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USE OF SIMULATED CLIENTS IN MARRIAGE AND FAMILY THERAPY EDUCATION

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Knowledge of how one should manage suicidal, homicidal, child maltreatment, and domestic violence situations is paramount in the training of marriage and family therapists (MFTs). Simulated patient modules were created to help clinical faculty address these crisis situations in a protected learning environment. The modules were implemented by the MFT faculty in collaboration with the Office of Clinical Skills Assessment and Education at East Carolina University's Brody School of Medicine. Qualitative data over the course of 2 years revealed six thematic domains regarding therapists' performance, therapists' emotions, the simulation experiences, and lessons learned. Educational, clinical, and research recommendations include tools to implement simulation exercises into marriage and family therapy programs as well as suggestions to assess for teaching effectiveness.

In the medical field, a form of instruction that has become increasingly more common in the training of physicians is the use of standardized or simulated patient (SP) scenarios. Typically, an SP scenario involves any "medical encounter conducted purely for educational purposes" (Adamo, 2003, p. 262), in which "participants have the opportunity to interact with patients in a controlled learning environment" (Donovan, Hutchison, & Kelly, 2003, p. 125). The most common terms for these scenarios are *standardized* or *simulated*, and these terms will be used in this article interchangeably.

Standardized patient encounters allow faculty to assess their students' clinical skills in a safe environment with no chance of harming an actual patient and provide students with an opportunity to transition to working with real patients (Barrows, 1993). Moreover, investigators (Colliver & Williams, 1993) suggested that the use of SPs was "as good or better an assessment of clinical performance than conventional methods," such as the use of "physician observers" (p. 455), or "paper and pencil examinations" (p. 457) that measure knowledge of clinical skills.

As a result of the success and effectiveness of the medical community's use of SPs, investigators and educators have begun to incorporate standardized patients or clients in other fields as well (Larson et al., 1999). However, the use of standardized clients outside of the medical

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setting has been limited. When simulations are used in nonmedical training, instructors commonly request that former students play the role of standardized clients (Crosble-Burnett & Eisen, 1992; Moss, 2000). This has presented concerns when students from previous cohorts portraying standardized clients did not have the adequate training, objectivity, or benefit of being unknown to the therapist in the simulated client scenario. This has the potential to create a less than optimal instructional experience. The utilization of standardized patients from an outside source (e.g., medical school clinical skills office; experienced community mental health professionals) may create a more realistic simulation than using students from the same peer group. Learning from the success that medical schools have reported, family therapy training programs could certainly benefit from more authentic methods of preparing students for clinical work (e.g., ethical and legal dilemmas), in addition to the incorporation of more standardized didactic teaching methods.

For example, in the field of family therapy, there are four types of clinical crises that most novice as well as seasoned therapists find challenging. In no particular order, they are domestic violence (DV), child maltreatment (CM), homicidal ideation (HI), and suicidal ideation (SI). When managing and treating these four situations in a therapeutic setting, there are many important assessments and legal steps that therapists must remember and incorporate into their work.

Given the seriousness of these situations, and the fear they inspire in practicing therapists, it may be helpful to have therapists in training first address these issues using a standardized teaching methodology. It is quite possible that students enrolled in a marriage and family therapy (MFT) master's program will never encounter one or more of the four crises mentioned during their training experience; however, employers will expect them to know how to manage these clinical situations personally and professionally. However, since this is a novel teaching methodology in the field of MFT, it is important to understand how it has been beneficial to other disciplines, particularly the medical field, which has the greatest amount of experience with it.

Benefits of Using Standardized Patients

One of the strongest arguments for using standardized patients in the medical field is the importance of providing medical students with standardized patient problem scenarios that are presented in an unvarying, scripted fashion, regardless of who is portraying the role (Barrows, 1993). According to Barrows, another reason for using SPs includes the availability of SPs to portray any illness and present the same problem multiple times to different students. The use of standardized patients also decreases the mistreatment of real patients by providing a transition from didactic learning to working with actual patients in a clinical setting. In addition, SPs give students the opportunity to refine their examination and communication skills while increasing confidence in their abilities.

When using standardized patients in an SP scenario, students are given opportunities that would normally be considered unsuitable/unethical when working with an actual patient or client. For example, students are given the option to stop and start again if needed during an interview (Barrows, 1993). A physician in training could actually request that the standardized patient come back as if it were a few hours, days, weeks, or months later after the illness has subsided or progressed, requiring a new level of care.

Perhaps the most important advantage of using standardized patients is that this teaching method enables students to practice realistic, critical, and challenging medical and emergency situations in a safe environment (Barrows, 1993). As with most professionals in training, many students may feel anxious dealing with intense situations, and simulations provide a safe environment to practice and refine clinical skills. Some examples include patients who are dying, who have been physically or sexually abused, and who intend to hurt themselves or others.

Challenges in Using Standardized Patients

While there are many advantages to using standardized patients, there are some assumed disadvantages, such as the time it takes to train someone to simulate an illness, and the relatively limited number of illnesses that can be simulated (Barrows, 1993). Experience has shown that it takes only 2–3 hr for training of the standardized patient to portray a simulated illness, and while it is true that not all illnesses can be simulated, there are many that can (Barrows, 1993). However, it is also possible that SPs or clients who do not actually have the illness, or who are overworked, may not accurately portray the illness experience (Adamo, 2003). Therefore, retraining and feedback to the actors and actresses is integral to maintaining the integrity of the exercise.

Standardized Patients in the Medical Field

Standardized patients have been used in many facets of the medical field. For example, SPs have been used in the assessment of alcohol abuse (Eagles, Calder, Nicoll, & Walker, 2001; Kahan et al., 2004), HIV risk assessment (Haist et al., 2004; Madan, Caruso, Lopes, & Gracely, 1998; Silvestre, Gehl, Encandela, & Schelzel, 2000; Zweifler, Wolf, Oh, Fitzgerald, & Hengstebeck, 2000), communication skill training (Donovan et al., 2003; Duffy, Gordon, Whelan, Cole-Kelly, & Frankel, 2004; Hardoff & Schonmann, 2001), and gaps between physician knowledge and actual clinical behavior (Kennedy, Regehr, Rosenfield, Roberts, & Lingard, 2004). Two of the aforementioned researcher teams (Eagles et al., 2001; Kahan et al., 2004) included the use of SPs in a blinded format (unknown to providers that the patients were actors/actresses). However, all other simulation teams included provider awareness as part of the protocol.

Standardized Patients in Mental Health Fields

Counselor education programs have utilized standardized client encounters to increase students' feelings of competence before entering clinical situations with actual clients (Larson et al., 1999). They found that students who believed they performed well on simulated client encounters tended to experience increased self-efficacy. In their review of the literature, Levitov, Fall, and Jennings (1999) posited that the use of standardized clients lessens possible risk of harm to clients, reduces ethical concerns, and provides training experiences that are more consistent with real situations that counselors may face in their clinical work. Crosble-Burnett and Eisen (1992) found that counseling and school psychology master's students who experienced a semester-long exercise with simulated families were able to gain a deeper understanding of the issues that divorced and remarried families face.

The field of social work has also used standardized patients in its graduate training programs. Standardized clients have been used successfully to train integrated geriatric care teams including medical residents, nurses, and social work students (Howe, Mellor, & Cassel, 1999; Mellor, Hyer, & Howe, 2002), and have also been used to help social work graduate students link social work theory to real-world practice (Moss, 2000). Kenyon (1994) posited that the use of standardized patients in social work training was beneficial for "teaching and evaluating reasoning skills, assessment skills, and challenging learners' knowledge base" (p. 176). Clearly, various mental health disciplines have experienced beneficial outcomes when utilizing standardized patients and have documented it as a valuable component in preparing students for clinical work. To date, investigators and educators in family therapy have not published on the use of simulations as a training tool.

The purpose of this study was to qualitatively report outcomes of a simulated client teaching methodology used to educate MFT master's students in the areas of DV, CM, SI, and HI. The outcome themes described in the results section will be used to illustrate how SP scenarios influenced the simulated clients, faculty supervisors, and student therapists. Educational, clinical, and research recommendations will be discussed, which include tools to implement simulation exercises into MFT programs as well as suggestions for maximum effectiveness.

METHOD

Background

East Carolina University's marriage and family therapy (MFT) master's program was first accredited in 1989 and averages 12 graduates a year. This program requires students to complete the following courses in their first year: family therapy theories, systems theory, ethics, research methods, statistics, family/child development, psychopathology, and a prepracticum course. Included in the prepracticum course are series of simulations whereby students learn how to complete paperwork, do initial joining, and work through numerous issues experienced by a simulated client/family. The purpose of the first series of simulations is for students to become familiar with the therapy room, paperwork, a variety of challenging but not life-threatening issues, and the termination process. Students then participate in a second round of simulations, learning how to incorporate their theory of change. The simulated clients are family therapists from the community, not trained actors. Because the clinical faculty recognized that DV, SI, HI, and CM generated anxiety among simulations with MFT students, they decided to develop a training method using trained actors. This experience would be reserved for the students' first practicum experience (the semester immediately following their prepracticum course) where they received live supervision on a weekly basis. This decision allowed for a more concentrated amount of time to be devoted to these areas of clinical concern and provided the practicum teams an opportunity to run through at least one simulated experience as a team before they worked together with a "real" client.

Participants

In keeping with the exploratory nature of the study, participants were not expected to constitute a representative sample. The participants consisted of second year MFT master's students from an accredited MFT program in the southeast region of the United States. Student participants ranged from 23 to 42 years of age. There were three males and 20 females who participated ($N = 23$). Three of these students were Black and the remaining 20 were White. At the time of the simulated experiences, about half of them had chosen to complete their second year internship requirement in medical environments; the remaining were placed in public schools, a substance abuse rehabilitation program, military bases, or family preservation services via in-home sessions with families.

Procedure

Participants reviewed the informed consent prior to the start of the summer semester practicum course (the first of three required practicums[1]). Each student participant volunteered to be the primary therapist for only one of the four simulations, with each simulation held on a different date. For the remainder of the simulations, he or she participated as a therapy team member with 2–3 classmates and one supervisor behind the one-way mirror.

If the student participants provided informed consent, then they were allowing the investigators to collect qualitative data via focus groups at the conclusion of each simulated experience. The investigators (group facilitators) informed student participants that their participation in the simulations was not contingent upon their participation in the research process. Student participants were not blinded to the simulation experiences; they knew when the simulations were happening, and which clients were actors and actresses. The simulations and all focus groups were videotaped. Clinical supervisors/group facilitators distributed the informed consent, supervised the simulation, and facilitated/participated in the postsession focus groups (as they would in a typical postsession supervision experience).

Simulated Client Training Protocol

East Carolina University's Office of Clinical Skills Assessment (OCSA) trains all SPs for the medical campus, as well as some of the departments on the main campus. The actors and actresses are citizens of the community who are reimbursed financially for time spent in training and in the simulations. They are trained by an OCSA staff member who instructs them on how to follow the scripts. The OCSA staff member collaborates with the instructors to make sure that the actors and actresses are performing as expected. All simulated clients are trained with the knowledge that their clinical encounters will be videotaped for training and/or research purposes. They are also trained to give basic feedback to the students if requested by the instructor overseeing the educational exercise. A summary of each script is presented in Appendix A.

Focus group discussions. Following each simulation, student participants and the clinical supervisor/focus group facilitator discussed what went well and what could have gone differently in the session. The actor(s) was invited to participate in all or a portion of the group process, knowing that the discussions were being recorded to study simulation effectiveness. Oftentimes the clinical supervisor would excuse the actors after they shared reflections and answered questions presented by the practicum team. After thanking and excusing the actors, each group was asked to continue the focus group so that the supervisor could ask questions from the protocol (see Appendix B). Question protocols were related to each specific crisis issue. Student participants were invited to ask questions of their supervisor related to the experience following the focus group discussion. Exchange of comments and concerns among the student participants regarding their experiences was encouraged.

All focus groups were held in video-ready therapy rooms at the training clinic. Focus groups were 15–60 min in length. They were conducted according to the protocol, and group leaders (*n*√3) received training to ensure uniformity in its implementation.

Analysis

All focus groups were transcribed from videotaped recordings. Each videotape and transcription were reviewed repeatedly by two of the investigators until the content became familiar. Then they proceeded to code the transcripts.

To begin, each transcript was read and notes were taken on key words and phrases. These key words and phrases were organized to form thematic categories (Creswell, 1994). Thematic domains were then formed based on a group of "like" categories.

Verification

In conducting and analyzing this research, indicators of rigor were used to ensure that the analysis withstood minimal investigator bias and that the meaning of specific comments was not taken out of context. Investigator triangulation was one method used to help increase the trustworthiness of the results. Instead of having just one investigator assigned to each transcript, a second was added to analyze the data. They analyzed the data until they reached agreement on the interpretation of the results. Investigators were trained by experienced qualitative investigators who then served as the peer debriefers. Investigators used peer debriefing as one mechanism of verification, by having a third investigator review all steps of coding and analysis to check for investigator bias. This third investigator also conducted a dependability audit by assessing the investigator's interpretations of the data to make sure the categories and domains were accurate representations. The paragraphs below document the results from these analyses.

RESULTS

Transcriptions from 11 focus groups were recorded and analyzed. A 12th focus group was conducted, but an equipment malfunction prevented their dialogue from being recorded. Each

student participant was included in a maximum of four focus groups, one per simulation topic. Simulated clients and practicum supervisors were also included in the focus groups. To protect the confidentiality of all student participants, pseudonyms took the place of actual names and all individually identifying information was removed. As a result of the qualitative data analysis process, six domains emerged. Each domain contained several thematic categories that covered its intent and scope, adding richness and context to the results. Domains and categories were extracted across all 11 focus groups.

Domain #1: Positive Feedback Regarding Therapist Performance

Without exception, all group participants immediately addressed the positive work/skill set of the therapist in the room. This strength-based thread was spontaneous and unsolicited. There were four thematic categories included under this domain: (a) overall clinical effectiveness, (b) joining, (c) inclusion of other people/systems, and (d) co-therapy.

Overall clinical effectiveness. This thematic category included general comments related to overall clinical effectiveness of the therapist, such as appropriate demonstration of clinical expertise, effective understanding of clinical severity, and efficient management of the therapeutic process. Focus group participants also referenced specific skills/actions of the therapist: not avoiding the difficult questions, respecting the client's level of comfort, transitioning well between topics, effectively using empowerment, redirection, controlling therapist biases, developing a good therapeutic plan, bringing in accurate information/resources, balancing between caring and firmness, giving good options, and searching for positives. Interestingly, the most descriptive comments about overall effectiveness came from the simulated clients. For example, following the SI simulation one actor said to the therapist, "Thank you for going ahead and admitting me into the hospital. You did a good job. You realized that I was not kidding this time. I am going to kill myself and I do not care."

Joining. Joining was mentioned as a critical component for effective clinical care by all group participants. This included getting to know specifics about the client(s), effectively using nonverbal communication, and conveying genuineness to the client. Group participants commented on therapists' effective use of eye contact, leaning in, displays of emotional control, sensitivity, politeness, empathy, sincerity, caring, validation, and compassion across all four of the crisis situations. One simulated client shared that "Trying to get to know us was very good. It definitely relaxed her [the therapist]." Joining with the children in the CM and HI simulations was consistently pointed out as a very useful way to gather information.

Inclusion of other people/systems. Participants discussed the importance of including other people and/or larger systems in the therapeutic process. The legal system (e.g., police, social services, etc.) and additional support systems (e.g., teachers, parents, and friends) were most often noted as possible resources. Participants also discussed the importance of using caution when inviting other systems into the therapeutic process, especially when there is a risk of harm to the client. One example of this "logical inclusion" was highlighted in a DV simulation when an actor was asked, "Who does not need to know you are here?" Meaning, not only is it important to know who should be included, but also in some cases, such as DV, who should not be included is important for reasons of safety.

Co-therapy. In one simulation exercise a co-therapy team was working together for the first time. They commented that this experience allowed them to identify and address differences between their styles and that sharing the responsibility helped them to feel more comfortable. One voiced to the other, "I thought you did well. I had never worked with you before this experience. I wondered if our styles would mesh. They meshed really well." The simulated client, other team members, and the supervisor also commented on the obvious level of comfort the co-therapists shared with one another. The supervisor commented, "The simulated client found comfort in the co-therapy and she thinks you [the co-therapists] found comfort in the co-therapy too."

Domain #2: Constructive Feedback Regarding Therapist Performance

Following each simulation experience, group participants offered constructive feedback to each therapist. The dialogues resulted in four thematic categories: (a) joining/pacing, (b) individual/family history, (c) therapeutic plan/process, and (d) communication.

Joining/pacing. Establishing a therapeutic relationship and making sure that the session followed an effective pace was heavily discussed among all focus groups. One supervisor noted that joining is critical in crisis situations, and should not be disregarded no matter what level of crisis severity the client is presenting. He commented, "My first question is what happened to joining? We just plopped right in." Another supervisor noted, "When he [the therapist] first came into the session, . . . he just went bam, bam, bam, 80 miles an hour. The second time [after the team break] he went back in and slowed down. The session was very different and the client responded very differently." A student participant noted the importance of pacing in the joining process. She said, "One thing that I have learned is the importance of matching your pace to the client and how essential that is." Group participants also noted that establishing contact with larger systems (i.e., teachers, pastors, friends, etc.) is an essential part of joining.

Individual/family history. Several of the simulated clients and supervisors commented that the therapists needed to ask more questions to obtain a full individual/family history before acting on the crisis information. Student participants requested more information about the safety of others in the home, the biopsychosocial history of the person in crisis, and the history of the presenting concern. One supervisor noted during the DV simulation, "You want to be able to ask directly and get a clear answer to how imminent the danger is to the wife, children, and to the husband."

Therapeutic plan/process. Comments centered on the development of a therapeutic plan that would increase the likelihood of client safety. As a result, student participants reflected on the need to become more comfortable asking the uncomfortable questions (e.g., ideations, plan, and intent). Group members reflected on how some therapists tried to cover too much ground, conducted incomplete assessments, and omitted discussions about social services, safe houses, and emergency rooms. Others commented that some therapists moved to contacting emergency services too quickly before obtaining necessary data, establishing rapport, and building trust. Supervisors took the opportunity to question the therapists about how sure they were that when the client left, he or she was really going to honor any agreement for safety, and then what to do with feelings of uncertainty. Lastly, therapists noted how they backed away, asked too many closed-ended questions, interrupted too soon, or derailed an interactional sequence to follow their own agenda, and how these things may not have been therapeutically effective.

Communication. This theme included discussion of both verbal and nonverbal communication. Student participants noted the need for therapists to increase their verbal communication or ask clients more questions, clarify any miscommunications spoken or perceived, and omit the use of negative body language (e.g., crossed arms, look of disapproval). Group participants commented that while some therapists may not have communicated verbally or nonverbally enough, others' use of communication was unclear and/or excessive. Following the simulation with an adolescent experiencing HIs, one supervisor noted, "Do not fear the silence, it is a big [i.e., helpful] thing with adolescents."

A number of focus group members' comments involved miscommunication (i.e., differences in client and therapist language). Supervisors/facilitators took time to deconstruct some of the language that the therapists used and its perceived impact. One supervisor noted, "I would be careful using words that fit for you . . . reflect on 'their' words and use 'their words.'" Simulated clients who participated in the initial portion of the focus groups referred back to specific words that may not have been effective. For example, one simulated client did not find the word *maltreatment* helpful. With regard to body language, repetitive behaviors on the part of the therapist (e.g., shaking foot) were observed as distracting.

Domain #3: Therapists' Emotions

Student participants not only learned from the experience of cognitively working through four different crises but also reported experiencing a range of emotions associated with each one. One supervisor noted to his group, "The hot seat is different because your emotions get involved." The four thematic categories that emerged were (a) nervous/tense, (b) scared/worried, (c) frustrated/irritated, and (d) pressured/comfortable.

Nervous/tense. Student participants who had never dealt with one or more of the crises, personally or professionally, expressed feeling nervous that they would not know what to do. For some, it was also their first time in front of their peers with a client, so that brought with it additional anxiety. Student participants recalled the stress experienced with previous crisis simulations and reported feeling nervous in anticipation of how "hard" the last one was. Two student participants specifically mentioned the word *tension* to describe how they felt during the simulation experience. One student participant stated, "You are so tense that you are not relaxed enough to hear." Only one student participant commented that he would have been more nervous if this were a real client experience.

Scared/worried. Feeling scared was related to the thought of facing one of the four crisis situations alone and/or unprepared. Several student participants reported feeling scared that they would forget to ask important information. One student participant also commented on the feelings of fear related to asking tough questions. She shared, "I guess I was kind of intimidated and kind of scared to ask certain questions." Student participants reported and processed feelings of worry related to the well-being and safety of the children, particularly with regard to the DV simulation. One student participant commented, "I do not know how in danger I feel the kids are; I just worry about them being around it [spousal abuse]." Lastly, they reported feeling worried that they would miss all warning signs and allow a client to leave without knowing he or she was in harm's way.

Frustrated/irritated. One therapist reported feeling frustrated that determination of CM did not meet her threshold of concern. She reported, "I think I am frustrated because I supposedly know that they [the parents] maltreat him and that is what is frustrating to me, because I would not see it [their parenting style] as maltreating." Another reported frustration after asking what he thought were "gold mine questions" and the simulated client did not respond accordingly. In another instance, the therapist even told the simulated client during the debriefing, "You were frustrating!" Another student participant commented that she felt irritated with herself when she was not able to uncover the CM as quickly as she believed she should have.

Pressured/comfortable. Some student participants shared that since they had experience working through these types of situations professionally, they felt pressure to perform better. One student participant reported that he did not perform as well as he wanted to because "I think a lot of it was that I felt under pressure." On the contrary, some student participants reported feeling very comfortable in the simulations. They related this to previous experience working for crisis hotlines or in walk-in clinics. However, one student participant who expressed feeling comfortable revealed that this was because of a peer who already experienced the simulation and gave her clues. Feeling comfortable was also tied to appreciation for the team's suggestions and support.

Domain #4: Positive Feedback Regarding the Simulation

Group members were directly asked about the positive aspects of the simulation experience, and the results of their discussions became the following five themes: (a) realistic, (b) responsive, (c) beneficial, (d) teaming, and (e) debriefing.

Realistic. Several student participants commented that the simulations seemed more "real" than they imagined they would be. One stated, "They are sitting right there and you really do have the responsibility . . . so I think it hit home a little bit more." Student participants who were serving as team members behind the mirror commented that they were so engaged in the

reality of the simulation that they felt as if they were in the room with the therapist. One student participant shared, "It was realistic for us behind the mirror and we could forget it was a simulation. We really felt like this was an actual client." As the student participants had the opportunity to experience simulated clients in a previous class, the level of professionalism and training of the simulated actors reportedly increased the authenticity of the learning experience. One student participant noted, "The ones in class did not seem even close to as real as these [simulations]." Another commented, "I thought that what made it more real was that the children [actors] were there."

Responsive. Group discussants appreciated the simulations where the actors were more responsive to therapeutic questioning and intervention. One shared, "I liked the fact that he was compliant and talked." This was following a simulation where the simulated client was severely depressed and lethargic. Overall, student participants appreciated having a client who would respond to their lead, as it lessened their overall anxiety and reportedly left them with a sense of accomplishment.

Beneficial. Student participants both in front of and behind the one-way mirror found the use of simulations to be effective, challenging, and helpful. They found that they learned more about themselves in the process. One commented that "I have dealt with crisis calls and a few face-to-face experiences, and it is just interesting to be on the other side of the mirror and watch the process take place . . . seeing it play out just reinforced for me . . . okay there is a sign there . . . ." Another noted, "I think it is a fantastic teaching tool . . . now I am looking forward to the other ones [simulations] that are coming after this, because I feel like it is helping prepare me for when I am actually going to meet a family that is going to have these issues and to be able to have that red flag go up so that I am staying aware and not just missing it."

Others noted the safety of learning how to manage these four crisis situations in a supportive learning context. They reported that this allowed them to try out different techniques. For example, one student participant shared, "I love these simulations, not even just the issues, but because I cannot hurt someone and I am getting good feedback." Most of the comments centered on the words *good*, *eye-opening*, *challenging*, and *definitely educational*. A supervisor replied after the HI simulation, "This is one of the best things we have ever done. I think it is just terrific."

Teaming. Student participants found it helpful to use the simulations while learning the team process. It gave student participants an appreciation for what it is like to be the therapist in front of the mirror. One student participant commented, "Just from the team perspective, I have a new appreciation for what it is like to be in the hot seat."

Debriefing. Student participants expressed appreciation for the opportunity to receive feedback from simulated clients during the group debriefings. One student participant shared, "She [the simulated client] was really helpful . . . telling us some things we could have looked for or said." Another commented, "I really, really, really enjoyed this discussion afterwards . . . I mean I know we do it after each group [real client experience] but this seems to be a little more intense or something."

Domain #5: Constructive Criticism Regarding Simulations

Members of each group also offered constructive criticism to the simulation experience. The criticism is grouped into the following four themes: (a) simulated client training, (b) not realistic, (c) better off not knowing, and (d) the time factor.

Simulated client training. Simulated clients commented that the use of the team model was unique for them. They were unprepared to be asked to step out of the room while part of the simulated client family remained with the therapist. This, as well as active involvement from the team (e.g., phone calls, coming into the room), reportedly made them feel a bit uncomfortable. One commented, "The phone ringing was disconcerting, even the idea of going back [behind the one-way mirror] and talking to the team was disconcerting." In

addition, three actors commented that more detailed scripts would have helped them to understand their characters more. One supervisor made the comment that the actor could not respond to the therapist's/team's line of questioning because she was limited by her script on what she could and could not do in certain situations. Other student participants questioned the way the actors were responding in the simulations. For example, one student participant stated, "There were times when they would laugh, that I was not sure if they were laughing as the actor or as the kid." Another commented, "Even though she was acting, I think some of her own heart and being might have gone into this." Lastly, student participants voiced the need for simulations that provided a better balance of mild to severe presentations of the four crises.

Not realistic. The realism of the crisis portrayals was questioned by a few student participants. Comments involved whether or not a teenager would show up for therapy on his own, the lack of responsiveness from the simulated client, how a certain simulation felt artificial, and how starting/stopping the simulation for learning purposes made it feel less authentic. One student participant shared, "Since we were leaving [the room] and calling in so much, it was hard for me to remember it was supposed to be 'real.' "

One student participant suspected that most "real" clients would not be as reticent to disclose, answer questions, or join with the therapist. Student participants noted that the simulations where the actors interacted and responded to therapeutic questioning were more educational. Interestingly, one student participant commented that "Learning how to work with someone who wants to work with you is more important than someone who does not want to work with you because you are just going to have the struggle of only having one hour and we probably would not learn as much from that."

Better off not knowing. Student participants noted that it might have been better not to know the actor's presenting problem before the simulation experience. One shared, "I think if I did not know what I was walking into, that I had signed up for this and it could have been anything . . . I think that would have helped more, because I kept looking for it." Another student participant shared that it would have been interesting if they were not even informed that it was a simulated experience until it was all over.

The time factor. Student participants suggested that giving more than an hour and a half to run each simulation would be beneficial. This would allow each simulation to be carried out as far as it could, and perhaps restarted to try multiple alternatives. Also, more time would allow for a more preparatory discussion and postsimulation education about the crisis, including other possible clinical presentations. For some student participants, it was not the length of the simulation that bothered them; it was the timing of it. They wished that they had these experiences earlier in their education and more often. One stated, "I would want this setup of simulations in the spring . . . because this seems so real. I also do not think it [seeing clients] got really real until we were on team tonight."

Domain #6: Lessons Learned

There were many lessons reportedly learned about the level of preparedness student participants felt after completing this experience. Focus group analysis resulted in the following five themes: (a) comfort/confidence level, (b) importance of joining, (c) gaps in preparedness, (d) importance of team, and (e) reaching into the discomfort zone.

Comfort/confidence level. Student participants noted that after each simulation experience they felt more comfortable and confident asking the tough questions to help elicit critical data. One student participant noted, "I think I was anticipating too much and it will help me in the future to be more calm and wait, just listen . . . look for cues . . . those red flags that come up." Another shared that she learned how to be more comfortable with silence, especially with teenagers. Student participants commented that as a result of the simulations they felt more prepared to manage the presented crises and to work with certain age groups. One student

participant shared, "I am glad that I did this one [CM] because as I always said, I have trouble with children and adolescents . . . the more experience, the better I think I will get at it."

Importance of joining. Joining was seen as an important skill that needed to be developed among the student participants. One student participant reported, "I think how important connecting was [in this simulation] . . . listening to instinct. I knew I was not connected to her [the simulated client] and I knew it did not happen until the end [of the session]." Another stated, "[The simulation] was important to me because it reminded me to alter my personality a little bit in the therapy room, depending upon the situation, to make sure that I meet that client where they are as opposed to coming in there with my way of doing things, my agenda, and my conversation style." Supervisors also mentioned the value of joining and helping people to explore the feelings that they may be trying to avoid. One supervisor noted, "If you think of someone who is in her situation, you want to get in touch with her discouragement, her depression, her sense of helplessness and hopelessness." Lastly, both supervisors and student participants recognized the importance of expressing empathy verbally and nonverbally as a mechanism of joining.

Gaps in preparedness. The majority of the comments made when discussing the benefits of simulations pointed to personal areas of growth (i.e., learning how to ask tough questions and completing safety contracts). While some noted the need for more training in these four crisis areas earlier in their educational experience, others recognized that they had learned about them in one or more classes, but it was imbedded in the context of so many other things. A few participants reported that this helped them to recognize who among them had no experience in certain crisis situations and who did. Many of the student participants had expected that if they asked questions, the clients would answer them. A supervisor pointed out, "So the idea is we ask the question and we get the answer, but then we do not stop with that answer. We somehow find a way to go through and pull out some more stuff to make sure that the answer is in fact correct." Several supervisors reinforced this point.

Importance of team. Group members shared their appreciation for the emotional and technical support provided by the team. A supervisor reminded student participants, "Team is here because you have got all the safeguards, the checks and balances. If you are on your own [after graduation], you still have resources, but you are most likely to be on your own. This is the most support you will ever have." One student participant learned that when the team gives you a suggestion that you are not sure of, you can deliver it to the client but phrase it as "the team was wondering . . ." Another noted that sometimes you cannot do all the wonderful things that the team suggests; you can just try to hit the main ones.

Reaching into the discomfort zone. This category included the recognition of red flags, the power of stereotypes, use of silence, and education about "bad" outcomes. The groups took time to go over "red flags" or signs that a person may be in crisis. In one group, a member shared how "I am really learning, but especially about child abuse and the different ways [clients may present]." Stereotypes and biases were perceived by some of the student participants as influencing their ability to see the "red flags." Several recognized that operating according to stereotypes may hinder therapeutic success. For example, in the CM simulation, one student participant shared, "I think in my mind I was thinking that the child was going to come in and be very shy and withdrawn, but instead he was the opposite. So that was good for me to see."

Other student participants were uncomfortable when silence was present in the room or when the simulation was not cut and dry/black-and-white. One student participant learned the importance of taking time during the session to just sit there and think. Another recognized that the simulation on SI taught him, "It is really hard to be silent and take the time to just listen to the client, which is something I need to learn, especially with suicide." Several groups took the opportunity to process the varied actions and outcomes that could result from each simulation. They discussed each simulation as it may present from mild to severe. They noted

that when it is not a black-and-white decision, how to manage the shades of gray is a large part of crisis work.

DISCUSSION

As evidenced by the fields of medicine, counseling, psychology, and social work, simulated client experiences are effective methods of assessing student participant competency while allowing student participants the opportunity to build and/or realize their level of confidence in challenging clinical situations. The results of this study point to the effectiveness of simulated client simulations in family therapy training. Through this experience, student participants and supervisors realized the benefits of allowing student participant therapists and their team members the opportunity to run through some of the more challenging clinical presenting concerns in a safe and supportive environment. Since the simulations all occurred in the context of their first four weeks of clinical practice, it also gave the supervisors a baseline for each student participant's skill set and how effectively the four student participants on each team will support one another in clinical situations. The debriefings also allowed the clinical faculty the opportunity to read the data and make improvements in the program's curriculum and simulation client scripts for the following year.

Educational Implications

It is quite possible that student participants could graduate from a master's MFT program and never have worked with one or more of the four simulation issues presented in this study. The investigators recognized this as a risk factor and designed this study to address their concern. With the newly established version 11. Commission on Accreditation for Marriage and Family Therapy Education (Commission on Accreditation for Marriage and Family Therapy Education, 2006) standards in effect, we realize how important it will be to develop assessment methods such as this one to measure therapeutic competency.

Certainly, the focus of this educational experience was for the students to gain competence in the four crisis areas through the simulation experience. The purpose of this article was to assess the effectiveness of the use of simulations in teaching master's level MFT students. However, the investigators/clinical faculty could consider the elements within each of the crises that would make a clinical case more or less challenging. Future education for the students could focus on specific elements of each crisis scenario that link to therapist feelings of competence or incompetence. This assessment would allow investigators to learn if one type of crisis situation is more anxiety provoking than another or if there is a common element across all four clinical presentations (i.e., the legal and ethical implications, when or if one should call child protective services or the police, etc). This experience may allow educators to understand the most intimidating components of a crisis from the student perspective.

The teaching, via simulations, was reportedly some of the richest. The students appeared to be emotionally and intellectually stimulated after a very provocative learning experience. The clinical faculty discussed the value of the simulations for the students, but also with regard to their own confidence and approach as supervisors. Whether it is through simulations or practicum experiences, a significant amount of debriefing, support, and feedback is needed to advance competent therapists.

Clinical Implications

The clinical benefits of using simulated client encounters were highlighted in the thematic categories and domains of this study. Not only did the focus groups discuss the therapist's performance and provide them with constructive criticism, but they also noted the important skills they learned as a result of this experience. The simulation helped some student participants to feel more at ease working with certain age groups, and others more at ease with being in front

of their peers and in front of a client (real or not) for the first time alone. Joining is one of the common factors that all models and approaches share as fundamental to therapeutic success. It was also one of the most widely discussed factors throughout this study. Joining was noted as essential to soliciting accurate clinical data and securing client confidence to formulate a treatment plan. For some, it was an immediate strength. For others, it was a skill to develop. The simulations pointed to gaps in clinical and academic preparedness. Some student participants noted a concern that the crises were not addressed as thoroughly in their coursework as they wanted, but others noted that perhaps the issues had been appropriately reviewed but they just did not realize the significance of studying them as thoroughly until now. Clinically, they realized how critical it is to have a support team when working with clients, not only now, but after graduation. This exercise helped them to establish themselves as a team and appreciate the contributions they make to the client's work. Lastly, these simulations allow for student participants to reach into their discomfort zones. It allowed them to recognize red flags that may indicate the presence of a crisis in therapy, the power of stereotypes, use of silence, and education about possible "bad" clinical outcomes. These lessons learned were far greater than those expected and therefore the clinical benefits exceeded investigator bias on the importance of this teaching methodology.

Research Implications

Additional research is needed on the incorporation of simulations into MFT training programs. Simulations that allow student participants to practice basic therapy skills, apply innovative techniques, and challenge biases and stereotypes that may interfere with their provision of ethical and effective clinical care are needed.

Furthermore, quantitative assessment protocols could be used by investigators to better capture student perspectives on their competence pre- and postsimulation experience. These outcomes could help to assess therapist preparedness for clinical work and construct a bridge between the scientist and practitioner worlds.

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APPENDIX A

CRISIS SIMULATION SUMMARIES

Suicidal Ideation (Willis, 1995)

Client is a middle-aged married female who presents with symptoms of depression. She is reportedly stressed by a recent suicide attempt made by her 17-year-old daughter. She is socially isolated with no support. Her marriage is reportedly distant at best. Her husband is on disability because of an injury sustained in combat. He has been diagnosed with bipolar disorder I and his wife believes that he also has posttraumatic stress disorder. She informs the therapist that she has made a previous suicide attempt. She is suicidal presently and has a plan. She offers little hope that things will improve and is quite challenging for a therapist who wants to

move immediately to recommending hospitalization. She responds well to empathy and to the negotiation of a plan, and by the end of the session will be receptive to hospitalization if approached gently about it.

Homicidal Ideation (Lamson & Hodgson, 2003)

Jacob is a quiet 16-year-old only child who is rarely home. When he is home, he stays in his room or the garage. He has never been considered popular and most kids avoid him because he appears shy and weird. His mother and father have been married for 18 years, but both work overtime to stay out of debt. His only sibling is a 2-year-old brother whom he loves. He sometimes feels jealous of the attention that his brother gets. He was referred to therapy because his teacher found a threatening note indicating his intent to possibly kill some kids at school. These boys reportedly "pick on him" every day. When asked if he has a plan, he responds that "probably shooting them would be the easiest." He does not have a way to carry out his plan, does not own guns or any kind of explosives, but he knows that he is mad enough to hurt someone if they tease him again. He responds well to establishing a plan for safety, addressing things he could do instead of hurting others, and is able to elaborate on how the kids make fun of him and how it gets him to the point of anger and HIs.

Child Maltreatment (Kenyon & Lane, 2002)

John is an 11-year-old boy who is fairly quiet and quite charming. He lives at home with his 14-year-old sister and parents. His father travels a lot and his mother is left to do much of the parenting. They were referred to the clinic by his teacher for child behavioral problems. The father was unable to attend the initial session. Upon written release, the teacher reveals to you that she recently saw marks on him that he denies are from abuse. She thought his story could explain the marks but just was not certain he was telling her the truth. He has been acting out lately at school, which is different for him. The simulation takes place at the second session where the son denies that any abuse has happened, blaming the marks his teacher saw on a friend's dog leash that got tangled around his legs. If asked about discipline, he states that he sometimes gets into trouble at home because he is too rambunctious and does not listen when asked to do something. His sister does worry about him being punished all the time, but will not "squeal" on her mother. According to mom, running the household is very stressful, especially with an active son. She takes her frustrations out on John, although this is not something she readily admits. She recently lost her temper after John lied to her about taking food from the refrigerator. She beat him with an extension cord. Similar events have taken place in the past, but this one was the worst. Her husband is not aware of the abuse and before his wife verifies that the abuse is happening, he gets impatient with the therapist's line of questioning. Mom reports that "The kids are so good when he's around. He has no idea how bad they act and what it's like around this place." She does not admit to the abuse at first but after a safe environment is created and a therapeutic relationship has been initiated, she begins to share and allows the therapist to negotiate a plan for safety and change.

Domestic Violence (Hodgson & Lamson, 2003)

The client is a 37-year-old female who is depressed and fed up with the verbal and physical abuse she endures at the hands of her second husband, Leonard. Lynette reports that Leonard has physically and verbally abused her off and on throughout their marriage. The abuse has gotten worse in the past 6 months since Leonard was laid off from the factory. He started drinking alcohol again after being in and out of recovery for 9 years. He does not physically abuse their two children but is impatient with them and sometimes calls them names. Lynette appears to be depressed and nervous. She sits slouched in her chair with moderate eye contact and gets tearful when talking about how tired she is of living like this. She speaks openly about the physical abuse once trust is established and the therapist prompts her to talk about her

relationship with her husband. If going to a safe house, or taking legal action, is mentioned, the client is not too receptive at first. She resists this until the therapist explains what her options may offer her, as well as the benefits and risks involved.

APPENDIX B

FOCUS GROUP FACILITATOR SCRIPT

Thank you for participating in this simulation training exercise on ______________ {suicide, child maltreatment, homicide, or domestic violence}. We would like to know about your experience of this simulation and its educational impact on you. I would like to talk with you for approximately 30 min now about your reactions to it. I will answer any additional questions you may have about this type of client after we complete our focus group discussion.

In a focus group discussion everyone participates; however, it is important for recording purposes that we do so one at a time. Please speak loudly and clearly into the microphone so your responses are recorded. Does anyone have a question about anything I have said? If not, I would like to start off the discussion by asking you:

Grand Tour Question

What was your experience of this simulation on {suicide, child maltreatment, homicide, or domestic violence}?

Probing Questions

What did you like about this experience? Please explain. . .

As a result of this simulation exercise, what did you realize about your clinical knowledge and/or level of preparedness in this area?

What didn't you like about this experience? Please explain. . .

How could it be improved?

NOTE

[1]Practicum courses meet 14 weeks, three times a week, for 4 hr. Students are required to select one of the three practicum nights to attend for the entire semester with the same supervisor overseeing his or her clinical work.