2 Assessment and Treatment of Deficits in Social Skills Functioning and Social Anxiety in Children Engaging in School Refusal Behaviors

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Since compulsory attendance in primary and secondary schooling came with the Education Act of 1944, student's absences have been markedly followed within the United States. Although most students attend school consistently, there is a subset of students who for one reason or another fail to attend school on a regular basis. Students may miss school for a variety of reasons including traditional truancy, anxiety, medical reasons, or fear of being bullied to name a few. Beyond missing out on educational opportunities, absenteeism deprives a child from the various social, emotional, and mental health services that are available in schools today. Absenteeism has been shown to be a risk factor for suicide attempt, teenage pregnancy, and substance use (Kearney, 2008). Additionally, chronic absenteeism is a precursor of eventual dropout (Alexander, Entwisle, & Kabbani, 2001) which is linked with economic, marital, social, and psychiatric problems (U.S. Census Bureau, 2005; Kearney, 2008).

Dr. Frank M. Gresham is the author of the Social Skills Intervention System, which includes an assessment tool (SSIS-RS) and a tiered model of Social Skills Instruction that is discussed within this chapter. Both the Social Skills Intervention System-Rating Scales and the SSIS intervention guides are used as examples of methods of assessment and treatment for individuals engaged in Social-Anxiety mediated school refusal behaviors within this chapter.

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Prevalence

Research by the National Center for Children in Poverty examining Early Childhood Longitudinal Study Kindergarten Cohort data (U.S. Department of Education, National Center for Education Statistics, 2006) showed that over 11% of kindergartners, over 8% of first graders, and 6% of third graders miss 18 or more days in a school year. Additionally, the data show that over half of the students who were chronically absent in kindergarten were chronically absent in first grade. These chronically absent students were rated by their teachers as having lower socioemotional development and functioning than children who had normal attendance (Romero & Lee, 2007). Chronically absent students were also rated as having low functioning in regards to interpersonal relations and self-control and were more likely to have internalizing and externalizing problem behaviors (Romero & Lee, 2007).

National Center for Education Sciences data also indicates that 19% of fourth graders and 20% of eighth graders were reported as missing school for 3 or more days in the previous month in 2005, a pattern that has held relatively steady between 1994 and 2005 (Table 2.1) (U.S. Department of Education, National Center for Education Statistics, 2006). Other trends of interest include that if the student was eligible for a free/reduced lunch, diagnosed with a disability, or was an English language

D. McKay and E.A. Storch (eds.), *Handbook of Assessing Variants and Complications in Anxiety Disorders*,
DOI 10.1007/978-1-4614-6452-5_2,

Table 2.1 Percentage of students who reported missing 3 or more days in the previous month

	0 days		1–2 days		3–4 days		5+ days	
	4th	8th	4th	8th	4th	8th	4th	8th
1994	52	44	30	33	11	13	7	9
1998	53	44	30	34	11	14	6	8
2002	52	45	30	35	11	13	6	7
2003	49	44	30	35	13	14	8	8
2005	52	45	29	35	12	13	7	7

Table 2.2 Percentage of students, by grade, with English-language accommodations or other school support

	1994		1998		2002		2003		2005	
	4th	8th	4th	8th	4th	8th	4th	8th	4th	8th
Total	18	22	17	22	18	20	22	22	19	20
ELL										
Yes	–	–	23	26	20	23	20	23	21	23
No	–	–	17	22	18	20	22	22	19	20
Classified as having a disability										
Yes	–	–	26	31	23	28	27	30	24	29
No	–	–	16	21	17	19	21	21	19	20
Free Reduced Lunch										
Eligible	–	–	21	26	21	24	25	26	23	25
Not Eligible	–	–	14	20	16	18	20	19	17	18
Location										
Central City	20	24	17	22	18	21	22	23	20	22
Urban fringe/large town	17	21	16	21	17	20	20	20	18	20
Rural/small town	17	20	18	23	18	19	23	22	20	19

ELL = English Language Learner

learner, he/she was more likely to have missed 3 or more days of school in the past month (Table 2.2).

History of Classification Systems

Given the variety of reasons a student may be absent from school, a number of theories regarding classification systems have been developed to describe the phenomena that lead a student to engage in behaviors such as refusing or attempting to refuse school or to experience great distress when at school. When researchers began to see chronic school absenteeism as a clinical concern, rather than merely a more common feature of delinquency as was typically described (e.g., Healy, 1915; Burt, 1925; Williams, 1927), the initial descriptions of nonattendance were primarily related to the role of anxiety in chronic school absenteeism.

Broadwin (1932) described two types of "truants;" first those who were truant for more traditional reasons such as, "a loss of interest because of inability to keep up with the pace of the class or because the child can do more advanced work, unwitting and even willful encouragement of the parents, and 'bad' associates," (p. 253) and secondly, those students who are truant because of, "a deep seated neurosis of the obsessional type or displays a neurotic character of the obsessional type" (p. 254). Broadwin (1932) suggests that these children are in need of additional study and describes them as students who are "miserable, fearful, and (will) at the first opportunity run home despite the certainty of corporal punishment". This description of truancy as a function not of

an aversive environment or competing reinforcement outside of school but of a neurotic character led to additional work looking at school absenteeism as a clinical problem rather than a delinquency one.

Partridge (1939) described five types of groups engaged in truancy: an undisciplined group, a hysterical group, a desiderative group, a rebellious group, and a psychoneurotic group that was markedly different from the first four groups. Similar to Broadwin's second group of truants, Partridge described the psychoneurotic group as individuals whose behavior was not simply a means of escaping environmental concerns or fulfilling wants but instead reflected an overabundance of anxiety. Partridge also noted that this group frequently had an overprotective parent.

Johnson, Falstein, Szurek, and Svendsen (1941) spoke similarly about an emotional disturbance that led to prolonged absences from school, which they referred to as "school phobia." Similar to Partridge and Broadwin, Johnson et al. reported a subset of school refusers for whom anxiety was considerable, which were different from those who were seen as simple truants. Johnson et al. suggested that school phobic children had an acute anxiety that was caused by either an emotional conflict or an organic disease. The children's anxiety subsequently created an increase of anxiety in their mothers, which was followed by a poorly resolved dependent relationship of these children to their mothers.

Building on the "school phobia" diagnosis, Coolidge, Hahn, and Peck (1957) talked about school absenteeism as something specific to the school and not wholly related to the dependent nature of children's relationships with their mothers. Like the Johnson description, Coolidge et al. described a neurotic type of school phobia that was characterized by younger children with anxiety symptoms that suddenly occurred. Unlike the Johnson descriptions, Coolidge et al. also included a more traditional group of school refusers who were typically older and had a more gradual onset of school refusal behaviors. This group was similar to the non-anxiety groups described by Broadwin (1932) and Partridge (1939) while still adhering to the school phobia term.

Kennedy (1965) continued on the Coolidge et al. (1957) dichotomy related to school phobia. He described school phobia as being either Type 1, having acute onset, or Type 2, reflecting a "way of life" that was more gradual in development and more chronic in nature. He suggested that both types had common symptoms including:

(a) Morbid fears associated with school attendance and a vague dread of disaster
(b) Frequent somatic complaints: headaches, nausea, drowsiness
(c) Symbiotic relationship with mother, fear of separation
(d) Anxiety about many things: darkness, crowds, noises
(e) Conflict between parents and the school administration

Despite their similarities, Kennedy maintained that the two types were two different categories of disorders that would require differing types of treatments.

Berg, Nichols, and Pritchard (1969) continued classifying school phobic children as acute (nonproblematic school attendance for at least 3 years prior to the current episode) and chronic (all other cases) but added additional classification requirements:

1. *Severe difficulty in attending school*, often amounting to prolonged absence.
2. *Severe emotional upset*, shown by such symptoms as excessive fearfulness, undue tempers, misery, or complaints of feeling ill without obvious organic cause on being faced with the prospect of going to school.
3. *Staying at home with the knowledge of the parents* when they should be at school, at some stage in the course of the disorder.
4. *Absence of significant antisocial disorders* such as stealing, lying, wandering, destructiveness, and sexual misbehavior (p. 123).

Definitional Issues

While there are a number of similarities across each of these explanations of excessive absence,

and though they frequently use similar terminology (with varying degrees of relatedness) there are a number of differences as well. Differences across the foundation of and use of classification systems have made it difficult for researchers and clinicians to come to a consensus about the definition and classification of students who engage in school refusal behaviors. This difficulty is bolstered by the fact that both the DSM-IV (American Psychiatric Association, 2000) and proposed DSM-V diagnostic categories (American Psychiatric Association, 2011) do not include a specific formal diagnosis related to problematic absenteeism. Instead, school refusal behaviors are typically addressed under coexisting conditions that often occur comorbidly with school refusal behaviors. These can include but are not limited to Oppositional Defiant Disorder, Conduct Disorder, Separation Anxiety Disorder, Panic Disorder with Agoraphobia, Generalized Anxiety Disorder, Social Anxiety Disorder, and Specific Phobia. While all of these diagnoses could be related to school refusal behaviors, it does not necessarily follow that a student who engages in school refusal behaviors would qualify for any of these disorders.

Despite the long standing theoretical bases that have led to these differing classification systems, they all leave something to be desired because of the number of different environmental contingencies that lead to the same behavior, school refusal. This is easily seen in the number of differing nosologies related to the same behaviors. Whether considered school phobia or psychoneurotic truancy, the behaviors being described are similar and could be related to a number of common symptoms as suggested by Kennedy (1965). Even though distinctions such as chronic vs. acute and anxiety related vs. conduct disordered may be useful in classification, it does not stand to reason that a student who is engaging in school refusal for the first time (acute) has not been anxious about school for a long period of time. Additionally, problematic conduct outside of school does not necessarily mean that a student does not have debilitating anxiety problems within school. Students who engage in externalizing problematic behaviors are not necessarily free from internalizing problems or social anxiety. Research has repeatedly found that individuals referred with school refusal problems have been comprised of a number of subgroups including individuals with anxiety disorders, depressive disorders, and both (Bernstein, 1991; Bernstein & Garfinkel, 1986).

This heterogeneity of school refusers led Kearney and Silverman (1993) to create a functional model of child-motivated school refusal behaviors. In this model they aimed to examine school refusal behaviors from a functional point of view, probing environmental contingencies that could reinforce school refusal behavior, rather than only assessing perceived diagnostic correlates that use internal states to explain behavior. This functional view allows a greater direct link from behavioral function to treatment. Similar to prior functional explanations of behavior (e.g., Iwata, Dorsey, Slifer, Bauman, & Richam, 1994; Durand & Crimmins, 1988), Kearney and Silverman break maintaining variables broadly into positive and negative reinforcement and then more specifically into avoidance of stimuli providing negative affectivity, escape from aversive social or evaluative situation, attention getting behavior, and positive tangible reinforcement.

Given the number of differing definitions of school refusal behaviors suggested over the years and taking into consideration data regarding differing functions related to topographically similar behaviors, the authors of this paper would like to endorse the use of the Kearney and Silverman definition of school refusal behaviors as a means to describe this class of behaviors. Kearney and Silverman (1996) describes school refusal behavior as, "child-motivated refusal to attend school or difficulties remaining in classes for an entire day." They go on to say:

> this definition includes youth aged 5–17 years who, to a substantial extent, (a) are completely absent from school, and/or (b) initially attend then leave school during school days, and/or (c) go to school following behavior problems such as morning temper tantrums, and/or (d) display unusual distress during school days that precipitates please for future nonattendance.
>
> (Kearney & Silverman, 1996, pp. 345)

This definition encompasses a number of historical classifications including delinquent truancy, school phobia, and anxiety-based absenteeism.

While research on functional profiles of students engaged in school refusal behaviors shows that many profiles do at times match prior definitions (i.e., that students motivated by negative reinforcement were more often reporting high levels of fear and anxiety than those in positive reinforcement groups (Kearney, 2002; Kearney & Albano, 2004) this model allows students who are engaging in school refusal behaviors for multiple reasons (mixed functions) to be included under one umbrella definition.

Anxiety Related School Refusal

A study by Weeks, Coplan, and Kingsbury (2009) investigated both what correlates with social anxiety in childhood and what the consequences may be for children who experience symptoms of social anxiety. Their sample included 178 children in second grade. They found that anxious students liked school less and avoided school more than their non-anxious counterparts. They also found that anxious students reported themselves as more lonely at school than same aged non-anxious students. Additionally, anxious students' teachers perceived them as weaker students academically than the non-anxious students. These findings suggest that anxious students who dislike school are likely to display more school refusal behavior than non-anxious students.

Assessment Tools

Because of the great heterogeneity related to school refusal behaviors and myriad of theoretical explanations for these behaviors, a number of assessment procedures have been utilized over the years to assess school refusal. As a means of covering multiple sources of assessment procedures, the current authors chose to report on a variety of assessments used to examine school refusal. These may be of varying benefit depending on the nature of school refusal. It is suggested that multiple methods are used when examining behavior, but that in all cases, assessments be used to inform intervention.

Diagnostic Interviews

Anxiety Disorders Interview Schedule for *DSM-IV*: Child and Parent Version (Silverman & Albano, 1996)

The ADIS is a semi-structured diagnostic interview that can be used to assess school refusal and related problems in youth ages 6–18 (Silverman & Albano, 1996). The Anxiety Disorders Interview Schedule for *DSM-IV*: Child and Parent Version (ADIS for *DSM-IV*:C/P) has both a child and a parent interview with questions in regard to school refusal behaviors that have occurred within the last year (King & Bernstein, 2001). The interview consists of six yes/no questions in relation to school refusal, including items, such as, "do you get very nervous or scared about having to go to school?" and, "do you miss or leave school early because you like it better home?." There are additional open-ended questions aimed at uncovering why school is anxiety-provoking and determining the duration of the school refusing behavior. The final part of the school refusal section includes 15 items common in a school setting (such as *speaking to other people* and *taking tests*) that are rated on a 0–8 scale for degree of fear for that item and for how much fear of that item interferes with the ability to attend school (Silverman & Albano, 1996). Silverman and Albano (1996) emphasize that significant scores on the school refusal behaviors section on the ADIS for *DSM-IV*:C/P require follow-up within *DSM-IV* diagnostic categories to better understand the nature of the problem.

In addition to the section on school refusal behaviors, the ADIS for *DSM-IV*:C/P includes sections for the assessment of each of the nine diagnostic categories of anxiety listed in the *DSM-IV*, sections for the diagnosis of mood disorders, and a section for the identification of externalizing disorders (Silverman & Albano, 1996). This large range of categories makes the ADIS for *DSM-IV:*C/P a useful tool to help determine the nature of school refusal behaviors and identify possible comorbid disorders (King & Bernstein, 2001; Silverman & Albano, 1996). The ADIS for *DSM-IV:*C/P has been shown to have good inter-rater reliability and test–retest reliability (for combined child and

parent interviews: $\kappa = 0.84$ for separation anxiety disorder, $\kappa = 0.92$ for social phobia, $\kappa = 0.81$ for specific phobia, and $\kappa = 0.80$ for generalized anxiety disorder; Silverman & Ollendick, 2005). Additionally, it has been shown to have concurrent validity with the Multidimensional Anxiety Scale for Children (MASC; March, Parker, Sullivan, Stallings, & Conners, 1997; Silverman & Ollendick, 2005).

An example of use of the ADIS for *DSM-IV:*C/P in youth with school refusal behavior is a study by Kearney and Albano (2004), in which they used the interview to obtain *DSM-IV* diagnoses for 143 school-refusing children, aged 5–17 years. Of that sample, close to a third did not meet criteria for a *DSM-IV* diagnosis with the remaining two-thirds meeting diagnostic criteria for primarily anxiety disorders, mood disorders, or conduct disorders.

To further assess for the presence of anxiety disorders in youth with school refusal, it can be advantageous to utilize self-report measures (King & Bernstein, 2001).

Survey and Self-report

Revised Children's Manifest Anxiety Scale-Second Edition (Reynolds & Richmond, 2008)

The Revised Children's Manifest Anxiety Scale Second Edition (RCMAS-2) is an updated version of the Revised Children's Manifest Anxiety Scale (Reynolds & Richmond, 1985), the most common self-report measure for anxiety disorders in children (Silverman & Ollendick, 2005). It was normed with an ethically diverse sample of more than 2,300 children between 6 and 19 years, with separate norms for three age groups 6–8 years, 9–14 years, and 15–19 years. The RCMAS-2 consists of 49 yes/no items, intended to cover physiological anxiety, worry, social anxiety, and defensiveness. In addition to these scales the RCMAS-2 has a new cluster of items meant to assess performance anxiety. The RCMAS, which scales correlate highly with the RCMAS-2 had an internal consistency of above 0.80 and test–retest reliability ranging from 64 to 76 across total scale and subscales (Reynolds & Richmond, 1985; Silverman & Ollendick, 2005).

Multidimensional Anxiety Scale for Children (March et al., 1997)

The MASC is a 39-item scale intended for youth aged 8–19 years that assesses physical symptoms of anxiety, social anxiety, harm avoidance, and separation/panic (March et al., 1997; Silverman & Ollendick, 2005). The MASC has good internal consistency, ranging from 74 to 90 across total scale and subscales and test–retest reliability of 34–93 at an interval between 3 weeks and 3 months (March, Sullivan, & Parker, 1999; Silverman & Ollendick, 2005).

Self-report

Social Anxiety Scale for Children-Revised (La Greca & Stone, 1993)

The Social Anxiety Scale for Children-Revised (SASC-R) is a 22-item scale that assesses three subscales of social anxiety in children aged 7–13 years. When rating themselves on this scale, children are asked to respond to each item using a 4-point Likert type scale ranging from *not at all* to *all the time*. Raters respond to three distinct factor sets including fear of negative evaluation (eight items), social avoidance and distress to novelty (six items), and general social avoidance and distress (four items). Technical adequacy as measured by internal consistency is good (La Greca & Stone, 1993).

Fear Survey Schedule for Children-Revised (Ollendick, 1983)

The Fear Survey Schedule for Children-Revised is an 80-item measure where children aged 8–11 are asked to rate each item on a 3-point scale to identify how much fear they encounter when engaging in the behavior. Though this measure is not specific to school refusal behaviors, there are a number of items that are school oriented including giving an oral report, riding in the car or bus, being sent to the principal, meeting someone for the first time, being teased, failing a test, having to go to school, playing rough games during

recess, getting a report card, taking a test, and having to stay after school. In addition to being reliable and valid, reviews of the Fear Survey Schedule for Children (Scherer & Nakamura, 1968; Last, Francis, & Strauss, 1989) have independently suggested that the measure can be used to discriminate between children who refuse school because of separation anxiety disorders and those who are truly school phobic children.

Visual Analogue Scale for Anxiety-Revised (Bernstein & Garfinkel, 1992)

The Visual Analogue Scale for Anxiety-Revised is an 11-item self-report rating scale, aimed at quantifying an individual's anxiety on 11 potentially anxiety producing situations. The test was normed with children between the ages of 8.6 and 17.6 years. The 11 items were selected from 40 items based on their correlation with scores on the Revised Children's Manifest Anxiety Scale (RCMAS, Reynolds & Richmond, 1985) and the State-Trait Anxiety Inventory for Children (STATIC, Spielberger, 1973). Of the 11 items, 7 are school related and include being called on by the teacher, eating alone in the lunchroom, starting school in the fall, riding the school bus, thinking about going to school on Monday, speaking in front of class, and walking into the school building. The 11 items have an internal consistency of 80 and test–retest reliability of 0.87 (Bernstein & Garfinkel, 1992).

School Refusal Assessment Scale-Revised (Kearney, 2002)

The School Refusal Assessment Scale-Revised (SRAS-R) is a 24-item scale aimed at determining what function maintains school refusal behavior. The normative sample included children between the ages of 6 and 17. Unlike all of the previously mentioned assessments, the SRAS-R is specifically designed to examine school refusal behaviors and thus all 24 items are directly related to school-based behaviors. Each of the four conditions—avoidance of stimuli providing negative affectivity, escape from aversive social or evaluative situation, attention getting behavior, positive tangible reinforcement—are represented by six questions that are rated on a 7-point Likert-type scale ranging from *never* to *always*. At the completion, the means for each of the four conditions is ranked and the highest scoring condition is considered to be the primary functional consequence maintaining the school refusal behavior. There are both parent and child forms, for which all item have significant test–retest reliabilities at both 7 and 14 days (Kearney, 2002). Additional work has been done to examine the factor structure of the scales (Kearney, 2006). With the exception of three items, there was strong support for a four factor structure that maps on to the proposed four functions of school refusal behaviors.

Social Skills and Social Anxiety

Given that social anxiety and a lack of social skills could be related to both students with issues concerning truancy or students with anxiety based school refusal, one means of alleviating school refusal behaviors would be the assessment and treatment of social skill deficits. The DSM-IV describes Social Anxiety as fear of social situations and fear of being negatively evaluated by others (American Psychiatric Association, 2000). Researchers have theorized that a student has a greater chance of developing a social anxiety disorder if the disorder is present in the student's parents (Beidel & Turner, 1997), if the student's parents have a parenting style that is either critical/unaffectionate or overprotective (Rapee, 1997), or if the student is shy or demonstrates an inhibited temperament (Ollendick & Hirshfeld-Becker, 2002; Weeks et al., 2009). Additionally, Coplan, Arbeau, and Armer (2008) demonstrated a relationship between children's shyness and their mothers' overprotective parenting style and/or their mother being classified as neurotic. This relationship may suggest a social learning hypothesis of anxiety development whereby children learn anxiety-related behaviors from observing them in others (Wood, McLeod, Sigman, Hwang, & Chu, 2003; Weeks et al., 2009).

Kearney and Albano (2004) examined 143 youths with primary-school refusal behaviors who were absent a mean of 37.22% of school days and found that as many as 3.5% would

qualify for a primary diagnosis of Social Anxiety Disorder, 10.5% would qualify as having a generalized anxiety disorder, and 22.4% would qualify as having Separation Anxiety Disorder. With as many as 7.7% of examined students who would qualify as having either a primary or secondary diagnosis of Social Phobia, it is clear that additional social skills assessment and intervention may be necessary for a subset of students who are engaging in school refusal behaviors.

From a functional point of view, students with social anxiety problems would seemingly be engaging in school refusal behaviors to avoid negative social interactions either with peers or teachers (i.e., to receive negative reinforcement). Given school refusal's history in truancy-related literature, it can be difficult to realize how prevalent anxiety and negative reinforcement is for individuals engaged in school refusal behaviors but students who engage in negatively reinforced school refusal behaviors are wide spread. Research using the School Refusal Assessment Scale (Kearney & Silverman, 1993) has suggested that a number of students engaging in school refusal behaviors are doing so to avoid or escape negative situations in school with almost 44% of parents ratings on the SRAS-P suggesting school refusal behaviors were motivated by negative reinforcement (Kearney & Albano, 2004). Additional research suggests that as little as 60% of students have a singularly positively reinforced school refusal profile (Dube & Orpinas, 2009).

Given the prevalence of school refusers who have difficulty with social anxiety, additional school-based assessments of social skills/social anxiety can be useful in developing intervention.

An evidence-based assessment of social skills/social anxiety in children can be aided by using the Social Skills Improvement System-Rating Scales (SSIS-RS; Gresham & Elliott, 2008). The first stage, if possible, for assessment is screening entire schools in order to find students at risk for developing behavior problems related to social skills. Students should be screened at school 2–3 times/year to determine whether they are at risk for developing problems associated with social anxiety. These times can either be set by the school calendar (beginning, middle, and end of school year) or when a complaint either from the student (school refusal behavior), his parents (bullying), or the school (number of absences) may require a screening. Screening is important as children with internalizing behavior problems may "fly under the radar" and be "invisible" in the classroom (Merrell & Gueldner, 2010). The importance of finding these students cannot be understated, as unserved children are at higher risk for more severe internalizing problems, externalizing behavior problems, peer rejection, lack of employment opportunities, and problems associated with substance abuse (Compton, Burns, Egger, & Robertson, 2002; Reinherz et al., 2006; Sourander & Helstela, 2005; Vasa & Pine, 2006).

Two additional methods of screening are outlined here. Screening students can also be done by using the Screen for Child Anxiety Related Emotional Disorders (SCARED; Birmaher et al., 1997; 1999). The SCARED is a 38-item screening tool that assesses the student's severity of different symptoms of Separation Anxiety, Generalized Anxiety, Social Phobia, and School Phobia over the past 3 months. Technical adequacy of the SCARED as measured by internal consistency and test–retest reliability is good (Silverman & Ollendick, 2005).

A last screening method for screening social anxiety and internalizing problems includes the Student Internalizing Behavior Screener (SIBS; Cook, 2010). The SIBS is a screening tool that uses teacher ratings to identify whether students in grades 1–5 are at risk for developing internalizing behavior problems. A quick screening instrument, the SIBS consists of seven items; and it has adequate technical adequacy via internal consistency and test–retest measures, as well as correlates highly with the Internalizing scale of the Achenbach TRF (Cook, 2010).

Once students are identified as at risk, completing the SSIS-RS yields a measure of social skills functioning, which shows whether there is a comprehensive deficit in social skills. Examining the items in which the student is either a performance or acquisition deficit allows for appropriate intervention planning. Additionally, if the student scores above average or higher on one of

the subscales, hypotheses from the SRAS may be further supported. If the student scores high on the externalizing subscale, then it may aid in conforming the functional hypothesis that the student would be pursuing attention or a tangible reward outside of the school setting. On the other hand, if the student scores high on the internalizing subscale, there may be more evidence for the hypothesis that the student is avoiding general school-related stressors or escaping aversive social and/or evaluative situations in school (Kearney, 2007).

While this negatively reinforced school refusal may exist in combination with other functions of behavior that are secondary, for any real gains to be made, interventions targeting school-based anxiety and social skills deficits should be on the forefront of treatment. A tiered model of interventions and assessment for students with social skills deficits that could be leading to school refusal behaviors is discussed below.

Social Skills Anxiety Treatment by Tiers

Response to Intervention (RTI) is a decision-making framework used to match the current needs of students to an appropriate intervention. With the reauthorization of IDEA in 2004, local education agencies (LEAs) are allowed to use RTI to determine whether a child has a specific learning disability, and the framework is being used similarly for behavior with the emergence of School Wide Positive Behavior Intervention Supports (SWPBIS). Response to Intervention uses student's data (response) to empirically validated interventions to determine whether the current level of instruction is adequate for that student in order for him/her to progress with students in his/her class. An RTI framework allows for a continuum of supports across three tiers.

Tier 1 is a universal tier, in which all students receive a research-based intervention and are screened throughout the school year to determine if their progress is adequate. Related to social skill anxieties, such universal interventions could include class wide instruction to explain steps directly related to the performance of social skills as well as what to do when in difficult social situations (as would be experienced by students with social anxiety problems).

If screening data determines the student is not progressing satisfactorily in the universal program, the student receives a Tier 2 intervention. These evidence-based interventions are used to supplement the universal intervention, and the goals of these interventions are to get the student's level of performance back on par with the rest of his/her instructional level. Related to social skill anxieties, secondary interventions could include a smaller group where there is role playing specific problematic situations that the student would likely face when in the regular school setting. This intervention would supplement the universal program and its aim would be to get the student up to speed so that he/she can benefit directly from the universal program. Similar to academic interventions, when the student catches up with the universal program, the additional intervention would be unwarranted.

If the student is not progressing quickly enough in a Tier 2 intervention or is not making any gains, he/she is referred for a Tier 3 intervention. For academics, these interventions are intensive, individualized instruction aimed at getting the student back to grade level. For behavior, these interventions are based on function-based assessment and appropriate replacement behaviors are explicitly taught to the student and reinforced with function-based reinforcement. For students with social skill anxieties with peers, Tier 3 interventions could include an examination of what specific aspects of peer interaction are problematic and working to reduce anxiety through cognitive behavioral therapies. Additionally, a functional intervention that would allow for a brief escape from social situations after appropriate interaction occurs could be put into place. When the student engages in targeted behaviors at a more typical level, he/she would be moved back into a Tier 2 intervention until the universal intervention is sufficient for adequate functioning.

Social Skills Intervention System

In a tiered model of intervention, the least restrictive intervention is considered the most appropriate,

and individualized intervention, focused on functional relationships of behavior are only utilized when nonfunction interventions (universal, small groups) have proved ineffective. For example, if a student is making appropriate behavioral and social progress in the general education setting where only the placement of school-wide rules and brief universal lessons describing appropriate social behavior are in place, it would seem inappropriate to pull them out for additional instruction or to put an intensive behavioral intervention in place. For this reason, within a tiered model of social instruction students move from the least restrictive environment (universal program only) to more moderately intensive programs (small group instruction/nonfunction-based intervention) to intensive individualized interventions (direct instruction, functional interventions targeting replacement behaviors).

One tiered model of instruction that could be useful for teaching social skills to students engaging in school refusal behaviors because of social anxiety can be found in the The Social Skills Improvement System (SSIS; Elliott & Gresham, 2007, 2008). The SSIS was written in order for practitioners and administrators to have a method of screening and teaching social skills to students matched to their level of need. Instructional programming, with measures to continuously measure performance/response, is manualized in Tier 1 and Tier 2 (for acquisition deficits, see below). Guidelines for conducting Tier 2 interventions for performance deficits (see below) and Tier 3 FBA-RBT interventions are available in the program, but because these interventions are increasingly individualized, stringently manualized interventions are not included.

Universal Social Skills Training

The SSIS-Classroom Intervention Program (CIP; Elliott & Gresham, 2007) is the universal program of the SSIS. The CIP teaches the top ten social skills as rated by 8,000 (or 800?) teachers across the country over a 10-week period. Evidence-based methods of instruction are used by the student's general education teacher to teach social skills in the same method as he/she would teach reading or math. Teachers track student's response to this intervention by using the Performance Screening Guide (PSG) which allows the teacher to rank the student's prosocial behavior on a 4-point Likert scale. At the completion of the program, if the student's teacher rates his/her prosocial behavior as a 1 or 2, he/she progresses to Tier 2 of the program.

The Social Skills Improvement System-Rating Scales (SSIS-RS) assess students in social skills, problem behaviors, and academic competence. Ratings can be acquired from the student himself, his teachers, and his parents, allowing for a comprehensive assessment. The social skills domains assessed are communication, cooperation, assertion, responsibility, empathy, engagement, and self-control. The problem behavior domains assessed are internalizing, externalizing, bullying, hyperactivity/inattention, and autism spectrum. The academic competence scale is on the teacher version and assesses the student's classroom performance in reading, math, motivation, parental support, and general cognitive functioning. The SSIS-RS is validated in test content, item-total correlations, inter-correlations, internal structure, and relations with other variables (Gresham & Elliott, 2008). Additionally, correlations with particular scales and subscales of the Behavioral Assessment Scale for Children-2 (BASC-2) and the Vineland Adaptive Behavior Scales, Second Edition are moderate to high (Gresham & Elliott, 2008; Gresham, Elliott, & Kettler, 2010).

The SSIS-RS ratings yield a standard score in the areas of social skills and problem behaviors; and additionally, the SSIS-RS allows for appropriate classification of the student's social skills deficit, which aids in both correctly identifying the problem and the appropriate intervention for that problem. Social skills deficits are typically distinguished between social skills acquisition deficits and social skills performance deficits (Gresham, 1981; Gresham et al., 2010).

Skill acquisition deficits are characterized as "can't do" problems. To elaborate, acquisition deficits stem from either the student's lack of knowledge of how to appropriately perform an appropriate skill or the student's inability to

choose the correct skill to emit in specific settings or situations (Gresham, 1981, 2002; Gresham et al., 2010). Therefore, the student was either never explicitly taught the appropriate skill or never reinforced for exhibiting the appropriate skill/behavior in a particular situation, and the skill has never been entrenched in the student's repertoire. Students with social anxiety regarding interactions with peers could have these difficulties from a lack of experience in engaging with peers (as could be seen in early grades) and would benefit from specific instruction in engaging with other students. Therefore, interventions for students with skill acquisition deficits require intervention strategies with similar evidence-based techniques for teaching any academic skill: direct instruction, modeling, practice, and performance feedback (Elliott & Gresham, 2008; Gresham et al., 2010).

Social skills performance deficits are then characterized as "won't do" problems. With a performance deficit, the student has the skill/behavior in his repertoire; but in the situation calling for this behavior, he chooses to use an alternative, inappropriate behavior (Gresham, 1981, 2002; Gresham et al., 2010). In other words, the student knows how to perform the appropriate skill, but is not due to a motivational/reinforcement issue. Students who have had prior experiences engaging with other students, but have gained a phobia specific to these interactions because of prior difficulties could be in this group. Despite knowing how to engage with other students, prior experiences have failed to be reinforcing. Interventions for students with skill performance deficits require altering the student's environment in a way that the student receives a more potent reinforcer at a higher rate than the reinforcement that is maintaining the inappropriate behavior (Gresham, 1981, 2002; Gresham et al., 2010).

The SSIS-RS allows for differentiation between these two classifications via the method in which the rater indicates the frequency and importance of each item. On the teacher and parent versions, frequency is indicated on a 4-point scale (never, seldom, often, and almost always) and importance is indicated on a 3-point scale (not important, important, and critical). The student version uses a 4-point scale for frequency (not true, a little true, a lot true, and very true) and the same 3-point scale for importance (Gresham & Elliott, 2008; Gresham et al., 2010). An item/behavior that could be classified as a skill acquisition deficit is defined as an item with a frequency score of never and an importance rating of either important or critical. Skill performance deficits are items that receive a frequency rating of seldom and an importance rating as critical (Gresham et al., 2010).

Individualized Interventions for Social Skills Anxiety

Failure to respond after receiving a Tier 2 intervention matched to skill deficit would progress the student to Tier 3. As stated earlier, the Tier 3 intervention involves replacement behavior training using reinforcers determined by Functional Behavior Assessment (FBA). A Functional Behavior Assessment is a multimethod assessment tool in which multiple personnel (a team) involved with the student on a day-to-day basis work together in order to determine the behavioral function maintaining the inappropriate behaviors.

The protocol for an FBA requires both direct methods of assessment (observations) and indirect methods of assessment (record review, functional assessment interviews with multiple personnel, direct behavior ratings). The team then makes hypotheses about the function of the student's behavior (attention, escape, access to tangibles) and uses reinforcers matched to that function to help build momentum for the new replacement behavior. Using the SSIS-RS, students who would qualify for this intervention would score 1 SD below the mean on Social Skills (<85) and 1 SD above the mean on Problem Behaviors (>115). The Problem Behaviors items on the SSIS-RS are considered to be "competing behaviors" that are receiving the reinforcement that the appropriate social skills should be attaining. Once a function-based intervention is in place, progress should be monitored using direct observation, direct behavior ratings, self-measurement, and other school archival data such as ODRs and conduct grades.

Conclusion

Kearney (2001) suggests that between 5 and 28% of children and adolescents engage in some type of school refusal behaviors, with as much as 44% of students engaging in these school refusal behaviors for negative reinforcement and as many as 7.7% of clinical samples of school refusers qualifying as having either a primary or secondary diagnosis of a Social Phobia (Kearney & Albano, 2004). Given this prevalence rate, assessment and intervention of social anxiety and concomitant social skills deficits are a necessity in schools today to help school refusers cope with and adapt to the school environment.

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