School-Based Intervention for Adolescents with Impairing Social Anxiety

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Abstract

Social anxiety disorder (SAD) is a common problem during adolescence that can result in a range of impairments to school-related functioning, including lower academic achievement and higher rates of peer rejection. Yet, most affected students with SAD do not receive mental health services, in part because SAD often goes undetected at home and school. Schools may be an appropriate venue for helping adolescents with SAD, as school-based interventions can directly target school-based impairment. Given the potential advantages of school-based mental health services, Masia Warner and colleagues developed Skills for Academic and Social Success (SASS), a cognitive-behavioral group treatment for adolescents with SAD designed for implementation in schools. This chapter provides an overview of the SASS intervention, including its structure and components, and describes findings from a series of randomized controlled trials which demonstrate its feasibility, efficacy, and effectiveness. We conclude by discussing future research directions, including the need to identify ways to enhance SASS' sustainability and extend its generalizability to youth in underresourced schools and underserved communities.

Anxiety disorders are the most common type of psychopathology during the middle and high school years, with a lifetime prevalence rate of 31.9% in a nationally representative sample of youth prior to age 18. Among anxiety disorders in adolescents, social anxiety disorder (SAD) ranks as second most common, after specific phobia (Merikangas et al., 2010). Characterized by an excessive fear and avoidance of social and performance situations (American Psychiatric Association, 2013), SAD peaks in onset around age 11 (Beesdo, Knappe, & Pine, 2009) and reaches a lifetime prevalence of 9.1% prior to age 18 (Burstein et al., 2011; Merikangas et al., 2010). When left untreated during adolescence, SAD is associated with a relatively persistent and stable course of symptoms into adulthood (Beesdo-Baum et al., 2012; Pine, Cohen, Gurley,

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A. W. Leschied et al. (eds.), *Handbook of School-Based Mental Health Promotion*, The Springer Series on Human Exceptionality, https://doi.org/10.1007/978-3-319-89842-1_21

Brook, & Ma, 1998), as well as increased risk of other serious mental health problems, such as depression, alcohol and drug dependence, and suicide (Beesdo et al., 2007; Dahne, Banducci, Kurdziel, & MacPherson, 2014; Kessler, 2003; Tomlinson, Cummins, & Brown, 2013; Wittchen & Fehm, 2003). Anxious youth are also vulnerable to impairments of social, family, academic, and occupational functioning, with adolescents with SAD at particular risk for social and school-related impairments (Blöte, Miers, Heyne, & Westenberg, 2015; Swan & Kendall, 2016).

Social Anxiety and School-Related Functioning

Many studies have examined the short-term and long-term impacts of SAD and other anxiety disorders on how adolescents function in the school environment (see review by Blöte, Miers, Heyne, et al., 2015). This body of research reveals a robust association between adolescent social anxiety and interference in school-related functioning, within both academic (e.g., achievement and school engagement) and interpersonal (e.g., friendships with classmates and bullying) domains.

Academic Performance

Research in adolescent samples links SAD with lower academic performance (Van Ameringen, Mancini, & Farvolden, 2003) and greater problems with learning and concentration in the classroom (Bernstein, Bernat, Davis, & Layne, 2008). In addition, common social fears of socially anxious teenagers may directly interfere with their classroom performance and ability to complete course requirements. For example, in a study of 2218 Swedish junior high school students, Gren-Landell et al. (2009) revealed that 91.4% of students with social anxiety reported impairment in the school domain due to their social fears, compared to 17.2% of the overall sample. These included speaking in front of the class and raising their hand during a lesson. Similarly, among a sample of 63 adolescents with SAD, Beidel et al. (2007) found that "oral reports or reading aloud" and "asking the teacher a question or asking for help" were identified as two of the most distressing social situations. These findings are consistent with those from the Social Anxiety and Normal Development (SAND) study (Westenberg et al., 2009), which found that socially anxious adolescents were more likely to experience distress and avoid a variety of school-related social situations, including answering questions in class, reading aloud, giving a speech in class, writing on the board, and taking tests. Thus, it is clear that situations which are commonly encountered during the school day can cause considerable difficulty for students with SAD.

Moreover, poor academic performance may be related to cognitive dysfunction implicated in SAD. Individuals with SAD demonstrate heightened attention to threatening stimuli (Roy, Dennis, & Masia Warner, 2015), negative interpretations of routine interactions and situations, and low expectations of personal performance (Alfano, Beidel, & Turner, 2006; Rapee & Lim, 1992). In addition, the attention of individuals with social anxiety is excessively self-focused and characterized by frequent negative self-images and thoughts, as well as hypervigilant self-monitoring of their behaviors (Clark & Wells, 1995). Such competing cognitive activity may impair memory capacity, the ability to inhibit goal-irrelevant information (Airaksinen, Larsson, & Forsell, 2005; Moriya & Sugiura, 2013), and concentration and attention to academic tasks (Bernstein et al., 2008). In sum, it appears that both social and cognitive impairments can contribute to poor academic performance in youth with SAD.

School Engagement and Completion

Because the school environment features many challenging social situations that are often avoided by socially anxious students, it can be difficult for them to remain engaged. In addition to participating less in the classroom, students with SAD may be less involved in extracurricular

activities, such as school clubs and sports. This frequent avoidance of interaction with classmates and teachers may further erode student engagement and school connectedness, or the extent to which students feel supported by others in the school environment. Students reporting low school connectedness tend to experience greater social anxiety and exclusion, as well as greater potential for degree non-completion (Blum & Libbey, 2004; Bond et al., 2007; Resnick, Harris, & Blum, 1993; Shochet, Dadds, Ham, & Montague, 2006). Indeed, social anxiety is also associated with increased risk for absenteeism, school refusal, and premature withdrawal from school (Heyne, Sauter, Van Widenfelt, Vermeiren, & Westenberg, 2011; Stein & Kean, 2000; van Ameringen et al., 2003). For example, in a longitudinal study of 1426 high school students, Monroe, Borzi, and Burrell (1992) reported that those with communication apprehension were more likely to drop out of school and avoid post-secondary education, citing fear of communicating with others as the primary reason. Van Ameringen, Mancini, and Farvolden (2003) reported similar findings in a sample of 201 anxious adults, who noted social fears (e.g., speaking up in class, feeling nervous in school) as their main reasons for disliking school and terminating school prematurely.

SAD is also associated with somatic complaints in adolescents (Ginsburg, Riddle, & Davies, 2006) that may contribute to additional disruption in their classroom involvement because of a frequent need to visit school nursing staff. Withdrawing from school activities due to social anxiety and related physical symptoms may serve to reinforce school-related fears. As students continue to move away from the school environment, they may be at further risk of negative academic outcomes and school dropout (Janosz, Archambault, Morizot, & Pagani, 2008; Wang & Holcombe, 2010), as well as risky health behaviors associated with absenteeism, such as illicit drug use and suicide attempts (Kearney, 2008). Taken together, it is evident that several characteristics linked to adolescents with SAD, including social avoidance and somatic complaints, can interfere with their ability to remain engaged and complete school.

Peer Relations and Friendships

The transition to middle school and high school requires adolescents to navigate a period marked by greater emphasis on interpersonal relationships, including social demands from classmates, social media, and dating. During adolescence, youth are also expected to become more independent and receive less help from their parents in developing social connections. Thus, the adolescent period can be quite challenging for many students and, not surprisingly, presents particular difficulties for students with SAD, who struggle in social situations. Youth with SAD often experience distress around social behaviors needed to engage unfamiliar peers, such as initiating and joining conversations and asking peers to hang out. Consequently, they may avoid these interactions and engage less with their classmates (Schneider, 2009), which can restrict the development of new friendships and social opportunities (Erath, Flanagan, & Bierman, 2007). Indeed, research suggests that socially anxious adolescents tend to be less popular (Van Zalk, Van Zalk, Kerr, & Stattin, 2011), have fewer friends, and perceive less support and intimacy in their friendships (La Greca & Lopez, 1998; Tillfors, Persson, Willen, & Burk, 2012; Vernberg, Abwender, Ewell, & Beery, 1992). They are also more likely to befriend other socially anxious classmates, which can unfortunately serve to maintain and exacerbate their own social anxiety (Van Zalk et al., 2011). In the school environment, discomfort around peers may manifest itself in different ways, ranging from discomfort around eating with others in the cafeteria to avoiding school clubs and activities (Beidel, Turner, & Morris, 1995, 1999; Gren-Landell et al., 2009). Ultimately, these difficulties with social behaviors and relationships at school may leave students with SAD feeling isolated and lonely (Beidel et al., 2007).

Peer Rejection and Victimization

A consistent body of research demonstrates an association between social anxiety and various forms of peer rejection, including exclusion,

teasing, and bullying by classmates (e.g., Blöte, Miers, & Westenberg, 2015; Inderbitzen, Walters, & Bukowski, 1997; Ranta, Kaltiala-Heino, Frojd, & Marttunen, 2013; Ranta, Kaltiala-Heino, Pelkonen, & Marttunen, 2009; Storch, Brassard, & Masia Warner, 2003). Moreover, evidence suggests that this association reflects actual treatment, rather than negatively biased perceptions of socially anxious students. For example, based on their study of 84 middle school students, Erath, Flanagan, and Bierman (2007) found that social anxiety was associated with decreased peer acceptance and increased victimization, as reported by youth and peers. Negative expectations of social performance and social withdrawal were identified as mechanisms by which social anxiety contributed to negative peer relations. Similarly, Blöte and Westenberg (2007) reported that socially anxious high schoolers felt more negatively treated by their classmates, a perception that was shared by their nonsocially anxious classmates. In addition, youth who are victimized at school may internalize the content of peer attacks and harassment (Troop-Gordon & Ladd, 2005), resulting in greater avoidance of social interactions (Storch, Masia Warner, Crisp, & Klein, 2005) and fear and avoidance of school itself (Kearney, 2008), which can exacerbate academic problems. Importantly, the relationship between social anxiety and peer rejection appears reciprocal (Rubin & Burgess, 2001; Siegel, La Greca, & Harrison, 2009). That is, while peer rejection may lead to social fears and avoidance, social anxiety may increase risk for experiencing peer rejection.

Rationale for School-Based Intervention

Despite the high prevalence, chronic course, and functional impairments associated with adolescent SAD, most affected students remain untreated. SAD is the second most untreated psychological disorder in adolescents, after specific phobia (Costello, He, Sampson, Kessler, & Merikangas, 2014). Among a nationally representative sample, a scant 12.1% of adolescents with SAD reported receiving mental health services, including only 21.3% of adolescents with *severe* SAD (Merikangas et al., 2011). Adolescents with SAD may be unlikely to access services because SAD often goes undetected at home and school (Kashdan & Herbert, 2001). For example, parents tend to have more difficulty recognizing signs of anxiety in their children and perceive anxiety as less burdensome, disruptive, and warranting intervention, when compared to more overt externalizing problems (Albano, DiBartolo, Heimberg, & Barlow, 1995; Angold et al., 1998; Wu et al., 1999; Thurston, Phares, Coates, & Bogart, 2015). Similarly, youth with SAD may be "invisible" in the classroom (Strauss, Lahey, Frick, Frame, & Hynd, 1988) and only come to the attention of school personnel when they refuse to attend school (Beidel & Morris, 1995). Although school-based mental health screenings can accurately identify students with SAD (Sweeney et al., 2015), they are a low priority for public schools, which are more likely to use their limited resources to support programs targeting overt behavioral problems, such as anger management and substance abuse prevention (Foster et al., 2005). For those teenagers identified through school-based mental health screenings, referrals for additional care are less frequently provided to those with internalizing problems (e.g., anxiety), compared to those with externalizing problems (Husky, Sheridan, McGuire, & Olfson, 2011). Even when adolescents are linked with mental health services, they may be reluctant to engage due to stigma about treatment and fears of negative evaluation (Jagdeo, Cox, Stein, & Sareen, 2009; Jorm, Wright, & Morgan, 2007; Meredith et al. 2009).

In light of how many adolescents with SAD go unrecognized and untreated, and the substantial impact of SAD on functioning in the school environment, there have been calls for efforts to increase and improve service delivery for SAD in school settings (Kashdan & Herbert, 2001). Schools may be an especially appropriate venue for treating adolescents with SAD for several reasons. First, SAD appears less responsive than other anxiety disorders to individual treatment formats (e.g., Ginsburg et al., 2011), presumably

because group-based interventions more easily facilitate social skills practice and exposure exercises targeting the social avoidance associated with the disorder (Beidel et al., 1999; Kendall, Settipani, & Cummings, 2012). It can be easier to organize a group intervention in a school than an outpatient mental health setting, where scheduling and logistical issues make group formats less feasible. Second, school-based interventions can directly address the school-related impairment caused by SAD, as well as more readily address the many triggers of SAD that commonly occur at school. School-based clinicians can coordinate exposure exercises both in the classroom (e.g., requesting teachers call on students to answer questions or read aloud) and out of the classroom (e.g., having students start conversations with peers in the cafeteria). Third, school-based clinicians (e.g., school counselors, school psychologists) are uniquely well-positioned to monitor student progress, particularly any changes in school and social functioning, and address issues or setbacks that arise. Fourth, situating mental health care in schools can inform school personnel of the signs and symptoms associated with SAD. This may increase the likelihood of early detection and intervention, given that teenagers with social anxiety access services more successfully when referred by school personnel (Colognori et al., 2012). Finally, school-based mental health services have been shown to address practical barriers to service utilization by adolescents, including financial costs, insurance coverage, transportation, and stigma (Slade, 2002).

Skills for Academic and Social Success (SASS)

Given the potential advantages of school-based mental health services, Masia Warner and colleagues developed an approach to intervention for adolescent SAD that tailored evidence-based strategies for delivery in school settings (Masia Warner, Colognori, & Lynch, 2018). This intervention, called Skills for Academic and Social Success (SASS), was adapted from Social Effectiveness Therapy for Children (SET-C), an empirically supported, clinic-based treatment that consists of 12 individual sessions of exposure, 12 group sessions of social skills training, and unstructured generalization exercises which provide opportunity for children with SAD to practice socializing with non-anxious peers. SET-C was chosen due to its demonstrated efficacy in attention control trials (Beidel, Turner, & Morris, 2000; Beidel, Turner, Young, & Paulson, 2005), as well as a group format and emphasis on activities with peers that match well with the natural availability of same-aged classmates in the school environment.

A number of significant modifications were necessary in adapting the intervention for school-based delivery. The number, length, and pace of sessions were reduced in order to facilitate implementation within a typical class period. Based on evidence suggesting that socially anxious adolescents are more likely than children to engage in negative self-talk (Alfano et al., 2006), a module on cognitive restructuring (called "realistic thinking") was added to the program. Finally, the school environment was incorporated into the program in order to enhance treatment gains and maximize real-world generalization of skills. For example, treatment exercises include teachers and school peers, and adolescents practice skills in school and community locations.

The core elements of SASS target many of the processes implicated in the school-related dysfunction commonly experienced by adolescents with SAD. SASS aims to teach cognitive reappraisal of feared negative outcomes in social and school situations, enhance social skills, and facilitate exposure to feared school situations. The theory of change underlying SASS proposes that these cognitive and behavioral changes will result in decreased social anxiety and avoidance, improved attention and concentration, decreased somatic complaints, and improved social functioning. In turn, these gains may result in improved school functioning by reducing the risk of premature school termination and increasing academic performance, school connectedness, and school engagement. In the rest of this chapter,

we describe the SASS program and findings from controlled trials evaluating its feasibility, efficacy, and effectiveness.

Structure and Components of SASS

SASS is comprised of 12 in-school group sessions, two booster group sessions to target relapse and remaining obstacles, and two brief individual sessions. Parents are encouraged to attend two parent group sessions to learn about social anxiety, the SASS treatment, and strategies for managing their teenager's social anxiety. Students also attend four weekend social events, at which they have the opportunity to socialize with prosocial peers ("peer assistants"), practice skills learned during the intervention, and engage in real-world exposure. The program lasts approximately three months, and the group and individual sessions are held during the school day during rotating class periods.

School Group Sessions

Group sessions in SASS are 30–40 min in length, kept small (three to six students), and facilitated by one to two group leaders. Each of the 12 sessions focuses on a different component of SASS: psychoeducation, realistic thinking (cognitive restructuring), social skills training, facing your fear (exposure), and relapse prevention. Sessions conclude with the assignment of practice exercises that are then reviewed at the beginning of the next session.

Psychoeducation In the first session, group leaders provide an overview of the rationale, structure, and components of SASS. Group leaders also work with the students to establish group rules and discuss the importance of confidentiality. In addition, students learn about the symptoms of social anxiety, with emphasis on the anxiety triad. Students are asked to describe their own anxiety symptoms, discuss the social situations that they fear or avoid, and provide examples of how social anxiety affects their bodily reactions, thoughts, and behaviors. A main goal of this session is for students to recognize the interaction between the emotional, cognitive, and behavioral manifestations of their social anxiety. Understanding the role of avoidance is also a key focus of this session. Lastly, to foster motivation, students are encouraged to identify specific changes they would like to see occur as a result of their participation, including social situations in which they would like to feel more comfortable.

Realistic Thinking The second session focuses on cognitive reappraisal, with strategies adapted from Ronald Rapee's (1998) book *Overcoming Shyness and Social Phobia: A Step-by-Step Guide.* In this session, students learn about the role of negative self-talk, how to identify unrealistic thought patterns, and steps for thinking more realistically. A main goal of the session is for students to understand the connection between thoughts and feelings. Group leaders provide several examples to illustrate how having a certain thought in a given situation can lead to a different emotional reaction. Next, group leaders explain that individuals with social anxiety tend to engage in negative self-talk. In order for this to be relatable to teenagers, group leaders refer to this as being "overly negative." Students learn about two types of cognitions associated with SAD: exaggerated negative expectations (e.g., "If I give a class presentation, I'll mess up") and exaggerated feared consequences (e.g., "If I mess up, everyone will remember that I messed up"). To think more realistically, students are taught to identify their negative thoughts (i.e. "What am I afraid of? What am I predicting will happen?"), ask questions to assess the reality of their predictions (e.g., "Am I exaggerating? How many times has this happened in the past?"), and think more flexibly by proposing alternative explanations. Group leaders then elicit real examples of feared social situations from the students in order to practice applying these realistic thinking strategies in session. Although this is the only session focused on cognitive restructuring, students are asked to practice these strategies at home, as well as in subsequent sessions as needed.

Social Skills Training Learning and practicing social skills can help increase the confidence of adolescents with SAD in facing social situations they might otherwise avoid. SASS covers four different social skills: (1) initiating conversations, (2) maintaining conversations and establishing friendships, (3) listening and remembering, and (4) assertiveness. Group leaders explain the concept and rationale of each skill, model them for students, and then facilitate role play exercises that allow students to engage in practice with their fellow group members. In each session, students participate in at least two role plays, which feature scenarios relevant to typical adolescent experiences (e.g., practicing how to start a conversation with a classmate). For each skill practice, group leaders provide feedback tailored to each student. Given that adolescents with SAD may appear unapproachable because of nervous nonverbal behavior (e.g., tense expression or jitteriness), suggestions may be given to encourage a friendlier demeanor, such as making eye contact, smiling, or speaking in a louder voice.

In the first social skills session, initiating conversations, students learn about opportunities for starting conversations (e.g., sitting next to someone in the cafeteria), ways to open conversations (e.g., commenting on something you have in common), and body language that conveys friendliness. Group leaders emphasize that conversation starters can be simple and even dull, in order to reduce the pressure that socially anxious teenagers may feel to sound witty or interesting. As part of the second skill, maintaining conversations and establishing friendships, students practice asking open-ended questions to facilitate conversations and changing topics appropriately, rather than prematurely due to feelings of discomfort. To bolster each student's confidence in establishing friendships, group leaders encourage them to practice extending invitations and identify common concerns about asking others to get together. The goal of the third skill, listening and remembering, is to combat anxiety interference, which occurs when teenagers with social anxiety become preoccupied by their own negative self-evaluations (e.g., "Do I sound boring?"). Thus, students are taught to pay attention to what their conversation partner says and to build on it during the conversation. As part of the fourth and final skill, assertiveness, students learn to refuse requests and express difficult feelings through the use of "I" statements (e.g., "I felt upset when you didn't complete your part of the project on time.").

Facing Your Fear Five sessions of SASS are devoted to exposure exercises in which group leaders work with students to confront feared and avoided social situations. Group leaders present the rationale of exposure, explaining that avoidance of social situations reinforces fear, whereas gradually facing these situations reduces discomfort in the long run. Next, group leaders explain that effective exposure is gradual in nature and usually requires staying in the situation and repeated practice. Metaphors are frequently used to illustrate these concepts. For instance, to convey the gradual nature of exposure, group leaders describe how a person with a fear of heights would not be expected to start at the top floor of the Empire State Building but would instead start at the first floor and climb a few floors at a time as they become more comfortable. Students then create a fear hierarchy (or "fear ladder") by ranking their feared social situations, in order from least to most anxiety-provoking. When developing hierarchies, group leaders emphasize the importance of addressing "core fears" related to embarrassment, criticism, and rejection. Common situations that target core fears include giving an incorrect answer in class, asking peers to get together, and making social mistakes, such as tripping in front of classmates.

Prior to starting each exposure, students are asked to provide their predictions (e.g., "What are you expecting will happen?"), along with a Subjective Units of Distress (SUDS) rating from 0 (completely calm) to 8 (absolutely terrified). Group leaders elicit SUDS ratings from students periodically during the exposure and upon its conclusion. SUDS ratings are expected to decrease at least 50% by the end of the exercise.

If a student is resistant to entering the feared situation, group leaders briefly explore the student's negative expectations and may adjust the exposure if necessary. Upon conclusion of the exposure, group leaders compare the initial and final SUDS ratings and ask students how the experience compared to their earlier predictions (e.g., "Was it as bad as you expected?"). Students then discuss their experience and provide feedback before identifying exposure exercises they will practice in between sessions.

Conducting exposures in school offers the opportunity to capitalize on the school environment by creating realistic situations that target common, everyday social fears. During exposure exercises, student practice entering feared situations in the group (e.g., reading aloud) or throughout the school (e.g., talking with an unfamiliar peer in the cafeteria). For example, one exposure session focuses on a "speed chatting" exercise, in which students pair up with their fellow group members to practice conversing. In an effort to encourage students to confront their nervousness around maintaining conversations, group leaders let each conversation last for a few minutes before switching up the pairs. Exposure exercises may also be tailored to a student's specific difficulties in school (e.g., meeting with teachers, approaching unfamiliar peers at lunch) or outside of school (e.g., calling for food delivery). In addition, because common school fears for adolescents with SAD involve talking with authority figures, group leaders facilitate exposures in school with the assistance of school personnel. Examples may include visiting the main office to speak with administrative staff or asking questions to the librarian. Finally, exposures may be developed to target fears of group activities, such as joining a club or approaching a coach to discuss joining an athletic team.

Relapse Prevention The final group session focuses on maintenance of gains and avoiding relapse. Each student gives a speech about their experience in the program, including what they learned and achieved, along with goals for future improvement. Group leaders then facilitate a discussion of strategies for continuing gains and managing setbacks to prevent relapse. Students identify warning signs that their social anxiety symptoms have returned or worsened, as well as strategies for addressing them. We have found it useful to remind students that setbacks are inevitable while instilling confidence in them based on their increased ability to cope with social situations.

Individual Sessions

Two 15-min individual sessions are conducted to check in with students about their treatment goals and address any issues that may impede their progress. In addition, students have the opportunity to share concerns they may not feel comfortable expressing in the groups, such as stressors (e.g., being bullied, academic struggles) that may interfere with their ability to complete practice exercises. Other aims of individual sessions can be to conduct a customized cognitive restructuring exercise, review social skills that may be challenging for the student, and develop and refine the student's fear hierarchy.

Booster Sessions

Group booster sessions are conducted monthly for two months after completion of the program. The purpose of these follow-up meetings is to evaluate progress, assess and discuss obstacles to improvement, and reinforce and identify strategies for establishing relationships. Additional exposure exercises may be conducted as needed.

Social Events

Four weekend social events are included in SASS to facilitate skill practice and generalization. Events may involve different activities (e.g., bowling, rollerblading, or laser tag) and are attended by group leaders, group members, and peer assistants (see next section for description). These activities allow for group members to practice social skills learned in the program and

engage in exposure to commonly avoided social situations, such as attending a gathering with unfamiliar peers, starting conversations, and eating and playing games/sports in front of others. Group leaders are also able to observe how group members function in realistic social situations. While group leaders facilitate the first event and encourage interaction between participants, they are typically less involved during subsequent events, unless a student is having significant difficulties. As the program progresses, later events may also be less structured (e.g., having a picnic) in order to provide a more naturalistic situation that challenges students to use their new skills.

Peer Assistants

Peer assistants are friendly, helpful, and prosocial students who assist with the program. The main role of peer assistants at social events is to promote a positive experience for the group members and help integrate them into activities. Peer assistants may also assist with social skills practice and exposure activities during group sessions, such as having conversations with group members in the school hallways. While students may be nominated by school personnel to serve as peer assistants, it is ideal to have students who previously completed the program return to be peer assistants, as they are typically sensitive and empathic toward the current group members. In addition, serving as a peer assistant can reinforce for them how much their social anxiety has improved since completing the program.

Parent Sessions

Parents are invited to two meetings during the course of the intervention. If parents cannot attend, group leaders offer to speak with them via telephone to provide a summary of the meetings and address any concerns. The first session provides parents with psychoeducation about social anxiety, as well as an overview of the SASS program. Parents of adolescents with SAD may feel frustrated by their teenager's avoidance behaviors (e.g., refusing to order food in a restaurant) and struggle to understand the extent of their teenager's distress. Therefore, if parents can develop greater understanding of the symptoms, distress, and impairment associated with SAD, they may be more patient with their teenager and receptive to implementing different parenting strategies.

The second parent session focuses on teaching parents to distinguish between unhelpful and helpful strategies for responding to their teenager's anxiety. Parents may initially express concern that their style of parenting has caused these difficulties in some way. As a result, group leaders use a nonjudgmental approach during this discussion, acknowledging that the unhelpful strategies (e.g., providing excessive reassurance, being overly directive, permitting avoidance) are common and natural reactions for parents when observing their children experience distress. However, parents learn that these strategies only provide their children with short-term relief of anxiety while promoting long-term avoidance of challenging situations. Therefore, parents are advised to discontinue the unhelpful strategies and instead communicate empathy, prevent avoidance, encourage constructive coping, and reinforce non-anxious behavior. If parents can implement these strategies effectively, they can help their children develop adaptive coping and problem-solving skills and promote increased autonomy important for ensuring a successful transition to young adulthood.

Teacher Involvement

Educating and collaborating with teachers are important advantages of school-based treatment. In addition to meeting with teachers to provide psychoeducation about social anxiety and an overview of SASS, group leaders work with teachers to identify areas of social difficulty for participating students. During the program, teachers work with group leaders to support their students and plan appropriate and graded exposure exercises in the classroom. For example, teachers may assign leadership roles in group

activities to students participating in the program. In addition, if a student has fears of class participation, the teacher may initially provide the student with the answer to a question before class and subsequently call on the student to answer the question. Eventually, the student practices answering questions sufficiently such that they can participate more spontaneously. As the program continues, teachers can also provide feedback about student progress and identify other areas to be addressed.

Outcome Studies of SASS

To date, SASS has been evaluated in a small open trial (Masia, Klein, Storch, & Corda, 2001) and three randomized controlled trials (RCTs): two efficacy trials, including a waiting-list control trial (Masia Warner et al., 2005) and an attention control trial (Masia Warner, Fisher, Shrout, Rathor, and Klein, 2007), and one effectiveness trial of SASS delivered by school counselors (Masia Warner et al., 2016). In the first RCT, Masia Warner et al. (2005) randomized 35 adolescents (ages 14–16) with SAD from two urban parochial schools to either SASS (n = 18) or a waiting list (n = 17). SASS was co-led by a clinical psychologist and a psychology graduate student trained in the intervention. Compared to the waiting list group, adolescents assigned to SASS experienced greater improvements in social anxiety, avoidance, and functioning, as noted by adolescent, parent, and blinded evaluator ratings. Among SASS participants, 94% were classified as treatment responders at post-intervention, compared to only 12% of control group participants. In addition, 67% of the SASS group, versus only 6% of the waiting list group, no longer met diagnostic criteria for SAD at post-intervention. Clinical improvement was maintained nine months after treatment completion. In addition to linking SASS to improvement over time compared with no treatment, this study demonstrated that SASS could be feasibly implemented in schools.

In the second RCT, Masia Warner et al. (2007) compared SASS (n = 19) to a credible attention control group (n = 17) in a sample of adolescents (ages 14–16) with SAD. The attention control was designed to match SASS in time and professional attention; however, it omitted the main SASS components (e.g., social skills, exposure) and consisted of psychoeducation, relaxation training, and four social events without peer assistants. Findings confirmed the superiority of the SASS intervention, with 82% of SASS participants classified as responders at post-intervention, compared to 7% of attention control participants. Of the SASS group, 59% no longer met the criteria for a diagnosis of SAD at post-intervention, versus 0% of the attention control group. Furthermore, at post-intervention and six-month follow-up, SASS participants had lower clinician-rated social anxiety severity and greater global improvement. Overall, this study supported the specific efficacy of SASS and provided justification for further study of its effectiveness and disseminability to school settings.

Most recently, Masia Warner et al. (2016) completed a large investigation of high school students with SAD to examine whether SASS could be delivered effectively by school personnel without specialized training in CBT. A total of 138 ninth through 11th graders from three public high schools were randomized to one of three conditions: SASS as delivered by school counselors (C-SASS), SASS as delivered by clinical psychologists with experience in CBT for youth anxiety (P-SASS), and *Skills for Living* (SFL), a nonspecific, manualized school counseling group program. To train school counselors in SASS, they attended a 5-hour workshop led by the treatment developer. School counselors also co-led a 12-week SASS training group with a postdoctoral fellow, who provided weekly consultation during this training phase as well as when counselors implemented the SASS program independently.

Findings revealed that significantly more participants in C-SASS (65% and 85%) and P-SASS (66% and 72%) were classified as treatment responders at post-intervention and 5 months later, compared to SFL participants (18.6% and 25.6%). At post-intervention and follow-up, students who completed C-SASS and P-SASS also

had lower severity of SAD than students who completed SFL. Diagnostic remission was higher for C-SASS (22% and 39%) and P-SASS (28% and 28%) than SFL (7% and 12%) at post-intervention and follow-up assessments; however, only a trend in favor of C-SASS was found at post-intervention, and remission rates were lower compared to previous trials. No differences between C-SASS and P-SASS were observed on any of the main clinical outcomes. Taken together, these findings support the disseminability of SASS by showing that school counselors can provide effective treatment to adolescents with SAD, with benefits comparable to care delivered by psychologists.

Future Directions

Enhancing Sustainability of SASS

Clinical trials demonstrate that SASS is an efficacious, school-based treatment for adolescent SAD that can be feasibly implemented in school settings and effectively delivered by school counselors with limited background in cognitive-behavioral therapy (CBT). However, to be a cost-effective and viable option for treating adolescent SAD in schools, the implementation of SASS cannot rely on significant ongoing involvement from research psychologists with expertise in CBT. Therefore, several critical areas require further development in order for SASS to be a sustainable intervention in schools. First, given that SAD is often undetected in students, the development of feasible screening and identification efforts at school is essential. One option may be to train teachers and other school personnel to better detect signs of SAD. Accuracy might be improved by having school counselors complete checklists of behaviors associated with SAD during routine student meetings. Brief student screenings could also be conducted during health classes, freshman orientation, or other school activities.

Moreover, further study is needed to determine the type and amount of training and consultation needed for school personnel to deliver SASS with effectiveness. Clearly, the level of training and supervision cannot compromise the quality of SASS implementation. Masia Warner et al. (2016) demonstrated that, with intensive consultation, school counselors can deliver SASS with strong adherence and competence, but this training model will likely be an obstacle to dissemination. Additional investigation is needed to determine the level of fidelity necessary to yield positive treatment outcomes. In addition, it may be possible to streamline SASS to target compliance of essential ingredients (Dobson & Singer, 2005; Kazdin & Nock, 2003). Alternative models of training should also be explored, such as distance learning, web-based or computerized training, telemedicine technology, and pyramid training, in which one extensively trained school personnel would train and supervise others (e.g., Demchak & Browder, 1990). Each of these options may promote skill maintenance over time while being more practical and affordable for schools.

Finally, feasible methods are also needed for monitoring students' response to intervention (e.g., severity and functioning). While independent evaluators are considered the "gold standard" in RCTs for assessing treatment response, this is not feasible and cost-effective in school settings. Evidence from the effectiveness trial of SASS suggests that adolescents and their parents may serve as reliable informants (Fox & Masia Warner, 2017). Another possibility is to examine the utility of obtaining treatment response ratings from school personnel.

Enhancing Generalizability of SASS

Overall, there is a paucity of intervention research involving racial and ethnic minority communities, particularly for anxiety (Huey Jr. & Polo, 2008). Of evidence-based treatments shown to be effective with minority children and adolescents, almost half target conduct problems, with only three studies (Ginsburg & Drake, 2002; Pina, Zerr, Villalta, & Gonzales, 2012; Silverman et al., 1999) of anxiety. In addition, prominent RCTs of CBT for youth anxiety disorders often feature

samples largely composed of participants from White and middle-class backgrounds (e.g., Pediatric OCD Treatment Study Team, 2004; Walkup et al., 2008).

Rates of SAD and other anxiety disorders are high among racial/ethnic minority students (Beidas et al., 2012; Merikangas et al., 2010; Yeh et al., 2002). For example, Asian-American and Latino high schoolers and college students have been found to report more social anxiety and school-related interference, when compared to other racial/ethnic groups (Lau, Fung, Wang, & Kang, 2009; Masia Warner et al., 2013). Yet, rates of mental health service utilization are particularly low among racial/ethnic minority students with anxiety disorders (Gudiño, Lau, Yeh, McCabe, & Hough, 2009; Merikangas et al., 2011), who are also at higher risk of prematurely terminating mental health services (Gonzalez, Weersing, Warnick, Scahill, & Woolston, 2011; Gordon-Hollingsworth et al., 2015).

School-based mental health services have emerged as a potentially critical strategy for increasing access to low-income and racial/ethnic minority youth (Cummings & Druss, 2011; Keeton, Soleimanpour, & Brindis, 2012; Lyon, Ludwig, Vander Stoep, Gudmundsen, & McCauley, 2013; Stephan, Weist, Kataoka, Adelsheim, & Mills, 2007) and addressing practical barriers to mental health care, such as cost and transportation (Weist, 1999). Minority youth are more likely to receive mental health services in schools than community clinics (Cummings, Ponce, & Mays, 2010; Jaycox et al., 2010). In a population-based survey of economically disadvantaged communities, more than three-fourths of children receiving mental health services were seen in the educational sector (Burns et al., 1995).

Therefore, an important direction for future research is to extend school-based intervention efforts to adolescents with the most significant unmet mental health needs, including students with SAD from low-income and racial/ethnic minority backgrounds. Consistent with models of cultural adaptation of evidence-based interventions (Cardemil, 2010; Castro, Barrera, & Martinez, 2004), one approach may be to tailor SASS to schools in racial/ethnic minority communities by addressing core values, beliefs, and norms of different student populations that impact expression of SAD and willingness to engage in treatment, along with ensuring cultural competence in school personnel delivering SASS. For example, the questioning of authority figures by youth may be considered inappropriate in traditional Latino and Asian-American families who value compliance and shyness (Kumpfer, Alvarado, Smith, & Bellamy, 2002). School personnel delivering SASS may be encouraged to design exposures that target social fears when they contribute to impairment, while still respecting the cultural values of their students. By enhancing the cultural sensitivity of SASS and adapting it to fit within the culture of the local community and school environment, it may help remediate unmet mental health needs of a broader population of youth with SAD.

Summary

School-based treatment is considered a valuable approach for addressing the high rates of adolescents with SAD who remain unrecognized and untreated. Intervening in schools is especially appropriate for treating SAD, which confers a number of academic and social impairments that make school challenging for socially anxious students. Inspired by these potential benefits, Masia Warner and colleagues developed Skills for Academic and Social Success (SASS), a cognitive-behavioral group treatment for adolescents with SAD designed for implementation in schools. In this chapter, we outlined the format and components of SASS and described findings from several clinical trials evaluating the program. Research demonstrates that SASS can be disseminated to schools and effectively implemented by school counselors without previous specialized training. Future research should explore ways to enhance SASS' sustainability, including developing efficient and cost-effective models of identifying students with social anxiety, as well as training and consultation for school counselors. Finally, extending the generalizability of SASS to racial and ethnic minorities and

underresourced schools is essential to addressing the unmet needs of youth with SAD in underserved communities.

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