

SOCIAL ACCEPTANCE AND COGNITIVE-BEHAVIORAL GROUP THERAPY FOR SOCIAL ANXIETY ON FEMALE CHILDREN

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ABSTRACT

As doing successful in every group works needs social acceptance, it was intended to examine the effect of social acceptance on cognitive-behavioral group therapy (CBGT) for female children with social anxiety disorder (SAD) and testing the effect of CBGT on social acceptance. This study was an experimental type. After performing Social Anxiety Questionnaire, clinical interview based on DSM-IV-TR was conducted, and 18 students (nine in each group) were selected in two trial and wait-list conditions using random sampling. Before treatment and after six sessions, the short form of Ohio Social Acceptance Scale was conducted on the experimental group. Also, before and at the end of 12 sessions of CBGT (two hours per session) Social Anxiety Questionnaire was completed in both groups. Data showed that although there is a huge differences among individuals' pre-test to post-test grade of social acceptance ($p < .000$, $F = 46.225$), SAD ($p = .025$, $F = 4.740$), and both of them shown by analysis of variance (ANOVA), covariance (ANCOVA) and multivariate covariance analysis (MANCOVA) that were significant totally, over controlling social anxiety of wait-list condition, covariate F of social anxiety was not significant rather than social acceptance that was significant ($p < 0.05$). Linear regression model reveal that 52% of variance of CBGT on social anxiety can be predicted significantly by social acceptance. Therefore, this study suggested that CBGT was associated with a marked positive response on children with social anxiety by increasing social acceptance that offer some implications for future research on social development and applications for practitioners working with teams.

Keywords: *Social Acceptance, Cognitive-Behavioral Group Therapy, Social Anxiety, Children*

Social anxiety (SAD) is the most prevalent among anxiety disorders, and effects on most areas of functioning, such as work, relationships, and leisure (Bieling et.al, 2006). Its prevalence at the end of childhood on girls is higher than boys, in which that estimates have been shown 2.55 to 16% (e.g., Essau, et.al, 1999). From a cognitive-behavioral perspective, SAD is believed to stem from beliefs that making a good impression on others is unlikely to occur, and that disastrous consequences will ensue (Bieling et.al, 2006). One of the optimal treatments for anxiety disorders is cognitive-behavioral therapy (CBT) and among varies type of CBT, cognitive-behavioral group therapy (CBGT) is the best one that is manufactured by Heimberg and Becker, specially set for social anxiety (Malyani. et.al., 2009). CBGT is included of exposure in sessions, cognitive restructuring, and homework, to help clients to get more satisfaction in their interactions with themselves and others (Heimberg and Becker, 2002). Although several experimental researches had supported the effectiveness of CBT for psychological disorders, from depression and anxiety to personality and psychosis disorders (Bieling, et.al. 2006), little research has done for supporting the effectiveness of CBGT.

Moreover, one of the best studied approaches for treating SAD is group treatment and since doing successful in every group works needs group cohesiveness between their members and for having group cohesiveness, it is necessary to have group association and then social acceptance (Bieling, et.al. 2006). Etymologically, social acceptance means "the numbers of choices that are based on a criterion of a person are acted" (Zaery, 2005). At the level of the group, children's peer relationships can be characterized in terms of likeability or social acceptance by other group members (e.g., popularity or rejection), in terms of visibility or salience in the group, how connected they are to the other children in the group (e.g., network centrality), their dominance in the group hierarchy, their "reputation" or how they are perceived

Research Article

by their peers, or in terms of the larger social networks in which they move and with which they identify. Peer acceptance is distinct from other aspects of peer functioning, most notably friendship and social network participation (Gifford-Smith and Brownell, 2003). In fact, acceptance emphasizes the admitting of negative thoughts and feelings rather than attempting to change their content may be particularly helpful, especially when conducted within the context of exposure-based treatments. In addition, clients with anxiety disorders typically engage in a range of avoidance behaviors, and consequently are cautious to engage in exposure-based treatments that target avoidance and encourage them to experience fear. Typically, acceptance that foster willingness to engage in fearful situations and target avoidance of the experience of anxiety instead of reducing the anxiety itself may increase receptiveness to engage in exposure therapy (Dalrymple, 2005). The CBT group therapist can use a number of strategies to increase cohesiveness (or/and social acceptance) such as: a) increase homogeneity of the group in pre-group selection, b) encourage consistent attendance, c) Provide a safe environment for self-disclosure, largely through modeling of acceptance, empathy, and helpful feedback, d) promote sharing of information, e) make connections between two or more group members' experiences, f) attend to group process in the here and now (Bieling, et al, 2006, p.31).

With respect to age and gender differences, Phillipsen (1999) demonstrated early-adolescent friendships were coordinated and self-disclosing more than were middle-childhood friendships. Girl/girl dyads made fewer suggestions, requests, and had fewer disagreements than did boy/boy dyads. High-accepted dyads were positive, coordinated, and sensitive more in their interactions, and they disagreed less than did low-accepted dyads. Students' reports of friendship support and satisfaction or conflict varied with age and gender.

There is evidence that suggested near relationship is related to social acceptance (Gifford-Smith and Brownell, 2003) and cognitive-behavioral therapy outcomes (Fogler, et al, 2007). In addition, Students with higher levels of social anxiety usually are more rejected from other students frequently nominated by their peers as being anxious and showing a more negative and less positive mood. Peer reports show that socially anxious students display behaviors (such as, frequent signs of bad mood and sadness, and constant worries and fears in social contacts) which place them at risk for lower peer acceptance and internalized symptoms (Levpušček and Berce, 2012). Taube-Schiff et al., (2007) declared that group cohesion ratings significantly increased over the course of CBGT for social phobia and were associated with improvement over time in SAD symptoms, as well as improvement on measures of general anxiety, depression, and functional impairment. Research in female adult samples has shown that CBGT must be efficient on SAD and can improve social skills like other methods such as supportive psychotherapy or medicine (e.g., Malyani, et al, 2009).

Concerning the high prevalence of children with social anxiety who wouldn't be able to enter in the life span because of self-assertiveness deficiencies and social phobia, the treatment of such problems can be a hopeful point of view for future in the field of scientific, psychological and social, or perhaps, with this solution people can improve their abilities in social development. Moreover, one of the best modern psychological treatments is CBGT that the limited research on predicting treatment outcome has typically been examined in children and adolescents with heterogeneous anxiety disorders and offers mixed results by other factor variables have been made a limitation in internal investigation of this area. Although research has consequently pointed out the importance of change processes by some factor variables (e.g., near relationship, group cohesion, etc.) during treatment for outcome measures, the effect of social acceptance during treatment as a potential moderator or mediator for treatment outcome in children suffering from social anxiety disorder is not yet well understood. Accordingly, the purpose of the present study is to specifically examine the role of social acceptance as a predictor of outcome in a homogenous sample of children with SAD: (1) effect of CBGT on SAD and social acceptance; (2) role of social acceptance (mediator or moderator) in effect of CBGT on SAD; (3) effect of social acceptance on the changes in children's social anxiety during CBGT (pre-test and post-test).

Research Article

At the other hand, a number of psychiatrists, psychologists, and coaches need accurate information about identifying such a predictor of a result of CBGT on SAD to improve clinical interventions, and invention of the best psychological techniques to remedy disorders and maintain mental balance in challenge time and unpredictable situations and/or cause heightening healthy. So, it remained to answer this question, whether social acceptance is effective on the potential changes as a result of cognitive-behavioral group therapy for female children with SAD.

METHODOLOGY

The Statistical community is all fifth-grade elementary female students in 2010-2011. As cultural differences has impact on social reactions (Lampert, Isaacson, & Lyttle, 2010), as well as gender differences (Phillipsen, 1999), to control some variables from social, cultural, and sexual differences, the statistical sample was limited to fifth-grade elementary girls in Jahrom city. With respect to the sample number in cognitive-behavioral group therapy, Heimberg and Becker (2002) have believed that the ideal group size for CBGT is six clients. This number is small enough to apply the frequent individual's attention. With six clients, each client can be under the focus of the group's effort at least one time in each session. With each additional client, this becomes increasingly more difficult to accomplish. In addition, six clients will prevent leaving during any sessions. Starting a group with fewer clients may increase the probability that size group may drop too low or the remaining group members may become discouraged. However, Bieling et al. (2006) believe that, in their group, they typically aim to have five to seven patients per group because in their experience, participants in larger groups tended to feel more socially-inhibited and had higher rates of drop- out early during the treatment, and may not get adequate attention during the session. By paying attention to the expectancy of the drop-out rates in treatment, 10 members were selected for experimental group and nine members were selected for wait-list condition randomly, and after administrating the CBGT, one subject from the treatment group was missed out of her absence more than three times during the sessions.

A therapist with MA degree in Clinical Psychology was the leader in CBGT that had passed required courses and had experiences about CBT. According to Heimberg & Becker (2002) and Bieling et al. (2006), it is nice to have help-therapist in CBGT, but it is not necessary. By the way, the leader could be able to handle sessions alone very well.

In this study, the utilized method was from random combinatory sampling (cluster random sampling and simple random sampling). In other words, at first from all areas of Jahrom city (city located in south part of Iran) including central and countryside, five elementary female schools randomly were selected. Then, Social Anxiety Questionnaire was administrated to all the fifth-grade students from those five schools, and those students who were reported getting high rate of SAD were chosen. After that, we ask them whether their parents allow them to participate in psychotherapy; they should return the acceptance list. Afterwards, 19 students returned their acceptance list. Clinical interview based on DSM-IV-TR was conducted and 19 students (nine in each group) were set into two groups randomly and determined treatment and control groups by chance. Members of both groups notified their satisfaction from the very beginning of this project-therapy design, and the information about the subjects was recorded in their files and was available only for the group therapists. Social Anxiety Questionnaire and the short form of Ohio Social Acceptance Scale were administrated on both of groups. The trial group was participated in cognitive-behavioral group therapy for 12 sessions (2hours per session). After six sessions, only experimental group have completed the short form of Ohio Social Acceptance Scale, whiles both of two groups, before and after the CBGT program have completed Social Anxiety Questionnaire.

Instruments

The short form of Ohio Social Acceptance Scale: This scale was developed by the Evaluation Division of the' Bureau of Educational Research at Ohio State University with the cooperative efforts of a group of

Research Article

elementary teachers in Ohio. The short form of this scale consists of three weighted paragraphs designed to represent a continuum from very close friendship to a very definite rejection scored from 1-3. When the items describe defective performance, the scoring is reversed. This research tool is 18-item/paragraph self-report questionnaire involves measures of interpersonal attitude and feelings that are irrespective of a specific functional-type criterion for higher than 5-6 years, and applicable individually and in groups. The test-retest reliability of this questionnaire for one week was $r=.74$ and for 8 month in girl students was $r=.65$. Eugene Byrd (1951) that searched about validity and reliability of this scale on nine years-old children after 8 weeks has express that the relationship between the choice of a person over group evaluation and her/his real choice when each child was let to choice her/his playmate was $r=.76$ and when they force children to play with each other in class was $r=.80$ and the relationship between first and second tests was $r=.89$. There was not any statistical difference between the correlations. It is noticeable that the level of choices validity was undoubtedly higher than the real choices and those were measured with unique criterion (Zaery, 2005). In the present study, data were indicated high level of Cronbach's alpha (.59) and split-half (.926) reliability coefficients of the short form of Ohio Social Acceptance Scale, totally.

Social Anxiety Questionnaire: This questionnaire is applicable individually and in groups, and running it takes about 25-15 minutes. It has 3 subscales of social phobia, social interaction and maladaptive behavior, and 19 items to determine the presence of DSM-IV diagnoses of SAD disorder for the people with higher than 10 years old. Students read each item and rank their agreement due to their health on a scale of 5 Likert states that can be calculated as a classification and quantification statistical way, which is arranged in a class of "never" to "always" degree scored across 1 to 5. It is claimed that validity and reliability of this questionnaire is acceptable (Masan Abadi, 2010). Studies have shown that Cronbach's alpha coefficient for the total scale was about .932. They indicated high level of test-retest (.932) and split-half (.929) reliability coefficients of Social Anxiety Questionnaire totally. Convergent validity of this scale was measured with SPAI was significantly correlated ($r= .75$; e.g., Shafiey, 2008).

Procedure :

Among most popular treatments, cognitive-behavioral group therapy (CBGT) which is made by Heimberg and Becker, is a group-oriented intervention that is designed for social anxiety dysfunction in which the cognitive restructuring is done in the field of artificial exposure practices (Maliany, et.al, 2009) while the present research has focused on it used from experimental method by pretest - posttest with control group design. At first, Social Anxiety Questionnaire and the short form of Ohio Social Acceptance Scale were administrated on both experimental and control groups. Then, clinical interview based on DSM-IV-TR was conducted on both of them. Afterwards, by contributing of principals, moderators, and fifth-grade school teachers, the ability of subjects to contribute with group and how it would be administrated the group sessions was evaluated from time to frequency of the sessions. At the first of 12 sessions, the leader told about how the group would be handled and group's equipment was explained, and all the participants guaranteed the secrecy of considered issues in the group (secrecy principle). The blackboard and slide show was used to help education of issues to group members to better understanding. The total plan was as:

During the first 20 minutes of each session, the previous session homework was checked and the problems of members were solved. After that, one hour was dedicated to cognitive part of each session, means learning and practicing cognitive restructuring, 10 minutes rest, and the last 30 minutes of the end of each session were dedicated to behavioral part of each session and practicing while at the final seconds, it was dedicated to summation and assigning the next session homework.

After 6 sessions, the short form of Ohio Social Acceptance Scale was conducted on the experimental group and at the end of 12 sessions of cognitive-behavioral group therapy (two hours per session), the

Research Article

Social Anxiety Questionnaire was performed and some gifts were donated to active participants (for incentivizing of participants). Outline of the meetings is as follows:

Session I: (a) Member's introduction and explanation of group rules, the program developed for the group, briefly describing the problem and the aim of each member for participation, representing clients' expectations of treatment outcomes; (b) Brief presentation of cognitive-behavioral model and ABC model, exercising relaxation through guided mental imagery.

Session II: (a) Presentation of emotional disturbance and cognitive restructuring theories, and ten styles of thinking with cognitive errors, the classification of beliefs and thought processes, rest; (b) Exercising relaxation through guided mental imagery.

Session III: (a) surveying the behavioral consequences of beliefs, training of induction thinking, analysis of vertical downward arrows, rest; (b) Practicing relaxation through guided mental imagery.

Session IV: (a) Advanced analysis of vertical downward arrows, content classification based on the totality of beliefs, rest; (b) Practicing relaxation through guided mental imagery.

Session V: (a) Preparing the original list of beliefs, cognitive maps, rest; (b) Exercising relaxation through guided mental imagery.

Session VI: (a) Variability of beliefs, objective analysis of beliefs, analysis of standard beliefs, rest; (b) Practicing relaxation through guided mental imagery.

Session VII: (a) Analysis of efficacy of beliefs, analysis of belief's harmony, rest; (b) Conference presentations, role playing in social situations, providing the feedback-oriented and focused on active listening techniques.

Session VIII: (a) Analysis of rational beliefs, rest; (b) Conference presentations, role playing in social situations, providing the feedback-oriented and focused on active listening techniques.

Session IX: (a) Create a hierarchy of anxiety, opposite thinking, rest; (b) Conference presentations, role playing in social situations, providing the feedback-oriented and focused on assertiveness and decisiveness techniques.

Session X: (a) Perception changes and cortical voluntary inhibition technique, rest; (b) Conference presentations, role playing in social situations, providing the feedback-oriented and focused on assertiveness and decisiveness complementary techniques.

Session XI & XII: (a) Self-punishment / self-rewarding, long-range changes, review and overview of recent discussions, exercises and discussion of difficult issues for members of this group, the overall content and presentation of strategies for continuing treatment after finishing the group therapy, Rest; (b) Conference presentations, role-playing and providing the feedback-oriented focused on the overall content, plan review (final summation), polling from members and give a suggestion, survey the aim of members at first session and the level of realization them, oral and written feedback from strong and weak group points, Preparing the group to finish the treatments, the closing.

To calculate the effect of social acceptance in cognitive-behavioral group therapy (CBGT) for female children with social anxiety, it was used from SPSS software to assess Kolmogorov-Smirnov test, regression, analysis of variance (ANOVA) covariance (ANCOVA), and multivariate covariance analysis (MANCOVA), etc.

RESULTS

Findings:

Kolmogorov-Smirnov test is used and approved the normality of data curve. The descriptive statistics showed that there is a huge differences among individuals' pre-test to post-test grade of social acceptance as social anxiety than wait-list condition that can be seen in table (1).

Research Article

Table (1): Descriptive statistic

group	style	statistics	SAD	Social acceptance
Experimental group	Pre-test	Mean	37.56	14.44
		Std. Deviation	5.13	1.33
	Post-test	Mean	28.89	24.00
		Std. Deviation	6.74	4.00
Wait-list condition	Pre-test	Mean	38.56	
		Std. Deviation	5.81	
	Post-test	Mean	43.00	
		Std. Deviation	8.35	

The difference between pre-test and post-test of social acceptance ($p < .000$, $F = 46.23$), SAD ($p = .025$, $F = 4.74$), and both of them shown by ANOVA, ANCOVA, and MANCOVA were significant (see table 2). In the process of MANCOVA, Wilks Lamda for style (pre-test, post-test; $p < .000$, $F = 41.12$) was significant rather than SAD score of control group ($p = .11$, $F = 2.63$). However, it confirms the effectiveness of Cognitive-Behavioral group therapy on social acceptance and SAD. Covariate F related to controlling SAD by Social-acceptance and SAD scores of control group ($p = .046$, $F = 3.43$) is lower than one without controlling Social-acceptance ($p = .025$, $F = 4.74$). So, it can be claimed that Social-acceptance has a moderator role in effectiveness of CBGT on female youth with SAD. It is notable that Leven test of equality of error variances was not significant at all kind of analysis of variance that confirms the equality of variances.

Table (2): The effectiveness of CBGT on social- acceptance and SAD

variables		Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Dependent	Control						
SAD (experimental)	SAD (control)	352.82	2	176.41	4.74	.025	.387
Social-acceptance	SAD	410.89	1	410.89	46.23	.000	.743
Social-acceptance SAD (experimental)	SAD (control)	449.67	2	224.84	32.60	.000	.813
		352.82	2	176.41	4.74	.025	.387
SAD (experimental)	SAD (control) Social-acceptance	386.25	3	128.75	3.43	.046	.424

Linear regression model (table 3) reveal that correlation between the results of CBGT for SAD and social acceptance in the pre-test (.068) is significantly fewer than post-test (.759) while it indicate that 58% of variance of CBGT on SAD can be predicted by social acceptance that can be reduced to 52% in statistical community that is significant at the level of $p < .02$ than did either in pre-test ($p > .86$). Since the results of Durbin-Watson is among 1.5 - 2.5, it could be resulted the independence of social acceptance scores from standardized or unstandardized error. Table (3) shows that the ratio of F is not significant related to the squared correlation ($R^2 = .005$) between the results of CBGT for SAD and social acceptance in the pre-test ($p = .862$, $F = .033$). However, F ratio for demonstration of the squared correlation ($R^2 = .575$) between the results of CBGT for SAD and social acceptance in the post-test ($p = .018$, $F = 9.486$) is significant and post-test social acceptance can predict the result of CBGT on SAD.

Research Article

Table (3): Linear regression model of the effect of Social acceptance in CBGT on SAD

Independent variable	Dependent variable	style	R	R ²	Adjusted R ²	Std. Error	Change Statistics					Durbin - Watson
							R ² Change	F Change	df 1	df 2	Sig. F Change	
Social acceptance	SAD of control group minus of experimental one	Pre-test	.068	.005	-.138	10.26	.005	.033	1	7	.862	1.67
		Post-test	.759	.575	.515	7.32	.575	9.49	1	7	.018	2.45

By one glance to the table (4), it would be realized that unstandardized coefficient (Beta) of social acceptance is -1.992, and the width of its origin is 61.924. So, the regression equation to predict the results of CBGT on SAD by social acceptance score is as follows:

Predicted score of SAD = 61.924 + (-1.992 × X1)

Note: X1 = the individual's social acceptance

In addition, table (3) shows that for every one unit of changes in standard deviation of social acceptance, -0.759 units of standard deviation scores of post-test SAD score would be changed as a result of CBGT. In other words, the impact factor of post-test social acceptance on the results of CBGT for SAD is B= -.759, and significant at p=.018, that is higher than pre-test one (B=-.068, p=.862).

Table (4): Regression Coefficients of the effect of Social acceptance on CBGT on SAD

Style	Model	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
pre	(Constant)	8.109	39.44		.206	.843
	Social acceptance	-.492	2.72	-.068	-.18	.862
post	(Constant)	61.924	15.71		3.94	.006
	Social acceptance	-1.992	.65	-.759	-3.08	.018

a. Dependent Variable: SAD of control group minus of experimental one

DISCUSSION

The aim of the present study was to investigate the reciprocal effect of social acceptance and cognitive-behavioral group therapy for social anxiety. In general, the social acceptance is associated with a marked positive response on a cognitive- behavioral group therapy cognitive- behavioral group therapy for social anxiety, as well as CBGT on social acceptance that means accordance with the general research hypothesis, one of the therapeutic variables effect on each group therapy, especially on CBGT is social acceptance. It may because of as Bieling, McCabe and Antony (2006) had told, social acceptance increases psychological flexibility by helping clients contact the costs of psychological inflexibility, and then establishing psychological acceptance skills, establishing cognitive deficiency skills, distinguishing self-as-context from the conceptualized self, contacting the present moment and establishing self-as-process skills, distinguishing choice from reasoned action (necessary to avoid values clarification from becoming excessively rule-governed), clarifying values, and distinguishing them from goals and actions, and teaching committed behavioral persistence and behavioral change strategies linked to choosing values. Therefore, CBGT consists of encountering in meeting, perceptive reconstruction, and some assignments would impact on social anxiety by increasing the numbers of choices that are based on an active nonjudgmental embracing of social experience.

In addition, this experimental study indicated that children with a principal diagnosis of SAD benefited from CBGT group program and this finding supported some researches on adults (e.g., Heimberg, et.al, 1998) while added that it is also effective on children that is because of CBGT can improve social,

Research Article

cognitive and behavioral skills of clients, and so it causes the treatment of SAD (Bieling, et.al, 2006). Furthermore, as Taube-Schiff et al., (2007) declared that group cohesion ratings significantly increased over the course of CBGT for social phobia and were associated with improvement over time in social anxiety symptoms, the results stepped up and pointed out that CBGT is associated with a marked positive response on children' social acceptance while social acceptance has a moderator role in effectiveness of CBGT on SAD. There is some evidence that cooperative techniques improved social acceptance as a reduction of negative choice (Gifford-Smitha and Brownell, 2003) while several cooperative techniques (e.g., role playing, providing the feedback-oriented, etc.) apply in CBGT based on Heimberg's model. Furthermore, high-accepted dyads are positive, coordinated, and sensitive more in their interactions, and they disagree less than do low-accepted dyads (Phillipsen, 1999). Therewith, improving such a good characteristics make a context to help treating marked and persistent fear of one or more social or performance situations in which the position(s) concerned with the assessment of the patients with negative overview or be critical glance by others.

As Fogler, Tompson, Steketee, & Hofmann (2007) clarified that near association is related to cognitive-behavioral group therapy outcomes, and Levpušček and Berce (2012) revealed that the most socially anxious students are belonged to the sociometric group of rejected students, and have a lower degree of acceptance by their classmates, our results showed that there is a significance relationship between the results of CBGT for SAD and social acceptance at the 6th session while 52% of variance of CBGT on SAD can be predicted by social acceptance at the middle of 12-session CBGT. Moreover, social acceptance has a marked impact factor ($B=-.759$) on social anxiety during the course of CBGT. It seems that acceptance of negative thoughts and feelings rather than attempting to change their content may be particularly helpful, especially when conducted within the context of exposure-based treatments; because it foster willingness to engage in fearful situations and target avoidance of the experience of anxiety instead of reducing the anxiety itself may increase receptiveness to engage in exposure therapy (Dalrymple, 2005). So, the third research hypothesis was conformed that told social acceptance is effective on outcomes of CBGT for SAD.

A possible limitation of the present study is represented by the use of a self-report questionnaire to assess social acceptance, potential self-report bias and social desirability bias might have occurred. Nevertheless, the results of this study were derived from small, specific populations and sample size that threatening external validity or generalize. Future work is needed to replicate the present findings in larger sample size utilizing randomized controlled comparisons. Further research may isolate psychological factors as psychotherapist instrumental targets in the management of SAD and other psychological disorders to heightening healthy and protecting special talent against a development towards frustration. Hence, it would be suggested to generalize the results of the present study, it is necessary to investigate on children and adolescents with SAD and other disorders across ages and gender. In addition, further investigation of this area on other factors that contribute to the efficacy of cognitive-behavioral group therapy -such as the effectiveness of the effects of group members' symptoms on one another, the effects of group members' personality styles on one another, the effects of improvement/worsening in one group member on the others, the ways in which group members interact with one another, the therapeutic relationship between the therapist and group (e.g., whether they like and trust one another), the therapeutic relationship among group members (e.g., whether they like and trust one another), the therapeutic relationship between co-therapists (if co-therapist is present), the effects of dropout and absenteeism on the group, the effect of individual variables on the group: patient expectations, patient satisfaction with treatment, patient variables that predict outcome, patient suitability for group treatment, and group mechanisms of change: inspiration, inclusion, group learning, shifting self-focus, group cohesiveness, emotional processing in the group setting and so on- would provide a basis for assessing the suitability of the incentive-based clinical interventions to maintain healthy behavior changes.

Finally, present research provided a general framework about social acceptance for the study of clinical psychotherapy in the scientific areas. In addition, this study is comparable to previews studies using

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homogenous sample of children with SAD to predict a special factor on the result of CBGT, has provided scholars in the areas of pathological, clinical, personality, positive, and social psychology and has implications of the unique contributions of complementary and supplementary feature of situational inducements and their interaction on remedy SAD, is that, the common clinical practice, of helping patients by mental practice to improve their functions might not be optimal practice regardless to social acceptance. It seems that the role of social acceptance to dominate the overall adaptive approach and heightening healthy by helping remedy of SAD and perhaps other disorders is clear. Other predictors require more careful empirical research, but the general framework of social acceptance seems to provide a useful way in describing the effectiveness of CBGT on SAD. Therefore, another practical and theoretical work to be done while the current models and frameworks are productive and contribute to research in childhood context and should be useful both theoretically and clinically.

CONCLUSION

This study demonstrated that CBGT is associated with a marked positive response on children with social anxiety by increasing social acceptance. So, social acceptance must be one of the predictor factors in the effect of cognitive-behavioral group therapy on female children with social anxiety. Exactly, it can significantly predict 52% of variance of CBGT on social anxiety which may have implications for clinical therapy in remedy social anxiety disorder. Further study is necessary to examine potential underlying mechanisms and future possible clinical applications in the prevention and treatment of SAD related to social acceptance.

REFERENCES

- Bieling P.J., McCabe R.E., & Antony M.M., (2006).** Cognitive-behavioral therapy in groups. New York: Guilford Press; 3(pt2): 190-215
- Dalrymple K.L, (2005).** Acceptance and Commitment Therapy for Generalized Social Anxiety Disorder: A Pilot Study. A Thesis Submitted to the Faculty of Drexel University in partial fulfillment of the requirements for the degree of Doctor of Philosophy.
- Essau C.A., Conradt J., Petermann F., (1999).** Frequency and comorbidity of social phobia and social fears in adolescents. *Behav. Res. Ther.*, 37(9): 831±843.
- Fogler J. M., Tompson M. C., Steketee G., & Hofmann, S. G., (2007).** Influence of expressed emotion and perceived criticism on cognitive-behavioral therapy for social phobia. *Behav. Res. Ther.*, 45: 235–249.
- Gifford-Smitha, M.E., Brownell, C.A., (2003).** Childhood peer relationships: social acceptance, friendships, and peer networks. *J. School Psychol.* 41(4): 235–284.
- Heimberg R.G., Becker R.E., (2002).** Cognitive-behavioral group therapy for social phobia: basic mechanisms & clinical strategies Treatment. New York: Guilford Press.
- Heimberg R.G., Liebowitz M.R., Hope D.A., Schneier F.R., Holt C.S., Welkowitz L.A., Juster H.R., Campeas R., Bruch MA., Cloutre M., Fallon B., & Klein, D.F., (1998).** Cognitive Behavioral Group Therapy vs. Phenelzine Therapy for Social Phobia 12-Week Outcome. *Arch. general Psychiat.*, Vole 55: 1133-1141.
- Herbert J.D., Gaudiano B.A., Rheingold A.A., Moitra E., Myers V.H., Dalrymple K.L., & Brandsma L.L., (2009).** Cognitive behavior therapy for generalized social anxiety disorder in adolescents: A randomized controlled trial. *J. Anxiety Disord.*, 23: 167–177.
- Lampert MD, Isaacson KL, & Lyttle J. (2010).** Cross-cultural variation in gelotophobia within the United States. *Psychol. Test. Assess. Model*; 52(2): 202-216.
- Levpušček, M.P., Berce, J., (2012).** Social anxiety, social acceptance and academic self-perceptions in high-school students. *Drustvena Istrazivanja*, 2(116): 405-419.
- Madden, Nancy A., and Slavin, Robert E., (1983).** Effects of Cooperative Learning on the Social Acceptance of Mainstreamed Academically Handicapped Students. *J Spec Educ.* 17(2): 171-182.

Research Article

Maliany M., Shaeiri M.R., Ghaedi G.H., Bakhtiari M., tativoli A., (2009). Effectiveness of Cognitive-Behavioral group therapy according Heimberg model to in decreasing of social anxiety syndrome. *J.Psychiat.Clin.Psychol.*, 1(15): 42-49.

MasanAbadi T., (2010). The survey of Actualizing & validity; reliability & modeling of Social Anxiety Questionnaire in student of Tehran high school. Thesis for perception of Master degree of psychometrics major in Central Tehran Azad University.

Phillipsen L.C., (1999). Associations between Age, Gender, and Group Acceptance and Three Components of Friendship Quality. *J. Early Adolescence.*, vol. 19, no. 4: 438-464.

Shafiey N., (2008). Normalization of Social Anxiety Inventory among students in Mashhad city. Thesis for getting master degree in Allame Tabatabaey University.

Taube-Schiff M., Suvak MK., Antony MM., Bieling PJ., & McCabe RE., (2007). Group cohesion in cognitive-behavioral group therapy for social phobia. *Behav. Res. Ther.*, 45: 687–698.

Zaery M., (2005). The survey of relationship between group acceptance and social skills with birth order in high school boy students of Tehran in 15th area. Thesis of M.A. in counseling of Rudehen Azad University.