Effectiveness of the Skills for Academic and Social Success with Portuguese adolescents

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Abstract

Social anxiety is common in adolescence, but by its very nature makes adolescents reluctant to ask for help, making it important to transpose effective interventions to community contexts. This research presents the effectiveness of such an intervention, with a group of five female adolescents, who reported high interference of their social fears in their daily life. The intervention involved psychoeducation, cognitive restructuring, behavioral exposure and assertive training. At postintervention, the therapeutic change was noticeable by external observables and the participants themselves, and the higher impact was felt for diminished social anxiety symptoms. At follow-up, change was better kept for assertiveness then for social anxiety, requiring future inspection. These findings add to the cumulative and transcultural evidence on the effectiveness of the Skills for Academic and Social Success.

Keywords

Social anxiety, intervention, effectiveness, clinical change, statistical change

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The Skills for Academic and Social Success (SASS; Masia et al., 1999) is a cognitive-behavioral, school based intervention for adolescents with social anxiety disorder, based on the Social Effectiveness Therapy for Children (Beidel, Turner, & Morris, 1998). It includes psychoeducation, realistic thinking, social skills training, exposure and relapse prevention as treatment components, and activates a social support network of parents, teachers and peers (see Fisher, Masia-Warner, & Klein, 2004 for a description). Previous works have proven its effectiveness, in a small open trial (Masia, Klein, Storch, & Corda, 2001), and relative to waiting list (Masia-Warner et al., 2005) and a credible attention control group (Masia-Warner, Fisher, Shrout, Rathor, & Klein, 2007). It may thus be considered a well-established evidence-based treatment (Silverman & Hinshaw, 2008), which instigates further investigation, namely with a cultural and clinically different group.

Portugal faces a lack of standardized intervention programs for social anxiety, with only one adequately evaluated (Salvador, 2010). Additionally, there's a general lack of evidence on preventive intervention towards adolescents with sub-clinical social anxiety (Rapee & Spence, 2004). Because clinical social phobia is evident in its avoidance of social events, a sub-clinical population will probably not so much avoid social events, but rather experience diminished social success (Beidel, 1998), possibly concomitant with assertive deficit (Levitan & Nardi, 2009; Vagos, 2010). Systematic and explicit assertive training may thus be particularly important for this sub-clinical group, considering several social assertive domains: display of positive and negative feelings, expression of and dealing with personal limitations, and taking initiative (Arrindell et al., 1990). Promoting assertive skills may improve the changes of positive interactions, and consequently diminish the anxiety felt in such events.

Considering this, the Portuguese SASS (Vagos & Pereira, 2009) planed four sessions for assertive skills training in each of those assertive social domains, in addition to the intervention components usually associate to social anxiety (Kashdan, & Herbert, 2001), which

are part of the SASS. The Portuguese SASS also included a student workbook, which is considered important as both guidance during the intervention, and as a self-help book when the intervention is concluded (Sauter, Heyne, & Westenberg, 2009). The present work intends to present evaluation data on the clinical and statistical effectiveness of this program on social anxiety and assertiveness levels. It was applied in two clinical trials, in two consecutive school years, with a sample of five female adolescents, following the same manual and timing for the planned activities. To evaluate its effectiveness, we performed an intra-group analysis on the results of the participating adolescents, regarding their social anxiety and assertiveness levels.

Method

Participants

Participants were recruited from one public secondary school. Teachers were informed of the program and asked to signal students who displayed anxiety and shy and isolated behavior. Eleven students were nominated and evaluated using a semi-structured pre assessment interview that included the social anxiety and interpersonal relationship sections of the ADIS-C-IV (Silverman & Albano, 1996), and co-morbidity screening (e.g. anxiety disorders, depression, substance use). Six students were selected, who presented a score higher than 4 for the ADIS-C-IV severity rating. One male student chose not to participate in the intervention. The remaining five girls and their parents consented to participate. Their ages varied between 15 and 17 years (M = 16). Two participants presented an additional secondary diagnosis (Table 1).

[Insert Table 1]

Instruments

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

Additionally, an analogical social difficulties scale ranging from 0 (none) to 100 (extreme) was used to evaluate each participant at the pre and postintervention moments. Ratings were given by the participant themselves, their respective parents, an independent clinical psychologist, and peer assistants to the programs' social events. At the same moments, the independent clinical psychologist also interviewed each participant using the ADIS-C-IV severity rating.

Intervention procedure and evaluation

The intervention followed the outline of the SASS (Masia et al., 1999), other than using psychoeducation, role-playing and corrective feedback for assertive skills training (Duckworth & Mercer, 2006) in sessions 3, 5, 7 and 9 (cf. schedule in Appendix A). Group leaders' log

[1] All instruments were used in their Portuguese version

indicate treatment integrity, because all activities planned for each group session, parents meeting and social event were accomplished. Individual sessions were personalized to each participant's needs. Teachers meetings did not occur. Participant's attendance was generally high for the group sessions (Table 1); subject 4 missed two social events, and her parents missed both parents meetings. The remaining participants attended all the planed social events and their parents participated in all the planed parents meetings.

Clinical and statistical change was measured for assessing intervention effectiveness. Clinical change considered three indicators: 1) social validity, referring to others' perception of change in the participants (Ogles, Lunnen, & Bonesteel, 2001), 2) recovery, meaning closeness to the non-clinical than the clinical group after intervention, and 3) reliable change, which assesses individual significant change (Jacobson & Truax, 1991; Wise, 2004). Statistical change measured intra-group mean comparisons and its' effect sizes, from pre to postintervention and follow-up moments, using the nonparametric statistic Wilcoxon signed rank.

Results

Social validity

Post-intervention ratings were subtracted from pre-intervention ratings, for each evaluator, meaning that higher results denote higher improvement. All evaluators, except the parents of subject 4, noticed some level of improvement from pre to postintervention (Figure 1).

[Insert Figure 1]

Ratings of change were higher for subject one, and the participants themselves were usually the most optimistic evaluators of their change.

Clinical change

Scores for the severity rating of the ADIS-C-IV were markedly reduced (Table 1).

Total scores for each participant's self-report measures, for the three evaluation moments, and the cut-off scores for recovery are presented in Appendix B. Table 2 presents participants' distribution according to recovery and reliable change categories.

Recovery rates varied between 40 to 60% for the social anxiety and avoidance measures at postintervention and between 20 and 100% at follow-up. Individual improvement rates varied between 60 to 80% for the social anxiety measure and between 20% and 60% for the social avoidance measure, but generally diminished at follow-up. There was manifest improvement but not recovery for negative thoughts typical of social anxiety.

[Insert Table 2 around here]

At postintervention, for frequency of assertive behavior, recovery rates varied between 50 to 75%, but dropped at follow-up. All participants showed improvement at displaying negative and positive feelings and taking initiative at postintervention and follow-up, and 40% of them also showed improvement at expressing and dealing with personal limitations at follow-up. For assertive cognition, all participants showed recovery in the affective personal ability subscale and 60% showed improvement in the interpersonal management subscale. At follow-up, recovery rates were kept.

Statistical change

Change at postintervention was statistically significant for negative thoughts of discomfort in social situations and SAASA anxiety while interacting in new social events. At follow-up, change was statistically significant for the assertive cognition of personal functional ability and for the assertive behavior of taking initiative (Table 3).

[Insert Table 3 around here]

Significant and close to significance ($p < .07$) changes attained large effect size values.

Discussion

This pilot study evaluated the effectiveness of the Skills for Academic and Social Success (Masia et al., 1999) with a Portuguese sub-clinical female adolescent group. The SASS is a school-based program, thus reaching adolescents who usually don't receive help despite their social anxiety symptoms (Masia et al., 2011), which may represent as much as 75.9% of community adolescents in Portugal (Cunha, Pinto-Gouveia, & Soares, 2007). All but one participant were considered respondents, and change was noticeable by external observers and the participants themselves, concurring with previous findings with the SASS (Masia-Warner, et al., 2007; Masia-Warner, et al., 2005; Masia, et al., 2001). Because social anxiety usually has not only perceived but also real negative interpersonal consequences (Alden & Bieling, 1998; Creed & Funder, 1998), the fact that external observers notice improvement in the participants adds clinical and ecological pertinence to this intervention.

To begin with, we would like to remark that changes expressed in the results reflect the change of five unique adolescents, with their own trajectories, needs and interpersonal experiences. Whatever may have influenced the individual therapeutic response also bears a strong impact in the final evaluation that can be made of the effectiveness of the intervention, and therefore needs to be considered. Firstly, it should be noticed that the non-respondent participant faced additional difficulties that may explain her outcomes (e.g., co-morbidity, the lowest attendance rate and parents who did not attend the parental meetings neither supported the students' participation in the group; Kearney, 2005). Secondly, the individual change profile varied according to the initial difficulty level reported, similarly to what had been previously found in Portugal (Salvador, 2010): higher change and improvement was found for those adolescents who initially reported higher level of difficulties, denoting a greater length of change possible for these subjects. This finding may be the reason why preventive programs are not so appealing to clinicians and investigators alike; the less the individual is impairment, the less you can objectively notice his or hers improvement. Nevertheless, we argue that change is also reflected in the subjective perception of change (like for instance, the adolescent finally looking the clinicians and colleagues in the eyes, or that after strong reluctance to participate in

the program , she then expresses sorrow that it will end) that psychologist should value and look for in their intervention efforts.

The intervention program had greater impact in diminishing the anxiety and avoidance of being observed by others and interacting in new social events, in diminishing the thoughts of discomfort in social situations and in augmenting the expression of negative feelings and taking initiative. Again, this replicates previous studies with the SASS that found its' impact on interacting in new situations or with new peers (Masia-Warner, et al., 2005). Additionally, the change found in assertive behavior reaffirms the usefulness of the intervention techniques that were implemented to this end. Because change was noticeable the most in interaction (and nor performance) social events, we may expect that our sub-clinical group will be better prepared not to be trapped in the negative interpersonal cycle that characterizes social phobia (Alden & Taylor, 2004). The assertive adolescent will not be shielded against social fears, but he will hopefully be better able to manage them, by expressing his personal wishes, wills and needs, with concomitant respect and empathy towards the needs and wills of others.

Surprisingly, change was kept for assertiveness at follow-up, but not for social anxiety, with the exception of diminished avoidance of interacting in new social events. This is not in line with previous works with the SASS (Masia-Warner, et al., 2007; Masia-Warner, et al., 2005). The fact that the recommended group booster sessions were neglected in the present work possibly associates with this finding, since they seem of great importance to sustained and generalized therapeutic gains (Lincoln, 2003). Considering these sessions, as well as the effectiveness of each intervention components, may be of future interest. Additionally, it will important to subdue some limitations to this work, namely the fact that external observers were not independent, because they knew of the students' participation in the program, and the lack of a control group, which could attest to the experimental condition producing better outcomes then the daily lives of adolescents or different experimental conditions.

Other than validating an intervention proposal, the effectiveness results confirm the validity and utility of transposing such clinical intervention techniques to community contexts

(Barlow & Hofmann, 1997). Nonetheless, we echo the obstacles named by Masia et al (2001; 2011) of working in school settings: teachers minimize the importance of the program and or the difficulties associated with sub-clinical social anxiety (Sauter et a., 2009), and hence signaled very few students and were unavailable to participate in teachers meetings, jeopardizing the practice and reinforcement of new behaviors in school settings. The fact that difficulties associated with social anxiety remain somewhat secondary in relation to, for instance, externalizing or behavioral problems, makes it ever so much important to take these kind of interventions to where they are needed, to educate teachers and school personnel on different needs and suffering associated with different conditions, and, ultimately to contribute to healthy and fulfilled adolescents and future adults. For now, we have cumulative and transcultural evidence on the effectiveness of the SASS for social anxiety in adolescence, applied in community settings, with a non-clinical sample.

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Table 1:

Participant demographic characteristics, diagnoses and severity ratings at pre and postintervention

Subject	Sex	Age	School year	Preintervention		Attendance	Postintervention	
				Diagnosis ADIS-C-IV	Severity		Diagnosis ADIS-C-IV	Severity
1	Female	17	11	Social anxiety	7	91,67%	No diagnosis	2
2	Female	17	11	Social anxiety	6	100%	No diagnosis	1
3	Female	16	11	Social anxiety Sec: Depression	5	75%	Depression	1
4	Female	15	10	Social anxiety	7	91.67%	No diagnosis	3
5	Female	15	10	Social anxiety Sec: GAD	5	100%	GAD	1

Note: Sec: = Secondary diagnosis; GAD = General Anxiety Disorder

Table 2:
N and percentage of recovery and reliable change for assertiveness and social anxiety measures

	Postintervention [a]					3 month follow-up				
	Recovery		Reliable change			Recovery		Reliable change		
	No N (%)	Yes N (%)	Deteriorated N (%)	No change N (%)	Improved N (%)	No N (%)	Yes N (%)	Deteriorated N (%)	Improved N (%)	No change N (%)
AISQ										
Outer emotional support	3 (60)	2 (40)	1 (20)	3 (60)	1 (20)	2 (40)	**3 (60)**	1 (20)	2 (40)	**2 (40)**
Functional personal ability	3 (60)	2 (40)	0 (20)	3 (60)	2 (40)	1 (20)	**4 (80)**	0 (0)	4 (80)	1 (20)
Interpersonal management	4 (80)	1 (20)	0 (0)	2 (40)	3 (60)	3 (60)	**2 (40)**	0 (0)	3 (60)	2 (40)
Affective personal ability	0 (0)	5 (100)	0 (0)	2 (60)	2 (40)	0 (0)	**5 (100)**	1 (20)	1 (20)	**3 (60)**
s-SIB performance										
Display of negative feelings	1 (25)	3 (75)	0 (0)	0 (0)	4 (100)	2 (40)	**3 (60)**	0 (0)	0 (0)	**5 (100)**
Expression of and dealing with personal limitations	1 (25)	3 (75)	0 (0)	4 (100)	0 (0)	3 (60)	2 (40)	0 (0)	3 (60)	**2 (40)**
Initiating assertiveness	2 (50)	2 (50)	0 (0)	0 (0)	4 (100)	2 (40)	**3 (60)**	0 (0)	1 (20)	4 (80)
Display of positive feelings	1 (25)	3 (75)	0 (0)	0 (0)	4 (100)	2 (40)	**3 (60)**	1 (20)	0 (0)	4 (80)
STABS										
Discomfort in social interactions	3 (60)	2 (40)	1 (20)	0 (0)	4 (80)	2 (40)	**3 (60)**	0 (0)	2 (40)	3 (60)
Discomfort in public performance	3 (60)	2 (40)	0 (0)	1 (20)	4 (80)	4 (80)	1 (20)	0 (0)	2 (40)	3 (60)
SAASA anxiety										
Interaction with the opposite sex	2 (40)	3 (60)	1 (20)	2 (40)	2 (40)	2 (40)	**3 (60)**	0 (0)	2 (40)	**3 (60)**
Assertive interaction	3 (60)	2 (40)	0 (0)	1 (20)	4 (80)	4 (80)	1 (20)	0 (0)	2 (40)	***3 (60)***
Observation by others	2 (40)	3 (60)	0 (0)	2 (40)	3 (60)	1 (20)	**4 (80)**	1 (20)	1 (20)	**3 (60)**
Interaction in new social events	2 (40)	3 (60)	0 (0)	1 (20)	4 (80)	3 (60)	2 (40)	0 (0)	1 (20)	**4 (80)**
Performance in formal social events	3 (60)	2 (40)	0 (0)	2 (40)	3 (60)	2 (40)	**3 (60)**	0 (0)	3 (60)	**2 (40)**
Eating and drinking in public	2 (40)	3 (60)	1 (20)	4 (80)	0 (0)	3 (60)	2 (40)	1 (20)	4 (80)	**0 (0)**
SAASA avoidance										
Interaction with the opposite sex	2 (40)	3 (60)	1 (20)	3 (60)	1 (20)	1 (20)	**4 (80)**	0 (0)	2 (40)	**3 (60)**
Assertive interaction	2 (40)	3 (60)	1 (20)	2 (40)	2 (40)	1 (20)	**4 (80)**	0 (0)	4 (80)	1 (20)
Observation by others	2 (40)	3 (60)	2 (40)	1 (20)	2 (40)	0 (0)	**5 (100)**	1 (20)	2 (40)	**2 (40)**
Interaction in new social events	2 (40)	3 (60)	0 (0)	3 (60)	2 (40)	0 (0)	**5 (100)**	0 (0)	3 (60)	**2 (40)**
Performance in formal social events	2 (40)	3 (60)	1 (20)	1 (20)	3 (60)	1 (20)	**4 (80)**	0 (0)	3 (60)	2 (40)
Eating and drinking in public	3 (60)	2 (40)	2 (40)	2 (40)	1 (20)	2 (40)	**3 (60)**	1 (20)	3 (60)	**1 (20)**

Note: AISQ = Assertive Interpersonal Schema Questionnaire; s-SIB = short Scale for Interpersonal Behaviour; STABS = Social Thoughts and Beliefs Scale; SAASA = Social Anxiety and Avoidance Scale for Adolescents; Deteriorated includes participants considered mildly deteriorated or worse; Improved includes participants considered improved or better, according to Wise et al. (2004); Positive changes that were kept or increased from post-intervention to follow-up assessment are presented in bold

[a] subject 2 did not fill the s-SIB at the postintervention moment

Table 3:

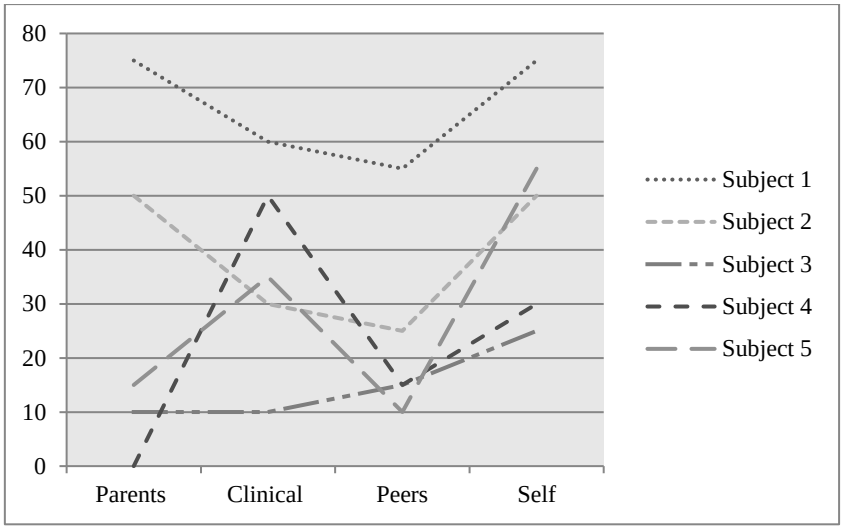
Descriptive measures by evaluation moments and effect sizes for change at postintervention and follow-up

	Pre	Post		Follow-up	
	Mean (SD)	Mean (SD)	Effect size	Mean (SD)	Effect size
AISQ					
Outer emotional support	20,8 (3,56)	20,4 (3,36)	-0,23	21,4 (2,3)	-0,25
Functional personal ability	13,4 (2,51)	14,6 (3,44)	-0,66	16,6 (2,19)*	**-0,91**
Interpersonal management	26,2 (7,39)	29,2 (7,39)	-0,73	30,4 (4,67)	-0,36
Affective personal ability	15 (3)	16,6 (0,89)	-0,6	16,8 (0,84)	-0,51
s-SIB performance					
Display of negative feelings	13,2 (5,76)	20,5 (9,88)+	**-0,8**	19 (6,85)+	**-0,8**
Expression of and dealing with personal limitations	19,4 (6,5)	21 (6,17)	-0,26	21 (5,61)	-0,41
Initiating assertiveness	13,2 (6,14)	18 (7,44)+	**-0,85**	18 (7,44)*	**-0,9**
Display of positive feelings	15,4 (6,35)	20,5 (7,32)	-0,65	19,4 (6,11)	-0,79
STABS					
Discomfort in social interactions	33,8 (10,06)	26,4 (8,53)*	**-0,91**	26,8 (7,89)+	**-0,82**
Discomfort in public performance	25,4 (8,35)	20,2 (8,61)	-0,6	20,6 (6,73)	-0,65
SAASA anxiety					
Interaction with the opposite sex	10 (2,83)	8,8 (3,89)	-033	8,8 (3,27)	-0,48
Assertive interaction	23,8 (11)	19,8 (9,23)	-0,73	20,6 (6,42)	-0,08
Observation by others	12,8 (5,63)	9,2 (3,83)*	**-0,91**	9 (2,83)	-0,66
Interaction in new social events	19,8 (7,33)	16 (5,87)+	**-0,81**	15,2 (5,22)	-0,79
Performance in formal social events	17,8 (4,32)	13 (4,53)	-0,36	12,6 (4,04)	-0,72
Eating and drinking in public	4,2 (1,3)	4,6 (1,82)		5 (2)	-0,6
SAASA avoidance					
Interaction with the opposite sex	8,2 (2,59)	8,2 (3,96)	-	6,4 (1,67)+	**-0,82**
Assertive interaction	17,2 (5,07)	14,6 (7,16)	-0,42	16 (4,58)	-0,48
Observation by others	8,6 (2,97)	8,6 (3,28)	-	6,4 (1,34)	-0,55
Interaction in new social events	11,8 (5,4)	8,8 (4,44)+	**-0,82**	7,6 (2,3)+	**-0,82**
Performance in formal social events	18,2 (6,72)	13,8 (5,76)	-0,61	12,6 (,.44)	-0,65
Eating and drinking in public	4,4 (0,54)	6,4 (2,61)	-0,72	5 (1)	-0,6

Note: AISQ = Assertive Interpersonal Schema Questionnaire; SIB = Scale for Interpersonal Behaviour; STABS = Social Thoughts and Beliefs Scale; SAASA = Social Anxiety and Avoidance Scale for Adolescents; Large effect sizes are presented in bold

* $p < .05$; + $p < .07$

Figure 1: Social validity measures



Appendix A:

Proposed schedule for the Portuguese SASS

Week 1	Group session 1: Psychoeducation about what is social anxiety
Week 2	Group session 2: Realistic thinking
Week3	Group session 3 Social skills – Expressing positive feelings
	Parent meeting 1: Psychoeducation about what is social anxiety
Week 4	Group session 4: Behavioral exposure
Week 5	Group session 5: Social skills – Taking initiative
	Social event 1: Small-talk
Week 6	Group session 6: Behavioral exposure
	Individual session 1: Expectation management
Week 7	Group session 7: Social skills – expressing and managing personal limitations
	Parent meeting 2: Psychoeducation about approaches to manage their child social anxiety
	Social event 2: Street survey on recycling
Week 8	Group session 8: Behavioral exposure
Week 9	Group session 9: Social skills 4 – Expressing negative feelings
	Individual session 2: Social support for after program
	Social event 3: Mall Pedy-paper
Week 10	Group session 10: Behavioral exposure
Week 11	Group session 11: Behavioral exposure
Week 12	Group session 12: Gain review and relapse prevention
	Social event 4: Farewell lunch

Appendix B: Scores obtained by each participant in each evaluation moment and cut-off points for recovery

	Participant 1			Participant 2			Participant 3			Participant 4			Participant 5			Recovery
	Pre	Post	Follow	Pre	Post	Follow	Pre	Post	Follow	Pre	Post	Follow	Pre	Post	Follow	Cut-off
AISQ																
Outer emotional support	20	20	19	18	22	22	24	19	21	17	16	20	25	25	25	21
Functional personal ability	13	13	14	14	16	16	13	12	16	10	12	17	17	20	20	15
Interpersonal management	23	28	25	25	29	28	27	26	33	18	24	19	38	39	37	31
Affective personal ability	18	18	16	15	17	17	16	16	18	10	16	17	16	16	16	16
s-SIB performance																
Display of negative feelings	9	13	15	12	-	12	13	18	18	9	16	20	23	35	30	16
Expression of and dealing with personal limitations	14	16	17	15	-	17	21	19	18	17	19	23	30	30	30	19
Initiating assertiveness	10	14	12	11	-	14	12	16	18	9	13	17	24	29	28	16
Display of positive feelings	14	22	19	11	-	15	18	17	16	9	13	17	25	30	30	17
STABS																
Discomfort in social interactions	36	30	35	34	27	27	31	30	31	48	36	27	20	14	14	28
Discomfort in public performance	26	21	26	22	16	23	20	26	21	38	30	24	16	8	9	20
SAASA anxiety																
Interaction with the opposite sex	11	9	12	11	5	6	12	11	12	11	14	9	5	5	5	9
Assertive interaction	23	19	23	19	13	20	25	27	27	41	31	23	11	9	10	15
Observation by others	13	8	10	12	6	6	10	11	12	22	15	11	7	6	6	10
Interaction in new social events	15	13	18	20	16	16	23	20	18	30	23	18	11	8	6	16
Performance in formal social events	18	12	13	14	13	14	17	17	17	25	17	13	15	6	6	12
Eating and drinking in public	5	4	5	3	3	3	4	6	7	6	7	7	3	3	3	4
SAASA avoidance																
Interaction with the opposite sex	6	5	5	9	6	6	10	13	7	11	12	9	5	5	5	8
Assertive interaction	16	13	17	17	11	17	24	16	19	19	26	19	10	7	8	15

Observation by others	12	7	8	8	5	4	4	9	7	8	11	6	6	4	4	8
Interaction in new social events	8	6	7	12	7	10	13	13	5	20	14	10	6	4	6	10
Performance in formal social events	13	12	14	16	12	16	16	20	14	30	19	12	16	6	7	14
Eating and drinking in public	6	7	6	5	5	5	5	13	7	6	9	7	5	5	5	5

Note: AISQ = Assertive Interpersonal Schema Questionnaire; s-SIB = short Scale for Interpersonal Behaviour ; STABS = Social Thoughts and Beliefs Scale; SAASA = Social Anxiety and Avoidance Scale for Adolescents