Title: Social Skills Groups Adapted from Seeking Safety Model for Adolescents and Young adults with Developmental Disabilities and Mental Health Diagnoses

Authors: Lina Rodas, Bridgid Mariko Conn, Caitlin S. Sayegh, Sari Glassgold, and Sara Sherer

Mental health providers from the University of Southern California University Center for Excellence in Developmental Disabilities (USC UCEDD) and the Children's Hospital Los Angeles Division of Adolescent and Young Adult Medicine (DAYAM) have adapted Seeking Safety to promote social skills development among adolescents and young adults with developmental disabilities (DD) and co-morbid mental health diagnoses. The USC UCEDD is a nationally recognized leader in developing and implementing quality services for infants, children, youth and adults with, or at risk for, behavioral, developmental, physical, and/or special health care needs and their families. The DAYAM is a comprehensive health care program dedicated to the needs of young adults and adolescents, and seeks to advance the health and well-being of adolescents through primary and specialty care, psychosocial support, research projects and advocacy efforts targeting high-risk, underserved adolescents and young adults. Of the 2,572 individuals served by the DAYAM Behavioral Health Program, approximately 12.4% have a diagnosis of an Autism Spectrum Disorder and 3.2% have a diagnosis of an Intellectual Disorder or Borderline Intellectual Functioning. This article describes the rationale for Seeking Safety-based groups for adolescents and young adults with DD and provides information other agencies could use to develop similar social skills groups focused on safe relationships, effective coping, and building relationships with peers.

The Impact of Social Skills Development among Young People with Developmental Disabilities

Social skills deficits experienced by adolescents with DD, such as Autism Spectrum Disorder (ASD) and Intellectual Disability (ID), place them at increased risk for peer rejection and social isolation (e.g., Blake, Lund, Zhou, Kwok, & Benz, 2012) during a particularly crucial period in their socio-emotional development (Sawyer et al., 2012). Bellini (2006) indicated that major contributors to loneliness among adolescents with ASD were marked impairments in social functioning, which included poor initiation of social interaction, difficulties with maintaining appropriate eye contact, issues with social reciprocity/engagement, and restricted ability to share enjoyment with others. Atypical social development related to information-processing deficits, stereotyped behaviors and/or restricted interests, and delayed mental age are major contributors to such youth having few friendships or friendships of limited depth (Bauminger, Solomon, & Rogers, 2010).

For most, adolescence represents a time of increased autonomy, individuation, and reliance on a growing peer support network; a phenomenon which is much less likely to occur for youth with DD. Deficits in social skills also contribute to limited exposure to and experience in socialization, which restricts opportunities essential for growth and development (Bohnert, Lieb, & Arola, 2016). Likewise, adolescents with developmental delays exhibit limitations in adaptive coping skills, such that they may struggle with coping with the anxiety related to social situations (Hollocks et al., 2014). As a result, adolescents with developmental disabilities often report significant emotional distress related to coping with these social skills deficits and the impact on their social relationships, including greater feelings of loneliness compared to typically developing peers (Ung at al., 2016). Further, such impairments in social skills increase adolescents' vulnerability to potentially traumatic experiences, such as bullying and victimization (Schroeder, Cappadocia, Bebko, Depler, & Weiss, 2014).

Youth are often referred to outpatient mental health settings for social skills interventions as research has documented the efficacy of using a group-based format to address skills training for concurrent social and mental health-related challenges as community-based intervention and outreach support treatment dissemination and generalization (Hillier, Fish, Cloppert, & Beversdorf, 2007), including greater availability of social support (Barry et al., 2003). Such interventions can serve to augment social skill development, provide opportunities for experiencing peer support, and increase positive coping for managing emotional distress related to social isolation, bullying, and other types of trauma.

Adapting Seeking Safety to Support the Development of Social Skills

Seeking Safety is an evidenced-based therapeutic intervention that was designed to be implemented in an individual or group format and targets maladaptive coping and trauma-related symptoms (Najavits, 2002). Seeking Safety emphasizes identification of practical solutions and practical application to the client's life, highlighting the importance of focusing on a client's potential rather than pathology. The intervention is structured around twenty-five topics within four major domains, focusing on psycho-education and skill-building with flexibility in terms of topics that are covered, order of topics, and amount of time spent on topics. Each session is structured around four agenda components: (1) Check-In ("temperature check" where clients practice labeling their current mood); (2) Quote (used to engage clients emotionally and to provide inspiration for discussion; therapists can use quotes from the Seeking Safety handbook or clients may bring in their own quotes that relate to the session topic); (3) Discussion (support clients in relating material to current and specific problems in their lives); (4) Check-Out (clients asked to name one thing they got out of the session, to identify one commitment for the following week, and to identify community resource(s) they can use).

Implemented in an outpatient setting, our social skills group is an open-ended program for adolescents and young adults with DD who present with co-morbid mental health diagnoses in an ethnically diverse, low-income urban community setting. Over the past 12 months, 56 adolescents and young adults between the ages of 12 and 21 years old have participated in these groups. Patients' DD diagnoses, most common co-morbid mental health diagnoses, gender, and ethnicity are reported in the table below. Patients were sometimes diagnosed with more than one DD and more than one mental health diagnosis.

Group Member Characteristics

	n	%
Developmental Disability		
Autism Spectrum Disorder	47	84.75
Intellectual Disability	6	10.17
Other (e.g., language or learning disorder)	9	15.25
Co-morbid Mental Health Diagnosis		
Anxiety Disorder	32	55.93
Depressive Disorder	18	30.51
Attention-Deficit/Hyperactivity Disorder	8	18.64
Disruptive Behavior Disorder	5	8.47
Posttraumatic Stress Disorder	4	6.78
Sex		
Male	42	76.27
Female	14	23.7
Ethnicity		
Latino/a/x	46	81.36
White (Non-Latino/a/x)	4	6.78
Asian/Pacific Islander	3	5.08
Other/Unknown	3	5.08

Group members often report difficulties with making friends, experiencing social isolation and loneliness, and being teased and bullied at school. Struggles within these social situations often manifests in social anxiety as well as behavioral and mood issues that reportedly

interfered with school and interpersonal relationships. Many of the group members were referred to this group due to specific interpersonal skills deficits, such as the ability to utilize appropriate eye contact, engage in reciprocal conversation (e.g., turn-taking in conversation and assuming a listener's perspective), play and interact socially in a paired or group setting, and participate in spontaneous conversations in naturalistic settings. Further, all group members exhibited lack of ease in social settings, which contributed to their social withdrawal/isolation and increased social anxiety. For most, the group served as an adjunct treatment to individual therapy.

The major aims for our group is increasing group members' abilities to develop and maintain meaningful friendships, including: reciprocal communication, active listening, appropriately responding to social cues, helping others, appropriate articulation of thoughts and feelings, and sharing information about oneself. Group content was adapted from the Seeking Safety curriculum (Najavits, 2002) to suit the needs and developmental level of this population (e.g., topics, quotes, etc.). The group is a typical weekly format with a 90-minute client group session. Finally, a parent group component, which will be discussed further in the next series installment, was added to enhance effectiveness, improve parent understanding, and generalize treatment progress across settings (e.g., home, community).

Our social skills group facilitators adapt Seeking Safety topics to meet the developmental and linguistic needs of the DD population. An example of this adaptation includes choosing a topic from the Seeking Safety curriculum, such as "Healthy Relationships", and identifying a quote amongst group members about an issue within healthy relationships that they may struggle with. Youth within our groups, in the past, have identified issues surrounding the social navigation of social media. We would then create a quote such as, "Who should I send a friend request to." Quotes are designed to be concrete, developmentally appropriate, and utilize

language all group members can understand. Once the quote is identified, group facilitators will check in with each group member about their interpretation of the quote, provide support with understanding and prompting if needed, and encourage group members to support each other in asking clarifying questions, eliciting additional information, or sharing similar experiences. This facilitation encourages group members to engage in reciprocal conversation, turn-taking, and sharing of information. At the end of group, facilitators will support "check-out" with group members and encourage a commitment around the group topic. For example, individuals could make commitments to change their current inappropriate social media behavior, accept friend requests, and/or request support when using social media.

Clients have shared with group facilitators how much they have enjoyed participating in a setting where they can make friends for the first time, build a community with peers who mirror and understand their difficulties, and share in progress that isn't always valued or understood amongst typically functioning youth. A few quotations from group members include:

- "I'm happy because I'm in group."
- "Group made me feel better."
- "The group members will miss me when I graduate."
- "I like having someone to celebrate my birthday with."
- "Now I talk more."

Group members often participate for multiple years, developing strong social bonds with one another, spending time together outside of group, and sharing information about naturalistic social activities, such as a bowling league for young adults with DD. Group therapists have observed that group members often come into group showing more withdrawal and social inhibition, and after a few months of getting used to the routine, learning social skills, and

developing comfort in their peer relationships, because more talkative, supportive of one another, and engaged in discussions.

Conclusion

This article has explained the need for effective social skills groups that include a focus on mental health needs and healthy coping skills. The social skills groups adapted from the Seeking Safety model have functioned well in our diverse clinic. Other agencies should consider implementing similar groups, and providing adolescents and young adults with DD with opportunities to develop skills for making and maintaining healthy relationships. This article is the first of a three-part series. Part 2 will describe the collateral group for the parents of these adolescents and young adults.

Acknowledgements: We acknowledge the psychologists who have facilitated these groups with us, especially Hana Carmona, Sophie de Figueiredo, Catherine Forbes, and James MacGaffey. We would also like to acknowledge our Adolescent Medicine postdoctoral fellows who have co-led these groups for over the past 10 years. We thank our colleagues, Ellen Iverson, Mari Radzik, and Moises Rodriguez, for their assistance with this work, and a previous postdoctoral fellow, Danielle Ramsay, whose contributions to this project helped to inform this article. Most importantly, we appreciate the youth who participate in these groups and teach each other how to cope with challenges with true resilience.

References:

Barry, T. D., Klinger, L. G., Lee, J. M., Palardy, N., Gilmore, T., & Bodin, S. D. (2003). Examining the effectiveness of an outpatient clinic–based social skills group for high-

functioning children with autism. *Journal of Autism and Developmental Disorders*, *33*(6), 685-701.

Bauminger, N., Solomon, M., & Rogers, S. J. (2010). Predicting friendship quality in autism spectrum disorders and typical development. *Journal of Autism and Developmental Disorders*, *40*(6), 751-761.

Bellini, S. (2006). The Development of Social Anxiety in Adolescents with Autism Spectrum. *Focus on Autism and Other Developmental Disabilities*, 21(3), 138-145. DOI: 10.1177/10883576060210030201

Blake, J. J., Lund, E. M., Zhou, Q., Kwok, O. M., & Benz, M. R. (2012). National prevalence rates of bully victimization among students with disabilities in the United States. *School Psychology Quarterly*, *27*(4), 210.

Bohnert, A., Lieb, R., & Arola, N. (2016). More than leisure: Organized activity participation and socio-emotional adjustment among adolescents with autism spectrum disorder. *Journal of Autism and Developmental Disorders*, 1-16.

Hillier, A., Fish, T., Cloppert, P., & Beversdorf, D. Q. (2007). Outcomes of a social and vocational skills support group for adolescents and young adults on the autism spectrum. *Focus on Autism and Developmental Disorders*, *22*(2), 107-115.

Hollocks, M. J., Jones, C. R., Pickles, A., Baird, G., Happé, F., Charman, T., & Simonoff, E. (2014). The association between social cognition and executive functioning and symptoms of anxiety and depression in adolescents with autism spectrum disorders. *Autism Research*, *7*(2), 216-228.

Najavits, L. (2002). *Seeking safety: A treatment manual for PTSD and substance abuse*. Guilford Publications.

Sawyer, S. M., Afifi, R. A., Bearinger, L. H., Blakemore, S. J., Dick, B., Ezeh, A. C., & Patton, G. C. (2012). Adolescence: a foundation for future health. *The Lancet, 379*(9826), 1630-1640.

Schroeder, J. H., Cappadocia, M. C., Bebko, J. M., Pepler, D. J., & Weiss, J. A. (2014). Shedding light on a pervasive problem: A review of research on bullying experiences among children with autism spectrum disorders. *Journal of Autism and Developmental Disorders*, *44*(7), 1520-1534.

Ung, D., McBride, N., Collier, A., Selles, R., Small, B., Phares, V., & Storch, E. (2016). The relationship between peer victimization and the psychological characteristics of youth with autism spectrum disorder. *Research in Autism Spectrum Disorders, 32*, 70-79. DOI: 10.1016/j.rasd.2016.09.002