

# **VA Social Skills Training for Serious Mental Illness**

## **Master Trainer Program Workshop Training Manual**

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## ***Table of Contents***

### **Section I. Master Trainer Workshop**

Page 3: Program Personnel Directory

Page 5: Master Trainer Workshop Agenda

### **Section II. Social Skills Training Workshop Information**

Page 11: Sample Training Day Agenda

Page 13: Social Skills Training Workshop Logistics

Page 15: Sample Procedures for Social Skills Training Session Practice

Page 19: Sample Sequence of SST Training Practice Sessions

Page 22: Examples of Skills for Practice Sessions

Page 24: Other Notes for SST Training Practice Sessions

Page 25: Notes on Social Skills Training Workshop Information

### **Section III. SST Teaching Tools**

Page 27: Training Techniques for SST Training Practice Sessions

Page 28: Common Training Challenges and Solutions

Page 31: Other Training Considerations

Page 32: Notes on SST Teaching Tools

### **Section IV. Providing Consultation to SST Clinicians**

Page 34: Components of Consultation Models

Page 34: Examples of Consultation Models

Page 34: Consultation Tools

Page 35: Tips for Consultation

Page 36: Notes on Providing Consultation to SST Clinicians

### **Section V. Feedback for SST Clinicians**

Page 38: Tips for effective feedback and facilitating improvements

Page 39: Commonly Occurring Issues for New SST Clinicians and Useful Feedback

Page 43: Notes on Feedback for SST Clinicians

## ***Section I. Master Trainer Workshop***

## ***Section I. Master Trainer Workshop***

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# VA Social Skills Training Program

## AGENDA MASTER TRAINER WORKSHOP

### **Day 1:**

**8:00a.m.** Registration, Convene, and Introductions

**8:30a.m.** ***Overview of the VA Social Skills Training "Master Trainer" Program***

**Alan S. Bellack, Ph.D., ABPP**

ABSTRACT: In this talk, Dr. Bellack will describe the Master Trainer component of the VA Social Skills program, define its overall objectives, and describe the relationship of the Master Trainer program to the VA Uniform Mental Health Services Package. He will also outline the essential components of SST that should be disseminated to VA clinicians.

**9:30a.m.** ***Master Trainer Program: Workshop and Beyond***

**Alan S. Bellack, Ph.D., ABPP**

ABSTRACT: In this talk, Dr. Bellack will outline the plan for the 3-day workshop for the Master Trainers. This will include the role of the Master Trainers in each day of the workshop as well as the role of Master Trainers in the clinician workshop break-out sessions. He will also define the expectations for the Master Trainers in terms of dissemination of social skills training (SST) within their site/VISN. He will also outline the plan for ongoing consultation with Master Trainers after the workshop as well as available resources.

**10:00a.m.** BREAK

**10:15a.m.** ***Keys to Teaching Social Skills Training***

**Amy Drapalski, Ph.D.**

ABSTRACT: This section of the training will focus on two primary areas: (1) teaching tools to use while training clinicians in SST and (2) components that should be included in a SST training. During this session Dr. Drapalski will review several training resources with the Master Trainers. She will focus discussion on the primary keys to teaching others how to lead SST groups. This will include reviewing primary teaching tools in training available in the SST Trainer Manual.

She will also provide potential outlines for different SST trainings and allow group discussion on each one of the models.

**11:15a.m. Consultation: Models and Tools**

**Amy Drapalski, Ph.D.**

ABSTRACT: This portion of the training will focus on consultation the Master Trainers will provide to clinicians within their sites/VISNs. The discussion will focus on different potential models of consultation as well as teaching tools to use in SST consultation. There will be a brief discussion on resources available to facilitate consultation (e.g., Social Skills Observation Checklist). An important focus will be on how to identify and define problems in SST administration and how to provide effective, useful, and timely feedback in consultation.

**12:00p.m. LUNCH**

**1:00p.m. Trainer Session**

**Alan S. Bellack, Ph.D., ABPP, Amy Drapalski, Ph.D., Matt Wiley, MPH**

During this session, the Master Trainers will have an opportunity to participate in a mock training break-out session. The Master Trainers will take turns co-leading a training session with a trainer. They will have the opportunity to provide active support and feedback while other trainees are pretending to learn how to lead social skills groups. They will also observe and participate in providing wrap-up feedback to other group members.

**3:00p.m. BREAK**

**3:15p.m. Roundtable Discussion**

The focus of this session will be to allow the Master Trainers to ask question of program leadership around program goals, trainings, and consultation. Master Trainers will be asked to come up with one practical/logistical challenge they may encounter within their VISN in their role as Master Trainer (e.g., in facilitating a SST workshop, in providing on-site consultation). They will be asked to discuss this in their first break-out session.

**4:00p.m. End of training day 1**

## **Day 2:**

**8:30a.m.** Convene and Introductions

**8:45a.m.** ***Plenary Presentation on Recovery and Introduction to VA initiative for dissemination of Evidence Based Practices***

**Alan S. Bellack, Ph.D., ABPP**

ABSTRACT: In this talk Dr. Bellack will describe the President's New Freedom Commission on Mental Health (2003) and will outline the primary recommendations that followed for the VA. These include the need to adopt and implement the Recovery Model in VA Mental Health Programs nationwide and the need to educate VA staff on recovery. Dr. Bellack will define recovery and what the components of recovery include for individuals with severe mental illness (SMI). He will outline why the use of Evidence Based Practices and manualized treatment is important in the Recovery Model and will describe the VA Uniform Services Package as it relates to treatment of individuals with SMI. He will focus on the use of Social Skills Training for individuals with SMI and the research support for the effectiveness of this training.

**9:30a.m.** ***Presentation of the Social Skills Training Model: What is the model and how do you teach it?***

**Shirley Glynn, Ph.D.**

ABSTRACT: In this talk Dr. Glynn will focus on describing the format and rationale behind the Bellack, Mueser, Gingerich, and Agresta (2004) social skills treatment. The talk will describe the model of the social skills intervention. The talk will also describe the basic components (i.e., steps) of the groups, the ideal size and make-up of the groups, role of group leaders, and other components necessary for an effective social skills group.

**10:15a.m. BREAK**

**10:30a.m.** Video viewing of a SST group and discussion

**11:15a.m. *Master Trainer Break Out Session***

**Alan S. Bellack, Ph.D., ABPP, Amy Drapalski, Ph.D.**

This component of the training will focus on discussions from each one of the Master Trainers on their plan for training implementation and consultation. Master Trainers will be asked to present and discuss one practical/logistical challenge they may encounter within their VISN in their role as Master Trainer (e.g., in facilitating a SST workshop, in



providing on-site consultation). They will also discuss their roles and prepare for the afternoon break out sessions with clinician trainees.

**12:15p.m. LUNCH**

**1:00p.m.** Breakout groups until 3:30 pm. **(10 minute break at 2:20p.m.)** This component of the training will include breakout groups with 2 SST trainers, 1-2 Master Trainers, and approximately 8-10 trainees. Trainers will first review the components and flow of the group sessions and then will model a basic group. Using some of the basic skills (e.g. expressing positive feelings, making a request, listening) participants will take turns in the role of the leader in facilitating the beginning steps of a social skills training group. Trainers will provide opportunities for  $\frac{1}{2}$  to  $\frac{3}{4}$  of the participants to take the role of the leader and will provide active support and feedback. If not taking the role of leader, participants will role-play being group members. ***Master Trainers will observe the 1<sup>st</sup> half of this afternoon's session and then actively participate as the lead trainers during the 2<sup>nd</sup> half.***

**3:30p.m. BREAK**

**3:45p.m. Break-Out Session Debriefing**

**Alan S. Bellack, Ph.D., ABPP, Amy Drapalski, Ph.D.**

During this session, Master Trainers will be debriefed by SST Trainers on their performance during the day's break-out sessions with SST trainees. They will be given specific feedback and discuss further development.

**4:30p.m.** End of training day 2

### **Day 3:**

**8:00a.m.** Convene

**8:15a.m.** Panel discussion on strategies for common clinical challenges in conducting groups (e.g., different levels of functioning, distractibility, difficulty following group format, reluctance to role play, providing critical feedback, cognitive difficulties, psychotic symptoms).

**9:00 am.** **Breakout groups** until 12:00p.m. **(15 minute break at 10:30a.m.)**. Trainees will reconvene in the same breakout sessions. Using some of the more advanced skills (e.g., entering into an ongoing conversation, asking for information, disagreeing with another person's opinion without arguing, asking someone for a date, refusing offers of drugs and alcohol) participants who did not get an opportunity on Day 1 will take turns in the role of the leader. Training will focus on facilitation of multiple role-plays. If not taking the role of leader, participants will role-play being group members. During the role plays, one or two clinicians playing group members may be asked to demonstrate behaviors associated with common challenges, such as difficulty concentrating or staying on the topic. Participants will have the opportunity to role-play conducting co-facilitation. ***Master Trainers will observe the 1<sup>st</sup> half of this afternoon's session and then actively participate as the lead trainers during the 2<sup>nd</sup> half.***

**12:00p.m.** **LUNCH**

**1:00p.m.** ***Final Debriefing***

**Alan S. Bellack, Ph.D., ABPP, Amy Drapalski, Ph.D.**

During this session, Master Trainers will be debriefed by SST Trainers on their performance during the day's break-out sessions with SST trainees. They will be given specific feedback and discuss further development.

**1:30p.m.** Wrap-up and evaluations

**2:00p.m.** End of training day 3

## ***Section II. Social Skills Training Workshop Information***

## ***II. Social Skills Training Workshop Information***

### **Sample Training Day Agenda**

**8:00a.m.    *Convene and Registration***

**8:15a.m.    *Introductions and Plan for the Day***

**8:30a.m.    *Plenary Presentation on Recovery and Introduction to VA initiative for dissemination of Evidence Based Practices***

ABSTRACT: This talk will include a brief discussion of the President's New Freedom Commission on Mental Health (2003) and the primary recommendations that followed for the VA. These include the need to adopt and implement the Recovery Model in VA Mental Health Programs nationwide and the need to educate VA staff on recovery. The speaker will define recovery and what the components of recovery include for individuals with severe mental illness (SMI). He/she will outline why the use of Evidence Based Practices and manualized treatment is important in the Recovery Model and will describe the VA Uniform Services Package as it relates to treatment of individuals with SMI. He/she will focus on the use of Social Skills Training for individuals with SMI and the research support for the effectiveness of this training.

**9:00a.m.    *Presentation of the Social Skills Training Model: What is the model and how do you teach it?***

ABSTRACT: In this talk the speaker will focus on describing the format and rationale behind the Bellack, Mueser, Gingerich, and Agresta (2004) social skills treatment. The talk will describe the model of the social skills intervention. The talk will also describe the basic components (i.e., steps) of the groups, the ideal size and make-up of the groups, role of group leaders, and other components necessary for an effective social skills group.

**9:30a.m.    *Demonstration of an SST group***

In this session the speaker will demonstrate a "mock" SST group. The trainees will act as group members. After the demonstration there will be a brief Q&A to discuss the mock group.

**10:45a.m.    *15-minute break***

**11:00a.m.    *Social Skills Training Practice Session I***

The next hour and a half of the training will focus on the trainees practicing as SST group leaders. The trainer will first review the components and flow of the group sessions. Then, using some of the

basic skills (e.g. expressing positive feelings, making a request, listening) participants will take turns in the role of the leader in facilitating the beginning steps of a social skills training group. The trainer will provide opportunities for half of the participants to take the role of the leader and will provide active support and feedback. If not taking the role of leader, participants will role-play being group members. Participants will have the opportunity to role-play conducting co-facilitation.

**12:30p.m. Lunch (until 1:30p.m.)**

**Note:** You may ask trainees to choose a skill that they would like to practice leading in session 2. They should be asked to choose a skill that they think is more challenging and also appropriate for the veterans they work with. They should be asked to read the skill thoroughly and to be prepared to lead it in session 2.

**1:30p.m. *Social Skills Training Practice Session II***

The next hour and a half of the training will focus on the trainees practicing as SST group leaders. Using some of the more advanced skills (e.g., entering into an ongoing conversation, asking for information, disagreeing with another person's opinion without arguing, asking someone for a date, refusing offers of drugs and alcohol) participants who did not get an opportunity before lunch will take turns in the role of the leader. Training will focus on facilitation of multiple role-plays. If not taking the role of leader, participants will role-play being group members. During the role-plays, one or two clinicians playing group members may be asked to demonstrate behaviors associated with common challenges, such as difficulty concentrating or staying on the topic. Participants will have the opportunity to role-play conducting co-facilitation.

**3:00p.m. *Orienting Veterans to the SST Groups***

In this talk the speaker will discuss orienting participants to the SST groups including establishing guidelines, describing SST groups, and setting individual goals.

**3:30p.m. *Logistical Discussion***

During this session, the speaker will (1) provide information to the trainees on the consultation and support that will be available to them after the workshop and (2) problem solve with the trainees any concerns they may have around starting the group (e.g., recruitment, curriculum, etc.).

**4:20p.m. *Evaluations.***

**4:30pm. *End of training day!***

## **Social Skills Training/Workshop Logistics**

**Length.** The training workshop that we describe in this manual occurs over a length of one full workday. The workshop can be modified to occur over a longer period (e.g., 2 days) or over a few days (e.g., the workshop could be broken into two days, four hours each). The trainer should dedicate at least 2 to 3 hours in the SST session practice as described below.

**Trainees.** The training groups should include about 8 (or fewer) trainees per one trainer. If possible, Master Trainers should attempt to select clinicians that meet outlined criteria for successful SST group leaders (see SST book page 82). When possible, the groups should include clinicians that are from the same VA site.

**Materials.** Materials needed for the training include:

- Laptop computer with PowerPoint
- Overhead projector
- Dry-erase board/flip chart
- Markers
- Large pieces of paper
- Tape
- Training Handbook
- Social Skill Training for Schizophrenia (Bellack, Mueser, Gingerich, & Agresta, 2004)

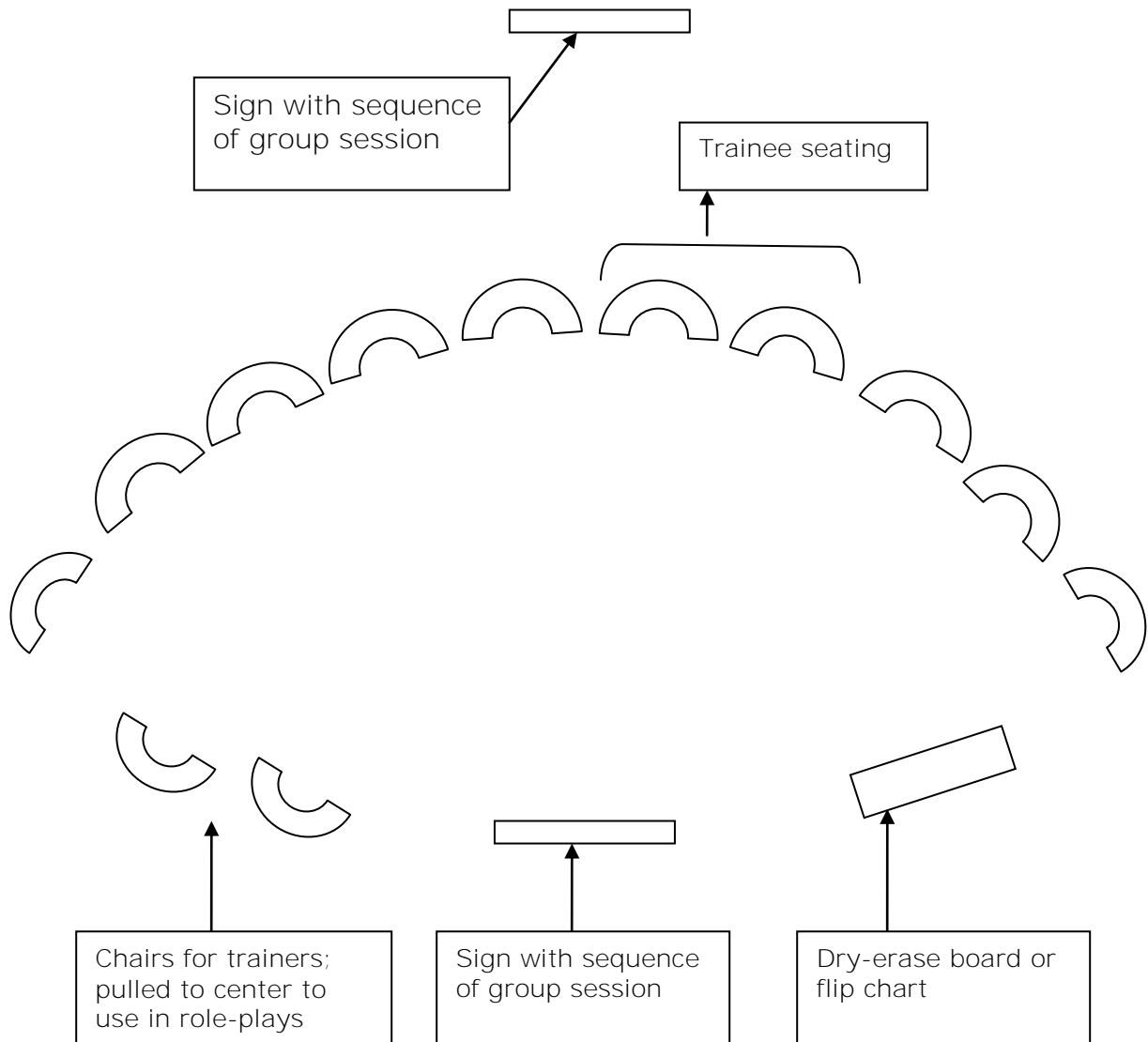
**Room set up.** The training room should be set up to parallel seating that occurs in actual social skills training groups (see Diagram following page). This includes trainee seating arranged in a semi-circle. A dry-erase board/flip chart with markers and two chairs should be placed at the front of the semi-circle. At the front-center of the semi-circle is a sign with the sequences of steps of a Social Skills Training group. We have also found that it is useful to place a copy of this list at the back of the room.

This should be written as follows:

### **SEQUENCE OF GROUP SESSIONS**

1. Review homework.
2. Establish a rationale for the skill.
3. Briefly have members share a relevant experience.
4. Discuss the steps of the skill.
5. Model the skill; review the model.
6. Have a group member role-play.
7. Elicit and provide feedback (positive, then corrective).
8. Have the member role-play again.
9. Elicit and provide feedback (positive, then corrective).
10. Repeat role-play again and provide feedback.
11. Repeat Steps 5-9 with each other group member.
12. Develop homework assignments.

**Diagram: Training room set up**



## **Sample Procedures for Social Skills Training Session Practice**

We have found that it can be helpful to follow a few basic procedures in order to provide an effective and efficient practice session. The following information is designed for training practice sessions that are broken into two sessions and includes the basic premises used in the SST national workshops.

**Definition of Terms.** It will be helpful prior to reading information on SST practice sessions to become familiar with the use of different terms. We use the term **trainer** to refer to the professionals leading the SST training and practice sessions. We use the terms **trainee**, **clinician**, and **group leader** interchangeably. As you will read, the trainees are encouraged to act as group leader running mock social skills groups in practice sessions. In this manual the term **group session** refers to mock social skills groups that the trainees are facilitating. While one or two trainees act as group leader, remaining trainees pretend to be **group members**. They are asked to act and respond in a way that a veteran with serious mental illness might.

**Overview of SST Training Practice Sessions.** The primary goal of the training sessions is to allow every trainee the opportunity to practice leading a mock social skills training group. Due to time constraints, trainees will not be able to lead an entire "group" from start to finish, but should have the opportunity to lead major components of a Social Skills Training group (i.e., develop rationale for the skill, discussing the steps of a skill, setting up role-plays, eliciting feedback, assigning homework). The great majority of time in these groups must be spent on practice. It is the responsibility of the trainer to keep discussions and Q&A brief and to the point. Otherwise time is spent on talking and not on practicing!

We have found that it is most effective to keep the practice focus in session 1 on the "first half" of the social skills group session sequence. In other words from *Step 1. Review Homework* or *Step 2. Establish a rationale for the skill* through Step 8. Have a group member do a second role-play or *Step 9. Elicit feedback from the group on the second role-play*. Session 2 should focus on trainees facilitating multiple role-plays (i.e., three or more) with one or more participants. However, it should be made explicit to trainees starting Session 1 that the primary goal of the groups is skill building through behavioral rehearsal.

**Establishing expectations.** The importance of starting the practice sessions by establishing the expectations, agenda, and structure of the practice sessions cannot be overestimated. There are several points that need to be made clear.

- (1) Make sure trainees understand that you will first review the sequence of the groups prior to their practice as group leader.
- (2) Let the trainees know that every one will have the chance to act as group leader with about half the participants in each session leading.

**(3) Many clinicians will be quite nervous about their experience in the training sessions. It is up to the trainer to make it exceedingly clear that all trainees will be provided active support and feedback when they are acting as group leader. Make it clear before starting any practice that**



**clinicians will not be allowed to flounder, but rather will be provided with the support they need to succeed.**

(3) Make sure that the other trainees understand that when one or two trainees are acting as group leader they are to pretend to be a veteran in the group. Therefore, when the leader elicits responses the other group members should use responses that are relevant for veterans with serious mental illness (SMI).

**Active support.** While trainees are acting as group leader, they should receive active support and feedback from the trainers. In fact, in our experience the more support the better! This will occur largely in a “parallel process”, meaning that the training tools used in the practice sessions are those that should occur in actual social skills training groups. This serves two purposes: 1. Allows trainees increased chances at success while learning how to lead the groups and 2. Provides a model of different teaching tools that can be used in social skills groups.

**Goals for first practice session.** The main goal of the first SST Training Session is for participants to acquire the basic skills of leading a social skills group. Trainees should complete the session with an understanding of the structure and basic sequence of a social skills group and an understanding of the primary teaching techniques that are used in the groups. The trainers should emphasize the importance of getting group members involved at every opportunity (e.g., reading the steps of the skill) and the need for behavioral and specific feedback on role-plays that focuses on what went well.

**Trainers should focus on the following in the first practice session:**

1. Skill practice in Practice Session 1 should focus on more basic skills. See Page 23 for examples.
2. Group leadership practice can either be as a sole-facilitator or as co-facilitators, depending on what is relevant for the clinicians in the group (i.e., what they will be doing at their respective sites).
3. The primary focus of first practice session is for trainees to gain an understanding of the primary components and sequence of the social skills groups. Trainees will focus practice on the first several steps of a group (i.e., from ***Step 1. Review Homework*** or ***Step 2. Establish a rationale for the skill*** through ***Step 8. Have a group member do a second role-play*** or ***Step 9. Elicit and provide feedback***). After trainees have an opportunity to facilitate a second role-play with one group member (and potentially facilitate feedback on that role-play depending on time) they should generally be stopped. However, it should be clear to trainees that skills in actual SST groups are practiced through multiple role-plays (i.e., usually three). Notably, practice in session 2 focuses on facilitation of multiple role-plays.

**Goals for second practice session.** The main goals of session 2 are for participants (1) to gain the main skills of setting up and facilitating multiple role-plays, (2) to acquire knowledge in implementing increasingly complicated and challenging skills, and (3) to practice dealing with common participant-related challenges.

**Trainers should focus on the following in practice session 2:**

1. Skill practice in session 2 should focus on more advanced skills. See Page 24 for examples.
2. Participants who did not get an opportunity in session 1 will take turns in the role of the leader.
3. Group leadership practice can either be as a sole-facilitator or as co-facilitators, depending on what is relevant for the trainees in the group (i.e., what they will be doing at their respective sites).
4. The first person that practices should lead a group from *Step 1 Review Homework* to *Step 8 Facilitating a second role-play with one group member*. This will provide the group with a refresher on the sequence of the groups.
5. After the first trainee practices, all subsequent practice should focus on the second half of the groups (i.e., from facilitating the first role-play with the first participant to assigning homework). This is important to promote practice and modeling of facilitating multiple role-plays in the groups. Prior to practice of the **"second half" of the groups it is necessary for a trainer to "fast forward" through the first half by stating something like "OK so we are going to pretend that you have just reviewed the homework, discussed a rationale and the steps of the skill, modeled the skill and received feedback on the model. You are now going to ask for the first volunteer to role-play."**
6. Depending on time constraints you may need to move trainees forward to assigning homework after they facilitate three role-plays with one participant.
7. In order to prepare group leaders for commonly occurring challenges with group members, group participants will be asked to **"act out" behaviors associated with common challenges using pre-prepared "Characteristic Cards" (see following page for card descriptions).** Trainers may consider waiting until after first "group session" to evaluate the readiness of the trainees to deal with the cards.

### **Card Descriptions:**

The following descriptions are written on a set of 10 cards to be passed out at session 2 to "group members" while trainee(s) are leading a "group."

IMPORTANT NOTE: Only 1 to 2 cards should be passed out at any given time.

**Card 1.** You refuse role-plays (but may be willing to "compromise" on participation - e.g., may be willing to do one step of skill or do role play from your seat if asked by leader)

**Card 2.** You are very quiet (either responding to internal stimuli or looking down at the ground)

**Card 3.** You dominate the group (e.g., try to answer all the questions, jump in first with feedback after role plays)

**Card 4.** You want to talk about outside topics (e.g., problems with payee, problems with board and care provider)

**Card 5.** You have difficulty with role-plays (e.g., don't make eye contact, speak very softly, leave out a step)

**Card 6.** You are a high functioning client who says how easy this is for you

**Card 7.** You keep falling asleep

**Card 8.** You give critical feedback about others' role-plays

**Card 9.** You are displaying manic symptoms (may need to pace, speak rapidly, etc.)

**Card 10.** You volunteer to do a role-play, but have a difficult time choosing a relevant scenario for yourself (e.g., make statements during the role-play set up such as "No, that won't work...")

## **Sample Sequence of SST Training Practice Sessions**

We have found that following a basic sequence in the practice sessions leads to an effective and efficient learning experience. This sample sequence is designed for training sessions that are broken into two sessions and is the basic sequence used in the national SST workshops.

- (1) Set up room in semi-circle (prior to session).
- (2) Write group session sequence on a board clearly visible to all participants (prior to session).
- (3) Trainer(s) introduce selves and ask for the names/work location and site of trainees if not already known. They should clarify if clinicians will be facilitating groups alone or with a co-facilitator.
- (4) If clinicians in this group will be acting as co-facilitators you may briefly describe the basic roles of primary and second facilitators at this time.
- (5) Outline agenda and sum-up the expectations for the practice session (See Page 16 **Establishing Expectations**) including the role of group members during mock groups. Encourage trainees to be relatively compliant in session 1 when acting as a group member.
- (6) Review steps of the group with a brief description (i.e., what occurs at each step and approximately how long each step should take). The steps include:
  1. Review homework.
  2. Establish a rationale for the skill.
  3. Briefly have members share a relevant experience.
  4. Discuss the steps of the skill.
  5. Model the skill; review the model.
  6. Have a group member role-play.
  7. Elicit and provide feedback (positive, then corrective).
  8. Have the member role-play again.
  9. Elicit and provide feedback (positive, then corrective).
  10. Repeat role-play again and provide feedback.
  11. Repeat Steps 5-9 with each other group member.
  12. Develop homework assignments.
- (7) Model a group using a basic skill (e.g., Expressing Positive Feelings, Making Requests, Listening to Others or see page 23 for list of **Examples of Basic Skills**) with a brief discussion afterwards. Trainers will not be able to lead an entire group (i.e., do role-plays with all group members) due to time constraints. It is recommended that the trainers do a brief homework review with one or two group members (pointing out that usually review would be with all participants), develop rationale, discuss steps, do and review a model, do a role-play or two with one group member, and then “fast forward” to homework development.

IMPORTANT NOTE: If a trainer modeled a SST in a recent portion of the training, they may consider not doing a model of a group as described above. Rather, they may choose a slightly more detailed description of each of the steps in a social skills group (see Step 6).

(8) Trainers may consider taking a break at this point to allow participants to review the basic skills in the SST book. This break may also help the trainee that will first act as group leader to transition their role from group member to group facilitator.

(9) Provide group members with a list of basic skills they can choose from. See page 23 for list of **Examples of Basic Skills**.

(10) Bring up the first participant sitting at the end of the semi-circle to practice leading a basic skill (this may be the skill that trainer(s) just modeled).

(11) Provide active support and coaching.

(12) After first participant is finished briefly discuss what worked and what to watch out for. **You may ask about the participant's experience as group leader.**

(13) Bring up next participant (i.e., next person in the semi-circle\*).

(14) Manage time so that about half the participants act as group leader.

(15) Briefly discuss the group before ending the session.

**\*\*\*If you are leading the training session in two separate sessions you will start the second session (after setting up the room appropriately) by:**

(1) Outline agenda and sum-up the expectations for the practice session. This should include that the first group leader will conduct the first half of a group, and all subsequent participants will practice facilitation of multiple role-plays with one or more participants and will practice assigning homework. It should also include a brief description of the "Characteristic Cards" which include examples of commonly occurring challenges that group participants will be asked to "act out." **As discussed in Establishing Expectations, make sure the trainees know they will receive active support when acting as group leader.**

(2) Quickly ask the group participants what skills they picked for practice (if you asked them to do so), write them on a large piece of paper, and tape them in a clearly visible location. You may consider asking folks to take 10 minutes at this time and write down the steps of their chosen skill on a large piece of paper.

(3) Briefly review steps of the group:

1. Review homework.
2. Establish a rationale for the skill.
3. Briefly have members share a relevant experience.
4. Discuss the steps of the skill.
5. Model the skill; review the model.
6. Have a group member role-play.
7. Elicit and provide feedback (positive, then corrective).
8. Have the member role-play again.
9. Elicit and provide feedback (positive, then corrective).
10. Repeat role-play again and provide feedback.
11. Repeat Steps 5-9 with each other group member.
12. Develop homework assignments.

(4) Ask the first participant to lead the skill they choose from Step 1. End it after they facilitate the second role-play with one group member.

(5) Provide active support and coaching.

(6) Briefly discuss what worked and what to watch out for. Ask about the **participant's experience as group leader.**

(7) Ask the next participant to lead the skill they chose starting with facilitating the first role-play with a group member.\* If they did not choose a skill refer them to the list on Page 24 for a more challenging skill. Depending on time you may need to ask them to stop after they have facilitated three role-plays and feedback with one member; then guide them to assign specific homework.

(8) Provide active support and coaching.

(9) After participation briefly discuss what worked and what to watch out for.

(10) Repeat until all participants have had a chance to act as group leader. If you have time have trainees that practiced in session 1 practice facilitating multiple role-plays.

(11) End session with a brief group discussion.

**NOTES: Very important time saver:**

\*When outlining the agenda of the session, remind participants that they will be called up in the order in which they are sitting. This saves time by avoiding waiting for volunteers.

## **Examples of Basic Skills for Session 1 Practice**

### \*Four Basic Skills:

- Listening to Others p. 197
- Making Requests p. 198
- Expressing Positive Feelings p. 199
- Expressing Unpleasant Feelings p. 200\*\*

### Conversation Skills:

- \*Listening to Others p. 197
- Starting a Conversation with a New Person p. 203
- Maintaining Conversations by Asking Questions p. 204
- Maintaining Conversations by Giving Information p. 205
- Maintaining Conversations by Expressing Feelings p. 206
- Ending Conversations p. 207

### Assertiveness Skills:

- \*Making Requests p. 198
- \*Expressing Unpleasant Feelings p. 200
- Asking for Information p. 219

### Friendship/Dating Skills:

- Expressing Positive Feelings p. 199

### Health Maintenance Skills:

- Making a Doctor's Appointment on the Phone p. 253

### Vocational/Work Skills:

- Following Verbal Instructions p. 266

\*\* Please note that we have found Expressing Unpleasant Feelings, although a Basic Skill, can be a bit challenging for some trainees in their first session practice. If unsure, it is probably best to encourage work on a different, simpler skill.

## **Examples of Advanced Skills for Session 2 Practice**

### **Good for Practice as Co-facilitator:**

#### Conversation Skills:

- ☐ Entering into an Ongoing Conversation p. 208

#### Conflict Management Skills:

- ☐ Leaving Stressful Situations p. 226

#### Health Maintenance Skills:

- ☐ Asking Questions about Medications p. 254
- ☐ Asking Questions about Health-Related Concerns p. 255
- ☐ Complaining about Medication Side Effects p. 256

#### Vocational/Work Skills:

- ☐ Interviewing for a Job p. 263
- ☐ Responding to Criticism from a Supervisor p. 265

### **More Challenging Skills:**

#### Conversation Skills:

- ☐ What to do When Someone Goes Off Topic p. 210

#### Assertiveness Skills:

- ☐ Refusing Requests p. 215
- ☐ Responding to Complaints p. 217
- ☐ Expressing Angry Feelings p. 218
- ☐ Asking for Help p. 221

#### Conflict Management Skills:

- ☐ Compromise and Negotiation p. 225
- ☐ **Disagreeing with Another's Opinion without Arguing p. 227**
- ☐ Responding to Untrue Accusations p. 228

#### Communal Living Skills:

- ☐ Checking out Your Beliefs p. 236

#### Friendship/Dating Skills:

- ☐ Refusing Unwanted Sexual Advances p. 247

#### Coping Skills for Drug and Alcohol Use:

- ☐ Offering an Alternative to Using Drugs and Alcohol p. 271
- ☐ Requesting that a Family Member or Friend Stop Asking You to Use Drugs and Alcohol p. 272



## **Other notes for SST Training Practice Sessions**

- When modeling and supporting clinicians in setting up role-plays, trainers should promote focus on individualized scenarios. Ways to do this include:
  - (1) When modeling setting up a role-play ask the group member what their social skills goal is and set up an individualized role-play related to that goal. Of course the trainees will need to make up a goal or can be provided examples.
  - (2) When modeling setting up a role-play ask the group member for a recent or upcoming situation in which they could use the skill.
  - (3) Encourage trainees to use one of these techniques when setting up role-plays.
- Trainers should promote clear role-play set up when modeling and supporting clinicians in setting up role-plays. Role-play scenarios should be set up to focus on the individualized goals and needs of group members. They should also clearly include whom the confederate is going to be, and if relevant, where and when the situation is occurring. Additionally, it is helpful to encourage and model when demonstrating role-play set up that the group member repeat what they are going to remember to do/say for each one of the steps of the skill prior to starting the role-play.
- Trainers should provide a brief description of the roles of co-facilitators in the groups. When this occurs depends on the make up of each practice session (i.e., some sessions may only include clinicians that are going to co-lead social skills and therefore the discussion should occur at the beginning of the first practice session).
- Trainees should be explicitly offered the opportunity to practice co-facilitation.
- Trainers are expected to shape the behaviors of the trainees to be increasingly sophisticated in leading the groups. This can be especially challenging with encouraging facilitating positive feedback and offering constructive corrective feedback (see the section **Common challenges and solutions**).
- We have found that it is extremely important to state, maybe a few times, the role of each trainee and the specific plan prior to a clinician starting a mock social skills group. This may sound something like, *"OK so let's start our next social skills session. Just to repeat, Susan you are the primary facilitator, which means you are responsible for leading the group. Mark you are the secondary facilitator and you will primarily be acting as confederate in role-plays. And Joel you are the veteran doing the role-plays in this scenario. The rest of you (point to remaining trainees) will be the group members. The skill that Susan is leading is Making Requests. Does anyone have any questions about the plan?"*
- You should have nametags available that clinicians can wear. The nametags include the names "Primary Clinician", "Secondary Clinician", and "Veteran," which should further help clarify roles. You are encouraged to use these nametags when modeling a SST group.

[illegible]

### ***Section III. SST Teaching Tools***

### ***III. SST Teaching Tools***

#### **Training techniques for SST Training Practice Sessions**

Here are some training techniques that are quite effective when teaching clinicians how to facilitate SST groups.

- Modeling: Trainers should use modeling to demonstrate how to lead a social skills group, how to handle difficult situations, and how to facilitate learning opportunities in social skills groups. When soliciting feedback and discussion on skills modeled trainers should solicit positive, behavioral, and specific feedback. They should clarify any general or unclear feedback and revise or redirect any negative feedback. The more it is made explicit to trainees about how to solicit behavioral and specific positive feedback the better!
- Positive reinforcement: Trainers should clap and verbally praise trainees for their participation at every opportunity. This should occur at the first opportunity in the sessions.
- Use of verbal coaching: At times, trainers should stand next to and just behind trainees and whisper suggestions while trainees are leading a group session. Trainers should inform trainees that they will use this tool to support them prior to beginning their practice.
- Use of nonverbal prompts: Trainers should point to the steps of the group to prompt the trainee as to what should occur next in the group. Trainers should inform trainees that they will use this tool to support them prior to their practice.
- Take a time-out: If a trainee is struggling with a section of a group session it can be very helpful for the trainer to stop the group, step in, and explain what has occurred and what would be helpful for the trainee to do next. After this brief explanation and redirection, the trainer should step out of the group and allow it to resume.
- Discussion: After a trainee has completed their turn of leading a group it is helpful to have a brief discussion focused on what the trainee did well. It is also important to provide constructive feedback on what would improve their SST group leadership skills. The trainers may also take a moment to ask the clinician about their experience as group leader. This discussion must be kept brief. Otherwise the focus of the groups will be on discussion and not on practice.

## **Common training challenges and solutions**

We have found a few challenges that commonly occur in SST Practice Training Sessions and some effective ways to handle these situations.

### **1. The group members get too feisty when acting as veterans with SMI making it too difficult for person in the group leader role.**

We recommend that if you use the "Characteristic Cards" that you use no more than 1 or 2 for each group session. Depending on how the first group with the cards plays out (i.e., how feisty the group members are), you may choose to limit to only 1 card per group session. Also, it may be helpful to have the first session 2 group session without the cards so that the trainees can become re-acquainted with the sequence and structure of the groups before adding in the clinical challenges.

It can also be helpful to remind the group members "to be kind" to the group leader by stating something like, "We are all learning here. We want the experience to be realistic, but not so challenging that all of the group leader's attention is spent on behavioral management rather than on learning how to run the groups."

### **2. The group leader tries to improvise rather than following the script and gets lost.**

If this occurs, it can be very helpful to take a "time out" as soon as it seems the group leader has gone off course from the group structure. The trainer should start the time-out feedback with a positive statement (e.g., "That was a really great first try!") and then provide some corrective feedback. Encourage the trainee to rely on the structure of the group to make sure that they follow the sequence and also to help ensure that the group time is spent on skill practice. Also, encourage them to refer to the steps of the group written up to help them follow the group sequence. You may also choose to point to the steps of the group sequence to help coach them. If you do so make sure to let them know that you will point to the steps of the group for support. This is also a great teaching opportunity to demonstrate the value of this type of nonverbal prompting in SST groups!

### **3. The group leader is negative/critical when giving feedback.**

If the group leader is negative or critical after a role-play or if the group leader allows a group member to be negative or critical it is very important that the trainer either take a brief time out or have a brief and explicit discussion at the end of that group session related to providing positive feedback. A central component of the groups is learning skills through positive reinforcement. If the above challenge occurs this can be turned into a great learning opportunity for all the trainees if handled appropriately. After initially providing positive feedback to the trainee, the trainer can state something like, "We have found that keeping feedback positive and constructive when it is corrective in nature seems to be the most effective way for folks to learn. So we have found it is most helpful to ask the group first after a role-play 'What went well about that role-play?' and after the positive feedback is

complete, then state something like 'What might make it even better?' If a group member starts out with negative feedback instruct the group leader to defer that feedback until after the positive feedback is complete. One way to do this is, "OK. So you think she didn't speak in a loud enough voice. Why don't you hold that feedback for one moment until I ask about what can make the role-play even better. First, let's start with what went well. What did you see that she did well in this role-play?" If possible, ask the trainee to try the exact same scenario again while keeping the above information in mind.

#### **4. The group leader allows vague or non-behavioral feedback from group members.**

If the group leader allows a group member to give vague or non-behavioral feedback the trainer could either take a brief time out or have a brief and explicit discussion at the end of that group session related to behavioral and specific feedback. The discussion should focus on the fact that learning occurs most effectively when it is positive and also specific and behavioral in nature (so that folks know exactly what they did well and what they should do again!). The trainer should take an example of what a group member or group members said and demonstrate how you can probe so that the feedback is more specific and **behavioral in nature. An example might be, "I want to point out something that occurred here that frequently occurs in social skills groups. One of the group members provided feedback on the role-play by stating 'it was better than the first role-play.' Immediately after that statement I would ask the veteran 'What was better about this one?'"** If the veteran is unable to provide more specific feedback I would ask the other group members or I would ask a yes or no question such as **'Was his eye contact better in the second role-play?'"** It is important the group understands *why* it is necessary for feedback to be specific and behavioral. We also find that other common vague and non-behavioral examples of feedback include: "she seemed confident", "he was assertive." If this occurs make a point to the group about following up on those comments by stating for example, "What did she do that made her seem confident?"

#### **5. The group leader is too authoritative and is not warm and supportive.**

This can be a difficult situation for a trainer to deal with. The trainee may have a clinical style that is authoritative or may have a personality that is not naturally warm and supportive. Clearly, the trainer is not going to change any ingrained behaviors or personality traits during the practice sessions. However, the trainer, after providing praise to the group leader, can very diplomatically suggest some behaviors that might in turn make the sessions more warm and supportive in nature. **The trainer might cautiously make a statement to the group such as "The group leader did an excellent job providing positive and specific feedback to the group members in this group session. Great job! What are other some ways that you as group leaders can help facilitate the group being fun and the veterans leaving the group feeling good?"** Ideas that might be generated could include: 1. Applause from the group leader and group members for volunteering for role-plays and after role-play completion, 2. Verbal praise at every opportunity including for

veteran presence in the group, 3. Laughter when appropriate, etc. Given time the trainer might encourage a group leader that demonstrated behaviors that were not warm/supportive to try one of these techniques and certainly should praise other trainees that model them. Trainers can always refer the trainee to the Social Skills Group Observation Checklist (Bellack et al., 2004). The first item on the checklist is: "Created a warm, welcoming atmosphere."

## **6. The group leader delivers the script of the group but does not really teach.**

This circumstance demonstrates the need for trainers to provide active, ongoing support to trainees. Group leader training will occur most effectively using a "learn by doing" approach. Trainers can whisper to the trainee or use brief time-outs to suggest ways to teach the skill to the group members and actually have the group leaders follow through with suggested techniques. For example, if a group member seems to struggle with a role-play, the trainer might suggest that the group leader write for the group member specifically what they are going to say in the next role-play and encourage the group leader actually to do so prior to the next role-play. Another example might be that a group member cannot remember the steps of a role-play. The trainer should whisper to the group leader to use nonverbal prompts by pointing to the steps written on the flip chart. At the end of providing positive feedback, the trainer could also encourage the clinician to ask the words "What would make the next role-play even better?" to the group members. This reinforces a constructive approach to skill building. Many clinicians seem to have difficulty with the concept of shaping. The trainers may also take this opportunity to explain shaping to the group. Also, as occurs in social skills groups, trainers should take every opportunity to praise participation as a group leader and also every effort made by the trainees.

## **Other Training Considerations**

A few final things to remember before doing the Social Skills Training Practice Sessions:

- Trainers are modeling how effective social skills are run by establishing and maintaining structure and an agenda. Therefore, trainers are responsible for moving the practice sessions along and assuring that every clinician gets to practice leading a group. This means that discussions must be kept brief and to the point.
- Trainers will find that feedback to trainees is most effective when it is timely, brief, and behaviorally driven. Very much like actual social skills groups, feedback seems to be best received when it first focuses on the positive and then focuses on constructive corrective action.
- Trainees seem to respond well when trainers provide ongoing and active support **by “shadowing” them during role-**plays. The support can occur through verbal prompts (e.g., whisper a response that the trainee could make) or nonverbal prompts (e.g., point to steps of group). When using this training technique it is important to make it clear to the trainee first what you are going to do before doing it (i.e., prior to the trainee acting as group leader).
- Trainers are responsible for helping make sure that the practice sessions are fun and that the participants leave feeling good!
- Training in the SST practice training sessions is extremely rewarding and a lot of fun. So have a great time!



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## ***Section IV. Providing Consultation to SST Clinicians***

## ***IV. Providing Consultation to SST Clinicians***

### **Components of Consultation Models**

- In-person vs. telephone vs. V-tel
- Individual vs. group
- Audio-taping/videotaping sessions vs. discussion of group
- **Set times for consultation** (weekly group meetings, “office hours”) vs. consultation as needed

### **Examples of Consultation Models**

#### **Example 1:** VISN 5 MIRECC SST consultation model

This consultation model is a group model with scheduled biweekly meetings. Trainees co-lead SST groups with an advanced SST clinician in the local PRRC or inpatient unit and video-tape these sessions. An SST consultant reviews the videotapes in the consultation session and provides feedback. Most clinicians attending are in person, but some V-tel in.

#### **Example 2:** VA-SST consultation model

This consultation model is primarily a group model with scheduled weekly meetings. Clinicians phone in to the meeting led by an SST consultant using a VANTS line. Calls consist of feedback from the consultant on reviewed audiotapes of SST sessions as well as discussions of concerns/successes brought up by clinicians. Consultation is also provided on an individual basis as needed. Written feedback is transferred via email/web.

#### **Example 3:** Office Hours consultation model

An Office Hours consultation model might consist of one to two regular hours of time a consultant devotes to SST consultation. In this model the hours should be clearly announced and/or posted for SST clinicians/trainees. The consultant may decide that consultants are free to drop by their office and/or phone during these scheduled hours to discuss issues around SST. The consultant may also choose to devote this time to any written feedback they would like to provide their clinicians.

### **Consultation Tools**

- Audiotapes/Videotapes
- Notes from consultation sessions
- Social Skills Observation Checklist (completed by clinician, SST book p. 283 and/or consultant, SST book p. 285)
- Social Skills Group Format (SST book p. 281)
- Notebook containing a record of feedback given, what skills were done in sessions, and clinician progress

## **Tips for Consultation**

There are several things that a SST consultant could do to help make the consultation experience more successful. Here are a few to keep in mind.

- Always be on time for consultation.
- Be available for ad hoc consultation if needed. At times, clinicians may need additional assistance outside of the regularly scheduled consultation time. Try to respond to requests for assistance in a timely manner.
- Always have a plan or agenda for the consultation time. You may or may not need it. However, having a plan beforehand will ensure that you use the consultation time efficiently. This can be particularly helpful if the clinicians do not bring many issues to the consultation.
  - Focus on the most current or pressing needs first. Discuss the most recent group and any concerns/successes as this will be freshest in the **clinician's mind**.
- Ask the clinician(s) to make brief notes of concerns/successes after each of their SST sessions and to bring them to consultation sessions. This will keep relevant issues fresh in their minds and ensure that they will not forget to discuss them during consultation.
- Take notes of feedback provided to clinicians. This will help you to notice any reoccurring themes (positive and negative) in the sessions. Recognizing these recurring themes will allow you to focus the consultation on areas that may need improvement and provide positive feedback for areas that are improving.
- Understand and clearly define your role. You are here to train clinicians in social skills training and to assist them in implementing social skills groups. You are not their clinical supervisor. Encourage clinicians to contact their supervisor with any concerns that are outside the scope of your role as a consultant.
- Take steps to ensure the confidentiality of the consultation group. Remind clinicians not to share things other clinicians discuss during consultation with others outside of the consultation group. Similarly, consultants should not share things discussed with clinicians during individual consultations during a consultation group without permission of that consultant.
- Try to make the consultation sessions collegial, collaborative, and fun. The more comfortable the clinicians feel in the group, the more likely they will attend the group and bring up challenges and problems.

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## ***Section V. Feedback for SST Clinicians***

## ***V. Feedback for SST Clinicians***

### **Tips for effective feedback and facilitating improvements**

Here are a couple of things to remember when providing feedback to SST clinicians.

- Provide positive feedback to SST clinicians first before corrective feedback. Always remark on what the person has done well or what you liked before providing feedback on how something could be improved. By doing this you are also modeling how clinicians should provide feedback within their SST groups.
- Present feedback in very specific, behavioral terms. Providing feedback **that is concrete and specific will increase both the clinician's** understanding of what you would like them to change and the likelihood of improvement.
- Try to determine how each clinician learns (verbal vs. audio learner). This will dictate if email or phone/in person discussions are the best form of communication.
- Ask co-facilitators to alternate roles of primary vs. secondary. Focus feedback to the primary facilitator but also provide feedback to the secondary facilitator.
- Know when to give feedback. How you provide feedback will depend on the format in which you decide to provide consultation. When using audiotapes rather than videotapes you may find that you may need to provide feedback more frequently. You may also want to review the tape ahead of time and cue it to parts you would like to review and discuss during consultation.
- Rely on your prior experiences receiving feedback from others and ask yourself a few questions: What did consultants or prior supervisors do that helped you learn how to effectively lead groups? Were there things you found particularly helpful for the consultant to discuss or problem-**solve with you? What didn't seem to work or to be helpful?**
- Use your personal challenges and successes in running SST groups to shape your feedback. What situations came up when you learning how to facilitate SST groups that were particularly challenging or difficult for you? How did you handle them? What feedback did your consultant provide that helped facilitate improvements? What feedback or processes did your consultant use that you did not find as helpful?
- Recognize when feedback is not facilitating change. If your attempts to provide feedback are not producing the desired results try and come up with alternatives. Feel free to be creative. Some people learn when presented with analogies. A relevant example for many VA employees

is the importance of providing specific, behaviorally focused feedback both in SST groups and in their own annual employee evaluations!

- Be prepared to provide feedback and guidance on practical/systems issues that clinicians may be facing when starting or continuing SST groups.

### **Commonly occurring issues for new SST clinicians and useful feedback**

There are several issues that frequently occur when clinicians are first learning how to facilitate SST groups. The following is a list of some of those issues and potential feedback that a consultant could provide a clinician to facilitate improvements in each area.

**Issue:** Allow too much time for discussion/processing

**Feedback:** Acknowledge that leading SST groups can be challenging for clinicians that typically conduct more process-oriented groups. Although the clinician seems to have established a good rapport with the group and group members seem to feel comfortable discussing issues and concerns (which should be recognized), reiterate that the goal of the group is to help group members learn skills to help them more effectively manage/navigate social situations. Reaching this goal requires learning the steps and practicing the skill. Encourage the clinicians to adopt the idea that the more time spent on discussion, the less time spent on role-plays. Encourage clinicians to rely on the agenda and refer back to it when veterans start talking about outside topics.

**Issue:** Hesitant to take role of "being in charge"

**Feedback:** Acknowledge that this can be difficult at first, particularly if a clinician has not previously taken on the role of a leader. Reiterate the importance and value of using the agenda and retaining the structure of the session (e.g., retaining the structure and following the agenda are imperative to reach goal of skill practice/development; it can be therapeutic for some veterans to have an agenda that is retained each session; etc.).

**Issue:** Quickly accept when veterans do not want to role-play

**Feedback:** Acknowledge that it may feel a little uncomfortable at first when a veteran states that they do not want to role-play. Encourage the clinician to offer suggestions for role-play alternatives for a reluctant person (e.g., do only the first step of the skill in a role-play, allow them to sit in their seat while role-playing rather than get up in front of the group, etc.). If these do not work you may consider suggesting the clinician meet with the veteran individually to discuss any concerns around role-play participation. You should also draw upon your past successes with similar clients.



**Issue:** Quickly accept when veterans do not want to role-play multiple (i.e., three) times

**Feedback:** Encourage clinicians to establish a group expectation that group members will complete three role-plays. Remind them that they should suggest that group members do repeated role-plays rather than asking them to do three role-plays. Also, remind clinicians of the benefits of repetition and overlearning and suggest ways they can state this in an SST session.

**Issue:** Models scenarios that are complicated and not relevant to vets

**Feedback:** Remind the clinician of some of the difficulties people with SMI face in doing role-plays (e.g., cognitive problems, difficulties with memory and attention, current psychiatric symptoms) and how these difficulties may impact their ability to do more complicated role-plays. Discuss with the clinician the more straightforward and relevant the model scenarios are to the veteran the more likely the veterans will be able to generalize learning to other role-plays in the group and real-life situations outside the group.

**Issue:** Role-plays go on for too long

**Feedback:** Encourage clinicians to limit role-plays to 30 seconds or less. Explain that the simpler and briefer a role-play is the more focused on the steps it will be.

**Issue:** Insufficient amount of positive reinforcement

**Feedback:** Remind clinicians the benefit of positive reinforcement. Encourage clinicians to establish a norm of applause after each role-play that a veteran completes. Also, encourage clinicians to use a great deal of **general verbal praise (e.g., “great job” or “great effort”), after, for example,** a veteran reports homework completion, after role-play completion, at the end of group, etc.

**Issue:** Clinician tells the veteran what scenario to practice in role-plays

**Feedback:** Encourage the clinician to use a collaborative approach when developing scenarios to practice in role-plays. The best approach is to start **out asking the veteran questions about relevant scenarios (e.g., “Now have you had a situation recently or will you have a situation coming up in which you might need to use the skill of Making Requests”) or scenarios related to their goals (e.g., “your goal is related to having a better relationship with your brother, right? OK so can you think of a scenario that you can practice in which you might need to make a request of your brother?).**

**Issue:** Clinicians co-facilitating a group express difficulty/issues with maintaining the roles of primary and secondary facilitators

**Feedback:** Recognize that it may be difficult for clinicians to go from a more traditional co-leader situation in a group where both clinicians contribute equally to the primary/secondary roles encouraged in SST groups. Discuss with the clinicians the value of having one person in charge for the veterans

(i.e., especially for those experiencing difficulty with attention and focus) as well as the facilitators (e.g., it allows the primary facilitator to focus on leading the group and helps share the burden when the roles are alternated session by session).

**Issue:** Clinician provides/allows positive feedback that is vague, non-behavioral, and/or not related to the steps

**Feedback:** Discuss with the clinician the importance of having specific feedback (i.e., so that the veteran doing the role-play knows *exactly* what to continue doing). You may find it helpful to use an analogy that is relevant to that clinician such as the value of having an annual job review that describes exactly what you are doing well and should continue doing well versus a review where the feedback is “keep up the good work.” Provide clinicians with helpful key phrases to use in group to clarify vague feedback from group members such as “What do you think was better about the second role-play?” or “You thought his role play was good. What was good about it?” If the clinician promotes or allows feedback that is more related to scenario content versus the steps, discuss with the clinician the value of focusing on the steps in feedback.

**Issue:** Clinician provides/allows corrective feedback that is vague and/or non-behavioral

**Feedback:** Discuss with the clinician the value of having clear and specific corrective feedback. Similar as above you may find it helpful to use an analogy such as the value of having an annual job review that describes exactly what you should change/improve (e.g., “please be on time every day) versus a review where the feedback is “there are some things you need to change.” Encourage the clinician to follow-up with vague feedback from group members by asking specifically what the veteran could do to improve or by clarifying with the veteran doing the role play how they will improve based on that feedback (e.g., “OK so the suggestion to make your next role play even better is that you try and be more specific with your request. What could you say in this next role play to make your request to your supervisor even more specific?”).

**Issue:** Clinician does not manage time of sessions leaving only one or two veterans role-playing each time

**Feedback:** Mismanagement of time in sessions can occur in several different places leaving inadequate time for veterans to practice. We have found that mismanaged time can frequently occur in the rationale development (i.e., time spent on outside discussion). It can also occur in the modeling of the skill (i.e., model is too long and complicated, review of the model is not focused on steps, facilitators doing multiple models of the skill). It will likely be most helpful to understand how long clinicians are spending in each section of the group agenda. For example, if a clinician is spending 15 -20

minutes in the rationale development it would be important to help them understand how they can become more efficient in that section. It is also helpful to clarify the goal of each section of the group so that clinician can know to move on when that goal is accomplished (e.g., the goals of step review are to clarify to steps of the skills, make it clear why each is important and provide a few examples if applicable, and answer any questions about the steps).

**Issue:** Clinician not using a shaping approach in sessions

**Feedback:** Depending on the clinician's training and experience with behavioral treatments they may or may not be familiar with the concept of shaping. It will be helpful for you to provide a basic definition of shaping (e.g., reinforcement of successive approximations toward a goal) and an explanation of how that translates to social skills training (e.g., the goal you are helping veterans work toward is successfully executing the steps of the skill). You may also provide explanation of what the most helpful procedures are in shaping in SST groups. These include clear, specific, positive feedback focused on the steps after every role-play; clear, specific corrective feedback (1 or 2) after first few role-plays; **potentially "summing up" all feedback** before subsequent role-plays; positive reinforcement for successfully executed corrective feedback; consistently encouraging behavioral rehearsal.

**Issue:** The clinician is experiencing practical/systems issues in starting a SST group.

**Feedback:** Some clinicians may experience practical issues (e.g., no group room available twice a week) or systems issues (e.g., little program support for adding SST to the program schedule) when starting a SST group. Consultants should be prepared to provide clinicians support and suggestions in how to handle these issues. The first line in offering suggestions is to think about any issues that you (or someone from your VA-SST consultation group – if applicable) faced when starting a SST group. What suggestions made by the VA-SST consultant or other group members helped? You may also think about resources that are available to you in the VA (e.g., the Uniform Mental Health Services Package), within your VISN or site (e.g., Local Recovery Coordinators that might be able to act as an advocate for the implementation of SST, or within the VA-SST program (e.g., reference information for SST as a valuable, practical and evidenced based practice). We also encourage you to talk with your consultant to brainstorm ways to help clinicians overcome practical/systems hurdles that they may face.

***Also what other ideas for dealing with clinical and practical/systems issues have you gained in this workshop? We encourage you to write them on the following page.***

[illegible]











