Facilitator might also offer concrete suggestions or describe techniques to individuals who seem to be unable to progress for one reason or another. Allow question time.

7. Summarise session and give homework assignments

   1. Allow two (2) weeks before Session 8. Within the break, ask each participant to deal assertively with the life situation they role-played in the group during session. Ask them to focus on overcoming a specific problem that have been observed in the course of the discussions.

Session 8: Practice, General Discussions, Evaluation and Post-test

Objectives:

1. To identify specific problems or difficulties individuals are expressing and practice skills that help overcome the barriers.

2. To solidify skill development and increase awareness of internal factors that may still be inhibiting individuals from asserting.

3. To give an overview of the progress of the group over the span of the workshop.

4. To evaluate individual growth, program accomplishment, and facilitator effectiveness.

5. Administer Post-test

Activities:

1. Review and share experiences participants encountered during the week. Facilitators should use active listening skills to tease out any special problems that could be worked on during the final session.
2. Follow the same procedures as outlined in Session 7, Assertion Skills Practice Role Play – Personal Life Situations, except that group members play the role of the person to whom the assertive response is being directed as well as play the asserter's role.
3. The leaders facilitate a free-flowing discussion dealing with whatever assertion related issues participants wish to raise.
4. Leaders solicit feedback about the overall workshop effectiveness with the use of Evaluation form (Appendix B). Arrange for a follow-up session approximately one month later.
5. Administer Post- test and terminate the training programme.

APPENDIX G

Cognitive Restructuring Treatment Sessions

Preamble

Low self-esteem is considered as an issue that plays a critical role in the development of a number of mental disorders and social problems, including depression, anxiety, anorexia nervosa, bulimia, violence, substance abuse, high-risk behaviours, and borderline personality disorder, in addition to feelings of hopelessness, suicidal tendencies, and attempted suicide (DeHart, Pelham, & Tennen; Mann et al. 2006).

Bad moods are unpleasant, they can reduce the quality of your performance, and they undermine your relationships with others. Cognitive restructuring helps you to change the negative or distorted thinking that often lies behind these moods. As such, it helps you approach situations in a more positive frame of mind.

Session 1: Introduction, welcoming and orientation.

Objectives: The session's aim will be:

5. To introduce self to one another and how participants want to be called during the period of the training.
6. To set goals for the entire training
7. To set rules that will govern the training programme.
8. To form groups within participant and select leaders for the groups.

Activities:

In this session, there will be self-introduction of researcher, research assistants and participants.

The goals for the entire training programme will be set by researcher(s) and participants. There will be also be a discussion to determine the ground rules that will govern the programme. The rules will cover areas such as punctuality and regularity, respect and tolerance towards one another, giving and receiving constructive feedback among others. Three groups will be formed within the treatment group and respective leaders will be elected.

Session 2: Concept and nature of low self-esteem

Objectives:

4. Participants to be able to explain the construct of low self-esteem
5. State four (4) causes and four (4) symptoms of low self-esteem
6. Explain in detail the effects of having low self-esteem

Activities:

9. Use an ice breaker to help participants settle for the session
10. Disuses points of information from the previous session that might need clarification.
11. Explain the objectives of the session to participants
12. Show a short video on self-esteem and lead in a discussion to analyse the video.
13. Introduce and explain the self-esteem the source and how self-esteem is formed.
    - Self-esteem is an evaluation of our worthiness as individuals, a judgement that we good, valuable people.
    - The value one places on him/herself
    - It reflects how the individual view and values the self at the most fundamental levels of psychological experience

The way people feel about themselves go along in to determine how they relates with others.

People with high self-esteem are able to make good choices about themselves in terms of decisions that affect them.

- Students ruled to have a good self-esteem to help them hold their heads high and feel proud of their accomplishments and abilities which in turn give them the courage to try new experiences and have respect for themselves.

14. Disuses with participants the issue of low self-esteem and how it affects individuals having it.

- Low self-esteem is having a generally negative opinion of oneself

Low self-esteem can be part of a current problem, the result of other problems or a problem itself.

- It can be a risk factor for other problems
- Low self-esteem comes from lack of self-acceptance and frustrated achievement

Low self-esteem can keep individuals from realizing their full potentials.

Low self-esteem has effects on various aspects of a person e.g. people with low self-esteem may say a lot of negative things about themselves.

It makes such people have difficulties in relating to other people.

People with low self-esteem are more ponied to depression.

Low self-esteem impacts on what you are able to put yourself forward to do, how you think about yourself and occupies your mind by

making you overly analyse how others maybe judging you. Low self-esteem is a state of mind, and it can be changed and you can improve your self-esteem only if you are willing to challenge the negative feelings and judgments you have toward yourself.

15. Allow time for participants to ask questions so that issues discussed will be clarified for the benefit of all.
16. Give Homework assignment:
    a. Identify and write down three human behaviours that depict that the individual exhibiting them have low self-esteem.
    b. Write up a contract that states the goals you wish to accomplish before the end of the final session of the training. State each goal as specifically as possible and where appropriate, give an example.

Session 3: Concept of Cognitive Restructuring, Basic Irrational Beliefs

Objectives:

3. The aim of this session is to help participants understand and explain cognitive means.
4. Help them identify irrational beliefs
5. Enable participants to recognize when they are having negative thoughts/cognitive distortion.

Activities:

1. Let a volunteer give an ice breaker.
2. Discussion of homework assignments, solicit questions and concerns from the previous session and clarify their issues.
3. Give a clear explanation of cognitive restructuring to participants and the benefits we derive from it. Example, Cognitive restructuring is a

method of identifying unhelpful patterns of thinking, or untrue assumptions, and learning new, more helpful ways of thinking about difficult situations. Cognitive restructuring is the therapeutic process of identifying and challenging negative and irrational thoughts. These sorts of thoughts are called cognitive distortions.

1. Teach participants what irrational beliefs are by introducing the A-B-C events from Albert Ellis' Rational Emotive Behavioural Therapy (REBT) where A stands for an activating event, B for a belief, and C for the consequences of our appraisal for our mood.
2. Explain how our thoughts can be distorted at time and the problems these distortions can pose. For example, Cognitive distortions are irrational thoughts that influence our emotions. Cognitive distortions are unhealthy thinking patterns can lead to the reinforcement of negative thoughts and emotions. Cognitive distortions are common but irrational ways of thinking that can negatively impact emotions and behaviours. Though everyone experiences cognitive distortions to some degree, the extreme form of these distortions can be maladaptive and harmful. There is transient negative automatic thought that we all might have from time to time in a particular difficult situation, but in the case of low self-esteem, these negative thoughts are global ideas about the self that keep on reoccurring in most situations.

When a person with low self-esteem enters a difficult situation, then negative beliefs about the self are activated which in turn generate negative predictions about what could go wrong and also generates anxiety and low mood. When our perception of ourselves is negative it

can lead to an overwhelming feeling of low self-worth, "I'm not good enough"; "not interesting enough"; and/or "I am not attractive enough."

3. Take them through the process of identifying negative thoughts/cognitive distortions
   - our thoughts, feelings and behaviours are constantly interacting and influencing one another. How we interpret or think about a situation determines how we feel about it, which then determines how we'll react. Our brains are constantly using thought to make interpretations about the world around us. When we see, hear, touch, smell, or taste something, our thoughts tell us what it all means. For instance, if you see a stranger walking toward you with a weapon, even though you do not know that he is dangerous, our thought may interpret the situation as threatening. This will make us feel fearful and we will either take to flight or scream for help. If on the other hand our thought interprets the scene to be a harmless farmer going to his farm, we can just walk past this same stranger with ease and even exchange greetings.
4. Help participants to identify their own cognitive distortions by looking for negative emotions.
   - Ask them to do a reflection and identify when their symptoms of depression, worthlessness, fear and or anxiety become worse or severe.

- Present different scenarios that will increase participants' awareness of situations where cognitive distortions are impacting their mood and behaviours.

5. Make them aware that it is the negative self-statements (which come out of their negative thoughts) they might have been making that might have contributed to their feeling of inadequacy.
   - Give participants thought record cards (also called a thought log) to be used for recording experiences, along with the thoughts, feelings, and behaviours that accompany them. Make them aware they are going to use them throughout the training period (Appendix C)
   - Teach them to record their thoughts", "feelings", "consequences etc. shortly after a situation ends as this will help them keep track of the situations that trigger their ill-feelings.
6. Let them break into their groups and present them with two (2) different scenarios to simulate them and fill the Thought Record with these guidelines:
   - Ask them to record only the facts of what happened (situation), without any interpretation.
   - Write your thought
   - Write a single word or a description of a feeling.
   - Record what you did in response to the situation.
   - What different thought could you have had?
7. Summarise the session, give homework assignment and terminate the session.

Homework

Imagine you and your friend at notice a man looking at you and walking in your direction on a crowded pavement. Using the Thought Record,

i. Describe the situation without interpretation

ii. Write down the thought that will automatically come to your mind

iii. State the possible emotion with the degree of intensity

iv. Describe the behaviour you could possibly put up

v. Write down an alternate thought and go through the steps ii.-iv.

Session 4: Some Cognitive Distortions

Objectives:

1. To identify four (4) cognitive distortions
2. To identify the individual's responsibility personal responsibility for their emotions

Activities:

1. Ask a volunteer to give an ice breaker to help relax participants for the session
2. Process homework assignment and clarify issues from the previous session that may need further clarification.
3. Explain the objectives for the session to participants.

   Revise the definition and explanations of cognitive distortions through questions and answers.
4. Introduce and discuss four cognitive distortions and their related consequences with participants. Example,

- Global Labelling: This where we generalize one or two qualities into a negative global judgment. These are extreme forms of generalizing and are also referred to as "labelling" and "mislabelling." In this instance instead of describing an error in context of a specific situation, people will attach an unhealthy label to themselves. For example, they may say, "I'm a loser" in a situation where they failed at a specific task. Mislabelling involves describing an event with language that is highly coloured and emotionally loaded. For example, instead of saying someone drops her children off at day care every day, a person who is mislabelling might say that "she abandons her children to strangers."
- Selective abstraction: This is a situation where people end up forming conclusions based on an isolated detail of an event. In this process other information is ignored, and the significance of the total context is missed. Here, the events that matter are those dealing with failures and deprivation.
- Personalization is the tendency to relate everything around one to oneself. In this distortion an individual may tend to think that everything people do or say is some kind of reaction to them. They may also compare themselves to others, trying to determine who is smarter in terms of academics, who looks better in terms of appearance, etc. one is somehow, continually forced to test their value as a person by measuring one's self against others. may also see themselves as the cause of some unhealthy external event that they were not responsible for.

- Blaming is a distortion where you hold other people responsible for your pain or take the other tack and blame yourself for every problem. Blaming often involves making someone else responsible for choices and decisions that are actually our own responsibility. In blame systems, you deny your right (and responsibility) to assert your needs, say no, or go elsewhere for what you want.

5. Let participants break into their groups and discuss three (3) scenarios under each of the distortion discussed for 10 minutes. Let each group present their work to entire group.
6. Summarise session, give homework and terminate the session.

Homework

a. In your interaction with family and friends, try and identity any sign of labelling" and "mislabelling" and/or selection abstraction either on your part or that of the other person(s). in your case, anytime you are able to avoid them, record it in your journal and bring to the next session.

Session 5: Some Cognitive Distortions (Contd)

Objectives:

1. To identify the role of self-statements in motivation, self-belief, and behaviour.
2. To identify more distortions and their effects on our lives

Activities:

1. Have a News time where participants would share their experiences over the past week. Review homework assignment and clarify and other issues from the previous session as raised by participants.

2. Explain the objectives for the session to participants
3. Ask participants write in their journals three (3) negative self-statements people usually make about themselves and let them share what they have written. Discuss with group how negative emotions are formed and the role we play s individuals in the development of such emotions.
4. Discuss four (4) cognitive distortions namely, All-or-nothing thinking, Overgeneralization, Mind-reading, and Emotional reasoning. Talk about the impact these can impact on worth and well-being in general. Example,

   All-or-nothing thinking is a distortion where situations are viewed in either/or terms. This occurs when individuals see the world in two categories, rather than in a more complex fashion 'Either you're a success or failure in life. There is no in-between'. This is also referred to as polarized thinking where people tend to perceive everything at the extremes, with very little room for a middle ground. The dangers involved here is the impact on how one judges himself

   With mind-reading, individuals believe they can discern the thoughts of others without any accompanying evidence. Such people are able to assume how people are feeling toward them. They imagine that people feel the same way they do and reacts to things the same way they do. Mind readers often jump to conclusions that are true for them without checking whether they are true for the other person. For example, one can say 'She doesn't have to tell me – I know she thinks I'm an idiot',

'the way she looked at me is evident that she's heard something bad about me'.

Emotional reasoning is a distortion where individuals assume that their feelings are facts even when the evidence points to the contrary). With emotional reasoning our emotions interact and correlate with our thinking process. Therefore, if you have distorted thoughts and beliefs, your emotions will reflect these distortions. An example is when a student is unable to answer a question put to him by a lecturer in class and considers himself as stupid. If left unchecked, he may begin to withdrawn gradually from social interactions because of the perception of worthlessness that he formed as a result of his inability to provide the right answer to a question.

Overgeneralization is a situation where one holds extreme belief on the basis of a single incident and apply them inappropriately to dissimilar events or settings. In this instance a single negative event is interpreted as a never-ending pattern of defeat and words such as never and always are used. Example, "I felt awkward during my first job interview. I am always so awkward." This distortion can lead to a restricted life, as individuals try to avoid future failures based on the single incident or event.

5. Let participants break into their groups and come out with a scenario under each of the distortions discussed and present them in role-plays. Allow 10 minutes for their group discussion and 5 minutes for each group to present their role-plays.

6. Allow time for questions and contributions from other groups and clarify issues that arise for better understanding.
7. Summarize the entire session, assign homework and terminate session.

Homework

a. Imagine you receive poor grades on a mid-semester test.

b. A friend did not attend a birthday party organized for you.

In both scenarios write down your thought, feeling, behaviour and alternate thought under the distortions discussed in today's session. Record them in your Thought record card.

Session 6: Identifying and challenging distorted (unhealthy) thoughts.

Objective:

1. To be able to identify distortions they identify with
2. To challenge the distortions using series of questions.

Activities:

1. Ask a volunteer to give an ice breaker
2. Discuss homework and clarify points they did not understand from the previous session.
3. Revise the cognitive distortions discussed so far and explain the objectives to participants.
4. Help participants to identify the unhealthy thoughts discussed which are true with them through questions such as:
   - What was going through your mind when you started to feel this way?
   - What does this situation say about you?

- What are you thinking about you, other people, or what might happen in the future?
- What is the worst thing that you think could happen to you?
- What are you thinking about how other people view you?
- What are you thinking about other people?

5. Take participants through de-catastrophizing technique. Here, "What if?" or "What's the worst that could happen?" will be used. (This sequence of questioning helps to reduce the irrational level of anxiety associated with cognitive distortions, highlighting the fact that even the worst-case scenario is manageable).
6. Teach participants the technique of *Putting their thoughts on trial* to challenge the distortions. For example.

In this exercise, participants will be taught to individually act as a defence attorney, a prosecutor, and a judge on their own cognitive distortions.

i. First, participants will act as a defence attorney by defending their negative thought. Researcher will ask them to make an argument for why the thought is true. Participants will be cautioned to stick to verifiable facts and exclude interpretation, guesses, and opinions.

ii. Next, they will act as the prosecutor. Now they will present evidence against the negative thought. Just like in the previous step, still sticking to facts, and not opinions.

iii. Finally, they will be asked to act as the judge. At this point, they will review the evidence, and deliver a verdict. The verdict should come in the form of a rational thought.

7. Let them break into their respective groups and practice the technique among themselves with two (2) different scenarios for 15 minutes and then present to the big group.
8. Allow time for questions and contributions from participants.

- Summarise session, assign homework and terminate session.

Homework

Identify two negative thoughts that have been affecting your worth and put those thoughts on trial. Write the trial proceedings in your journal and bring to the session.

Session 7: Behaviour Modification

Objectives: Participants will be able to:

1. modify their negative self-statements by replacing them with positive self-statements
2. develop and test some cognitive restructuring techniques to counter self-defeating statements

Activities:

1. Ask a volunteer to give an ice breaker to help participants settle down for the session.
2. Allow 10 minutes for News Time where participants can take turns to share any experience they encountered in the course of the week. The news items should not be necessarily in connection with the training programme.
3. Discuss the homework and clarify any point form the previous session that may need further elaboration and have a general review of the previous session.

4. Explain the objectives of the session to participants
5. Emphasis the need to modify their negative self-talks by replacing them with positive self-statements. Example,
   - Self-talk is the manifestation of our thoughts and beliefs. This habit starts right from the childhood and impacts our various life experiences. A greater proportion of our self-talk is negative or self-critical. Negative self-talk breeds negative responses and behaviour. Entertaining negative self-talks or statements will make it almost impossible to overcome the cognitive distortions that have been dealt with in the course of the training. Our subconscious can be re-programmed to eliminate negative or self-limiting thoughts through feeds of positive statements.
   - Negative self-talk habits can be done away with and be replaced with positive affirmations. Positive affirmations are the personal short statements (positive self-talks) that help to derive desired outcomes
   - Teach them to create a list of positive self-statements to begin with the new behaviour. Example,
   - • I love myself for who I am; Fear is only a feeling, it cannot hold me back; I know that I can master anything; Today I am willing to fail in order to succeed; I have the strength to make my dreams come true
6. Teach them some techniques such as thought stopping, cognitive rehearsal, dispelling irrational beliefs to counter self-defeating statements.

- Irrational thoughts are thoughts that hold no truth and add no value to yourself. They are debilitating and can ruin self-esteem. Irrational thoughts can creep into your head without you realizing it and make you feel bad about yourself. Example, "If you would have done that better this wouldn't have happened to you", "I didn't get a good grade; my lecturer doesn't like me."
- Every irrational thought stems from something it can be from having parents who put a lot of pressure on you, or a boss that puts pressure on you. Irrational beliefs are considered by Albert Ellis to be the primary reason for human misery and dysfunction.
- Irrational Beliefs can be challenged, questioned, disputed to help us change our emotional responses to events.
- Thought-stopping can be an effective self-help strategy to help some people overcome negative thinking and gain a new perspective on life.
- using the thought stopping technique may give you a sense of control and when followed with positive and reassuring statements, you are breaking the negative thought habit and reinforcing a sense of reassurance.
- To stop unwanted thoughts, you focus on the thought and then learn to say "Stop" to end the thought.
    - List your most stressful thoughts. These are the thoughts that distract you from your daily activities and make you worry more.

- Imagine the thought. Close your eyes. Imagine a situation in which you might have this stressful thought.
- Stop the thought. Set a timer, watch, or other alarm for 3 minutes. Then focus on your unwanted thought. When the timer or alarm goes off, shout "Stop!"

7. Let them break into their groups and practice the techniques learned and do presentation to the entire group.
8. Summarise the session, assign homework and terminate the session.

Homework

a. Create a list of 15 positive self-statements in your journal and practice them over and over from now till the next session
b. Practice dispelling of irrational thoughts and thought stopping techniques and record your experience in your journal.

Session 8: Practice, General Discussions, Evaluation and Post-test

Objectives:

1. To identify specific problems or difficulties individuals are expressing and practice skills that help overcome the barriers.

2. To solidify skill development and increase awareness of internal factors that may still be inhibiting individuals from functioning to their fullest capacity.

3. To give an overview of the progress of the group over the span of the workshop.

4. To evaluate individual growth, program accomplishment, and facilitator effectiveness.

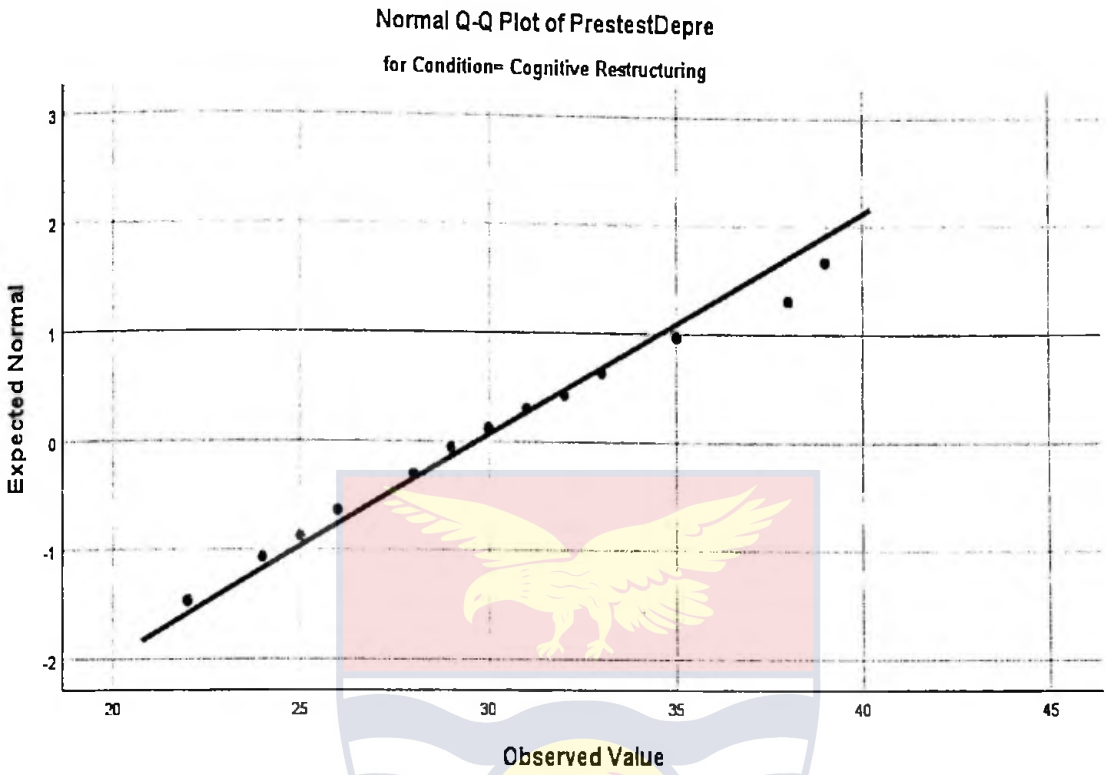
5. Administer Post-test

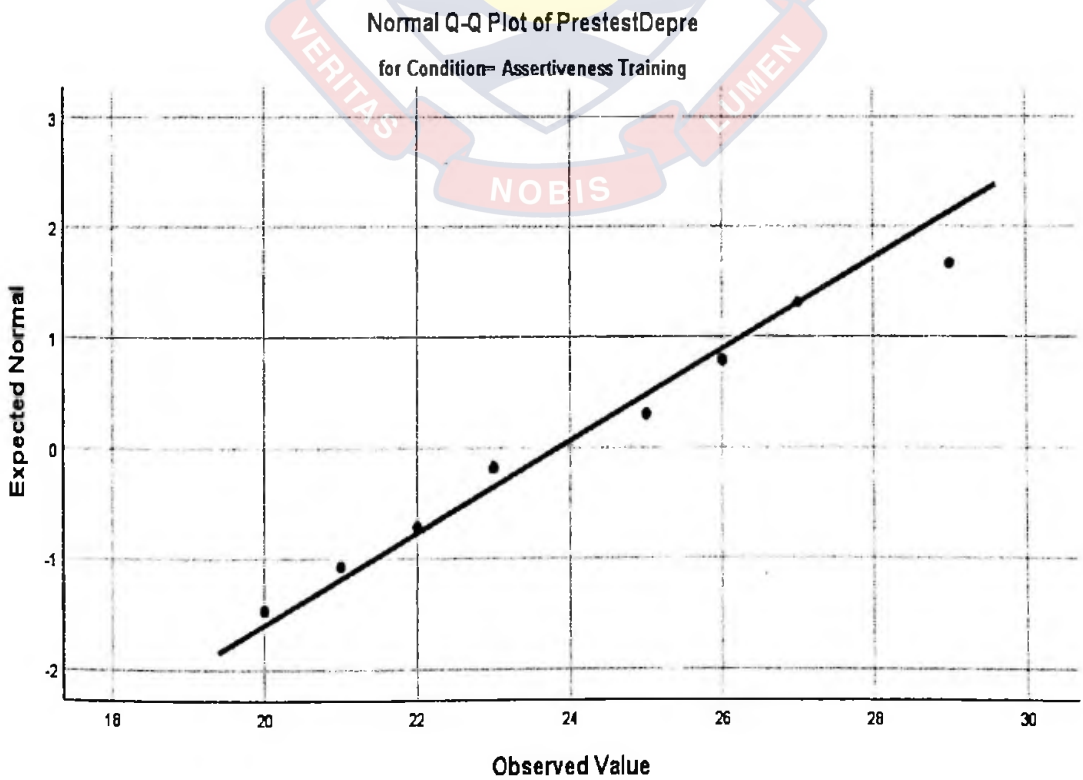
Activities:

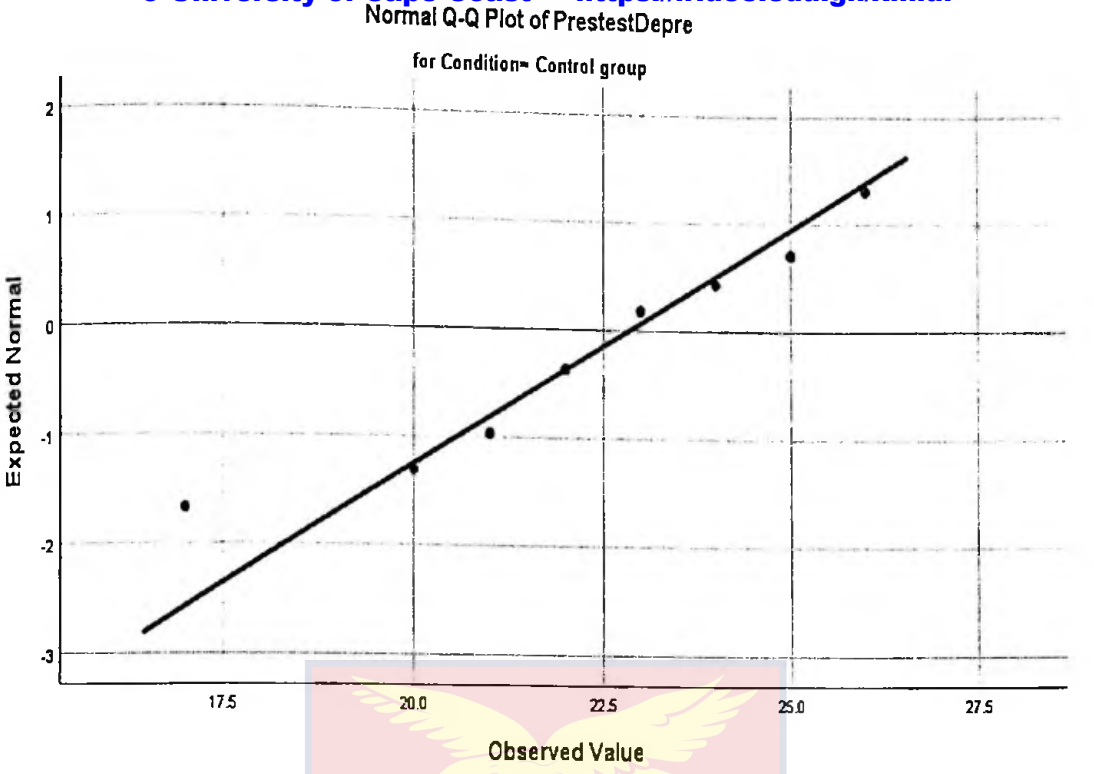
1. Review and share experiences participants encountered during the week.
2. Discuss homework assignment. Let participants volunteer to demonstrate the thought-stopping technique in turns.
3. The leaders facilitate a free-flowing discussion dealing with whatever negative thought related participants wish to change and general issues of concern.
4. Leaders solicit feedback about the overall workshop effectiveness with the use of Evaluation form (Appendix B).
5. Administer Post- test and terminate the training programme.

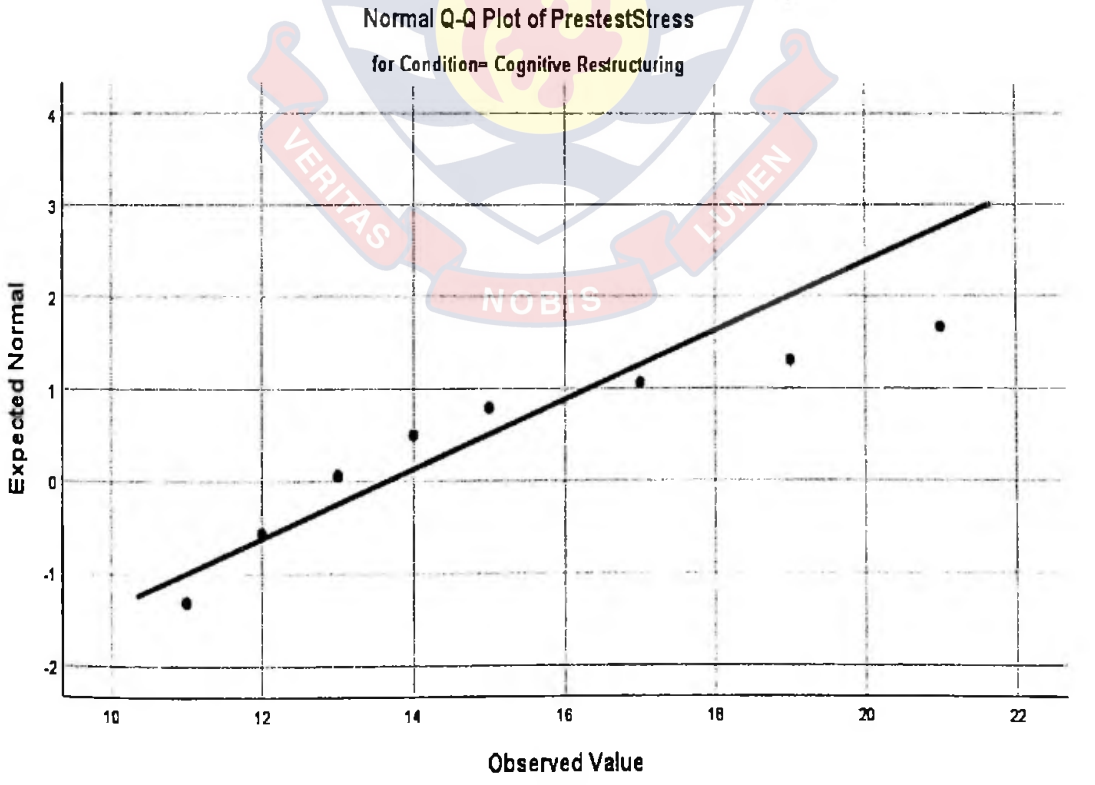
APPENDIX H

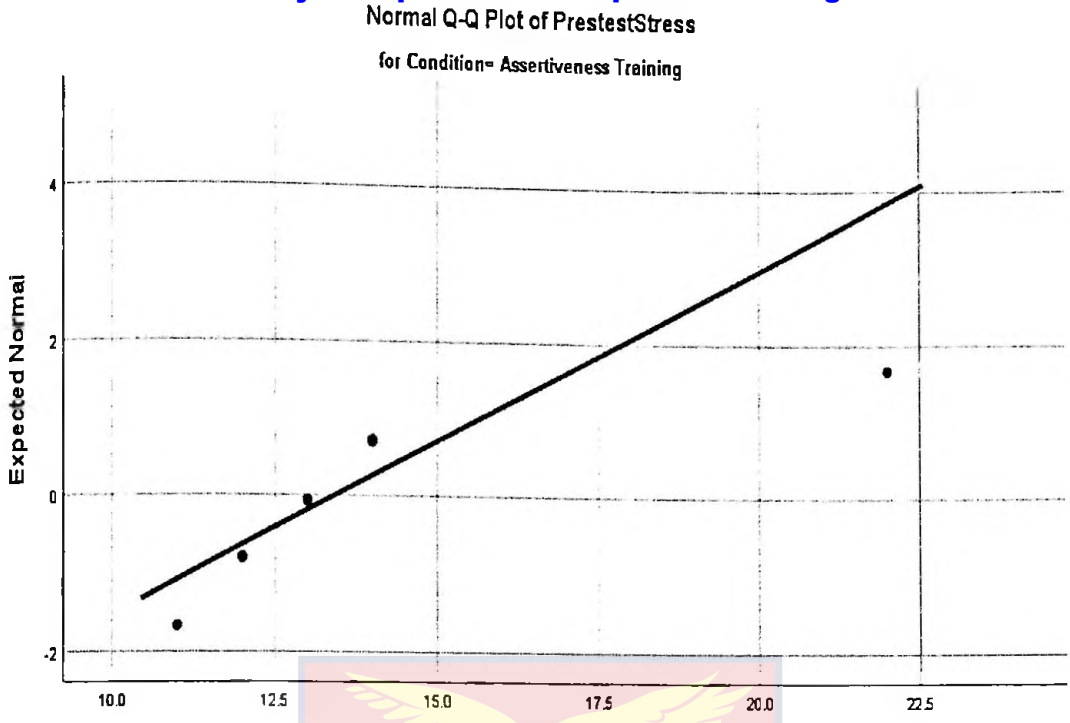
NORMALITY TEST

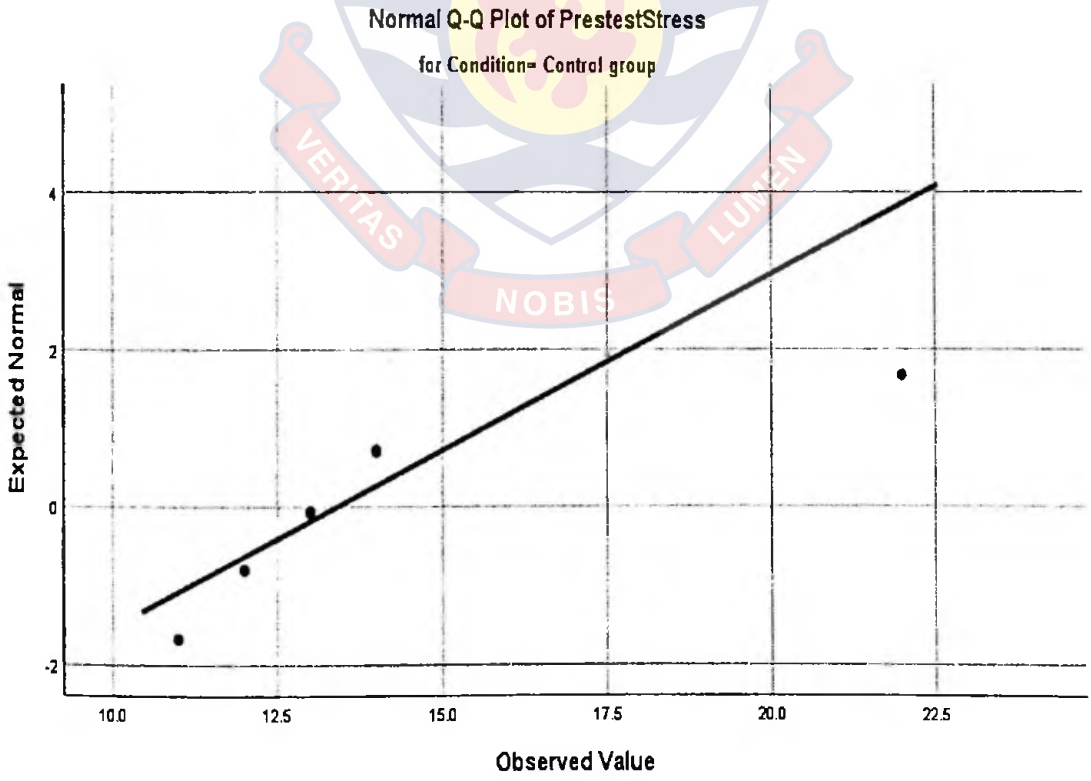


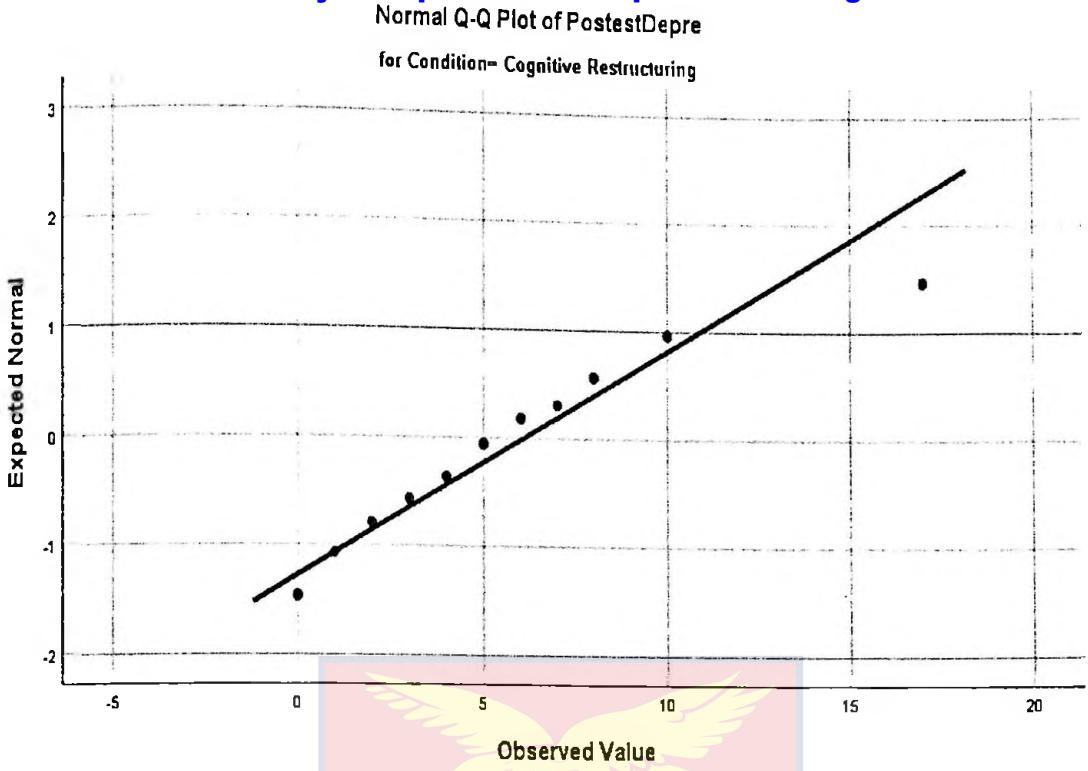


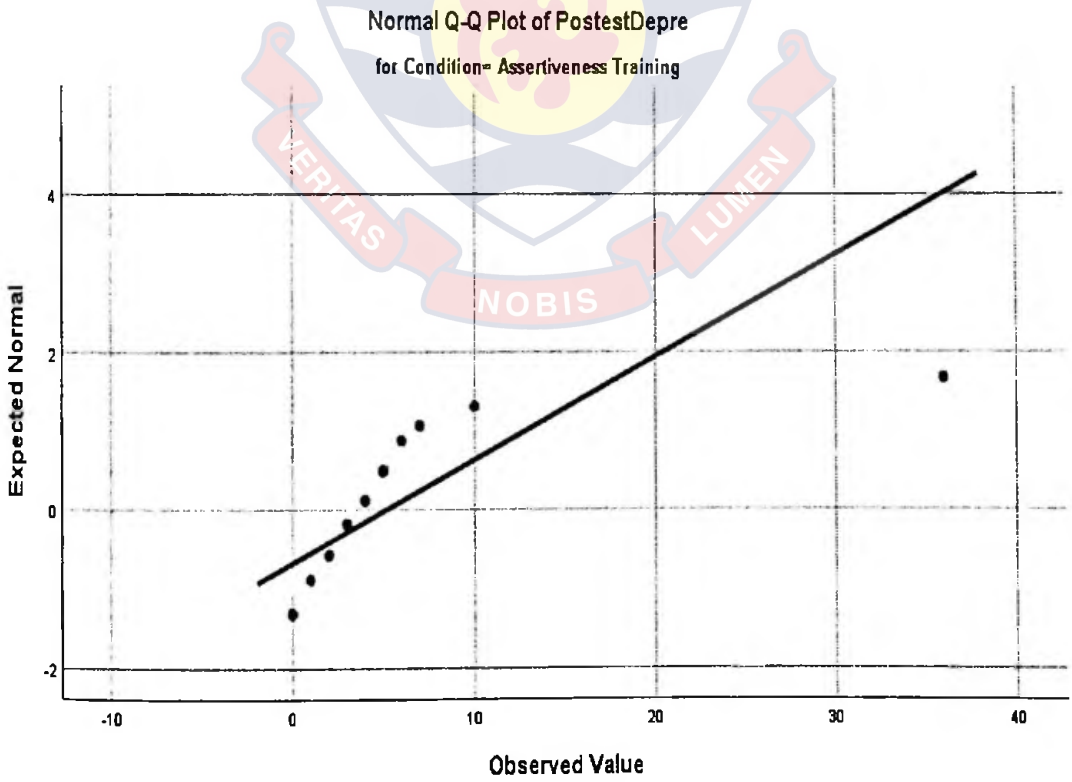


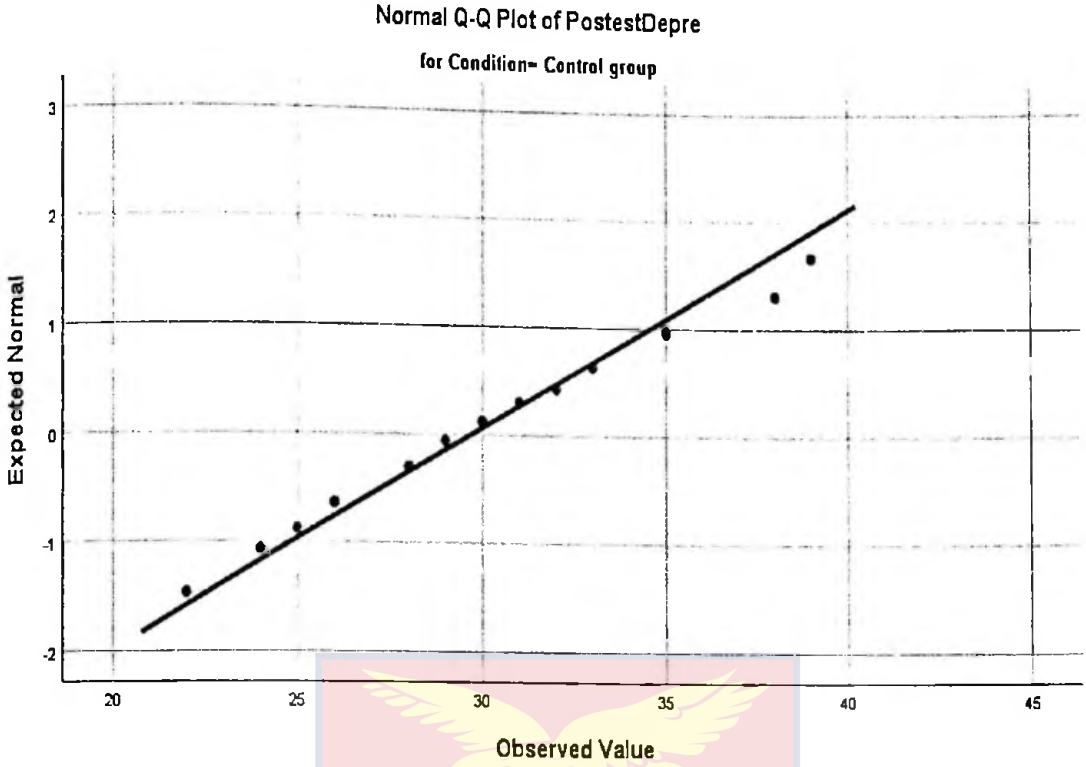


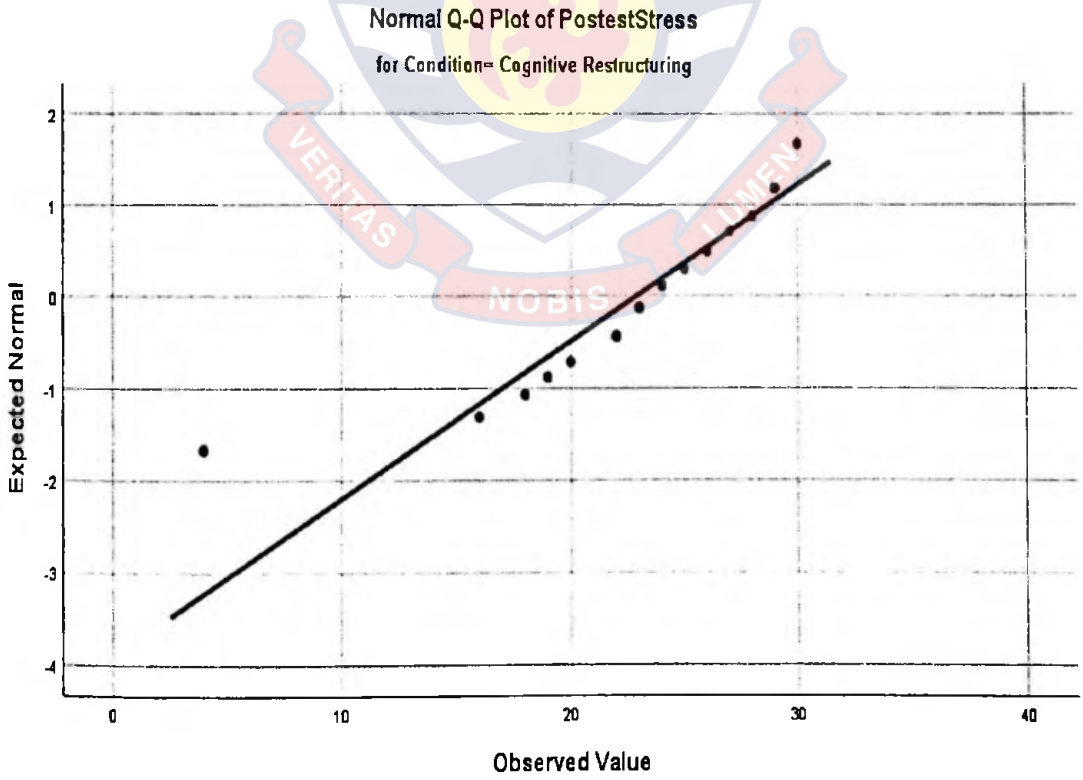


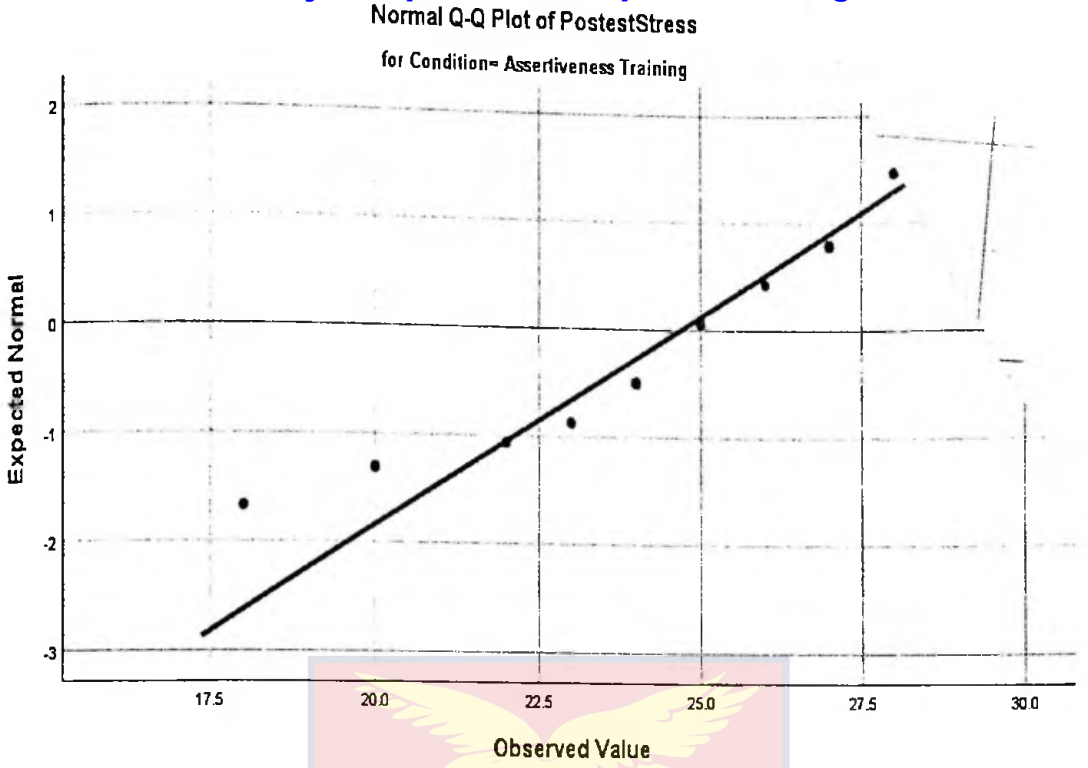


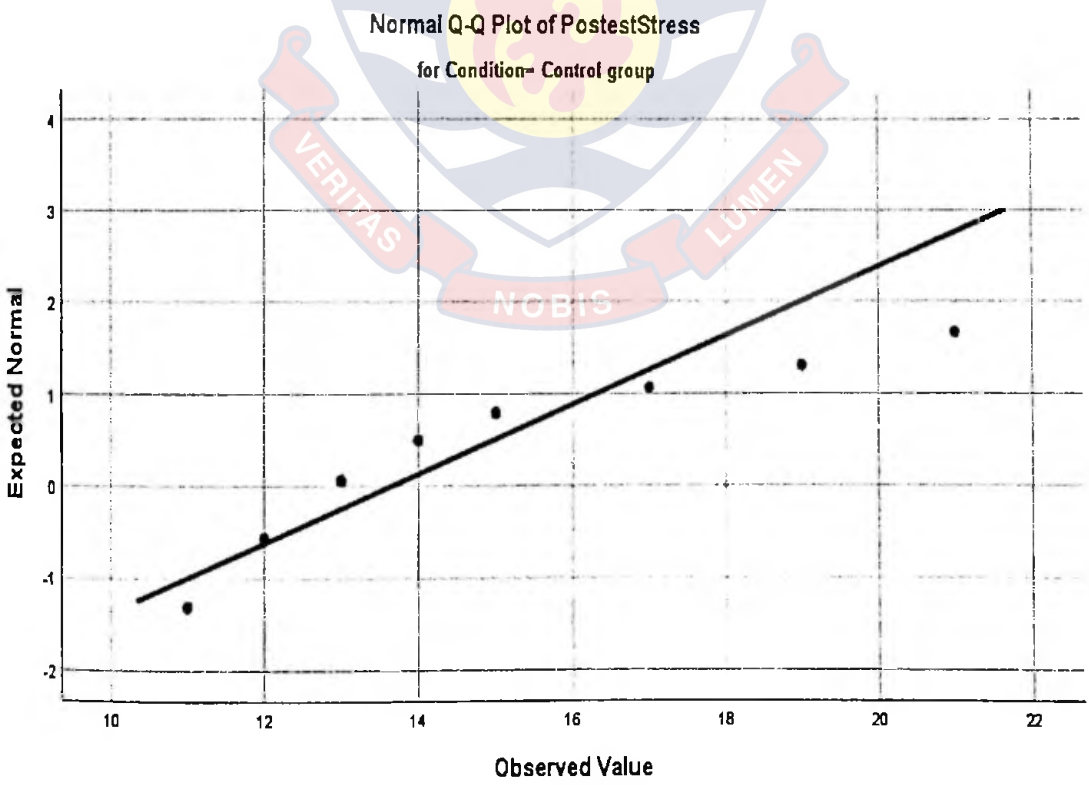












APPENDIX I

ETHICAL CLEARANCE

UNIVERSITY OF CAPE COAST
INSTITUTIONAL REVIEW BOARD SECRETARIAT
TEL: 0558093143 / 0508878309
E-MAIL: irb@ucc.edu.gh
OUR REF: UCCIRB/28/242
YOUR REF:
9TH OCTOBER 2020

Ms. Esther Amprofi Boham
Department of Guidance and Counselling
University of Cape Coast

Dear Ms. Boham,

RE: MODIFICATION OF THESIS TITLE

We write with reference to your letter dated 7th October, 2020 requesting for a modification of your ethical clearance approved topic. This is to inform you that the University of Cape Coast Institutional Review Board (UCCIRB) has given approval to enable you modify your topic from *Effects of Assertiveness Training and Cognitive Restructuring on Self-esteem and Depression among Technical University Students in Southern Ghana* to **Effects of Assertiveness Training and Cognitive Restructuring on Low Self-esteem and Depression among Technical University Students in Southern Ghana.**

On the basis of that:

1. Your approval reference number remains **(UCCIRB/CES/2018/09)**
2. Your research aim and/ or objectives remain the same as earlier approved.
3. Your study setting, sample and sampling procedure remain unchanged.
4. Any modification to the above by you nullifies your ethical approval.

The UCCIRB appreciate your effort and concern for improving and maintaining the rights of research participants.

Yours faithfully,

Samuel Asiedu Owusu, PhD
UCCIRB Administrator

ADMINISTRATOR
INSTITUTIONAL REVIEW BOARD
UNIVERSITY OF CAPE COAST