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Assessing Clinical Competency: The Simulated Patient Assessment and Research Collaboration

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CULTIVATION OF CLINICAL COMPETENCY IN PSYCHOLOGY TRAINEES: THE SIMULATED PATIENT ASSESSMENT AND RESEARCH COLLABORATION

by

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ABSTRACT

The efficacy of using simulated patients (SPs) to train clinical interviewing skills in pre-practicum- and practicum-level mental health clinicians was evaluated compared to the use of traditional role-play with peers. Participants, regardless of group, engaged in a 15-minute videotaped simulated clinical session with an SP as a pre- and post-test measurement and completed five laboratory sessions, either utilizing role-play with peers or with an SP. Participants' counseling self-efficacy (CSE), measured by the Counseling Self-Estimate Inventory (COSE); state anxiety, measured by the State-Trait Anxiety Inventory, Version Y-1 (STAI Y-1); and self-reflective anxiety, measured by the Fear of Negative Evaluation scale (FNE), were assessed pre- and post-intervention. An inventory to evaluate participants' clinical competency acquisition, the Skills in Psychological Interviewing: Clinical Evaluation Scale (SPICES), was developed for the study.

All participants, regardless of group, improved significantly on all measurements except fear of negative evaluation. No differences were observed between groups on outcome variables. However, all participants' pre- and post-test interaction with the SP may

account for these improvements. CSE, state anxiety, and fear of negative evaluation were found to account for a small amount of variance in clinical competency acquisition in this study. The piloted SPICES scale exhibited good validity and strong inter-rater reliability estimates. Results support the efficacy of these training methods in decreasing student clinicians' anxiety levels and in increasing students' CSE and skill acquisition; furthermore, a clinical competency measure is introduced.

Keywords: simulated patients, role-play, clinical competency, counseling self-efficacy

Chapter I: Statement of the Problem

Typically, psychology trainees utilize role-play in the development and practice of interviewing skills. Role-plays allow students to take on a character (such as client or therapist) in order to learn a new skill. A benefit of this method is the opportunity for empathy development, as the student gains insight into the patient experience. Furthermore, students often closely approximate accurate diagnostic presentations, given their psychological knowledge. Role-play has been found to be a valid form of skill development, provided that the simulations emulate a true therapeutic situation. Additionally, they are cost-effective and easy to implement. However, role-play scenarios are often artificial; spontaneously created; and, therefore, variable. Furthermore, the exercises are often not taken seriously by students, and interaction with one's peers often precludes objectivity during the role-play (Kaslow et al., 2009).

A simulated patient (SP) is an actor who is trained to portray a set of symptoms consistently across clinical interactions (Barrows, 1993). According to Barrows, using an SP facilitates the assessment of clinical skills in a safe environment and eliminates the likelihood of harming an actual patient. Medical schools have utilized SPs since 1963, and at least 80% of medical schools in the United States currently use them for training and for assessment of their students (Clay, Lane, Willis, Peal, Chakravarthi, & Poehlman, 2000). SP interactions are comparable to real patients and settings, are standardized, and provide feedback from an impartial party (Kaslow et al., 2009). SP experiences may lessen the risk of possible harm to clients, reduce the likelihood that ethical dilemmas will be handled poorly, and certainly provide training experiences that are more consistent with actual patient encounters than peer role-play alone. Practice with SPs has

been touted as a potentially useful training tool to aid in beginning mental health clinicians' clinical competency acquisition (e.g., Kaslow et al., 2009). However, there is a paucity of research on the efficacy of use of SPs in graduate psychology. This study set out to determine the effectiveness of utilizing SPs in the training of mental health graduate students' interviewing competency. As skill acquisition and trainee performance are closely associated with self-efficacy gains and reduced task-specific and performance-related anxiety (Daniels & Larson, 1998), the impact of training with SPs upon participants' CSE, self-reflective anxiety, and state anxiety was examined. Furthermore, the comparability of this newer approach to the traditionally-used role-play with peers was determined. This study contributes to the growing literature on the best-case practices for enhancing the preparation of psychology trainees.

Experiences of Psychology Trainees

Throughout the educational psychology literature, much attention has focused on the experiences of psychology trainees during their first forays into psychotherapy. Elucidation of these experiences, both of positive and negative valence, is particularly important, as training lays the foundation for students' future therapeutic work (Hill, Sullivan, Knox, & Schlosser, 2007). Contingencies during training and reactions toward them can leave permanent impressions upon neophyte clinicians' views of the therapeutic process, of how they view themselves as practitioners, and of their understanding of the profession as a whole (Skovholt & McCarthy, 1988). Consistently, trainees report apprehension over their ability successfully to conduct and effectively to manage their first psychotherapeutic interactions as well as feelings of incompetence (Williams, Judge, Hill, & Hoffman, 1997). In a comprehensive study of psychotherapists at various levels

of professional development, an overwhelming 83.2% of novice trainees with less than a year and a half of counseling experience reported pervasive feelings of inability to effectively counsel clients. However, perceived inadequacy was reported by therapists at all professional levels as they compared their current ability and performance levels to idealized standards (Orlinsky et al., 1999). This self-focus typically provokes anxiety and associated arousal levels, thereby increasing fear over evaluation, decreasing task performance, and increasing distraction from the task at hand (Gibbons et al., 1985).

Feelings of incompetence and related anxiety experienced by more senior members of the profession are often linked to detrimental outcomes, namely stress, burnout, personal difficulties, and even leaving the profession. Furthermore, low levels of perceived self-efficacy are associated with negative therapeutic outcomes such as alliance rupture, client disengagement, and untimely termination. Although veteran psychologists' feelings of inadequacy are complex (e.g., comparatively, trainees' feelings of inadequacy are more closely linked to inexperience), early interventions to increase therapists' senses of mastery and to enhance coping with perceived inadequacies are warranted (Theriault & Gazzola, 2010; Theriault, Gazzola, & Richardson, 2009).

Models of novice therapists' development. A number of theorists have created models of therapist development. Several conceptualizations of novice therapists highlight their struggles with anxiety and perceived incompetence. Hogan (1964) described beginning therapists as "neurosis-bound" and as insecure (p. 164). As such, they rely heavily upon their supervisors for guidance and are relatively blinded by self-preoccupation to their actual influence on clients. Hogan suggested that novice clinicians' high motivations for learning are primarily defenses against anxiety. They readily adopt

supervisors' suggestions and instructions without reflection and primarily learn through direct imitation in order to defend against low competency levels (Hogan, 1964).

Similarly, Loganbill, Hardy, and Delworth (1982) focused upon trainees' limited worldviews as a result of egocentricity. Although novices have a sense of their skill deficits, they are usually unaware of what specific skills they lack. This lack of awareness can lead to one of two outcomes. Congruent with Hogan, these authors maintained that trainees can become completely dependent upon their supervisors' guidance due to their lack of confidence; however, others can attempt to hide their inexperience and self-doubt by feigning competency and viewing supervision as unnecessary (Loganbill, Hardy, & Delworth, 1982).

Grater (1985) further built upon these models. He suggested that novice therapists' generalized anxiety is coupled with an intense fear of failure, high concern over supervisors' evaluations, and a lack of an identity as a therapist. Grater emphasized the trainees' needs for focus on skill acquisition to manage anxiety, as well as specific, concrete instruction concerning potential therapeutic events. In agreement with theoretical predecessors, Grater's model asserts that trainees primarily rely upon instruction and modeling to relieve anxiety (Grater, 1985).

Skovholt and Ronnestad (2003) further delineated novice therapists' developmental period into two distinct stages. In the conventional stage of the development, which takes place before formal training, therapists rely on intuitive ways of helping others. Spurred by successful helping situations with friends and family, they rely upon advice-giving and problem-solving. In the professional training stage, the authors propose that trainees' anxieties mainly stem from being unable to utilize those

relied-upon strategies and from their lack of skillfulness with evidence-based techniques. Thus, they are readily motivated to decrease deficits by adopting new skills and by imitating their mentors (*cf.* Hill, Sullivan, Knox, & Schlosser, 2007).

Direct investigations into the experiences of psychology trainees. A number of recent studies set out to provide an evidential basis for these theories of therapist development. Expanding upon previous research that focused on one or a limited number of targeted experiences at a time, these investigations used open-ended questionnaires and journals, respectively, to evaluate the gamut of experiences encountered by novice therapists during their introductory semester of practicum training. Williams, Judge, Hill, and Hoffman (1997) found common in-session reactions and feelings among targeted trainees. Anxiety and discomfort were the most commonly experienced sentiments over the first semester. Specifically, trainees reported anxiety when confronted with periods of silence, faced with difficult issues, and considering client termination. Trainees additionally felt uncomfortable when facing cultural discord as well as when talking about taboo subject matter. They also admitted hesitation to probe the client for more information as well as confusion over what to focus upon in session. Trainees also endorsed apprehension over potential client conflict within the therapeutic relationship.

Although the novice therapists reported a high level of empathy for their clientele, they expressed an uncertainty over the boundaries of their newfound role. They expressed strong desires to align themselves with the client and to "rescue" them, to solve their clients' problems directly, and to give advice. They also felt personally responsible for assuaging their clients' negative moods. Additionally, they expressed difficulty in managing their own feelings about and reactions to within-session discussions. Self-

doubt over performance was paramount and often served as a distraction from the sessions. Disengagement was also a response to emotional reactivity as well as to confusion over what the client was saying and how to react. Trainees' set agendas for the sessions, as well as monitoring of their own performance, also served to detract from their in-session experiences. Furthermore, therapists reported anxiety about remaining focused on the client and frustration over not being able to do so. Trainees further expressed frustration over their limited knowledge. Future anxiety over working with difficult, complex cases was also endorsed. These doubts were observed to lessen over time, correlating with greater skill acquisition and experience gains. While similar themes were observed throughout the group's responses, the authors highlighted that each trainee's experience and concerns are highly individualized (Williams, Judge, Hill, & Hoffman, 1997).

Lee, Eppler, Kendal, and Latty (2001) extended this direct investigation approach to first-year marriage and family therapy practicum students. The authors instructed the students to journal about a particular event daily which "*captured something important in terms of their professional development"* as well as their personal psychological reaction to the event (Lee, Eppler, Kendal, & Latty, 2001, p. 53). Interestingly, all students highlighted the importance of peer support during the training process. Stressors of clientele exposure were endorsed, especially when they were introduced to complex cases. The students expressed feeling unprepared for clinical experience, even after completing theoretical, interviewing, and intervention-based classes, and reported feelings of inadequacy. Furthermore, the students all expressed concern over judgments of clinical competency by professors, supervisors, clients, and their peers and described

feeling that unrealistic expectations were placed upon them by both professors and themselves. Students additionally often struggled with their professional identities, including such variables as their age, personality, and skill set. They also reported stressors stemming from their concurrent coursework and from multiple roles (e.g., as therapist, student, co-worker, family member), as well as from a struggle to maintain personal well-being. Students endorsed wrestling with inhibition as well as with cognitive and emotional confusion over dual relationships and conflicts of interest. They further displayed feelings of guilt and anxiety. However, trainees also expressed positive aspects of their experience. They reported feelings of excitement over their newfound roles, preparation for eventual careers, and the diversity of human experience as displayed by their clients. Particularly meaningful was the students' discovery that their therapeutic effectiveness and enjoyment of therapy was reliant upon the extent to which their own emotions were addressed and resolved. They also endorsed feelings of personal growth and self-discovery (Lee, Eppler, Kendal, & Latty, 2001).

Howard, Inman, and Altman (2006) also utilized this critical-incident methodology in a sample of trainees in masters-level counseling and human services and school counseling programs. These students had completed a semester of practicum experience. The majority of reported critical incidents included recognition and formulation of professional identity. Trainees reported feelings of confusion and fear regarding their newfound roles which contributed to ambivalence over their proposed career choice and their motivation to remain in the field. They also described feelings of restraint stemming from their status as student learners. These students expressed feeling overwhelmed by the amount of information to learn and skills yet to acquire. They also

reported self-awareness both of negative and of positive reactions to clients or to their own emotionality, which detracted from their in-session experiences. They further indicated maturation in their understanding of theoretical perspectives, therapeutic processes and intervention, and what processes made therapy effective as a whole (Howard, Inman, & Altman, 2006)

Hill, Sullivan, Knox, and Schlosser's study (2007) closely paralleled the findings of Howard, Inman, and Altman (2006). Trainees criticized several aspects of their performance, namely problems with self-awareness, choosing the "correct" response to clients' statements, selecting the correct intervention to perform, guiding the direction of the encounter, and articulating their responses to clients. They expressed concerns over cultural division and not being able to identify consistently with their clients. They also endorsed a high performance anxiety and a felt pressure to execute their skills successfully. The novice therapists described concerns over perceived skill deficits, especially when clients' presenting problems exceeded their knowledge base. Feelings of incompetence and frustration were consistently indicated. Conversely, they also expressed worry about over-identification with their clients' difficulties as well as difficulty remaining objective. Trainees also struggled with their therapeutic roles, identifying more as a friend to their client than as a therapist. They endorsed a pull to "fix" the client, to give advice, to self-disclose improperly, to mollify the client, and even to cry while in session. Furthermore, self-awareness surrounding these issues was found to detract from their presence in the session. Participants in this study also endorsed improved competence, comfort with the therapeutic role, and self-confidence as a function of experience and time. The trainees further highlighted a number of coping

mechanisms they employed to reduce anxiety, namely reliance on supervision and skill acquisition, use of positive self-talk, and increased preparation for sessions in order to gain a sense of control (Hill, Sullivan, Knox, & Schlosser, 2007).

Overall, these studies have revealed several consistent findings in the experience of psychology trainees. Students reported positive experiences related to excitement over the learning process and over entrance into the field as a whole. Furthermore, they reported increases in self-efficacy and in self-discovery related to experiential gains. However, students consistently endorsed feelings of inadequacy, frustration, and anxiety over their newfound roles and the new challenges they present. These reactions commonly stem from a lack of knowledge, therapeutic skill, and sufficient practice with clients.

Skovholt and Ronnestad (2003) discussed the experiential underpinnings influencing these common reports in early psychotherapy training. They stressed the exhausting nature of the demands placed upon beginning therapists, namely weighing, assimilating, amalgamating, and adapting new information at a high speed when preparing for actual client interactions. Furthermore, the thinking processes required by psychotherapy are extraordinary; they are often not linear; sequential; or oftentimes, even logical. They are mastered after years of experience, and clients, not professors, serve as the teachers. The authors suggested that grappling with these new cognitive demands leads to self-consciousness, which in itself diverts the attention necessary to think in this manner. Accordingly, emotional and cognitive dissonance becomes prominent.

Although necessary, the knowledge gained in classes does not neatly translate into actual practice. Theoretical ‘guides’ of psychotherapy as presented in training programs

are developed as overarching models for a wide variety of situations. Furthermore, the conceptual maps that trainees previously relied upon to help others in their personal lives are now recognized as inadequate. Oftentimes, students lament their own training for ill preparation; however, the students frequently blame themselves for their shortcomings. The new therapist experiences a barrage of conceptions, emotions, worries, and hopes. The authors emphasized that therapists need the capacity to tolerate, to conceptualize, to regulate, and to express those emotions in a way that promotes personal and professional benefit. Furthermore, the authors recognized that trainees' senses of themselves as practitioners is fragile and incomplete. The gamut of feelings surrounding trainee status ranges from enthusiasm to despair, pride to shame. The trainee often holds romanticized views of the field, with the vision of changing lives positively and forever. This often leads to romanticized views of the self. Trainees' thought patterns often turn to *"If I am able enough, skilled enough, warm enough, intelligent enough, powerful enough, knowledgeable enough, caring enough, present enough—then the other will improve"* (Skovholt & Ronnestad, 2003, p. 53). Unfortunately, when this does not occur (as is the nature of the human change process) trainees become disillusioned with the field, themselves, or even humankind. Evidence contrary to this disillusionment can only come with experience, but the authors emphasized the role that validation, clarity, and hope can play in the resolution of such internal struggles. Accordingly, they touted the importance of personal mastery and professional guidance in building trainees' senses of self-efficacy (Skovholt & Ronnestad, 2003).

Self-Efficacy

Social psychologist Albert Bandura developed the construct of *self-efficacy*. Bandura posited "perceived self-efficacy is concerned with judgments of how well one can execute courses of action required to deal with prospective situations" (Bandura, 1982, p. 122). The concept of self-efficacy is central to Bandura's Social Learning and Social Cognitive Theories (Bandura, 1977; 1986). Bandura proposed that human adaptation and action are based upon cognitive, vicarious, self-managing, and introspective processes (Bandura, 1986). Correspondingly, one's personal attributes (cognition, affect, and biology), behaviors, and environment interact to produce the ability to process information, to self-regulate, to constitute reality, and to engage in behaviors (*reciprocal determinism*). Bandura advanced the concept of human agency, which theorizes that individuals are active participants in their own development and, in turn, are able to influence their environments. As a result, human beings can exercise control over their own thoughts, emotions, and actions. However, Bandura emphasized that one's *self-beliefs* are critical both to the implementation of this control and to one's sense of agency (Bandura, 1986).

The formation of self-efficacy beliefs. Cognitive mechanisms are central to learning and to retaining patterns of behavior. Through imitating others, a notion is developed about how the target behavior is performed. This notion then functions as a guide for future performance. One then hones performance based on environmental feedback and self-evaluative reactions. Divergences between personal standards and actual performance produce motivated, corrective changes in behavior, provided that only a moderate discrepancy between standard and performance exists. Essentially, then,

people create self-incentives for action by making personal satisfaction contingent on performance standards (Bandura, 1977, 1989; Bandura & Cervone, 1983). Self-performance that falls significantly short of one's imposed requirements may lead to lowering of personal standards and to demanding less of oneself. Such events can lead to dissuasion or even discontinuation of effort. However, accomplishments that reach or even surpass standards provide reinforcement, impetus to raise personal standards, and motivation for future action (Bandura & Cervone, 1983). Humans also cognitively create outcome expectancies, namely, predictions that specific behaviors will result in particular consequences. By symbolic representations of forethought, envisioned future consequences can serve as motivators and regulators of current behavior (Bandura, 1977, 1989; Bandura & Cevone, 1983). Likewise, efficacy expectancies are predictions that one is able to implement the requisite behavior to produce expected outcomes. These expectations vary on several levels, namely in *magnitude* (affecting generalizability to increasingly difficult tasks), *generality* (expectations extending beyond circumscribed situations), and *strength* (stability of efficacy beliefs in the face of contrary evidence) (Bandura, 1977).

Efficacy information is gleaned through a number of mechanisms. Particularly influential are performance accomplishments, as they provide an authentic experiential basis for competency evaluation. Successful execution of tasks *(mastery experiences*) raises efficacy expectancies, while failures lower them. In this regard, early, repetitive outcomes are particularly influential when learning new tasks or facing new situations (Bandura, 1977; 1982). However, the overcoming of occasional failures through concerted effort is particularly efficacy-enhancing. Furthermore, this motivated

perseverance is often extended to other obstacles, thereby generalizing self-efficacy beliefs to additional conditions (Bandura, 1977).

Vicarious experiences also serve to enhance personal efficacy. Observation of others with similar characteristics as oneself acting successfully in target situations enhances confidence in personal abilities. Conversely, observations of others' failures can decrease one's self-efficacy beliefs (Bandura, 1977; 1982). Furthermore, observation and modeling serve to convey information about the nature and predictability of events, as well as coping mechanisms for trying events (Bandura, 1982). However, efficacy beliefs gathered in this matter are often more vulnerable to change in the face of disconfirming evidence, as direct proof of one's skill set has not been gained. Likewise, social persuasion to enhance one's confidence often produces transitory changes in self-efficacy beliefs. When combined with tangible aids and a conducive environment, however, verbal encouragement promotes greater effort exertion and skill development by the individual (Bandura, 1977, 1982). Indubitably, encouragement has the greatest impact upon those who have the skill sets to act in accordance with others' heightened appraisals; therefore, realistic encouragement promotes more permanent efficacy gains (Bandura, 1982). Furthermore, physiological reactivity to challenging situations informs efficacy appraisals. High physical reactivity often impedes performance; therefore, one is likely to have low competency predictions during anxious arousal. Moreover, anticipatory self-doubt often extends to future events and avoidance activities.

Behavioral coping mechanisms aid in the instillation of a sense of cognitive control and the accrual of smaller mastery experiences. Both physiological arousal and self-efficacy beliefs are, thereby, affected in a reciprocal fashion (Bandura, 1977; 1982).

Contextual factors often affect competency judgments. Chronic low efficacy appraisals which have served self-protective purposes are often resistant to change. Also, one's locus of control affects changes in self-efficacy gleaned from either successes or failures. Ascribing successes or failures to one's own effort impacts self-efficacy judgments to a greater extent than successes or failures attributed to unusual circumstances. Additionally, crediting accomplishments to either ability or to effort has implications for future competency predictions. Successes resulting from minimal effort expenditure yield self-efficacy gains, where successes resulting from high effort lead to smaller efficacy gains due to reduced ability attribution. In the same vein, simple task achievements provide little effect on efficacy, while successful execution of challenging tasks elicits feelings of mastery (Bandura, 1977).

Efficacy governs one's choice to engage in coping behaviors, how much effort one expends, and for how long effort persists in the face of adversity, as well as choice of pursuits and social milieus (Bandura, 1977, 1982, 1989; Bandura & Cervone, 1983; Bandura & Locke, 2003; Bandura & Wood, 1989). Self-efficacy guides behavior and motivation; if an individual believes himself or herself to be inefficacious, he or she will likely possess little incentive to perform and to persevere. Therefore, it is perceived that self-efficacy beliefs guide functioning through cognitive, motivational, emotional, and decisional mechanisms (Bandura & Locke, 2003).

Personal knowledge, skill set, and transformational operations are essential but not sufficient for successful performances. It is well established that humans often do not behave at optimal levels, despite knowing what to do in particular situations. Bandura stressed that self-referent thought serves as an important mediator in the association

between knowledge and performance (Bandura, 1977). Indeed, people with the same skill sets may perform sub-standardly, satisfactorily, or exceptionally, depending on their efficacy convictions. It is theorized that these convictions affect how individuals effectively utilize the skill sets they possess (Bandura & Wood, 1989). One is likely to pursue and to engage in activities they predict will fall within their perceived competencies. Those with high self-efficacy beliefs envision success and cognitively rehearse beneficial reactions to prospective setbacks. These phenomena have been demonstrated in several investigations, as participants envisioning successful completion of tasks routinely display enhanced performance as well as enhanced overall functioning over time (Bandura, 1977, 1989; Bandura & Cervone, 1983; Bandura & Locke, 2003; Bandura & Wood, 1989). It is thereby concluded that the relationship between efficacy beliefs and cognitive simulation is bidirectional; high competency beliefs promote the envisioning of success, while successful enactment helps to foster self-efficacy (Bandura, 1989). However, those with low self-efficacy will tend to avoid situations that they predict will surpass their abilities, to envision disappointment scenarios, and to dwell upon personal shortcomings. Subsequently, motivation and performance are negatively affected (Bandura, 1977, 1989; Bandura & Cervone, 1983; Bandura & Wood, 1989). Oftentimes, individuals will automatically exclude several behavioral options based on self-efficacy beliefs without weighing the costs and benefits (Bandura & Locke, 2003). Consequently, self-efficacy may affect preparative and enactment efforts differently. Some self-doubt spurs the individual to gather knowledge and to prepare further for particular situations, while those with high perceptions of efficacy have little motivation to engage in preparatory efforts. Likewise, high perceptions of efficacy intensifies one's

actual performance strivings, while self-doubt serves to hinder enactive efforts. Therefore, it is recognized that optimal performance requires strong self-efficacy perceptions coupled with manageable levels of ability anxiety (Bandura, 1982; Bandura & Locke, 2003).

Self-efficacy and the development of goals. Bandura (1982) stressed that a particularly effective method to bring about and to sustain self-efficacy development (and concomitant levels of behavioral and performance motivation) is to adopt proximal, attainable subgoals which lead to larger future accomplishments. Contiguous subgoals provide immediate incentives and behavioral guides. Accomplishment of these smaller goals serves as a marker of progress along the way to one's ultimate goals and contributes to a growing conception of self-efficacy. Social learning theory proposes that activation of those self-appraisal mechanisms hinges upon one's goals and feedback upon one's performance (Bandura & Cervone, 1983; Bandura & Locke, 2003). Furthermore, in a reciprocal fashion, the stronger one's aptitude beliefs, the loftier goals they set and the firmer their commitment and motivation towards those goals (Bandura & Wood, 1989).

Bandura and Cervone (1983) set out to investigate further the interaction between self-evaluative and self-efficacy mechanisms, goal systems, and performance motivation. As previously mentioned, discordance between one's personal performance standards and actual behavioral accomplishments can produce motivated effort to change one's behavior. However, whether this disparity serves as a motivator or discouragement is influenced by perceptions of ability. Those with low self-efficacy beliefs are more likely to be easily disheartened by failures, while those with high self-efficacy beliefs are likely

to persevere in their efforts. In this investigation, participants performed a demanding activity and received a combination of performance feedback and imposed, discernible goals; imposed goals alone; performance feedback alone, or neither feature. Combinations of performance feedback and imposed targets significantly intensified participant motivation, supporting the tenets of social learning theory. As expected, imposition of goals or feedback alone produced no changes in motivated behaviors. Interestingly, set goals produced gains in participants' performances, but did not produce changes in motivation levels. The authors, therefore, concluded that when engaging in both goal-setting and evaluative feedback, dissatisfaction with one's performance impacts the effort put forth, while in either setting goals or receiving feedback alone, one's effort seems to be contingent on percepts of self-satisfaction (Bandura & Cervone, 1983).

Bandura and Wood (1989) called attention to the importance of environmental factors in both the development of self-efficacy beliefs and in individuals' strivings toward goals. Neither self-efficacy beliefs nor the social environment are steadfast; therefore, multiple subskills must be constantly improvised to meet changing circumstances. The authors further posited that one's social environment holds potentialities that are activated by one's actions. Calling to mind the assertion that behavior is governed by competency beliefs as well as environmental factors and feedback, those with low self-efficacy views are likely to exert small influence on even opportunistic environments. On the other hand, those with high efficacy beliefs exercise resourcefulness in gaining a sense of control in limiting environments. It follows that the greater the environmental constraints, the stronger the self-efficacy needed to create environmental changes. When individuals perceive a personal capability to control the

environment concerning personally meaningful events, they are especially motivated to exercise their skills fully, enhancing the likelihood of successful interactions. In turn, these mastery experiences provide evidence of personal efficaciousness as well as controllability of the environment. Conversely, if others view situations as uncontrollable, they are likely to employ their skills only weakly, increasing the likelihood of failure and subsequent reduction in both efficacy and controllability beliefs.

These hypotheses were subsequently confirmed in an investigation using a simulated organization (Bandura & Wolfe, 1989). Those participants holding the perception that established organizations are uncontrollable exhibited low self-efficacy beliefs as well as a lowering of personal goals and standards, even when goals were easily reachable. Actual attainment of goals was also affected. Conversely, those who adopted the belief that organizations were controllable exhibited a high sense of self-efficacy, effective analytic thinking, and both the setting and attainment of goals. Interestingly, those participants who were assigned tasks they could seldom execute displayed lower self-efficacy over time; however, even after several failures, they maintained stronger efficacy beliefs than those given more manageable tasks but operating under low controllability beliefs. The authors expressed that this phenomenon highlights the resiliency potential that those with strong self-efficacy beliefs possess. Individuals with belief in their own capabilities are likely to persevere in the face of setbacks, learning from their mistakes and viewing adversity as challenges rather than evidence of personal shortcomings (Bandura & Wolfe, 1989).

In light of these findings, Bandura refined his Social Cognitive Theory to represent the dual systems inherent in the regulation of personal incentive and behavior -

"a proactive discrepancy production system working in concert with a reactive discrepancy reduction system" (Bandura & Locke, 2003, p. 91). Individuals are not solely motivated by a desire to repair personal shortcomings. Instead, they exercise proactive control through the setting of challenging goals and standards, thereby creating discrepancies themselves. In this inherently motivating process, they then exercise the effort necessary to complete those tasks based on their estimate of what it takes to succeed. Effort is then altered as a result of reactive feedback. Those with high competency beliefs subsequently set even higher performance standards, causing the chain to begin anew. However, Bandura and Locke (2003) emphasized that focus upon these feedback loops ignores the role of human agency in self-regulation. The authors highlighted individuals' tendencies to adopt standards and goals serving purposes of personal value; prophylactically to manage the recourse, effort, and planning necessary to reach personal standards; and to respond affectively to personal performance. Furthermore, individuals' metacognitions include appraisal of the accuracy of their self-efficacy judgments, of the suitability of their goals, of the adequacy of mechanisms to reach those goals, and of the personal meaning of their enterprise (Bandura & Locke, 2003).

Counseling Self-Efficacy (CSE)

As part of the renewed interest in the experience and preparation of psychology trainees, much research has investigated the acquisition of skills and subsequent performance in the educational and therapeutic setting. However, it is now widely recognized that therapeutic efficacy is not fully explained by procedural knowledge and the subsequent enactment of "correct" procedures. In order to be effective in session,

therapists must organize and enact those procedural microskills, using improvisation to meet the ebbs and flows of the therapy session. Initiation and regulation of procedures is mediated by a host of internal processes and specific therapist individualities (Daniels & Larson, 1998). As such, research has recently begun to expand into the realm of specific trainee characteristics that may affect their therapeutic work. Such personal variables include the trainee's cognitive processes, goals, and levels of counseling self-efficacy (CSE; Larson, 1998). Larson and colleagues (1992) defined CSE as a therapist's beliefs about his or her capability to counsel a client effectively. In turn, the therapist's self-efficacy beliefs, along with affective, motivational, and cognitive processes, serve to determine his or her behavior, thought progressions, and emotions while in session. CSE also serves as a basis for therapists' responses, persistence, and risk-taking behavior with clients. CSE further affects therapists' goals, plans, and outcome expectancies in educational, supervisory, and therapeutic domains. Moreover, CSE may determine the extent to which psychology trainees will persist and the effort they will put forth in their training when acquiring the complex skills that therapy requires (Daniels & Larson, 1998; Larson et al., 1992). Although relatively inexperienced, neophyte therapists possess three main types of knowledge - namely procedural counseling knowledge, declarative knowledge of psychological theories, and personal helping experience. CSE serves as the primary agent between these branches of knowledge and the actual execution of effective counseling actions, regardless of level of experience (Larson, 1998).

Larson adapted Albert Bandura's Social Cognitive Theory (Bandura 1977, 1982, 1986, 1989, 1990) to a model designed to conceptualize the self-efficacy formation and specific beliefs of psychology trainees, named the Social Cognitive Model of Counselor

Training (SCMCT; Larson, 1998). As previously mentioned, Bandura expressed that one's personal agency (comprised of the synergy of the individual's self-efficacy beliefs as well as affective, cognitive, and motivational processes) allows him or her to adapt to varying, multifarious environments (such as educational and therapeutic domains). This is a dynamic, interactive, and complex process. Personal agency, previous actions, and the environment thereby interact to result in motivated behavior (Bandura, 1990; Larson, 1998). Psychology trainees, then, are active agents in the construction of their educational, supervisory, and therapeutic environments as well as their own actions (Daniels & Larson, 1998). Bandura also expressed that these actions and larger behaviors are not reducible to microskills, stating that the production of complex actions (such as psychotherapy) necessitates "continuously improvising multiple subskills to manage ever changing circumstances most of which contain ambiguous, unpredictable, and often stressful elements" (Bandura, 1990, p.391; Larson, 1998). Bandura also maintained that personal agency is exercised by forethought in the expectancy of potential encounters and preparation for a myriad of therapeutic events. Goals (both personal and for their clientele) are, thereby, set, based on both this forethought and on feedback (Daniels & Larson, 1998).

Components of personal agency. As mentioned previously, Bandura's concept of personal agency is comprised of several internal processes in addition to self-efficacy beliefs - namely affective, cognitive, and motivational processes (Bandura, 1990). Larson (1998) highlighted the several competing cognitions new clinicians often face. Primarily, these cognitions are often reactive in nature. In both educational and therapeutic settings, the trainee selectively attends to and deliberates based on feedback from several sources.

The trainee evaluates his or her own counseling or supervisee actions from internally-based standards. In the procedurally-based realm, peers, supervisors, and clients themselves serve as agents for feedback on performance. The trainee processes that feedback and modifies his or her therapeutic actions (during current performance or future encounters), constructing further plans of action. The creation of plans, a proactive process, includes the cognitive processes of encoding, pattern matching, and goal setting for both the immediate (e.g., in-session) and distant (e.g., client outcome) futures. The therapist is also monitoring the progression of the therapeutic endeavor and weighing competing sources of information (e.g., meeting specific procedural goals versus allowing the client to continue to describe a story). Additionally, the therapist is concurrently weighing, assimilating, and adapting new information while retrieving previous information (e.g., appropriate procedural subskills) (Heppner & Krauskopf, 1987; Larson, 1998; Skovholt & Ronnestad, 2003).

As previously expressed, new clinicians often experience feelings of inadequacy, frustration, and anxiety over their newfound roles and the novel challenges they present (e.g., Hill, Sullivan, Knox, & Schlosser, 2007; Williams, Judge, Hill, & Hoffman, 1997). Stoltenberg, McNeill, and Delworth (1998) liken this to a straightforward lack of therapeutic microskills, an overwhelming concern over negative evaluations from educators, supervisors, and clients, and a lack of self-efficacy beliefs (Stoltenberg, McNeill, & Delworth, 1998). Ronnestad and Skovholt (1993) indicated that trainees' anxiety seems to lead to an external orientation for aptitude evaluation, thereby limiting therapeutic growth (Ronnestad & Skovholt, 1993). In the same vein, Larson (1998) stressed that one's evaluation of his or her own skill level is central to the amount of

anxiety he or she experiences in the face of unknown elements of the practicum experience (Larson, 1998). In turn, self-efficacy beliefs were found to predict trainee performance in a role-play therapeutic interaction, with lower self-efficacy associated with poorer performance, and vice versa (Larson et al., 1992). Indeed, the literature indicates that those with higher levels of self-efficacy report less anxiety in their interactions with clients (Friedlander, Keller, Peca-Baker, & Olk, 1986; Larson et al., 1992; Leach, Stoltenberg, McNeill, & Eichenfield, 1997). In the same vein as Bandura's Social Learning Theory (Bandura, 1986), Larson emphasized that those new therapists with higher CSE would likely appraise their anxiety as a challenge and as a motivating force, set appropriately challenging therapeutic goals, and engage in positive self-talk (Larson, 1998).

Self-evaluation in SCMCT is described as therapists' appraisals of their performances in session, with emphasis on the degree to which they focus on constructive, changeable facets of their work. Larson (1998) reviewed several studies on the relationship between self-evaluation and CSE. She emphasized that a positive relationship between self-evaluation and CSE exists (Daniels & Larson, 1998; Larson et al., 1992; Larson et al., 1998); therefore, it follows that trainees may benefit more from focusing on positive aspects of their counseling performance rather than personal shortcomings (Daniels, 1997). Indeed, it has been shown that when trainees receive positive feedback (either delivered by another person or by reviewing positive aspects of their enactment) about their therapeutic performance, their counseling-related anxiety decreases and their CSE improves (Daniels & Larson, 1998; Daniels & Larson, 2001; Larson et al., 1992). Daniels and Larson (2001) theorized that the internalization of

positive feedback resulted from new clinicians' internalization of their interactions as mastery experiences. On the other hand, negative feedback is likely translated as a failure experience, lowering CSE percepts and raising anxiety and self-doubts regarding their training aptitude (Daniels & Larson, 2001). Furthermore, evaluation of therapeutic missteps as a normal part of the learning process rather than as a reflection of personal shortcomings is likely to facilitate both CSE and subsequent performance (Bandura & Wood, 1989). Therapists' stable personal characteristics have also been found to affect the aforementioned areas. Therapists' personalities, aptitude and abilities, levels of achievement, levels of social desirability, perceptions of "fraudulence" in the therapeutic role, self-consciousness, and personal self-concept are viewed as integral components (Daniels & Larson, 1998; Larson et al., 1992).

All in all, the facets of personal agency described above, along with their intersection with acquired procedural knowledge, outcome expectancies, goal formation, cognitive and affective processes, and personal appraisal, interact to determine new therapists' abilities to respond to their clientele and to provide psychotherapy effectively. The reciprocal interaction between CSE and these constituents has been observed; new clinicians with higher CSE develop more favorable outcome expectancies, evaluate their skill sets and individual performances more positively, are less distressed by anxious cognitions, perform more favorably in therapeutic interactions, and are more satisfied with their performances in general. Interestingly, those therapists with CSE perceptionss which slightly exceed performance levels have been shown to intervene more effectively than those with lower CSE (Daniels & Larson, 1998; Larson, 1998; Larson et al., 1992). Larson (1998) theorized that those with slightly higher CSE than performance would

likely view therapeutic encounters and outcomes as positive; set manageable and constructive goals; effectively evaluate incoming feedback; view their feelings of anxiety as motivational; and hold more affirmative, productive views of their performances. As a result, their procedural and declarative knowledges would more easily expand, and their performances would subsequently benefit. On the other hand, she warned about the theorized deleterious effects that low CSE beliefs evoke. Trainees with low CSE are likely to view their therapeutic performances as ineffective and to have negative outcome expectancies; to have scattered, abstruse therapeutic goals; to focus on non-pertinent aspects of feedback; and to succumb to overwhelming anxiety (Larson, 1998).

Mechanisms to Increase CSE

Several investigations into trainee's self-efficacy note that overall, the passage of time and advancement in the developmental levels of trainees are associated with self-efficacy gains (Al-Darmarki, 2004; Larson et al., 1992; Leach, Stoltenberg, McNeill, & Eichenfield, 1997). Larson et al. (1992) observed that CSE measurements were highest in those with more years of counseling experience, more advanced professional degrees, and more semesters of supervision. On a more immediate scale, trainees were observed to have gains in self-efficacy merely over the span of their first practicum experience (Larson et al., 1992). Leach and colleagues (1997) observed a positive relationship among the developmental level of psychology trainees, degree of counseling experience, familiarity with particular client presentations, and CSE (Leach, Stoltenberg, McNeill, & Eichenfield, 1997). Experiential-related self-efficacy gains were found to be associated with reductions in anxiety, increased confidence in therapeutic competencies, and comfort in the therapeutic role in the 2007 study by Hill and colleagues. The authors

attributed this to the natural maturation during the learning process (Hill, Sullivan, Knox, & Schlosser, 2007). Correspondingly, Stoltenberg and colleagues indicated that the simple garnering of experience decreases anxiety and increases understanding of the complex therapeutic process. Furthermore, they expressed that the learning process and the passage of time increase therapists' awarenesses of their clientele's experiences and their own desires to perform autonomously (Stoltenberg, McNeill, & Delworth, 1998). Despite these findings, Daniels and Larson (1998) indicated that trainee development and its associated CSE, role clarity, motivation, and relevant affective and cognitive processes may not progress in a linear fashion. Consequently, focus on particular components of psychology students' training programs is instrumental in promoting gains in these areas.

Larson (1998) integrated Bandura's four main experiential sources underpinning the development of self-efficacy into the SCMCT; namely mastery, modeling, social persuasion, and affective arousal. As hypothesized, trainees' cognitive evaluations of these sources largely govern and adjust CSE (Daniels & Larson, 1998; Bandura, 1989; Larson, 1998).

Mastery experiences. As proposed by Bandura, mastery experiences are the most compelling originators of self-efficacy (Bandura, 1977; 1982; 1989). In the case of psychology trainees, mastery experiences include training situations in which they successfully enact target counseling behaviors. Daniels and Larson (1998) emphasized that the ultimate mastery experiences in psychology training programs are interactions with actual clients; however, mastery experiences can also be gained through in-class activities such as role-plays or engagement in simulated sessions (Daniels & Larson, 1998). As a result, it is conceivable that the phenomenon of self-efficacy increasing with

the passage of time is mainly due to the accumulation of mastery experiences gained. Larson (1998) identified several conditions whereby mastery experiences increase CSE. She expressed that the greatest likelihood for CSE gains include situations which foster gradual improvement or perseverance in the face of failures and which ultimately result in improvement. These include therapeutic tasks that bring a moderate level of difficulty for the trainee, effort expenditure, individualized exertion, optimal training conditions, appraisal of successes as a result of effort and failures as a result of insufficient effort, and attention to positive aspects of their performances (Larson, 1998). It is, therefore, suggested that CSE can be elevated by leading supervisees to recognize the mastery components of their training processes, therapeutic encounters, and actions (Daniels & Larson, 2001).

Modeling experiences. Bandura (1977; 1989) indicated that observing modeling of targeted competencies is another effective means of increasing one's self-efficacy perceptions. In the case of therapists' training, modeling opportunities include chances for the trainee to observe a prototype of a successful therapeutic interaction, from discrete microskills to full-length sessions. These experiences may be presented in a number of ways in training. For example, one's supervisor may model particular behaviors, one may view a videotape of counseling interactions, one may observe a live therapy session, or one may view other students role-playing targeted skills. Drawing on Bandura's conditions for effective modeling experiences (1989), Larson indicated that the modeling encounters with the greatest chance of increasing CSE include those in which the targeted competency is slightly above the current skill level of the trainee; the objectives for that competency are clear, representative and relevant to their current therapeutic work, and

diverse in nature; the model completes the task successfully and demonstrates effort in doing so; the model is perceived as similar to themselves; and the trainee recognizes that their skill deficits with respect to the targeted competency are simply due to a lack of knowledge and not to a personal shortcoming. Furthermore, from learning –based and self-efficacy standpoints, it is suggested that modeling may be most helpful early on in training to teach counseling skills, and mastery experiences are most effective after the trainee has observed the desired way to employ these behaviors (Bandura, 1989; Daniels & Larson, 1998; Larson, 1998).

Social persuasion and affective arousal. This final mechanism for promoting CSE in psychology trainees is implemented largely by educators and supervisors. Bandura (1977) described social persuasion as the third most influential mechanism, behind mastery and modeling experiences, respectively. Relating Bandura's theory to the SCMCT, Larson (1998) defined social persuasion as the degree to which supervisors offer constructive, yet supportive, feedback and reinforcement as well as beneficial educational experiences for the trainee. Further drawing from models of social influence, Larson (1998) then elucidated several conditions that affect the degree of CSE gains. The trainee's motivation to accept the supervisor's message, how the trainee processes and interprets that message, the reliability and relevance of the feedback, the credibility of both the supervisor and his or her feedback, the skill level of the supervisor in the targeted behaviors he or she is appraising, the trainee's understanding of the task at hand, the supervisor/supervisee relationship, and the degree to which the feedback is pro-attitudinal all affect CSE. Larson highlighted the importance of feedback from both a self-efficacy and a training standpoint. In the learning of such a complex and ambiguous

skill as psychotherapy, feedback allows the trainee to recognize the most relevant aspects of training for therapeutic success. The supervisor's selective attention to particular details shapes the trainee's view of what effective psychotherapy is. Feedback also allows the trainee to recognize which interactions were integral mastery experiences holding the greatest implications for learning (Larson, 1998). Furthermore, as mentioned earlier, the supervisor's feedback is viewed as particularly salient, given the supervisor's expert position in the trainer/trainee relationship. During the rather ambiguous and anxiety-provoking time period of introductory psychotherapy training, new clinicians tend to rely most heavily on the supervisor's influence (e.g., Grater, 1985; Daniels & Larson, 2001; Hogan, 1964; Lee, Eppler, Kendal, & Latty, 2001). Feedback from supervisors, then, is paramount in shaping personal efficacy beliefs for these new skills.

Daniels and Larson (2001) set out to determine the particular effects of positive versus negative feedback on trainee's CSE in an experimental investigation. Negative evaluations, whether warranted or not relative to trainee performance during a simulated session, served to increase students' anxiety levels as measured by the State-Trait Anxiety Inventory and to decrease scores on the Counseling Self-Estimate Inventory. The authors theorized that trainees receiving negative feedback interpreted their simulated encounters as failure experiences, thereby decreasing self-efficacy levels and increasing their overall anxiety. However, those receiving positive feedback translated their performances as reflecting a degree of mastery and experienced subsequent lowering of anxiety and associated gains in CSE. Therefore, considering that suggestions of improvement are a necessary component for learning to occur, the supervisor must

balance the valence of such feedback with a degree of constructiveness (Daniels & Larson, 2001).

Training of Beginning Psychotherapists

Truax and Carkhuff (1967) are credited with implementing a paradigm shift in the training of beginning psychotherapists. Prior to their work, training programs focused primarily upon conceptual skills and theoretical content ideas. These early training programs were based on Rogerian client-centered therapy, a relationship-based approach in which effective therapy stemmed from facilitative conditions brought about by the therapist's relational skills. However, these specific skills were not delineated; indeed, it was believed that the skills were part of a general, abstract attitude, which could not easily be conveyed (Hill & Lent, 2006; Moreland, Ivey, & Phillips, 1973; Ridley, Kelly, & Mollen, 2011; Truax & Carkhuff, 1967). Truax and Carkhuff recognized two main approaches to trainee education - a didactic-intellectual method in which theories were imparted using a top-down mode and a relationship-oriented approach in which students engaged in self-exploration in a supportive student/teacher bond. In these approaches, students were introduced to the idealized therapist variables of warmth, empathy, and the like but were not instructed in specific behaviors to bring these variables about. The authors began to conceptualize behaviors necessary for therapeutic interaction only in the areas of genuineness, warmth, and empathy. In a seminal practice, they utilized role-play to teach these skills and provided performance feedback to trainees in a safe learning environment. After engaging in training, the students then were able to conduct sessions with actual clients. These sessions were then recorded and reviewed with supervisors (Truax & Carkhuff, 1967).

Ivey and colleagues (1968; 1971) began to build upon Truax and Carkhuff's model, with the ultimate goal of translating theory into practice. Ivey's pivotal work introduced the microcounseling prototype, which continues to be the predominant mechanism for training new therapists over four decades since its conception (Hill & Lent, 2006; Ivey, 1971; Ivey, Normington, Miller, Morrill, & Haase, 1968; Ridley, Kelly, & Mollen, 2011). Ivey's work was based on the belief that the overwhelmingly complex practice of therapeutic interviewing can be broken down for training. Interviewer behaviors were now operationally defined and could be concretely described, monitored, and recorded (Moreland, Ivey, & Phillips, 1973). Such skills included attending behaviors, open-ended questioning, paraphrases, reflection statements, and summarizations. Ivey also presented skills in a fashion ranging from the most fundamental (e.g., attending behaviors) to the complex (reflection). Trainees mastered one skill at a time through verbal instruction and description, observational learning (modeling), practice, receiving supervisory feedback and reinforcement, and, finally, through simulations of the training environment (e.g., role-playing). Ivey also utilized a baseline interview from which comparisons of progress were made and tracked throughout development. Skills were eventually integrated, facilitating the eventual formation of students' personal interviewing styles. The microcounseling approach afforded students a training protocol whereby they could effectively internalize interviewing behaviors in a relatively short period of time. The program is touted as the most clearly delimited, effective, and cost-efficient method for the training of psychotherapists. Furthermore, through its close approximation to Bandura's (1977) Social Learning Theory, Ivey expressed the belief that his program facilitated trainees'

self-efficacy in their counseling abilities through a safe, experiential environment (Baker & Daniels, 1989; Bandura, 1977; Hill & Lent, 2006; Ivey, 1971; Ivey, Normington, Miller, Morrill, & Haase, 1968).

Several studies have been compiled on the effectiveness of this training method on graduate students' acquisitions of therapeutic skills. In a meta-analytic study analyzing 23 experiments, an effect size of .63 was observed for microcounseling protocols as compared to no-treatment or active control conditions (Baker, Daniels, & Greeley, 1990). Its effectiveness has been recognized in its use with novice therapists, employing only the most fundamental microcounseling skills in a limited time period, and the generalizability to actual therapy sessions is unknown (Ridley, Kelly, & Mollen, 2011). Microcounseling, then, has been described as a best-fit practice to this group of beginners, as it utilizes a structured, educator-guided process which focuses on discrete skills (Hill & Lent, 2006).

The Clinical Competency Movement

Another paradigm shift in the training of mental health professionals has evolved, echoing long-standing models of training found in health care professions such as dentistry and medicine (Hatcher et al., 2013a; Rodolfo et al., 2013). Increasingly, the American Psychological Association (APA), the National Association of School Psychologists (NASP), the American Counseling Association (ACA), other graduate credentialing bodies, and departments of education have required that graduate educators demonstrate evidence that their students exhibit competency in the skill sets that they teach (e.g., American Counseling Association, 2005; Kaslow et al., 2004; National Association of School Psychologists, 2006). Epstein and Hundert (2002) comprehensively defined clinical competency as the "habitual and judicious use of

communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served" (Epstein & Hundert, 2002, p. 226). In 2004, Nadine Kaslow, one of the leaders in the psychological clinical competency movement, expanded upon this definition, outlining competence as the individual's "demonstrated ability to understand and to engage in specific tasks in a manner consistent with the expectations for training in a specific profession" (Kaslow et al., 2004, p. 775).

Competency-based education programs strive to delineate specific competency goals and training outcomes, to design curriculum and training experiences that will ensure that these goals and outcomes are met, and to include overt instruction in developmentally-appropriate competencies throughout the training program. In a dynamic process, curriculum and learning opportunities are constantly shaped in response to continuous assessment of student competency advancement and overall outcomes (Hatcher et al., 2013a). Through competency-based education, students' learning experiences are more streamlined and effective. Assessment of competence facilitates learning overall and serves as a benchmark for evaluating personal progress. This learning approach also promotes swifter recognition of students' individualized needs, development of customized learning plans, and the opportunity for earlier remediation if competency attainment is lagging (Hatcher et al., 2013a; Kaslow et al., 2007).

Focus on competency attainment in psychological training moves the profession forward and, most importantly, protects the public by ensuring service from proficient psychologists. Ensuring that students achieve competency in graduate psychology is demanded by consumers, licensing bodies, and policymakers. Delineation, continual

assessment, and regulation of competency attainment promote public accountability and credibility (Hatcher et al., 2013a; Kaslow et al., 2007; Rodolfo et al., 2013).

History of the clinical competency movement. Although the competency movement has gained considerable force in recent years, it was believed that simple completion of a doctoral degree in psychology provided clinicians with the necessary tools for competent practice. Correspondingly, attention focused upon standardization of training programs to promote competency. As accreditation standards were founded, focus turned towards competency-based models to evaluate students' progression through those programs (Kaslow et al., 2007; Rodolfo et al., 2013). The first model to delineate competencies for psychological education was created in 1986 by the National Council of Schools and Programs in Professional Psychology (NCSPP; Fouad et al., 2009; Hatcher et al., 2013; Kaslow, 2004; Kaslow et al., 2009). The model listed six main competency areas - namely relationship, assessment, intervention, research and evaluation, consultation and education, and management and supervision. These areas were based upon fundamental scientific knowledge and upon standards and ethics central to the practice of psychology. Furthermore, the NCSPP identified a number of cross-cutting competencies which permeate the six core areas (e.g., diversity). Curricula designed to bring about these competencies were subsequently designed (Fouad et al., 2009; Kaslow et al., 2007). The NCSPP conference demarcated a shift from an emphasis upon the simple gathering of knowledge in subject areas to identifying essential competencies as the ultimate goal of psychological education (Kaslow et al., 2007; Peterson, Peterson, Abrams, & Stricker, 1997). Based upon this conference, the APA's Committee on Accreditation and Association of Psychology Postdoctoral and Internship Centers revised

its guidelines for training programs. All educational bodies were then required to identify program-specific training objectives designed to meet the clinical competencies congruent with the program's training model. From then on, the accreditation of educational programs in psychology has been based upon the program's ability to demonstrate its students' clinical competency development (Fouad et al., 2009; Kaslow, 2004).

The APA furthered its competency-based agenda with the 2002 "Competencies Conference: Future Directions in Education and Credentialing in Professional Psychology." In an effort to streamline the psychological competency movement by coordinating training criteria with other areas of health care, the workgroup founded its agenda upon standards set by the Accreditation Council for Graduate Medical Education and the American Board of Medical Specialties Toolbox of Assessment Methods. Furthermore, they drew from standards set from psychiatry in the outlining, education, and assessment of psychiatric competencies (Kaslow et al., 2009). This conference brought about an amalgamation of various educational and training groups, of credentialing bodies, and of ethnic minority psychology establishments, all from several different countries and succeeded in the further elucidation of eight core clinical competencies, as well as their education, training, and assessment. Here, two main groups of aptitudes were delineated: six "core foundational" competencies (overarching all professional undertakings; e.g., ethical behavior) and six "functional" competencies (required for specific professional activities; e.g., assessment and supervision) (Hatcher et al, 2013b). These were integrated into what became known as the "cube model," depicting the intersection of all clinical competencies subsumed within the foundational

and functional categories. The model also took into account trainees' developmental stages in the articulation of competencies (Rodolfo et al., 2005). The Assessment of Competencies Benchmarks Work Group was subsequently formed. Expanding on the cube model, the group delineated competencies for three main points within psychologists' training - readiness for practicum, internship, and entry into practice. Behavioral anchors were developed to aid in assessment of these competencies (Hatcher et al., 2013b).

Next, the Work Group disseminated a listing of 15 core competencies essential for psychology training within the 2009 Competency Benchmarks publication. The core foundational competencies included Professionalism, Reflective Practice, Scientific Knowledge and Methods, Relationships, Individual and Cultural Diversity, Ethical and Legal Standards and Policy, and Interdisciplinary Systems. The functional competencies included Assessment, Intervention, Consultation, Research/Evaluation, Supervision, Teaching, Administration, and Advocacy. The Benchmarks document also identified essential components for each competency as well as additional behavioral anchors to aid in competency identification. Within those anchors, a myriad of essential micro-counseling skills were identified, including such variables as the ability to establish rapport, to convey empathy, and to utilize appropriate verbal and nonverbal communication skills (Fouad et al., 2009; Hatcher et al., 2013b; Kaslow, 2004; Kaslow et al., 2004; Kaslow et al., 2007). The APA later streamlined the competency benchmarks into six primary areas - professionalism, relational, application, science, education, and systems. The reorganization is depicted in Table 1.

Table 1

Competencies Benchmarks: Original and New Design

Original Benchmarks (2009)	New Benchmarks Design (2011)
Foundational Competencies	Foundational Competencies
1. Professionalism	I. Professionalism
2. Reflective practice/Self assessment/Self-care	1. Professional values and attitudes
3. Scientific knowledge and methods	2. Individual and cultural diversity
4. Relationships	3. Ethical legal standards and policy
5. Individual and cultural diversity	4. Reflective practice/Self assessment/Self-care
6. Ethical legal standards and policy	II. Relational
7. Interdisciplinary systems	1. Relationships
	III. Science
	1. Scientific knowledge and methods
	2. Research/evaluation
Functional Competencies	Functional Competencies
8. Assessment	IV. Application
9. Intervention	1. Evidence-based practice
10. Consultation	2. Assessment
11. Research/Evaluation	3. Intervention
12. Supervision	4. Consultation
13. Teaching	V. Education
14. Management-administration	1. Teaching
15. Advocacy	2. Supervision
	VI. Systems
	1. Interdisciplinary systems
	2. Management-administration
	3. Advocacy

Note: Adapted from "Competency Benchmarks: Practical Steps Towards a Culture of Competence," by R. L. Hatcher, N. A. Fouad, C. L. Grus, L. F. Campbell, S. R. McCutcheon, and K. L. Leahy, 2013, *Training and Education in Professional Psychology, 7*(2), p. 86. Copyright 2013 by the American Psychological Association.

Best Practices for Building Competency in Training

The Competency Task Force recognized the need to link the essential skill sets subsumed within the core competencies with the best educational, experiential, and assessment-based practices for competency development (Fouad et al., 2009). The Competency Assessment Toolkit for Professional Psychology detailed a number of mechanisms by which competency attainment may be demonstrated. Such multitrait-multimethod approaches included 360-degree evaluations, annual/rotation performance

reviews, case presentation reviews, client/patient process and outcome data, competency evaluation rating forms, consumer surveys, live or recorded performance ratings, Objective Structured Clinical Examinations, portfolios, record reviews, self-assessments, structured oral examinations, and written examinations. The authors also listed two experiential-based means by which to gain clinical competency - role-playing and the use of simulated patients in training. Furthermore, they emphasized the potential of these methods in the assessment of burgeoning competencies (Kaslow et al., 2009).

Competency Evaluation Rating Forms (CERFs). Kaslow and colleagues (2009) define CERFs as documents which list specific behavioral anchors to assess targeted competencies. Individuals are rated on a Likert-type scale with regard to these anchors. This allows for trainees to be evaluated on a continuum for easy comparison to others and for tracking development over time (Kaslow et al., 2009). Members of the Work Group soon recognized that the Competency Benchmarks document was not easily translated by training programs into an evaluative tool, due both to its size and complexity (DeMers, 2009; Hatcher et al., 2013b). This led to the re-organization of the Competency Benchmarks as depicted in Table 1, to elimination of unnecessary language, and to using mutually-agreed upon terms throughout the document. The behavioral anchors were then simplified, further operationalized, updated, and then removed from the actual body of the document for a more streamlined appearance. A Likert-type scale was developed in which raters are asked to pair the trainee's behavior with the identified competency ("Not at All/Slightly," "Somewhat," "Moderately," "Mostly," and "Very"). This method facilitates objectivity, in contrast with asking raters to place the trainee on a particular continuum (e.g., "ready for practicum") or to make a judgment on their

development (e.g. “meets expectations). Furthermore, the group included space for qualitative feedback on performance within the document (Hatcher et al., 2013b). Several authors recognized the importance of tailoring the document to particular training programs, practice sites, populations, and presentations (e.g., DeMers, 2009, Hatcher & Lassiter, 2007; Hatcher et al., 2013b; Schaffer, Rodolfa, Hatcher, & Fouad, 2013). Hatcher and colleagues (2013) proposed four steps to aid in this process - “1. Choose clusters consistent with training goals and objectives, 2. Choose competencies and essential components within each cluster, 3. Choose or modify behavioral anchors (examples) from the Appendix to match the selected competencies, and 4. Decide on standards for each competency” (Hatcher et al., 2013b, p. 88).

Kaslow and colleagues (2009) recognized that CERFs, as concrete indices of students’ progress, provide for a means of assessing competency with high face, construct, content, and discriminant validity. However, they also acknowledged the great difficulty with operationalizing such complex behavior as depicted in each competency domain. Furthermore, they stressed the need for extensive training in use of the measure to reach consensus on clinical competency acquisition (Kaslow et al., 2009).

Role-plays. This experiential technique entails portrayal of a particular character presentation or situation in order to acquire a new skill and to enable comprehension of educational concepts (Kaslow et al., 2009; Poorman, 2002). Role-plays offer the opportunity for instructors to illustrate techniques and concepts which may be difficult to communicate verbally (Berg, 1978). Ments (1999) defines role-play as “the experiencing of a problem under an unfamiliar set of constraints in order that one’s own ideas may emerge and one’s understanding increase” (Ments, p. 9). In psychological role-playing,

these characters include consultants; supervisors; instructors; students; and, most frequently, therapists and clients (Kaslow et al., 2009; Poorman, 2002). In the classroom, the instructor identifies the particular clinical competencies that are to be exercised. The issues, involvedness, and duration of the exercise are determined, and a scenario is subsequently formed (Kaslow et al., 2009). The instructor provides his or her students with a vignette which includes the context and the parameters of the situation. General role descriptions are also provided, although the level of detail and directive varies by instructor (Ments, 1999). Additionally, the method of assessment and student feedback mechanism to be used is determined and described (Kaslow et al., 2009).

Performance feedback is a central strength of role-playing and provides for a powerful and motivating learning experience. Instructors can stop the interaction at any point to provide observations and guidance. Instructors, therefore, have the opportunity to justify their suggestions based on concrete performance indicators. Students, too, are able to provide rationalizations for their approaches (Berg, 1978). Furthermore, students receive insight into how their approaches and communication styles affect others as the model therapist receives feedback from his or her 'client.' This feedback helps to shape the neophyte therapists' vocabulary and mechanism for therapeutic expression (Berg, 1978; Tolen & Lendrum, 1995). The student is able to simulate his or her role as a therapist and to become more aware of the nuances that the role brings. The student is also introduced to the cognitive processes and the intellectual and emotional reactions that the role evokes. Perhaps more importantly, the student gains a degree of empathy for future clientele.

Portrayal of the client role entails direct perspective-taking. Students begin to recognize the emotionality and vulnerability that their clients may experience. As a result, they become better able to recognize those indicators in others and are able to mirror them back to the client (Ments, 1999; Poorman, 2002). Furthermore, it has been suggested that students are able to approximate client symptomatology closely, given their academic knowledge of diagnostic criteria and associated clinical presentations. Consequently, role-play has been found to be a valid method of enhancing skill development, provided that the simulations approximate a true therapeutic encounter (Berg, 1978; Kaslow et al., 2009; Larson et al., 1999; Tolen & Lendrum, 1995).

It is further recognized that role-playing provides a sense of mastery. Based on the relative ambiguity of the role-played scenario as it develops, the student must improvise and call upon inner resources, learning, and personal experience. Successful coping with uncertainty leads to a particularly meaningful learning experience, as well as increased self-efficacy (Bandura, 1989; Larson, 1998; Ments, 1999). As such, role-play has become an easy to implement, cost-effective, and accepted standard of psychology training (e.g., Baker, Daniels, & Greeley, 1990; Ivey, 1971; Larson, 1998; Larson et al., 1999).

Caveats to role-play. Despite its widespread use, the practice of role-play in psychology training is not without its shortcomings. While its flexibility in implementation can be considered a strength of the approach, role-play scenarios are spontaneous; evolving; and, therefore, variable. As a consequence, the validity, the generalizability, and the replicability of role-play have been difficult to assess, both in the classroom and in research settings (Beutler & Howard, 2003; Kaslow et al., 2009). Although students may have an academic knowledge of the disorders and of the client

presentations to be portrayed as stated earlier, they may not be able to portray an actual client adequately and believably. In addition, the artificial nature of the exercise may preclude the students from portraying genuine emotion, or even from having an investment in the learning experience (Kaslow et al., 2009). It is conceivable that psychology trainees are far more invested in studying the clinician role and that they may not take their portrayal of the client in earnest (Pomerantz, 2003). Beutler and Howard (2003) expressed that role-play exercises are unlikely to inspire characterizations that are effortful, believable, or accurate. Because of this, the consequential portrayals are often of varying quality and have low internal and external validity (Beutler & Howard, 2003). Furthermore, oftentimes students role-play with classmates whom they know personally. In cases of pre-existing relationships, it is conceivably more difficult to adopt new identities. Interaction with one's peers often detracts from objectivity as well as from taking the exercise seriously (Pomerantz, 2003). In the same vein, the student may not be able to portray a 'non-expert' client when interacting with their peers. The 'client' may unknowingly prompt the interviewer as they progress through an idealized clinical interaction. The 'client' may also wish to assist the interviewer in his or her performance and consequently volunteer unsolicited information (Adamo, 2003). Furthermore, it is unlikely that novice trainees have the knowledge to portray or to respond to clients or situations deemed high-risk. Patient behaviors and scenarios such as suicide gestures, abuse victimization, violence, seduction, and intoxication are among just a few of those situations difficult to portray in artificial role-plays. These scenarios would be best enhanced by utilizing an environment that is both safe for 'student' and 'client,' yet realistic in nature (Beutler & Howard, 2003).

Hill and Lent (2006) further suggested that trainees may be able to utilize their skills competently with rudimentary client presentations and straightforward situations, but they will likely experience difficulty with more complex scenarios. Extended experience with more sophisticated training protocols is needed to allow trainees successfully to apply their skill set and to manage their anxiety (Hill & Lent, 2006). Borrowing from social-cognitive theory (Bandura, 1982), Larson et al. (1999) called to mind human beings' reliance on the predictability and controllability of the environment for cues about their own self-efficacy. Specifically in psychology training, she suggested that trainees are best able to learn and to retain new skills when educational opportunities are viewed as manageable. Furthermore, the extent to which the student is able to anticipate likely scenarios serves to enhance the retention of knowledge as well as to increase CSE (Larson et al., 1999).

Simulated patients (SPs). One such educational strategy is the use of simulated patients. SPs are defined as actors (lay people, professional actors, or volunteers) specifically trained to simulate clinical presentations with specific symptoms across various clinical domains. SPs are trained to replicate the behavioral symptomatology and affect associated with a specific diagnosis for educational purposes. Learners then perform assigned tasks with the SPs such as interviewing, diagnosing, or enacting an intervention as if they were relating to actual clients or patients in a clinical setting (Barrows, 1968; 1993; Kaslow et al., 2009; Wallace, Rao, & Haslam, 2002). Consistency of portrayals is facilitated by carefully designed and detailed scripts. Furthermore, performance checklists are designed to limit deviations from the script (Cantrell & Deloney, 2007). However, as highlighted by DeMers (2009), this standardization must be

balanced with the scenario's (and character's) approximation of actual clinical experiences (DeMers, 2009). It is concluded that if trained properly, an SP should be indistinguishable from an actual patient by practiced clinicians (Norman et al., 1982). A review of the literature indicated that detection rates of SPs in clinical settings were as low as 0-18% (Beullens, Rethans, Goedheys, & Buntinx, 1997).

At least 80% of medical schools in the United States currently use SPs for training and evaluation purposes (Perera, Perera, Abdullah, & Lee, 2009). SPs are used in a wide variety of fields, including medicine, nursing, social work, dentistry, pharmacy, psychiatry, aviation, crisis responding, and the military, among several others (Cleland, Abe, & Rethans, 2009; Linsk & Tunney, 1997; Wallace, Rao, & Haslam, 2002). Furthermore, SPs are now beginning to be introduced into psychology and counseling training programs in various capacities (Roberts, Bordes, Christiansen, & Lopez, 2005).

In 1991, the Association of Standardized Patients was formed in response to the field's sudden boom. This association, now primarily web-based, set out to create a core curriculum and standards of practice for SP educators and program directors. Modules of education include "Foundations of Methodology," "Case and Checklist Development," "Recruitment and Training of Standardized Patients," "Using Standardized Patients for Instruction," "Assessment," "Administering a Standardized Patient Program," "Basics of Research and Scholarship," and "Special Topics" (Association of Standardized Patient Educators, 2014). Conferences, workshops, webinars, and electronic newsletters disseminate this knowledge throughout the year. The organization also promotes standards for SP use, disseminates validated SP cases, provides guidelines for the ethical use of SPs, lists postings for SP recruitment, promotes collaboration between

organizations, and allows for the sharing of practices and resources among educators (Adamo, 2003; Association of Standardized Patient Educators, 2014).

Since the initiation of their use in 1963, the utility of SPs has been well-established within the literature. They have been used to teach diagnostic skills, to evaluate students' clinical competencies, to enhance communication skills, to provide training in ethical conundrums, to introduce students to difficult patients, and to provide institutions with feedback on their training efficacy (Barrow, 1993; Cantrell & Deloney, 2007; Cleland, Abe, & Rethans, 2009; Howley, 2004; Klamen & Yudkowsky, 2002; Wallace, Rao, & Haslam, 2002). SPs are often utilized within Objective Structured Clinical Examinations (OSCEs), a common evaluation mechanism used throughout medical education. OSCEs are now a part of medical licensing evaluations in North America, Canada, Australia, the United Kingdom, and New Zealand and are now increasingly used within several health care disciplines (Miller, 2010). These exams consist of several stations in which different clinical scenarios are portrayed that target particular skill sets. Students are evaluated both upon particular components of competencies and broad, overarching foundational and functional competencies. Examiners rate students' competency within these skill sets using instruments such as checklists; Likert-type rating scales; and open-ended, qualitative feedback (Adamo, 2003; Kaslow et al., 2009). As cited in Kaslow et al. (2009), the psychometrics of the OSCEs have been well-established, with good inter-rater, inter-station, and split-half reliability; good generalizability; strong content, construct, and concurrent validity; and a high degree of fidelity (Kaslow et al., 2009, p. S37).

Whether utilized in education or in assessment, SPs can be trained to portray a wide variety of patient presentations predictably. SPs themselves can also be trained to evaluate students and to give detailed feedback on their performances during interactions, giving students the unique opportunity to receive patient feedback *in vivo* (Cleland, Abe, & Rethans, 2009). The SP is thus prepared to be used as a teaching and assessment tool. Much like in the use of role-play, the instructor is able to "pause" the procedure and to provide feedback or suggestions. However, during this time, the SP remains in character and pretends to have no awareness of what is happening in the room. The instructor and students can discuss their own thought processes, hypothesize what the patient may be thinking, plan future actions, reflect on interpersonal skills, and consider a myriad of other things that they would be unable to discuss in front of an actual patient. After the didactics are complete, the interaction continues from where the student and the SP left off. SPs can also be used over time. Sufficient detail can be added to the case (e.g., life events, symptomatology) and further scenarios can be scripted to follow the student's continued learning. Interactions can, therefore, simulate exchanges at any time during the patient's progress (Barrows, 1993; Cleland, Abe, & Rethans, 2009).

SP methodology. SP scenarios must be meticulously drawn out with a significant amount of detail. Authenticity is of utmost importance when creating a successful simulation to promote both student engagement in the exercise and generalization of learning experiences to the real world. Ideally, scenarios should be created for all skill levels; furthermore, they should allow for a variety of student questioning and responses. It is also recommended that scenarios be complex enough to allow students to demonstrate multiple competencies at various times. Correspondingly, the educational

needs of each student must be clarified and understood, taking the trainee's developmental level into account. The measures used to evaluate acquisition of these skills and to give feedback to the trainee should be ascertained. It is recommended that cases be designed to meet training needs. 'Critical' events must be included which lead to the desired behaviors. Careful storyboarding should, therefore, allow for standardization of portrayals and for control over how and when competencies will be demonstrated (Salas, Wilson, Burke, & Priest, 2005). With regard to character development, one should include sufficient detail of the client/patient to be portrayed, considering their pseudonym, age, language spoken and /or accent, gender, body type, race and ethnicity, physical presentation (e.g., posture, scars, physical gate, etc.), and education level, among others. The presenting problem should be described, and a circumscribed history leading to the encounter should be detailed (Adamo, 2003; Cantrell & Deloney, 2007).

One must judiciously select SPs to portray these roles. SPs are recruited by a number of methods, most frequently by postings and advertisements. Usually, advertisements indicate that no medical or acting experience is necessary; however, some institutions prefer to target students or amateur actors (Cleland, Abe, & Rethans, 2009; Collins & Hardin, 1998). SPs must be chosen to fit the demographic variables detailed above. Furthermore, with regard to their suitability for employment, several authors suggest that one should determine the SPs' scheduling availability, reliability when showing for trainings and events, ability to integrate trainers' feedback into their performance, demonstrated ability to provide feedback for students, general comfort with emotionality, proclivity for affective portrayal, and ability to sustain emotionality throughout an entire interaction before they are hired (Adamo, 2003; Cleland, Abe, &

Rethans, 2009). McNaughton and colleagues (2008) express the importance of SP's flexibility and personal reflection, not only upon the role the SP is portraying but upon his or her own emotive reactions to the narrative (McNaughton, Ravitz, Wadell, & Hodges, 2008).

In training, SPs are walked through the storyline, and any questions they may have regarding facets of the case are answered. It is suggested that a detailed checklist containing the most important highlights of the case be constructed and used throughout training. This ensures that the SP recognizes the essentials of his or her presentation and also prevents the SP from straying from the script. SPs are not only to portray the symptomatology and detailed stories of the client consistently, but also their attitudes and nonverbal responses must be reliable (Cleland, Abe, & Rethans, 2009; Salas, Wilson, Burke, & Priest, 2005). Importantly, Brenner (2009) advocated that the SP must be carefully trained to convey emotion convincingly so that he or she is able evoke empathy in the interviewer (Brenner, 2009).

The SP is instructed never to interrupt a student nor to offer any information unless questioned. Authors also suggest that trainers include potential questions students may pose as well as scripted answers for the SP to give in an effort to standardize presentation. The SP also practices the encounter several times to ensure accuracy (Cantrell & Deloney, 2007; Cleland, Abe, & Rethans, 2009). For enhanced modeling, some training methods suggest that the SP view video recordings of interactions or conditions similar to those that they will simulate (Allen, Evans, Foulkes, & French, 1998). After sufficient practice, the checklist can then be used to determine the proportion of clinical features correctly portrayed in the encounter. Furthermore, the SPs

must be trained to track student behaviors and to give feedback. Clear guidelines and working knowledge of the competencies of interest must be imparted, as well as the competencies expected of students at each educational stage (Cleland, Abe, & Rethans, 2009).

Barrows (1993) suggested that SPs can be adequately prepared for a particular case in only two to three hours; however, the training period typically varies by institution. It is recommended that the SP undergo evaluation during repeated encounters to determine the fidelity of his or her performance (Adamo, 2003; Barrows, 1993). Also, feedback both from students and from faculty members regarding the SPs' performances is used to improve their work (Perera, Perera, Abdullah, & Lee, 2009; Salas, Wilson, Burke, & Priest, 2005). Relatedly, experts suggest that individual SPs be used repeatedly in an effort to maintain performance quality as well as the SP's interest and enthusiasm (Cleland, Abe, & Rethans, 2009).

Strengths of SP usage. The utilization of SPs offers several of the same benefits as role-play (e.g., practicing and learning of skill sets in a safe learning environment, introduction to the cognitions and emotions common to students' eventual roles, opportunities for feedback, provision for direct assessment of competencies). However, with SPs, real clinical situations can be closely replicated. Impartial actors outside of students' education cohorts are employed; consequently, these educational sessions provide for greater verisimilitude than role-play exercises (Kaslow et al., 2009; Linsk & Tunney, 1997; McNaughton, Ravitz, Wadell, & Hodges, 2008). Furthermore, these interactions can take place in the actual clinical settings in which students will eventually work. They provide for assessment of an all-encompassing range of skills in an integrated

manner with situations of varying difficulty and complexity, including "extreme" behaviors (e.g., hostility, aggression). Although lifelike, the safe, controlled environment allows students freely to attempt learned techniques and to engage in problem-solving without harm to an actual patient or client (Leigh et al., 2007; McNaughton, Ravitz, Wadell, & Hodges, 2008; Muse & McManus, 2013). Interactions with SPs also provide the opportunity for reflective practice in this clinically authentic, yet educational, environment. In real-time, the student is able to reflect upon his or her thought processes, decision-making, and intervention implementation with the SP, instructors, and classmates, if present (Linsk & Tunney, 1997).

Validity and reliability have been hailed as the primary strengths of the SP approach. Simulations promote high construct validity. Therefore, use of SPs enhances the fidelity of competency assessments. This evaluation mechanism allows educators the opportunity to observe students' knowledge and skill sets in action while in a closely-replicated clinical situation. These scores are also reproducible. Furthermore, in regard to competency acquisition, the SP is able to present in a way which targets desired skills. The standardization of cases also allows for direct comparison to other students in both formative and summative evaluations (Kaslow et al., 2009; Linsk & Tunney, 1997). Perhaps most importantly, the high external validity of simulations facilitates the transfer of clinicians' skills to real-world environments. It is suggested that trainees who experience simulated sessions develop a more accurate 'template' of what to expect during real encounters and better internalize appropriate responses to similar events which may occur in actual practice. This promotes a greater sense of preparedness and confidence as well as quicker decision-making (Salas, Wilson, Burke, & Priest, 2005). As

such, the use of SPs has been consistently found to minimize trainee anxiety and to increase self-efficacy (e.g., Barrow, 1993; Cantrell & Deloney, 2007; Kaslow et al., 2009; Klamen & Yudkowsky, 2002; Linsk & Tunney, 1997).

Caveats to SP use. Although sparse, drawbacks to SP usage have been identified. The utilization of SPs is labor-intensive and costly. In 2003, the average salary for SPs was $15/hour spent on training, travel, and performances, and current estimates are as high as $20/hour (Association of Standardized Patient Educators, 2014). Certified trainers are also compensated. Furthermore, it is suggested that multiple SPs be trained on a particular case in the event of an emergency, adding to the budget. Careful planning (e.g., utilizing a case multiple times to reduce training costs) and scheduling (e.g., having the SPs interact with several students in a shorter amount of time) is recommended. Substantial training demands exist in the preparation of assessors for the simulations and in the use of instruments to evaluate student achievement. There is also a noticeable lack of training standardization across institutions. Relatedly, questions of SP consistency remain. It is further recognized that a high number of SP cases should be developed by each particular training program to ensure sufficient reliability and diversity, adding to program costs (Adamo, 2003; Leigh et al., 2007; Kaslow et al., 2009). Furthermore, authors warn that clinical scenarios and presentations may be over-simplified when developing and scripting cases in this training approach (Sharpless & Barber, 2009), as some complex presentations are difficult to simulate (Hodges et al., 1997). Finally, it is argued that the short length of traditional SP interactions precludes content validity, as typical intake interviews within the mental health field average 50 minutes (Hodges et al., 1997).

Use of SPs in psychology. Despite the aforementioned concerns, overall, interaction with SPs has been found to be comparable with real patients and settings; to provide a standardized learning experience which allows for direct comparison of students' performances; and to allow for objective, constructive feedback to students. Although rarely seen in the training of psychologists, standardized patients offer numerous benefits specific to the profession. This approach to training provides even those students who are not yet working clinically with realistic scenarios to practice clinical skills and to evaluate ethical dilemmas (Levitov, Fall, & Jennings, 1999; Muse & McManus, 2013). Students are presented with anxiety-provoking situations which are likely to occur in a therapeutic setting, such as conducting a suicide assessment or determining the appropriateness of abuse reporting. Experiencing these scenarios with SPs provides the opportunity for clinical training without the risk of harm to a client; may potentially reduce the later, actual risk of possible harm to clients; and provides training experiences that are more consistent with actual patient encounters than role-play alone. Another recognized benefit of using SPs in psychology is the enhanced exposure to different client presentations and psychopathology than are typically available during first practica or clinical rotations (Brenner, 2009). Use of SPs bypasses the practical considerations of practice-based assessments, such as informed consent and patient confidentiality concerns (Muse & McManus, 2013). Additionally, videotaping clinical interactions with SPs is a common practice. This provides the rare opportunity for students to view both parties' behaviors while in session. Oftentimes, clinical situations do not allow for video recording, and/or clients are reluctant to consent to recording (Klamen & Yudkowsky, 2002). Furthermore, although documented use of SPs in the

psychological literature is sparse, Fairburn and Cooper (2011) proposed that SP usage provides for the most sensitive, focused, and practical mechanism of the practice and assessment of clinical intervention skills, considering the aforementioned benefits of this approach (Fairburn & Cooper, 2011).

In related mental health-based fields, use of SPs has been well-received. In a number of studies examining the use of SPs in psychiatry, students consistently praise the SPs' clear presentations of symptoms, their wide range of symptomatology, their directness in responses to student questions, and their emphasis on symptoms rather than treatment issues (although those are recognized as an important part of the educative process) (Brenner, 2009). Furthermore, they found that the opportunity to receive direct feedback from the SPs on their communicative style was quite beneficial. They also appreciated the value of using SPs as a bridge between classwork and actual interaction with clients and expressed feeling better prepared for clinical contact as a result. The use of simulated patients, therefore, offers an excellent transition to actual practicum experience (Barrow, 1993; Brenner, 2009). Moreover, many psychiatry programs are now implementing the OSCE as a training tool and a licensing requirement (e.g., Wallace, Rao, & Haslam, 2002).

Usage of simulated counseling sessions first appeared in the mental health literature nearly 50 years ago as a way of examining the impact of various simulated clients' conduct and characteristics upon therapists' behaviors (Munley, 1974). Use soon extended to research upon targeted therapeutic skills, such as verbal and non-verbal behaviors, problem-solving, confrontation, suicide assessment, and empathy, using both live and videotaped simulated sessions (*c.f.,* Berven, 1985; Cross, Matthieu, DeQuincy, &

Knox, 2010; Davis et al., 1985; DeViva, 2006; Hess et al., 2006). DeViva (2006) noted that participants' feedback regarding actors' portrayals of resistant clients was consistently positive - namely, that the portrayals were quite realistic. Fidelity checks also ensured consistency with written scenarios (DeViva, 2006). As recognition of the utility of SPs in the assessment of these clinical skills is growing, several researchers have advocated for the introduction of the OSCE in mental health training to evaluate learners' progress (e.g., Cramer, Johnson, McLaughlin, Rausch, & Conroy, 2013; Kaslow et al., 2009; Miller, 2010).

It has been highly recommended that SPs be used in the training of clinical competencies specific to particular interventions and theoretical orientations in the field of mental health. Researchers have suggested that particular case presentations could be selected to represent the intervention's fundamental strategies and procedures as put forth in treatment manuals and by experts in the field. They have highlighted the need for this type of assessment in promoting the efficient and effective dissemination of evidence-based treatments, both in effectiveness studies regarding these interventions and in the delivery of them by practitioners (Fairburn & Cooper, 2011; Roberts, Borden, Christiansen, & Lopez, 2005).

A number of recent articles have incorporated the use of SPs in the training of clinical psychologists in cognitive behavioral therapy (CBT). In 2005, Sholomskas and colleagues investigated a CBT training approach, the outcome of which was determined by use of a one-hour treatment scenario role-played with an experienced clinician using a standardized clinical presentation (Sholomskas et al., 2005). Further investigations of CBT-related interventions have followed suit (e.g., Fairburn & Cooper, 2011; Muse &

McManus, 2013; Sharpless & Barber, 2009). Dimeff and colleagues (2009) also used simulated patients to evaluate three methods of training providers in Dialectical Behavior Therapy skills (Dimeff et al., 2009). Use of SPs has also been shown to be an effective means of evaluating psychoanalytic therapy skills (Westerman & Steen, 2009). Use of SPs within the Motivational Interviewing literature has provided evidence that this behavior observation method is a valid assessment of clinicians' knowledge and skill acquisition as well as adherence to training models (Baer, Rosengren, Dunn, Wells, & Ogle, 2004; Baer et al., 2009; DeViva, 2006; Dimeff et al., 2009; Freeman & Morris, 1999; Miller, Yahne, Moyers, Martinez, & Pirritano, 2004). However promising, it is recognized that further evaluation of simulations' validity and reliability is warranted (Muse & McManus, 2013).

Purpose of the Study

Despite the potential benefits of using SPs in professional psychology, there has been little investigation into their use in the field of mental health as a training tool. As stated previously, role-plays conducted by graduate school peers are most frequently used to facilitate the development of skills for clinical practice. The purpose of the current study was to investigate whether role-playing with an SP results in enhanced skill development when compared to role-playing with peers. The results will provide data to support the development of specific, best-practice modalities of instruction for beginning psychologists. Furthermore, this study set out to construct a reliable, valid measure with which to measure the developing clinical competency of mental health clinicians early in their graduate training, addressing a gap within the competency acquisition literature.

Hypotheses

Hypothesis one. Regardless of condition (i.e., either SPs or role-play), all participants' CSE levels will increase, state anxiety levels will decrease, and self-reflective anxiety will decrease when comparing participants' pre- and post-intervention ratings when conducting a clinical interview. This hypothesis is based upon the findings that self-efficacy gains due to the gathering of experience and mastery situations were associated with reductions in anxiety, increased confidence in therapeutic competencies, and comfort in the therapeutic role (Daniels & Larson, 1998).

Hypothesis two. However, it is hypothesized that role-play with SPs will lead to CSE gains and anxiety reduction over and above that gained during role-play with peers, as it is theorized the high external validity of simulations facilitates the transfer of clinicians' skills to real-world environments (Salas, Wilson, Burke, & Priest, 2005). Further, role-play with SPs will lead to greater gains in clinical competency acquisition than role-play with peers, due to the hypothesized greater self-efficacy gains and anxiety reduction that SP interaction provides. As theorized by Larson (1998), higher self-efficacy and associated reduced anxiety levels facilitate the expansion of both procedural and declarative knowledge and subsequently improve performance (Larson, 1998).

Hypothesis three. It is hypothesized that psychology trainees' self-efficacy gains and anxiety reduction will contribute significantly to the prediction of clinical competency acquisition.

Chapter II: Method

Participant Recruitment

Data were collected for this study during the summer semesters (May-June) of the 2012-2013 and the 2013-2014 academic years. Institutional Review Board (IRB) approval was granted on April 24, 2012 and renewed April 16, 2013. All first-year clinical psychology graduate students within the Center for Psychological Studies (CPS) were invited to participate during Phase One of the study, while the invitation was extended to all students within the CPS during Phase Two in order to increase participation. Students were recruited by flyers posted throughout the CPS, by email messages distributed through the CPS's clinical psychology student listserv, and by postings on social media websites. The study was advertised as an optional experience that could enhance students' clinical experiences outside of practicum. In order to boost recruitment, the incentive of entering each student into a drawing for two $100 gift cards (for those who attended all sessions including pre-test and post-test) and four $50 gift cards (for those who attended four out of five sessions including pre-test and post-test) was also advertised. Furthermore, CITI-trained project representatives entered first-year clinical graduate courses to detail the project's requirements as well as to answer any questions. Interested participants were directed to a project email account through which all correspondence between the author and participants was conducted. Participants were asked to provide their availability throughout the week. A study schedule was then constructed to accommodate participants' availabilities most effectively.

Study Design

Participants were assigned to one of two conditions, skill development through role-play (Control condition) or practice with an SP (Experimental condition), utilizing a table of random numbers. Participants in each condition were required to attend five three-hour laboratory sessions and to engage in a 15 minute pre- and post-assessment interview with an SP. Each group utilized identical case study scenarios. Laboratory sessions for both groups were facilitated by advanced graduate students who were not involved in the pre- and post-ratings of participants. The group facilitators were trained by the author and by faculty members at the CPS.

Sample Characteristics

Phase one. A total of 17 students enrolled in Phase One of the study, five males and 12 females. Participants ranged between 20 and 44 years of age, with the average age 24.4 years. Eleven individuals identified as Caucasian, two as Asian, and four as Latino/Latina. Three indicated that Spanish was their first language (although they were fluent in English), while 14 participants stated that English was their first language. All of these participants were in their first year of the clinical psychology doctoral program located within the CPS. Fourteen were enrolled in the Psy.D. program, and three were in the Ph.D. program, respectively. Six individuals had attained a master's degree in psychology prior to enrollment in NSU's doctoral program. Three of these individuals had previous clinical experience in their master's practica, totaling 20, 100, and 1100 hours of clinical interaction, respectively. All Phase One participants majored in psychology during their undergraduate education. Seven students indicated that they had not had a minor area of study; one minored in the sciences, three in the social sciences,

one in business, and five in "other" areas (e.g., various languages, art history, and political science.)

Attrition and attendance. Three individuals from Phase One withdrew from the study, one participant from the Experimental group and two from the Control group. All of these participants were females. Two of these participants withdrew after the first laboratory session, while the third withdrew after the second session. On average (excluding those who attrited), members of the Experimental group attended four out of five sessions, while members of the Control group (excluding those who attrited) attended three out of five sessions.

Phase two. A total of 32 students enrolled in Phase Two of the study; eight males and 24 females. Ages ranged from 20 to 49 years, with an average age of 24 years. Eight individuals identified as Caucasian, nine as Latino/Latina, three as African American/Afro-Caribbean, two as "Other" or preferred not to answer. Four indicated that Spanish was their first language and one reported Creole as his/her first language (although all were fluent in English), while 24 individuals stated that English was their first language. Participants' enrollments in program types are depicted in Table 2.

Table 2

Participants' Program Enrollment, Time Two

Number of Individuals	Program	Part- or Full-Time	Online- or Campus-Based	Year in Program
2	Ph.D. Clinical	Full	Campus	First
18	Psy.D. Clinical	Full	Campus	First
1	M.S. Counseling	Full	Online	First
1	M.S. Counseling	Part	Campus	Second
1	M.S. Counseling	Part	Campus	Third
1	M.S. Forensic	Full	Online	First
1	M.S. General Psychology	Full	Online	Second
1	M.S. General Psychology	Full	Campus	Fourth
2	M.S. Mental Health Counseling	Full	Campus	First
1	M.S. Mental Health Counseling	Full	Campus	Second
1	M.S. Mental Health Counseling	Part	Campus	Third
1	M.S. Mental Health Counseling	Full	Online	First
1	M.S. Mental Health Counseling	Full	Online	Second

Four individuals had attained previous master's degrees, two in psychology, prior to enrollment in NSU's doctoral program. Three of these individuals had previous clinical experience in their master's practica, totaling 20, 100, and 1100 hours of clinical interaction, respectively. Twenty-one participants indicated that they had majored in psychology in their undergraduate institutions, one in the sciences, six in the social sciences, one in education, one in business, and one in an "other" area of study. One participant minored in psychology, three in the sciences, four in the social sciences, two in business, and one in an "other" area of study.

Attrition and attendance. Six individuals from Phase Two withdrew from the study after the pre-test session; two participants from the Experimental group and four from the Control group. Five of these participants were females and one was a male. Four

of these individuals, all in their first year of clinical training, were enrolled in the clinical psychology Psy.D. program, while two were in the master's in Mental Health Counseling program. On average (excluding those who attrited), members of the Experimental group attended four out of five sessions, while members of the Control group (excluding those who attrited) attended three out of five sessions. Due to camera malfunction, two post-test videos were not able to be rated; both of these participants were members of the Control group.

Group Characteristics

Collapsing across time, each group consisted of 24 individuals. The Control group was comprised of seven males and 17 females, while the Experimental group was comprised of six males and 18 females. The frequencies of respondents identifying as members of each designated age category are depicted in Table 3.

Table 3

Frequency of Respondents Endorsing Each Age Category

	Age Category					
	20-24	25-29	30-34	35-39	40-44	45-49
Control	13	4	2	1	0	4
Experimental	19	3	1	0	1	0
Total	32	7	3	1	1	4

The frequencies of respondents identifying as members of each ethnicity category, endorsing each type of language as their first spoken, current enrollment in each program type, and as holding particular undergraduate major types are depicted in Tables 4-7.

Table 4

Frequency of Respondents Endorsing Each Category of Ethnicity

	Ethnic Group					
	Black, African American, or Afro-Caribbean	Hispanic or Latino/a	White	Asian	Other	No Response
Control	3	5	13	1	2	0
Experimental	0	7	15	1	0	1
Total	3	12	28	2	2	1

Table 5

Frequency of Respondents Endorsing Each Category of First Language Spoken

	Language			
	English	Spanish	Creole	Other
Control	18	4	1	1
Experimental	19	3	0	2
Total	37	7	1	3

Table 6

Frequency of Respondents Endorsing Each Program Type Category

	Program Type					
	Ph.D. Clinical	Psy.D. Clinical	M.S. Counseling	Forensic Psychology	M.S. General Psychology	M.S. Mental Health Counseling
Control	3	13	1	0	1	6
Experimental	2	18	2	1	1	0
Total	5	31	3	1	2	6

Table 7

Frequency of Respondents Endorsing Each Undergraduate Major Category

	Undergraduate Major					
	Psychology	Sciences	Social Sciences	Education	Business	Other
Control	16	1	4	1	1	1
Experimental	21	0	2	0	0	1
Total	37	1	6	1	1	2

Case Development

SPs portrayed the symptoms of various DSM-IV diagnoses based on de-identified biopsychosocial intake reports. Most of these clinical reports were written by graduate students on actual clientele seen in NSU's Psychology Services Center, a mental health provision center within the CPS; however, three cases were obtained from the Association of Standard Patient Educators listserv (Association of Standard Patient Educators, 2012). Cases were selected based upon clearly-defined symptomatology as well as thorough, circumscribed histories that could easily be portrayed by SPs. Furthermore, cases were written in a manner which could be adapted to the actor available to portray the case (e.g., client gender). It was ensured by faculty members that cases were detailed enough to allow trainees to respond in multiple ways to SP responses and to allow trainees to display multiple counseling skills. The diagnoses portrayed were Social Phobia, Specific Phobia, Generalized Anxiety Disorder, and Major Depressive Disorder. Scenarios necessitating suicide assessment and potential abuse reporting were also included. Based upon these detailed histories, the author constructed checklists to ensure that particular aspects of the clinical presentation would be portrayed by the SP. Such checklists served to restrict SPs' variation from the script. Finally, a list was

constructed of questions which could potentially be asked by the interviewer and of corresponding scripted responses from the SP.

Case Studies

Pre-test and laboratory one. The same case was employed for both the pre-test evaluation and the initial laboratory session in order for the participants to expand upon information garnered in the first interview. This case was based upon a 32-year-old, married female exhibiting symptoms of Major Depressive Disorder. This client presented with bouts of crying, depressed mood, insomnia and nighttime awakenings, decreased appetite and energy, anhedonia, feelings of guilt, and concentration difficulties. Furthermore, she endorsed suicidal ideation and a specific plan, but denied intent, citing her young children as preventatives. These symptoms had been exacerbated by her husband's arrest for fraud. The client also reported prior physical, emotional, and verbal abuse by an alcoholic father (Appendix F).

Laboratory two. This case was based upon a 59-year-old, married female exhibiting symptoms of Specific Phobia. This client presented with increased physiological arousal (tachycardia, muscle tension, sweating, dizziness, and freezing) whenever she was on a plane, in an elevator, or speaking publicly. Her symptoms had been consistently present for 25 years. Furthermore, the client endorsed a medical history of high cholesterol and sleep apnea (Appendix G).

Laboratory three. This case was based upon a 52-year-old, married male exhibiting symptoms of Post-Traumatic Stress Disorder. This client described returning from military service in Iraq four months prior to the interview. He endorsed symptoms of exaggerated startling, hypervigilance, anger and irritability, nightmares, flashbacks,

significant survivor guilt, avoidance of reminders of the event, and emotional numbing. The client also endorsed concurrent substance use (Appendix H).

Laboratory four. This case was based upon a 28-year-old, single female exemplifying symptoms of Social Phobia. The client endorsed experiencing anxiety at social gatherings, when speaking in front of others, and in interpersonal relationships due to a fear of negative evaluation. She described physiological reactivity within social situations - namely gastrointestinal upset, blushing, sweating, and increased heart rate. Furthermore, the client complained of insomnia due to rumination and anxious mood. She also presented with a history of bereavement and of familial mental illness (Appendix I).

Laboratory five. This case was based upon a 22-year-old, single female exemplifying symptoms of Generalized Anxiety Disorder. The client endorsed significant anxiety within several domains of daily living, as well as insomnia, significant muscular tension, stomach upset, rumination, and weight loss. She also reported familial discord, substance usage, and receipt of threats from a brother's ex-girlfriend (Appendix J).

Post-test assessment. This case was based upon a 26-year-old female who did not fully meet criteria for any diagnosable DSM-IV psychiatric condition. A domestic dispute between her mother and elderly grandmother preceded the client's symptoms. She reported that she, her mother, and her brother had been the primary caretakers for her two ill, bedridden grandparents for over six years and that her entire family suffers from a great deal of caregiver-related stress. The client reported a long history of verbal and physical abuse from her mother and brother, especially when under tension. She detailed a number of somatic symptoms (frequent heart palpitations, chest pain, muscular tension,

and shortness of breath), as well as feelings of guilt, frequent crying spells, and worry, all related to her familial situation. The client also expressed that she will be coming to psychotherapy in secret, as her family does not approve of disclosing familial (or personal) information to others (Appendix K).

SP Training

All SPs were trained by Heather McCarthy, D.O., a professor within NSU's College of Osteopathic Medicine who is also the Medical Director of NSU-COM Standardized and Simulated Patient Lab, and Donna Chase, MBA, Academic Coordinator. SPs were selected based upon their approximations to the characteristics described in the case scenarios (e.g., gender, age, physicality, personality traits, level of education, language). SPs were trained in the characters' body languages, movements, styles of speech, emotional states, and facial expressions. CPS faculty members introduced the SPs to the typical interactions which occur between psychologists and clients. SPs were trained for three hours upon each case they were instructed to portray. A total of 11 SPs were trained for Phase One of the study, with several actors portraying multiple cases. Six of these SPs were then re-trained on their previous characters for Phase Two of the study, engaging in a one hour "booster" session, which consisted of one hour of training, while nine additional SPs were trained for Phase Two. Again, several actors portrayed multiple cases. In Phase One, five SPs participated in the pre-test assessments, while the larger sample size in Phase Two necessitated six SPs. Two SPs participated in each of the five laboratory sessions during Phase One, rotating halfway through the encounter. During Phase Two, a total of four SPs participated in each lab session (two for each of the two laboratory groups) and rotated halfway through the

encounter. Five SPs participated in the post-test assessments for Phases One and Two. SPs were compensated $20/hour for their involvement in training, in laboratory sessions, and in pre- or post-test assessments.

Measures

Fear of Negative Evaluation Scale (FNE). The FNE, developed by Watson and Friend in 1969, is utilized to evaluate anxiety over the potential of being negatively appraised. The 30-item questionnaire employs a True/False rating technique. Items assess test takers' apprehension over others' evaluations, avoidance of situations in which the subject may be negative evaluated, and the level of expectation that the subject was to be evaluated negatively (Watson & Friend, 1969). Internal consistency has been measured at $\alpha = .92$ (Leary, 1983), and test-retest reliability was observed by the authors to be $r = .68$ (Watson & Friend, 1969).

State-Trait Anxiety Inventory (STAI). The STAI was developed in 1983 by Spielberger, Gorsuch, Lushene, Vagg, and Jacobs. Questions on the STAI assess concepts such as nervousness, calmness, joy, satisfaction, comfort, and the presence of disturbing thoughts. It is a 40-item inventory; 20 statements assess how one generally feels (state anxiety) and 20 statements assess how one feels at the moment (trait anxiety). Internal consistency scores were observed to range from $\alpha = .82$ to $\alpha = .92$ for the trait scale and from $\alpha = .86$ to $\alpha = .92$ on the state scale. For scores on the trait scale, test-retest reliabilities ranged from $r = .73$ to $r = .86$, while they ranged from $r = .16$ to $r = .62$ for scores included in the state scale (Spielberger, Gorsuch, Lushene, Vagg, & Jacobs, 1983).

Counseling Self-Estimate Inventory (COSE). The COSE, developed by Larson et al. (1992), is a 37-item measure used to evaluate how one feels that they would behave

as a counselor in a therapeutic interaction. Five overarching factors are assessed - namely, counselor trainees' confidence in using micro-counseling skills, attending to process, responding to difficult client behaviors, behaving in a culturally competent manner, and being aware of one's values. Internal consistency of the measure has been found to be high ($\alpha = .93$), and three week test-retest reliability for total score was observed to be $r = .87$. Furthermore, the COSE showed good convergent reliability estimates; it correlated negatively with the STAI State ($r = -.42$) and STAI Trait ($r = -.51$) scales as well as with the Problem Solving Inventory ($r = -.71$). The measure is also sensitive to change after skill acquisition and counseling experience (Larson et al., 1992).

Simulated Patient Assessment Demographic Evaluation Survey (SPADES). This 14-item survey was created by the researchers to collect demographic information for all participants. Items include gender, age, ethnicity, primary language, program type, previous graduate degrees, and in which discipline. In addition, data regarding the extent of previous experience in clinical interviewing or counseling as well as the type(s) of setting(s) in which the clinical experience was obtained, the number of hours of training at that location (or those locations), relevant clinical interviewing and/or counseling techniques coursework to date, and types of undergraduate major and minor (if applicable) were obtained.

Simulated Patient Assessment of Clinician Effectiveness Scale (SPACES). This scale was developed by the researchers in an effort to allow the SP to provide feedback on interviewer performance. The researchers modeled the inventory on the Arizona Clinical Interview Rating Scale, an instrument commonly used to evaluate the interviewing techniques of medical students (Stillman, Brown, Redfield, & Sabers,

1977). The measure consists of seven items which are rated on a four-point Likert-type scale. The content of the items includes assessment of perceived clinician confidence, perceived comfort level, the feeling of being understood, perceived genuineness, and the flow of conversation.

Skills in Psychological Interviewing: Clinical Evaluation Scales (SPICES). Developed by the researchers to evaluate clinical interviewing skills, SPICES consists of 26 questions which are rated on a four-point Likert-type scale. Within each item, behavioral anchors are provided to aid the rater in accurately evaluating the participant and to reduce ambiguity. During the development of the measure, student and faculty researchers generated a list of essential clinical skills that have been identified in the literature, including such variables as the ability to reflect, to impart genuineness, to mirror the client effectively, to make appropriate eye contact, to monitor nonverbal cues, and to normalize the client's concerns, using the APA's Competency Benchmarks as a guide. Once the initial inventory of competencies was created, the skills were simplified into component parts and operationalized to enhance the ease by which the participants would be evaluated. The measure was subsequently distributed to faculty members, both in school psychology and in clinical psychology, who have been identified as expert interviewers based upon extensive years in practice, to evaluate the items. The researchers requested that the experts identify the items that they judged effectively assessed the outlined competencies, as well as those items that they viewed as unnecessary. They were further asked to provide other relevant feedback. Revisions were made to increase the sensitivity of the rating scale, to eliminate items that were redundant, to increase the clarity and specificity of items, to rename factors, and to

eliminate items that would not likely be observed in the target audience of beginning clinicians. The measure's utility, ease of use, and validity were subsequently assessed by additional piloting of the measure by clinical psychologists and graduate students both within clinical and school psychology programs. The measure was then modified based on their feedback.

Revision process. Initially 12 elements of competency, *Deportment; Preparedness for Interview; Cultural Competency/Diversity*; *Effective Session Management*; *Concern for the Welfare of Others*; *Elicits Clients' Understanding of the Referral Problem*; *Expressive Skills*; *Receptive Skills*; *Non-Verbal Communication/Providing Comfort*; *Applies Knowledge Of Ethical, Legal, and Professional Standards and Guidelines*; *Diagnosis/Case Conceptualization*; and *Ending the Session*, were included in the measure. A list of measureable behaviors on which the students are to be evaluated was subsumed under each category, resulting in the inclusion of 61 items. A five-point Likert-type scale was constructed to evaluate each component with the anchors of *Does Not Demonstrate Competence Necessary for Practicum, Demonstrates Minimal Competence Necessary for Practicum, Demonstrates Emerging Competence Necessary for Practicum, Demonstrates Competence Necessary for Practicum,* and *Surpasses Competency Criteria Necessary for Practicum.* The option of "N/A" was added for skills not observed during the evaluation. Initial piloting of the data yielded internal consistency coefficients ranging from $\alpha = .84$ to $\alpha = .86$. Inter-rater reliabilities ranged from $r = .63$ to $r = .81$.

In accordance with the APA's reorganization of the Competency Benchmarks, the measure was further streamlined to include 11 benchmarks within three functional

domains: *Professionalism* (Ethical and Legal Standards and Policy, Awareness of Application of Ethical Decision-Making, Ethical Conduct, Professional Values and Attitudes, Concern for the Welfare of Others, Efficacy, and Individual and Cultural Diversity); *Relational* (Relationships, Affective Skills, and Expressive Skills); and *Application* (Assessment). After initial piloting of the measure by post-doctoral residents, it was pared to include 26 items with assistance of the residents' feedback. Furthermore, operational definitions of each competency area and an appendix consisting of behavioral anchors for each item were included to facilitate the accuracy of raters' evaluations and to reduce ambiguity. The following instruction was clarified: "*How characteristic of the trainee's behavior is this competency description?*," and a four-point Likert-type scale was included, namely *Not at All Characteristic*, *Somewhat Characteristic*, *Moderately Characteristic*, *Extremely Characteristic*, and *No Opportunity to Observe.*

Procedure

Pre-test. All participants were assigned a coded identification number after their informed consent for participation in the study was obtained. Prior to the pre-assessment interview, students in both conditions provided demographic information utilizing the *Simulated Patient Assessment Demographic Evaluation Survey* (SPADES), and the *Fear of Negative Evaluation* (FNE), the *State-Trait Anxiety Scale-Version Y-1* (STAI Y-1), and the *Counseling Self-Estimate Inventory* (COSE) were administered. Interviews were held in therapy rooms located within the CPS's Psychology Services Center in order to enhance the realism of the simulations. Each participant was randomly assigned to one of the five SPs portraying the case. Students were instructed to conduct an intake evaluation and to assume that consent for treatment and confidentiality mandates had already been

discussed. After 15 minutes, laboratory facilitators signaled the end of these one-on-one interviews. Due to the potentially anxiety-provoking nature of the pre-test, a CPS faculty member debriefed each participant after completion of his or her respective interview. Sessions were digitally video recorded and archived so they could be later evaluated by post-doctoral residents utilizing the *Skills in Psychological Interviewing Clinical Evaluation Scales* (SPICES) and so that participants could later evaluate their own progress throughout the study. Participants also received feedback from the SPs using the *Standardized Patient Assessment of Clinician Effectiveness Scale* (SPACES) after completion of their interviews.

Laboratory sessions. All sessions were held in classrooms at the CPS and were three hours in length. Laboratory facilitators were trained by the author and faculty members on the sessions' procedures. Each facilitator was subsequently given a detailed session protocol and sessions were videotaped and reviewed in order to ensure fidelity of implementation. This author viewed the introduction phase of each laboratory session and then randomly sampled two 15-minute subsections of each videotape to ensure that the sessions' structures closely followed the protocol. Each laboratory session had two facilitators in either condition. All leaders rotated between the two conditions each week to eliminate facilitator effect. Prior to each laboratory session, participants in both groups received basic information about the case to be portrayed in the form of a screening intake. The screening form was modeled after those used in the CPS's Psychology Services Center. The order of participant interaction in both groups was randomly assigned prior to each session. Each individual role-play or SP interaction was 10 minutes in length. Both conditions included a 15-minute break halfway through the three hour

session, and in the Experimental condition SPs were rotated during the break to reduce fatigue. Each participant received five minutes of verbal feedback on those interviewing skills included in the SPICES measure from both the group facilitators and peers. Both groups also received written copies of the facilitators' comments. Furthermore, either the SP or the student role-playing the client completed the SPACES measure based on the interviewers' performances. All participants received copies of these evaluations. Each session closed with a summary of group performance and general progress.

Post-test. The protocol from the pre-test assessment was followed for the post-test assessment. Participants again completed the FNE, COSE, and STAI (Y-1) prior to the post-test interview. The SPs also rated participant performances utilizing SPACES. All videotapes were evaluated by post-doctoral residents using SPICES. All participants were again de-briefed by the author.

Chapter III: Results

A priori Analyses

In order to ensure that no *a priori* differences existed between groups, a series of parametric and of non-parametric statistical analyses were performed. Chi-square tests for independence (with Yates Continuity correction) indicated no significant association between participant group and sex, $\chi^2(1, N = 48) = 1.00$, $p > .999$, $\varphi = -.05$, nor between participant group and attrition, $\chi^2(1, N = 48) = 1.14$, $p = .286$, $\varphi = -.21$.

The various age categories assessed ("20-24," "25-29," "30-34," "35-39," "40-44," and "45-49") were collapsed into two groups: "Under 30 Years Old" and "Over 30 Years Old," for analysis. The Control group was comprised of 17 individuals under the age of 30 and seven individuals who were over the age of 30. The Experimental group

was comprised of 22 individuals under the age of 30 and two individuals who were over the age of 30. A Chi-square test for independence (with Yates Continuity correction) indicated no significant association between participant group and age, $\chi^2(1, N = 48) = 2.19$, $p = .139$, $\varphi = -.27$.

The existing categories of ethnicity ("Black, African-American, or Afro-Caribbean," "Hispanic or Latino/a," "White," "Asian," "Other," or no response given) were collapsed into three groups- "Caucasian," "Hispanic," and "Other," for analysis. The Control group was comprised of 13 Caucasian individuals, five Hispanic individuals, and six individuals identifying as members of other ethnic groups. The Experimental group consisted of 15 Caucasian individuals, seven Hispanic individuals, and one individual identifying as a member of another ethnic group. A Chi-square test for independence indicated no significant association between participant group and ethnicity, $\chi^2(2, N = 48) = 4.03$, $p = .133$, Cramer's V= 0.29.

The four existing language categories ("English," "Spanish," "Creole," and "Other") were collapsed into two groups for non-parametric analysis: "English" and "Other." The Control group was comprised of 18 individuals who indicated that their first language spoken was English, while six individuals reported that their first language spoken was one other than English. The Experimental group consisted of 19 individuals who indicated that their first language spoken was English, while five individuals reported that their first language spoken was one other than English. A Chi-square test for independence (with Yates Continuity correction) indicated no significant association between participant group and first language spoken, $\chi^2(1, N = 48) = 0.00$, $p > 0.999$, $\varphi = -.05$.

The various program categories ("Ph.D. Clinical," "Psy.D. Clinical," "M.S. Counseling," "Forensic Psychology," "M.S. General Psychology," and "M.S. Mental Health Counseling") were collapsed into two groups: "Doctoral" and "Masters'," for analysis. The Control group was comprised of 16 members of the Doctoral program, while eight were enrolled in Masters' programs. The Experimental group consisted of 20 individuals enrolled in Doctoral programs, while four individuals reported that they were part of Masters' programs. A Chi-square test for independence (with Yates Continuity correction) indicated no significant association between participant group and program type, $\chi^2(1, N = 48) = 1.00,\ p = .317, \varphi = -.19$.

The various undergraduate major categories were collapsed into two groups, "Psychology" and "Other," for analysis. The Control group was comprised of 16 members who had majored in Psychology, while eight had majored in other areas of study. The Experimental group consisted of 21 individuals who had majored in Psychology, while three individuals reported that they had majored in other areas of study. A Chi-square test for independence (with Yates Continuity correction) indicated no significant association between participant group and undergraduate major type, $\chi^2(1, N = 48) = 1.89,\ p = .170, \varphi = -.25$.

Independent samples t-tests were conducted to compare participants' reported year in their respective programs, as well as the number of clinical hours participants had engaged in before participating in the study. There was no statistically significant difference in reported year for the Experimental ($M = 1.08$, $SD = 0.28$) and the Control groups ($M = 1.42$, $SD = 0.830$); however, the assumption of equal variance was violated as indicated by Levene's test ($F = 15.92$, $p < .001$); after adjustment, $t(28.26) = 1.86$, $p =$

.073 (two-tailed). The magnitude of the differences in the means (mean difference = 0.33, 95% CI: -0.03 to 0.70) was small ($\eta^2 = .07$).

With regard to the number of prior clinical hours (endorsed by those who had reported having previous clinical experience within each group [n = 11; five Control, six Experimental]), there was no statistically significant difference between the Experimental ($M = 370$, $SD = 404.72$) and the Control groups ($M = 829$, $SD = 999.48$); $t(9) = 1.04$, $p = .327$ (two-tailed). The magnitude in the differences in the means (mean difference = 459, 95% CI: -542.91 to 1460.91), compared with the sizes of the standard deviations, was small ($\eta^2 = .11$).

Likewise, no significant differences existed in participants' pre-test measures of CSE (COSE; $t(46) = 0.49$, $p = .625$ (two-tailed)), trait anxiety (STAI (Y-2); $t(46) < 0.001$, $p > 0.999$ (two-tailed)), state anxiety (STAI (Y-1); $t(46) = -0.07$, $p = .987$ (two-tailed)), fear of negative evaluation (FNE; $t(46) = -0.04$, $p = 0.971$ [two-tailed]), or clinical competency (SPICES; $t(46) = 0.30$, $p = 0.77$ (two-tailed)) (Table 8).

Table 8

Pre-Test Measurements

Measure	Experimental *M* (*SD*)	Control *M* (*SD*)	*t*	*p*	Mean Difference	CI	η^2
COSE	147.33 (21.31)	150.46 (22.64)	0.49	.625	3.13	[-9.95, 15.90]	.005
STAI (Y-1)	38.67 (8.79)	38.67 (10.30)	< 0.001	> .999	< 0.001	[5.56, 5.56]	< .001
STAI (Y-2)	37.96 (8.49)	37.92 (8.65)	-0.02	.987	-0.04	[-5.02, 4.94]	< .001
FNE	15.96 (7.68)	16.04 (8.14)	-0.04	.971	-0.08	[-4.68, 4.51]	< .001
SPICES	75.60 (6.78)	75.02 (6.82)	0.30	.768	0.58	[-3.37, 4.54]	.002

Note. CI = confidence interval; COSE = *Counseling Self-Estimate Inventory*; STAI (Y-1) = *State-Trait Anxiety Inventory* (Version Y-1: state anxiety); STAI (Y-2) = *State-Trait Anxiety Inventory* (Version Y-2: trait anxiety); FNE = *Fear of Negative Evaluation*; SPICES = *Skills in Psychological Interviewing: Clinical Evaluation Scales.*

Psychometric Properties of SPICES

The SPICES scale was observed to have good internal consistency, with a Cronbach's alpha coefficient calculated as $\alpha = 0.778$. In order to investigate individual items of the SPICES scale, Item-Total Statistics were calculated. Analysis indicated that the revision of eight scale items and their corresponding behavioral anchors would improve the reliability of the scale. Deletion of *Suicide Assessment* (0.783), *Threat Assessment* (0.781), *Abuse Assessment* (0.781), *Personal Hygiene* (0.784), *Attire* (0.785), *Time Management* (0.789), *Diversity* (0.782), and *Response to Client's Expression of Concerns* (0.780) would all increase SPICES's Cronbach's alpha slightly if deleted. Furthermore, several items correlated weakly with SPICES Total Scores, namely *Informed Consent* (.269), *Limits of Confidentiality* (0.257), *Suicide Assessment* (0.211), *Threat Assessment* (0.109), *Abuse Assessment* (0.146), *Personal Boundaries* (0.250), *Personal Hygiene* (-0.024), *Attire* (0.082), *Time Management* (-0.127), *Diversity* (0.015),

Response to Client's Expressions of Concerns (0.004), and *Closure of the Session* (0.292) (Table 9).

Table 9

Item-Total Statistics for SPICES Items

SPICES Item	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
Informed Consent	.269	.773
Limits of Confidentiality	.257	.778
Suicide Assessment	.211	.783
Threat Assessment	.109	.781
Abuse Assessment	.146	.783
Personal Boundaries	.250	.777
Personal Hygiene	-.024	.784
Attire	.082	.785
Non-Judgmental Attitude	.491	.765
Appreciation for Client's Life Circumstances	.672	.757
Compassion for the Client	.550	.762
Structure of the Interview	.547	.757
Time Management	-.127	.789
Diversity	.015	.782
Response to Client's Feelings	.591	.758
Response to Client's Expressions of Concerns	.004	.780
Indirect Messages/Communications	.403	.769
Management of Interpersonal Conflict	.351	.774
Management of Ambiguity and Uncertainty	.633	.756
Language in Professional Communication	.342	.773
Tone of Speech	.505	.763
Communication of Ideas and Information	.514	.762
Nonverbal Communication	.560	.757
Open-Ended Questioning	.508	.764
Paraphrasing or Summarizing	.435	.763
Closure of the Session	.292	.772

Note. SPICES = *Skills in Psychological Interviewing: Clinical Evaluation Scales*

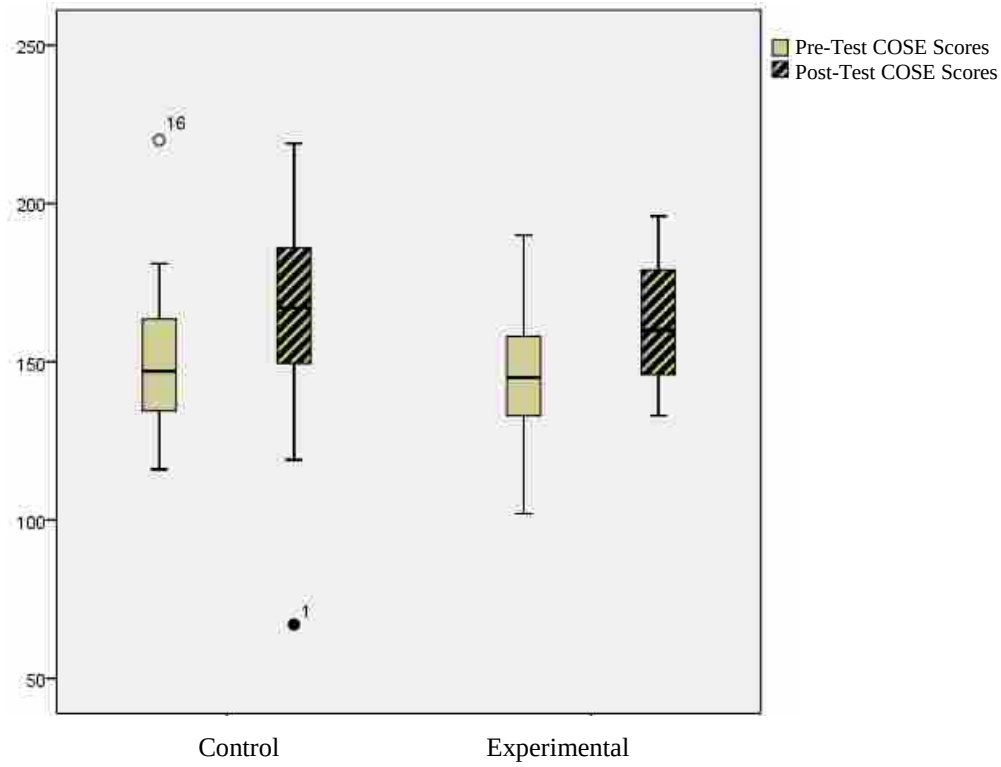
The Pearson product-moment correlation coefficient was used to investigate the inter-rater reliability of the SPICES scale. Preliminary analyses were performed to ensure there was no violation of the assumptions of normality, linearity and homoscedasticity. There was a strong, positive correlation between the two raters' Total Scores on the SPICES scale, $r = 0.608$, n=86, $p < 0.01$.

Outcome Measures

CSE. Investigations of outliers and normality within participants' CSE scores, as measured by the COSE, were conducted. Two outliers, both within the Control group, were observed (Figure 1).

Figure 1

Outliers in COSE Scores as Assessed by Boxplot



Note. COSE = *Counseling Self-Estimate Inventory*. Outliers represent values greater than 1.5 box-lengths from the edge of the box.

COSE scores were normally distributed for both groups at each time point, as assessed by Shapiro-Wilks's test ($p > .05$). There was homogeneity of variances, as assessed by Levene's test of homogeneity of variance (all values $p > .05$); similarly, there was homogeneity of covariances, as assessed by Box's Test of equality of covariance matrices ($p = .143$).

A mixed design ANOVA was conducted to assess the impact of the intervention on participants' CSE. There was no significant interaction between group and time, Wilks's Lambda =.99, $F(1, 38) = .41$, $p = .526$, $\eta^2 = .01$, suggesting no difference in the effectiveness of the two interventions in increasing participants' CSE. There was a substantial main effect for time, Wilks's Lambda = .63, $F(1, 38) = 22.20$, $p < .001$, $\eta^2 = .37$, with both groups exhibiting an increase in CSE at post-test (refer to Table 10 and Figure 2). Finally, the main effect comparing Experimental to Control group was not significant, $F(1, 38) = .35$, $p = .559$, $\eta^2 = .01$.

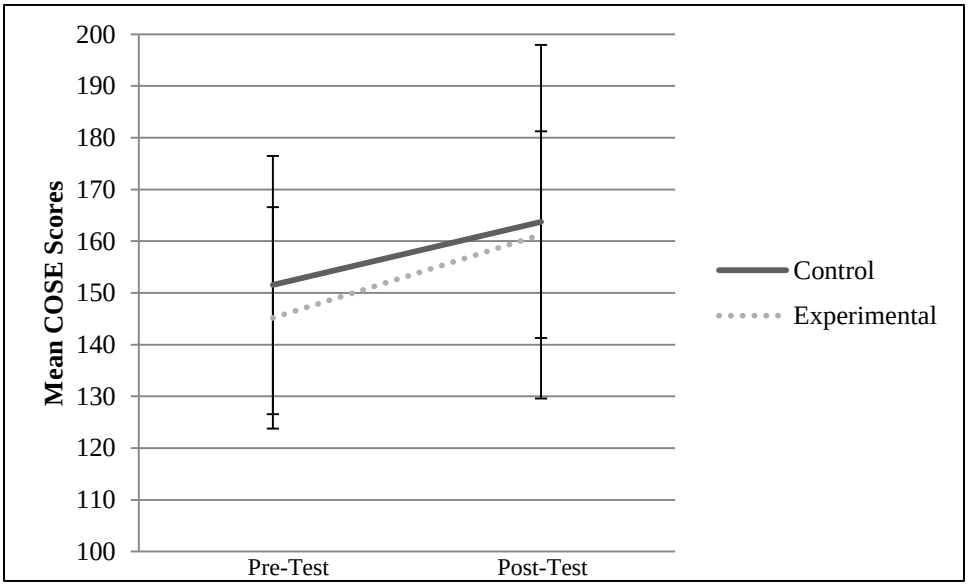
Table 10

CSE Scores for Experimental and Control Groups before and after Intervention

	Participant Group					
	Experimental			Control		
	n	M	SD	n	M	SD
Pre-Test	21	145.19	21.40	19	151.53	24.95
Post-Test	21	161.24	19.97	19	163.74	34.17

Figure 2

Change in CSE from Pre- to Post-Test



Note. COSE = *Counseling Self-Estimate Inventory*.

State anxiety. Investigations of outliers and of normality within the distribution of participants' state anxiety scores, as measured by the STAI (Y-1), were conducted. There were no outliers in the data. STAI (Y-1) scores were normally distributed for both groups at each time point, as assessed by Shapiro-Wilks's test ($p > .05$). There was homogeneity of covariances, as assessed by Box's Test of equality of covariance matrices ($p = .172$). However, Levene's Test of Homogeneity of Variances was violated for participants' post-test scores. Analysis of variance testing is reasonably robust to violations of homogeneity of variance assumptions, provided that group sizes are reasonably similar (Stevens, 1996, p.249); as such, the results of testing are not unduly influenced (Table 11).

Table 11

Levene's Test of Homogeneity of Variances for STAI (Y-1) Scores

	F	df1	df2	Sig.
Pre-Test STAI (Y-1)	1.343	1	38	.254
Post-Test STAI (Y-1)	5.179	1	38	.029

Note. Tests the null hypothesis that the error variance of the dependent variable is equal across groups. STAI (Y-1) = *State-Trait Anxiety Inventory, Version Y-1*.

A mixed design ANOVA was conducted to assess the impact of the intervention on participants' state anxiety. There was no significant interaction between group and time, Wilks's Lambda = .95, $F(1, 38) = 1.69$, $p = .201$, $\eta^2 = .04$, suggesting no difference in the effectiveness of the two training methods in decreasing participants' state anxiety before conducting a simulated clinical interview. There was a substantial main effect for time, Wilks's Lambda = .65, $F(1, 38) = 20.39$, $p < .001$, $\eta^2 = .35$, with both groups exhibiting a decrease in state anxiety at post-test (refer to Table 12 and Figure 3). Finally, the main effect comparing Experimental to Control was not significant, $F(1, 38) = .87$, $p = .358$, $\eta^2 = .02$.

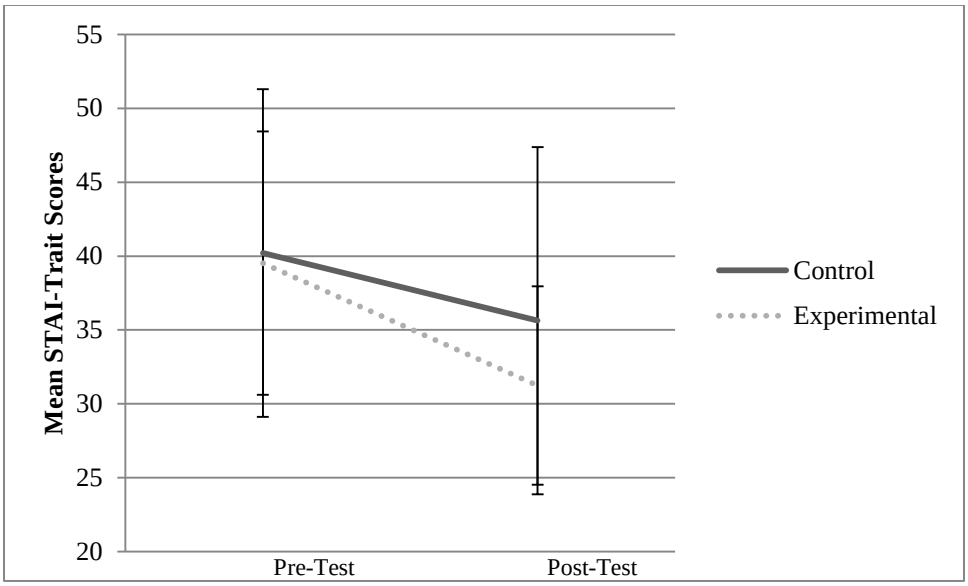
Table 12

State Anxiety Scores for Experimental and Control Groups from Pre- to Post-Test

	Participant Group					
	Experimental			Control		
	n	M	SD	n	M	SD
Pre-Test	21	39.52	8.91	19	40.21	11.09
Post-Test	21	31.24	6.71	19	35.63	11.75

Figure 3

Change in State Anxiety from Pre- to Post-Test



Note. STAI = *State-Trait Anxiety Inventory.*

Fear of negative evaluation. Investigations of outliers and normality within participants' fear of negative evaluation scores, as measured by the FNE, were conducted. There were no outliers in the data. FNE scores were normally distributed for both groups at each time point, as assessed by Shapiro-Wilks's test ($p > .05$). There was homogeneity of variances, as assessed by Levene's test of homogeneity of variance (all values $p > .05$); similarly, there was homogeneity of covariances, as assessed by Box's Test of equality of covariance matrices ($p = .491$).

A mixed design ANOVA was conducted to assess the impact of the intervention on participant's fear of negative evaluation. There was no significant interaction between group and time, Wilks's Lambda = .95, $F(1,38) = 2.10$, $p = .155$, $\eta^2 = .05$, suggesting no difference between the two training programs in decreasing fear of negative evaluation

before conducting a simulated clinical interview. There was no substantial main effect for time, Wilks's Lambda = .93, $F(1,38) = 2.74$, $p = .110$, $\eta^2 = .07$ (refer to Table 13 and Figure 4). The main effect comparing Experimental to Control group also was not statistically significant, $F(1,38) = .96$, $p = .333$, $\eta^2 = .03$.

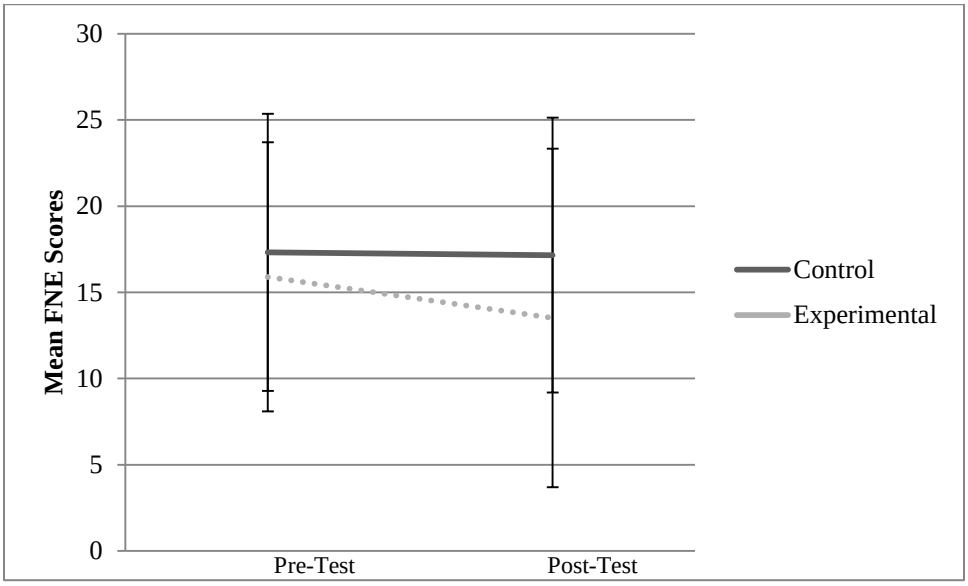
Table 13

Fear of Negative Evaluation Scores for Experimental and Control Groups before and after Intervention

	Participant Group					
	Experimental			Control		
	n	M	SD	N	M	SD
Pre-Test	21	15.90	7.80	19	17.32	8.03
Post-Test	21	13.52	9.82	19	17.16	7.97

Figure 4

Change in Fear of Negative Evaluation from Pre- to Post-Test

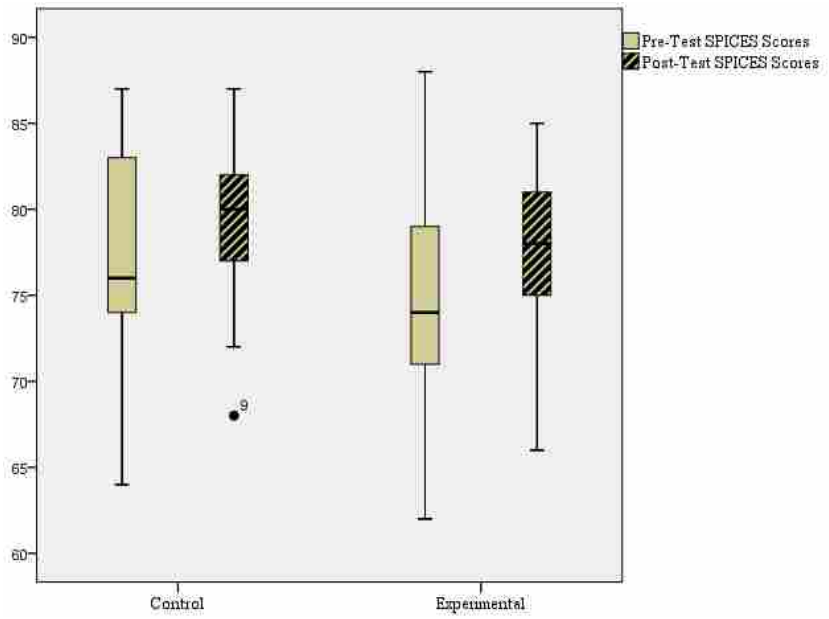


Note. FNE = *Fear of Negative Evaluation Scale.*

Clinical competency acquisition. Investigations of outliers and normality within participants' clinical competency scores, as measured by the SPICES scale, were conducted. An outlying score within the Control group was observed (Figure 5).

Figure 5

Outliers in SPICES Scores as Assessed by Boxplot



Note. SPICES = *Skills in Clinical Interviewing: Evaluation Scale.* Outliers represent values greater than 1.5 box-lengths from the edge of the box.

SPICES scores were normally distributed for both groups at each time point, as assessed by Shapiro-Wilks' test ($p > .05$). There was homogeneity of variances, as assessed by Levene's test of homogeneity of variance (all values $p > .05$); similarly, there was homogeneity of covariances, as assessed by Box's Test of equality of covariance matrices ($p = .952$).

A mixed design ANOVA was conducted to assess the impact of the intervention on participants' clinical competency acquisition. There was no significant interaction between group and time, Wilks's Lambda = 1.00, $F(1, 38) < .01$, $p = .997$, $\eta^2 < .01$,

suggesting no difference in the effectiveness of the two training programs in increasing clinical competency. There was a substantial main effect for time, Wilks's Lambda = .86, $F(1, 38) = 5.78$, $p = .022$, $\eta^2 = .14$, with both groups exhibiting increases in clinical competency at post-test (refer to Table 14 and Figure 6). The main effect comparing Experimental to Control was not significant, $F(1, 38) = 1.18$, $p = .290$, $\eta^2 = .03$.

Table 14

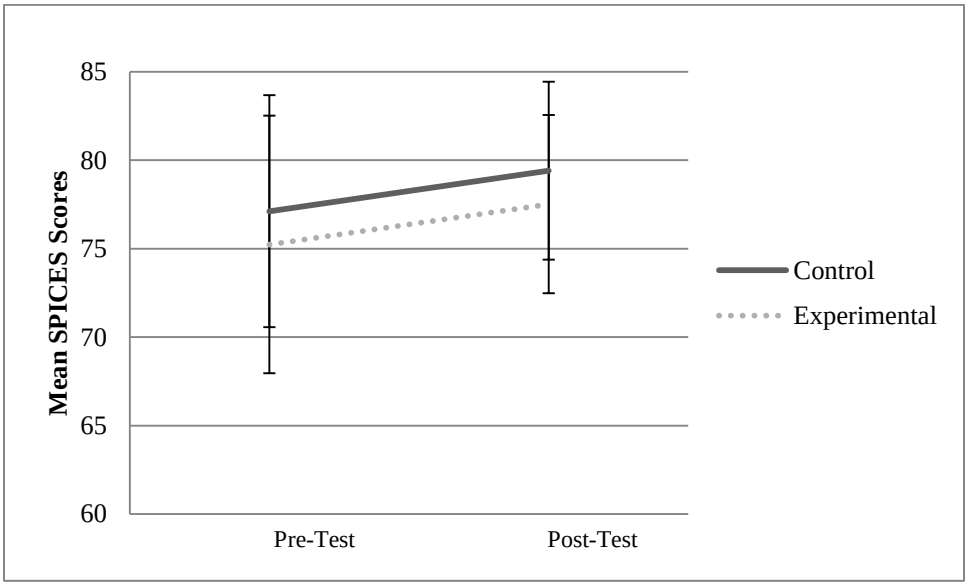
SPICES Scores for Experimental and Control Groups before and after Intervention

	Participant Group					
	Experimental			Control		
	n	M	SD	n	M	SD
Pre-Test	21	75.24	7.28	17	77.12	6.56
Post-Test	21	77.52	5.03	17	79.41	5.03

Note. SPICES = *Skills in Psychological Interviewing: Clinical Evaluation Scales.*

Figure 6

Change in Clinical Competency from Pre- to Post-Test



Note. SPICES = *Skills in Psychological Interviewing: Clinical Scales.*

Relationship of number of sessions attended to outcome measurements. To determine the effectiveness of the training sessions, the relationships between the number of sessions attended and each outcome measure were investigated using Pearson product-moment correlation coefficients. Preliminary analyses were performed to ensure no violation of the assumptions of normality, linearity, and homoscedasticity. There was virtually no correlation between number of sessions attended and change in performance on the SPICES measure; however, a moderate, negative correlation was observed between number of sessions attended and change in state anxiety (reaching statistical significance), and small negative correlations were observed between the number of sessions attended and changes in fear of negative evaluation and CSE (Table 15).

Table 15

Pearson Correlations between Number of Sessions Attended and Change Scores

	n	*r*	*p*
Change in SPICES	40	.01	.951
Change in COSE	40	.28	.080
Change in FNE	40	-.19	.243
Change in STAI (Y-1)	40	-.40	.011

Note. SPICES = *Skills in Psychological Interviewing: Clinical Evaluation Scales;* STAI (Y-1): *State-Trait Anxiety Inventory, Version Y-1*; COSE: *Counseling Self-Estimate Inventory*; FNE: *Fear of Negative Evaluation.*

Associations between training variables and change scores. The impact of participants' year in their respective training program and the number of previous hours of clinical training they had performed upon change score measurements was investigated using Pearson product-moment correlation coefficients. Preliminary analyses were performed to ensure no violation of the assumptions of normality, linearity, and homoscedasticity. Correlations ranged from small to negligible (Tables 16 and 17.)

Table 16

Pearson Correlations between Participants' Program Year and Change Scores

	n	*r*	*p*
Change in SPICES	40	.01	.935
Change in COSE	40	-.11	.494
Change in FNE	40	.19	.243
Change in STAI (Y-1)	40	.18	.261

Note. SPICES = *Skills in Psychological Interviewing: Clinical Evaluation Scales;* STAI (Y-1): *State-Trait Anxiety Inventory, Version Y-1*; COSE: *Counseling Self-Estimate Inventory*; FNE: *Fear of Negative Evaluation.*

Table 17

Pearson Correlations between Hours of Previous Experience and Change Scores

	n	*r*	*p*
Change in SPICES	40	-.03	.882
Change in COSE	40	-.16	.330
Change in FNE	40	.01	.963
Change in STAI (Y-1)	40	.10	.542

Note. SPICES = *Skills in Psychological Interviewing: Clinical Evaluation Scales;* STAI (Y-1): *State-Trait Anxiety Inventory, Version Y-1*; COSE: *Counseling Self-Estimate Inventory*; FNE: *Fear of Negative Evaluation.*

Relationships of change scores. Standard multiple regression was used to assess the ability of participants' changes in CSE, state anxiety, and fear of negative evaluation to predict their clinical competency acquisition. Preliminary analyses were conducted to ensure that there was no violation of the assumptions of normality, of linearity, of multicolinearity, and of homoscedasticity. Interrelationships between measurements are listed in Table 18.

Table 18

Correlation Matrix for Multiple Regression Variables

		Change SPICES	Change STAI (Y-1)	Change COSE	Change FNE
Pearson Correlations	Change SPICES	1.000	-.258	-.224	.007
	Change STAI (Y-1)	-.258	1.000	-.374	.169
	Change COSE	-.224	-.374	1.000	-.075
	Change FNE	.007	.169	-.075	1.000
Sig. (1-tailed)	Change SPICES	.	.059	.088	.483
	Change STAI (Y-1)	.059	.	.009	.148
	Change COSE	.088	.009	.	.323
	Change FNE	.483	.148	.323	.
N	Change SPICES	38	38	38	38
	Change STAI (Y-1)	38	40	40	40
	Change COSE	38	40	40	40
	Change FNE	38	40	40	40

Note. SPICES = *Skills in Psychological Interviewing: Clinical Evaluation Scales;* STAI (Y-1): *State-Trait Anxiety Inventory, Version Y-1*; COSE: *Counseling Self-Estimate Inventory*; FNE: *Fear of Negative Evaluation.*

These variables did not significantly predict participants' clinical competency acquisition, $F(3, 34) = 2.62$, $p = .067$, adj. $R^2 = .12$. Thus, the model explained only 12% of the variance in clinical competency acquisition. Participants' decrease in state anxiety made the largest unique contribution ($\beta = -.26$) to competency acquisition. A *decrease* in CSE also made a statistically significant contribution ($\beta = -.12$) to competency acquisition (Table 19).

Table 19

Summary of Multiple Regression Analysis

	B	SE_B	β	*p*	Partial Correlation
Intercept	2.26	1.20			
Change in STAI (Y-1)	-.26	.11	-.40	.02	-.37
Change in COSE	-.12	.05	-.37	.03	-.34
Change in FNE	.06	.19	.05	.76	.05

Note. *B* = unstandardized regression coefficient; SE_B = standard error of the coefficient; β = standardized coefficient.

Hierarchical multiple regression was then used to assess the ability of the previous measures to predict competency acquisition after controlling for the influence of participants' initial level of clinical competency. Preliminary analyses were conducted to ensure that there was no violation of the assumptions of normality, linearity, multicolinearity, and homoscedasticity. Pearson's correlations between the variables are listed in Table 20.

Table 20

Correlation Matrix for Hierarchical Regression Variables

		Change SPICES	Pre-Test SPICES Scores	Change STAI (Y-1)	Change COSE	Change FNE
Pearson Correlation	Change SPICES	1.000	-.693	-.258	-.224	.007
	Pre-Test SPICES Scores	-.693	1.000	.039	.349	.113
	Change STAI (Y-1)	-.258	.039	1.000	-.374	.169
	Change COSE	-.224	.349	-.374	1.000	-.075
	Change FNE	.007	.113	.169	-.075	1.000
Sig. (1-tailed)	Change SPICES	.	.000	.059	.088	.483
	Pre-Test SPICES Scores	.000	.	.407	.014	.244
	Change STAI (Y-1)	.059	.407	.	.009	.148
	Change COSE	.088	.014	.009	.	.323
	Change FNE	.483	.244	.148	.323	.
N	Change SPICES	38	38	38	38	38
	Pre-Test SPICES Scores	38	48	40	40	40
	Change STAI (Y-1)	38	40	40	40	40
	Change COSE	38	40	40	40	40
	Change FNE	38	40	40	40	40

Note. SPICES = *Skills in Psychological Interviewing: Clinical Evaluation Scales;* STAI (Y-1): *State-Trait Anxiety Inventory, Version Y-1*; COSE: *Counseling Self-Estimate Inventory*; FNE: *Fear of Negative Evaluation.*

Participants' initial levels of clinical competency were entered at Step One, explaining 46.5% of the variance in participants' clinical competency acquisition. After entry of participants' changes in measured state anxiety, CSE, and fear of negative evaluation at Step Two, the total variance explained by the model as a whole was 50.1%, $F(4, 33) = 10.29$, $p < .001$. Participants' decreases in CSE, fear of negative evaluation, and state anxiety measurements explained an additional 8% of the variance in clinical competency acquisition over and above their initial clinical competency measurements, although this change was not significant; R squared change = .08, F change (3, 33) = 1.86, $p = .156$. In the final model, only two variables significantly predicted clinical

competency acquisition, with pre-test SPICES scores recording a higher beta value (β = -.66, $p < .001$) than change in STAI (Y-1) scores (β = -.29, $p = .033$).

Participants' Feedback

Twenty-three participants completed a post-study feedback survey; 14 respondents were members of the Experimental group, while nine were members of the Control group. Participants were asked to rank four facets of the study in order of perceived helpfulness. Forty three percent of respondents indicated that they found "*Experiencing a simulated session"* to be most helpful, 23% found "*General practice of clinical interviewing skills"* to be the most helpful aspect of the study, an additional 23% found "*Feedback from group facilitators*" to be most helpful, while 13% indicated "*Feedback from the simulated patient or role-played client"* was the most beneficial aspect of the study. Participants were then asked to indicate their agreement with various study outcomes, the responses of which are listed in Table 21.

Table 21

Frequency of Ratings for Feedback Questionnaire Items

	Rating	Frequency	Percent
The laboratory sessions were helpful in the training of my interviewing skills.	3	1	4.3
	4	9	39.1
	5	13	56.5
This intervention has decreased my anxiety over client interaction.	3	3	13.0
	4	11	47.8
	5	9	39.1
I do not feel more prepared for future interactions with clients.	1	10	43.5
	2	10	43.5
	3	3	13.0
I found the pre- and post-test simulated sessions to be unrealistic.	1	12	52.2
	2	7	30.4
	3	3	13.0
	4	1	4.3
I found the pre- and post-test simulated sessions to be anxiety-provoking.	1	5	8.7
	2	11	8.7
	3	4	21.7
	4	1	39.1
	5	2	21.7
I found the SPACES rating scale (filled out by "clients") to provide me with little useful feedback.	1	5	21.7
	2	11	47.8
	3	4	17.4
	4	1	4.3
	5	2	8.7
I found the facilitators' feedback during the laboratory sessions to be helpful.	4	9	39.1
	5	14	60.9
I found my peers' feedback during the laboratory sessions to be worthless.	1	12	52.2
	2	10	43.5
	4	1	4.3
Overall, I feel that I received an adequate amount of feedback during this study.	1	1	4.3
	3	1	4.3
	4	8	34.8
	5	13	56.5
I found the cases portrayed to be inadequate depictions of clients I expect to see.	1	13	56.5
	2	5	21.7
	3	3	13.0
	4	2	8.7
I am glad that I participated in this study.	4	7	30.4
	5	16	69.6
I feel that a program such as this should not be implemented in mental health graduate programs.	1	23	100

Chapter IV: Discussion

Hypothesis One

Results support the hypothesis that all participants, regardless of group assignment, would improve on measurements of clinical competency acquisition, as assessed by the SPICES measure, while concurrently experiencing increases in CSE and decreases in state anxiety after the six week-long intervention. This is congruent with research suggesting that self-efficacy gains due to the gathering of experience and of mastery situations are associated with reductions in anxiety; with increased confidence in therapeutic competencies; and ultimately, with improved clinician performance (Al-Darmaki, 2004; Daniels & Larson, 1998; Daniels & Larson, 2001; Hill, Sullivan, Knox, & Schlosser, 2007). Results underscore the importance of experiential-based learning opportunities in addition to classroom-based education.

Undeniably, the ultimate mastery experiences in psychology training programs are interactions with actual clients; however, a protocol such as the one outlined within this study provides for early mastery opportunities for pre-practicum students, both within the classroom and within a simulated clinical setting. For more advanced students already practicing clinically, such a protocol offers the opportunity for real-time feedback on counseling behaviors as opposed to feedback based upon delayed recall of therapy sessions or review of session recordings during clinical supervision. Furthermore, in our study, only small to negligible correlations were observed between the change in outcome measurements and participants' program year and hours of previous clinical experience, respectively. Therefore, enrollment in a later training year did not impact the magnitude of change in outcome variables that participants experienced, indicating that

students at all levels of training can benefit from additional interviewing experience. Qualitative feedback from those participants at more advanced training levels indicated that they found the study to be useful despite participation in concurrent clinical work.

Contrary to expectations, no change in participants' fear of negative evaluation was observed. Although the FNE was completed immediately prior to presumably anxiety-provoking, evaluative situations (pre- and post-tests), it is likely that the items of the FNE assessed participants' trait-based characteristics (Weeks et al., 2005) and, therefore, were relatively stable over time. Although the effect did not reach statistical significance overall, it is notable that the Experimental group experienced a decrease in FNE scores over time, while the Control group's measurements remained virtually stable, suggesting that a larger sample size may have produced significant results, albeit with a small effect size.

Hypothesis Two

The hypothesis that role-play with SPs will lead to enhanced clinical competency, self-efficacy gains, and anxiety reduction over and above that gained during role-play with peers was not supported. It is theorized that the high fidelity of interactions with SPs, where the actual behaviors the practitioner performs in practice and the environment in which they take place are closely approximated, promotes particularly salient mastery experiences. The resulting higher self-efficacy and associated reduced anxiety levels facilitate the expansion of knowledge and subsequently improve performance (Leigh et al., 2007; Salas, Wilson, Burke, & Priest, 2005). On the other hand, it has been suggested that classroom-based role-play exercises are unlikely to inspire characterizations that are effortful, believable, or accurate. As such, the consequential portrayals are often of

varying quality and have low internal and external validity (Beutler & Howard, 2003). However, it is notable that both Experimental and Control groups engaged in high fidelity simulations within an actual therapy clinic during the pre-and the post-test, which could have attenuated between-group differences. Attendance in the laboratory sessions themselves was not significantly associated with the magnitude of change in outcome variables (aside from that of state anxiety) which provides some support that pre- and post-test simulation may have been sufficient to produce much of the change observed in clinical competency levels and in CSE. Indeed, a large percentage of participants rated the experiencing of a simulated session in the training clinic as the most helpful feature of the study in facilitating their learning. Furthermore, the external validity of SP interaction was greatly reduced during laboratory sessions, where students participated in more traditional classroom-based activities similar to those already experienced in their respective programs' curricula. It is also noteworthy that the peer-based role-plays were highly structured in this protocol. Moreover, participants were given a relatively detailed clinical intake form before each session, giving them time to prepare for their client portrayals, thereby reducing both the spontaneity and the variability of their interaction with their peers. Review of the videotaped laboratory sessions revealed that all "client" portrayals (either by SP or by participant) appeared believable and "accurate;" also, the role-plays performed by students were described as effortful.

It is also conceivable that any between-group differences were hampered by small sample sizes, considerable attrition, and associated lack of power. This possibility is supported by the fact that virtually all of the changes were in the hypothesized directions, even though they did not reach statistical significance.

Considering these findings which seem to indicate that the use of SPs provides no consistent incremental benefit versus role-play with peers during clinical activity (if educators can sufficiently ensure highly structured learning experiences), it may follow that interaction with SPs serves as a better assessment tool than an everyday didactic tool. Several authors cite the considerable time; the resource demands; and, especially, the cost of SP introduction into graduate programs as the significant downsides of this approach (e.g., Kaslow et al., 2009; Sharpless & Barber, 2009). Educators could, however, conceivably work around the cost- and resource-related drawbacks by utilizing upper-level graduate students (likely unfamiliar to the class) as SPs and/or by employing professional SPs only for formal evaluations.

A strength of SP usage not employed in this study is the ability to portray adequately clinical situations of increasing complexity, risk, and difficulty; correspondingly, allowing the SP to present in way that is most relevant to the upper-level competency being measured by the educator (Leigh et al., 2007). A narrow range of competencies was measured in this study; also, only initial interviews were simulated. Trainees may be able to portray rudimentary client presentations and straightforward situations, but they will likely experience difficulty with more complex scenarios, including multiple therapy sessions, due to their lack of experience and knowledge.

Hypothesis Three

Given the aforementioned presumed association between beginning clinicians' anxiety levels, CSE, and clinical competency, it was hypothesized that participants' decreases in fear of negative evaluation and state anxiety and increases in CSE would serve as significant regression predictors of participants' clinical competency acquisition.

Participants' *decrease* in CSE, fear of negative evaluation, and state anxiety measurements explained an additional 8% of the variance in clinical competency acquisition over and above their initial clinical competency measurements, a result which did not reach statistical significance. The linear combination of these change scores and initial competency measurements described approximately half of the variability in participants' competency acquisition. Larson and Daniels (1998, 2001) posited that feedback upon performance, whether its valence, amount, or constructiveness, also contributes to mental health clinicians' enhanced CSEs and performances and, therefore, may have contributed to the overall variance in outcome measurements. Larson and Daniels (2001) also went as far as to impress upon educators and supervisors that competency in counseling skills will not develop without feedback that emphasizes positive aspects of performance which is accompanied by specific ways to improve their skills. Relatedly, in the present study, participants indicated that they had found feedback from group facilitators and "clients" (both SPs and peers) to be helpful in enhancing their interviewing skills.

It is conceivable that 'outside' learning or experience may have contributed to the variance in competency acquisition. Aside from the aforementioned positive effects of experiential learning upon trainees' self-perceptions and successful enactments of targeted skills, a number of studies have indicated moderate-to-strong relationships between the simple gathering of theoretical and procedural knowledge in counseling coursework and both CSE and counselor performance (Larson & Daniels, 1998; Lent, Cinamon, Bryan, Jezzi, Martin, & Lim, 2009). This effect was noted to be stronger for the learning of more concrete microskills (e.g., exploration and action-based skills)

versus more theoretical competencies (e.g., insight and process-related skills) (Hill, Roffman, Stahl, Friedman, Hummel, & Wallace, 2008). In the present study, all participants were enrolled in summer semester courses of their respective programs at the time of the study, and some were also completing a practicum.

As expected, a decrease in state anxiety was observed to be a significant, although a weak-to-moderate, predictor of increased clinical competency. Several authors have reported the deleterious effect that counseling-related anxiety and related feelings of incompetence and fraudulence have upon the successful execution of counseling skills (e.g., Al-Darmaki, 2004; Hiebert, Uhlemmann, Marshall, & Lee, 1998; Stoltenberg, McNeill, & Delworth, 1998; Larson & Daniels, 1998). Feelings of anxiety, along with accompanying lowered CSE, have also been observed to determine the type of response trainees give to clients' statements (e.g., challenging versus passive) (Sipps, Sugden, & Faiver, 1988). Overall, Ronnestad and Skovholt (1993) warned that high anxiety can lead students to develop an external orientation and locus of control related to skill development, considerably limiting their growth as clinicians.

No significant relationships were observed between fear of negative evaluation or CSE. The lack of association between evaluation anxiety and competency acquisition was to be expected due to overall lack of change in FNE scores over time. Furthermore, authors have suggested that trainees' fears of performance evaluation through audio- or video-taping is over-emphasized in the supervision literature; although sometimes reported by beginning clinicians, it is not necessarily pervasive, as demonstrated in a series of studies by Ellis and colleagues (Ellis, Krengel, & Beck, 2002; Ellis, 2010). The authors hypothesized that this effect may be due to trainees' abilities to balance self-

reflection by shifting between internal and external foci in a manner that did not significantly impact their anxiety levels nor their clinical performances (Ellis, Krengel, & Beck, 2002).

With regard to CSE, Larson and Daniels (1998), along with Bandura and colleagues (1977, 1983, 1989), emphasized the importance of feedback from the environment, both in the creation of self-efficacy beliefs and in the honing of behavior. Correspondingly, in the absence of direct feedback from evaluators, it is expected that personal CSE estimates will be distinct from more observable measures of performance - namely, trained raters' scores. It follows that those perceptions not shared with the counselor are not likely to interrelate with the counselor's CSE (Larson & Daniels, 1998).

Although it was not found to be a significant predictor of competency acquisition in the current study, a small, negative relationship between change in CSE and skill attainment was observed instead of the expected positive association. This trend may reflect Bandura and Locke's (2003) assertion that "Some self-doubt about one's performance efficacy provides incentives to acquire the knowledge and skills needed to master challenges" (p. 96). Emphasizing control theory, Vancouver and Kendall (2006) posited that perceived self-efficacy impacts performance expectations, causing the individual to expect incongruity between personal ability and performance tasks and to motivate him or her to obtain the resources needed.

Limitations of the Study

As previously stated, small sample sizes and participant attrition contributed to a deficit in statistical power within this study. In order to enhance participation and to retain participants, future research may include fewer laboratory sessions, as this study

required a substantial time commitment throughout six weeks in the summertime. Furthermore, camera malfunctions excluded two post-test videos from the analysis.

The clinical psychology doctoral program, comprised of mostly young females, was over-represented in this study sample; consequently, the external validity and generalization of results to other NSU programs or to other training programs is impacted. Although reliability and validity estimates based on the initial piloting of the SPICES measure were at least adequate, results may have been enhanced with more firmly established psychometrics. Finally, the addition of a no-treatment control group would aid in design rigor.

Implications for Training and Future Research

The current study demonstrated the efficacy of two experiential-based training tools, role-play with student peers and role-play with SPs. Such high-fidelity training methods were found to affect mental health trainee's CSE, anxiety, and overall clinical competency acquisition positively. This underscores the importance of inclusion of experientially-based didactic learning opportunities within graduate school curricula, even in addition to existing clinical practica and supervision. Reiteration of the study, increasing sample size and including individuals more representative of the trainee population at large, would increase both confidence in the effectiveness of the training protocol and the external validity of the study's findings.

A reliable, valid, and user-friendly assessment tool for the measurement of clinical competency was developed, based closely upon the APA's distributed Competency Benchmarks for trainees at pre-practicum levels, addressing a noticeable gap in the clinical competency literature. Gathering further data on its psychometric

properties would contribute to evaluation of its utility. This study evaluated a relatively narrow range of basic competencies specific to entry-level graduate students. A direction for further research would be to determine desirable higher-level competencies and to evaluate them utilizing the intervention detailed in this study with more advanced graduate students. Creation of another version of the assessment tool piloted in this study based upon higher-level competencies would also contribute substantially to the literature. As stressed by several authors, elucidation of competencies, both specific to individual training programs and to mental health education at large; mechanisms to train those competencies; and sound tools to assess them, are needed to advance the practice of competency building and assessment and to foster the overarching "culture of competence" in mental health professions (Hatcher et al., 2013b; Kaslow et al., 2009; Rodolfo et al., 2005; Rodolfo et al., 2013; Schaffer, Rodolfo, Hatcher, & Fouad, 2013).

This study also highlighted the role that decreasing students' anxiety level surrounding clinical contact has upon the acquisition and the enactment of targeted competencies. It follows that actions or interventions to decrease students' counseling-related anxiety, outside of simple learning- and experience-based effects, would likely enhance the effectiveness of training programs. Several authors have emphasized the importance of both educators and supervisors in the reduction of students' anxiety. Increasing students' confidence through positive feedback, support, reassurance, empathy, and affirmation has been associated with significant reductions in anxiety levels, as supported by both quantitative and qualitative investigation (Daniels & Larson, 2001; Hill, Sullivan, Knox, & Schlosser, 2007; Larson & Daniels, 1998). Given that trainee anxiety typically leads to some degree of external orientation during skill

development (Ronnestad & Skovholt, 1993), taking a relatively active and directive approach will likely lead to anxiety reduction (Hill, Sullivan, Knox, & Schlosser, 2007). However, experts warn that excessive structure and directiveness may exacerbate such external orientations, narrowing students' learning and ultimately fostering feelings of incompetence (Gazzola & Theriault, 2007). Educators, then, are recommended to encourage trainee exploration of practice and theory, to enhance motivation for learning and further practice of counseling skills, and to promote preparation before practice of skills or actual clinical encounters (Hill, Sullivan, Knox, & Schlosser, 2007; Vancouver & Kendall, 2006). Furthermore, the encouragement of traditional means to attenuate anxiety, such as positive self-talk, rationalization, seeking support from others, and even journaling, is also encouraged (Hill, Sullivan, Knox, & Schlosser, 2007).

Conclusion

This study provides preliminary evidence for the effectiveness of utilizing both SPs and role-plays in increasing the clinical competency levels of introductory mental health graduate students. The APA is currently vetting new standards of accreditation that will result in substantive changes to the way in which we train and assess graduate students in psychology. One particular area that is relevant to this study is the requirement that programs engage in direct observation of their trainees to assess competence. Since psychotherapy sessions have traditionally been out of the purview of supervisors, the use of role-plays with standardized patients can meet this requirement. Our findings help to elucidate the mechanism of clinical competency acquisition, particularly through the gain of practice-based mastery experiences performed in the absence of actual client contact, as well as the associated decreases in anxiety and

increases in self-efficacy that such experiences produce. Such research, coupled with core competency delineation and associated assessment, helps to form the foundation for the development of competent professionals. Ultimately, this provides the profession at large direction for the future and supports its accountability to the public.

References

Adamo, G. (2003). Simulated and standardized patients in OSCEs: Achievements and challenges 1992-2003. *Medical Teacher, 25*(3), 262-270. doi: 10.1080/0142159031000100300

Al-Darmaki, F. (2004). Counselor training, anxiety, and counseling self-efficacy: Implications for training psychology students from the United Arab Emirates University. *Social Behavior and Personality, 32*(5), 429-440. doi: 10.2224/sbp.2004.32.5.429

Allen, J., Evans, A., Foulkes, J., & French, A. (1998). Simulated surgery in the summative assessment of general practice training: Results of a trial in the Trent and Yorkshire regions. *British Journal of General Practice, 48,* 1219-1223. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1410184/

Association of Standard Patient Educators. (2014). *About ASPE*. Retrieved from http://www.aspeducators.org/about-aspe.php

American Counseling Association (2005). *ACA code of ethics*[PDF document]. Retrieved from http://www.counseling.org/resources/aca-code-of-ethics.pdf

American Psychological Association. (2012). *Competency benchmarks in professional psychology* [PDF document]. Retrieved from http://www.apa.org/ed/graduate/revised-competency-benchmarks.aspx

Baer, J., Rosengren, D., Dunn, C., Wells, E., Ogle, R. L., & Hartzler, B. (2004). An evaluation of workshop training in motivational interviewing for addiction and mental health clinicians. *Drug and Alcohol Dependence, 73,* 99–106. doi: 10.1016/j.drugalcdep.2003.10.001

Baer, J. S., Wells, E. A., Rosengren, D. B., Hartzler, B., Beadnell, B., & Dunn, C. W. (2009). Agency context and tailored training in technology transfer: A pilot evaluation of motivational interviewing training for community counselors. *Journal of Substance Abuse Treatment, 37,* 191–202. doi:10.1016/j.jsat.2009.01.003

Baker, S. B., & Daniels, T. G. (1989). Integrating research on the microcounseling program: A meta-analysis. *Journal of Counseling Psychology*, *36*(2), 213-222. doi: 10.1037//0022-0167.36.2.213

Baker, S. B., Daniels, T. G., & Greeley, A. T. (1990). Systematic training of graduate-level counselors: Narrative and meta-analytic reviews of three major programs. *The Counseling Psychologist, 18,* 355-421. doi: 10.1177/0011000090183001

Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. *Psychological Review, 84*(2), 191-215. doi: 10.1037//0033-295X.84.2.191

Bandura, A. (1982). Self-efficacy mechanism in human agency. *American Psychologist, 37*(2), 122-147. doi: 10.1037//0003-066X.37.2.122

Bandura, A. (1986). Fearful expectations and avoidant actions as coeffects of perceived self-efficacy. *American Psychologist,* 1389-1391. doi: 10.1037/0003-066X.41.12.1389

Bandura, A. (1989). Regulation of cognitive processes through perceived self-efficacy. *Developmental Psychology, 25*(5), 729-735. doi: 10.1037//0012-1649.25.5.729

Bandura, A. (1990). Conclusion: Reflections on ability determinants of competence. In R. J. Steinberg, & J. Kolligian, (Eds.), *Competence considered* (pp. 315-409). New Haven, CT: Yale University Press.

Bandura, A., & Cervone, D. (1983). Self-evaluative and self-efficacy mechanisms governing the motivational effects of goal systems. *Journal of Personality and Social Psychology, 45*(5), 1017-1028. doi: 10.1037//0022-3514.45.5.1017

Bandura, A., & Locke, E. A. (2003). Negative self-efficacy and goal effects revisited. *Journal of Applied Psychology, 88*(1), 87-31. doi: 10.1037/0021-9010.88.1.87

Bandura, A., & Wood, R. (1989). Effect of perceived controllability and performance standards on self-regulation of complex decision making. *Journal of Personality and Social Psychology, 56*(5), 805-814. doi: 10.1037//0022-3514.56.5.805

Barrows, H. S. (1968). Simulated patients in medical teaching. *Canadian Medical Associates Journal, 98,* 674-676. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1924019/

Barrows, H. S. (1993). An overview of the uses of standardized patients for teaching and evaluating clinical skills. *Academic Medicine, 68*(6), 443–451. doi: 10.1097/00001888-199306000-00002

Berg, B. (1978). Learning family therapy through simulation. *Psychotherapy: Theory, Research, and Practice, 15*(1), 56-60. doi: 10.1037/h0085841

Bervin, N. L. (1985). Reliability and validity of standardized case management simulations. *Journal of Counseling Psychology, 32*(2), 397-409. doi: 10.1037//0022-0167.32.3.397

Beullens, J., Rethans, J. J., Goedhuys, J., & Buntinx, F. (1997). The use of standardized patients in research in general practice. *Family Practice, 14*(1), 58-62. doi: 10.1093/fampra/14.1.58

Beutler, L. E., & Howard, M. (2003). Training in psychotherapy: Why supervision does not work. *The Clinical Psychologist, 56*(4), 12-16. doi: 10.1037/e533232009-003

Brenner, A. M. (2009). Uses and limitations of simulated patients in psychiatric education. *Academic Psychiatry, 33,* 112-119. doi: 10.1176/appi.ap.33.2.112

Cantrell, M. J., & Deloney, L. A. (2007). Integration of standardized patients into simulation. *Anesthesiology Clinics, 25,* 377-383. doi: 10.1016/j.anclin.2007.03.003

Clay, M. C., Lane, H., Willis, S. E., Peal, M., Chakravarthi, S., & Poehlman, G. 2000. Using a standardized family to teach clinical skills to medical students. *Teaching and Learning in Medicine, 12*(3), 145–149. doi:10.1207/S15328015TLM1203_5

Cleland, J. A., Abe, K., & Rethans, J. (2009). The use of simulated patients in medical education: AMEE Guide No 42. *Medical Teacher, 31,* 477-486. doi: 0.1080/01421590903002821

Collins, J. P., & Harden, R. M. (1998). AMEE Medical Education Guide No. 13: Real patients, simulated patients, and simulators in clinical examinations. *Medical Teacher, 20*(6), 508-521. doi: 10.1080/01421599880210

Cramer, R. J., Johnson, S. M., McLaughlin, J., Rausch, E. M., & Conroy, M. A. (2013). Suicide risk assessment training for psychology doctoral programs: Core competencies and a framework for training. *Training and Education in Professional Psychology, 7*(1), 1-11. doi: 10.1037/a0031836

Cross, W., Matthieu, M. M., Lezine, D., & Knox, K. L. (2010). Does a brief suicide prevention gatekeeper training program enhance observed skills? *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 31*(1), 149-159. doi: 10.1027/0227-5910/a000014

Daniels, J. A., & Larson, L. M. (1998). Review of the counseling self-efficacy literature. *The Counseling Psychologist, 26*(2), 179-218. doi: 10.1177/0011000098262001

Daniels, J. A., & Larson, L. M. (2001). The impact of performance feedback on counseling self-efficacy and counselor anxiety. *Counselor Education and Supervision, 41*(2), 120-131. doi: 10.1002/j.1556-6978.2001.tb01276.x

Davis, K., Hector, M., Meara, N., King, J., Tracy, D., & Wycoff, J. (1985). Teaching counselor trainees to respond consistently to different aspects of anger. *Journal of Counseling Psychology, 32,* 580–588. doi: 10.1037/0022-0167.32.4.580

DeMers, S. T. (2009). Real progress with significant challenges ahead: Advancing competency assessment in psychology. *Training and Education in Professional Psychology, 3*(4), S66-S69. doi: 10.1037/a0017534

DeViva, J. C. (2006). The effects of full-day and half-day workshops for health care providers in techniques for increasing resistant clients' motivation. *Professional Psychology: Research and Practice, 37*(1), 83–90 . doi: 10.1037/0735-7028.37.1.83

Dimeff, L. A., Koerner, K., Woodcock, E. A., Beadnell, B., Brown, M. Z., Skutch, J. M., ... Harned, M. S. (2009). Which training method works best? A randomized controlled trial comparing three methods of training clinicians in dialectical

behavior therapy skills. *Behavioural Research and Therapy, 47,* 921–930. doi: 10.1016/j.brat.2009.07.011

Ellis, M. V. (2010.) Bridging the science and practice of clinical supervision: Some discoveries, some misconceptions. *The Clinical Supervisor, 29*(1), 95-116. doi: 10.1080/07325221003741910

Ellis, M. V., Krengel, M., & Beck, M. (2002). Testing self-focused attention theory in clinical supervision: Effects on supervisee anxiety and performance. *Journal of Counseling Psychology, 40*(1), 101-116. doi: 10.1037//0022-0167.49.1.101

Epstein, R. M., & Hundert, E. M. (2002). Defining and assessing professional competence. *Journal of the American Medical Association, 287,* 226–235. doi: 10.1001/jama.287.2.226

Fairburn, C. G., & Cooper, Z. (2011). Therapist competence, therapy quality, and therapist training. *Behaviour Research and Therapy, 49,* 373-378. doi: 10.1016/j.brat.2011.03.005

Fouad, N. A., Grus, C. L., Hatcher, R. L., Kaslow, N. J., Hutchings, P. S., Madson, M. B., Collins, F. L., & Crossman, R. (2009). Competency benchmarks: A model for understanding and measuring of competence in professional psychology across training levels. *Training and Education in Professional Psychology, 4*(Suppl.), S5–S26. doi: 10.1037/a0015832

Freeman, K. A., & Morris, T. L. (1999). Investigative interviewing with children: evaluation of the effectiveness of a training program for child protective service workers. *Child Abuse and Neglect, 23*(7), 701-713. doi: 10.1016/S0145-2134(99)00042-3

Friedlander, M. L., Keller, K. E., Peca-Baker, T. A., & Olk, M. E. (1986). Effects of role conflict on counselor trainees' self-statements, anxiety level, and performance. *Journal of Counseling Psychology, 33*(1), 73-77. doi: 10.1037//0022-0167.33.1.73

Gazzola, N., & Theriault, A. (2007). Super- (and not-so-super-) vision of counsellors-in-training: Supervisee perspectives on broadening and narrowing processes. *British Journal of Guidance and Counselling, 35*(2), 189–204. doi: 10.1080/03069880701256601

Gibbons, F. X., Smith, T. W., Ingram, R. E., Pearce, K., Brehm, S. S., & Schroeder, D. J. (1985). Self-awareness and self-confrontation: Effects of self-focused attention on members of a clinical population. *Journal of Personality and Social Psychology, 48*, 662–675. doi: 10.1037/0022-3514.48.3.662

Grater, H. A. (1985). Stages in psychotherapy supervision: From therapy skills to skilled therapist. *Professional Psychology: Research and Practice, 16*, 605–610. doi: 10.1037/0735-7028.16.5.605

Hatcher, R. L., Fouad, N. A., Campbell, L. F., McCutcheon, S. R., Grus, C. L., & Leahy, K. L. (2013a). Competency-based education for professional psychology: Moving from concept to practice. *Training and Education in Professional Psychology, 7*(4), 225-234. doi: 10.1037/a0033765

Hatcher, R. L., Fouad, N. A., Grus, C. L., Campbell, L. F., McCutcheon, S. R., & Leahy, K. L.(2013b). Competency benchmarks: Practical steps toward a culture of competence. *Training and Education in Professional Psychology, 7*(2), 84-91. doi: 10.1037/a0029401

Hatcher, R. L., & Lassiter, K. D. (2007). Initial training in professional psychology: The practicum competencies outline. *Training and Education in Professional Psychology, 1*(1), 49-63. doi: 10.1037/1931-3918.1.1.49

Hiebert, B., Uhlemann, M. R., Marshall, A., & Lee, D. Y. (1998). The relationship between self-talk, anxiety, and counseling skills. *Canadian Journal of Counselling, 32,* 163-171. [PDF document]. Retrieved from http://files.eric.ed.gove/fulltext/EJ569852.pdf

Heppner, P. P., & Krauskopf, C. J. (1987). An information processing approach to personal problem-solving. *The Counseling Psychologist, 15*, 371-447. doi: 10.1177/0011000087153001

Hess, S. A, Knox, S., Schultz, J. M., Sloan, L., Brandt, S., Kelley, F., Hoffman, M. A., & Hill, C. E. (2008). Predoctoral interns' nondisclosure in supervision. *Psychotherapy Research, 18*, 400-411. doi: 10.1080/10503300701697505

Hill, C. E., & Lent, R. W. (2006). A narrative and meta-analytic review of helping skills training: Time to revive a dormant area of inquiry. *Psychotherapy: Theory, Research, Practice, Training, 43*(2), 154-172. doi: 10.1037/0033-3204.43.2.154

Hill, C. E., Roffman, M., Stahl, J., Friedman, S., Hummel, A., & Wallace, C. (2008). Helping skills training for undergraduates: Outcomes and prediction of outcomes. *Journal of Counseling Psychology, 55*(3), 359–370. doi: 10.1037/0022-0167.55.3.359

Hill, C. E., Sullivan, C., Knox, S., & Schlosser, L. Z. (2007). Becoming psychotherapists: Experiences of novice trainees in a beginning graduate class. *Psychotherapy: Theory, Research, Practice, Training, 44*(4), 434-449. doi: 10.1037/0033-3204.44.4.434

Hodgson, J. L., Lamson, A. L., & Feldhousen, E. B. (2007). Use of stimulated clients in marriage and family therapy education. *Journal of Marital and Family Therapy, 33*(1), 35-50. doi: 10.1111/j.1752-0606.2007.00003.x

Hogan, R. A. (1964). Issues and approaches in supervision. *Psychotherapy: Theory, Research, and Practoice, 1,*139–141. doi: 10.1037/h0088589

Howard, E. E., Inman, A. G., & Altman, A. N. (2006). Critical incidents among novice counselor trainees. *Counselor Education and Supervision, 46,* 88-102. doi: 10.1002/j.1556-6978.2006.tb00015.x

Howley, L. D. (2004). Performance assessment in medical education: Where we've been and where we're going. *Evaluation & the Health Professions, 27*(3), 285-303. doi: 10.1177/0163278704267044

Ivey, A. E. (1971). *Microcounseling: Innovations in interviewing training*. Springfield, IL: Charles C .Thomas.

Ivey, A. E., Normington, C. J., Miller, C. D., Morrill, W. H., & Haase, R. F. (1968). Microcounseling and attending behavior: An approach to prepracticum counselor

training. *Journal of Counseling Psychology, 5*(2), 1-12. doi: 10.1037/h0026129

Kaslow, N. J. (2004). Competencies in professional psychology. *American Psychologist, 59,* 774–781. doi: 10.1037/0003-066x.59.8.774

Kaslow, N. J., Borden, K. A., Collins, F. L., Forrest, L., Illfelder-Kaye, J., Nelson, P. D., & Rallo, J. S. (2004). Competencies conference: Future directions in education and credentialing in professional psychology. *Journal of Clinical Psychology, 60*(7), 699-2004. doi: 0.1002/jclp.20016

Kaslow, N. J., Grus, C. L., Campbell, L. F., Fouad, N. A., Hatcher, R. L., & Rodolfa, E. R. (2009). Competency assessment toolkit for professional psychology. *Teaching and Education in Professional Psychology, 3*(4), S27-S45. doi: 10.1037/a0015833

Kaslow, N. J., Rubin, N. J., Bebeau, M. J., Leigh, I. W., Lichtenberg, J. W., Nelson, P. D., Portnoy, S. M., & Smith, I. L. (2007). Guiding principles and recommendations for the assessment of competence. *Professional Psychology: Research and Practice, 38*(5), 441-451. doi: 10.1037/0735-7028.38.5.441

Klamen, D. L., & Yudkowsky, R. (2002). Using standardized patients for formative feedback in an introduction to psychotherapy course. *Academic Psychiatry, 26*(3), 168-172. doi: 10.1176/appi.ap.26.3.168

Larson, L. M. (1998). The social cognitive model of counselor training. *The Counseling Psychologist, 26,* 179-218. doi: 10.1177/0011000098262002

Larson, L. M., Clark, M. P., Wesely, L. H., Koraleski, S. F., Daniels, J. A., & Smith, P. L. (1999). Videos versus role-plays to increase counseling self-efficacy in pre-practica trainees. *Counselor Education and Supervision, 38*(4), 237-248. doi: 10.1002/j.1556-6978.1999.tb00574.x

Larson, L. M., Suzuki, L. A., Gillespie, K. N., Potenza, M. T., Bechtel, M. A., & Toulouse, A. L. (1992). Development and validation of the Counseling Self-Estimate Inventory. *Journal of Counseling Psychology, 39*(1), 105-120. doi: 10.1037//0022-0167.39.1.105

Leach, M. M., Stoltenberg, C. D., McNeill, B. W., & Eichenfield, G. A. (1997). Self-efficacy and counselor development: Testing the integrated developmental model. *Counselor Education and Supervision, 37*(2), 115-124. doi: 10.1002/j.1556-6978.1997.tb00537.x

Leary, M. R. (1983). A brief version of the Fear of Negative Evaluation Scale. *Personality and Social Psychology Bulletin, 9,* 371-375. doi: 10.1177/0146167283093007

Lee, R. E., Eppler, C., Kendal, N., & Latty, C. (2001). Critical incidents in the professional lives of first-year MFT students. *Contemporary Family Therapy, 23*(1), 51-61. doi: 10.1023/A:1007872132292

Leigh, I. W., Smith, I. L., Bebeau, M. J., Lichtenberg, J. W., Nelson, P. D., Portnoy, S., …Kaslow, N. J. (2007). Competency assessment models. *Professional Psychology: Research and Practice, 38*(5), 463-473. doi: 10.1037/0735-7028.38.5.463

Lent, R. W., Cinamon, R. G., Bryan, N. A., Jezzi, M. M., Martin, H. M., & Lim, R. (2009). Perceived sources of change in trainees' self-efficacy beliefs. *Psychotherapy Theory, Research, Practice, Training, 46*(3), 317-327. doi: 10.1037/a0017029

Levitov, J. E., Fall, K. A., & Jennings, M. C. (1999). Counselor clinical training with client-actors. *Counselor Education and Supervision, 38*(4), 249-259. doi: 10.1002/j.1556-6978.1999.tb00575.x

Linsk, N. L., & Tunney, K. (1997). Learning to care: Use of practice simulation to train health social workers. *Journal of Social Work Education, 33*(3), 473-490. doi: 10.1080/10437797.1997.10778887

Loganbill, C., Hardy, E., & Delworth, U. (1982). Supervision: A conceptual model. *The Counseling Psychologist, 10,* 3–42. doi:10.1177/0011000082101002

McNaughton, N., Ravitz, P., Wadell, A., & Hodges, B. D. (2008). Psychiatric education and simulation: A review of the literature. *Canadian Journal of Psychiatry, 53*(2), 85-93. Retrieved from http://publications.cpa-apc.org/browse/documents/296

Ments, M. V. (1999). The effective use of role-play: Practical techniques for improving learning (2nd ed.). London: Kogan Page.

Miller, J. K. (2010). Competency-based training: Objective structured clinical exercises (OSCE) in marriage and family therapy. *Journal of Marital and Family Therapy, 36*(3), 320-332. doi: 10.1111/j.1752-0606.2009.00143.x

Miller, W. R., Yahne, C. E., Moyers, T. B., Martinez, J., & Pirritano, M. (2004). A randomized trial of methods to help clinicians learn motivational interviewing. *Journal of Consulting and Clinical Psychology, 72*, 1050–1062. doi:10.1037/0022-006X.72.6.1050

Moreland, J. R., Ivey, A. E., & Phillips, J. S. (1973). An evaluation of microcounseling as an interviewer training tool. *Journal of Counseling and Clinical Psychology, 41*(2), 294-300. doi: 10.1037/h0035136

Munley, P. H. (1974). A review of counseling analogue research methods. *Journal of Counseling Psychology, 21*, 320-330. doi:10.1037/h0036734

Muse, K., & McManus, F. (2013). A systematic review of methods for assessing competence in cognitive-behavioural therapy. *Clinical Psychology Review, 33*, 484-499. doi:10.1016/j.cpr.2013.01.010

National Association of School Psychologists. (2006). School psychology: A blueprint for training and practice III [PDF document]. Retrieved from http://www.nasponline.org/resources/blueprint/finalblueprintinteriors.pdf

Orlinsky, D., Ronnestad, M. H., Ambuhl, H., Willutzki, U., Botermans, J., Cierpka, M., … & Davis, M. (1999). Psychotherapists' assessments of their development at different career levels. *Psychotherapy*: *Theory, Research, Practice, Training*, *36*(3), 203-215. doi:10.1037/h0087772

Perera, J., Perera, J., Abdullah, J., & Lee, N. (2009). Training simulated patients: Evaluation of a self-assessment and peer/tutor feedback to improve performance. *BMC Medical Education, 9*(1), 37-42. doi: 10.1186/1472-6920-9-37

Peterson, R. L., Peterson, D. R., Abrams, J. C., & Stricker, G. (1997). The National Council of Schools and Programs of Professional Psychology education model. *Professional Psychology: Research and Practice, 28,* 373–386. doi: 10.1037/12068-001

Pomerantz, A. M. (2003). Who plays the client? Collaborating with theater departments to enhance clinical psychology role-play training exercises. *Journal of Clinical Psychology, 59,* 363-368. doi: 10.1002/jclp.10079

Poorman, P. B. (2002). Biography and role-playing: Fostering empathy in abnormal psychology. *Teaching of Psychology, 29*(3), 32-36. doi: 10.1207/S15328023TOP2901_08

Ridley, C. R., Kelly, S. M., & Mollen, D. (2011). Microskills training: Evolution, examination, and call for reform. *The Counseling Psychologist, 39*(6), 800-824. doi: 10.1177/0011000010378438

Roberts, M. C., Borden, K. A., Christiansen, M. D., & Lopez, S. J. (2005). Fostering a culture shift: Assessment of competence in the education and careers of professional psychologists. *Professional Psychology: Research and Practice, 36*, 355–361. doi:10.1037/0735-7028.36.4.355

Rodolfa, E., Bent, R., Eisman, E., Nelson, P., Rehm, L., & Ritchie, P. (2005). A cube model for competency development: Implications for psychology educators and regulators. *Professional Psychology: Research and Practice, 36*(4), 347-354. doi: 10.1037/0735-7028.36.4.347

Rodolfa, E., Greenberg, S., Hunsley, J., Smith-Zoeller, M., Cox, D., Sammons, M., . . . Spivak, H. (2013). A competency model for the practice of psychology. *Training and Education in Professional Psychology, 7*(2), 71-83. doi: 10.1037/a0032415

Ronnestad, M. H., & Skovholt, T. M. (1993). Supervision of beginning and advanced graduate students of counseling and psychotherapy. *Journal of Counseling and Development, 71*, 396-405. doi: 10.1002/j.1556-6676.1993.tb02655.x

Salas, E., Wilson, K. A., Burke, C. S., & Priest, H. A. (2005). Using simulation-based training to improve patient safety: What does it take? *Journal on Quality and Patient Safety, 31*(7), 363-371. doi: 10.1016/j.aorn.2013.02.001

Schaffer, J. B., Rodolfa, E. R., Hatcher, R. L., & Fouad, N. A. (2013). Professional psychology competency initiatives: Reflections, contrasts, and recommendations for the next steps. *Training and Education in Professional Psychology, 7*(2), 92-98. doi: 10.1037/a0032038

Sharpless, B. A., & Barber, J. B. (2009). A conceptual and empirical review of the meaning, measurement, development, and teaching of intervention competence in clinical psychology. *Clinical Psychology Review*, *29,* 47-56. doi:10.1016/j.cpr.2008.09.008

Sholomskas, D. E., Syracuse-Siewert, G., Rounsaville, B. J., Ball, S. A., Nuro, K. F., & Carroll, K. M. (2005). We don't train in vain: A dissemination trial of three strategies of training clinicians in cognitive-behavioral therapy. *Journal of Consulting and Clinical Psychology, 73*(1), 106-115. doi: 10.1037/0022-006X.73.1.106

Sipps, G. J., Sugden, G. J., & Faiver, C. M. (1988). Counselor training level and verbal response type: Their relationship to efficacy and outcome expectations. *Journal of Counseling Psychology, 35,* 397-401. doi: 10.1037//0022-0167.35.4.397

Skovholt, T. M., & McCarthy, P. (1988). Critical incidents: Catalysts for counselor development. *Journal of Counseling and Development, 67*(2), 69-72. doi: 10.1002/j.1556-6676.1988.tb02016.x

Skovholt, T. M., & Ronnestad, M. H. (2003). Struggles of the novice counselor and therapist. *Journal of Career Development, 30*(1), 45-58. doi:10.1177/089484530303000103

Spielberger, C. D., Gorsuch, R. L., Lushene, R., Vagg, P. R., & Jacobs, G. A. (1983). *Manual for the State-Trait Anxiety Inventory*. Palo Alto, CA: Consulting Psychologists Press.

Stevens, J. (1996). Applied multivariate statistics for the social sciences (3rd ed.). Mahwah, NJ: Lawrence Erlbaum.

Stillman, P. L., Brown, D. R., Redfield, D. L., & Sabers, D. L. (1977). Construct validation of the Arizona Clinical Interview Rating Scale. *Educational and Psychological Measurement, 37*(4), 1031-1038. doi: 10.1177/001316447703700427

Stoltenberg, C. D., McNeill, B., & Delworth, U. (1998). *IDM supervision: An integrated model for supervising counselors and therapists.* San Francisco, CA: Jossey-Bass Publishers.

Theriault, A., & Gazzola, N. (2010). Therapist feelings of incompetence and suboptimal processes in psychotherapy. *Journal of Contemporary Psychotherapy, 40,* 233-243. doi: 10.1007/s10879-010-9147-z

Theriault, A., Gazzola, N., & Richardson, B. (2009). Feelings of incompetence in novice therapists: Consequences, coping, and correctives. *Canadian Journal of Counseling, 43*(2), 105-119. Retrieved from http://connection.ebscohost.com/c/articles/41046675/feelings-incompetence-novice-therapists-consequences-coping-correctives

Tolen, J., & Lendrum, S. (1995). *Case material and role-play in counseling training.* London: Routledge.

Truax, C. B., & Carkhuff, R. R. (1967). *Toward effective counseling and psychotherapy: Training and practice.* Chicago, IL: Aldine.

Vancouver, J. B. & Kendall, L. N. (2006). When self-efficacy negatively relates to motivation and performance in a learning context. *Journal of Applied Psychology, 91*(5), 1146–1153. doi: 10.1037/0021-9010.91.5.1146

Wallace, J., Rao, R., & Haslam, R. (2002). Simulated patients and objective structured clinical examinations: Review of their use in medical education. *Advances in Psychiatric Treatment, 8,* 342-348. doi: 10.1192/apt.8.5.342

Watson, D., & Friend, R. (1969). Measurement of social-evaluative anxiety. *Journal of Consulting and Clinical Psychology, 33,* 448-457. doi: 10.1037/h0027806

Weeks, J. W., Heimberg, R. G., Fresco, D. M., Hart, T. A., Turk, C. L., Schneier, F. R., & Liebowitz, M. R. (2005). Empirical validation and psychometric evaluation of the Brief Fear of Negative Evaluation Scale in patients with social anxiety disorder. *Psychological Assessment, 17*(2), 179–190. doi:10.1037/1040-3590.17.2.179

Westerman, M. A., & Steen, E. M. (2009). Revisiting conflict and defense from an interpersonal perspective: Using structured role-plays to investigate the effects of conflict on defensive interpersonal behavior. *Psychoanalytic Psychology, 26,* 379-401. doi:10.1037/a0017714

Williams, E. N., Judge, A. B., Hill, C. E., & Hoffman, M. A. (1997). Experiences of novice trainees in pre-practicum: Trainees', clients', and supervisors' perceptions of therapists' personal reactions and management strategies. *Journal of Counseling Psychology, 44*(4), 390-399. doi:10.1037//0022-0167.44.4.390

Appendix A

Study Consent Forms

NOVA SOUTHEASTERN UNIVERSITY

NOVA Southeastern
Institutional Review Board
Approval Date: APR 2 4 2012
Continuing Review Date:
APR 2 3 2013

Consent Form for Participation in the Research Study Entitled
The Simulated Patient Assessment and Research Collaboration

Funding Source: Nova Southeastern University's President's Faculty Research and Development Grant

IRB protocol # **0410120ZExp.**

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Project Manager
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For questions/concerns about your research rights, contact:
Human Research Oversight Board (Institutional Review Board or IRB)
Nova Southeastern University
(954) 262-5369/Toll Free: 866-499-0790
IRB@nsu.nova.edu

Site Information
Nova Southeastern University
Center for Psychological Studies
3301 College Avenue
Fort Lauderdale, FL 33314

What is the study about?
You are invited to participate in a research study. The goal of this study is to identify best-practices in the training of psychology graduate students' basic interviewing skills.

Why are you asking me?
We are inviting you to participate because you are currently a first-year graduate student in psychology. There will be approximately 60 participants in this research.

Initials: _____ Date: _____ Center for Psychological Studies 3301 College Avenue • Fort Lauderdale, Florida 33314-7796 (954) 262-5750

study.

What will I be doing if I agree to be in the study?
Participants will be required to attend six, three-hour laboratory sessions and engage in a 15 minute pre- and post- assessment interview with a standardized patient. A standardized patient is an actor specifically trained to simulate symptoms across various clinical interactions. Prior to the pre-assessment interview, participants will provide demographic information using the Simulated Patient Assessment Demographic Evaluation Survey (SPADES), developed by the researchers. Participants will also complete the Fear of Negative Evaluation (FNE), State-Trait Anxiety Scale (STAI), and the Counseling Self-Estimate Inventory (COSE) prior to the pre- and post-assessment interviews. During the pre- and post-assessment, with a standardized patient participants will be video recorded and rated by trained upper level graduate students utilizing the Skills in Psychological Interviewing: Clinical Evaluation Scales (SPICES). The SPICES measure assesses students from a developmental perspective based upon the benchmark clinical competencies established by the American Psychological Association. Furthermore, the investigators developed the Standardized Patient Assessment of Clinician Effectiveness Scale (SPACES), a brief assessment measure for use by the simulated patient to evaluate the participating student.

During the laboratory sessions, students will practice interviewing microskills. Laboratory sessions will involve case studies to provide opportunities to engage in mock sessions and to enhance interviewing skills. These case studies are de-identified, using modified biopsychosocial reports written for use in NSU's Psychology Services Center. Laboratory sessions will last approximately two hours and will take place in the Center for Psychological Studies.

Is there any audio or video recording?
This research project will include digital video recording of the pre- and post-interactions with a standardized patient. This video recording will be viewed by trained post-doctoral residents who will rate the video recordings with the SPICES measure. Participants will be assigned an I.D. number upon signature of the informed consent form, and all assessment tools will utilize these numbers. Records, which will include the SPADES, SPICES, SPACES, COSE, FNE, and STAI protocols, as well as the video-recorded pre- and post- sessions, will be maintained by the principal investigator in a locked cabinet to minimize risk. Only the project manager will have access to these documents, while the post-doctoral residents will have access to these recordings for rating purposes. All identifying information will be destroyed via shredding the documents three years after completion of the study. Moreover, digital recordings of pre- and post-sessions will be deleted three years after completion of the study. Because your image and your voice will be potentially identifiable by anyone who hears and sees the recording, your confidentiality for things you say or do on the recording cannot be guaranteed although the researcher will try to limit access to the tape as described in this paragraph.

What are the dangers to me?
The loss of confidentiality is a conceivable risk. Mild anxiety may be experienced due to videotaping or performance of interviewing skills in front of a laboratory group. However, these risks are consistent with classroom activities already experienced in graduate training. "If you have questions about the research, your research rights or have a research-related question, please contact Dr. Sarah Valley-Gray via telephone at (954) 262-5274 or via email at vallegra@nova.edu. You may also contact the IRB at (954) 262-5369 or toll free at 866-499-0790 with questions about your research rights."

Are there any benefits to me for taking part in this research study?
You will be able to practice clinical skills in a simulated therapy setting. You will also be assessed and be provided feedback regarding your strengths and weaknesses in clinical interviewing prior to entering an actual clinical setting during practicum. This will allow you an additional opportunity to practice basic counseling skills prior to being required to conduct psychotherapy with an actual client.

Will I get paid for being in the study? Will it cost me anything?
There are no costs to you or payments made for participating in this study. You will be provided with snacks during laboratory sessions. Additionally, you will receive modest incentives such as NSU/CPS marketing/promotional items.

How will you keep my information private?
As stated previously, records which will include the GPADES, GPICES, GPACES, CCSE, FNE, and STAI, as well as the video recorded pre- and post- sessions, will be maintained by the principal investigator in a locked cabinet to minimize risk. Participants will be assigned an I.D. number upon signature of the informed consent form, and all assessment tools will utilize these numbers. A coding key linking assigned ID to name will be maintained by the project manager. The document itself will be password-protected and maintained on a password-protected computer. All information will be destroyed via shredding the documents three years after completion of the study. Moreover, digital video recordings of pre- and post-sessions will be deleted three years after completion of the study. The IRB may review research records.

All information obtained in this study is strictly confidential unless disclosure is required by law.

What if I do not want to participate or I want to leave the study?
You have the right to leave this study at any time or refuse to participate. If you do decide to leave or you decide not to participate, you will not experience any consequences. Unless requested otherwise, if you choose to withdraw from the study, any information collected about you **before** the date you leave the study will be kept in the research records for 36 months from the conclusion of the study and may be used

Initials: _____ Date: _____

as a part of the research.

Voluntary Consent by Participant:
By signing below, you indicate that

- this study has been explained to you
- you have read this document or it has been read to you
- your questions about this research study have been answered
- you have been told that you may ask the researchers any study related questions in the future or contact them in the event of a research-related injury
- you have been told that you may ask Institutional Review Board (IRB) personnel questions about your study rights
- you are entitled to a copy of this form after you have read and signed it
- you voluntarily agree to participate in the study entitled *The Simulated Patient Assessment and Research Collaboration*

Participant's Signature: _____ Date: _____

Participant's Name: _____ Date: _____

Signature of Person Obtaining Consent: _____

Date: _____

Initials: _____ Date: _____

Consent Form for Participation in the Research Study Entitled
The Simulated Patient Assessment and Research Collaboration

Funding Source: Nova Southeastern University's President's Faculty Research and Development Grant

IRB protocol # 04101202Exp

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For questions/concerns about your research rights, contact:
Human Research Oversight Board (Institutional Review Board or IRB)
Nova Southeastern University
(954) 262-5369/Toll Free: 866-499-0790
IRB@nsu.nova.edu

Site Information
Nova Southeastern University
Center for Psychological Studies
3301 College Avenue
Fort Lauderdale, FL 33314

What is the study about?
You are invited to participate in a research study. The goal of this study is to identify best practices in the training of mental health graduate students' basic interviewing skills.

Why are you asking me?
We are inviting you to participate because you are currently a graduate student in either the Center for Psychological Studies or in the School of Humanities and Social Sciences. There will be approximately 40 participants in this research study.

What will I be doing if I agree to be in the study?
Participants will be required to attend five, three-hour laboratory sessions and engage in a 15 minute pre- and post- assessment interview with a simulated patient. A simulated patient is an actor specifically trained to simulate symptoms across various clinical interactions. Prior to the pre-assessment interview, participants will provide demographic information using the *Simulated Patient Assessment Demographic Evaluation Survey* (*SPADES*), developed by the researchers. Participants will also complete the *Fear of Negative Evaluation* (*FNE*), *State-Trait Anxiety Scale* (*STAI*), and the *Counseling Self-Estimate Inventory* (*COSE*) prior to the pre- and post-assessment interviews. During the pre- and post-assessment with a simulated patient, participants will be video recorded and rated by trained upper level graduate students utilizing the *Skills in Psychological Interviewing: Clinical Evaluation Scales* (*SPICES*). The *SPICES* measure assesses students from a developmental perspective based upon the benchmark clinical competencies established by the American Psychological Association. Furthermore, the investigators developed the *Simulated Patient Assessment of Clinician Effectiveness Scale* (*SPACES*), a brief assessment measure for use by the simulated patient to evaluate the participating student. Finally, at the conclusion of the study, participants will be asked to complete an anonymous satisfaction survey evaluating their experience in the study.

During the laboratory sessions, students will practice interviewing microskills. Laboratory sessions will involve case studies. These case studies are de-identified, modified biopsychosocial reports written for use in NSU's Psychology Services Center. Laboratory sessions will provide opportunities to engage in mock sessions and to enhance interviewing skills. They will last approximately three hours and will take place in the Center for Psychological Studies.

Is there any audio or video recording?
This research project will include digital video recording of the pre-test and post-test interactions with a simulated patient. This video recording will be viewed by trained post-doctoral residents who will rate the video recordings using the *SPICES* measure. Participants will be assigned an I.D. number upon signature of the informed consent form, and all assessment tools will utilize these numbers. Records, which will include the *SPADES*, *SPICES*, *SPACES*, *COSE*, *FNE*, *STAI*, the anonymous participant

satisfaction survey, and the video-recorded pre- and post-sessions, will be maintained by the principal investigator in a locked cabinet to minimize risk. Only the project manager will have access to these documents, while the post-doctoral residents will have access to these recordings for rating purposes. All identifying information will be destroyed via shredding the documents three years after completion of the study. Moreover, digital recordings of pre- and post-tests will be deleted three years after completion of the study. Because your image and your voice will be potentially identifiable by anyone who hears and sees the recording, your confidentiality for things you say or do on the recording cannot be guaranteed, although the researcher will try to limit access to the tape as described in this paragraph.

What are the dangers to me?
The loss of confidentiality is a conceivable risk. Mild anxiety may be experienced due to videotaping or performance of interviewing skills in front of a laboratory group. However, these risks are consistent with classroom activities already experienced in graduate training. If you have questions about the research, your research rights or have a research-related question, please contact Dr. Sarah Valley-Gray via telephone at (954) 261-6274 or via email at vallegr@nova.edu. You may also contact the IRB at (954) 262-5369 or toll free at 866-499-0790 with questions about your research rights.

Are there any benefits to me for taking part in this research study?
You will be able to practice clinical skills in a simulated therapy setting. You will also be assessed and be provided feedback regarding your strengths and weaknesses in clinical interviewing.

Will I get paid for being in the study? Will it cost me anything?
There are no costs to you or payments made for participating in this study. You will be provided with snacks during laboratory sessions. We will raffle off two $100 gift cards to those that attend all sessions including pre-test and post-test and four $50 gift cards to those that attend 4 out of 5 sessions including pre-test and post-test. The raffle will be held immediately following the post-test session.

How will you keep my information private?
As stated previously, records including the *SPADES, SPICES, SPACES, COSE, FNE, STAI*, anonymous participant satisfaction survey, and the video recorded pre- and post-sessions, will be maintained by the principal investigator in a locked cabinet to minimize risk. Participants will be assigned an I.D. number upon signature of the informed consent form, and all assessment tools (except for the anonymous survey) will utilize these numbers. A coding key linking assigned ID to name will be maintained by the project manager. The document itself will be password-protected and maintained on a password-protected computer. All information will be destroyed via shredding the documents three years after completion of the study. Moreover, digital video recordings of pre- and post-tests will be deleted three years after completion of the study. The IRB may review research records. All information obtained in this study is strictly confidential

unless disclosure is required by law.

What if I do not want to participate or I want to leave the study?
You have the right to leave this study at any time or refuse to participate. If you do decide to leave or you decide not to participate, you will not experience any consequences. Unless requested otherwise, if you choose to withdrew from the study, any information collected about you **before** the date you leave the study will be kept in the research records for 36 months from the conclusion of the study and may be used as a part of the research.

Voluntary Consent by Participant:
By signing below, you indicate that

- this study has been explained to you
- you have read this document or it has been read to you
- your questions about this research study have been answered
- you have been told that you may ask the researchers any study related questions in the future or contact them in the event of a research-related injury
- you have been told that you may ask Institutional Review Board (IRB) personnel questions about your study rights
- you are entitled to a copy of this form after you have read and signed it
- you voluntarily agree to participate in the study entitled *The Simulated Patient Assessment and Research Collaboration*

Participant's Signature: _____ Date: _____

Participant's Name: _____ Date: _____

Signature of Person Obtaining Consent: _____

Date: _____

NOVA SOUTHEASTERN
Institutional Review Board
Approval Date: APR 16 2015
Continuing Review Date: APR 15 2016

Initials: _____ Date: _____

Appendix B

Simulated Patient Assessment and Research Collaboration Demographic Evaluation Survey

Simulated Patient Assessment and Research Collaboration

Demographic Evaluation Survey
(SPADES)

Check the response that best describes you.

1. **Sex**:
   - ☐ Male
   - ☐ Female

2. **Age**:
   - ☐ 20-24
   - ☐ 25-29
   - ☐ 30-34
   - ☐ 35-39
   - ☐ 40-44
   - ☐ 45-49
   - ☐ 50-54
   - ☐ 55-59
   - ☐ 60+

3. How do you describe yourself?
   - ☐ Black, African American, or Afro-Caribbean
   - ☐ Hispanic or Latino/a
   - ☐ White
   - ☐ Asian
   - ☐ Other (please specify) _____

4. What was your first language?
   - ☐ English
   - ☐ Spanish
   - ☐ French
   - ☐ Creole
   - ☐ Other (please specify) _____

5. In which program are you currently enrolled?

- ☐ Ph.D. in Clinical Psychology
- ☐ Psy.D. in Clinical Psychology
- ☐ Psy.D. in School Psychology
- ☐ Psy.S. in School Psychology
- ☐ M.S. in Counseling
- ☐ M.S. in Forensic Psychology
- ☐ M.S. in General Psychology
- ☐ M.S. in Mental Health Counseling
- ☐ M.S. in School Counseling
- ☐ M.S. in College Student Affairs
- ☐ M.A. in Cross-Disciplinary Studies
- ☐ M.S. in Conflict Analysis/Resolution
- ☐ Ph.D. in Conflict Analysis/Resolution
- ☐ M.S. in Family Therapy
- ☐ Ph.D. in Family Therapy
- ☐ DMFT
- ☐ M.S. in National Security Affairs
- ☐ Other:_____

6. Are you a full-time or part-time student?

- ☐ Full-time
- ☐ Part-time

7. Are you primarily a campus-based or an online-based student?

- ☐ Campus-based
- ☐ Online-based

8. In which year of your program are you currently enrolled?

- ☐ 1st
- ☐ 2nd
- ☐ 3rd
- ☐ 4th
- ☐ 5th

9. Have you previously participated in the SPARC study?

- ☐ No
- ☐ Yes

10. Have you earned any previous graduate degrees?

- ☐ No
- ☐ Yes

11. If yes, in what discipline?

- ☐ Psychology or related field (e.g., mental health counseling)
- ☐ Other (please specify) _____

12. Have you had any previous clinical experience?

- ☐ No
- ☐ Yes

13. If yes, please specify the type of setting

_____
_____
_____

14. Approximately how many hours of training did you experience at this location? _____

15. Please describe the type of clinical experience you had at this location

_____

16. Please list relevant clinical interviewing coursework you have had to date

_____
_____
_____
_____
_____

17. What was your undergraduate major?

- ☐ Psychology
- ☐ Sciences (e. g., chemistry, biology, etc)
- ☐ Social Sciences (e.g., sociology, philosophy, criminal justice)
- ☐ Education
- ☐ Business
- ☐ Other (please specify) _____

18. What was your undergraduate minor?

- ☐ Psychology
- ☐ Sciences (e. g., chemistry, biology, etc)
- ☐ Social Sciences (e.g., sociology, philosophy, criminal justice)
- ☐ Education
- ☐ Business
- ☐ Other (please specify) _____
- ☐ None

Appendix C

Skills in Psychological Interviewing: Clinical Evaluation Scales

Skills in Psychological Interviewing: Clinical Evaluation Scales (SPICES)
Readiness for Practicum-Level,
Intake Interview Rating Form

Clinical Competency: *An individual's demonstrated ability to understand and to engage in specific tasks in a manner consistent with the expectations for training in a specific profession* (Kaslow et al., 2009)

FOUNDATIONAL COMPETENCIES
PROFESSIONALISM

A. Ethical and Legal Standards and Policy: Application of ethical concepts and awareness of legal issues regarding professional activities with individuals, groups, and organizations
Knowledge of Ethical, Legal, and Professional Standards and Guidelines: *Demonstrates basic knowledge of the principals of the APA Ethical Principles and Code of Conduct (ethical practice and basic skills in ethical decision making); demonstrates beginning level knowledge of legal and regulatory issues in the practice of psychology that apply to practice while placed at practicum setting*

1. Informed Consent*

(as demonstrated by referring to an agency-approved consent form, thoroughly explaining to the client [or parent/guardian, if working with a minor], attempting to ensure that client understands, indicating the interviewer's training status, and obtaining or referring to obtaining the client's [or the parent's/guardian's] signature.)

1-Does not address verbal or written consent

2-Addresses informed consent issues (either accurately or inaccurately) but does not obtain (or refer to obtaining) signature

3-Obtains (or refers to obtaining) signature but explains informed consent issues inaccurately or incompletely

4-Obtains (or refers to obtaining) signature and explains informed consent issues accurately and completely

2. Limits of Confidentiality**

1-Fails to address limits of confidentiality

2-Addresses limits to confidentiality inaccurately or incompletely

3-Indicates limits to confidentiality but inadequately explains one or both

4-Indicates limits of confidentiality fully

**Limits to confidentiality may apply under the following circumstances: Danger to self; Danger to others; Suspected abuse of a child or vulnerable adult; Court order; Placing mental health status at issue in litigation; Self-defense of professional in legal action

Awareness and Application of Ethical Decision-Making: *Demonstrates awareness of the importance of applying an ethical decision model to practice*

3. Suicide Assessment

1-Fails to ask about suicidality or to follow-up if client communicates suicidal ideation
2-Asks about suicidality inappropriately (e.g., "You're not suicidal, are you?")
3-Asks about suicidality appropriately but fails to evaluate for ideation, intent, plans, and means when necessary
4-Asks about suicidality appropriately and evaluates for ideation, intent, plans, and means (or client indicates none)

4. Threat Assessment

1-Fails to ask about homicidality or to follow-up if client communicates homicidal ideation
2-Asks about homicidality inappropriately (e.g., "You're not homicidal, are you?")
3-Asks about homicidality appropriately but fails to evaluate for ideation, intent, and plans
4-Asks about homicidality appropriately and evaluates for ideation, intent, and plans (or client indicates none).

5. Abuse Assessment (physical, verbal, emotional, and sexual)

1-Fails to ask about possible abuse or to follow-up if client communicates abuse issues
2-Asks about possible abuse inappropriately (e.g., "You don't abuse anybody, do you?")
3-Asks about possible abuse appropriately but fails to evaluate including history, signs of abuse, and current threat level
4-Asks about possible abuse appropriately and evaluates including history, signs of abuse, and current threat level

Ethical Conduct: *Displays ethical conduct and values*

6. Personal Boundaries

1-Conveys non-constructive or non-constructive, excessively intimate information
2-Conveys constructive but excessively intimate information
3-Self-discloses constructively in an attempt to normalize or to build rapport, but focus is largely shifted from the client
4-Self-discloses constructively to normalize client concerns and to build rapport or interview does not require self-disclosure

B. Professional Values and Attitudes: *as evidenced in behavior and comportment that reflect the values and attitudes of psychology*

Appearance: *Understands how to present oneself in a professional manner*

7. Personal Hygiene

1-Disheveled and/or unclean (e.g., unkempt hair or too much makeup/cologne/perfume, etc.)
2-Mostly clean cut, but may have loud nail polish, shaggy beard, etc.
3-Clean cut, neat hair
4-Meticulously groomed and coiffed

8. Attire

1- Dressed in a provocative or unkempt manner (e.g., low cut, tight, and/or short clothing for females; low slung and/or tight for males)
2. Dressed too casually or inappropriately (e.g., jeans or shorts and/or t-shirt and/or sandals and/or dirty/stained clothes)
3-Dressed in appropriate but casual attire
4-Dressed in professional attire

Concern for the Welfare of Others: *Demonstrates awareness of the need to uphold and to protect the welfare of others and to facilitate client disclosure*

9. Non-Judgmental Attitude

1-Is consistently critical of client either verbally, non-verbally, or both
2-Expresses criticism toward client verbally, non-verbally, or both at times
3-Rarely displays criticism toward client
4-Demonstrates consistent acceptance of client

10. Appreciation for Client's Life Circumstances

1-Fails to acknowledge or is dismissive of client's stressors
2-Minimizes the significance of client's stressors
3-Acknowledges client's stressors but without conveying the significance of the impact
4-Acknowledges and conveys the importance of client's life circumstances

11. Compassion for the Client

1-Fails to demonstrate compassion for the client
2-Rarely demonstrates compassion for the client
3-Sometimes demonstrates compassion for the client
4-Often/always demonstrates compassion for the client

Efficiency: *Demonstrates organization and effectiveness within the* session

12. Structure of the Interview

1-Fails to provide any identifiable structure (e.g., allows conversation to wander, no discernible goals for session, minimal conversation, or entirely client-dominated)
2-Provides some structure, but allows frequent digressions (many questions are followed by tangential client comments without redirection)
3-Provides structure allowing only occasional digressions (a few questions are followed by tangential client comments without redirection)

4-Provides consistent, responsive structure so client is redirected to salient issue(s)

13. Time Management (Note: Key points consist of presenting problem(s), support system,
family history, substance use/abuse, job/school history, mental health treatment history, medical history, and legal history).

1-Uses time inefficiently; obtains fewer than two key points in allotted time
2-Obtains four or fewer key points in allotted time
3-Obtains six or fewer key points in allotted time
4-Obtains more than six key points in the allotted time

C. Individual and Cultural Diversity: *Awareness, sensitivity, and skills in working professionally with diverse individuals, groups and communities who represent various cultural and personal backgrounds and characteristics defined broadly and consistent with APA policy.*

Interaction of Self and Others as Shaped by Individual and Cultural Diversity and Context: *Demonstrates knowledge, awareness, and understanding of interactions between self and diverse others.*

14. Diversity (e.g., age, gender, race, religion, culture, ethnicity, sexual orientation, language)

1-Conveys intolerance, either explicitly or implicitly, for salient diversity issues (e.g., makes insensitive/disrespectful comments, nonverbal communication conveys insensitivity/disrespect)
2-Does not acknowledge salient diversity issues
3-Promotes some discussion of client's diversity but does not explore its impact upon presenting problem(s)
4-Explores client's diversity and its impact upon presenting problem(s)

RELATIONAL

D. Relationships: *Relates effectively and meaningfully with individuals, groups, and/or communities*

Interpersonal Relationships: *Displays interpersonal skills* **(e.g., develops rapport through posture, facial expression, and voice tone)**

15. Response to Client's Feelings

1-Ignores or does not reflect client's feelings
2-Reflects client's feelings inaccurately and responds ineffectively
3-Reflects client's feelings accurately but responds ineffectively
4-Reflects client's feelings accurately and responds effectively

16. Response to Client's Expressions of Concerns

1-Consistently interrupts client while he/she is trying to share information and fails to acknowledge client's concerns
2-Does not interrupt client constructively and/or fails to acknowledge client's concerns
3-Acknowledges client's concerns, but interrupts the client frequently
4-Only interrupts client constructively and acknowledges client's concerns

17. Indirect Messages/Communications

1-Only responds to the direct messages communicated and ignores or does not acknowledge incongruent tone, non-verbals, etc.
2-Acknowledges client's indirect messages inaccurately and responds ineffectively
3-Acknowledges client's indirect messages accurately but treats them as of secondary importance
4-Acknowledges and responds effectively to both the direct and the indirect communication of the client

Affective Skills: *Displays personal affective skills*

18. Management of Interpersonal Conflict

1-Actively argues and is inappropriately emotional with the client
2-Does not overtly argue, but is inappropriately emotional (e.g., withdraws or appears hostile) with the client
3-Does not overtly respond to conflict, but is noticeably negatively affected (e.g, appears anxious or upset)
4-Manages interpersonal conflict in a mature and professional manner (e.g., using a calm tone and a reflective statement) or no interpersonal conflict observed

19. Management of Ambiguity and Uncertainty

1-Does not tolerate ambiguity and uncertainty and rushes to problem definition and resolution
2-Demonstrates difficulty tolerating ambiguity and uncertainty and rushes to problem definition without sufficient data
3-Tolerates ambiguity and uncertainty but does not clarify problem definition
4-Tolerates ambiguity and uncertainty and facilitates clear problem description(s)

Expressive Skills: *Communicates ideas, feelings, and information clearly using verbal, nonverbal, and written skills*

20. Language in Professional Communication

1-Uses profanity or inappropriate language (e.g., slang) during session
2-Uses language more typical of informal social interactions
3-Uses occasional professional jargon (e.g., use of "technical" terms/acronyms without clarification)
4-Uses language that is clear, coherent, socially appropriate, and consistent with the client's cognitive and emotional level

21. Tone of Speech

1-Uses a tone that is harsh and impairs the development of rapport
2-Uses a tone that is difficult to understand and may interfere with rapport
3-Uses a tone that is intelligible but reflects anxiety (e.g., pressured speech) or is inadequately comforting
4-Uses a tone that sounds comforting and relaxed

22. Communication of Ideas and Information (taking into account client's educational and

developmental level)

1-Fails to communicate information and ideas

2-Communicates ideas and information in a confusing or difficult to interpret manner

3-Communicates information and ideas with some lack of clarity and at times fails to be congruent with client's educational and developmental level

4-Communicates information and ideas clearly and consistent with the client's educational and developmental level

23. Nonverbal Communication (e.g., eye contact, posture, attention to client)

1-Poor nonverbal communication

2-Fair nonverbal communication

3-Good nonverbal communication

4-Excellent nonverbal communication

FUNCTIONAL COMPETENCIES

APPLICATION

E. Assessment: *Assessment and diagnosis of problems, capabilities and issues associated with individuals, groups and/or organizations*
Skills: *Displays basic helping skills*

24. Open-Ended Questioning (when appropriate to question)

1-Utilizes only closed-ended questions

2-Utilizes primarily closed-ended questions

3-Utilizes open-ended questions at least half of the time

4-Primarily utilizes open-ended questions

25. Paraphrasing or Summarizing

1-Fails to utilize paraphrasing and/or summarizing

2-Inappropriately or excessively utilizes paraphrasing and/or summarizing

3-Appropriately but rarely utilizes paraphrasing and/or summarizing

4-Consistently and appropriately utilizes paraphrasing and/or summarizing

26. Closure of the Session

1-Ends the session abruptly

2-Does not end abruptly but fails to summarize or to suggest a plan

3-Does not end abruptly and either summarizes the session or suggests a plan but not both

4-Does not end abruptly, summarizes the session, and suggests a plan

Appendix D

Standardized Patient Assessment of Clinician Effectiveness Scale

Standardized Patient Assessment of Clinician Effectiveness Scale (SPACES)

Instructions: Indicate how much each statement reflects your experience of today's session. Circle one number for each item using the following scale.

1	2	3	4
Disagree	Somewhat Disagree	Somewhat Agree	Agree

The clinician seemed confident during the session	1 2 3 4
The clinician made me feel at ease during the session	1 2 3 4
The clinician asked questions to help me to explore my thoughts and feelings	1 2 3 4
The clinician allowed me to talk without interruption	1 2 3 4
The therapist understood what I was saying	1 2 3 4
The conversation flowed easily throughout the session	1 2 3 4
The clinician seemed genuinely interested in what I was saying	1 2 3 4

Appendix E

Participant Satisfaction Survey

The Simulated Patient Assessment and Research Collaboration
Satisfaction Survey

Please Indicate:

- Participant sex: _____
- Participant current graduate program:_____
- Participant year in program: _____
- Participant laboratory group:
  - ☐ Role-Play with Peers
  - ☐ Role-Play with Simulated Patients

Please Indicate your level of agreement with the following statements, where:

1=Strongly Disagree
2=Disagree
3=Neither Agree nor Disagree
4=Agree
5=Strongly Agree

_____The laboratory sessions were helpful in the training of my interviewing skills.
_____This intervention has decreased my anxiety over client interaction.
_____I do not feel more prepared for future interactions with clients.
_____I found the pre- and post-test simulated sessions to be unrealistic.
_____I found the pre- and post-test simulated sessions to be anxiety-provoking.
_____I found the SPACES rating scale (filled out by "clients") to provide me with little useful feedback.
_____I found the facilitators' feedback during the laboratory sessions to be helpful.
_____I found my peers' feedback during the laboratory sessions to be worthless.
_____Overall, I feel that I received an adequate amount of feedback during this study.
_____I found the cases portrayed to be inadequate depictions of clients I expect to see.
_____I am glad that I participated in this study.
_____I feel that a program such as this should not be implemented in mental health graduate programs.

Please rank in order of helpfulness

_____Experiencing a simulated session
_____General practice of interviewing skills during laboratory sessions
_____Observing videotapes of yourself performing an interview
_____Feedback from post-docs after pre-and post-tests
_____Feedback from simulated patient/role-played client
_____Other:_____

Please indicate how this study could be improved:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Appendix F

SP Case: Major Depressive Disorder

Identifying Case Factors:

Presenting complaint: Depression, sleep problems

SP Demographics:

Name: Michelle Dudley
Gender: Female
Age: 30-50
Ethnicity: Any

SP Opening Statement: "All I want to do is sleep and I'm tired all the time."

History of present illness:
Your husband was arrested two months ago for misappropriating house foreclosure funds. If he goes to prison, which seems likely, you will be the sole support of the family. The mortgage scandal has hit the front page of the newspaper. You feel ashamed to even go shopping or go to church in the event that you run into people that know you. You are dreading the public exposure of sitting in the courtroom during the trial. You are enraged with your husband for bringing this shame on you and the children. You and your husband have not been emotionally close in recent years and you wish you could leave him. You feel that you would be abandoning your husband when he most needs you most if you were to leave. Moreover, you are certain that his parents and your children would hate you for doing so. Your mother always taught you, "You don't kick a dog when he's down."

You sleep in two different rooms, but act cordial to each other in front of your two daughters. You cannot even look him in the eyes, and have not even spoken to him since the arrest when you are not in front of the girls.

You used to make it a point to see your three closest girlfriends for brunch every Sunday after church. You cannot face them anymore, and even if you did, you would definitely not be able to enjoy yourself. You can't even sit through a church service. You are angry at God for putting your family through this. You used to sew and scrapbook for fun, but can't enjoy it anymore.

Symptoms:

- Depression
    - You feel humiliated (stemming from over-identifying with husband's disgrace); also you feel shame about wanting to abandon him (these feelings stem from childhood experiences and teachings).
- Can't eat-food has no taste, and you're not hungry. You have lost 15 pounds in

the past two months.
- You cry nightly after the girls have gone to bed.
- You wake up 3 to 4 times a night; it takes you an hour to fall asleep. You average 4-5 hours of sleep a night.
- You are fatigued, you cannot think clearly, you have no concentration, and even your movements are slowed.
- You get no pleasure out of life.
- You have daily headaches, and your body generally aches.
- You feel guilty and hopeless.
- You think of suicide often and have a plan, but would not go through with it because of your girls.

Background Information:
You were born and grew up in Davie, FL, and have remained here all of your life. Your mother was a schoolteacher and your father managed an auto body shop. You have no siblings. Your father suffered from alcoholism. He was punitive and critical. You were afraid of him because he would go into rages when he drank, mostly on weekends. Your mother is very meek, and he often slapped her. He never hit you, but often was verbally abusive towards you both. He would call you "stupid" if you brought home anything but an A (which was very rare). He would belittle you for not being more social, and would even make fun of you for studying so hard. He would also laugh at you for being so quiet. Your mother is very loving. Deep down, you do feel angry with her for not leaving your father, but you have never verbalized it. You know she tries her best to see the best in people, and would rather take the abuse then break up the family. Your family never quite fit into the neighborhood and was avoided because of your father's ill temper and abuse. You felt different, inferior, shunned. Your father quit drinking when you went to college at age 18, and apologized profusely for his actions. Your relationship is cordial, and you are unsure if you want to become close with him. You and your mother have always been close. You can't bring yourself to burden her with your recent problems.

Your mother and father were only children. Your father's parents both died when you were very young. Your grandmother died of breast cancer and grandfather died of cirrhosis from alcoholism. Your mother's parents were very involved in your life. Both died of natural causes before your girls were born (were both in their 80's when they passed.)

You had a lot of the same friends throughout your school years. You loved school, it was your escape, and you received straight A's throughout. You played basketball in junior high and high school. You dated a few boys in high school. You met your husband in college and married him after you graduated. You have been married for 9 years. Your relationship was very loving until two years ago, when he became "distant." You began to fight a lot after the children went to bed, and began to feel he was hiding something from you.

Your husband still lives at home—you agreed to keep things as normal as possible for the girls' sake. That was your last real conversation. You feel disgusted when you have to

be around him, and it's such a stress to keep up appearances for the kids. You sleep in different rooms.

Your daughters are five and three years of age. Both are enrolled in soccer and dance class. Both are loving and very "good" children. They are relatively unaware of what has taken place, although the oldest has begun to question why you two "don't kiss anymore." You also have told them that you sleep in different rooms because "daddy snores."

You are a schoolteacher. You taught kindergarten for 8 years. The school where you work is in a low-income neighborhood. It was recently torn down and you will be transferred to another school next year. You don't like the principal at the new school and you are sad that you and your colleagues are being separated. At the same time, you have watched the families of your students become ever more beset by poverty, addictions, and homelessness of late. There seems to be less parental support now than when you began teaching. You are burned-out and distressed that you are probably going to be the only source of income for the family.

You do not smoke or drink. You had your first drink at 21, and do not like the taste of alcohol.

Past medical history:
You broke your left arm when you were 11, but the rest of your medical history is unremarkable. You get the occasional cold and got the flu two years ago, but nothing serious. Your family does not have a significant medical history.

Family medical history:
Your parents are both alive and live in the same home that you grew up in in Davie, FL. Your father has high blood pressure and takes medicine for it. You don't remember the name. Your mother has some arthritis, but nothing serious.

Psychiatric history:
You were in counseling during college after your father finally apologized to you for the challenges. You began counseling to deal with your childhood problems. You never were significantly depressed before this time. Therapy was helpful, and you continued for two years. You have never been prescribed psychotropic medication, but are interested in being referred for a sleep aid and an antidepressant.

Specific body type/physical requirements for SP: Portray 30- 50 year old female.

Patient presentation: You are clean and well groomed. You are wearing conservative clothing in muted colors. You will cry throughout the session. You will rarely look the examiner in the eyes, instead looking at your hands in your lap or down at the floor. Your voice will be very quiet. Sometimes, you will be slow to answer questions, and will even lose concentration at times, staring worriedly into space. Your movements are slow, and your body posture is slouched. You often rub your hands together. Your expression

is very sad and hopeless, and your eyes appear blank.

How to Respond
You can expect the course of the interview to start with a query about your presenting symptoms (sleep disturbances, headaches). You will reply with the opening statement and then offer other details in response to questioning. You will disclose more information and be more open emotionally if the learner creates an atmosphere of trust and empathy. He or she might invite disclosure through use of silence, acknowledging your feelings, asking open-ended questions, etc.

In regard to your feelings of shame and humiliation the student might ask:

> "Could it be that people don't judge you for your husband's behavior? Perhaps they have sympathy for you? Admire your loyalty?
> Is choosing not to abandon your husband a sufficient reason for staying with him? Do you feel that you have to meet everyone's expectations of you?"

Standardized Patient Case

1. **NAME OF PATIENT**: MICHELLE DUDLEY

2. **PATIENT PRESENTATION**:
   Initial Body Language/Affect: *Slowed, dull, sad, hopeless*

3. **RESPONSE BY SP TO STUDENT'S FIRST QUERY**:

a) "How are you feeling", "What brings you in today?" etc.
"All I really want to do is sleep; I'm tired all of the time."

b) If the student remains silent, nods as if waiting for more information, or asks an open-ended question like "Tell me more about the…" "Describe the… to me", "Go on", the patient says:

"I have trouble staying asleep every night, so I'm always tired. Most of the time, though, I stay in bed because I have no energy. I feel so upset and preoccupied with problems lately. I think I sleep to escape feeling miserable."

Concerns:
"How am I going to make it through my husband's trial?"

<u>Information given with SPECIFIC questioning regarding timeline, frequency, etc:</u>

When Questioned about the Trial:

- My husband was arrested two months ago for misappropriating home foreclosure funds. If he goes to prison, which seems likely, I will be the sole support of the

family. I'm afraid I'll lose my house—where would we live?? I could never burden my parents or my friends-who, by the way, seem to have abandoned me. The mortgage scandal has recently hit the front page of the newspaper. I feel ashamed to even go shopping, to go church, anything! I'm so afraid someone will recognize that I'm *his* wife. I feel so awkward at work-the other teachers just stare at me, I can see them judging me. They must wonder if I knew what he was doing—maybe if I played a role in it. I haven't actually encountered them since the news broke-but my students' parents must look down on me—I bet they don't want me anywhere near their kids! I am dreading the public exposure of sitting in the courtroom during the trial.

- I am enraged with my husband for bringing this shame on me and the children. We have not been emotionally close in recent years and I wish I could leave him, but I feel I would be abandoning him when he most needs support. I'm certain that his parents and my children would hate me if I left him.
- He still lives at home—we agreed to keep things as normal as possible for the girls' sake. That was our last real conversation. I can't even bear to look at him or talk to him whenever I'm not in front of the girls. I feel disgusted when I have to be around him, and it's so stressful to keep up appearances for the kids. We sleep in different rooms.
- My kids are relatively unaware of what has taken place, although the oldest recently asked why "mommy and daddy don't kiss anymore." I forced myself to kiss him then. It was so hard to do -I was disgusted. I told them that we sleep in different rooms because "daddy snores."

When Questioned about Symptoms:

- I feel depressed all the time, every day. Nothing seems to make me feel better. Even my children have begun to notice, and I feel terrible about that.

  Are you able to do the things you used to enjoy, etc.?
- I used to make it a point to see my three closest girlfriends for brunch every Sunday after church. I cannot face them anymore, and even if I did, I would definitely not be able to enjoy myself. I can't even sit through a church service. I am so angry at God for putting our family through this. I used to sew and scrapbook for fun. I would make quilts for the girls. I loved to take pictures of the girls at their soccer games or at dance recitals and then turn them into great scrapbooks. I can't do it anymore—it just reminds me that I will never have the life I was used to—our family will never be the same again. I just can't enjoy anything anymore.

  What are your eating habits like lately/Have you noticed a change in your eating/appetite lately, etc.?
- I just can't eat anymore. Food has no taste. I have lost 15 pounds in these two months.

  Do you feel more agitated than you used to? Or even more slowed down then you used to be, etc.?
- I feel so slowed down. My kids have started to notice—I just can't keep up with them. They keep saying, "Mommy, wake up!"

Has your concentration changed, etc.?

- I feel terrible, I can't concentrate. I have to hide the fact that I can't even follow what my kids are saying half the time. I've been forgetting to take them to doctor's appointments or to practice. I even forgot to send in the money for their dance recital costumes. I'm a bad mom.

What is your energy like, etc.?

- I have no energy and I'm just always tired.

Do you feel guilty? Do you feel worthless, etc.?

- I feel so guilty that our children have to go through this. I should have divorced my husband years ago—I always felt he was doing something "shady" behind my back. I just knew he would hurt us. I feel so ashamed. This whole thing MUST be my fault. I am so weak. I just feel worthless.

Do you have thoughts of hurting yourself, etc.?

- Sometimes I just feel I shouldn't be here anymore. Isn't that terrible? I used to be able to throw those thoughts out—just for the kids' sake. How could I leave them with all of this? They just keep coming back.
- I'm so embarrassed, but I think of suicide all day long.

Do you have a plan of how you would do it, etc.?

- Isn't it terrible? Yeah, I've thought of how I would do it. My husband has a gun locked up in the garage. I would take it out into the woods where my girls wouldn't hear or see…

Do you think you would do it?

- No, I don't think I could or would do it. I couldn't do that to the girls. But it scares me how clear the picture of it is….

Would you say you are anxious?

- I do worry about the future and for the trial. But I'm much more sad than anxious.

<u>Communication and Openness of SP:</u>

You will be rather open to examiner and answers questions easily.

<u>Creating empathic opportunities: What could the SP say, or how would the SP behave, to create opportunities for the examinee to express empathy?</u>

You will cry throughout the session. You will rarely look the examiner in the eyes, instead looking at your hands in your lap or down at the floor. Your voice will be very quiet. Sometimes, you will be slow to answer questions, and will even lose concentration at times, staring worriedly into space. Your movements are slow, and your body posture is slouched. You often rub your hands together. Your expression is very sad and hopeless, and your eyes appear blank.

Area	Words patient would use
Onset When did the problem start?	Two months ago when my husband got arrested
Duration	Nothing makes my sadness better. I can't shake this.

Is it this way all of the time, or does it ever get better?	
Progression Is the problem or pain getting worse?	Yes, I think it is getting worse. It's all I think about, and it consumes me.
Aggravating factors What makes the problem worse?	When I see people we know. I just imagine what they think of us. I feel so sad when I see pictures of the whole family together, and I know nothing will ever be the same. Any time he is around me, my skin absolutely crawls.

Hx area	**Descriptive Information**
Medical History	None.
Surgical History	None
Injury History	None
Current Medications, Prescription and OTC:	None, *but would like to be referred for an anti-depressant and a sleep aid.*
Family History Parents	**Father**: recovering alcoholic. Just recently begun speaking to him when girls were born. Abusive towards you and your mother until you went to college. Relationship is still distant and strained, ambivalent about building close relationship. Father is 65 years old. No major health problems; thankfully alcohol did not damage his liver. **Mother:** quiet woman, very loving. Forgiving of her husband. You are not angry with her for not leaving your father—you know she did it for you. (This is a big reason you wish to remain with your husband). You know that she probably would help you through this time, but just can't reach out to her—you don't want to burden her because of all she's been through. She is 62 years old, and thankfully in good health.
Siblings	No siblings.
Children	Daughters ages five and three. Both in soccer and dance class. Both loving and very "good" children, at the top of their classes in school. They are relatively unaware of what has taken place, although the oldest has begun to question why you two "don't kiss anymore." You also have told them that you sleep in different rooms because "daddy snores."
Other Relevant History	Your mother and father were only children. Your father's parents both died when you were very young.

	Your grandmother died of breast cancer, and grandfather died of cirrhosis from alcoholism. Your mother's parents were very involved in your life, and both died of natural causes before your girls were born (were both in their 80's when they passed.)
Occupational History	You are a schoolteacher. You taught kindergarten for 8 years. The school, which is in a low-income neighborhood, was recently torn down and you will be transferred to another school next year. You don't like the principal at the new school and you are sad that you and your colleagues are being separated. At the same time you have watched the families of your students become ever more beset by poverty, addictions, and homelessness. There seems to be less parental support now than when you began teaching. You feel burned-out and distressed that you will be the only source of income for the family.
Marital Status	Married 15 years, met at college at Florida Atlantic University. Relationship has been strained for the past two years.
Sexual History	Monogamous with husband
Psychological or Psychiatric hx.	Received counseling when went to college to deal with issues stemming from your father's abuse. Sought counseling on your own. Never diagnosed with disorder, never prescribed medication. Found counseling to be helpful, continued it for first two years of college.
Last medical appointment and reason:	9 months ago for a physical
Support Systems & Religion:	Three close girlfriends, but you don't see them anymore…you're just too ashamed. You barely speak to your parents as it is, especially not now. You ignore their phone calls. Your husband's parents live in Jupiter, FL. You have been ignoring their calls since the arrest. You can't face them. You don't have any other family in the area.
Environmental Considerations	Live in Davie in a nice neighborhood.
Diet & Exercise:	You used to be very active and rode your bike every day…you just don't have the energy anymore. You still try to cook healthy meals for your family, but You can't bring yourself to eat. You only really eat dinner with the girls, but you just pick at your food.
Tobacco/Alcohol:	Never
Other Substances:	None

NSU Psychology Services Center
Telephone Intake

Name: Michelle Dudley
Age: 32
Date of Birth: 6/8/71

Reason for calling
"I can't sleep anymore and I feel really down. My husband's trial is coming up."

Marketing
How did you hear about us: Children's health fair
Ever been to any NSU clinics?: No
Been to following NSU clinic(s): No

Symptoms
Sleep Problems:
Falling/staying asleep
Comment: only getting 4/5 hours a night

Sadness/Depression
All the time
Comment: "I cry nightly after the girls have gone to sleep"

Anxiety
"I am anxious over my husband's trial and how our family will be treated afterwards"

Abuse History:
Current: None
Past:
Physical? Yes
Verbal? Yes
Emotional? Yes
Comments: Father; was an alcoholic-sober for 14 years

Issues in the past that are affecting the present?
No

Flashbacks/Nightmares?
A few nightmares
Comment: "About my girls being ostracized at school after my husband was found guilty…"

Ever been sexually assaulted?
No.

Difficulties in Interpersonal Relationships?
"Marriage has been strained for two years-husband still lives in house awaiting his trial. Can't bear to even look or speak to him."

"Still building a relationship with my father-not sure where I want that to go."

Medical/Health
Medical Issues:
"Have been getting migraines lately when I'm especially tired."

Medical Hospitalizations
Just birth of two girls (ages 3 and 5). Normal births.

Prior Psychiatric/Psychological
Outpatient therapy
Yes.
Comment: Private practice first two years of college, dealt with issues from father. "Helpful."

Suicide
Ideation. Plan. "Don't think I could do it because of the girls—I couldn't do that to them"

Homicide
Denied

Substance Use History
None

Healthy Lifestyle
Change in Appetite
Decreased.
Comment: "Don't feel like eating. Food has no taste."

Remarks
Currently involved in any legal/court issues?
Husband on trial for misappropriating house foreclosure funds.
Children relatively unaware of what has happened. Father still in house. Stressful to keep up appearances.

Fee/Waitlist Information
Are you employed? Yes, teacher.
Number in household: 4

Caller was advised of the standard fee.

Appendix G

SP Case: Specific Phobia

BIO-PSYCHOSOCIAL EVALUATION
CONFIDENTIAL

Reason for Referral

XX, a XX, XX, XXX, female, was self-referred to the Anxiety Treatment Center (ATC) at the Psychology Services Center (PSC) of Nova Southeastern University (NSU). XX was self-referred to ATC due to an increase in persistent worry, fear, and physiological distress she currently experiences when encountering certain situations.

Presenting Problem

XX reported experiencing extreme anxiety and fear when she has to fly on a plane. She reported such distress in this situation that she takes the train instead of flying. Client has flown but stays "paralyzed, looking forward, and not moving," even if she has to use the restroom, throughout the entire flight. She reports feeling as though each step she takes is moving the plane and could make it fall. Client reported that if she plans a trip six months from now, she will worry for the entire six months until the flight.

XX reported also experiencing anxiety and fear when she has to take the elevator. She reported that she avoids taking the elevator and instead walks the necessary flights of stairs. Client works in a hospital and instead of taking the elevator, she walks up and down eight flights of stairs multiple times a day. She reports that her fear started when someone told her "the elevator could plummet beneath the ocean floor." She has a fear of falling and when encountering heights, she feels as though "something is pulling her down" and will make her fall over and die. Client reports that she can force herself to go in an elevator, if accompanied by a friend, but that she will not go in one by herself. Client reported that she feels her fear of flying and anxiety with elevators is getting worse and has set a goal "to get help before I die."

History of Presenting Problem

She reports that flying interferes most in her life because she feels as if it is limiting her choices of places to go. She reports the problem began when her first husband died because she feared "what would happen to her children?" should she die too. Client discussed a story of a family friend pilot who took up another friend one day and the plane crashed. Client also reported feeling guilty because when a close friend was ill and she was too anxious to fly to visit her. Client reported that the last flight she took was to Baltimore last year. She forced herself to go on but could not force herself for the return trip and took the train instead. She stated she takes the train when possible but reports that "it is too expensive and takes more time." Client reports that she has not been to Jamaica and seen her home there since XX. She has thought about taking a boat over there but "it takes a week to get there." XX reports that her main goal in to be able

to fly and visit her daughter in XX more.

Relevant Background Information:

Medical/Psychiatric History

XX reported meeting all motor and language developmental milestones within normal limits. She denied a history of developmental or medical issues during childhood. However, client did report a serious head injury in a car accident, at age five, which required hospitalization. After recovering, her mother told her that in grade school, she would write words backwards but that only lasted for a couple months. Client has no memory of the accident or impairment and denies any current motor or language difficulties. Client has recently been diagnosed with "borderline glaucoma." She reported results for it were negative but she is at risk for getting it because her mom has glaucoma. Client reported having an appendectomy when she was 10 or 11 years old and a D and C, also called uterine scraping, two years ago. Client reported last physical was XX and her doctor said she had high cholesterol.

Client reported disliking medication. She reported the only things she takes are Vitamin C and Vitamin B-12. She also reported taking Focus Formula because she feels she is getting forgetful and heard that this is helpful. XX reported that she has sleep apnea and uses a machine to sleep.

Client reported trying to seek treatment at the XX in XX but could not afford to pursue treatment. She reported attending an anxiety group therapy, during the summer of 2009, at a local school and disliked it because "it was too general" and her anxiety was "specific." XX also reported attending a social anxiety group therapy at XX in XX but only attended for a week and left right before she had to give a speech as an exposure.

Substance Use History

XX denied any use of substances or drugs. She reported "rarely drinking" and if she does, it is socially and will have "a small glass of wine." Client reported that her father was a heavy drinker so she feels "turned off by it." Client denied any other family members abusing alcohol or drugs.

Family History

XX reported growing up in XX. Client is an only child and reports she was a "spoiled child" and got everything she needed. She describes her mother as "soft and easygoing" and her father as "brutal and abusive." When she was young, XX reports that her father emotionally abused her and her mother. She believes that is where her nervousness stems. She reported always feeling on edge to make sure she did everything right and "keep his shoes shined" so as not to get in trouble. She reports that to this day her mom is her best friend. She also loves and reports being very close to her three girls who are XX, XX, and XX years old. XX's major goal is to go see her daughter in Washington, DC. Client reports that all members of her family are in great support of her seeking treatment for her problems. XX reports supporting her family here and in Jamaica.

Educational/Professional History

In XX, XX received a scholarship to attend boarding school and stayed there until graduation. Client reported being fairly independent for most of her life. She reported having many friends but missing home and always liked when family came to visit or the breaks when she could go home. Client reported that she was an "A-B" student and never had to repeat a class or grade. Client reports she is a visual and hands-on learner. XX reported leaving XX in XX to England for nursing. XX graduated with her bachelors and returned to XX to work but after a couple of months she decided to move in with her aunt in Alabama. She reported not being able to find work there and went to live with another aunt in New York.

In XX, client reported meeting her first husband and having her children. She also reported living in poverty there and working as a maid while she took her licensing exam. In XX, XX reported moving down to XX. XX reported being unemployed for the past 2 years and is still paying off bills from that time. In XX, she found a position at XX as a recovery nurse and described enjoying her work.

Social History

XX reported she always had a great social life growing up. Her mother, children, friends, and her church are reported to be her support system and make her "feel better." Despite her shyness, client reports that she has always had many good friends. XX reports feeling anxiety with strangers but once she is comfortable with you, she reports feeling "open and free" to converse.

Client reports being married twice. She reported being married to her first husband for XX years. She also reported that he was physically abusive and died of a heart attack. She reported that she met her current husband on a plane, married him in XX, and separated in XX. She reported that he has always lived in XX and does business in the United States. Per client's report, he wants her to move to XX but she does not want to live there. She reports that he can be verbally abusive and does not speak to him and if she does, it is once every couple months.

Mental Status Examination and Behavioral Observations:

The client presented as an XX female whose appearance was consistent with her chronological age. She was neat in appearance and appropriately dressed for the evaluation. She was alert throughout the evaluation. XX's activity level was appropriate and she was able to maintain attention throughout the entire evaluation. XX was orientated to person, place, and time. Her speech was clear and audible. Throughout the initial interview, XX was cooperative and attentive. Rapport was easily established. The client managed to maintain good eye contact with the examiner and interacted positively. XX denied past or present hallucinations or delusions and denied past or present suicidal or homicidal ideation, plan, or intent.

Diagnostic Impressions (DSM-IV-TR):

Axis I	300.29 Specific Phobia
Axis II	799.9 Diagnosis Deferred
Axis III	None
Axis IV	Financial Problems
Axis V	GAF = 61 (Current)

Summary & Recommendations:

Based on the clinical interview, XX evidenced persistent fear that is excessive and cued by the presence or anticipation of a specific situation, i.e. flying and elevators, and XX reports recognizing that the fear is excessive. Exposure to these situations provokes an immediate anxiety response in the form of a panic attack and for this reason, the situations are avoided. Per client reports, Panic Disorder is excluded because the attacks are not unexpected or recurrent. The avoidance and distress interferes significantly in XX's normal routine, occupational functioning, and there is distress over having the phobia. The duration of the problem has been at least 6 months. Based on the current information, it appears that XX meets criteria for a diagnosis of *Specific Phobia*.

Tentative Treatment Goals and Strategies:

XX seems optimistic and motivated for treatment. XX would likely benefit from cognitive-behavioral therapy in individual format for the treatment of specific phobia symptomatology. Treatment should consist of psychoeducation regarding her anxiety and worry, as well as the physiological distress she has experienced. Furthermore, treatment should consist of learning and implementing relaxation techniques to reduce physiological symptoms related to her anxiety and worry and identifying alternative pleasant activities that promote relaxation and decrease stress. The use of cognitive restructuring should focus on the identification of and challenging XX's anxious thoughts and persistent worry. XX would also learn to appropriately identify the start of a panic attack and cope with experiencing them. Additionally, treatment should consist of learning appropriate problem-solving skills and implementation of such skills in anxiety provoking situations as well as exposure to such situations.

Standardized Patient Case

1. NAME OF PATIENT: JANE SMITH

2. PATIENT PRESENTATION:

a) Initial Body Language/Affect:

NERVOUS, CONCERNED

3. RESPONSE BY SP TO STUDENT'S FIRST QUERY:

a) "How are you feeling", "What brings you in today?" etc.

I FEEL LIKE I'M GOING CRAZY, AND SOMETHING'S GOTTA CHANGE.

b) If the student remains silent, nods as if waiting for more information, or asks an

open-ended question like "Tell me more about the…" "Describe the… to me", "Go on", the patient says:

IT HAPPENS WHENEVER I AM ON A PLANE, OR IN AN ELEVATOR. MY HEART BEATS REALLY FAST, I SWEAT, TREMBLE, HAVE HOT FLASHES, FEEL LIGHTHEADED, OR FEEL PARALYZED WITH FEAR.

Concerns:

I'M WORRIED I'M GOING CRAZY OR HAVING A HEART ATTACK.

Information given with SPECIFIC questioning regarding timeline, frequency, etc:

AFTER MY FIRST HUSBAND DIED (ABOUT 25 YEARS AGO) I STARTED TO WORRY THAT IF I FLEW AND THE PLANE CRASHED MY CHILDREN WOULD HAVE NO ONE. I PRETTY MUCH STOPPED TRAVELING, UNLESS I COULD GET THERE BY TRAIN. THE LAST TIME I FLEW WAS A YEAR AGO, AND I WAS SO ANXIOUS ABOUT FLYING BACK THAT I TOOK A TRAIN.

IT'S KIND OF THE SAME THING WHEN I AM IN AN ELEVATOR – I WORRY THAT IT'S GOING TO FALL AND I WILL DIE. I ALWAYS TAKE THE STAIRS AT WORK.

Communication and Openness of SP:

SP IS OPEN AND IS AWARE THAT HER FEAR IS EXCESSIVE.

Creating empathic opportunities: What could the SP say, or how would the SP behave, to create opportunities for the examinee to express empathy?

IT MAKES ME FEEL GUILTY BECAUSE I HAVEN'T BEEN ABLE TO VISIT MY FAMILY BACK IN JAMAICA OR MY DAUGHTER IN D.C. I FEEL LIKE I'M TRAPPED BECAUSE I'M AFRAID TO FLY.

What the student might say **What you would say**

Area	Words patient would use
Onset When did the problem or pain start?	A long time ago – about 25 years ago
Duration How long does it last?	Until I am off of the plane or out of the elevator.
Progression Is the problem getting worse?	It's been the same, but now it feels like it's getting in the way of me being able to do things I enjoy.
Frequency How often does it occur?	Every time I get on a plane, get in an elevator by myself
Intensity On a scale of 1-10 how bad are the symptoms?	It's really frightening--a 10
Quality Can you describe it?	My heart races, I feel lightheaded, I sweat, have hot flashes, and start to tremble
Alleviating factors	

What makes the problem better?	Getting out of the situation
Aggravating factors What makes the problem worse?	Nothing that I can think of
Precipitating factors	After my first husband died (about 25 years ago) I started to worry that if I flew and the plane crashed what would happen to my children. I pretty much stopped traveling, unless I could get there by train. The last time I flew was a year ago, and I was so anxious about flying back that I took a train. It's kind of the same thing when I am in an elevator – I worry that it's going to fall and I will die. I always take the stairs at work. I've never been comfortable in large groups, even as a little girl. I feel like everyone can tell I'm anxious and that they will think I'm crazy. I won't even use the intercom at work because I don't want any attention, so I walk all of the messages to the doctors in person.

Hx area	Words patient would use
Medical History	High cholesterol Risk for glaucoma Sleep apnea
Surgical History	Appendectomy at age 10 or 11 Two years ago a "D and C" (uterine scraping)
Injury History	Head injury after a car accident at 5 years old
Current Medications, Prescription and OTC:	Vitamin C, Vitamin B-12 Focus Formula because I feel like I'm forgetting things
Family History Parents Siblings	 Parents are both alive and live in Jamaica. Mother has glaucoma. Father was a heavy drinker when I was growing up. No siblings

Occupational History	Recovery nurse
Marital Status Children	I met my current husband on a plane. We got married in 2001 but have been separated since 2004 (2nd marriage); he is verbally abusive and we speak only once every couple of months. He lives in Jamaica and wants me to move down there, but I don't want to. My first husband died of a heart attack. We were married for 13 years. He was physically abusive. I have 3 children ages 34, 30, and 28
Sexual History	Monogamous in all relationships
Psychological or Psychiatric hx.	I tried to get help in the fall of 2009, but I couldn't afford to keep going. I also tried an anxiety group in 2009, but they were working on anxiety that you feel all of the time. My anxiety is much more specific to airplanes. In 2010 I went to another anxiety group; I left when they wanted me to do a speech as part of an exposure.
Last medical appointment and reason:	September 2010 – routine physical
Support systems& Religion:	Mother, daughters, friends, and church
Environmental Considerations	None
Diet & Exercise:	I walk a lot at work, up and down eight flights of stairs because I won't take the elevator.
Tobacco:	Never
Alcohol:	I rarely drink, maybe 1 glass of wine.
Other Substances:	None

Identifying Case Factors:

Presenting complaint: Extreme anxiety and fear when flying on a plane or riding in an elevator, persistent feelings of worry, and physiological distress

SP Demographics:

Name: Jane Smith

Gender: Female

Age range: 55-60

Ethnicity: Jamaican

Setting: NSU PSC Anxiety Treatment Clinic

SP Opening Statement: "I feel like I'm going crazy, and something's gotta change."

History of present illness:

You are Jane Smith, a 55-60 year old married woman. You are a recovery nurse in a local hospital.

Since you were young you have been a nervous and shy person. As an adult you try to avoid any situations that require you to speak in front of a group of people. When you are unable to avoid these situations your heart beats faster, you sweat, tremble, have hot flashes, and feel lightheaded. You worry that others can see how anxious you are and will think you are crazy.

Your fear of flying started after your first husband died (over 25 years ago) because you were afraid of what would happen to your children if you died too. When you have flown in the past you spend the entire flight sitting as if you were paralyzed, looking forward, and not moving. You don't get up even if you have to use the restroom because you feel like every step that you take moves the plane and could force it to fall. Even planning to fly somewhere causes you extreme anxiety.

You feel guilty that your fear of flying has prevented you from visiting family and friends. You have not been back to Jamaica since 2005. You have considered taking a boat over, but haven't yet because it takes a week to get there. You took a plane to Baltimore last year, but felt so anxious about the return flight that you came home by train. You take the train whenever you can, but realize that it's expensive and more time-consuming. Your goal is to be able to visit your daughter in Washington, D.C.

You also have a fear of riding in elevators and will only go in one if accompanied by a friend. At work, you walk eight flights of stairs multiple times a day as a means of avoiding the elevator. Your fear started when someone told you that an elevator could plummet beneath the ocean floor. You have a fear of falling and when you encounter heights, you feel that something is pulling you down and will make you fall over and die.

You sought treatment in the fall of 2009, but could not afford to continue. Prior to that, in the summer of 2009, you tried to attend an anxiety therapy group but disliked it because it was "too general" for your anxiety which you feel is "specific". In the spring of 2010 you were in another anxiety therapy group but left right before you had to give a speech as an exposure.

Past medical history:

You were in a car accident when you were 5-years old and suffered a head injury requiring hospitalization. Your mother told you that for a few months after you recovered you would write words backwards. You do not remember this or the accident and you have not experienced any long-term motor or language difficulties.

You had an appendectomy when you were 10 or 11-years old.

Two years ago you had a uterine scraping, which you refer to as a "D and C".

At your most recent physical you were told you have high cholesterol.

You were also recently diagnosed with "borderline glaucoma". The results of the glaucoma test were negative but you explain that you are at high-risk for developing glaucoma because your mother has glaucoma.

You currently take daily supplements of Vitamin C and Vitamin B-12. You also take "Focus Formula" because you feel like you are forgetful and you have been told that it will help.

You have sleep apnea and use a machine to sleep.

Family medical history:
Your parents are both alive and live in Jamaica. Your parents are both in good health with the exception of your mother's glaucoma.

Background Information:
You were born and raised in Jamaica, You were an only child and describe yourself as being "spoiled", always getting everything you needed. You don't discuss what your parents did for work, but you describe your mother as being "soft and easygoing" and your father as being "brutal and abusive." Your father was emotionally abusive toward you and your mother when you were younger and you believe that this is where your nervousness stems from. Growing up you always felt pressured to make sure you did everything right to avoid getting into trouble. You describe your mother as always being your best friend, even to this day.

As a child you received a scholarship to attending boarding school. You stayed there until you graduated. You were always independent. You had many friends but missed home. You looked forward to when family visited you or when you were able to go home. You were a good student (As & Bs) and learned best by seeing and doing. You left Jamaica to go to nursing school in England. After you graduated with your bachelor's degree you returned to Jamaica to work. After a few months you decided to move to Alabama to live with an aunt. You weren't able to find work, so you moved to New York and lived with another aunt.

You met your first husband when you lived in New York. You also had all three of your daughters when you lived there. (They are now 34, 30, and 28 years old.) You were very poor and worked a maid while you took your licensing exam. In 1983 you moved down to Florida. You were unemployed for two years until you found a job a year and a half ago working as a recovery nurse, which you enjoy.

You were married to you first husband for 13 years. He was physically abusive and died of a heart attack. You met your second husband on a plane. You married in 2001 and separated in 2004. He has always lived in Jamaica, but does business in the United States. Your husband wants you to move to Jamaica but you don't want to live there. He can be verbally abusive and you only speak to him once every couple of months.

You have always had a great social life. Your current support system consists of your mother, daughters, friends, and church. In spite of your shyness, you have always had many friends. You are anxious around people you don't know, but after you get to know

them you feel much more comfortable conversing with them. Your family is supportive of you seeking treatment for your problems.

You have no history of alcohol or substance abuse. You rarely drink now and if you do, it is just a small glass of wine. Your father was a heavy drinker, so you feel "turned off" by drinking. No one else in your family abused drugs or alcohol.

Patient's response to special interviewing techniques:
You make a few remarks, such as "I'm not crazy," or "This probably sounds crazy" when talking about your symptoms, particularly when describing your thoughts that others can tell that you are anxious. You're trying to come off as being "normal," but deep inside you're worried that something is seriously wrong.

Specific body type/physical requirements for SP:
Average weight and height

Patient presentation:
You are clean and well groomed. You are casually dressed. You come across as reserved but engaged in session. You are cooperative and polite. You seem to be nervous at the beginning of session, making intermittent eye contact and laughing occasionally when responding to questions from provider. Your nervous laughter recedes a bit as the session progresses. As you talk, your position in the chair becomes more relaxed (settle into the chair) and your eye contact improves.

NSU's Psychology Services Center

Telephone Intake

Name: Jane Smith
Age: 59
Date of Birth: 5/3/53

Reason for calling
"I feel like I'm going crazy and something's gotta change. I go nuts whenever I'm on a plane, in an elevator, or if I have to talk in front of people."

Marketing
How did you hear about us: Boomers and Beyond Health Fair at Nova
Ever been to any NSU clinics?: No
Been to following NSU clinic(s): No

Symptoms
Sleep Problems:
Sleep apnea
Comment: "I sleep much better now with my C-PAP machine"

Sadness/Depression
Sometimes
Comment: "I get stressed about my finances."

Anxiety
"Just in those situations really. I feel like I'm going insane or having a heart attack."

Abuse History:
Current: None
Past:
Physical? Yes
Verbal? Yes
Emotional? Yes
Comments: Both ex-husbands; one deceased from heart attack, other separated

Issues in the past that are affecting the present?
"I had a friend die in a plane crash. I also feel really guilty- my close friend was ill and I just couldn't fly to visit her."

Flashbacks/Nightmares?
No.

Ever been sexually assaulted?
No.

Difficulties in Interpersonal Relationships?
No.

Medical/Health
Medical Issues:
Sleep apnea, high cholesterol, "borderline" glaucoma

Medical Hospitalizations
Birth of three girls. Normal births.

Prior Psychiatric/Psychological
Outpatient therapy
Yes.
Comment: Could not pursue therapy at private practice due to cost. Attended few sessions of two different anxiety group therapy. "Groups were not helpful."

Suicide
"Never."

Homicide
Denied

Substance Use History
Drug Use
No.

Alcohol Use
No.
"My father was a heavy drinker."

Healthy Lifestyle
Change in Appetite
No.
Comment:

Remarks
Currently involved in any legal/court issues?
No.

Fee/Waitlist Information
Are you employed? Yes, recovery nurse.
Number in household: 4

Caller was advised of the standard fee.

Appendix H

SP Case: Post-Traumatic Stress Disorder

Identifying Case Factors:

Presenting complaint: Anxiety, flashbacks, nightmares, hyperarousal

SP Demographics:

Name: Timothy Starnes
Gender: Male
Age: 30-50
Ethnicity: Any

SP Opening Statement: "I can't get the scene out of my head. I saw two of my guys get killed over in Iraq. Why them? Why not me? I see them in my thoughts-in my dreams-everywhere."

History of present illness:
You are an active-duty soldier in the army who has returned home four months ago from a second tour in Iraq. You hold the title of Sergeant Major. Four months earlier, two members of your unit were killed by an IED on the side of the road. Your unit was then launched into battle on the street. You saw the men die, and were helpless to prevent it. Furthermore, you were forced to see their bodies lying on the ground for hours due to the fighting. You feel immense guilt over your inability to act. You have seen several comrades killed in combat, but were particularly close to these two young men. You served as somewhat of a mentor to those men, who were the same ages of your two sons. You feel immense survivor guilt. You often wonder why those men, who were much younger than yourself, had to die while you lived. You finished out your tour of Iraq shortly after the event and returned home to your wife and sons. You have experienced great difficulty in reintegrating to life at home. You took leave from your auto mechanic job for a month when you returned home. You had gone back to work, but had to take leave again two weeks ago due to inability to concentrate.

You enlisted in Army at age 22, and have held various roles and ranks since then. You graduated from college at the age of 30 with a degree in chemical engineering. However, your passion and focus have always been upon military service, and you have never pursued employment in the chemical engineering field. In 1990, you were deployed to Kuwait during Gulf War immediately after graduating college. You have also worked in military operations in DC. In 2003, you were deployed to Iraq for 12 months. After this tour at the age of 52, you never expected to have to return, yet you were then deployed to Iraq 12 months ago.

Your wife and sons have tried to be supportive since you returned home, but you are reluctant to open up to them and burden them with your troubles. You feel detached from

them as well, as you realize they could never understand what you have gone through. You have no true friends outside of the military, and do not want to seek them out as they would serve as reminders of that day.

Symptoms:

- Post-traumatic stress
    - Four hours of sleep a night
    - Constant nightmares of that day—always the same dream
    - Flashbacks
    - Extreme distress over reminders of that day (i.e., blades of a fan remind him of helicopter blades; hot days remind him of Iraq, etc.)
    - Physical reaction to reminders—sweating, shaking, breathing troubles, heart races, tension
    - Usually avoids talking about what happened
    - Loss of pleasure in daily activities
    - Feels "detached" from others
    - Feels empty and numb
    - Expresses wish for death—not actively suicidal and would not hurt himself—is just tired and frustrated with his problems
    - Often irritated by his family and often raises his voice
    - No concentration
    - Hypervigilant
    - Startles easily
    - "Sad" over events at times, never tearful

Background Information:

You were born in Washington, D.C., an only child. Your father was a congressman. He was well-respected in government circles, and well-liked by all. He often worked long hours, but always made time for you. Your mother, however, has a long-standing history of depression and alcohol use. Although your father was very loving towards her, she often expressed feeling quite lonely. She was always a supportive, loving mother towards you, but her drinking and sadness wore upon you. You turned to academics and football as an escape. You are highly intelligent, and received a full scholarship to the University of Miami for Chemical Engineering at the age of 18.

Your father passed away at the age of 60 from a heart attack, after a long-standing history of heart disease. You were 21 years old at the time. You were completely devastated, and wanted desperately to honor the great man he was. After speaking with your father's brother at the funeral, who had spent years in the Army, you became determined to serve your country, as your father did, albeit in a different capacity. Your mother abhorred the idea of you leaving to serve, but respected your wishes. She vowed to quit drinking, in order to give you the most support she could. She has been sober ever since, and you two remain close. However, you cannot bring yourself to tell her of your current troubles.

You finally graduated at the age of 30 with your Chemical Engineering degree. However, you never felt "right" entering that field after experiencing active combat. You supported

yourself as an auto-mechanic (you and your father often would work on cars when you were younger) in between services. You met your wife as a customer, and dated for five years before getting married. You have had a good, strong, trusting relationship throughout your deployments, and your wife has coped well with having a husband in the military-she often expresses her great pride in your service. She is supportive in your time of need, although is unsure how to help. She works as an accountant nearby.

You have two sons, aged 16 and 18. They are also very proud of their father's service, and even call you their "hero." Your youngest son experienced some acting out in school (i.e., talking out of turn, being disruptive in class, arguing with the teachers, hitting other children—all of which was completely out of character) in 2003 during your year-long deployment. He was often reprimanded by the school during that year, and met with the guidance counselor weekly. Their sessions together were helpful, and his behavior returned to normal upon your homecoming. Your older son was particularly withdrawn during this time. On the whole, however, the boys have remained well-mannered and have excelled academically. The family also coped well with your move to Washington DC to oversee military operations for five years, beginning in 1996. The family moved back to Florida after September 11th, as your wife felt uneasy living in the area any longer. You felt compelled to serve over in Afghanistan, but your wife pleaded for you to stay until things "settled down." She accepted your decision to serve in Iraq, as she saw how restless you became when returning to your auto-mechanic job when battles raged on. You had a happy homecoming after the year in Iraq, and felt satisfied with your military service. You were surprised to be deployed again last year. Your family expressed pride in your continued service, and you went willingly.

Your oldest son is deliberating entering the military. You are very much against this decision, and wish to "shield" him from the things that you have seen. However, you can't find the words to convey this to your son (and don't wish to even tell him the things you have experienced), so you focus on your desire to see him pursue an M.D. He has expressed an interest in health care. You often try to impress upon him that becoming a doctor would be a 'better' way to serve others than entrance into combat. He has begun to argue that providing medical service in the army would be the best of both worlds. You have warned him about the personal dangers of this, but can't impress upon him the horrors he would likely see.

You have traditionally had a lot of close friendships since childhood; however, the vast majority of them have been made through the military. You currently do not contact anyone outside of the family, as the military friends serve as reminders of your ordeal.

You are a Christian who traditionally has been involved in religious community. You used to derive strength from beliefs/practices but are beginning to question existence of a God who would allow such tragedy. You have continuously eaten a healthy diet, given your inherited high cholesterol, and you have traditionally exercised regularly to maintain a 'military physique.' However, recently, you have no motivation to exercise regularly. Upon awakenings by nightmares, you perform pushups until your arms give out to try to erase the images.

You deny a history of substance abuse but reluctantly admit since coming home you are drinking 4-5 mixed drinks each night to calm your nerves and help with sleep. You are mildly concerned, given your mother's history of alcoholism, but maintain that you have control over your habits. Your wife has expressed concern and this "annoys" you, but you understand that she is just looking out for you.

Past medical history:
You have routine assessments by a cardiologist, given your father's history of heart disease. Your cholesterol is the only significant concern, and it is well maintained.

Psychiatric history:
You have never sought psychotherapy before. You are against the idea of taking any medications to aid with anxiety or sleep.

Specific body type/physical requirements for SP: Portray 50 year old male, physically fit.

Patient presentation: You are clean and well groomed. You appears tense and on edge. You startle easily (any loud noise). However, you are generally pleasant toward the interviewer, and are cooperative. You are reluctant to speak about substance usage. You appear to be "in a fog" from time to time during the interview, particularly when you describe comrads who were killed in combat, your guilt, and difficulty readjusting to family life.

How to Respond
You can expect the course of the interview to start with a query about your presenting symptoms (sleep disturbances, headaches). You will reply with the opening statement and then offer other details in response to questioning. You will disclose more information and be more open emotionally if the learner creates an atmosphere of trust and empathy. He or she might invite disclosure through use of silence, acknowledging your feelings, asking open-ended questions, etc.

Standardized Patient Case

1. NAME OF PATIENT: TIMOTHY STARNES

3. PATIENT PRESENTATION:

b) Initial Body Language/Affect:

He appears tense and on edge. He startles easily (any loud noise). He is sometime visibly angry or appears to be "in a fog" from time to time during the interview, particularly when he describes several comrads who were killed in combat and difficulty readjusting to family life.

3. RESPONSE BY SP TO STUDENT'S FIRST QUERY:

a) "How are you feeling", "What brings you in today?" etc.

"I can't get the scene out of my head. I saw two of my guys get killed over in Iraq. Why them? Why not me? I see them in my thoughts-in my dreams-everywhere."

b) If the student remains silent, nods as if waiting for more information, or asks an open-ended question like "Tell me more about the…" "Describe the… to me", "Go on", the patient says:

"I watched, helpless, as they were killed by an IED on the side of the road. None of us could save them or prevent them from dying…but what's worse is that we were unable to retrieve the bodies for many hours due to the fighting. I feel so guilty. "Why did I survive and they didn't? They were young, I have lived my life. I keep thinking over and over that we somehow could have prevented their deaths, that we failed them."

Information given with SPECIFIC questioning regarding timeline, frequency, etc:

How are you sleeping?

"I get about four hours of sleep a night-at most. As soon as I close my eyes, I'm right back in Iraq. I hate to admit it, but I'm almost afraid to fall asleep-I know I'll have a nightmare. I have had the same dream every night for four months. Every time I have it I wake up. I immediately drop to the ground and do push-ups until my arms give out—I'll do anything not to think. I can't do anything all day-I'm so exhausted"

Do you ever experience flashbacks/ ever feel as if the traumatic event were happening again?

"Sometimes, out of thin air, I'll be right back on that dusty street corner, in the middle of everything. I can feel the heat, I can smell the ammo, I can hear the explosions. I can feel the bullets whizzing by me. I can even feel the weight of my pack. I just see those guys covered in blood" (trail off…)

Do you experience distress when you see, hear, or smell things that remind you of that day?

"This is going to sound crazy, but every time I see the blades of a fan I'm immediately transported back to that day. I guess they look and sound like helicopter blades or something.

How do you react when you experience these reminders?

"I sweat, I shake, I can't breathe, my heart races—it's just awful."

Do you make an effort to avoid thoughts, feelings, or conversations associated with what happened?

"Yeah, everyone wants me to talk about what happened. I just can't talk about it with them so I came to you."

Do you make an effort to avoid activities, places, or people that remind you of what happened?

"I just can't bring myself to go to any events that honor veterans—I feel like I shouldn't be honored, I failed those guys. Plus, it brings me right back. I would never be able to see any of the guys from my troupe."

Do you ever have trouble remembering any aspects of that day you feel you should remember?

"No-I wish I did. I see it all, every night and every day."

Can you enjoy the things you used to enjoy before this happened?

"No, nothing is enjoyable. I can't bring myself to do much at all, really."

Do you feel "detached" from others?

"Definitely. No one can understand what that was like. No one here was over there."

Do you ever feel that it's hard to experience emotions, like love?

"I know I love my wife and kids. But, honestly, I just feel empty; numb."

Do you ever feel as though your life would be unexpectedly cut short?

"I can't envision myself in the future. You know, sometimes I wish I would be dead."

Do you ever have thoughts about hurting yourself?

"No. I'm so sick of these nightmares and everything, that I think I would be better off dead, but I would never do it. The military was all about honor—what kind of soldier would I be if I killed myself?"

Are you more irritable than usual or do you have angry outbursts?

"Definitely. I feel irritable and impatient with my wife and kids. I was never like this before. I get annoyed over the smallest things they do. I never really have outbursts, I have raised my voice more than usual, but that's it."

How has your concentration been?

"I can't concentrate on anything. Especially conversations--I just can't follow them."

Do you find yourself being more vigilant than you really need to be?

"Yeah, I'm constantly scanning my surroundings. I almost feel like I'm bracing for an ambush or something.

Do you find yourself being startled easily?

"I jump at anything. Especially car horns. I almost swung at my wife when she kissed me from behind. I didn't mean to—I feel terrible about it."

Communication and Openness of SP:

You are slightly guarded in the beginning, but eventually let things "pour" out now that you have someone to talk to about this.

Creating empathic opportunities: What could the SP say, or how would the SP behave, to create opportunities for the examinee to express empathy?

"I keep seeing their bodies blown apart. Did God see them and care for them?"

What the student might say	**What you would say**
Area	Words patient would use
Onset When did the problem start?	Four months ago, when this particular battle occurred.
Duration How long does it last?	I am like this all of the time, even when I sleep I can't escape.
Progression Is the problem getting worse?	It's been constant, but I'm getting so frustrated—and just tired of it.
Intensity On a scale of 1-10 how bad are the symptoms?	I'm constantly at a 10
Quality Can you describe it?	My heart races, I freeze, I sweat, I tremble, I can't breathe
Alleviating factors What makes the problem better?	Not much. I can't escape. When my family backs off sometimes, I can cope a bit better.
Aggravating factors What makes the problem worse?	When I feel pressured by my family to talk about things. It just makes me angry.

Hx area	Patient Presentation
Medical History	High cholesterol You have never been injured in combat.
Surgical History	None
Injury History	None
Current Medications, Prescription and OTC:	Symmetrex for high cholesterol Vitamin B-12-your wife suggested you take it for "stress"

Family History Parents	 Your mother has a history of depression and heavy drinking, but she has been sober for 20 years. She is 75 yrs old. Your father is deceased from a heart attack at age 60.He had a history of heart disease.
Occupational History	Enlisted in Army at age 22 Held various roles in army and graduated from college age 30 degree in chemical engineering In 1990 deployed to Kuwait during Gulf War immediately after graduating college Worked in military operations in DC In 2003 deployed to Iraq for 12 months Never expected to have to return, then deployed to Iraq 12 months ago, has been home for 4 months.
Marital Status Children	Married at the age of 35 to wife. Good, strong, trusting relationship throughout deployments. Wife has coped well with previous deployments. She is supportive in your time of need, although is unsure how to help. Two sons, aged 16 and 18
Sexual History	Monogamous in all relationships
Psychological or Psychiatric hx.	None. You have been psychologically "healthy" previous to this event.
Last medical appointment and reason:	Four months ago upon return to the US
Support systems & Religion:	Mother, wife, sons. However, you do not want to reach out to them. You have no friends outside of the military. Christian—have begun to question how God could let things like this happen.
Environmental Considerations	None
Diet & Exercise:	You use the exercise to escape your feelings. You eat healthily. Not all that interested in food lately.
Tobacco:	Never
Alcohol:	(Reluctant to admit…)

	You deny a history of substance abuse but admit since you got home that you are drinking 4-5 mixed drinks (Manhattans) each night to calm your nerves and help with sleep. You do not become intoxicated. His wife has expressed concern and this “annoys” him but he understands that she is just looking out for him.
Other Substances:	None

NSU's Psychology Services Center

Telephone Intake

Name: Timothy Starnes
Age: 52
Date of Birth: 7/4/1962

Reason for calling
"I've been having terrible nightmares since I got home from Iraq. I can't take them anymore. I can't talk to anyone else about this stuff."

Marketing
How did you hear about us: Website
Ever been to any NSU clinics?: No
Been to following NSU clinic(s): No

Symptoms
Sleep Problems:
Yes.
Comment: "I maybe get four hours a night. I've been having the same dream for four months."

Sadness/Depression
Sometimes
Comment: "I'm sad about what happened. Just really guilty. It doesn't get me too down—I just miss those guys."

Anxiety
"I startle over nothing—I'm constantly on guard for no reason. I think I'm going nuts."

Abuse History:
None.

Issues in the past that are affecting the present?
"Just what happened over there."

Flashbacks/Nightmares?
Daily and nightly
Comment: "They come out of nowhere. Always the same scene."

Ever been sexually assaulted?
No.

Difficulties in Interpersonal Relationships?
"I feel like I am getting more and more irritated by my family. I know they're just trying to help—but really, they can never understand."

Medical/Health
Medical Issues:
High cholesterol
Chest pain, palpitations, shortness of breath, muscle tension, sweating upon flashbacks/awakening from nightmares

Medical Hospitalizations
None.

Prior Psychiatric/Psychological
Outpatient therapy
No.
Comment: "I normally don't do this psychology stuff. I just didn't know where else to turn, and I can't live like this."

Suicide
Denied.

Homicide
Denied.

Substance Use History
Drug Use
No.

Alcohol Use
"I sure don't think so…my wife is pretty concerned though, I have to admit."

Healthy Lifestyle
Change in Appetite
Slight.
Comment: "I'm not really interested in food. However, I do eat."

Remarks
Currently involved in any legal/court issues?
No.

Fee/Waitlist Information
Are you employed? "Not currently. I tried when I got back from Iraq, but I just couldn't concentrate."
Number in household: 4

Caller was advised of the standard fee.

Appendix I

SP Case: Social Phobia

SP Demographics:

Name: Lisa Gibbons
Gender: Female
Age range: 19-25
Ethnicity: Caucasian
Setting: Anxiety Treatment Center
SP Opening Statement: "I want to be social but I just can't. I'm becoming a hermit!"

History of present illness:

You experience anxiety at social gatherings, if you have to speak in front of others, and in interpersonal relationships. You experience a "pain" in the pit of your stomach, heartburn, and feel physically ill when confronted with any social situation. You can feel your face turn bright red, palms sweat, and heart race when anticipating social situations. You are often keyed up and unable to relax in general, and you attribute this to a constant fear of being evaluated by others. You feel that in social situations you are always being negatively evaluated by others and that you are going to embarrass yourself. When you begin to feel this way you leave the situation to be alone. Occasionally, you have trouble falling and staying asleep because you constantly ruminate over that day's interaction with others or worry about meeting with people the following day.

You admit that people do tend to "like" you (although you can't imagine why) and invite you places. However, friends tend to drift away because you often can't bring yourself to actually attend the events when they occur. You will often make up an excuse to get out of the event or even get sick in order to not attend. For example, during New Year's you were invited to go out and celebrate but began to feel so physically ill about the social interaction that you could not bring yourself to leave the house. This habit makes you feel very lonely because you yearn to be more social and outgoing. You say that anxiety affects every aspect of your life because "life is about relationships" with others. Overall, you don't interact much with the outside world unless absolutely necessary…and you feel you have become a "hermit."

Authority figures, especially those at work, are also a source of anxiety. You have trouble asserting yourself and giving ideas, as well as asking for a raise. You work from home due to your social anxiety. You provide internet-based technology support. All of your communication is via the telephone. Your anxiety has increased to the point that you experience symptoms of anxiety upon leaving your apartment. Business conferences are also a significant source of anxiety because you not only have to leave your apartment but also attend a conference with many people. You have gotten to the

point where you begin experiencing anxiety as soon as you hear of an upcoming conference.

You first became aware of your social anxiety at the age of 14, shortly after transferring from a small Catholic school to a large public high school. When faced with the challenge of making new friends, you became increasingly withdrawn. You began to feel that you would appear "boring." You lost contact with your former group of close friends, suspecting that they never truly liked you. Relationships with family members are also affected—you feel they are only "nice to you because they have to be." You often worried they will not tell you the truth about how disliked you truly are for fear of hurting your feelings. You also state you have had a series of long-term relationships, all of which ended because you are "too sensitive" and fearful your boyfriend would leave you.

Past medical history: You have no history of any significant medical problems. Your last physical exam was two years ago and you continue to be in good health. You do not take any prescribed medications for your anxiety; however, you sometimes take Benadryl or Melatonin (2mg), over the counter medications, to help you sleep.
In 2004, you saw a counselor in college for your anxiety, and remained in therapy "on and off" throughout your final three years of college. You felt that the therapy was very helpful, and you were disappointed that you had to terminate treatment upon graduation. You felt "too anxious" to seek out a therapist on your own until the fall of 2010 when you moved to Cooper City for your job. You then began attending group therapy for social anxiety. You felt a decrease in your symptoms but the program was only offered for a year. You experienced a "relapse" right after the last meeting because you felt that you lost your "lifeline." You then worked up the courage to seek individual therapy at this time.

Background Information:

You were born and raised in Buffalo, New York, by your biological parents. You are the oldest child of a middle class, Catholic, Caucasian family. Your parents have been happily married for 30 years. Your family has often struggled with finances. Both of your parents received their GEDs, but did not pursue higher education. Your younger sister, age 22, is a college freshman.

Both of your parents reportedly receive psychotherapy for Major Depressive Disorder. Furthermore, your sister was diagnosed with ADHD and Bipolar II Disorder. Diagnoses of Major Depression, various anxiety disorders and Bipolar II are present on both maternal and paternal sides of your family. You have always gotten along well with both of your parents as well as your sister. Moreover, you have had close relationships with your small, extended family. You describe your family as "accepting" and "very loving," but at times interaction with your family members is "rough," as they can be "rather moody." You also possessed a "small but close" group of friends throughout your childhood.

Discipline in your home was relaxed; however, you attended a strict Catholic school from pre-school until eighth grade. You have since relaxed your Catholic ties, but still retain

the moral values. To this day, however, you feel "guilty" over any wrongdoing in which you may engage. Your academic achievement has always been high, attaining an A average throughout your education. You describe yourself as a "bookworm" who used your studies to "escape" social interaction. You graduated from SUNY in 2007 with a Bachelor's degree in Information Technology and Finance. Your parents are "proud and supportive." Your parents have always had high expectations for your conduct and achievement, but did not 'push' you. Most of your drive came from high internal standards.

You moved to Cooper City, Florida in January 2010. You wish you knew more people, although you are afraid to meet them. You live by yourself in an apartment and feel alone here in Florida. You enjoy going to the beach, playing poker, and going golfing, however, you rarely engage in these activities since you have no one to go with. You often call home for support.

Patient's response to special interviewing techniques: "I can't figure it out—I want so badly to make friends, but I'm so scared that I never will."

Specific body type/physical requirements for SP: Female in their early/mid 20's.

Patient presentation: Casually dressed and well groomed. You have rushed speech and avoid eye contact. Your attitude is cooperative and attentive. You are open regarding your history. You show a broad range of emotions during the session, appropriate to the topics discussed. You seem somewhat anxious. You sit in a tense position and fidget restlessly. Your intelligence is above average.

Standardized Patient Case

1. NAME OF PATIENT: LISA GIBBONS

4. PATIENT PRESENTATION:

c) Initial Body Language/Affect:

Nervous, shy

3. RESPONSE BY SP TO STUDENT'S FIRST QUERY:

a. "How are you feeling", "What brings you in today?" etc.

"I want to be social but I just can't. I'm becoming a hermit!"

b) If the student remains silent, nods as if waiting for more information, or asks an open-ended question like "Tell me more about the…" "Describe the… to me", "Go on", the patient says:

I get a "pain" in the pit of my stomach, heartburn, and feel ill when I have to talk to or to approach anyone. I can feel my face turn bright red, my palms sweat, and my heart race. I feel that in social situations I am always being negatively evaluated by others and that I am going to embarrass myself.

Concerns:

"I don't interact much with the outside world unless absolutely necessary, which isn't good-I feel I'm not getting anywhere in life! I feel very lonely—I really do want to be more social and outgoing. Anxiety effects every aspect of my life because life is really about relationships with others."

Information given with SPECIFIC questioning regarding timeline, frequency, etc:
"I first noticed my social anxiety at the age of 14, shortly after transferring from a small Catholic school to a large public high school. The thought of making new friends and fitting in overwhelmed and terrified me. I always felt that I appeared boring or was a loser. Needless to say, I didn't speak up much. I then figured my old group of friends saw me in the same way, so I became 'afraid' of them too. This problem has been constant ever since."
"I guess people like me, although I have no idea why. I do get invited places and stuff. Usually I chicken out after a few days and make up some excuse why I can't go. If somehow I do bring myself to go, I always seem to get so worked up with worry right beforehand I literally get sick and cancel. Unfortunately, those potential friends get so sick of me cancelling they just don't invite me anymore."
"I'm very afraid when it comes to work too. I work from home, thank goodness, but when I do have to interact with supervisors, I can barely even get words out! Forget about asking for a raise!"

"My anxiety has gotten so bad that I get anxious just leaving my apartment. I still do, however."

"My anxiety is only tied to social situations. I've never just gotten anxious for no reason, or out of the blue."

"I don't think I have what you would consider panic attacks. I mean, I can get worked up pretty easily when I'm thinking about social interactions—and I especially get them when I'm with someone, which is really embarrassing. I just get these weird anxiety feelings when I have to interact with someone."

Communication and Openness of SP:

SP is open, motivated, and rapport is easily established.

What the student might say **What you would say**

Area	Words patient would use
Onset When did the problem or pain start?	"The anxiety has been bothering me since high school" "I've had difficulty falling asleep since then as well—it usually takes me about an hour or more to fall asleep. I guess I average about 6 hrs per night."
Duration How long does it last?	"I feel like it's pretty much always there. Although sometimes I can relax at home, I'm always replaying interactions with people in my head and analyzing my performance…or even worrying about who I'll meet or how I'll act the next day."
Progression Is the problem or pain getting worse?	"Definitely getting worse-I'm to the point where I really have to force myself to go out of the house. I can do it, but it's really unpleasant."

Frequency How often does it occur?	"Every day"
Location Where is the pain or problem?	"I often get stomach pain when I have to be social."
Radiation Does the pain move or travel from one site to another?	no
Intensity On a scale of 1-10 how bad is the pain?	"The pain reaches a maximum of 7 or so on a scale from 1 to 10"
Quality Can you describe it	"It's just a dull ache or pressure in my stomach"
Alleviating factors What makes the problem or pain better?	"Getting out of the situation!"
Aggravating factors What makes the problem or pain worse?	"Whenever I start to mess up my words, or when I can feel myself blush, or when I think someone looks at me funny, or when people don't laugh at my jokes, oh wow—just anytime I think I'm doing really badly when I talk to someone, really. Like now!"
Precipitating factors What were you doing just before the pain started?	"Talking with anyone-it doesn't matter if I know them or not. Sometimes I don't even need to be talking to them—I'll think that someone is looking at me strange or judging me for how I look or act."

Hx area	Words patient would use
Medical History	"I'm lucky-I've always been healthy. I've never seen anyone for my stomach or anything—I know it's just anxiety."
Surgical History	None
Injury History	None
Current Medications, Prescription and OTC:	"Sometimes I'll take a Benadryl or Melatonin on nights when my insomnia is really bad and I have to get up early the next day. I guess I may do that once a week or so, not very often."
Family History Parents Siblings	"My mom and dad are great—very supportive. I miss them, and talk to them a lot."

Other relevant	"My sister has always been very "trying"—ADHD and Bipolar disorder are a bad combination. I love her, but she makes me angry at times. We've struggled in the past." "All four of my grandparents are deceased, and I miss them all so much, especially my grandma, who always believed in me. I have a small extended family who lives back in New York."
Occupational History	"I've always been the "tech" girl...all through college I worked for the computer help desk. I actually stayed on after graduation—it was perfect, all over the phone! I left in 2010 when I got hired my current company down here in Florida, and still get to give internet help over the phone."
Marital Status	None
Sexual History	"In long-term relationships. Never outside of them."
Psychological or Psychiatric hx.	"I actually really loved therapy throughout college…it was very helpful, and nice to be able to actually talk to someone who I know wasn't judging me, although I did worry about that from time to time. I was upset to not be able to continue when I graduated. I was too scared to seek someone out by myself until I couldn't take it anymore when I moved down here to Florida. I forced myself to go to the social anxiety group that Nova held. I was devastated when the group ended after a year—they really became my lifeline. It was nice to be around people like me. Unfortunately, I couldn't bring myself to make actual friendships from the group—I was too scared. I forced myself to come back today because I just can't live like this anymore, it's really holding me back."
Last medical appointment and reason:	"Two years ago for a physical for work."
Support systems& Religion:	Family Religion is Catholic
Environmental Considerations	None
Diet & Exercise:	"I eat healthily and exercise—it makes me feel better about myself, and hopefully others feel the same."
Tobacco:	Never
Alcohol:	"Rarely. I don't drink by myself, and never go out…"
Other Substances:	never

NSU's Psychology Services Center

Telephone Intake

Name: Lisa Gibbons
Age: 25
Date of Birth: 8/7/87

Reason for calling
"I want to be social but I just can't. I'm becoming a hermit!"

Marketing
How did you hear about us: Online
Ever been to any NSU clinics?: No
Been to following NSU clinic(s): No

Symptoms
Sleep Problems:
Falling and staying asleep
Comment: "Sometimes I take a Benadryl if I can't sleep."

Sadness/Depression
Sometimes
Comment: "My inadequacies bother me."

Anxiety
"Socially. I get anxious just thinking about social situations."

Abuse History:
Current: None
Past:
Physical? None
Verbal? None
Emotional? None

Issues in the past that are affecting the present?
No.

Flashbacks/Nightmares?
No.

Ever been sexually assaulted?
No.

Difficulties in Interpersonal Relationships?
No.

Medical/Health
Medical Issues:
"None that are serious. I get nauseated, get heartburn, and feel physically ill when confronted with any social situation."

Medical Hospitalizations
None

Prior Psychiatric/Psychological
Outpatient therapy
Yes.
Comment: Throughout college. Attended social anxiety groups at Nova when moved here from New York—found them very helpful and was devastated when they ended.

Suicide
"Never."

Homicide
Denied

Substance Use History
Drug Use
No.

Alcohol Use
No.

Healthy Lifestyle
Change in Appetite
No.

Remarks
Currently involved in any legal/court issues?
No.

Fee/Waitlist Information
Are you employed? Yes, provides technology support over the phone.
Number in household: 1

Caller was advised of the standard fee.

Appendix J

SP Case: Generalized Anxiety Disorder

BIO-PSYCHOSOCIAL EVALUATION
CONFIDENTIAL

Reason for Referral

XX, a XX, single, XX female, was self-referred to the Anxiety Treatment Center (ATC) at the Psychology Services Center (PSC) of Nova Southeastern University (NSU) for worry symptoms and significant stress levels.

Presenting Problem

XX presented with symptoms of anxiety, which included severe tension in her neck and stomach for the past year. Per client report, the pain in her neck and stomach reach a maximum of 8 on a scale from 1 to 10. Client stated that this pain is present more days than not. Furthermore, client reported difficulty falling asleep most nights over the past 18 months due to "racing thoughts." XX stated that her thoughts are primarily related to daily stressors. For example, XX reported worrisome thoughts about completing her tasks at school and making enough money at work on a daily basis. She reported worrying that she will not finish assignments on time or do a poor job on them. She also reported that she is working very hard and doesn't feel like she is making the money she deserves. XX denied current depressive symptoms.

In addition to these general worries, around XX, client described an incident that raised her anxiety. As per client report, her mother's boyfriend found marijuana in the trunk of her car. Although XX denied her use of marijuana as a problem, she stated that her mother makes her take weekly drug tests since this time. XX reported that as further punishment for her use of marijuana, she had been "grounded." Client described this as very frustrating. She also reported being stressed because of difficulties with romantic relationships. For instance, she reported that she ruminates about a relationship she ended in XX. XX stated that her frequent worrying about her romantic relationships makes it difficult to concentrate while at school or at work. XX stated that she frequently "over-thinks" relationships and that she takes things "too personally." For example, she reported feeling nervous that classmates or co-workers were saying negative things about her ex-boyfriend. She indicated that she frequently feels overwhelmed and stressed due to how often she ruminates about her past relationships.

In addition, XX reported that her anxiety was recently raised by statements made by her ex-boyfriend's sister. Per client's report, she has repeatedly e-mailed threatening remarks and insults to XX over the past three weeks. Client explained that the e-mails were sent as a direct result of the break-up. Client reported that the messages included threats of physical violence. Client also reported that the messages involved the use disparaging remarks like "slut" to talk about her. XX stated that she only is doing this because "she is mad about me breaking up with her brother."

History of Presenting Problem

Per client report, XX has been a worrier since high school. She stated that she worried about getting good grades and her romantic relationships. She discussed that she was concerned with earning good test scores and not letting herself get behind

academically. However, she reported that her anxiety did not have a significant effect on her ability to function in high school. XX stated that her anxiety rose to significant levels when she broke up with her boyfriend of eight months, in XX. She reported that she lost 20 pounds shortly after the break up due to a loss of appetite. Per client's report, she has not been able to gain the weight back. Reportedly, she finds herself ruminating about the breakup, and becomes upset with herself, thinking, "Why am I still bothered by this?" Both she and her ex-boyfriend worked together at a local restaurant until she quit in XX, due to the end of the relationship. XX discussed that her relationship with her mother has never been a source of significant anxiety. She stated that the only significant conflict and anxiety between them was in regards to the marijuana found in her car. XX went on to report that her drug use was recreational and did not serve to lower her anxiety.

Relevant Background Information

Developmental/Medical History

XX denied any developmental delays such as motor or speech difficulties as a child. Furthermore, she denied maternal use of alcohol, cigarettes, or non-psychiatric drugs while pregnant with XX XX denied any current serious medical problems. She stated that her last doctor's visit was in the beginning of XX. She saw the doctor because of minor gastrointestinal complaints. She stated that the doctors did not give an official diagnosis and did not prescribe any medicine. Client denied any history of head injury or loss of consciousness.

Psychiatric History

XX reported that her mother and father "made her" go to counseling following their divorce in XX. She attended three sessions with her family before terminating treatment. She stated that she did not need therapy and that the sessions were not helpful for her. Furthermore, she felt that the therapist talked down to her. Client denied seeking any further therapy or counseling services. XX reported that she taught herself and has practiced deep-breathing techniques over the past two years to help alleviate her anxiety symptoms. XX did not report any further details on how she learned the breathing techniques. She claimed that the breathing techniques helped somewhat. XX reported taking 40 mg of Citalopram over the past year for anxiety and depression, as prescribed by her primary care physician. Client denied past or present homicidal or suicidal ideation, plan, or intent.

Substance Use History

Client reported past abuse of alcohol and marijuana. She stated that she began smoking marijuana with her friends at the age of XX. XX added that she smoked marijuana approximately once a week for nearly five years, until XX. Per client's report, she quit using when her mother's boyfriend found her marijuana in the trunk of his car in XX.

XX reported abusing alcohol as well. She stated that she began drinking alcohol at the age of XX on a weekly basis. Per XX's report, she still drinks alcohol with friends approximately once per month. XX did not elaborate regarding how many drinks or what kinds of drinks she consumed. She reported blacking out from drinking alcohol several times since the age of 17. Client did not provide any further details. Client stated that she finds her past drinking behaviors irresponsible, and that she has reduced the frequency

with which she drinks. XX denied any treatment history or further significant consequences as a result of substance abuse.

Family History

XX stated that she currently lives at home with her mother and her mother's boyfriend. XX reported that her parents divorced in 2003. XX reported that her mother is XX years old and works as a law enforcement officer for the XX. XX reported that her mother's boyfriend, 65, is also a law enforcement officer for the Broward Sheriff's Office. XX reported that she has a good relationship with her mother but considers her mother's boyfriend to be "annoying." Per client's report, there is tension in the household due to the fact that he found marijuana while looking in the client's car, which resulted in her current curfew and monthly drug tests.

XX reported she has a good relationship with her father, who is a law enforcement officer XX. XX reported that she has one XX-year old brother who sells health insurance. Client reported that her brother is a "troublemaker" who constantly tries to "embarrass me." She reported that her brother gives her no respect and does not treat her well. For example, XX reported that he recently struck her in the face while she was driving him to a family gathering. She reported that the injury hurt, but he did not hit her very hard. She denied any physical, sexual, verbal, or emotional abuse by any family member. She stated that she was hit by her brother only on this one occasion.

Educational & Employment History

XX reported obtaining mostly A's and B's throughout middle and high school. She denied having to take any special classes or repeat any grade. Currently, she is a third year Dental Assistant student XX in XX.

XX reported working as a waitress for three years at a local restaurant. She reported working there from XX to XX. XX's reported reason for quitting her job was the constant questioning from employee's about her break-up with a co-worker. She also stated that the restaurant was poorly managed and she did not get paid well. Currently, she works at a different local restaurant as a hostess. She reports having worked there for nearly one year.

Social History

XX reported having 10 to 15 close friends. She denied difficulty in making or keeping friends. Client reported that she enjoys shopping, tanning, and going to the beach with her friends. She reported having been in 3 significant romantic relationships. Her first significant relationship began in XX and ended in XX. She reported that she ended their relationship because her boyfriend was four years older than her but lacked motivation to do anything in life. XX reported that due to their breakup, she quit her job as a waitress at a local restaurant in XX. She reported that he spread rumors about her sexual promiscuity and the constant questioning by employees compelled her to quit. Her next significant relationship lasted for one year, from XX to XX. She reported that she ended this relationship because of her disapproval of his drug habit. Client reported a three month romantic relationship that ended in XX. This relationship also ended because her significant other had a substance abuse problem. She reported that she feels "jaded" after her first break-up and does not care about the other relationships.

Legal History

Client denied involvement with the legal system.

Mental Status and Behavioral Observations

XX appeared her stated age of XX. She was dressed casually and appropriately for the session. She was oriented to person, place, and time, and situation. Her speech was appropriate and she made appropriate eye contact. The client's attitude was cooperative and attentive. She appeared to be open regarding her history. Client demonstrated appropriate and coherent thoughts relevant to the topic. Client denied any hallucinations or delusions. Intelligence was in the average range based upon vocabulary and she did not appear to evidence any memory deficits. Client demonstrated a broad range of emotional expression that was appropriate to the topic. XX demonstrated good concentration as well as insight. Client denied any past or present suicidal or homicidal ideation, plan, or intent. Rapport was easily established with the client, who appeared to be motivated for treatment.

Diagnostic impressions (DSM IV TR)

Axis I:	300.02 Generalized Anxiety Disorder
	305.20 Cannabis Abuse, In early partial remission
Axis II:	R/O Dependent Personality Disorder
Axis III:	No medical conditions
Axis IV:	Family difficulties
Axis V:	**GAF** = 60

Summary & Recommendations

XX, a XX, XX female, was evaluated at the Nova Southeastern University Anxiety Treatment Center for the presence of excessive worry and anxiety. Findings from the clinical evaluation suggest the presence of excessive anxiety and worry occurring more often than not. These worries have been present for 18 months. She experiences muscle tension, sleep disturbance, difficulty concentrating, and feeling restless and feeling on edge. Client worries about interpersonal relationships, vocational performance, and difficulties with her family. This cluster of symptoms warrants a diagnosis of *Generalized Anxiety Disorder.*

XX would likely benefit from cognitive-behavioral therapy in an individualized setting for treatment of her anxiety symptoms. The therapy should consist of psychoeducation regarding the nature of generalized anxiety and stress, as well as the cognitive model. Cognitive restructuring should focus on identifying and challenging XX's anxious thoughts. Treatment should also include relaxation techniques to help client lower her anxiety symptoms. Additionally, treatment should consist of learning appropriate problem-solving skills. Client strengths include support from friends and family and motivation for treatment. Obstacles to treatment include a busy and stressful schedule due to school and work obligations.

Identifying Case Factors:

Presenting complaint: Symptoms of anxiety, which include: Muscle tension, sleep disturbance, difficulty concentrating, feeling restless and on edge, excessive worry, and feeling overwhelmed.

SP Demographics:

Name: Tracey Finny
Gender: Female
Age range: 19-25
Ethnicity: Caucasian
Setting: Anxiety Treatment Center

SP Opening Statement: "I've always worried a lot but lately the stress has just gotten to be too much, I really need to change this and I thought maybe this could help"

History of present illness:

You have been a "worrier" since high school. It used to be associated with getting good grades and romantic relationships. Currently your worries are primarily related to daily stressors, such as about completing your tasks at school and making enough money at work on a daily basis. You also worry that you will not finish assignments on time or do a poor job on them. In addition, you feel frustrated because you feel that you are working very hard yet are not making the money you feel you deserve. You have also been experiencing severe tension in your neck and stomach for the past year. The pain in your neck and stomach reach a maximum of 8 on a scale from 1 to 10 and is present more days than not. Furthermore, you have difficulty falling asleep most nights over the past 18 months due to "racing thoughts."

Your anxiety became especially bad when you broke up with your boyfriend of 8 months in July of 2009. You lost 20 lbs and was constantly thinking about the failed relationship causing you to feel overwhelmed and making it difficult for you to concentrate on daily tasks. You still frequently feel overwhelmed and stressed out due to difficulties with romantic relationships and excessive rumination. This frequent worrying about your romantic relationships makes it difficult to concentrate while at school or work. You also tend to "over-think" relationships and take things "too personally." For example, you feel nervous that classmates or co-workers were saying negative things about your ex-boyfriend, after you broke up with him.

In addition, over the past 3 weeks, you have been very stressed because you have been receiving threatening e-mails from your ex-boyfriend's sister. The messages included threats of physical violence and insults such as referring to you as a "slut". mother's boyfriend found marijuana in the trunk of your car. Although you deny abuse of marijuana as a problem, your mother still makes you take weekly drug tests. You are also

very frustrated because as further punishment for the use of marijuana, you had been "grounded" by you mother.

Past medical history: You have no history of any significant medical problems.

Background Information: You currently live in Miami, FL with your mother and her boyfriend. Your parents divorced in 2003. Your mother, father, and her boyfriend all work as law enforcement officers. You have a good relationship with your mother but consider your mother's boyfriend to be "annoying." There is tension in the household due to the fact that he found marijuana while looking in your car, which resulted in your current curfew and monthly drug tests.

You have a good relationship with your father. You also have a 27-year old brother who sells health insurance. You feel that your brother is a "troublemaker" who constantly tries to embarrass you and acts disrespectful towards you. For example, he recently struck you in the face while you were driving him to a family gathering. This was the only time he hit you and you have not had any physical, sexual, verbal, or emotional abuse by any family member.

You have about 10 to 15 close friends. You do not believe that you have any difficulty in making or keeping friends. On your free time you enjoy shopping, tanning, and going to the beach with your friends. You have been in 3 significant romantic relationships. Your first significant relationship began in December 2008 and ended in July of 2009. You ended the relationship because he was four years older than and lacked motivation to do anything in life. Due to that breakup, you had quit your job as a waitress at a local restaurant after the ex-boyfriend spread rumors about your sexual promiscuity to other employees.

Your next significant relationship lasted for one year, from September 2009 to September 2010. You ended this relationship because of disapproval of his drug habit. Next was a three-month romantic relationship that ended in January of 2011. This relationship also ended because your significant other had a substance abuse problem.

In middle and high school you earned mostly A's and B's. Currently, you are a Dental School student at a Community College in Miami, Florida.
You have worked as a waitress for three years at a local restaurant, quitting after your first breakup. Currently, you work at a different local restaurant as a hostess. You have been there for nearly one year.

Your mother and father made you go to counseling when they divorced in 2003. You attended three sessions with your family before terminating treatment. You felt that you did not need therapy and the sessions were not helpful for you. You also felt that the therapist talked down to you. You taught yourself and have practiced breathing techniques over the past two years to help alleviate the anxiety symptoms. You feel that the techniques helped somewhat, but you do not know exactly how to properly do them. You have also been taking 40 mg of Citalopram over the past year for anxiety and

depression, as prescribed by your primary care physician. You have no past or present homicidal or suicidal ideation, plan, or intent.
In the past you have used alcohol and marijuana. You began smoking marijuana with your friends at the age of 15. You used it approximately once a week for nearly five years, up until your mother's boyfriend found it in your car. You began drinking alcohol at the age of 17 on a weekly basis. You currently still drink socially approximately once a month. When you drink, you typically have about 4-5 mixed drinks or beers. You have blacked out from drinking alcohol several times since the age of 17 and felt you acted irresponsible so currently you have reduced the frequency with which you drink. You have no legal history.

Patient's response to special interviewing techniques: "I thought I could control the anxiety on my own but I have no idea what I am doing, I feel like such a failure"

Specific body type/physical requirements for SP: Female in their early/mid 20's.

Patient presentation: Casually dressed and well groomed. You have appropriate speech and eye contact. Your attitude is cooperative and attentive. You are open regarding your history. You show a broad expression of emotions in session, appropriate to the topics discussed. You seem somewhat anxious. You sit in a tense position and play with your jewelry/bite your nails a few times during the session, indicating some nervousness. Your intelligence is average, and you have good concentration as well as insight. You are able to establish rapport with the therapist, and are motivated for treatment.

Standardized Patient Case

1. **NAME OF PATIENT: TRACEY**

2. **PATIENT PRESENTATION:**
   Initial Body Language/Affect:
   Slightly nervous, concerned
3. **RESPONSE BY SP TO STUDENT'S FIRST QUERY:**
   "How are you feeling?", "What brings you in today?" etc.
   "I've always worried a lot but lately the stress has just gotten to be too much, I really need to change this and I thought maybe this could help."

- **If the student remains silent, nods as if waiting for more information, or asks an open-ended question like "Tell me more about the…" "Describe the… to me", "Go on", the patient says:**
  "I've been having pain in my stomach and neck, trouble sleeping, trouble concentrating, feeling restless and on edge all the time, and just overall feeling overwhelmed."

Concerns:
"All this stress and anxiety is interfering with my life. I'm always worried about something and it's causing me to have difficulty doing everyday things such as studying

because I'm so distracted as well as tired from not sleeping well."

Information given with SPECIFIC questioning regarding timeline, frequency, etc:
"I have been a "worrier" since high school. It used to be related to getting good grades and romantic relationships but now the worries are usually about everyday stuff like getting everything done at school and work."

"I worry that I will not finish my assignments on time or do them poorly, it matters a lot to me that I do a good job"

"I'm also really frustrated because I work very hard yet I'm not making much money."

"I've been experiencing severe tension in my neck and stomach for the past year"

"The pain reaches a maximum of 8 on a scale from 1 to 10 and is there more days than not"

"I've had difficulty falling asleep most nights over the past 18 months, my mind just wont stop racing when I go to bed"

Communication and Openness of SP:

SP is open, motivated, and rapport is easily established.

What the student might say	**What you would say**
Area	Words patient would use
Onset When did the problem or pain start?	The anxiety has been bothering me since high school I've been experiencing severe tension in my neck and stomach for the past year I've had difficulty falling asleep over the past 18 months
Duration How long does it last?	I feel like it's pretty much always there
Progression Is the problem or pain getting worse?	I don't know if it's getting worse but it is definitely not getting better
Frequency How often does it occur?	More days than not
Location Where is the pain or problem?	I often feel pain mostly in my neck and stomach
Radiation Does the pain move or travel from one site to another?	no

Intensity On a scale of 1-10 how bad is the pain?	The pain reaches a maximum of 8 on a scale from 1 to 10
Quality Can you describe it	It just feels like a huge boulder fell on me and I cant get out
Alleviating factors What makes the problem or pain better?	Breathing exercises I learned help a little, but I don't know if I am doing them right
Aggravating factors What makes the problem or pain worse?	Whenever something stressful happens it makes it even worse
Precipitating factors What were you doing just before the pain started?	I get the muscle tension a lot last time it was when I came home work working a long shift and I had to study for an exam I just felt so stressed out

Hx area	Words patient would use
Medical History	I've never had anything serious. My last doctor's visit this year was because I had stomachaches, but he never gave me a diagnosis or prescribed anything.
Surgical History	none
Injury History	none
Current Medications, Prescription and OTC:	40 mg of Citalopram. I've been taking it over the past year for anxiety and depression, I got it from my primary care physician.
Family History Parents Siblings Other relevant	Mother and father divorced in 2003. Both live locally and I have a good relationship with them, not so much though with my mother's boyfriend he is annoying. My 27-year-old brother is kind of a jerk to me. All four of my grandparents are alive, and I see them often. I have several aunts and uncles who live out of state.
Occupational History	I've worked in the restaurant business for the past 4

	years. Right now I'm a hostess. I'm also going to dental school; I want to be a dental hygienist.
Marital Status	Nope definitely not married or have any kids
Sexual History	Usually only slept with men I was in a relationship with except for two and that was a mistake…
Psychological or Psychiatric hx.	My parents made me go to counseling when they divorced in 2003. I attended three sessions with my family before ending that. To be honest at the time I didn't feel that I needed therapy and the sessions were not helpful.
Last medical appointment and reason:	Few months ago for stomach problems.
Support systems& Religion:	Family, friends, catholic
Environmental Considerations	none
Diet & Exercise:	I eat ok and exercise sometimes. I often don't have much of an appetite though.
Tobacco:	I tried it a few times but did not like it
Alcohol:	About 4-5 mixed drinks or beers once a month socially
Other Substances:	I used to smoke marijuana about once a week with my friends since I was 15 for 5 years. I quit when my mother's boyfriend found it in my car and I got into a lot of trouble for it.

NSU's Psychology Services Center
Telephone Intake

Name: Tracey Finny
Age: 22
Date of Birth: 3/12/1990

Reason for calling
"I've always worried a lot but lately the stress has just gotten to be too much."

Marketing
How did you hear about us: College counseling center
Ever been to any NSU clinics?: No
Been to following NSU clinic(s): No

Symptoms
Sleep Problems:
Yes.
Comment: "I have trouble falling asleep due to racing thoughts."

Sadness/Depression
"Some."

Anxiety
Yes.
Comment: "It's over anything and everything. I can't control it."

Abuse History:
Current: "My ex-boyfriend's sister has been threatening me."
Past:
Physical? No.
Verbal? No.
Emotional? No.
Comment: "My older brother hit me once."

Issues in the past that are affecting the present?
"My parents divorced in 2003, but I'm doing okay with it. I can't stand my mother's boyfriend."
"I've had some pretty bad breakups lately."

Flashbacks/Nightmares?
No.

Ever been sexually assaulted?
No.

Difficulties in Interpersonal Relationships?
Mother's boyfriend.

Medical/Health
Medical Issues:
"I've had a lot of stomach problems—the pain can get really bad. I saw a doctor for them, but he didn't diagnose me with anything or give me medication."

Medical Hospitalizations
None.

Prior Psychiatric/Psychological
Outpatient therapy
Yes.
Comment: "My parents made me go when they got divorced. It wasn't helpful."

Suicide
Denied.

Homicide
Denied.

Substance Use History
Drug Use
Not current.
Comment: "I used to smoke marijuana once a week. My mom's boyfriend found it in my car last year—it caused such a drama. I haven't used it since."

Alcohol Use
Yes.
Comment: "It used to be really bad-I used to black out. I control it now."

Healthy Lifestyle
Change in Appetite
Yes.
Comment: "My stomach hurts all the time-I don't want to eat."

Remarks
Currently involved in any legal/court issues?
No.

Fee/Waitlist Information
Are you employed? Student/restaurant hostess.
Number in household: 3
Caller was advised of the standard fee.

Appendix K

SP Case: Abuse Assessment

Presenting Problem

XX is a XX, XX female who was referred to the Biofeedback and Health Psychology Center (BHPC) at Nova Southeastern University (NSU) by her cardiologist. The client reported she admitted herself to XX's emergency room after an episode of tachycardia, sharp chest pains, lightheadedness, and shortness of breath. No abnormalities of the heart were found after holter monitor and echocardiogram evaluations. A domestic dispute between her mother and elderly grandmother preempted the client's symptoms. XX states that she, her mother and brother have been the primary caretakers for her two ill, bedridden grandparents for over six years. The entire family reportedly suffers from a great deal of caregiver-related stress. The client reports verbal and physical abuse from her mother and brother, especially when under tension. She details a number of persistent somatic symptoms (frequent heart palpitations, chest pain, muscular tension, and shortness of breath), as well as an "overwhelming" sense of guilt, frequent crying spells, and worry. The client expressed that she will be coming to psychotherapy in secret, as her family does not approve of disclosing familial (or personal) information to others.

History of Current Problem

The client stated that she has always felt a great deal of tension because of the demands placed upon her, but has been able to effectively cope with her stressful home life. However, she expressed that her mother has become increasingly more unpredictable, striking her for small infractions, verbally berating her, restricting her from seeing her friends, and not allowing her to leave the house without permission. Furthermore, the client has recently been forced to sleep in the family's Florida room after coming down with the flu, forbidden to enter the home. XX states that she has had to take showers and to use the restroom in her university's gymnasium during this time. She states that she has been made to feel exceedingly guilty due to her inability to help the family while ill. XX states that she wishes to leave the home to pursue a teaching career, but states she is unable to leave her beloved grandfather, and is bound by duty to assist her family.

Upon further questioning about the domestic dispute that preempted her somatic episode, the client became tearful. She admitted her mother attempted to strike her grandmother. Suffering from dementia and emotionally labile, the grandmother reportedly provoked the client's mother. The client states that she jumped in the middle of the fight, pushing her grandmother to the side, and took her mother's blows to the chin. She expressed her grandmother was unharmed. Angered still, her mother reportedly began to whip the client with a belt. The client revealed a laceration on her right arm. The client stated she has never actually seen her mother physically harm her grandmother, although several bruises have been found on her grandmother's arms. XX stated that she is unsure if this is a result of the several blood thinners her grandmother is prescribed.

Other Relevant History

Family History:

XX was born in XX, and was raised by her mother. The client's mother reportedly works three jobs to support her family and to care for her aged parents. The client reported that her father lives in New York, although her parents are not officially separated. The client's father intermittently sends the family $500 per month. The client admitted that he has broken several promises to assist the family in the care of her grandparents, and when he does travel to XX, does nothing productive. XX describes her father as "immature," detached, and anti-social," and states that she "does not understand him." Furthermore, she admits that she does not understand her parents' relationship. The client's mother is extremely emotionally, verbally, and physically abusive towards her. She stated that expectations for her are quite different than those of her older brother, whom she describes as "able to do anything." The client is reportedly allowed to do little else than care for her grandparents and go to school; if she strays from these expectations, she is beaten. The client indicates an incessant need to please her mother. Her brother, although a source of support at times for the client, is also verbally and physically abusive. The client reports a long history of abuse in her extended family as well.

Educational History:

XX stated she has traditionally performed well in school. However, she expresses her achievement has never reached her brother's, a source of disappointment in her mother's eyes. The client is also preparing for her GREs in anticipation of applying to graduate school, though she states that her mother will not allow her to study in the home. XX states she will often wake up at 3 AM to study while her mother is asleep.

Occupational History:

XX reportedly has held only one job, a paid internship that she had following high school. She stated that she has little time to work between round-the-clock care for her grandparents and schooling. The client expressed that she would like to work to help out the family, but expressed her mother will not allow her to leave the home.

Social History:

XX expressed that she has a supportive circle of friends she met at school, even though she rarely sees them. However, she states that that she distrusts men, and describes herself as quite naïve. The client further states that she is extremely uncomfortable with male attention, and feels quite guilty over males' advances. As a result, she has never had a relationship.

Psychiatric/Medical History:

XX reported that she has never experienced any serious medical problems with the exception of the aforementioned heart palpitations.

The client stated that she has never received psychological treatment prior to evaluation at BHPC.

Substance Use History:

XX denied usage of any substances.

Spirituality:

XX stated that she describes herself as "spiritual."

Mental Status Examination and Client Strengths

XX presented for the evaluation session appropriately dressed and well groomed. XX arrived on time for her appointment. She was alert and oriented to time, place, and person. Her speech was unremarkable, and she was able to clearly communicate the details of her history in a well-thought out, expressive manner. The client was cooperative and attentive, but failed to maintain good eye contact. XX denied any current hallucinations or delusions and her memory appeared to be fully intact, as she provided extensive details regarding the topics discussed. She appeared to be of above average intelligence based on her vocabulary and ability to understand abstraction. XX denied suicidal or homicidal ideation. Her mood and affect appeared to be dysthymic, as she cried throughout much of the evaluation. XX's social judgment was found to be adequate. Her insight into her presenting problems was appropriate. The client's strengths included her desire to make positive changes in her own life, her love for her family members, and her sense of dutifulness to her family.

Standardized Patient Case

Gender: Female

1. Name of Patient: Jamie Crest

2. Patient Presentation:

a. Initial Body Language/ Affect:

You are very tearful, and appear very shy. You seem slightly suspicious of the clinician, and the clinician has to really pull responses out of you.

3. Response by SP to Student's First Query:

a. "How are you feeling", "What brings you in today?" etc.

"I've been having lots of chest pain. My doctor couldn't find anything wrong with me and said I must be stressed out. It's been really tense at home."

b. If the student remains silent, nods as if waiting for more information, or asks an open-ended question like "Tell me more about the…," "Describe the …to me," "Go on," the patient says: *"I was worried I was going to have a heart attack or something."*

Information given with SPECIFIC questioning regarding timeline, frequency, etc:

I admitted myself into Broward General's emergency room when my heart started to race really bad. I felt a really sharp chest pain. I was dizzy and short of breath. My chest has been hurting a lot recently, and it started about a year ago when my grandparents both got really sick.

I have always felt a great deal of tension because of the demands placed upon me-my mom is really tough. However, recently my mother has become increasingly more

unpredictable. She hits me a lot, usually once a day. She hit me with a belt (show slash mark on arm). She makes fun of me for everything, and tells me I'm a bad daughter, that I don't help out around the house enough, even though I spend all of my time taking care of my grandparents and cleaning the house. I'm not allowed to see my friends, even though I'm 25 years old. I feel like such a baby. I really want to please her, but I don't think I'll ever be able to.

Due to a recent flu I have been unable to enter the home. My mother made me sleep in my car and I took showers at the FAU gym. I feel guilty that I cannot help the family while being ill.
My most recent episode occurred because I was protecting my grandmother from my mother. I got struck in the chin instead of my grandmother because I wanted to protect her. After that my mother got angrier and began to whip me with a belt. I have never seen my mother harm my grandmother but I have seen bruises on my grandmother's arms.

Possible Questions about Symptoms:
Do you feel depressed?

- I do feel sad about my situation, and sometimes I cry. It's not a big problem though. I know I have to take care of my family.

Have your eating habits changed?

- No. I've always been a picky eater. I have to cook all the time for my family.

Do you feel more agitated than you used to? Or even more slowed down then you used to be, etc.?

- Sometimes I do get irritated with my mom. I yell back at her, but then she hits me and yells and screams. I haven't noticed any changes in my movements.

Has your concentration changed, etc.?

- Sometimes I'm a little distracted, especially when my grandparents are doing worse or when I remember times where my mom was really mean. But I can concentrate just fine.

What is your energy like?

- It's okay. I'm tired a lot. Sometimes I can't get enough sleep—sometimes my mom will make me stay up late cleaning or taking care of grandma and grandpa when they are sick/make messes.

Do you feel guilty? Do you feel worthless, etc.?

- My mom tells me I'm worthless all the time. Sometimes I believe her, but most of the time it makes me mad. She makes me feel guilty about wanting to study or go out. I feel responsible for my family, but I guess I'm not really guilty. I think she's unfair.

Do you have thoughts of hurting yourself, etc.?

- Once I dug my fingernails into my arm when I was felt really bad about making my mom yell at me in front of my grandparents. That's it though. I would never commit suicide or even think about it.

Would you say you are anxious?

- I worry about my grandparents' health and about my mom really hurting me. That's about it. I guess I'm more stressed out than anxious.

Can you control your worrying?

- Yeah for the most part. When I'm with my mom though and she's yelling, it's hard to control. Otherwise, I'm okay.

What other physical things do you feel when you are stressed?

- My muscles are tense a lot, my back and shoulders hurt. Sometimes it's hard to breathe. That's it though.

Do you have trouble sleeping?

- I don't really have trouble sleeping, but I don't get to sleep very much because my mom will make me stay up late cleaning or taking care of grandma and grandpa when they are sick/make messes.

Do you have nightmares? Especially about certain times your mom has hit you or it's been really bad at home?

- I have had some bad dreams, but they've been about school. My mom isn't ever in my dreams, and I'm really glad about that. Once I dreamt that my grandparents died, and that was really sad.

Do you have flashbacks about any times your mom has come at you?

- I mean, I think about those times, and I get sad and worried it may happen again. But I've never had any flashbacks.

Do you avoid things that remind you of those bad times?

- Well, I really can't since I live with her and can't get out of the house.

Do you talk about this with anyone?

- I can't. It will embarrass the family. I probably shouldn't even be talking to you. I try to talk to my brother, but he just gets mad. He hits me too.

Do you feel your future will be cut short somehow?

- No. I see my future as taking care of my grandparents until they die and then just taking care of my mom until she dies. I don't think I'll ever be able to get a real job or get married or anything. The future is kinda sad, but I see one.

Do you feel really anxious in social situations?

- I don't really get to be social. But my friends are my friends. I don't get nervous in front of them, but I could never tell them what's going on at home.

Communication and Openness of SP:

You will be coming to psychotherapy in secret, as your family does not approve of disclosing personal information to others. You seem guarded.

What the student might say	**What you would say**
Area	Words patient would use
Onset When did the problem start?	About a year ago when my grandparents got really sick. But, violence has always been in my house. We've all lived with a lot of stress.
Duration How long does it last?	When I get the chest pain and stuff, usually about an hour but I feel weird all night.
Progression Is the problem or pain getting worse?	Yes

Frequency How often do your mom's episodes occur?	My mother is extremely emotionally, verbally, and physically abusive toward me every day.
Location Where is the pain or problem?	I get frequent heart palpitations, chest pain, muscular tension, and shortness of breath. It happens about twice a week, maybe.
Intensity On a scale of 1-10 how bad is the pain?	While I feel the pain it's frightening and I would give it about an 8. But on a regular day I would feel about a 1 or a 2.
Quality Can you describe it?	Well most of the time I am able to control the pain. This time was different I had to go to the emergency room I felt like I was having a heart attack.
Alleviating factors What makes the problem pain better?	It just goes away.
Aggravating factors What makes the problem or pain worse?	Verbal and physical abuse from my mother or brother when I am under tension.
Precipitating factors What were you doing just before the pain started?	My mother was fighting with my grandmother and almost hit her but I jumped in the middle of the fight, pushed my grandmother to the side, and got struck in the chin by mother. My mother got angrier and whipped me with a belt afterwards.
Medical History	I have had no serious medical issues besides my recent heart palpitations.
Surgical History	None
Injury History	None
Current Medications: Prescription and OTC:	None
Family History Parents Siblings Other relevant	My parents are still married but my father lives in New York. I do not understand him. My mother is verbally, physically, and emotionally abusive towards me. I am allowed to do little only than to care for my grandparents and go to school. If I do not do this I get beaten. 1 older brother My grandparents are 90 and 91 and live with us. They've been bedridden for six years. My grandpa is blind and can't move around very well. He got pneumonia about a year ago and hasn't been the same since. My grandma I think has dementia. She has

	weird outbursts.
Occupational History	I've only held one job. It was a paid internship following high school. I have little time to work because I care for my grandparents. My mother won't allow me to work and help out the family.
Marital Status Children (childbirth) History	Single No children
Sexual History	I am extremely uncomfortable with male attention and I feel guilty when males make advances at me. I do not trust men and I have never been in a relationship.
Allergies	None
Psychological or Psychiatric History	No psychological treatment prior to evaluation at BHPC
Last medical appointment and reason:	Earlier this week I was having sharp chest pains and admitted myself into emergency room.
Support systems & Religion:	I have a supportive circle of friends. At times I would consider my brother a support system. I would also describe myself as a "spiritual" person.
Environmental Considerations	N/A
Diet & Exercise:	N/A
Tobacco:	None
Alcohol:	None
Other Substances:	None

SP Demographics:

Name: Jamie Crest
Gender: Female
Age range: 20-27
Ethnicity: Any
Setting: Biofeedback and Health Psychology Center (BHPC) at Nova Southeastern University

SP Opening Statement: "My cardiologist sent me here after admitting myself into Broward General's emergency room."

History of present illness:
You are Jamie Crest, a 26 year old female
You admitted yourself into the Broward General's emergency room after experiencing an

episode of tachycardia, sharp chest pains, lightheadedness, and shortness of breath. A domestic dispute between your mother and elderly grandmother caused these symptoms to arise.
You along with your mother and brother have been the primary caretakers for your two ill, bedridden grandparents for the past 6 years. There is caregiver related stress present in your family. Your mother and brother verbally and physically abuse you especially when they are under a great deal of tension.
The domestic dispute that brought on the heart palpitations, shortness of breath, muscular tension, crying spells, and guilt occurred when your mother tried to strike out your grandmother. Your grandmother suffers from dementia and is emotionally labile but according to your mother she provoked the argument. You jumped in the middle of the fight and got a blow to your chin. This made your mother angrier and she began whipping you with a belt.
You have never actually seen your mother hit your grandmother. But you have seen bruises on your grandmother's arms. You attribute these to the blood thinners your grandmother is prescribed.
Recently your situation has gotten worse. Your mother is not allowing you to see your friends, leave the house, is becoming unpredictable, strikes you for small infractions, and verbally berates you. You just got the flu and are forbidden from coming into your home. This takes you further away from helping out the family. This has also caused you to feel guilty because you can't care for your grandfather.

Past medical history:
You have never experienced any serious medical problems besides the recent heart palpitations. You also have never received psychological treatment prior to the evaluation.

Family medical history:
Your parents are both alive. Your parents do not live in the same state. Your father lives in New York and your mother lives with you, your brother, and two ill parents in Florida. Your mother is extremely emotionally, verbally, and physically abusive towards you. You are allowed to do a lot less than your older brother who can do whatever he wants. You are also physically and verbally abused by your bother but at times see him as a supportive system. You have a long history of abuse in your extended family as well.

Background Information:

- You were born and raised in Ft. Lauderdale, Florida by your mother. Your mother works three jobs to support your family and care for her aged parents. Your father lives in New York but your parents are not officially separated. He does not help out your family but does send $500 per month. You do not have a great relationship with him because he has broken many promises to assist the family but does nothing. You believe your father is "immature," detached, and antisocial. You do not really understand him.
- You want to please your mother in all that you do, despite the fact that she is verbally, physically, and emotionally abusive towards you. She seems to control various aspects of your life and if you stray from her demands you will be beaten.

- You were a good student in school but your achievement has never reached that of your brother's, which is a source of disappointment for your mother. You are currently preparing for your GRE in hopes of applying to graduate school to for your Master's degree. Going to graduate school would not make your mother happy and she may not let you study in her home. For example, you used to wake up at 3AM to study while your mother was asleep.
- You held only one job, a paid internship after high school. You have little time to work because you are caring for your grandparents all the time. You would like to work to help out the family but your mother will not allow you to leave the house.
- You have a supportive group of friends. You distrust men and describe yourself as naïve. You are extremely uncomfortable with male attention, and feel guilty over male's advances. You have never had a relationship.
- You denied any use of any substance.
- You describe yourself as "spiritual"

Patient's response to special interviewing techniques: You appear "normal" but deep inside you are worried about something. This is the first time you are telling anyone what is going on in your family. You tell the therapist that you are coming into psychotherapy in secret because your family does not approve of disclosing familial or personal information to others.

Patient presentation: You are well groomed and dressed appropriately to the evaluation. You are on time for your appointment. You are able to clearly communicate the details of your history in a well thought out and expressive manner. You are cooperative and attentive but don't maintain good eye contact. You spend most of the session looking at the floor. You seem very shy, and speak in a quiet tone. You also deny any suicidal or homicidal ideation. You cry throughout the evaluation.

NSU's Psychology Services Center

Telephone Intake

Name: Jamie Crest
Age: 26
Date of Birth: 7/21/1986

Reason for calling
"My cardiologist sent me here after admitting myself into Broward General's emergency room."

Marketing
How did you hear about us: Website
Ever been to any NSU clinics?: No
Been to following NSU clinic(s): No

Symptoms
Sleep Problems:
No.
Comment: "I don't get very much of it. Sometimes my mom won't let me sleep—I have to take care of my grandparents when they are sick or make messes."

Sadness/Depression
Sometimes
Comment: "I get frustrated over being treated like a baby. I feel my mother is unfair. I'm also sad about my grandparents being sick."

Anxiety
"I'm really stressed out. There's just so much to do at home. I'm also scared about my grandparents getting worse. I am also scared my mom may really hurt me someday when she flies off of the handle, or even worse, my grandparents."

Abuse History:
Current: "I don't want to call this abuse. It may be, but I feel guilty saying anything about my family"
Past:
Physical? "My mom has hurt me before. I've also been hurt by my brother."
Verbal? "They can be really, *really* mean."
Emotional? "They really do make me feel bad about myself."

Issues in the past that are affecting the present?
"My father. He's really let us down. He lives in New York and breaks a lot of promises to us"

Flashbacks/Nightmares?
A couple
Comment: "I had a really bad dream my grandparents died. Sometimes I have bad dreams about school."

Ever been sexually assaulted?
No.

Difficulties in Interpersonal Relationships?
"I'm really afraid of men. They've all let me down or hurt me in the past."
"I don't understand my father at all."
"My mother scares me sometimes."

Medical/Health
Medical Issues:
Chest pain, palpitations, shortness of breath, muscle tension
"I recently got over the flu. My mom wouldn't let me inside the house. I slept in my car."

Medical Hospitalizations
Just visit to ER for chest pain

Prior Psychiatric/Psychological
Outpatient therapy
No.
Comment: "No one can know I'm here. It would bring shame on my family."

Suicide
Denied.

Homicide
Denied.

Substance Use History
Drug Use
No.

Alcohol Use
No.

Healthy Lifestyle
Change in Appetite
No.
Comment: "I don't really eat much anyway."

Remarks

Currently involved in any legal/court issues?
No.

Fee/Waitlist Information
Are you employed? Student.
Number in household: 6

Caller was advised of the standard fee.

Additional Information
"Please, please don't let anyone know I'm here."