CORE TASKS OF PSYCHOTHERAPY: WHAT DO “EXPERT” THERAPISTS DO

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CORE TASKS OF PSYCHOTHERAPY: WHAT “EXPERT” THERAPISTS DO BASED UPON THERAPEUTIC PRINCIPLES OF CHANGE


1. Develop a collaborative therapeutic relationship/alliance and help the patient “tell” his/her story. After listening attentively and compassionately to the patient’s distress and “emotional pain”, help the patient identify “strengths” and signs of resilience. “What did he/she accomplish in spite of...?” “How was this achieved?” Obtain the “rest of the story”. Use Socratic Questioning.

   i. Foster bonding between the patient and the therapist. Address any ruptures or strains in the therapeutic alliance and address any therapy interfering behaviors.
   ii. Collaborate with the patient in establishing treatment goals and the means to achieve these goals.
   iii. Encourage the patient’s motivation to change and promote the patient’s belief that therapy can help. (Use Motivational interviewing procedures.)
   iv. Monitor the patient’s progress and use the information to guide ongoing treatment.

2. Be culturally-sensitive when conducting assessments and treatment and develop knowledge and competence in ethnic diversity.

   i. As Bowman (2007) highlights, “Become more aware of your existing assumptions, and accept that some of these assumptions may not apply to ethnic minority groups” (p. 113)
   ii. Conduct an ethnicultural assessment that taps the patient’s level of acculturation, circumstances and impact of migration on family and on self.
   iii. Assess for culturally specific symptomatology and provide culturally based interventions.
   iv. Treatment should be sensitive to the patient’s expectations, cultural interpersonal style, values and metaphors/language. Interian and Diaz-Martinez (2007) provide a good example of such cultural adaptation with Hispanic patients as they alter psychotherapy to include such Hispanic concepts as Simpatico, respecto, Formalismo (setting examples), Personalismo, Fatalismo, Marianismo (self-sacrifice), Desahoyo (getting things off one's chest) Poner de mi parte (doing one’s part), Dichos (sayings and proverbs) and religious values. (See Handout on spirituality for examples of other culturally and spiritually-oriented interventions). In conducting these culturally-based interventions, it is important not to
impose cultural stereotypes and recognize marked differences within cultural groups (See Bowman, 2007)

v. Tailor interventions to ethnic groups. For example, see Hinton et al., (2006) treatment of Cambodian refugees for panic attacks.

vi. Address any potential cultural barriers that might arise in treatment.

vii. Be willing to consult with individuals who may be more equipped to deal with ethnic diversity and learn to conduct multicultural therapy.

3. On an ongoing basis, educate the patient about his/her problems and possible solutions and facilitate awareness. Use various ways to educate and nurture a sense of curiosity and discovery.

i. Conduct Risk and Protective Factors assessment and provide constructive feedback. Probe about the patient’s views of presenting problems and his/her theories of behavioral change.

ii. Use a Case conceptualization Model and share therapy rationale.

iii. Have the patient engage in self-monitoring and conduct situational and developmental analyses.

iv. Use videotape modeling films and other educational materials (simple Handouts with Acronyms)

v. Use a “Clock metaphor” – “Vicious Cycle” Model

12 o’clock -external and internal triggers

3 o’clock -primary and secondary emotions

6 o’clock -automatic thoughts, thinking patterns and schemas or beliefs. Note common core recurrent patterns (ala Persons, 1986)

9 o’clock -behaviors and resultant consequences

The therapist can use his/her hand to convey the Clock Metaphor by moving his/her hand slowly from 9 o’clock around to 6 o’clock. The therapist can say:

"It sounds like this is just a vicious... (without finishing the sentence, allowing the patient to interject – “cycle or circle”. To which the therapist can then say, “In what way is this a vicious cycle? Are you suggesting...?"

The therapist can then help the patient come to appreciate how his/her appraisal of situations (12 o’clock), feelings (3 o’clock), thoughts (6 o’clock) and behaviors and the reactions (9 o’clock) they are all interconnected. The patient can be invited to “collect data” (self-monitor), if indeed, the
“vicious cycle”, as the patient describes it, actually occurs. In this way, the patient can bring into subsequent sessions data supporting the clock metaphor.

If you, (the patient) are engaging in such cyclical behavior, then what is the impact, what is to toll, what is the emotional and behavioral price that you are paying? If not, then what can you do about it?

It is not a big step for the patient to suggest that one of the things he/she could do is “Break the cycle”. “Break the cycle. What did you have in mind?”, the therapist can ask. The therapist can now explore collaboratively with the patient how he/she can break the cycle. Moreover, the therapist can help the patient come to appreciate how he/she has already been trying to “break the cycle” (e.g., by engaging in avoidance behaviors, or being aggressive).

Another way to use the Clock Metaphor is to help the patient’s view his/her primary and secondary emotions (3 o’clock) as the “commodities” that the patient does something with. The therapist can ask:

“What do you do with all those feelings (emotions)?”

The patient may respond that he/she “stuffs the feelings”, or “drink them away”, and if he/she does that, then what is the impact, the toll, the price he/she pays. Is that the way he or she wants things to be? If not, then what can be done about it?”

Once again, the therapist can use the “art of Socratic questioning” as a way to help the patients generate possible coping solutions. There is a greater likelihood of patients engaging in behavior change efforts if he/she comes up with the ideas and the accompanying reasons for engaging in such behaviors, than if the therapist merely offers suggestions and directives, acting as a “surrogate frontal lobe” for his/her patient.

vi. Therapist models thinking: Ask the patient: “Do you ever find yourself, out there, in your day-today experience, asking yourself the kind of questions that we ask each other right here?”

vii. Educate about relapse prevention strategies.

viii. There is caveat that should be highlighted concerning the psycho-education of patients. Devilly and his colleagues (2006) have noted that under some conditions providing information can undermine the recovery process and act as a self-fulfilling prophecy of despair. They note that in the work on Psychological Debriefing that providing individuals with information about potential trauma responses may have a paradoxical effect on depression and PTSD.
4. Help the patient re-conceptualize his/her “problem” in a more hopeful fashion.
   
   i. Do life-review (timelines). Identify “strengths.”
      
      Timeline 1 – Birth to present.
      Note stressors and various treatments.
      
      Timeline 2 – Birth to present.
      Note “strengths” and “In spite of” and use “How” and “What” questions. Note evidence of any strengths that may extend back in time to prior generations and what they did to “survive” and cope with stressors. Note signs of “cultural resilience”.
      
      Timeline 3 – Present into future
      Highlight: How things are now and how would the patient like them to be in the future?
      
      The therapist can go on to ask:
      
      What can we do to help you achieve your goals of....? What have you tried in the past to achieve you goals of....? What has worked? What has not worked, as evident by....?
      
      If we worked together, and I hope we will, how would we know if you were making progress? What changes would some one else notice in your behaviors?
      
      Let me ask one more question, if I might. Can you foresee or envision anything that might get in the way or act as a barrier or obstacle to your achieving your goals of....? What do you think could be done to anticipate and address such potential barriers?
      
   ii. Use collaborative goal-setting (short-term, intermediate, long-term goals)
   iii. Use videotape modeling films
   iv. Use letter-writing, journaling
   v. Use group processes – open-ended groups
   vi. Use Alumni clubs of successful patients (coping models)
   vii. Use hopeful mentors

5. Ensure that the patient has intra – and interpersonal coping skills
   
   i. Highlight the discrepancies between valued goals and current behaviors and consequences and consider what can be done to close this gap.
   ii. Train and nurture specific coping skills to the point of mastery.
   iii. Build in generalization – do not merely “train and hope” for transfer (Follow the specific steps of what you need to do before, during and after training
in order to increase the likelihood to achieve generalization and
ensure maintenance. (See Meichenbaum, 2001, pp. 334-341.)
iv. Put the patient in a consultative mode. (The patient needs to explain,
and/or demonstrate skills learned.)

6. Encourage the patient to perform "personal experiments”
   i. Solicit commitment statements and self-explanations and self-generated
      reasons for behavioral change.
   ii. Facilitate "corrective emotional experiences" (ala Alexander & French,
       1946).
   iii. Involve significant others.
   iv. Ensure that the patient takes the “data” from his/her personal experiments
       as “evidence” to unfreeze his/her beliefs about self and the world.

7. Ensure that the patient takes credit for change
   i. Use attribution training – use metacognitive statements (“notice,” “catch,”
      “interrupt,” “game-plan”)
   ii. Nurture a sense of mastery and efficacy (“In spite of...How...”) Use the
       language of “becoming”.
   iii. Monitor the degree to which the patient ascribes personal agency for
       change. Note the number of unprompted examples of where the patient
       takes the therapist’s voice with him/her, especially active transitive verbs.
   iv. Help the patient change his/her personal narrative or the “stories” he/she
       tells oneself and others.

8. Conduct relapse prevention – follow treatment guidelines on how to conduct relapse
   prevention (See Meichenbaum, 2001, pp. 355-361)
   i. Be sensitive to the beliefs, behaviors and interpersonal conflicts that may
      block recovery.
   ii. Consider the episodic nature of the patient’s psychiatric disorders and any
      possible anniversary effects.
   iii. Identify and help the patient develop coping strategies.
   iv. Consider family and peer factors that can both undermine and support
      change. Consider the impact of a High Expressed Emotional Environment on
      the recovery process of the patient (criticism, intrusiveness).

Additional Psychotherapeutic Tasks for Treating Patients With a History of
Victimization

(Note that approximately 50% of psychiatric patients have a history of victimization.)
9. Address **basic needs and safety** and help the patient develop the tools for **symptom regulation** including treating symptoms of **comorbidity**

   i. Treat the sequelae of PTSD and Complex PTSD.
   ii. Conduct an **integrated treatment** program, rather than sequential or parallel treatment programs.
   iii. Normalize, validate and reframe symptoms as a means of coping and as a form of survival processes, “Stuckiness” issue.

10. Address “**memory work**” and help with the patient’s belief system

   i. Consider various forms of “retelling” his/her trauma story – A “restorying” process.
   ii. Relive with cognitive restructuring: Contextualize memories – discriminate “then” and “now”, putting memories in the past.
   iii. Consider what implications (beliefs) the patient has drawn as a result of victimization experiences (“What lingers from…”; “What conclusions do you draw about yourself and others as a result of…”)
   iv. Consider impact of “shattered assumptions” and how to re-script narrative. Listen for and use the patient’s use of metaphors.

11. Help the patient find “**meaning**” : Adopt a constructive narrative perspective

   i. Consider what the patient did to “survive”.
   ii. What evidence of strengths in self and others.
   iii. What “lessons” learned that the patient can share with others - What can be salvaged from survivorship that the patients can make a “gift” to offer others?
   iv. What is the role of faith (spirituality)?

12. Help the patient re-engage life and **reconnect with other**: Address the impact of trauma on family members, significant others and community.

   i. How move beyond “victim” role to that of being a “survivor”, even a “thriver”.
   ii. How engage in a proactive “helper” role.
   iii. How to connect with adaptive/supportive peers and community resources.
13. A major way individuals often cope with the aftermath of exposure to traumatic events is to use some form of religion or spirituality. There is a need for therapists to explore with patients for whom such spiritually-oriented coping procedures are central, various ways to integrate them into the psychotherapy process. In doing so, therapists need to be sensitive to cultural, developmental and gender differences.

i. Assess for the role of spirituality in coping process
ii. Where indicated, collaborate with local healers
iii. Work with local social organizations and social support systems
iv. See Handout on How to Integrate Spiritually-oriented Treatments


i. Interventions at the individual level
ii. Interventions at the social or collegial level
iii. Interventions at the level of the social agency
iv. Work with local social outreach agencies
v. See Handout of Ways to Reduce Vicarious Traumatization
1A. Background Information
1B. Reasons for Referral

9. Barriers
   9A. Individual
   9B. Social
   9C. Systemic

8. Outcomes (GAS)
   8A. Short-term
   8B. Intermediate
   8C. Long term

7. Summary of Risk and Protective Factors

6. Strengths
   6A. Individual
   6B. Social
   6C. Systemic

2A. Presenting Problems (symptomatic functioning)
2B. Level of Functioning (Interpersonal problems, Social role performance)

3. Comorbidity
   3A. Axis I
   3B. Axis II
   3C. Axis III
   3D. Impact

4. Stressors (present/past)
   4A. Current
   4B. Ecological
   4C. Developmental
   4D. Familial

5. Treatments Received (current/Past)
   5A. Efficacy
   5B. Adherence
   5C. Satisfaction
FEEDBACK SHEET ON CASE CONCEPTUALIZATION

Let me see if I understand:

Boxes 1 & 2: REFERRAL SOURCES AND PRESENTING PROBLEMS

"What brings you here is...." (distress, symptoms, present and in the past)
"And it is particularly bad when...." "But it tends to improve when you...."
"And it is affecting you (how....in terms of relationships, work, etc.)"

BOX 3: COMORBIDITY

"In addition you are also experience (struggling with)...."
And the impact of this in terms of your day-to-day experience is...."

BOX 4: STRESSORS

"Some of the factors (stressors) that you are currently experiencing that seem to maintain your problems are.... or that seem to exacerbate (make worse) are...."
(Current/ecological stressors)
"And its not only now, but this has been going on for some time as evident by ...." (Developmental stressors)
"And its not only something you have experienced, but your family members have also been experiencing (struggling with)...." "And the impact on you has been..." (Familial stressors and familial psychopathology)

BOX 5: TREATMENT RECEIVED

"For these problems the treatments that you have received where – not type, time, by whom."
"And what was most effective (worked best) was.... as evident by...."
"But you had difficulty following through with the treatment as evident by...." (obtain an adherence history) "And some of the difficulties (barriers) in following the treatment were...."
"But you were specifically satisfied with...and would recommend or consider...."

BOX 6: STRENGTHS

"But in spite of...you have been able to...."
"Some of the strengths (signs of resilience) that you have evidenced or that you bring to the present situation are...."
"Moreover, some of the people (resources you can call upon (access) are...." "And they can be helpful by doing...." (Social supports)

BOX 7: SUMMARY OF RISK AND PROTECTIVE FACTORS

"Have I captured what you are saying?" (Summarize risk and protective factors)
"Of these different areas, where do you think we should begin?" (Collaborate and negotiate with the patient a treatment plan. Do not become a "surrogate frontal lobe" for the patient.)

BOX 8: OUTCOMES (GOAL ATTAINMENT SCALING PROCEDURES)

"Let's consider what are your expectations about the treatment. As a result of our working together, what would you like to see change (in the short-term)?"
"How are things now in your life? How would you like them to be? How can we work together to help you achieve these short-term, intermediate and long-term goals?"
"What has worked for you in the past?"
"How can our current efforts by informed by your past experience?"
"Moreover, if you achieved your goals, what would you see changed?"
"Who else would notice these changes?"

BOX 9: POSSIBLE BARRIERS

"Let me raise one last question, if I may. Can you envision, can you foresee, anything that might get in the way – any possible obstacles or barriers to your achieving your treatment goals?"
(Consider with the patient possible individual, social and systemic barriers. Do not address the potential barriers until some hope and resources have been addressed and documented.)
"Let's consider how we can anticipate, plan for, and address these potential barriers."
"Let us review once again...." (Go back over the Case Conceptualization and have the patient put the treatment plan in his/her own words. Involve significant others in the Case Conceptualization Model and treatment planning. Solicit their input and feedback. Reasses with the patient the treatment plan throughout treatment. Keep track of your treatment interventions using the coded activities (2A, 3B, 4C, 6B, etc.) Maintain progress notes and share these with the patient and with other members of the treatment team.
WAYS TO BREAK THE “VICIOUS CYCLE”: USE OF THE CLOCK METAPHOR

(See Well et al. 2008 “Chronic PTSD Treated with Metacognitive Therapy”. Cognitive and Behavioral Practice, 15 85-92 for further examples)

12 o’clock Interventions – external and internal triggers

1. Have the patient become aware of how they are hyper-vigilant about possible threats.

2. Collaboratively consider if threat assessment is inflated.

3. Consider the “impact, toll, price” of such threat monitoring behaviors. Consider the advantages and disadvantages (pros-cons) of such behaviors.

4. Examine underlying beliefs that contribute to such hyper-vigilance. For example, “Paying attention to danger means I can avoid it in the future”, “If I worry about bad things, in the future I won’t be blindsided”.

5. Practice redirecting attention to non-threatening features of external and internal environments.

6. Check out perceptions with trusted others.

3 o’clock Interventions – primary and secondary emotions

1. Increase awareness of primary (automatic) and secondary emotions. For example, anger may be a secondary emotion to being humiliated, embarrassed, feeling guilty.

2. Explore what the patient does with such emotions. View emotions as a “commodity” that one does something with (e.g., stuff emotions, drink them away, engage in high-risk behaviors).

3. Explore what is the “impact, toll, price” of such acts. Consider the pros and cons of such behaviors.

4. View such coping efforts (e.g., dissociative behaviors) as a “stuckiness” problem that worked in the past, but are no longer useful (e.g., hyper-vigilance in combat soldiers). Consider transitional stressors.

5. Learn various ways to manage hyper-arousal that contribute to and exacerbate such feeling (e.g., relaxation and mindfulness activities).
6. Consider the automatic thoughts and cognitive appraisals that contribute to such emotional reactions.

6 o'clock Interventions – cognitive events (automatic thoughts and images – “hot” cognitions) cognitive process (mental heuristics, thinking patterns, distortions and errors); cognitive structures, schemas and beliefs.

1. Normalize and validate feelings and accompanying beliefs.
2. Assess for occurrence and impact of cognitive activity (rumination, suppression, ...see Interview).
3. Use cognitive restructuring procedures of monitoring and testing out automatic thoughts. “Personal Scientist” or “Detective” metaphor.
4. Explore metacognitive beliefs about symptomatology or the nature of the “story” the patient tells him/herself and others. Consider the pros and cons of holding such beliefs – “impact, toll, price”.
5. Use healing metaphor ala Wells et al. (2008, pp. 90-91)

“Just like your body, your mind is equipped with a means of healing itself. If you have a physical scar it is best to leave it alone and not keep interfering with it, as this will slow down the healing process. So it is with your mind after trauma. Your intrusive thoughts and symptoms are like a scar, and it is best to leave them to their own devices. Do not interfere with them by worrying or ruminating in response to them or by avoiding or pushing thoughts away. You must allow the healing process to take care of itself and gradually the scar will fade”.

6. Teach a detached mindfulness of acceptance, rather than challenging thoughts. Choose not to influence or engage thoughts by analyzing them, pushing them away or actively trying to change their content.

7. Learn how to apply worry-postponement. As Wells et al. (2008 p. 91) convey to the patient:

“You have seen how trying to control your thoughts does not work very well, and how worrying about things keeps the sense of danger and anxiety going. Do you think you could stop worrying about and analyzing what happened? Perhaps you could run an experiment to see if this is possible. For homework, I would like you to notice worry or ruminating and say to yourself, “That’s a worry. I don’t need to work this out now, I’ll work it out later”. Then set aside a 10 minute worry period that you can use later in the day. You can even have a worry chair you can use. So you are saving up your worry and ruminating until
8. Help the patient appreciate how engaging in contra-factual thinking such as “Why did this happen to me? What have I done to deserve this? Am I mentally weak? and What if” questions.

9. Help the patient appreciate the nature of his/her beliefs. As Foa et al. (1995) convey to victimized individuals,

“After an assault, many rape survivors conclude that the world is unpredictable and uncontrollable, and they view the world as dangerous. Another consequence that is common after an assault is that the survivors develop extremely negative views about themselves. For example, you may feel you are less adequate than you thought you were or that you are extremely vulnerable and incapable of coping with stress. Have you had such feeling and thoughts?

What is the impact of such feelings and thoughts? How do such feelings and thoughts affect you on a daily basis?

Such thoughts can cause anxiety, avoidance and depression and make it difficult to recover from the assault.

It will be useful for us to spend some time evaluating the accuracy of these beliefs and whether or not they are helpful to your recovery.

When you begin to catch yourself engaging in such thinking, you distress and difficulties will begin to decrease.”

10. Help the patient exert control over thoughts and behavior. The therapist can convey to the patient who has been assaulted:

That person who raped you controlled your life for two hours. The question, before us now, is whether you are going to allow him to control the rest of your life?

11. Use prolonged direct therapy exposure procedures.

9o’clock Interventions — behavioral acts and resultant consequences

1. Help the patient appreciate how he/she presently attempts to “break the cycle”. Be specific. Also consider how long this pattern of coping has been going on. Conduct a developmental analysis. For example, is the use of substances a way to self-medicate, or avoidance a way to “dose oneself”; or intrusive ideation a way to

2. Consider the “impact, toll, and price” of using such coping efforts. Are they working or are they making things worse? Consider pros and cons of engaging in such behavioral acts.

3. Use motivational interviewing procedures to change such behaviors.

4. Use metaphors as a way to have the patient appreciate the self-defeating nature of his/her behavior.

Walser and Hayes (2006, pp. 160-163) offer the following metaphors as ways to engage patients into treatment.

**Therapist:** Here is a metaphor that will help you understand what I am saying. Imagine you are blindfolded and given a bag of tools and told to run through a large field. So there you are, living your life and running through the filed. However, unknown to you, there are large holes in this field, and sooner or later you fall in. Now remember you were blindfolded, so you didn’t fall on purpose; it is not your fault that you fell in. You are not responsible for being in that hole. You want to get out, so you open your bag of tools and find that the only tool is a shovel. So you begin to dig. And you dig. But digging is the thing that makes holes. So you try other things, like figuring out exactly how you fell in the hole, but that doesn’t help you get out. Even if you knew every step that you took to get into the hole, it would not help you to get out of it. So you dig differently. And you’re still not out. Finally, you think you need to get a “really great shovel” and that is why you are here to see me. Maybe I have a gold-plated shovel. But I don’t and even if I did, I wouldn’t give it to you. Shovels don’t get people out of holes – they make them.

**Client:** So what is the solution? Why should I even come here?

**Therapist:** I don’t know, but it is not to help you dig your way out. Perhaps we should start with what your experience tells you; that what you have been doing hasn’t been working. And what I am going to ask you to consider is that what you have been doing can’t work. Until you open up to that reality, that bottom line, you will never let go of the shovel because as far as you know, it’s the only thing you’ve got. But until you let go of it, you can’t take hold of anything else.
Another metaphor offered is as follows:

"Are you familiar with the Chinese finger trap? This toy is a tube generally made of straw. You place your two index fingers in the tube and then try to pull them out. What happens is the more you pull the tighter the straw tube clamps down on your fingers, making it virtually .... becoming the trap. The more effort you put into escaping, the more uncomfortable you feel – the more trapped you become. Trying to escape negative emotional experience can work like a Chinese finger trap. The harder you try not to have the emotions, the more the emotions "clamp" down on you. Examples of this kind of problem include excessive drinking to escape anxiety. Now you not only have the problem of anxiety, but you also have the problem of excessive drinking and all that that brings with it.


5. Teach intra and interpersonal skills and build in treatment guidelines to foster generalization.
REPORT CARD ON HOW WELL YOUR TRAINING PROGRAMS FOSTER GENERALIZATION

How many of these 23 features are included in your training program? What grade would you give to your Intervention Program to foster generalization?

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

1. Uses explicit collaborative goal-setting when discussing the reasons and value of transfer and relates training tasks to treatment goals.

2. Explicitly instructs, challenges and conveys an “expectant attitude” about transfer.

3. Uses discovery learning, labeling transfer skills and strategies.

4. Solicits participants’ public commitment and uses behavioral contracts.

5. Anticipates and discusses possible barriers to transfer.

6. Chooses training and transfer tasks carefully (build in similarities and use ecologically-valued training tasks).

7. Develops a “community of learners” (e.g., Alumni Club).

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

8. Keeps training simple – uses acronyms and reminders.

9. Use performance-based training to the point of mastery.

10. Teaches metacognitive skills – involving self-monitoring, planning, etc.

11. Accesses prior knowledge and skills, uses advance organizers and scaffolds (individually tailors) instruction.

12. Conducts training across setting, using multiple trainers and environmental supports.


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

15. Puts trainees in a consultative role (uses reflection, opportunity to teach others, puts trainees in a position of responsibility).

16. Ensures participants directly benefit and receive reinforcement for using and describing transfer skills.

17. Provides between sessions coaching.

18. Provides active aftercare supervision — fade supports and “scaffolds” assistance.

19. Ensures participants take credit and ownership for change (self-attributions). Nurtures personal agency.

20. Ensures that participants collaborate in designing personal transfer activities.

21. Involves significant others.

22. Provides booster sessions.

23. Conducts a graduation ceremony.
REFERENCES


