

REPORT CARD ON HOW WELL YOUR TRAINING PROGRAMS

FOSTER GENERALIZATION

How many of these features are included in your training program?

What grade would you give to your Intervention Program in its ability to foster generalization?

In order to foster transfer at the OUTSET OF TRAINING, my training program:

1. Establishes a good working alliance with trainees, so the trainer is viewed as a supportive constructive “coach.”
2. Uses explicit collaborative goal-setting to nurture hope. Discusses the reasons and value of transfer and relates training tasks to treatment goals.
3. Explicitly instructs, challenges and conveys an “expectant attitude” about transfer.
4. Uses discovery learning, labelling transfer skills and strategies. Use a Clock metaphor. (12 o’clock refers to internal and external triggers; 3 o’clock refers to primary and secondary emotions and accompanying beliefs/theories about emotional expression; 6 o’clock refers to automatic thoughts, thinking patterns such as rumination and beliefs and developmental schemas; 9 o’clock refers to behavioural acts and resultant consequences). These contribute to a “vicious cycle”.
5. Solicits trainees' public commitment and uses behavioral contracts.
6. Anticipates and discusses possible barriers to transfer.
7. Chooses training and transfer tasks carefully (builds in similarities and uses ecologically-valued training tasks).
8. Develops a “community of learners” (e.g., advanced trainees, an Alumni Club).

In order to foster transfer DURING TRAINING, my training program:

9. Keeps training simple- uses acronyms and reminders (wallet-size cards and a “Hope Chest”).
10. Uses performance-based training to the point of mastery. Provides regular feedback and has trainees self-evaluate and record performance.
11. Accesses prior knowledge and skills, uses advance organizers and scaffolded instruction.
12. Teaches metacognitive skills-involving self-regulation, planning and self-rewarding.

13. Conducts training across settings, using multiple trainers and environmental supports.
14. Uses cognitive modeling, think alouds, journaling, rehearsal and role playing procedures.
15. Promotes generalization through between session assignments and between session coaching. Have trainees engage in deliberate practice.
16. Includes relapse prevention activities throughout training that decreases the chances of setbacks after training is completed. “Inoculates” against failure.

In order to foster transfer at the CONCLUSION, my training program:

17. Puts trainees in a consultative role (uses reflection, provides trainees with an opportunity to teach others, puts trainees in a position of responsibility).
18. Ensures trainees directly benefit and receives reinforcement for using and describing their transfer skills.
19. Provides active aftercare supervision-fades supports and “scaffolds” assistance, and where indicated, provide continuation treatment.
20. Ensures trainees take credit and ownership for change (self-attributions). Nurtures personal agency.
21. Ensures participants design personal transfer activities and become self-advocates.
22. Involves training significant others and ensures that they support, model and reinforce the trainees' new adaptive skills.
23. Provides booster sessions.
24. Conducts a graduation ceremony and offers a Certificate of Accomplishment.

CHECKLIST OF WHAT TRAINERS SHOULD DO AT THE OUTSET, DURING AND FOLLOWING TRAINING IN ORDER TO INCREASE THE LIKELIHOOD OF GENERALIZATION

PROCEDURAL CHECKLIST ON WAYS TO IMPROVE GENERALIZATION

AT THE OUTSET OF TRAINING ACTIVITIES:

1. Establish a good working alliance with the trainee because the quality of this relationship is the single most important factor in producing positive outcomes and it exceeds the proportion of outcome attributed to any other feature of the training. The quality of the relationship predicts drop out rate and level of compliance. The trainee needs to feel respected, accepted, engaged, and be treated as a collaborator. Hostile, confrontational, fear-engendering interactions are counter-productive and ineffective. If training is being conducted on a group basis, then the level of group cohesion and identity with the group is predictive of outcome. The trainer should be viewed as a “constructive supportive coach.”
2. Engage the participants in explicit goal-setting. Highlight that the treatment is not only about changing, but transferring (extending) the newly acquired skills (changes) learned in the training program to new situations/settings.
3. Discuss the challenge to generalize or transfer skills. Lead participants to view generalization as an attitude, rather than just as a set of transferable skills. Participants need to find (search out) opportunities to practice what was learned in a supportive environment.
4. Raise concerns about transfer from the outset of training. Have participants examine how learning such skills will help them achieve their short-term and long-term goals. Discuss why learning these skills is of value. Relate skills and homework tasks to treatment goals. Use Motivational Interviewing strategies to engage trainees.
5. Provide participants with opportunities to come up with suggestions of what should be done to transfer skills. Use collaborative Socratic questioning and discovery-oriented learning procedures. The concepts to be learned should emerge as part of an activity requiring little verbal expression so trainees can figure out what is being taught and why. The trainer can use shaping and scaffolding procedures with prompts of Socratic questioning. When required, directed teaching methods can be added.
6. The skills should be taught in a manner that allows the training to build one skill upon another in a sequenced fashion. Name and describe each skill that is being taught. Encourage the trainees to view these skills as “tools” that they can carry with them and draw upon as needed. Label and refer to transfer strategies and convey that generalization is the goal of treatment. Help them understand how

similar skills can be applied across multiple settings (e.g., self-talk, problem-solving). Trainers should discuss, model, and label metacognitive self-regulatory strategies.

7. **Tell participants explicitly that transfer is expected. Encourage and challenge patients to apply and adapt skills and strategies to varied and novel situations, rather than learn to apply specific skills to discrete behaviors and settings. Use “like a” statements throughout training. “This skill is like...” Use teachable stories and anecdotes.**
8. **Solicit public commitment statements of what they are going to do and why. Write out on a decisional balance sheet, the pros and cons of making changes. Use behavioral contracts that include transfer activities.**
9. **Tailor instructions to the developmental needs of the participants and be sensitive to gender and cultural differences and train skills that are ecologically valid. Training should build upon the trainees' strengths and abilities.**
10. **Throughout the course of training anticipate and discuss possible barriers and obstacles to implementing homework (both external and internal barriers). Include in the training program skills designed to handle potential barriers.**
11. **Help participants select training and transfer tasks carefully-where there is a high likelihood of similarity. The more similar the features of the training and the real life setting, the greater the likelihood of generalization (e.g., use exposure-based training and provocation challenge procedures in training that are ecologically valid and are as similar to real life as possible).**

DURING THE TRAINING ACTIVITIES

12. **Nurture a “community of learners” -- where participants can help each other (e.g., an Alumni Club of graduates, other trainees, pro-social peers).**
13. **Ensure that the training tasks are tailored to the trainees' levels of competence, namely, slightly above the trainees' current ability levels (“teachable window” or work within the “zone of proximal development” or “zone of rehabilitation potential”). Skills to be taught should be broken down into identifiable parts. Trainers should use minimal prompts and fade supports (scaffold instruction), as trainees gain competence.**
14. **Keep training simple by using acronyms to summarize teaching skills (e.g., SNAP—Stop Now And Pause; RETHINK—Recognize, Empathize, Think, Hear, Integrate, Notice, Keep present problem at hand, or Linehan's Dialectical Behavior therapy uses such acronyms as RAID, SCIDDLE, RSVL, DEAR MAN), so they come to be readily retrievable mnemonics. Use reminders such as wallet-size index cards. Have trainees keep a Training Folder and refer back to it often.**

15. Provide prolonged, in-depth training with repeated practice to the point of mastery, in order to ensure conceptual understanding. Facilitate skill practice and provide constructive feedback. The length of training should be performance-based, rather than time-based. Provide extended individual and group training where indicated, so participants can develop mastery of skills and strategies. Provide help and coaching to complete “homework” assignments. Have trainees engage in deliberate practice that is goal-directed.
16. Promote awareness of skills and teach problem-solving metacognitive executive skills and strategies (self-monitoring, planning and freeze-frame procedures) that can be applied across settings. Use overt and covert rehearsal and self-monitoring. Use Clock Metaphor (12 o’clock - - external and internal triggers; 3 o’clock - - primary and secondary emotions; 6 o’clock - - automatic thoughts and images, thinking style such as rumination, schemas, beliefs and values, 9 o’clock - - behaviors and resultant consequences). Help trainees appreciate how these elements contribute to a “vicious cycle” and learn ways to break the “vicious cycle”.
17. Begin by accessing participants' knowledge. Provide advance organizers (“big picture” reminders of goals) and informed instruction (how the content of this session relates to previous sessions; “*Where have we been? and “Where are we headed?”*”).
18. Explicitly instruct on how to transfer. Use direct instruction, discovery-oriented instruction and scaffolded assistance (fade supports and reduce prompts as trainees' performances improve). Employ videotape coping modeling films as training material. Have the trainees make a self-modeling video of successfully performing the skills that they can watch. The training can include such skills as the ability to label emotions and use feeling language; use a calm down plan and how to take a time out; how to solve interpersonal conflicts using social problem-solving, negotiation and assertive communicative skills (e.g., “I” statements, instead of “you” statements).
19. Conduct training across response domains and settings. Training should be conducted “loosely.” This involves varying stimulus contexts for training. Use diverse examples to illustrate the application of skills to different behaviors and to different situations. Use multiple trainers. Work on skills development and maintenance in real world settings using environmental modifications and supports. The trainer should maintain close contact with significant others who should be viewed as “change agents” (e.g., parents who are trained as therapists, or residential staff, classroom teachers, probation officers who are taught how to support, model and reinforce the desired behavioral changes).
20. Use cognitive modeling, think aloud-diaries, journals, behavioral and imaginal rehearsal and role playing. Have an Alumni Club of recent graduates who act as teaching models, like a 12-Step AA sponsor.

21. Nurture a “cognitive shift” and attitudinal change. Can use modeling films, bibliotherapy, story-telling that nurtures a new “possible self.” Help trainees alter the stories they tell themselves and that they tell others. Have the trainees make a “self-advocacy” videotape of where they have been, where they are now psychologically, and what they hope to achieve in the future, and moreover, how they plan to get there. Trainees might develop a “Hope Chest” that includes items that reflect a different pro-social life-style.
22. Have participants repeat reasons why they should engage in transfer activities; reconfirm public commitment statements; review goal statements with “If...then” and “Whenever...” rules.
23. Review with the trainee, his or her relapse prevention training procedures throughout training. Have trainees analyze and learn from transfer failures and successes and keep a Relapse Prevention (RP) workbook. The trainer should design "Relapse Prevention Sheets" with the trainee. These sheets should contain reminders of key responses for any problematic situations that the trainees can refer to when necessary. Encourage trainees to use RP concepts and language.

AT THE CONCLUSION OF TRAINING ACTIVITIES

24. Put trainees in consulting reflective roles. Following an experiential exercise have participants reflect on the activity (i.e., think about what they just did and what it meant, how can they use these skills in future situations). Have participants teach (demonstrate, coach) and explain verbally or diagrammatically (alone or with others) their acquired skills and transfer strategies. Have participants be in a position of responsibility, giving presentations to and consult with other beginning participants or younger individuals. Have them make teaching videotapes. Be sure to have trainees describe the reasons for engaging in such transfer tasks and how doing so will help them achieve their treatment goals.
25. Ensure that participants directly experience the benefits (“pay offs”) of choosing new (non-aggressive) options. Ensure that trainees receive naturally occurring rewards.
26. Label and reinforce participants' transfer activities. Talk about maintaining and building upon change.
27. Provide between session coaching. Access to ongoing counselling (computer chat lines, telephone counselling and telephone hotlines).
28. Have the trainee develop an explicit written relapse prevention plan and “trouble shoot” possible solutions to potential obstacles, barriers and responses to possible lapses. Encourage trainees to view “failures” as a reflection of a lack of skills, not enough practice, the training program not being sensitive to trainees' needs and skill levels, rather than a sign of being a “sick,” “bad,” or an “incompetent” person.

29. Provide active aftercare case management supervision. (e.g., Assertive Community Treatment, Supported Employment). Use Websites, Interactive Diaries Technology - see www.warfighterdiaries.com and ongoing computer chat-lines. Fade supports and “scaffold” assistance throughout training.
30. Review progress and ensure that trainees take credit (make self-attributions) and declare ownership for performance gains and transfer efforts. Have participants talk about what they learned and take “personal ownership” of coping skills. Trainers should use “how” and “what” questions. (“How did they change? How can they maintain improvements?” “What did they do differently this time, as compared to what you did in the past?”) Nurture trainees' sense of personal agency and personal efficacy. “Are you saying that in spite of x, you were able to do what? How did you do that?”
31. Encourage trainees to design personal transfer activities. Enlist trainees in a mutual search for situations in which the coping skills can be employed, discussed and practiced. Ask the trainees to discuss and identify the variety of situations where they could apply new skills and strategies. Prompt the trainees to set goals for implementing these skills over the next week. Provide monitoring forms to map progress. Have the trainees adopt a “*personal scientist's*” approach.
32. Involve significant others in training. Keep in touch with significant others (peers, parents, teachers, administrators, family members) from the outset of training and through follow-up. Use a primary prevention institutional-wide intervention program that involves peers and all staff. Use a bystander intervention program to supplement training for the targeted group.
33. Space out training sessions to every other week, then monthly, so trainees can assume more responsibility for implementing changes.
34. Provide booster sessions and ongoing follow-up group meetings. Have trainees enter group training if they fail to handle lapses successfully. (Use the analogy of a General medical practitioner where patients go for annual checkups. “Fine-tuning” is a smart thing to do). There is research to indicate that merely sending participants a post card after intervention expressing interest and concern enhanced efficacy. (See www.melissainstitute.org -Meichenbaum *Lessons learned working with suicidal patients*).
35. Use a graduation ceremony, involving significant others and include certificates of completion and appreciation. Provide trainees with “transitional objects” (e.g., pictures, logos, tee shirts, trainer's business card and ways to remain in touch). Consider how to use Internet resources, IPOD technology and Interactive Diaries Technology.