Effectiveness of Skills for Academic and Social Success (SASS) With Portuguese Adolescents

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ABSTRACT

Social fears are common among adolescents and may considerably impair their lives. Even so, most adolescents do not seek professional help for these difficulties, making it important to promote evidence-based and preventive interventions in community samples. This research presents the effectiveness of an intervention with a group of five female adolescents who reported serious interference of their social fears in their daily life. At post-intervention, effectiveness was noticeable by high recovery, reliable individual change, and intra-group statistical change. The intervention showed impact for measures of social anxiety, avoidance, and assertiveness, and such impact was steady at 3-month follow-up. These findings add to the cumulative and transcultural evidence on the effectiveness of Skills for Academic and Social Success (SASS).

Skills for Academic and Social Success (SASS; Masia et al., 1999) is a cognitive-behavioral school-based intervention for adolescents with social anxiety disorder. It includes psychoeducation,

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realistic thinking, social skills training, exposure, and relapse prevention as treatment components, and activates a social support network of parents, teachers, and peers (see Fisher, Masia-Warner, & Klein, 2004, for a description). Previous works have suggested its effectiveness in a small open trial (Masia, Klein, Storch, & Corda, 2001), in relation to a waiting list condition (Masia-Warner et al., 2005) and in an attention control trial (Masia-Warner, Fisher, Shrout, Rathor, & Klein, 2007). Its effectiveness so far invites further investigation with a cultural and clinically different group. Meanwhile, Portugal faces a lack of standardized intervention programs for social anxiety, especially ones applicable to community contexts, even if over 50% of the general adolescent population report at least one very intense social fear, and 84% of these adolescents do not request or are not referred to professional help (Cunha, Pinto-Gouveia, & Soares, 2007). Additionally, evidence is lacking on preventive intervention with adolescents with sub-clinical social anxiety (Rapee & Spence, 2004) who present with diminished social success rather than social avoidance, possibly combined with assertive deficit (Levitan & Nardi, 2009). These adolescents may particularly benefit from systematic and explicit assertive training.

Considering this, the present work intends to preliminarily evaluate the effectiveness of the SASS with Portuguese adolescents. The Portuguese SASS (for a detailed description, see Vagos & Pereira, 2009) specifically planned four sessions for assertive skills training, including psychoeducation, role-playing, and corrective feedback (Duckworth & Mercer, 2006). Consequently, measures of both social anxiety and assertiveness were selected, following two clinical trials based on the same manual and schedule applied in two consecutive school years, with a sample of five female adolescents.

RECRUITMENT, EVALUATION, AND INTERVENTION PROCEDURES

Participants displaying anxiety and shy or isolated behavior were referred by teachers. Of 11 nominated students, 6 were selected who presented criteria for social anxiety and a score higher than 4 on the Anxiety Disorders Interview Schedule for Children for
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DSM-IV (ADIS-C-IV) severity rating (Silverman & Albano, 1996). One boy declined to participate in the intervention, whereas five girls aged between 15 and 17 years old ($M = 16$) and their parents consented. Two of them presented with an additional secondary diagnosis, one of depression and another of generalized anxiety.

Participants filled out answers on self-report measures$^{1}$ for social anxiety and assertiveness, at the pre-, post- and 3-month follow-up. The Assertive Interpersonal Schema Questionnaire (AISQ) evaluates four types of assertive cognitions: outer emotional support, functional personal ability, interpersonal management, and affective personal ability (Vagos & Pereira, 2010). The performance scale of the short Scale for Interpersonal Behavior (s-SIB) assesses frequency of assertive behaviors in four social domains: display of negative and of positive feelings, expression of and dealing with personal limitations, and initiating assertiveness (Vagos, Pereira & Arrindell, 2014). The Social Thoughts and Beliefs Scale (STABS) evaluates the presence of negative thoughts typical of social anxiety, relating to discomfort in social interactions and in public performance (Vagos, Pereira, & Beidel, 2010). The Social Anxiety and Avoidance Scale for Adolescents evaluates anxiety (SAASA anxiety) and avoidance (SAASA avoidance) of social events, namely interaction with the opposite sex, assertive interaction, observation by others, interaction in new social events, performance in formal social situations, and eating and drinking in public (Cunha, Pinto-Gouveia, & Salvador, 2008).

Each participant was also evaluated by an independent clinical psychologist using the ADIS-IV at post-intervention. Clinical and statistical change was measured for assessing intervention effectiveness. Clinical change was assessed considering two criteria: recovery and reliable change. Recovered participants presented post-intervention scores closer to the scores obtained by non-clinical samples than to the scores obtained by clinical ones; reliable change, on the other hand, measured the significance of individual change by comparing the scores obtained by each participant at pre- and post-intervention and at pre-intervention and follow-up (Jacobson & Truax, 1991; Wise, 2004). Statistical change measured intra-group mean comparisons and its effect sizes using nonparametric statistics.

$^{1}$ All instruments were used in their Portuguese version.
The intervention followed the outline of the SASS, other than using psychoeducation, role-playing, and corrective feedback for assertive skills training in sessions 3, 5, 7, and 9 (see the schedule in Appendix 1). Group leaders’ logs indicated treatment integrity, because all activities planned for each group session, parents’ meeting, and social events were accomplished. Individual sessions were personalized to each participant’s needs. Teachers’ meetings did not occur. Participants’ attendance was generally high; one participant missed two group sessions and one social event, and two other participants missed one group session.

RESULTS

Clinical Change

Recovery and reliable change were generalized to measures of both social anxiety and assertiveness. Recovery was particularly generalized concerning diminished social avoidance and increased practice of assertive behavior. Concomitant recovery was found for anxiety and avoidance of performance in formal social situations, being observed by others, and interacting with the opposite sex; avoidance of interaction in new social events also showed striking recovery. For assertiveness, the highest percentage of recovery referred to the endorsement of more positive thoughts about personal likeability and capability (Figure 1A).

Reliable change was less generalized to outcome measures than recovery. It was concomitantly found for anxiety and avoidance of being observed by others and of interacting in new social events. Similar to recovery, each participant markedly improved in endorsing personal likeability and for displaying negative feelings (Figure 1B). Finally, scores for the severity rating of the ADIS-C-IV were also markedly reduced for all participants (Figure 1C).

2. For ease of communication, only measures where the majority of the participants showed recovery or reliable change at post-intervention or follow-up are referred to and presented in Figures 1A and 1B, and only measures where significant or close to significant changes were found are referred to and presented in Figure 1D.
### Figure 1A. Recovery Rates at Post-intervention and Follow-Up Evaluations

| Variable                        | Post-intervention | Follow-up 1 | Follow-up 2 |
|--------------------------------|-------------------|-------------|-------------|
| Symptom severity               | 60                | 60          | 60          |
| Pain                            | 40                | 40          | 40          |
| Fatigue                         | 40                | 40          | 40          |
| Mood                            | 40                | 40          | 40          |
| Quality of life                 | 60                | 60          | 60          |
| Physical function               | 40                | 40          | 40          |
| Social function                 | 20                | 20          | 20          |
| Role function                   | 40                | 40          | 40          |
| Pain interference               | 40                | 40          | 40          |
| Emotional function              | 40                | 40          | 40          |
| Interpersonal function          | 40                | 40          | 40          |
| Social interaction              | 40                | 40          | 40          |
| Sleep                           | 40                | 40          | 40          |
| Incontinence                    | 40                | 40          | 40          |
| Symptom severity                | 60                | 60          | 60          |
| Physical function               | 40                | 40          | 40          |
| Role function                   | 40                | 40          | 40          |
| Emotional function              | 40                | 40          | 40          |
| Social interaction              | 40                | 40          | 40          |
| Sleep                           | 40                | 40          | 40          |
| Incontinence                    | 60                | 60          | 60          |
| Symptom severity                | 60                | 60          | 60          |
| Physical function               | 60                | 60          | 60          |
| Role function                   | 40                | 40          | 40          |
| Emotional function              | 40                | 40          | 40          |
| Social interaction              | 40                | 40          | 40          |
| Sleep                           | 40                | 40          | 40          |
| Incontinence                    | 60                | 60          | 60          |
| Symptom severity                | 60                | 60          | 60          |
| Physical function               | 60                | 60          | 60          |
| Role function                   | 40                | 40          | 40          |
| Emotional function              | 40                | 40          | 40          |
| Social interaction              | 40                | 40          | 40          |
| Sleep                           | 40                | 40          | 40          |
| Incontinence                    | 40                | 40          | 40          |
### Figure 1B. Reliable Change Rates at Post-intervention and Follow-Up Evaluations

| B: Reliable change | Detrimental | No change | Improved |
|--------------------|-------------|-----------|----------|
| **SMA 1 anxiety**  |             |           |          |
| Post-intervention   | 0           | 60        | 40       |
| Follow-up           | 0           | 60        | 40       |
| **SMA 2 anxiety**  |             |           |          |
| Post-intervention   | 40          | 20        | 40       |
| Follow-up           | 20          | 40        | 40       |
| **SMA 3 anxiety**  |             |           |          |
| Post-intervention   | 20          | 80        |          |
| Follow-up           | 20          | 80        |          |
| **Interaction with social others** |          |           |          |
| Post-intervention   | 0           | 60        |          |
| Follow-up           | 0           | 60        |          |
| **Expression of emotion and interaction with the opposite sex** |          |           |          |
| Post-intervention   | 0           | 100       | 0        |
| Follow-up           | 0           | 60        | 40       |
| **Display of negative feelings** |          |           |          |
| Post-intervention   | 0           | 100       |          |
| Follow-up           | 0           | 100       |          |
| **Affectional personal ability** |          |           |          |
| Post-intervention   | 0           | 60        | 40       |
| Follow-up           | 20          | 20        | 60       |
| **Other emotional support** |          |           |          |
| Post-intervention   | 20          | 60        | 20       |
| Follow-up           | 20          | 40        | 40       |
Figure 1C. Social Validity Rates at Post-intervention and Follow-Up Evaluations
Figure 1D. Statistical Change at Post-intervention and Follow-Up Evaluations
Statistical Change

Change at post-intervention was statistically significant \((p < .05)\) for negative thoughts of discomfort in social situations and anxiety while interacting in new social events and being observed by others. At follow-up, change was statistically significant for the assertive cognition of personal functional ability and for the assertive behavior of taking initiative. Close to significant changes were found for avoiding interaction in new social events and with the opposite sex (only at follow-up), for thoughts of discomfort in social interactions (only at follow-up), and for displaying negative feelings and taking initiative (only at post-intervention). Significant and close to significant \((p < .07)\) changes (Figure 1D) attained large effect size values, ranging from 0.8 to 0.91.

DISCUSSION

This pilot study evaluated the effectiveness of Skills for Academic and Social Success (SASS; Masia et al., 1999) with Portuguese sub-clinical female adolescents. The SASS is a school-based program reaching adolescents who usually do not receive help despite their social anxiety symptoms, which was the case with 84% of a large school-based Portuguese adolescent sample (Cunha et al., 2007). All but one participant were considered responsive in that their symptoms of social anxiety and severity ratings were greatly decreased, and individual and intra-group change was evident, concurring with previous findings (Masia et al., 2001; Masia-Warner et al., 2005, 2007). Given the sub-clinical symptoms of the participants, it was easier for them to approach the normative group, even if their individual difficulties were less generally improved.

The Portuguese SASS had significant impact in diminishing the anxiety and avoidance of interaction in new social events and with the opposite sex, and of being observed by others. Again, this replicates previous studies with SASS that found its impact on interacting in new situations or with new peers (Masia-Warner et al., 2005). Additionally, the change found in assertive behavior, particularly for displaying negative feelings (where participants presented the highest difficulties at pre-intervention), reaffirms
the usefulness of these intervention techniques. Also important was the impact of the intervention in contributing to more positive thoughts about personal likeability and capability of the participants, possibly due to the group dynamics themselves where both idiosyncratic difficulties and contributions were acceptable, and approximation to the desired performance was corrected and reinforced.

These findings confirm the validity and utility of transposing clinical intervention techniques to community contexts (Barlow & Hofmann, 1997). Nevertheless, we echo the problems cited by Masia and colleagues (2001, 2011) of working in school settings: Teachers minimized the importance of the program, referred few students, and were unavailable for teachers’ meetings, jeopardizing the practice of new behaviors in school settings. Given that few students were selected, it was not possible to create a control group, which could attest to the experimental condition producing better outcomes than the daily lives of adolescents. For now, we have cumulative and transcultural evidence on the effectiveness of SASS for social anxiety in adolescents (and possibly to assertiveness), be it clinical or non-clinical, which should be further investigated using a wider sample and examining its intervention components.
APPENDIX. PROPOSED SCHEDULE FOR THE PORTUGUESE SASS

| Week 1       | Group session 1: Psychoeducation about what is social anxiety |
|-------------|------------------------------------------------------------|
| Week 2      | Group session 2: Realistic thinking                        |
| Week 3      | Group session 3: Social skills—Expressing positive feelings |
|             | Parent meeting 1: Psychoeducation about what is social anxiety |
| Week 4      | Group session 4: Behavioral exposure                       |
| Week 5      | Group session 5: Social skills—Taking initiative           |
|             | Social event 1: Small talk                                 |
| Week 6      | Group session 6: Behavioral exposure                       |
|             | Individual session 1: Managing personal expectations about social fears and about the intervention |
| Week 7      | Group session 7: Social skills—Expressing and managing personal limitations |
|             | Parent meeting 2: Psychoeducation about how to help their children manage social fears |
|             | Social event 2: Street survey on recycling                  |
| Week 8      | Group session 8: Behavioral exposure                       |
| Week 9      | Group session 9: Social skills 4—Expressing negative feelings |
|             | Individual session 2: Activate and maintain social support after the intervention termination |
|             | Social event 3: Mall treasure hunt, where participants had to successively complete tasks in order to achieve the final goal and prize |
| Week 10     | Group session 10: Behavioral exposure                      |
| Week 11     | Group session 11: Behavioral exposure                      |
| Week 12     | Group session 12: Gain review and relapse prevention        |
|             | Social event 4: Farewell lunch                             |

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