choose courses of action that will help them connect with people in their lives that they want to be connected to.

Through teaching and practicing the concepts of Reality Therapy and Choice Theory, adolescents were encouraged to be active participants in modifying less effective thought patterns (through increasing cognitive reappraisal) and avoidance/safety behaviors (decreasing emotional suppression) that may give them relief in the short term but are maladaptive in the long term. Various strategies and interaction patterns in Reality therapy are all seen to be interventions that will help facilitate the change: first, the relationship-building aspects of the activities can enhance their positive view of social situations; and second, specific interventions such as altering total behavior patterns, engaging in self-evaluation through facilitator questioning, group sharing, and individualized creation of doable plans based on individual needs.

Method

This section describes the research design used for the study, the profile of the participants, instruments used and procedures in data gathering and analysis.

Research Design

This study was a mixed-method design, specifically, a concurrent triangulation design as described by Hanson et al. (2005). In this design, both the qualitative and quantitative data collected are given equal priority, and interpretation rests on finding out the extent to which the data converge or triangulate. Given the nature of the study which is an intervention, both methods helped shed light on the outcomes and nuances of intervention effects.

The qualitative method used for process data was Consensual Qualitative Research (CQR) (Hill, 1997). This method falls within the postpositivist and constructivist paradigm, which is ideal for understanding psychotherapy processes, as it employs the use of consensus

by a team of researchers (postpositivism) in plumbing the depth and richness of qualitative data (constructivism) (Ponterotto, 2005).

CQR has several important components (Hill, 2012) that makes it a rigorous method. CQR is considered inductive thereby allowing for results to arise from the data. The use of open-ended questions allows participants to respond to the topic freely without the constraints of questionnaires, and the researcher derives meaning emerging from the words, narratives, and stories while also understanding the participants' contexts. Another important component of CQR is the use of small samples that can provide rich and insightful experience of a topic. Recognizing the potential biases that can emerge from researchers' meaning making of people's stories, CQR uses multiple perspectives via a team of qualified judges to make sense of the complexity of the data and an auditor/auditor for checks and balances of the team's perspectives of the data. The consensus process is a crucial part of CQR, where the team of judges look at the data independently and then come together to discuss and agree on how the data can best be represented. This ensures that the interpretation of the data is more thorough and precise. CQR also emphasizes how data was gathered, for data collection and analyses to be ethical, trustworthy, and attentive to cultural context. Finally, CQR requires constantly going back to the raw data (interview of participants) to resolve disagreements among judges' interpretation of data and provide clarity at each step of the process.

For this research, quantitative data was gathered which, according to Hill et al. (2005) can be used to triangulate qualitative data. A repeated measures design was used to study the emotion regulation outcomes, specifically changes in Cognitive Reappraisal and Emotional Suppression, using the Emotion Regulation Checklist for Children and Adolescents (ERQ-CA). The measure was done at three time points. The first time point was measured upon enrollment of the participant to the program as baseline, the second time point was measured on the day up to a week after the last online group therapy session, and the third time point

was measured a month after the last group therapy session, to note if the session effects if any

we maintained up to that point. Figure 3 outlines the flow of data gathering and analysis.

Figure 3

Flow of Data Gathering and Analysis
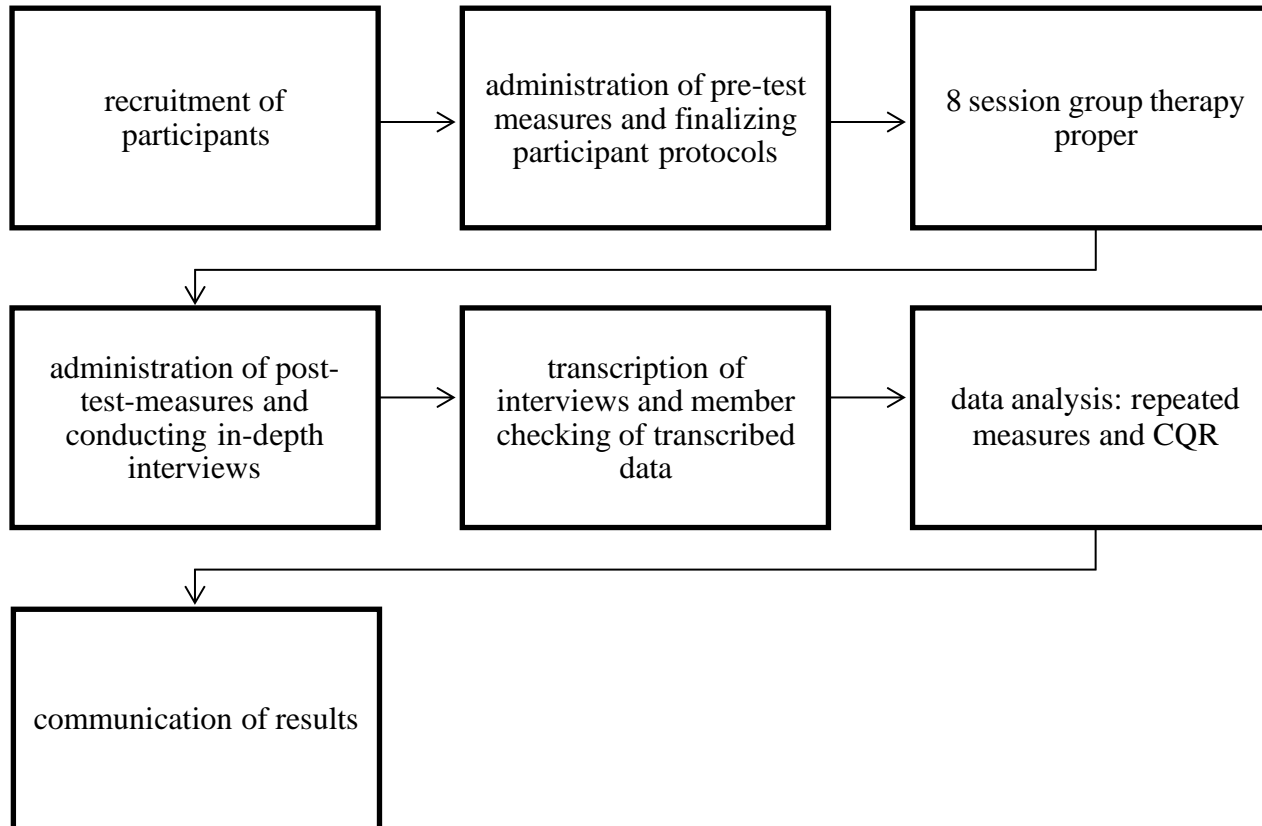
Participants

Participants were drawn from a volunteer, non-clinical sample of Filipino female adolescents enrolled in private schools who were between the ages of 15 to 18. They were recruited through announcements coursed through their schools. Inclusion criteria for participation were as follows: (1) female, (2) between the ages of 15-18, (3) obtaining scores equal to or above 50 in the Social Anxiety Scale for Adolescents (SASA) (4) willing to undergo treatment and assessment and have adequate internet capacity and privacy.

Exclusion criteria were as follows: (1) those who are below 15 and above 18 years old and (2) going through psychotherapeutic or psychopharmacological treatments during the course of the research. However, those who have completed their treatments can be included in the selection process.

The final group was composed of 11 female adolescents. Four of the participants came from the NCR, five participants were from Luzon, and two were from the Visayas. Initially, there were 14 adolescents who signed up, but two backed out prior to the start of the group sessions while one dropped out and was lost to follow up after joining the first two sessions. There were numerous failed attempts to contact the participant who dropped out, and she was not heard from again, and thus, her reason for dropping out could not be ascertained.

Measures

Two scales were administered prior to the sessions – the Social Anxiety Scale for Adolescents (SAS-A) and the Emotion Regulation Questionnaire for Children and Adolescents (ERQ-CA). These measures were again administered on the last session day, and then one month post-treatment.

Emotion Regulation Questionnaire for Children and Adolescents (ERQ-CA)

This is based on the ERQ (Gross & John, 2003) which has 10 items that assess the emotion regulation strategies of cognitive reappraisal (CR) (six items) and emotional suppression (ES) (four items) (Gullone & Taffe, 2011). There is no ERQ-CA total score. For the two items (i.e., CR and ES), each item is scored on a 5-point Likert scale (1 – strongly disagree to 5 – strongly agree). Range of scores is from 6 to 30 for CR and 4 to 20 for ES. Higher scores mean greater use of the particular ER strategy (Gullone et al., 2010). The ERQ-CA is reported to have good internal consistency (α = .83 for Reappraisal, .75 for Suppression) and 12-month test-retest reliability (r = .40 for Reappraisal, .57 for Suppression), construct validity that is invariant across age and sex groups, and has adequate convergent validity (Gullone & Taffe, 2011).

Social Anxiety Scale for Adolescents

This scale was used for this study's purposes, to be able to include or exclude participants from the study. The SAS-A is a self-report measure, which looks at adolescents' feelings related to social anxiety (La Greca & Lopez, 1998). It has 18 items and 4 filler items. Adolescents fill up a 5-point Likert scale corresponding to degree with which they believe each item characterizes them (1 – not at all to 5 – all the time). Several studies have demonstrated good reliability and validity for the SAS-A (Erath et al., 2007; Inderbitzen-Nolan & Walters, 2000; La Greca & Lopez, 1998; Storch et al., 2004). It has three subscales with good internal consistency and 2-month test-retest reliability: FNE (Fear of Negative Evaluation - eight items) (α = .91, r = .78), SAD-New (Social avoidance and distress in new situations – six items) (α = .83, r = .72), SAD-General (Generalized Social Avoidance and Distress – four items) (α = .76, r = .54) and 4 filler items. SAS-A Total scores equal to or above 50 is said to correspond to clinically significant levels of social anxiety (La Greca, 1998; Ranta et al., 2012).

Interview protocol

The interview guide was constructed by the author upon consultation with an expert on qualitative research and psychotherapy with adolescent and adult population, to tap the experience of participants in undergoing the online group therapy sessions. The questions constructed were meant to be open-ended enough to capture the range of possible experiences without leading the participants. General questions were related to subjective experiences (thoughts, feelings, impulses) as well as strategies used to regulate these experiences. The questions were also meant to tap the participants' experience of undergoing the process of online group therapy. Questions were refined after the conclusion of the first interview with one of the session participants.

Procedures

Selecting and Contacting Participants

Recruitment of participants converged with the period when the World Health Organization declared that the SARS-COV virus (COVID-19) has become a pandemic. Thus, due to the government's directives for all to shelter in place, all recruitment and intervention strategies were done online, utilizing common communications and social media platforms. Recruitment was done through a Facebook page that the researcher created for this study. In addition, the researcher emailed all schools listed in Metro Manila through a web search, that had Grades 10-12. In the Philippines, students within the grades 10 to 12 levels span the age ranges of 15 to 18 (officialgazette.gov.ph). After contacting various schools through their websites, emails and through referrals from the researcher's network, a virtual meeting was set up by the researcher with school representatives who signified interest in participating, to explain the details of the study. Materials that were shared to the schools who showed willingness to participate included an explainer video created by the researcher, two (2) pdf orientation slides about the study – one for students and another for school administrators,

Informed consent and assent forms for those who are between the ages of 15-17, and

Informed consent forms for those were are 18 years old. All forms and materials were

accessible online. Interested participants got in touch with the researcher through her given

email address in the informed consent. After the necessary consent forms were procured, the

researcher got in touch with each one and sent them the online measures. Eventually, the

participant pool came from three sources: two schools are based in NCR and one school is

based in the Visayas Region.

Ensuring Secure Transmittal of Data Throughout the Process

Since all the research tasks that involved different stakeholders (participants,

clinicians, research team) were conducted online, efforts were taken by the researcher to

ensure security and privacy of the data being exchanged. Everyone is always reminded about

the security and privacy of the data. This means that the researcher has taken steps to protect

the privacy of all stakeholders to uphold the Data Privacy Act of 2012 (RA 10173). The

researcher ensured that all platforms to be used are HIPAA compliant – HIPAA or Health

Insurance Portability and Accountability Act of 1996 is a law in the United States to create

national standards to protect sensitive health information of individuals (Centers for Disease

Control and Prevention [CDC], 2022). Though this researcher is not a covered entity by the

HIPAA, the former still undertook the best practices under this law in order to ensure that any

electronic transmission of data is covered by the privacy rule inherent in this federal law. The

following platforms described below have been noted to be HIPAA compliant, to ensure the

confidentiality, integrity, and availability of all electronic protected health information. The

links to the white papers on how these products ensure compliance are included in Appendix

H.

The researcher used her Google Workspace Account where she is administrator, to

control and access all data being exchanged that is related to the research. During the duration

of their participation in the research, the team and the research assistants were assigned their

own email address under the researcher's google workspace, so that all data is securely kept

within the researcher's possession once the engagement with them was completed.

A paid Zoom account with security features was also utilized by the researcher. For

the length of their participation in the research the facilitator (therapist) as well as the

supervisor were provided with Zoom accounts under this researcher's main account. As an

added feature, the Zoom room was "locked" after the participant/participants entered the

online space.

A secure version of Jotform (web/app-based form building tool), was procured by the

researcher to get information and exchange documents with stakeholders. So, for instance,

the scheduling form for the interview, informed consent and assent forms (which could be

marked with a digital signature from the platform) and tracking of payables (proof of receipt

of payment for services), were all sent via this platform.

Online Group Therapy Sessions

The group sessions were all conducted online. Though online groups can present their

own challenges in terms of requirements for members to be more present, focused and

attuned compared to face-to-face settings, Weinberg (2020) discusses a way of looking at the

online space as a viable way of healing for groups. He called the group cohesion in therapy

groups "E-ntimacy, not intimacy" (p. 147), and mirrors many of the experiences of face-to-

face group therapy such as universality of experience, the group as representing society and

thereby mirroring power struggles as well. Other factors such as catharsis, instillation of

hope, imparting information and altruism, which are part of face-to-face group therapy

sessions, were all seen by Weinberg to be helpful in internet-based group interventions.

There were two groups that received the intervention – the morning group consisted

of five participants – originally there were six participants, but one dropped out; and the

afternoon group had six participants. Some sessions activities were taken from the Take Charge of Your Life program developed by the William Glasser Institute (WGI), after permission was secured from the President of the WGI. Some activities were adapted/modified by this researcher (Appendix A). However, the overarching framework for the treatment manual was guided by the WDEP (Procedures for change) upon which Reality Therapy rests.

There were eight weekly group sessions lasting for 60 minutes each, which included teaching of concepts of Choice Theory and Reality Therapy, and experiential activities related to social anxiety where participants can practice the concepts. The online group therapy sessions spanned two months (May 2022 to July 2022). On the first session, the group members were oriented about basic online therapy protocols. Some practical considerations for conducting online group therapy as stipulated by Weinberg (2020) were also part of the protocol. These included: screening and preparing group members for the online sessions, explaining technical issues and online etiquette, having a group agreement about staying focused on sessions, refraining from contact outside the group sessions, technical explanations about the secure platforms to be used for group sessions, and making sure the facilitator (therapist) increases their online presence through typical therapist behaviors (e.g., appropriate self-disclosure, identifying group members' emotional states). For all sessions, the Zoom platform owned by the researcher was used.

Sessions were led by one facilitator who is a Registered Psychologist, and a Certified Practitioner in Choice Theory/Reality Therapy. She followed the treatment manual created by the researcher, outlining goals and objectives per session day, activities including reviewing previous weeks' homework activities. Two orientation/training sessions were conducted by the researcher to ensure quality delivery of the program (including technological competence) and adherence to the manualized treatment plan. The facilitator was supervised by an

independent Registered Psychologist who is also a Certified Supervisor and Specialist in

Choice Theory/Reality Therapy, to ensure rigor and fidelity to the program. Both the

supervisor and the facilitator signed a confidentiality agreement with the researcher, as well

as a memorandum of understanding stipulating the terms and conditions of their engagement

with the researcher on the project.

Like the study of Salzer et al. (2017), all treatment sessions were recorded to assess

for treatment fidelity, and adherence to the treatment protocol and only to be used for

Supervision sessions. Consent for recording sessions was included in the Informed Consent

and Assent forms given to the program participants. Three supervision sessions were

conducted throughout the two months of group therapy sessions, to ensure that the facilitator

was able to adhere to the treatment manual. The researcher also viewed the recorded videos

and coordinated with the supervisor and facilitator on activities implementation, as needed.

During the supervision sessions, two to three sessions were selected randomly for each

treatment group at the start, mid-point, and conclusion of the sessions which the supervisor

and facilitator reviewed. In the study of Alampay et al. (2019), program fidelity was assessed

by assigning a trained psychology graduate student as process observer who then used

observation logs for qualitative notes and a few scales that measured facilitation skills,

adherence to session module, and group process. For this study, some similarities in how the

process observation were conducted. The Supervisor and Facilitator are both trained and

certified in the conduct of Reality Therapy and Choice theory, and they each filled out a

Likert scale as they observed the recordings of the session, to rate the facilitator's

competence and degree of adherence to the session module and activities (see Appendix C).

This researcher subsequently perused the ratings. In terms of session adherence, the facilitator

was often observed to adhere to the session module and activities (e.g., followed the

procedures in the manual). In terms of therapist competence the facilitator was rated as "often

observed" in her delivery of skills and techniques as required in the intervention (e.g., accurate modeling of techniques for the concept taught for the day).

On the last day of the therapy session, the participants were administered the measurements online by being given the link to the post-tests. After one month, the participants were contacted by the researcher via email, and again given the link to the same post-tests. They were subsequently scheduled for interview, to draw out their experiences of participating in the online group therapy, after they turned in their one-month post-test results.

Strategies to Improve Adherence and to Deal with Participant Attrition.

To ensure that participants will adhere to protocols, they were given regular reminders through calendar and text alerts when the date of their session was upcoming. There was only 1 participant that was able to attend all the 8 sessions. Others attended from 5 to 7 sessions. Common reasons for missing sessions included: attending graduation ceremonies (especially for those who were completing Grade 12), attending personal family events that coincided with their session, and poor internet connection. In total, there were 5 participants for the morning group and 6 participants for the afternoon group with completed data. One participant dropped out prematurely and was lost to follow up despite numerous attempts by the researcher to get their feedback.

In-depth Interview and Transcription

The researcher contacted all the participants for interview within a month of the last session. They filled up an online sign-up form using a secure version of the online form building and creator, Jotform, to claim open slots for the online interview. With the consent of the participants and their guardians, all interviews were conducted via a secure Zoom platform and these interviews were recorded. To ensure privacy and confidentiality, participants were encouraged to refrain from naming their school or location as well as their

name. The first participant's interview served as the pilot for the interview guide for refining the questions created by the researcher which was reviewed by an expert on qualitative research. Succeeding participants were sent the interview guide so they could reflect on their experience of the sessions as well as their responses.

Upon completion of the interview, the researcher sent the audio files of participants to two enumerators who were oriented on data security and who also signed non-disclosure contracts with the former. The audio files were given code numbers that were assigned to each participant (e.g., P1 for "Participant 1") for transcribing. The transcription had line numbers for easy reference during analysis. The interview transcripts were then sent to the participants interviewed, so they can read, and make corrections or additions. All participants returned their transcripts with almost no corrections and concurred with the transcriptions of their interviews. Once the participants approved their transcriptions, these were shared online to the research team, via a shared google drive under the researcher's google workspace account.

Data Analysis

Quantitative Data Analysis

Outcome data was charted in separate Microsoft Excel sheets. These were: subscales of ERQ CA, namely Cognitive Reappraisal and Emotional Suppression; Total scores, and subscale scores of SASA, namely, Fear of Negative Evaluation (FNE), Social Anxiety and Distress in New Situations (SAD-New), Social Anxiety and Distress General (SAD-G) and Total Social Anxiety score. Separate One-way Repeated Measures Analyses of Variance for these scales were then performed using the latest version of IBM-SPSS (Statistical Package for the Social Sciences). The independent variable was the online group therapy intervention, and the dependent variables were the raw scores in Cognitive Reappraisal and Emotional Suppression scales of the ERQ-CA. Using Sawilowsky's (2009) updated guidelines of

Cohen's (1988) effect sizes (η^2) the following effect size magnitudes were observed: .01 - very small effect, .20 – small effect, .50 - medium effect, .80 – large effect.
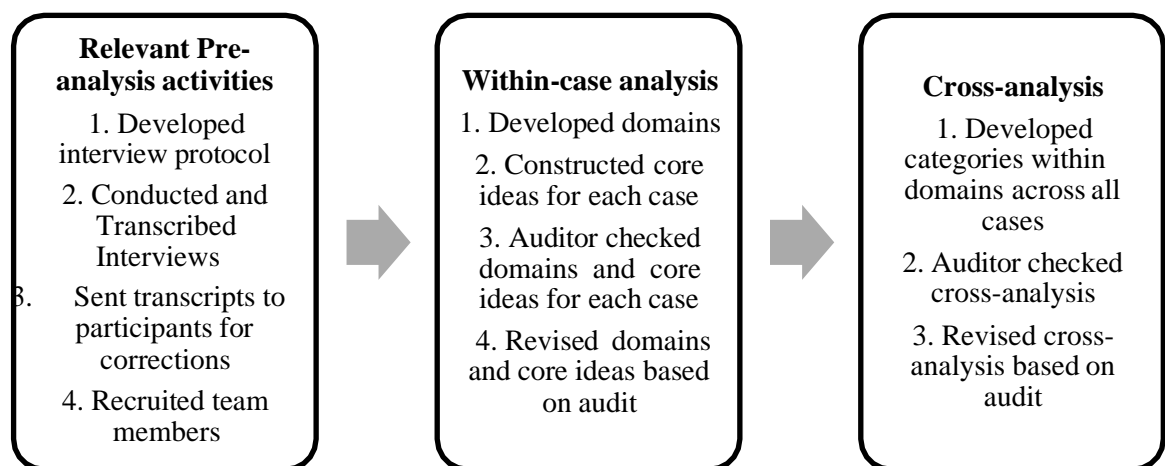
Consensual Qualitative Research

Interview data was analyzed using CQR, following the steps outlined by Hill (2012). Figure 4 summarizes the steps for data collection and analysis that this researcher used.

Figure 4

Steps in Consensual Qualitative Research

Relevant Pre-analysis activities	**Within-case analysis**	**Cross-analysis**
1. Developed interview protocol 2. Conducted and Transcribed Interviews 3. Sent transcripts to participants for corrections 4. Recruited team members	1. Developed domains 2. Constructed core ideas for each case 3. Auditor checked domains and core ideas for each case 4. Revised domains and core ideas based on audit	1. Developed categories within domains across all cases 2. Auditor checked cross-analysis 3. Revised cross-analysis based on audit

The research team was composed of the researcher as the primary team member and two other members forming the consensus team, and an external auditor. The two members of the consensus team are both Registered Psychologists, with PhD in Clinical Psychology, who are experienced in doing Qualitative Research. They were chosen for their experience in doing research and one of them has extensive research in psychotherapy with different populations and age groups as well. The external Auditor has audited CQR data analytic procedures and results for more than 10 times (excluding this current research project), and other qualitative results multiple times. He is a PhD degree holder since 2010 and has been teaching Graduate level (master's and doctoral) research methods courses since 2013. He is also very well versed in the process of CQR having facilitated workshops on the topic in professional organization conferences (Psychological Association of the Philippines and

Philippine Association for Counselor Education, Research and Supervision) as well as various academic institutions in Metro Manila, Luzon, Visayas, and Mindanao. He has been a Primary Team member of seven different research projects using CQR and one dissertation project, all of which have been successfully completed.

A total of six online meetings were held by the three members of the team doing the coding and consensus – the first two were brief meetings for orientation on the CQR process, including discussion of potential biases of each one and possible power dynamics imbalances that could occur and thus, consensus and open discussion was stressed as a norm from the beginning. The last four sessions were to meet on the coding and arrive at consensus at every step of the process. In between meetings, the research team would correspond via group chat for coordination and emails for exchange of documents. Data from a selected participant was used as the pilot case, for the team in practicing reaching consensus. The team learned to have open discussions about segments of texts, with each one giving their rationale for interpreting data. Disagreements are resolved through these discussions, as well as repeated reading of relevant transcript segments.

The Auditor was available to the researcher for questions beyond the two auditing activities that he did (after generation of core ideas and after cross analysis). He also provided guidance as needed through phone calls for this researcher who was new to the CQR process.

Within-Case Analysis.

Domains.

Development of Domains was the first step of the team. According to Hill and Knox (2012), domains are "broad subject areas" which are tools used for organizing the data. Working on one transcript, the team did a close reading of the interview together, and proposed ideas for potential domains. Subsequently, this preliminary domain list was applied to two additional transcripts. The members then read assigned transcripts to apply these

domains and discussed if there were emerging domains, and then worked together to achieve consensus on the domains list.

Core Ideas.

After group consensus was achieved on the final domains list, core ideas were created. According to Hill and Knox (2012) core ideas present the interviewee's ideas in a more succinct manner. Thus, this involves paraphrasing the narrative to clarify the interview data and allow the team to compare ideas across cases later. The researcher constructed the core ideas and the team worked together to complete the consensus version which was sent to the Auditor. Based on the audit review, revised domains and core ideas were created by the team for cross-analysis.

Cross- Analysis.

Working from the consensus version (CSV) the next step of the process was the cross-analysis. This involved identifying common themes or categories emerging within the domains across the various cases. Hill and Knox (2012) alternately use the term "themes" and "categories" but mean these to be synonymous. The team met again after the researcher created the categories based on Auditor's comments to discuss and reach consensus on the final categories. The team subsequently assigned frequency labels for each category, as part of the cross-analysis. This is done to determine the representativeness of the themes. The following labels were used: "general" for categories that consist of data from all or all but one of the participants; "typical" for categories that consist of data from more than half of the participants up to the cut off for general; and "variant" for categories that have data from at least two participants up to half of the participants.

Member checking was done by sharing with the participants through their email the themes, core ideas and exemplars that have been audited. Out of 11 participants, 8 responded to the researcher and gave their approval of the coding.

Ethical Considerations

Privacy and consent were always emphasized as the two crucial ethical features of this research. This important because all everything from start to end of the research process including the interventions were done online.

The researcher obtained informed consent from guardians and assent from the adolescent participants between the ages of 15-17. Participants who were 18 years old signed their own informed consent forms. The consent forms contained potential benefits and risks. Additional consent was secured for recording the sessions for supervision and treatment fidelity. Tokens for participation were given for all those who participated and completed the study.

The researcher was always available to answer questions related to consent at any time during the research process.

Researcher as Instrument

The researcher's professional and personal experiences influenced the creation and conduct of this research. The researcher undertook measures to maximize the benefits and minimize the risks these influences. The researcher primarily identifies as a Clinician. She is a psychologist who has been Certified in the practice of Reality Therapy for 5 years. As researcher allegiance could influence therapeutic effect sizes, (Dragioti et al., 2015) the researcher did not take part in the therapy sessions. Employing a trained therapist and a supervisor both of whom were also Certified in Choice Theory and Reality therapy, to conduct the sessions independently ensured that the researcher was not causing undue influence on its outcomes.

As a practicing clinician, the researcher has held a long-time interest in the study of anxiety, specifically social anxiety. She has seen the chronic and unremitting nature of this condition and thus comes into the research with her own set of understanding about it.

Employing CQR as a qualitative research methodology, with its strong emphasis on team consensus and having an external auditor has been very effective in minimizing the researcher's bias. Additionally, she has worked with children and adolescents suffering from social anxiety for a long time and has developed her own biases about its intractable nature. Developing a manualized treatment protocol and structures to adhere to this protocol as well as interviewing the stakeholders themselves, that is, the adolescent participants, helped to bring out new insights and themes from the data.