Teaching Clinical Interviewing Skills Using Role-Playing: Conveying Empathy to Performing a Suicide Assessment

A Primer for Individual Role-Playing and Scripted Group Role-Playing

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KEYWORDS

• Role-playing • Scripted group role-playing • Clinical interviewing
• Suicide assessment • Chronological Assessment of Suicide Events (CASE Approach)

KEY POINTS

- Clinical interviewing skills can be experientially taught and skill retention tested using both traditional individual role-playing and an innovation known as scripted group role-playing (SGRP).
- Recent strategies for enhancing individual role-playing include: improved reverse role-playing; approaches for decreasing trainee anxiety; constructively handling unexpected consequences of role-playing; more realistic patient portrayals.
- SGRP allows supervisors to experientially train up to 28 trainees *simultaneously* in interviewing tasks as complex as sensitively eliciting suicidal ideation and uncovering domestic violence.
- SGRP essentially eliminates "acting" from role-playing resulting in several educational achievements including: striking increase in trainee acceptance and satisfaction with role-playing; markedly more effective use of training time.
- SGRP holds promise for training and nationally certifying psychiatric residents, graduate students, and medical/nursing students in essential interviewing skills such as suicide assessment.

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Time pressure on busy trainees, who work within capped hours of service, and on busy supervisors, who need to maintain clinical hours to generate their salaries, places a premium on efficiency in training students to master clinical skills. Just as surgical trainees sometimes practice surgical skills in laboratory settings to master basic techniques before performing them on patients,[1] graduate students from all disciplines can benefit from less stressful training situations that focus on specific skill sets through the use of individualized role-playing by skilled coaches. In addition, it now is commonplace for clinical institutions such as community mental health centers, inpatient units, and crisis call centers to provide ongoing training for both new and experienced staff using role-playing to ensure quality assurance.

Role-playing has a major advantage over the use of mere didactics, because it requires a level of understanding that must be translated into actual behavioral practice and subsequent demonstration of the interviewing skills. With the advent of sophisticated applications of role-playing (such as microtraining,[2,3] macrotraining,[4] and scripted group role-playing [SGRP] as introduced in this article), core engagement techniques, in addition to complex interviewing tasks such as transforming crises, eliciting symptoms for accurate diagnosis, and uncovering suicidal ideation, can be taught to a level of competence. Such quality assurance of performance standards is outranked only by direct observation of the student with an actual patient. The freedom from actual clinical demand may reduce the stress level in the learning phase, so that mistakes can be corrected without fear of dire consequences.

Through role-playing, a supervisor can create multiple iterations of the desired skill until competence is obtained. The skill training can subsequently advance in intensity and complexity, including chances to practice using the skill with the supervisor playing the role of resistant clients. Practice continues until the trainer and trainee are confident that the skill is understood and is accessible on demand, and that the trainee is beginning to feel comfortable with its use. Arising from the sound foundation created by role-playing, further skill enhancement can occur if the supervisor has the opportunity to observe the trainee using the techniques with an actual patient, ensuring that the acquired skill has been generalized to clinical practice. Once again, this type of rigorous training has similarities to the sophisticated development of surgeons who achieve proficiency through the intense repetition of skills with patients while being monitored by skilled senior staff.

Using role-playing effectively is not an easy task. If not done well, its results can be disappointing. Moreover, using role-playing is not every instructor's cup of tea; for some teachers it is simply not going to be a good fit. Nevertheless, we believe that many supervisors, even some who initially may feel uncomfortable with it, can be taught to use role-playing successfully and with great enjoyment.

Indeed, we have found role-playing to be one of our most enjoyable of teaching formats. As the developer of macrotraining, I (S.C.S.) have been studying role-playing and serial role-playing intensively for almost 30 years. My coauthor (C.B.) has used role-playing for nearly 20 years as part of the Dartmouth Interviewing Mentorship Program. Together we hope to provide a user-friendly primer that introduces a variety of practical considerations for using role-playing fruitfully in both the individual and group format.

This article focuses on 2 distinct aspects of role-playing: the use of role-playing with individuals and its use with groups of trainees. In Part 1 we address how to perform a single generic role-play well, whether it is used in a simple application, such as offering a student a chance to practice interviewing skills, or in more sophisticated applications, such as microtraining and macrotraining, whereby the goal is to teach interviewing techniques and/or complex interviewing strategies to levels of verifiable

competence. Our focus is on practical methods of creating believable role-plays and how to use them to teach specific interviewing skills strategically, while always carefully trying to decrease any anxieties the trainee may have about role-playing itself.

In Part 2, this updated article proffers the opportunity to introduce to the literature an innovative training strategy known as scripted group role-playing (SGRP), a topic not addressed in the original article. SGRP introduces a role-playing format that allows each member of an audience to learn and practice, to an enhanced level of expertise, complex interviewing strategies as might be needed in exploring topics such as suicidal ideation or domestic violence. The second author (C.B.) was not involved in the creation or development of SGRP. Consequently, I (S.C.S.) was the sole author of Part 2, where the benefits, uses, and tips for utilizing SGRP are described in detail.

This informal article is neither a research article nor an academic review: it is a sharing of practical knowledge from teacher to teacher, a hands-on manual of sorts, drawn from our own experience. We do not pretend to have all the answers, and we would love to hear from you of any new ideas you have.

In Part 1, regarding individual role-playing, the approach is 6-fold:

1. To provide a brief history of the varied uses of role-playing
2. To describe the unique training advantages that role-playing offers
3. To delineate some specific tips for role-playing more effectively and for transforming potential problems
4. To address some unexpected consequences of role-playing
5. To provide tips for creating realistic role-playing characters
6. To suggest a list of specific interviewing skills that can be particularly well addressed by role-playing

In Part 2, regarding role-playing used in groups, the approach is 5-fold:

1. To address the significant and complex problems that arise when role-playing is utilized within a group format as opposed to its use with a single trainee
2. To introduce SGRP, which addresses these problems by proffering a style of role-playing that has been well received by trainees for teaching complex interviewing tasks (such as eliciting suicidal ideation) in an effective fashion in a psychologically safe environment
3. To provide a model of how trainers can utilize SGRP to train clinicians to use the Chronological Assessment of Suicide Events (CASE Approach), an innovative interviewing strategy for eliciting suicidal ideation and intent
4. To provide initial empirical data on trainee satisfaction with SGRP
5. To provide practical tips in utilizing SGRP and designing scripted group role plays

PART 1. EFFECTIVE USE OF ROLE-PLAYING WITH A SINGLE TRAINEE

A Brief History of Role-Playing

Role-playing has become a popular and ubiquitous method of training interviewing skills. It is used for training clinicians in numerous disciplines, including medical students, nursing students, psychiatric residents, and residents from other specialties such as primary care and internal medicine, and for training graduate students in techniques of counseling, clinical psychology, social work, and substance abuse counseling. Role-playing also is used as a method of ongoing quality assurance for staff at hospitals, mental health centers, and crisis call centers. Its use can be broken into 3 broad categories.

In its simplest form, clinical instructors use role-playing to provide opportunities for students to practice interviewing skills in an experiential fashion (and in a safe

environment where there are no clinical ramifications). In this setting, creative instructors also can use role-playing to present a variety of clients (eg, from diverse socioeconomic and cultural backgrounds and with specific types of psychopathologies or stressors) and differing clinical situations (eg, crisis intervention, ongoing therapy, and inpatient care).

In its more sophisticated and rigorous applications, role-playing can be used to train a single specific interviewing technique, such as using an open-ended question, to a point of behavioral competence (microtraining) or to train complex interviewing strategies, such as eliciting suicidal ideation or uncovering a history of domestic violence, also to a level of behavioral competence (macrotraining).

Another sophisticated use of role-playing is the use of standardized patients (role-played by actors, patients, or instructors) to measure behavioral skills and/or provide feedback about the impact of the student's interviewing style.

The broad utility of role-playing is reflected in the wide range and great number of articles studying or reviewing its use in all three of the categories described, including such remarkably diverse settings as nonmedical classrooms for distance learning in Germany,[5] improving the interest and retention of students exploring careers in mental health research,[6] training primary care residents in interviewing,[7] trouble-shooting the cooperative function of medical teams,[8] addressing patient safety issues and preventive steps by simulating situations that have gone awry,[9] and evaluating sophisticated urologic procedures.[10] A nursing review offers concise cautionary notes regarding the challenges of designing effective simulations,[11] and a Belgian study on teaching communication to medical students provides a candid summary after 6 years of training with a small-group format.[12]

Two advances in role-playing, microtraining and macrotraining, warrant more detailed attention. In the 1960s Ivey[2] developed a sophisticated form of role-playing termed microtraining (also called "microcounseling"), which revolutionized role-playing as an educational tool. Ivey focused on faithfully transmitting one interviewing technique at a time to a student. He realized that providing didactic teaching would not be sufficient to pass on such a behavioral skill, nor would the "loose" practicing of the skill using role-playing. Ivey believed that the trainer must address the skill through the use of modeling and serial role-playing to ensure accurate learning, consolidation of the skill, and generalization of the skill to actual clients, and to enhance the likelihood of long-term retention of the skill at a level of mastery. Ivey's focus was not just on "practice"; it was on practicing until true competence had been shown. His paradigm of microtraining achieved this goal through serial role-playings of a single interviewing technique until it had been consolidated and generalized by the student.

In classic microtraining, the interview question or behavior to be trained must be well defined behaviorally, and usually is described in a manual and modeled on videotape. Some students may be able to "test-out" of the session if they can demonstrate the skill in question. For those who do not know or have not mastered the skill, a microtraining session is used. The trainer focuses on one skill at a time (eg, the use of open-ended questions, empathic statements, or reflecting statements).

After brief reading and a few minutes of didactics enhanced by modeling (often by watching a video), the trainee learns the specific skill through role-playing until the trainer is comfortable that the trainee can demonstrate the skill to a level of competence. In a brief period of time, often 6 to 7 minutes, the trainee practices and consolidates the newly acquired skill using serial role-playing as many times as possible. If time allows, new role-playing incidents with different types of clients are introduced to determine whether the trainee can generalize the newly acquired interviewing skill.

Ivey transformed role-playing from an educational tool that was loosely applied by trainers into an educational technology whereby he delineated specific behaviors by instructors who used role-playing to enhance and consolidate the learning to the point that the trainee could demonstrate actual clinical competence in the pertinent interviewing technique. Ivey did more than speculate: he went in search of empirical data that his training ideas withstood scrutiny. As a result, microcounseling has a large evidence base and may well represent the best-documented interviewing training technique at mentors' disposal. Its evidence base has been accumulating for decades.[13] A review by Daniels[14] found more than 450 studies documenting its efficacy.

My colleagues and I developed the next evolution in role-playing, macrotraining, in the mid-1980s. A practical monograph that describes effective methods for using macrotraining was published in a previous issue of the *Psychiatric Clinics of North America*.[4] Although an interview is composed of individual techniques amenable to microtraining, in the real world of clinical interviewing these techniques do not exist in isolation but always are integrated into specific interviewing tasks. Such tasks often revolve around the gathering of a specific database while maintaining engagement with the client. Typical interviewing tasks (all of which can be taught via macrotraining) might include gathering a picture of symptoms to make a differential diagnosis, eliciting information related to a drug and alcohol history, uncovering information related to interpersonal functioning and social history, and eliciting suicidal ideation. Especially with sensitive topics such as domestic violence, incest, and suicidal ideation, it becomes critical for clinicians to be able to ask questions about difficult-to-share material while simultaneously attending to and nurturing the therapeutic alliance.

Microtraining is effective for teaching individual interviewing techniques, especially those techniques vital to engagement, such as attending behavior and communicating empathy, and using open-ended questions, reflecting statements, and summarizing statements. The next question was whether one could delineate a complex interviewing task such as eliciting suicidal ideation into single small steps that eventually flowed into a larger sequence of effective questioning. If so, could this simplification of the complexities of a real-life interviewing task, such as uncovering incest, be amenable to the serial use of microtraining in each of the steps of the process until the trainee could perform the entire interview flexibly and accurately?

The goal of macrotraining is to teach such complex interviewing strategies to a level of competence in a single session, using serial role-playing of sequences of questions. Complicated interviewing tasks such as eliciting suicidal ideation, planning, and intent often are composed of numerous questions and strategies rather than a single technique as taught in microtraining. Consequently, macrotraining sessions typically last 30 minutes to 4 hours.

Macrotraining was designed both to teach the wording and sequencing of specific types of questions and to allow the trainer, by directly observing the interviewer's tone of voice and use of other nonverbal communications, to ensure that the questions are asked in an engaging fashion.

Thus, while teaching the sequential questioning involved in a complex interviewing strategy, the macrotrainer can ensure that all of the critical basic engagement skills classically taught in microtraining are being used effectively. To date, the most striking use of macrotraining is the teaching of the widely used interviewing strategy for eliciting suicidal ideation, intent, and behaviors known as the **C**hronological **A**ssessment of **S**uicide **E**vents (the CASE Approach).[15] The goal is to make sure that all trainees can demonstrate proficiency in this key clinical task before graduation. Macrotraining has

been successfully utilized to certify clinicians in the use of the CASE Approach since the late 1990s.[16]

Before closing our brief history of role-playing, we refer the reader to the third sophisticated use of role-playing: the use of standardized patients for the testing of behavioral skills. Perhaps the best example of this use has been the development of the Objective Structured Clinical Examination, a tool frequently used in medical student and allied health education.[17]

The Benefits of Role-Playing as an Educational Tool

To use role-playing effectively, the first thing a trainer needs is belief—belief that role-playing works and that role-playing provides some specific and unique educational opportunities not available with more traditional methods of teaching. In this section we share a series of benefits to the use of role-playing. Let us begin by sharing one of our favorite techniques, "reverse role-playing," because it nicely illustrates the unique educational power of role-playing. Two definitions are helpful. "Standard role-playing" occurs when the trainer portrays a patient and the student is asked to be the interviewer (practicing the skill in question). "Reverse role-playing" occurs when the trainer and the student reverse roles. In reverse role-playing, the trainer interviews and the student portrays the client. Reverse role-playing is described here in some detail, because it demonstrates what role-playing can accomplish that simply is not possible through didactics, reading material, or even video supervision.

We think you will find that the rotation of roles between the trainer and the student can be beneficial in a variety of situations. In its simplest application, it is used when a trainee is unfamiliar with the relevant skill. Reverse role-playing allows the trainer to model the skill for the trainee at the outset, so the expected target behavior is clear.

Another advantage of reverse role-playing, especially when used early in a session, is that it demonstrates that the trainer is willing "to be put on the spot". In fact, if you do not perform the interviewing technique as well as you wanted, a comment such as, "Boy, I wish I had done that a little differently. Maybe this would have been better. What do you think?" can go a long way toward establishing rapport with the trainee.

We often encourage students to critique our techniques. This openness to feedback conveys a genuine desire for ongoing learning and also models for trainees the importance of asking for feedback when teaching or when conducting therapy itself. In essence, reverse role-playing provides a potent metacommunication of nonhierarchical learning that we believe is communicated most convincingly through reverse role-playing.

There is an even more powerful use of reverse role-playing. Sometimes a trainer encounters a student who does not really believe in the efficacy of an interviewing technique that is being taught. Ultimately, perhaps, the trainer and the student will have to agree to disagree. There is no cookbook way to interview, and we all select interview techniques we enjoy using. On the other hand, the student's hesitancy sometimes is based on inaccurate information or on an erroneous assumption. In such instances, reverse role-playing may provide a valuable tool for transforming the resistance.

Supervisees often are more willing to use new skills once they have felt their impact by playing the patient's role. By being on the receiving end of the technique, they have direct experience with which to reassess their projected fears or misgivings. For example, they might be afraid that the interviewing technique will not work or will be

disengaging. If their personal experience in the reverse role-playing is to the contrary, the misgivings dissolve. The following is a more specific example.

As experienced clinicians, we all know that sometimes overly loquacious clients or markedly tangential clients must be redirected and that doing so sometimes requires interrupting the client. Some students are reluctant to use such appropriate interruptions, because they fear that such an intervention is rude and risks disengagement.

This situation is ideal for the use of reverse role-playing whereby the student is asked to portray a wandering client while the trainer uses skilled interruptions effectively to structure the trainee's "client" without causing disengagement. At the end of the reverse role-playing, the student will have learned from direct experience that the structuring by the interviewer felt fine. There can be no more convincing argument than uncovering the truth for oneself.

We often introduce this exercise by saying, "Let's do a role-play in which you play the wandering patient, and I use the structuring techniques; you can see how it actually feels." We also point out to the resident that patients generally want to provide the information that the clinician needs to help them, but patients do not necessarily know what that information is. The structuring helps, and many patients feel more comfortable if the clinician deftly provides cues for when to move to different aspects of a particular topic or even to a brand new topic. The patient actually might feel at sea if the interviewer simply remains nondirective during the main body of the interview.

The following example from the second author's (C.B.) experience shows the striking power of reverse role-playing to transform a learning disagreement by allowing the trainee to experience the interview strategy from the receiving end. One of her psychiatric residents imagined that a victim of domestic violence would find an exploration of some of the details of the violent incident intrusive in an initial interview, especially if there was an effort to delineate the details of the extent of the partner's violence to date. After she used reverse role-playing (during which the trainee assumed the role of the victim) to demonstrate how to uncover such information sensitively, the trainee found it more credible that a person could reasonably tolerate such questioning. The resident even understood, from her own personal feelings during the reverse role-playing, that a patient actually might feel relief that someone finally understood enough to realize how bad things had become. C.B. tacitly demonstrated this knowledge by asking questions that could come only from knowledge of how abuse progresses.

At this point, some fine-tuning information was given to the resident on what type of information needed to be uncovered in such situations and how to do so in a sensitive fashion. Then standard role-playing was used whereby the resident could practice the techniques. Fortuitously, in a follow-up session of supervision in which Barney observed the resident doing a scheduled intake interview, the patient had a significant history of domestic violence. To her credit, the resident managed to sculpt the region well, uncovering pertinent bits of information and doing so in a competent and engaging fashion. After the patient left the interview room she commented on the resident's success, hoping to reinforce it so that it might become part of the resident's ongoing repertoire of skills.

The benefits of role-playing are extensive and fall into the following categories:

1. Assessing the student's skills accurately
2. Building confidence and consolidating skills
3. Broadening case material
4. Learning to transform angry and awkward moments
5. Strengthening clinical reasoning
6. Modeling new interviewing techniques

7. Gaining comfort with new interviewing skills
8. Enhancing videotape supervision

Assessing skills accurately

One of the most important advantages of role-playing is the direct observation of a student's skills to assure that competence is present. No student can be fully aware of what he or she is doing while doing it; therefore, a student's report that a technique is being done well may or may not be accurate. Indeed, a student may be saying the correct words but may accompany the technique with nonverbal behaviors that are disengaging or have a poor sense of timing. In another spectrum, cognitive knowledge base, role-playing can help establish the limits of the supervisee's knowledge and experience. To explore a given region of data, such as the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (DSM-5) criteria of a specific diagnosis or the information required in a sound social history, the trainee must be familiar with the body of information to be elicited and must be able to consider which questions to ask to gather that data most efficiently. Role-playing uncovers any weaknesses in this knowledge base quickly and clearly.

Paradoxically, in a few instances role-playing can give a more accurate representation of skill competency than a video of a student's interview with an actual patient, a point seldom addressed in the literature. Videos can create artifacts that may result from the trainee's anxiety about being filmed, with a resulting loss of spontaneity or natural employment of interpersonal skills, a problem we refer to as "video freeze." In other instances, specific singular issues that may have been prompted by the particular patient in the video may detract from the student's overall display of skill. For instance, a clinician who normally is adept at gathering information regarding diagnosis in a sensitive fashion may appear stilted if this particular patient was hostile early in the interview, during the filming, and had thrown the student off balance. This situation on the video will of course focus the trainer's attention immediately on helping the student deal with hostility, but it also may give an inaccurate portrayal of the student's typical diagnostic skills. It may help to role-play the part of a nonhostile interview in which the student's diagnostic skills would be needed, to determine whether the skill is truly lacking or was merely compromised by the presence of the camera.

Videos also may lead to inaccurate overestimation of a trainee's knowledge base; for example, if a frequently hospitalized patient was taped and spontaneously gave information so readily that little skill was required by the interviewer, the interviewer might appear artificially talented at obtaining a robust database.

Building confidence and consolidating skills

One of the most powerful advantages of role-playing is the consolidation of skill through repetition. Repetition (with slight variation to avoid boredom) is the cornerstone of both the microtraining of single skills and the macrotraining of complex interviewing sequences. Such consolidation can play a pivotal role in enhancing the likelihood that the student will generalize the interviewing skill and maintain it over time.

Similarly, it may be worthwhile to role-play some of the trainee's strengths and reinforce them. Such role-playing of "safe skills" may convince a student who is wary of role-playing that it is a reasonably comfortable experience with minimal attached stress. Practicing strengths also can protect against the specific supervisory misstep of focusing too much on the acquisition of new skills while a recently acquired skill fades through lack of positive reenforcement from the trainer.

Broadening case material

No matter what the inherent quality of the program in which a student is trained, there will be some sampling bias among the patient types the student encounters. For instance, programs may vary in how often the student works with people suffering from acute psychotic episodes, war-related posttraumatic stress disorder, or eating disorders or encounters with clients from minority cultures. Role-playing of different situations with which students are less familiar or unacquainted will help them feel more prepared when they encounter a novel patient complaint or type of presentation. Although attempting to prepare a student for all rarely encountered situations is impractical, there is utility in screening the trainee's experience to find out if there are common clinical problems that the trainee is underprepared to handle effectively.

Learning to transform angry and awkward moments

Even a supervisor who is sitting in on interviews, watching through a one-way mirror, or routinely reviewing video sessions may never see the student handling certain difficult situations. Two key difficult situations are angry exchanges and awkward questions from clients directed to the interviewer, such as, "Do you believe it is ever okay to kill yourself?" or "Do you believe in God?" or "What is your sexual orientation?" or "Do you believe me?" (asked by a patient regarding his or her own delusional belief).

Learning to handle anger gracefully and nondefensively or to respond appropriately to awkward questions highlights two other uses of role-playing. Role-playing may well be the most effective method for training the student in this particular set of clinical skills. Role-playing allows the student to address a specific awkward moment repeatedly while experimenting with different types of responses in a totally safe environment. It gives ample time for the student to share personal feelings generated by the awkward moment that may need to be discussed before effective training can continue. Once the student becomes comfortable with various ways of handling the awkward moment, the skill can be consolidated through an iteration of targeted role-plays.

Strengthening clinical reasoning

As the alliance of the supervisor/supervisee pair develops over time, the trainer can present the trainee with increasing levels of challenge in their role-playing. This graduated challenge offers the trainer a better chance to assess and improve the student's ability to evaluate clinical situations more astutely, and to solve problems more effectively in various hypothetical situations.

Role-plays can provide a forum for inquiry and gaining mastery, and motivated trainees often bring clinical material from their on-call or clinic experiences to interviewing supervision. In such instances, the trainer can discuss the trainee's concerns and then collaborate to develop strategies for the trainee to try out, subsequently using role-playing created on the spot to match the trainee's concerns. Reverse role-playing can offer the trainee a chance to see exactly what the proposed interviewing technique feels like.

Supervisors can draw from their own experience to provide training in related but less commonly encountered issues, so that trainees can be better prepared to handle the unexpected. With increasing comfort in the technique, trainees can minimize the time spent discussing, "What should I do if…?" Instead, they are more eager to jump into role-playing to see what the suggested intervention might offer.

Modeling new interviewing techniques

"A picture is worth a thousand words" is eminently applicable to learning interviewing and psychotherapy skills. As mentioned earlier, reverse role-playing is invaluable in

this regard when videotaped illustrations of technique are not available. Reverse role-playing also has the advantage of immediately modeling a technique with the exact type of client with whom the trainee encountered difficulties, a technique not available from a premade video.

Gaining comfort with new interviewing skills

Many of the factors that make role-playing ideal for teaching new interviewing skills have been touched on in the discussion of the uses of role-playing. An advantage that has not yet been noted is that the ability to practice a focused technique in multiple iterations can reduce the trainee's experience of "stage fright" or "the mind going blank" when trying something new, and can push the trainee to address specific fears or weaknesses. Role-playing provides a safe arena in which the student realizes that techniques are being practiced and that errors are expected and acceptable, and in which the training dyad can address issues requested by the student and at the student's own pace. To use role-playing to teach complex new interviewing skills and strategies to a level of competence, we once again direct you to the educational technologies of microtraining[2] and macrotraining.[4]

Enhancing video supervision

Video supervision can be enhanced if supervisor is skilled in the use of role-playing, microtraining, and macrotraining. We call such supervision "role-play–enhanced video supervision." If a particular problem for which a specific interviewing technique could be useful is spotted during video supervision, it can be highly effective to replay the relevant segment, describe the skill, and immediately follow the demonstration with role-playing to try out the new technique. Subsequent role-playing can be used to consolidate the learning.

When facilic supervision (a supervision language and schematic shorthand for spotting problems with how residents structure interviews and helping them to create conversationally graceful transitions between topics)[18,19] is used in conjunction with filming video, new avenues for the productive use of role-playing arise. If the trainer sees on the video that the resident has problems gracefully exploring a specific diagnostic region, this problem can be highlighted, and the trainer, using reverse role-playing, can immediately model more effective ways for naturalistically exploring the desired symptoms. The trainee then can try out the new techniques in standard role-playing.

At times, a student's skill deficit may be related to emotionally charged material or countertransferential feelings (eg, a student routinely does a poor exploration of the region of substance abuse related to the student's father suffering from alcoholism). In such cases, the use of interpersonal process recall[20] can help the trainee better address the indicated clinical skills. This triadic combination of video, interpersonal process recall, and role-playing can be powerful.

Some Tips for More Effective Role-Playing

Minimizing anxiety related to role-playing

Students vary significantly in their attitudes toward role-playing, ranging from obvious enthusiasm to intense dislike. The direct observation of one's skills can generate an intense awareness of scrutiny, with a heightened sense of a trainee's vulnerability. We have found a variety of attitudes and methods that can significantly enhance a trainee's sense of appreciation for, and comfort with, role-playing.

With regard to the trainer's attitude, two key attributes have helped guide our actions over the years: humility and fallibility. We manifest these attributes by

emphasizing that we are teaching a wide variety of tools to broaden a clinician's options, rather than teaching "the right way" to conduct interviews. We emphasize that we are trying to generate enthusiasm about the power and nuances of clinical interviewing whereby we eagerly invite discussion, differences of opinion, and creative approaches to strategizing. We hope that we are providing the trainee with the tools to engage in a lifelong study and refinement of interviewing process. To re-enforce further that we, too, are learning, and that we, too, make mistakes, we occasionally find it useful to recount our own errors or misfires when a technique that seemed to be indicated did not work well with an individual patient.

Flexibility—knowing what else to try when a given approach is unsuccessful—is a much more useful goal than a robotic repetition of technique. Helping interviewers allow for blunders or gaffes, and even modeling how to apologize to a patient who finds a particular phrase or intervention offensive or disquieting, can help trainees abandon constricting ideas that reduce their humanity, and can allow the appropriate use of their personalities in interviews.

If a student believes that patients are fragile and apt to fall apart unless the interviewer displays perfect empathy, he or she may be reluctant to offer any empathic statements for fear of being out of synch with the patient. Casting off the myths that the trainer is a perfect interviewer, or that perfection is even an achievable goal in the real world of clinical interviewing, can reduce the burdens under which particularly anxious or high-achieving trainees may labor.

Before beginning role-playing, we recommend asking, "Have you ever done role-playing, and what was it like for you?" Many students have had good experiences, but a sizable number have not, especially if they have experienced poorly executed role-playing. Typical biases include the idea that role-playing is silly, unrealistic, artificial, useless, or makes one feel uncomfortable[4]. That is quite a list! It is better to have these concerns on the table than constantly undermining the role-playing experience as one proceeds. Once doubts are out on the table, the supervisor has the opportunity to transform such biases or to reduce them. When an occasional trainee expresses strong misgivings about role-playing, we recommend beginning by acknowledging and accepting his or her concerns with a comment such as:

> *You know, you are absolutely right. Role-playing can really be pretty much a waste of time. I personally had some bad experiences with it in my training, where it just didn't do anything for me. What I've learned over the years is that there are good ways to do it and not so good ways, and I think I've learned a lot of ways to make it work well. Part of the trick is making the patients seem real, and I've gotten pretty good at that. You'll have to let me know if I'm not believable in a given role, but I've got some pretty interesting patients to show you that are based directly on my own clinical practice.*

We also find it useful to describe gently (using soft sell, not hard sell) some of the unique advantages to role-playing to the trainee:

1. Role-playing allows the role-players to study a specific type of clinical situation that may occur only sporadically with actual patients (eg, a patient describing delusions), whenever they wish, and as often as they wish.
2. Role-players can go at their own pace, and the trainee will determine what pace is best.
3. Role-players can practice whatever they want.
4. Role-players have the luxury of focusing on only one clinical interviewing technique at a time.

5. There are absolutely no clinical pressures on role-players because they are merely practicing. There is no real patient in the room, and any mistakes either role-player makes have no ramifications.

After the very first role-play during a training session, we also recommend asking, "How did that go for you?" Depending on the student's answer, we might ask, "Is there anything we might do to make this even more comfortable or useful for you?"

In the experience of the second author's (C.B.) work with trainees and with clients, she feels indebted to the work of the behavioral psychologist Pryor.[20] Pryor's work in positive reinforcement training across multiple species is instructive in basic principles for creating a safe, effective, and enjoyable environment for behavioral change. She has convincing experience that establishes the need for:

1. Having clear expectations
2. Marking the desired behavior precisely as it emerges
3. Recognizing initial steps that are approximations toward the desired goal
4. Gradually raising the bar on the skill level of the performance that is needed to get recognition
5. Eliminating expression of the trainer's frustration to the subject
6. Rewarding correct behavior
7. Attending to the subject's fatigue or frustration, and ending the training session on a positive note with a skill that is under mastery

Pryor also offers an intriguing approach toward reducing performance anxiety. She notes that training the last step in a behavioral sequence first can be a key to successful completion of a behavioral chain, especially when learning this last skill set to competence assures recognition and reward.

The principle in such training "backward from the end" is that the most rehearsed skill set (because the trainee has role-played it to competence) and, therefore, the area of greatest confidence becomes something that the trainee is moving toward during the remainder of the role-playing sessions. Rather than experiencing anticipatory anxiety, the trainee anticipates the relief of approaching a comfort zone.

(Clinicians who use positive imagery and hypnosis may see a parallel to the technique for decreasing anticipatory anxiety or phobic avoidance whereby clients imagine safety from a feared task by rehearsing a successful conclusion and then develop the sequence in reverse. For example, a patient who has airplane phobia could begin by picturing a successful landing and getting off the plane and then work backward in small steps, eventually picturing the sequence from the beginning, at the stage of preparing to leave for the airport.)

Back to interview training, suppose you were training a resident to do an entire initial interview, and he or she has a history of trouble helping patients to close down at the end of an interview. You might start by role-playing the closing of the interview first, with the trainee practicing the closing until competence is achieved while you provide positive feedback with each element of improvement to instill more confidence. From this point onward, as you begin training the resident, in steps, for the rest of the interview, the trainee always will know that he or she is moving toward a task (the closing of the interview) with which the student now feels comfortable and competent. This technique might be helpful for students with performance anxiety about finishing on time, gathering enough data, or being able to bring the interview to an acceptable close.

Another aspect of decreasing anxiety deals with addressing the emotional impact of the role-playing as the session goes on. For instance, it is sometimes best to end role-playing early if the trainee seems to be exhausted or disheartened by not

"getting it right." Ideally the trainer can go back to an earlier role-playing scenario that the trainee fulfilled well, ensuring that the supervision session ends on a note of success. At other times, one may shift completely away from role-playing and use didactics, in addition to a sense of humor, to bring the session to a nonthreatening and comfortable end.

Another aspect of reducing anxiety relates not to the session at hand but to the use of ongoing role-playing with a student whom one may be supervising over a longer period, as when a trainer/trainee pair is sustained over the course of a year. Here a new principle enters the picture. Within the safety of a well-developed longitudinal relationship with the supervisor, a trainee may be able to tolerate and derive benefit from deeper scrutiny.

In short-term role-playing training, one usually focuses on the exact wording and sequencing of behaviorally specific interview techniques and strategies. Attitudes conveyed by the interviewer, however, can have a great impact on how well that interviewer is received by a given patient. These attitudes are transmitted through qualities such as tone of voice, timing of intervention, other nonverbal mannerisms, and the basic attributes of the resident's personality. (Some residents can come across as self-important "big shots" or as poor listeners who seem as though they do not "really care"; others may be prone to making narcissistic insults or have a paternalistic demeanor.) Clearly it is important to address these problems. We have found that the tone of the delivery of our feedback and our ability to maintain a respectful attitude are important in helping residents with such delicate matters that reflect back on their personality structures.

Equally important, during longitudinal supervision, we purposefully avoid focusing on many such nonverbal communication problems until much later in the year, to allow more time for rapport to be established before trying to alter behaviors that the trainee might view as too personal or potentially invasive. Once a safe supervisory relationship has become well established over months, it sometimes is surprising how many of these more delicate matters can be addressed successfully through direct discussion and also through role-playing.

You may encounter a few trainees who have remarkably elevated anxiety related to role-playing. In a rare instance, a trainee may have a true social phobia with an intense fear of "performing" any task whereby he or she will be observed directly. If you encounter such a situation, role-playing may be counterproductive, and the teaching of the interview strategy that was the subject of the role-playing session may be approached better in less directly observed ways while helping the trainee seek professional help for the ongoing social phobia.

Effectively interrupting the role-playing to make a teaching point

In theory, one can wait to provide feedback to the trainee until the role-playing is completed, and there are good reasons for doing so in specific settings. On the other hand, it is much more common to want to provide immediate feedback, especially if the trainee is doing a technique poorly. One reason for such prompt interruption is that one does not want the trainee to consolidate the error by repetition. Also, from a behavioral learning perspective, it can be more advantageous to provide corrective feedback as soon as possible after the problematic behavior and to reward good behavior promptly. We refer to this interruption of role-playing as "marking" the role-play.

In behavior modification with nonhuman animals, a clicker device often is used to mark a behavior as soon as it happens.[21] Although such a device could be used as a marker in role-playing, we have found it much easier to agree on a specific hand

signal, which either the trainer or the trainee can use at any time, to stop the role-playing. Such a hand signal functions like a time-out signal used to call for a break in the action of a football game.

Unless a time-out has been called, the dyad remains in role at all times. Students who are hesitant to do role-playing are notorious for breaking out of role often, greatly diminishing the likelihood that a realistic feeling will begin to unfold. This problem can be addressed easily by enforcing the norm that, unless a time-out is called, both parties will remain in role. It cannot be overemphasized that, for role-playing to become "real" to the participants, it is critical that they stay in role unless the role-playing has been marked by one of the participants. Trainees benefit greatly when the simulation achieves the emotional intensity that would be generated in an actual clinical interview (eg, the fear of someone with paranoia, the despair of a depressed patient, or the hostile irritability of someone who is manic). If trainees have encountered and mastered such emotionally charged situations during role-playing practice, they are less apt to be disconcerted by them when subsequently encountered in clinical practice.

Even if the student has done a good job, you should try not to smile or nod encouragement, because this action breaks the role-playing: the patient you are portraying would not make such a gesture. You can give simple, on-the-spot positive feedback effectively by marking the session, breaking out of role briefly, and saying something like, "That was a great use of open-ended questions; keep going, and let's see what else you uncover," then returning immediately into role. Such a consistent adherence to the rules of role-playing keeps the sessions on track and realistic, much as sticking to group norms in group therapy is vital to the functioning of the group.

Handling Unexpected Consequences of Role-Playing

Role-playing, by its very nature, is ad lib. A trainer never knows exactly which direction a specific role-play may take, because this direction depends on the student's responses. Spontaneity is the name of the game, sometimes for the good and sometimes for the bad.

On the bad side, the focus of the learning may move unexpectedly to a new topic. Thinking on the fly, with one's plan being to focus on a single teaching point, we as trainers may believe we are training only the topic of focus; however, the trainee is responding to our dialogue and nonverbal behaviors and to the trainee's own internal associations. Although we believe we are training one specific point or technique, and even if we clearly state that intention to the trainee, the student may be detecting something else in the role-playing that is notable for the trainee but may have been unintentional or incidental in the mind of the supervisor. I sometimes ask for questions or comments at the end of a role-playing to see if unintended points were made or if some ambiguity arose.

Unscheduled shifts into new teaching areas are not always problematic. Indeed, as the level of comfort and familiarity between trainee and trainer increases over multiple meetings in a longitudinal supervision, it may become both easy and advantageous to flow with the new direction the trainee takes, addressing serendipitous teaching points that may be very useful to the trainee. One always can return subsequently to the intended teaching point.

Another unintended consequence of role-playing is related to the emotional intensity generated by the role-playing itself. Although many students begin by saying that role-playing does not feel real to them, the situation can become all too real in the hands of a gifted role-player. The evolution of a role suddenly can become

compellingly intense, and trainees may use it to put forth some profound or distressing interaction they have had with patients in the past. At other times, the trainer's portrayal of a patient may elicit a reaction in the student that seems excessive, and even a brief inquiry from the trainer may result in the student's revealing an important incident such as incest in the trainee's own life.

Supervisors vary in how they attend to such revelations, by briefly exploring the incident as it relates to its immediate impact on the trainee as a clinician or by referring the trainee to a psychotherapy supervisor whose role more frequently includes dealing with countertransference. Of course, in conjunction with the residency director, a decision sometimes is made to suggest individual therapy if there clearly is a significant area of concern for the trainee's mental health or if the trainee's emotional distress hinders his or her clinical work.

On a much lighter note, however, the most common serendipitous consequence of role-playing is laughter and the use of humor by both the trainer and the trainee. When a role-played patient with manic disinhibition is baiting a young trainee by picking on his or her lack of training or flies into a hysterically funny set of loose associations, sometimes you just have to laugh. If one is at a critical point in teaching a technique, and there is just a bit of a chuckle from the trainee, it often is best simply to stay in character, and the trainee will follow suit. If both parties are struck by a particular spontaneously funny circumstance, it usually is best to mark the session, pull out of role, and laugh with abandon. Such moments can be valuable in creating a comfortable and enjoyable alliance with the student. The humanness of both parties is reassuring and delightfully refreshing.

Tips for Creating Realistic Characters in Role-Playing

The following tips are adapted from the *Training Manual for Macrotrainers*.[22] In role-playing, it often is useful to picture a specific client you have encountered in your practice and to borrow heavily from that client's presentation in your role-playing. In visualizing the client, you should pay particular attention to your memories of the client's hand gestures, tone of voice, rate of speech, and posture. These details often give a stamp of reality to role-playing, because they may be quite different from your own nonverbal mannerisms.

For instance, a patient who has a severe depression generally speaks at a much slower rate than the typical trainer, and this difference should be apparent to the trainee (but will undoubtedly require your conscious effort while in the role).

As you begin to use role-playing regularly, it is useful to prepare a stock set of role-plays from which you can borrow freely. For instance, you may develop readily reproducible characters that portray excessively wandering clients, shut-down clients, the classic client who responds with "I don't know" to every question, a suicidal client with minimal intent and actions, a suicidal client with intense intent and actions taken on his or her suicidal plan, a delusional client, or a client with marked loosening of associations. As you use these personalities over the years, your portrayals can become more vivid and more realistic.

As stated earlier, to help enhance the realism of the role-playing, both parties should stay strictly in role. Always make it plain whether you are in role or out of role, using a hand signal for time-outs as markers. Before you start role-playing, you should take a moment to visualize the role and get into character, then picture what you are going to do, recalling the character or patient who embodies the target quality or history. Proceed with, "Okay let's go," and begin the role-playing. Be sure to think about making your attire congruent with that of the patient being portrayed: you may want to remove items such as ties, scarves, or suit coats.

Usually a couple of minutes are needed for the realism of the role-playing to take hold. Consequently, you should not enter the skill you wish to teach until the role-playing has continued long enough to give the student a feel for the patient you are portraying. Likewise, when first learning how to use role-playing to enhance interviewing skills (and students' role-playing skills do improve), students sometimes fall out of role, falter, or giggle in the early moments of the role-playing. Stay in role! The student will follow suit, greatly speeding up your ability to use role-playing as an effective educational tool.

In teaching more complex interviewing skills, as occurs during macrotraining, you often will create new roles designed specifically to meet the training needs of the student at that exact moment. Once again, it is helpful to try to picture a patient you encountered in the past. A newly minted role may not be as realistic as those you use regularly. That is fine and to be expected. It always is more important to build role-playing that allows the trainee to learn the desired skill than to create an "Oscar-winning" performance.

If you are creating role-playing in which the trainee is to consolidate a skill by practicing the exact skill again, but with a different patient, one should try to make the new patient have a distinctly different personality. We find that recalling the memory of a real patient and focusing on showing distinctive mannerisms (nervously picking at one's nails, twirling hair, or looking down at the floor to avoid eye contact) that differ from the previously portrayed patient makes it much easier to separate adjacent role-playings.

Finally, while you are designing role-playings on the spot, you must keep in mind the guiding principle, "keep it simple." Trainers should aim to teach one skill at a time; be sure you know what the skill you want this particular role-playing to develop in the student and make sure the student is ready to learn that skill. In essence, ensure that you are not asking too much of a particular student: he or she must be ready to move on to the next step. Before you begin role-playing, it is useful to restate the task and ask, "Do you have any questions about what you are trying to do in this role-play?"

Specific Interviewing Skills Well Addressed by Role-Playing

The number of clinical skills well addressed by role-playing is extensive, from interviewing techniques to psychotherapeutic skills, limited only by the behavioral specificity of the techniques and the imaginations of the trainers. Over the years we have found some interviewing techniques and strategies that can be addressed with particular success using role-playings, which are listed here. We feel certain that you will create many more.

1. Individual interviewing techniques (optimally taught through microtraining)
   a. Open-ended questions
   b. Closed-ended questions
   c. Empathic statements
   d. Reflecting statements
   e. Summarizing statements
   f. Gentle commands, qualitative questions, statements of inquiry[19]
   g. Validity techniques
      Behavioral incident[23]
      Gentle assumption[24]
      Shame attenuation, symptom amplification, denial of the specific[22]
   h. Facilitative nonverbal communications (eg, head nodding, forward leaning)

2. Interviewing sequences and strategies (optimally taught through macrotraining)
   a. Sequential use of basic engagement techniques to strengthen the alliance
   b. Scouting training: performing the first 7 minutes of the interview in an engaging fashion with different types of patients, then asking the interviewer to provide his or her plans for shaping the rest of the interview[16]
   c. Effectively handling the flow of questioning while sculpting out a specific DSM-5 diagnosis in a sensitive and comprehensive fashion
   d. Focusing wandering or hypomanic patients
   e. Opening up shut-down or frightened patients
   f. Interviewing psychotic and paranoid patients
   g. Transforming angry moments (including verbally abusive patients)
   h. Nondefensively handling awkward or intrusive questions directed at the clinician
   i. Sensitively and comprehensively eliciting potentially taboo histories:
      Sexual history and sexual orientation
      Domestic violence
      Incest
      Alcohol and substance abuse
      Antisocial, criminal, and homicidal thoughts or behaviors
   j. Eliciting suicidal ideation, planning, intent, and behaviors using the Chronological Assessment of Suicide Events[2,4,15]
   k. Providing psychoeducation
   l. Talking effectively with patients about their medications and addressing their concerns about side effects[25]

PART 2. SCRIPTED GROUP ROLE-PLAYING

Introduction

When role-playing is used in groups, it can be utilized in one of two formats: (1) as a platform for group discussion and/or (2) in a skills enhancement format whereby participants experientially practice interviewing techniques and strategies. When used primarily as a platform for discussion, role-plays (which often involve the instructor as one of the participants) are frequently performed in front of the group as a means of generating discussion and brainstorming. I have used this format repeatedly, and it can be quite powerful. I have used it effectively in groups as large as 120 participants, although it generally works best in significantly smaller groups.

If a trainee is assuming the role of the interviewer in front of a group of other participants, social and performance anxiety can be fairly intense. Indeed, "volunteers" seem to decrease in number as the size of the class increases. It becomes critical to minimize anxiety immediately, with both the class and the volunteers from the class. Although an entire paper could be written addressing the art of running such classes, such a discussion is beyond the scope of this article. However, I would like to share a specific phrasing that I have found to be useful in minimizing performance anxiety in this setting. As the very first volunteer is stepping up to participate in the initial role-play, I often make a comment such as:

> *I just want to emphasize the purpose of our role-plays today. We are not here to critique John's interview or pass on constructive criticism to John or anyone who helps us out with our role-plays today. Instead we are using the role-plays as a platform to launch our discussions. The role-play will allow us to actually see something that we can tangibly play with. Our goal will be to brainstorm on different ways of handling the situations presented by the clients. Indeed, John may even try out some of our ideas and we will see their pros and cons*

as they unfold. We will function with the help of John, and all of you who help us out today, as a team that gains a more nuanced understanding of how clients are presenting and the numerous ways in which we can effectively approach specific tasks and challenges. Our role-plays today will provide us with a real-time training field where we can try out our ideas together in a way that is simply not possible in the clinic itself. I think you will find that these role-plays will give us a rich launching pad for discussion and brainstorming. Before we start let's give John a big hand for being the first to help us out and then let's get to work.

Let us now move to the focus of this part of the article, for I want to address the much more challenging and, arguably, more important second format of group role-playing: the skills enhancement format. To make this format useful the trainer must come up with a viable answer to the following question: "Can role-playing be used in a group format to provide immediate constructive feedback that results in skill enhancement to all members of the class?" Three more specific questions frame the challenge more operationally:

1. Can a group format be conducive to providing feedback in a fashion that is enjoyable and minimizes social performance anxiety?
2. Can a productive number of new techniques be taught to all participants in the time available?
3. In addition to single, simple interviewing techniques, can complex interview strategies (such as uncovering suicidal ideation and intent, differential diagnosis, sensitively uncovering incest and other forms of domestic violence) be taught to demonstrable competence in a group format?

Truth be told, not everyone feels that the answer to these questions is "yes."

A sizable chunk of motivated trainees simply do not like role-playing in groups. The roots of their dislike are many and diverse, such as: (1) feeling uncomfortable and "being put on the spot" when asked to be the interviewer in front of colleagues; (2) and acting (as required when role-playing the patient) not being a comfortable skill set for the participant, or; (3) as many participants comment, the "whole thing just feels stupid to me and unrealistic." Indeed there are trainees, as well as subsequent experienced clinicians, who will not attend a workshop if they know beforehand that role-playing is going to be used.

It is important as teachers to accept a primary educational truth: trainees do not learn well if they do not like the training approach with which they are being taught. Period. However, this is not the trainee's fault but the trainer's fault. The trainer of any specific clinical interviewing skill set must determine the fashion in which the trainee is best suited to learn. A significant number of graduate students and professionals find role-playing in a group format to be artificial and an inappropriate medium for their development.

Herein lies the problem and the paradox. Interviewing techniques (such as open-ended questions, empathic statements, and reflecting statements) are core skill sets to master for any graduate from psychiatric residencies and nurse clinician programs to clinical psychology, social work, and counseling graduate programs. In addition, even more strikingly, complex interviewing skills such as eliciting suicidal ideation/intent, uncovering incest/domestic violence, and transforming anger from a patient are critical skills that are needed on a daily basis and may have life-saving implications. Any trainee from such programs should be able to demonstrate proficiency in such complex interviewing skills on graduation, but these skills are often most easily taught and tested via role-playing.

*Micro*training can be used to teach single interviewing skills to competence (Ivey)[2], and *macro*training (Shea)[4] can be used to teach complex interviewing strategies to competence. But the limitation of these *individualized* role-playing approaches is a practical one of immense importance in graduate and postgraduate training: time, not enough of it. Especially with regard to complex and critical interviewing skills such as eliciting suicidal ideation, there may not be enough interested instructors to effectively train to competence each trainee in a specific year of a graduate class in these skills. Such complex skills can be effectively taught with macrotraining but may require several hours to do so per trainee.

Even outside the discipline of mental health, these complex interviewing skills are of immense importance. Who could argue with the idea that all medical, nursing, physician assistant, and clinical pharmacy students should be trained to effectively and sensitively uncover suicidal ideation, when it has been shown repeatedly that more than 50% of all people who die by suicide have seen a physician/primary care provider within 1 month of death[26]? Each of these students could be successfully taught this skill through the use of macrotraining, but macrotraining the elicitation of suicidal ideation and intent can take between 2 and 4 hours per student per instructor.[4] If a specific medical school class consists of 150 students, it is simply not feasible for that school to provide 300 to 600 hours of individualized role-playing despite the fact that suicide assessment is a critical skill set. If this skill set is not learned, the student may be unable to spot serious suicidal intent in his or her subsequent practice with potentially dire results.

The answer must lie in creating a style of role-playing designed specifically for larger groups of trainees who in some fashion "pair off" into smaller role-playing groups (pods) to practice together. As promising as this answer sounds, I would bet that just about any instructor who has ever taught such a class has no doubt encountered the plethora of new obstacles that arise with their use.

First, and foremost, unlike one-on-one role-playing performed alone in the safety of a supervisor's office, performance anxiety can skyrocket in such groups. Trainees can experience anxiety around two entirely different tasks: (1) anxiety related to the performance of the requested interviewing technique or strategy in front of peers, and/or (2) anxiety related to acting the role of a client. Often triggered by these anxieties, a significant number of the trainees will enter the session "dreading role-playing." Unfortunately, especially if the trainee's defense mechanism for handling such anxiety is a passive-aggressive one or is based on a feigned showing of disinterest, problems can quickly metastasize to the entire small learning pod. Just one such trainee in a pod of two or four participants can significantly undercut the learning experience for all participants in the pod. Two such disinterested trainees are basically a death-knell to effective learning for the other participants.

Disinterested trainees are not the only problem. Sometimes, participants who "just *love* role-playing" love role-playing because it gives them a chance to win an Oscar. It has been my experience that such budding actors/actresses seldom pass up on this "chance of a lifetime." These role-players are crying (sometimes real tears), pounding their fists in pain, or creating antagonistic clients who thwart the interviewer at every corner of the role-play.

Because class participant role-players do not know, nor have been trained to know, the exact best fashion in which to play the patient so as to optimize the learning of the colleague practicing the interviewing skill or strategy, the role-playing exercises can become grossly inefficient. Unlike individual skill-enhancement role-playing strategies such as Ivey's microtraining or Shea's macrotraining, whereby the role-playing is being done by the trainer, the role-play's effectiveness is at the whim of the trainee role-player.

The role-plays can quickly become far too long and/or too difficult to do effectively because the role-player has created a client whose psychopathology or communication style would warrant a different interviewing technique than is being practiced.

In contrast to individualized role-playing, arguably the greatest problem in a group format is a markedly, sometimes drastically, reduced amount of time in which the trainer can directly observe each of the participants to provide constructive feedback, as the instructor must be hopping from group to group while all the different groups are practicing simultaneously. If the goal of the training is the passing on of the skills needed to perform a complex interviewing task such as suicide assessment or the uncovering of incest, this problem is formidable.

In the remainder of this article, an innovative style of group role-playing, SGRP, is described as it has been utilized to train clinicians in a widely applied method for uncovering suicidal ideation, planning, actions, and intent: the Chronological Assessment of Suicide Events (the CASE Approach). SGRP has been evolving for nearly 15 years and is now well field tested (some of the results from which are briefly shared herein). Indeed, since 2012 experiential training on the CASE Approach using SGRP[16] has been placed on the Best Practices Registry regarding trainings available on suicide assessment and prevention. The Best Practices Registry was created and is maintained by the Suicide Prevention and Resources Center (SPRC), supported by an ongoing grant from the Substance Abuse and Mental Health Services Administration (SAMHSA).

SGRP offers a new approach to group role-playing that effectively addresses all of the concerns listed earlier. It also answers the "challenging questions" raised earlier in this section with a "yes." In short, SGRP allows a sizable number of participants (up to 28 per class) to be trained to enhanced fidelity in complex interviewing strategies (in this case the elicitation of suicidal ideation, planning, behaviors, and intent) using role-playing in a fashion that is enjoyable to all participants with the exception of a rare few.

My goal is to introduce the reader to the principles of SGRP and foster both an interest in and the tools necessary to begin your own exploration of the use of SGRP in whatever aspect of interviewing you are training, from simple, core interviewing techniques to complex interviewing strategies of your choice. It is not meant to be a manual for the use of SGRP, but I hope it can provide enough information for the reader to make his or her own excursions and experimentations in its use. To achieve this goal I will do the following: (1) review the challenge of training toward fidelity one of the most critical of all interviewing strategies—the elicitation of suicidal ideation; (2) examine the field testing results when SGRP has been applied to this educational task; and (3) describe the core characteristics and principles of SGRP.

Illustration of Scripted Group Role-Playing: Putting Scripted Group Role-Playing to the Test

Using scripted group role-playing to train clinicians in suicide assessment

I will focus here on the use of SGRP in training clinicians to uncover suicidal ideation, planning, behavior, and intent, for four reasons: (1) suicide assessment is one of the most important and daunting of interviewing challenges; (2) a widely acclaimed interviewing strategy, the CASE Approach, has been well delineated in the literature; (3) the CASE Approach is a sophisticated interview strategy requiring the use of seven different interviewing techniques woven into a variety of different interviewing strategies—this degree of sophistication highlights the ability of SGRP to train a large number of clinicians to a level of enhanced skill in a complex interviewing strategy; and (4)

SGRP has been utilized and field tested extensively in the training of clinicians across disciplines and experience groups with regard to the CASE Approach.

The CASE Approach was first described in the literature in 1998 by its innovator Shea[19,27] and has subsequently been received enthusiastically among mental health professionals, substance abuse counselors, college and high school counselors, primary care clinicians, the military and Veterans Affairs (VA) systems, and the correctional profession.[15,28–38] The CASE Approach is presented routinely as a core clinical course at the annual meetings of the American Association of Suicidology[39] and is recommended as a resource for telephone crisis providers by the National Suicide Prevention LifeLine.[40]

For the reader to better appreciate the power of SGRP as a viable method for training a large group of clinicians in complex interview strategies, it is valuable to provide a brief overview of the CASE Approach itself. Before doing so, three educational terms from the specialty of clinical interviewing can serve as lenses for our exploration. (1) An "interviewing principle" is a guiding concept for approaching an interviewing task. Interviewing principles are abstractions that suggest why an interview technique or strategy is being used and when to use it. For instance, an interviewing principle might be: before asking a question about a sensitive or taboo topic, such as suicide, say something that metacommunicates to the patient that it is safe to share information about the topic in question. (2) By contrast, an "interviewing technique" (the real-world application of an interviewing principle) is a behaviorally specific set of words (often a single statement or a single question) that has been operationalized and tagged with a name. Thus, the aforementioned interviewing principle can be employed by using either of two specific interviewing techniques: normalization and shame attenuation, of which an example of shame attenuation would be, "With all of the pain of your divorce, have you been having any thoughts of killing yourself?" (3) An interviewing strategy is the sequential use of two or more interviewing techniques to address a complex interviewing task. The CASE Approach is a sophisticated interviewing strategy for uncovering suicidal ideation.

More specifically, the CASE Approach is a flexible and practical interview strategy for eliciting suicidal ideation, planning, behaviors, and intent designed to help the interviewer explore both the inner pains of the client and the suicidal planning that often reflects these pains. It was designed to increase validity, decrease errors of omission, and increase the client's sense of safety with the interviewer while discussing intimate details regarding actual suicidal ideation, intent, and behaviors. In the CASE Approach, clinicians are trained to flexibly uncover suicidal ideation and intent using a sophisticated set of questions and interview strategies, as opposed to asking a simplistic set of rote questions on the mere presence of suicidal plans. The techniques and strategies of the CASE Approach are concretely behaviorally defined; consequently, it can be taught readily and the skill level of the clinician tested easily, and documented for quality assurance purposes individually (via macrotraining) and within a group format (via SGRP).

In the CASE Approach, the interviewer explores the suicidal feelings, ideation, plans, intent, and actions of the client over four contiguous time regions, hence its name. First, the clinician begins by sensitively and carefully exploring the client's presenting suicidal ideation/actions if present, a period of time that generally includes the last 48 hours but can go back a week or two as deemed necessary (Region #1 Presenting Suicide Events). Second, the clinician explores the client's suicidal ideation/actions during the previous two months (Region #2 Recent Suicide Events). After completing this exploration, Region #3 (Past Suicide Events), consisting of the past suicide attempts, is explored. Finally, the clinician explores Region #4 (Immediate Suicide Events) consisting of

suicidal feelings, ideation, and intent that arise during the interview itself, and the client's views on possible future suicidal thoughts and what to do if they arise (Fig. 1).

A hallmark of the CASE Approach is the flexible use of seven specific interviewing techniques, designed to increase the validity of the elicited data, while exploring each of the four chronological regions described. These seven validity techniques (normalization, shame attenuation, the behavioral incident, gentle assumption, denial of the specific, the catch-all question, and symptom amplification) were culled from the preexisting clinical interviewing literature in the fields of counseling, clinical psychology, and psychiatry.

Limitations of space prevent a detailed description of the CASE Approach here (appropriate resources for a complete review of the approach are provided later), but I want to share enough of the strategy that the reader can grasp how SGRP can be effectively utilized to train clinicians in its use. To accomplish this process, let us look at one of the validity techniques used in the CASE Approach, "the behavioral incident," and how it is used in Region #1 of the CASE Approach (eliciting suicidal ideation, intent, and behaviors in the last 48 hours).

"Behavioral incidents," an interviewing technique originally described by the clinical psychologist Pascal,[23] are questions that ask for specific facts, behavioral details, or trains of thought, as with, "How many pills did you take?", "Did you load the gun?," or "What stopped you from jumping?," or which simply ask the patient to describe what happened sequentially, as with, "What did you do next?" Thus there are two types of behavioral incidents: (1) fact-finding behavioral incidents and (2) sequencing behavioral incidents. By using a series of behavioral incidents sequentially, the interviewer can create an interviewing strategy that can sometimes help a patient to enhance validity by recreating, step by step, the unfolding of a potentially taboo topic such as a suicide attempt or an act of domestic violence.

In this interview strategy, during the exploration of Region #1 (The Presenting Event), the interviewer asks the patient to describe the suicide attempt from beginning to end. During this description the clinician gently, but persistently, utilizes a series of behavioral incidents guiding the patient to create a "verbal video" of the attempt step by step. Readers familiar with cognitive-behavioral therapy (CBT) will recognize this strategy as one of the cornerstone assessment tools of CBT—a "behavioral analysis."

If an important piece of the account is missing, the clinician returns to that area, exploring with a series of clarifying behavioral incidents, until the clinician feels confident that he or she has an accurate picture of what happened. This serial use of behavioral incidents not only increases the clinician's understanding of the extent of the patient's intent and actions, it also decreases any unwarranted assumptions by the clinician that may distort the database. Creating such a verbal video, the clinician

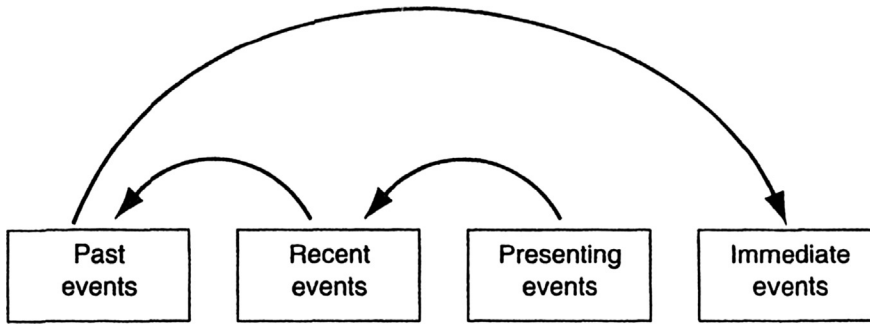

Fig. 1. Chronological Assessment of Suicide Events (CASE Approach).

will frequently uncover a more accurate picture of the suicidal behavior and the suicidal intent it may reflect in a naturally unfolding conversational mode.

In this fashion the clinician can feel more confident of delineating an accurate picture of how close the patient actually came to attempting suicide. The resulting scenario may prove to be radically different and more suggestive of imminent danger from what would have been relayed by the patient if the interviewer had merely asked an opinion of the client such as, "Did you come close to actually using the gun?," to which an embarrassed or cagey patient might quickly reply, "Oh no, not really."

Perhaps one of the most sophisticated uses of the validity techniques occurs in Region #2 of the CASE Approach (Recent Suicide Events, including suicidal thoughts, plans, and behaviors over the past 2 months). In this region of the CASE Approach, five of the validity techniques, namely the behavioral incident (BI), gentle assumption (GA), denial of the specific (DS), the catch-all question (CAQ), and symptom amplification (SA), are flexibly interwoven to uncover hidden suicidal intent and behaviors, with a special emphasis on uncovering the suicidal method of choice in a patient hesitant to share his or her true method of choice and severity of intent (**Fig. 2**).

Without knowledge of the definitions and uses of all the validity techniques, **Fig. 2** may not make a lot of sense, but all the reader needs to glean from it, for our purposes, is the fact that this exploration uses a complex series of interviewing sequences (strategies) composed of well-defined interviewing techniques. Despite its complexity, most participants being trained via SGRP can learn this sequence and behaviorally perform most, if not all, of it at the end of the training session in a reasonable manner without any cue sheets.

Many options exist for the reader to learn more about the CASE Approach. For an up-to-date article I recommend the two-part article on the CASE Approach, which is available as a free pdf at the homepage of the Training Institute for Suicide assessment and Clinical Interviewing (TISA).[29,30] If you prefer a book chapter, the recent chapter entitled "The Interpersonal Art of Suicide Assessment: Interviewing Techniques for Uncovering Suicidal Intent, Ideation, and Actions" from *The American Psychiatric Publishing Textbook of Suicide Assessment and Management*, 2nd Edition, is devoted entirely to the CASE Approach and is an excellent resource.[15] To understand how the CASE Approach can be integrated with other critical aspects of performing an effective suicide assessment including the judicious use of risk/protective factors, practical approaches to the clinical formulation of risk, and principles for soundly documenting risk from clinical and forensic perspectives, the reader is referred to the book *The Practical Art of Suicide Assessment: A Guide for Mental Health Professionals and Substance Abuse Counselors*.[32]

Having briefly explored both the utility of the CASE Approach and some of its clinical nuances, it should be easy to imagine its potential clinical and educational value. At the same time one can envision the challenge of teaching such a complex interviewing strategy to a reasonable degree of fidelity with a large number of graduate students or medical/nursing students, or to hospital staff. Moreover, as noted earlier, whatever learning approach the graduate school, residency, or institute would choose to use, the approach would need to be both enjoyable and effective for trainees to realistically gain from it, a characteristic that historically has proved to be elusive with group role-playing formats.

In this regard, before describing how to perform SGRP, it seems requisite to provide data that lend some support to the idea that SGRP may have the power to accomplish the aforementioned task. Such an advance would open the door for educators to ensure that entire graduate school classes in mental health disciplines or entire medical and nursing school classes could be effectively trained to elicit suicidal ideation

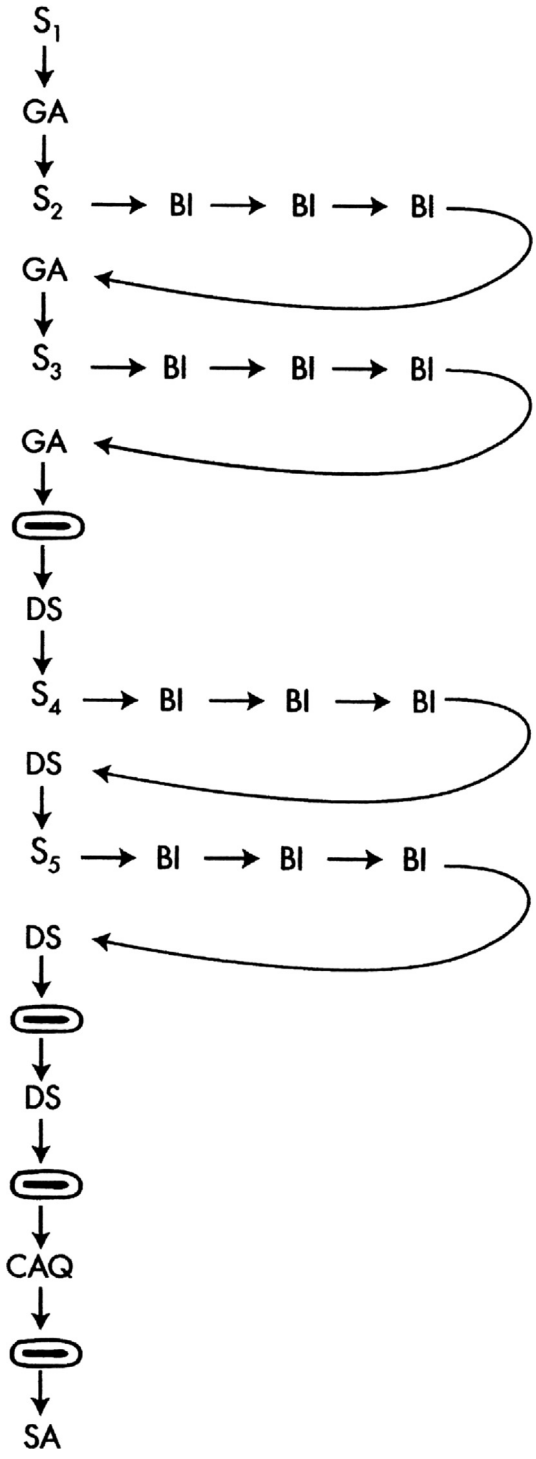

Fig. 2. Prototypic exploration of the region of recent suicide events. The schema should be flexibly adapted in response to clients' answers and clinical presentation. BI, behavioral incident; CAQ, catch-all question; DS, denial of the specific; GA, gentle assumption; S, suicide method; SA, symptom amplification. Bar within ellipse indicates client denial of suicidal ideation.

and intent in an effective fashion. Such a sweeping educational accomplishment could potentially save many lives.

A participant satisfaction study on scripted group role-playing

At the TISA (www.suicideassessment.com), initial development and subsequent refinement of SGRP has been ongoing for over 15 years. TISA has been providing formal certification in the CASE Approach to mental health professionals for more than 5 years. For the purposes of improving design, an early internal quality assurance study was undertaken of 20 consecutive SGRP trainings with varying degrees of participant size ranging from 8 to 28. The study was not done under strict research protocols, and is presented as a seed study, with all of the typical limitations of seed research. For instance, accurate records of percent participant evaluation return were not kept, although it is estimated that an 85% or higher evaluation return was achieved. (Note that subsequent to this study, TISA has been providing Level 1 Certification Trainings on the CASE Approach in which *certification is not granted unless the participant returns a completed evaluation form*. Only 2 evaluations have not been accounted for in 19 trainings. The results in the evaluation scores show no apparent differences from the results found in the original quality assurance study whose results are reported below.)

The SGRP format is described in detail in the last section of this article. It was developed in answer to the provocative question, "How would role-playing be experienced by participants if there was little or no acting involved?" Consequently the most striking innovation in SGRP is the use of scripted role-playing. In SGRP all role-plays are scripted, with little or no need for acting, which greatly decreases participant fears of role-playing while increasing both efficiency of practice and ability to consolidate techniques effectively. Because all of the role-plays are designed by the training team, each role-play creates an ideal opportunity for the clinician attempting to master the given interviewing technique or strategy to practice it. In addition, as the role-plays are designed by the training team, they efficiently address each learning skill and eliminate wasted time by "overacting" participants.

Each validity technique and its use in the CASE Approach is practiced in pods of four, participants (referred to during training as A, B, C, and D) actively coached by the trainer(s) and fellow participants in each of the four-person practice pods. Didactic training and video illustration is provided on all four regions of the CASE Approach. Intensive experiential training using SGRP is done on Region #1 (Presenting Events) and Region #2 (Recent Events), a process that is the focus of more than 90% of the day. By the end of the day, many of the participants have been able to behaviorally demonstrate, without any written cues, the ability to perform both of these complex regions of the CASE Approach in a reasonably sensitive and comprehensive fashion.

Generally speaking, of the 28 trainees there might be 1 to 3 who struggle somewhat during the day but can still replicate about 30% of the strategy. Despite their struggles with the more complex aspects of the CASE Approach (such as Region #2 concerning recent suicide events over the past 2 months), these trainees achieve by the end of the day an effective ability to raise the topic of suicide sensitively and to subsequently explore, by creating a verbal video with behavioral incidents, the extent of the patient's action taken on the presenting method. By contrast, most of the trainees can reasonably reproduce, without cues, the techniques and strategies of the first two regions of the CASE Approach including the complex interview sequences of Region #2 (see **Fig. 2**). In a group of 28 participants there are, remarkably, usually a handful of trainees who can demonstrate even the most complex sequences of Region #2 to complete fidelity without cues.

The 20 trainings comprising the study (with a combined cohort of 427) promptly began at 8:30 AM and ended at 5:00 PM, with a minimum of 6.5 hours of actual training time. The remaining time was allotted to lunch and periodic brief breaks. Consisting primarily of role-playing, interspersed with small segments of didactic training and video demonstrations, such full-day role-play trainings were rigorous and demanding to say the least.

Participants were asked to respond to the following 5-point Likert Scale statement by rating it from 0 (disagree) to 4 (agree): "The content of the training provided useful information for my clinical work."

The average response to this statement was a 3.9 across all disciplines including licensed clinical social workers (LCSWs), nurses, psychiatrists, psychologists, therapists, counselors, and other mental health professionals (see **Figs. 1** and **2**). This highly positive response supports the belief that the CASE Approach, as taught via SGRP, provides innovative interviewing techniques for uncovering suicidal ideation and intent that are valued by participants ranging from the least experienced (graduate students) to the most experienced with many years of experience behind them.

For instance, in this cohort of 427, 99 of the clinicians reported having been in clinical practice for more than 20 years (ranging from 20 to 45 years postgraduate training). These experienced clinicians also rated the above statement at 3.9, reflecting that the CASE Approach contains new material not encountered in previous continuing education regarding suicide assessment. It is rare to find experienced clinicians responding to a full day's training on suicide assessment with such enthusiasm and even rarer when they are asked to perform role-playing throughout the day.

In addition, participants were asked to rate the following 5-point (0–4) Likert Scale statement: "I would recommend this training to a fellow colleague."

A total of 427 participants responded (**Figs. 3** and **4**). The average response to the above statement was once again 3.9 across all participants. There was no

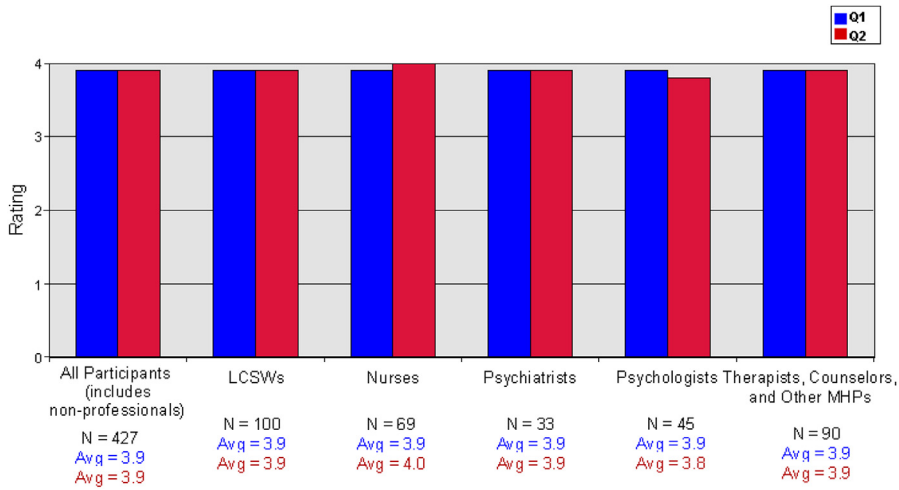

Fig. 3. By professional discipline, average participant rating for scripted group role-playing (SGRP) on the chronological assessment of suicide events (CASE Approach). Results in blue are the average of the trainees' responses to Question #1: "The content of the training provided useful information for my clinical work" rated from 0 (disagree) to 4 (agree). Results in red are the average of the trainees' responses to Question #2: "I would recommend this training to a fellow colleague" rated from 0 (disagree) to 4 (agree). (Compiled from 20 consecutive trainings using SGRP, April 22, 2012, Shawn Christopher Shea, MD.)

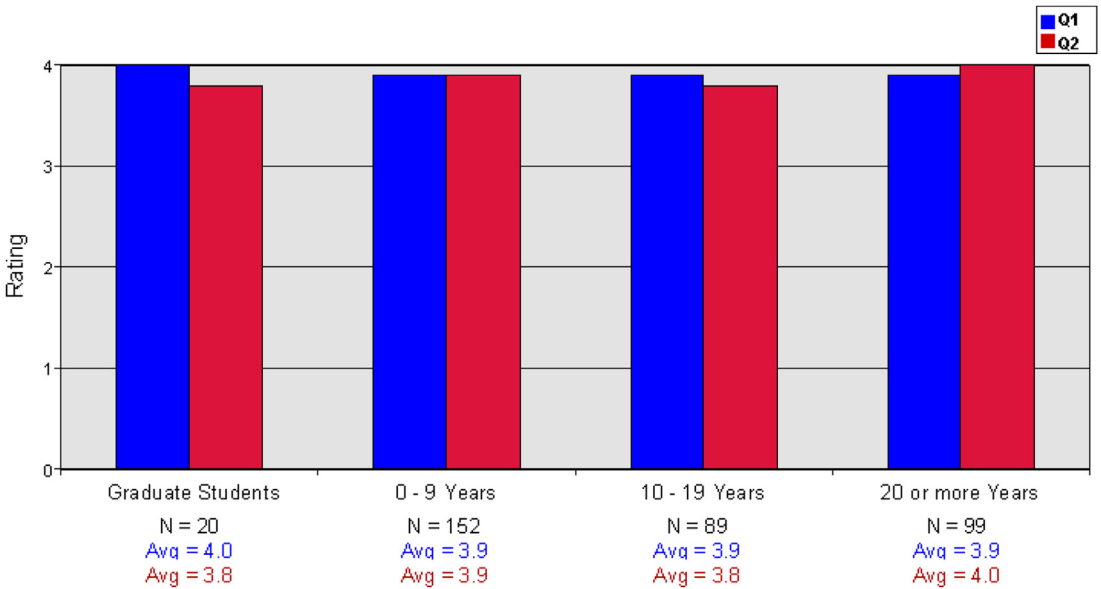

Fig. 4. By years of clinical experience, average participant rating for scripted group role-playing (SGRP) on the chronological assessment of suicide events (CASE Approach). Results in blue are the average of the trainees' responses to Question #1: "The content of the training provided useful information for my clinical work" rated from 0 (disagree) to 4 (agree). Results in red are the average of the trainees' responses to Question #2: "I would recommend this training to a fellow colleague" rated from 0 (disagree) to 4 (agree). (Compiled from 20 consecutive trainings using SGRP, April 22, 2012, Shawn Christopher Shea, MD.)

significant difference in this average across all disciplines including LCSWs, nurses, psychiatrists, psychologists, therapists, counselors, and other mental health professionals. Once again there was no difference among various groups delineated by years of experience.

This satisfaction rating is a high one in any training, but is remarkably high for a full-day training based primarily on role-playing. It demonstrates the power of SGRP to make skill-enhancing role-playing psychologically safe and enjoyable.

The surprising results seem to reflect the degree with which the CASE Approach itself is providing new interviewing techniques for suicide assessment, which are believed to be both novel and of practical use to even experienced clinicians. Of more immediate relevance to this article, however, these results mean that SGRP has created a role-playing environment that feels safe, sophisticated, and comfortable for participants across all disciplines and across all levels of experience.

Moreover, in this cohort of 20 different trainings, SGRP demonstrated robust generalizability to different clinical settings being given in locations as diverse as hospitals (El Camino Hospital, El Camino, California), college counseling centers (University of Oregon), Native American reservations (Six Nations Reservation in Brantford, Canada), VAs (Fort Wayne, Indiana) and telephone-based crisis centers where role-playing is done back-to-back in SGRP to simulate telephone intervention (West Bend, Indiana).

Another striking feature of SGRP is the fact that participants across all disciplines (including nonprofessionals such as volunteers at crisis lines for suicide prevention) and participants ranging across all levels of experience (from graduate students to clinicians with more than 40 years of experience) *can be taught in the same class*. Indeed this cross-fertilization, in both discipline and clinical experience, seemed to enhance learning and enjoyment.

As trainers, empirical data as shown herein are always valued. In addition, I feel trainers are particularly cognizant of the importance of qualitative data from participants as well. As one can imagine, the qualitative comments on SGRP in all examples of its use have been particularly robust. As an illustration, I now share a small sample of comments from the last SGRP performed before the writing of this article in which participants commented specifically about their experience of the role-playing:

> "Usually not a fan of role-play, but with it being specific and reinforcing the interviewing techniques, it was definitely worthwhile and actually enjoyable."
>
> —Psychiatrist, 15 years postgraduation experience

> "The scripted role-play is a brilliant idea. It ensures that all are involved utilizing the skill set taught. The CASE Approach has made me more confident in my interview skills."
>
> —Nurse, 6 years postgraduation experience

> "This would be an excellent graduate course. Wish we had had more hands-on practice like this. Scripted role-play felt very comfortable, and I am someone who will avoid role-plays at all costs."
>
> —Social worker, LCSW-A, first year postgraduation

> "Practical information presented. Really enjoyed role-play, and I typically HATE role-plays." (Note that besides being printed in all CAPS, the word "hate" was double underlined.)
>
> —Licensed professional counselor, 12 years postgraduation

Format and principles of scripted group role-playing

To illustrate the principles and format of SGRP, I now describe its use in teaching the CASE Approach. SGRP can be used to teach any interviewing technique or strategy (uncovering incest/domestic violence, uncovering substance use, performing a sensitive differential diagnosis). It is used, to its best capabilities, when one is teaching behaviorally specific and operationalized interviewing techniques and/or interviewing strategies that are composed of specific sequences of recommended techniques as seen with the CASE Approach.

Structure of the training pods and flow At one end of the room, a didactic teaching section is created where all didactic instruction is performed (occupying only about one-fifth of the room's area). Behind the rows of chairs the pods are arranged in the remaining four-fifths of the room consisting of groups of 4 participants each, allowing ample room between pods to decrease noise, for all pods are simultaneously active during role-playing.

Each participant receives a packet of role-plays indicating a pod number and a designation as to their position in the pod (A, B, C, D). Each individual interviewing technique (behavioral incident, gentle assumption, and so forth) that is used in the CASE Approach is always didactically taught, and subsequently the participants move to their respective pods to experientially practice the technique directly after the didactics of each technique. Later in the day, as interviewing techniques are sequenced into interview strategies such as uncovering Region #1 (Presenting Suicide Events) and Region #2 (Recent Suicide Events) of the CASE Approach, each region will be practiced within a pod, providing the chance to learn the new sequence but to also consolidate any previously learned interviewing techniques, for they are repeatedly used in the interview sequences.

When beginning a pod module regarding a single specific interviewing technique (such as normalization, shame attenuation, gentle assumption) or an interview strategy (such as creating a verbal video with a sequence of behavioral incidents), the trainer asks all "A's" to pick up their role-play folders: they will play the patient. The "B's" will practice the interviewing technique (such as normalization, shame attenuation) or interview strategy (such as creating a verbal video with behavioral incidents). The "C's" and "D's" will function as coaches, immediately providing feedback after the interviewing technique or strategy has been practiced. With SGRP, the coaching provided by the trainers is significantly enhanced by the coaching feedback given from participants to each other. I have been impressed by the quality of participant-to-participant feedback in SGRP. As the 7 pods of 4 are practicing, the trainer circulates about the room from pod to pod providing constructive feedback and modeling as needed (note that SGRP can be done with a total group number ranging from 4 to 28; a number larger than 28 is not recommended as it dilutes the coaching time from the trainer). While the trainer provides feedback to one pod, the other pods continue their work. After the first run-through of the technique and after the coaching has been provided by participants C and D, the participant coaches ask the role-play to be repeated several times so as to consolidate the interviewer's acquisition of the new technique or strategy being practiced.

After all groups have performed these tasks, the trainer asks all "B's" to pick up their role-play folders: they will play the patient. The "A's" now practice the specific technique (normalization, shame attenuation, gentle assumption, and so forth) or strategy (eg, verbal video). "C's" and "D's" coach yet again. Note that the act of coaching is a learning experience itself, for the coaches must process the concept of the technique or strategy in a sophisticated manner to provide feedback.

After all groups have performed these tasks, the trainer asks all "C's" to pick up their role-play folders: they will play the patient. The "D's" now practice the specific technique (eg, normalization) or strategy (eg, verbal video). The "A's" and "B's" now coach. Note that these coaches are slightly more seasoned, for they have each had a chance to practice the technique or strategy and they have both experienced being a patient with whom the technique or strategy is being utilized when they played the patient role. Consequently, these coaches may provide an even more sophisticated level of feedback.

After all groups have performed these tasks, the trainer asks all "D's" to pick up their role-play folders: they will play the patient. The "C's" now practice the specific technique (normalization) or strategy (verbal video). The "A's" and "B's" coach yet again.

Before each role-play begins, the participants playing the role are given 2 to 3 minutes to read through the role-play. This quiet time allows them a chance to note their directions and to become comfortable with what they will read directly. There are also written cues of what content must be included if they are providing a sentence or two of "more spontaneous dialogue."

When designing your role-plays for A through D, it is important to purposefully design each role-play to demonstrate for the pod a specific nuance of the interview technique or strategy that is being practiced. For instance, when creating role-plays A through D for practicing the making of a verbal video, the designer may make "A" a role-play regarding an overdose, "B" a role-play on the use of a gun, "C" a role-play on hanging, and "D" a role-play on jumping from a bridge or building. Thus, with every role-play each member of the pod is learning a new nuance about the technique or strategy being used.

As the day proceeds, once the specific techniques that are to be used in a more complex interviewing strategy have been practiced, the training moves on to practicing the more complex interviewing strategies. In short, as the day proceeds the role-plays become more and more complex as one moves from practicing interviewing techniques to practicing interviewing strategies such as exploring Region #1 or Region #2 of the CASE Approach.

At no time should interviewers have anything on their laps. Cue sheets or "cheat sheets" are not allowed, as they slow skill acquisition.

Core principles for designing scripted group role-plays Historically the term "scripted role-playing" has been used to describe a variety of formats. It is sometimes used not as a method of skills enhancement role-playing but as a platform for group discussion, as has been described by Schweickert and Heeren[41] when teaching sexual history taking. In this format, a scenario in which the words of both the patient and the clinician are completely written is used. The role-play is then read by two participants for use as a platform for group discussion. Although this is an excellent and creative method for generating group discussion, in such a format there is no chance for participants to actually practice interviewing techniques.

In the group format of skill enhancement whereby participants are expected to receive a chance to experientially practice interviewing techniques, "scripted role-playing" generally means that the participant playing the patient has been given written instructions on who he or she is playing, characteristics of the patient, and possible symptoms, stresses, and so forth. Occasionally these scripts include some specific statements that the "patient" should say. As the role-play is begun, the other participant then practices his or her interviewing skills.

SGRP is a significantly more advanced form of scripted role-playing. Acting is essentially removed or greatly minimized, which I have found markedly decreases

participant anxiety, eliminates problems with participants overacting, and enhances the focus of the role-plays. All role-playing of patients is done by the participants in the training pods, not by the trainer.

In SGRP all role-plays begin with a cue statement *read* by the role-player from his or her script. This initiating statement is designed to create the best possible cue for the participant learning the technique to practice it. *In addition, before the role-play begins, the trainer reads the cue statement aloud to the entire set of participants and states the exact words of the interviewing technique that the interviewer is to use*. This simple and immediate modeling of the interviewing technique being practiced markedly increases the likelihood of the interviewer succeeding, both consolidating the technique and creating a positive sense of gained expertise. The trainer then tells the role-players to read their cue statements and the role-playing begins. As soon as the interviewing technique is done, the role-play is stopped by the coaches and feedback is provided by the participant coaches in the learning pod.

When the role-play involves practicing a more complex interview strategy composed of a sequence of interview techniques (such as practicing making a verbal video of the extent of action taken on a suicide attempt), *a hallmark of SGRP is the fact that specific, sometimes detailed, instructions are given in the written role-player sheet as to when to say what and how to say it, so as to maximize the learning experience for the participant practicing the interview strategy*. Appendices 1 and 2 present examples of scripted role-plays.

SUMMARY

Hopefully, this article provides a useful introduction to the art of role-playing in both the individual format and group format using SGRP. There is little doubt that role-playing can provide powerful learning opportunities, but to do so it must be done well. The purpose of this article is to impart some guidance toward this goal.

Of particular importance has been the opportunity in this revised article to introduce the concept of SGRP. The potential promise of this educational advancement in the format of group role-playing (allowing large groups of trainees to practice and master complex interviewing skills in a reasonable amount of time) is tangible and within reach. SGRP may greatly enhance and assure the acquisition of critical complex interviewing skills in health care providers across all disciplines, an educational goal that has not been achievable to date. SGRP can be used to train skills in a variety of tasks such as uncovering incest/domestic violence, uncovering substance abuse, achieving improved competence in crisis intervention skills, performing a sensitive differential diagnosis, and, of course, suicide assessment.

Regarding the latter skill set, the promise of SGRP, as a tool to concretely reduce the suicide rate, is particularly exciting. As mentioned earlier, it is well documented that at least 50% of patients who kill themselves have seen a primary care clinician within 1 month of their deaths.[26] A typical primary care clinician is seeing patients who warrant a suicide assessment on a daily basis. To prepare medical, nursing, physician assistant, and clinical pharmacy students for this future task, as part of the numerous competency skills they are required to demonstrate before graduation, every student could be required by their faculty to participate in a single-day training in the CASE Approach using SGRP. Acquiring this skill would require only a single day of training in the course of a 4-year program.

If such training resulted in only 50% of these students subsequently effectively uncovering suicidal ideation in their subsequent careers, and if such improved delineation resulted in preventing a subsequent suicide in only 50% of the times it

was used, the suicide rate could, theoretically, be reduced by 12.5% across the country. This type of model has been successfully used on a national level in emergency medicine and nursing, where a full day of coached training and certification is required in Advanced Cardio Life Support (ACLS), with the subsequent saving of many lives over the following decades.

Obviously such training would also be of immediate use in the education of psychiatric residents and nurses, in addition to graduate students across all mental health disciplines. Although the research on SGRP is in an early stage of development, the hope it represents is indeed tangibly exciting.

REFERENCES

1. The 360 degree view: a question of competence. Rochester Medicine 2006;26.
2. Ivey A. Microcounseling: innovations in interviewer training. Springfield (MO): Charles C. Thomas; 1971.
3. Daniels T. Microcounselling research: what 450 data-based studies reveal. In: Ivey A, Ivey M, editors. Intentional interviewing and counseling. Belmont (CA): Wadsworth Publishing; 2003. Interactive CD-ROM.
4. Shea SC, Barney C. Macrotraining: a "how-to" primer for using serial role-playing to train complex clinical interviewing tasks such as suicide assessment. Psychiatr Clin North Am 2007;30:e1–29.
5. Becking D, Berkel T, Betermieux S, et al. Altering the roles of learners and tutors in a virtual practical training by means of role-playing. In: Lassner D, McNaught C, editors. Proceedings of World Conference on Educational Multimedia, Hypermedia and Telecommunications. Chesapeake (VA): AACE; 2003. p. 2278–81.
6. Phelps CL, Willcockson I. The LEARN curriculum: hands-on classroom experiments. New York: Society for Neuroscience Abstract Viewer & Itinerary Planner; 2002 [abstract: 22.42].
7. Smith RC, Lyles JS, Mettler J, et al. The effectiveness of intensive training for residents in interviewing: a randomized, controlled study. Ann Intern Med 1998; 128(2):118–26.
8. Baker DP, Gustafson S, Beaubien JM, et al. Medical team training programs in health care. Advances in Patient Safety 2005;4:253–67.
9. Barach PR, Mohr JJ. Microsystems simulation: designing and evaluating an approach to patient safety and systems thinking. Abstract A:1108. Presented at the Anesthesiology Abstracts of Scientific Papers Annual Meeting. 2002.
10. Knowles C, Kinchington F, Erwin J, et al. A randomized controlled trial of the effectiveness of combining video role play with traditional methods of delivering undergraduate medical education. Sex Transm Infect 2001;77:376–80.
11. Jeffries PR. A framework for designing, implementing, and evaluating simulations used as teaching strategies in nursing. Nurs Educ Perspect 2005;26(2): 96–103.
12. Deveugele M, Derese A, De Maesschalck S, et al. Teaching communication skills to medical students, a challenge in the curriculum? Patient Educ Couns 2005; 58(3):265–70.
13. Scisson EH. Counseling for results: principles and practice of helping professions. Pacific Grove (CA): Brooks/Cole; 1993.
14. Daniels T. Microcounseling research: what over 450 data-based studies reveal. In: Ivey A, Ivey M, editors. Intentional interviewing and counseling, Interactive CD-ROM. Pacific Grove, CA: Brooks Cole Publishing Co.; 2003. p. 15.

15. Shea SC. The interpersonal art of suicide assessment: interviewing techniques for uncovering suicidal intent, ideation, and actions. In: Simon RI, Hales RE, editors. The American psychiatric publishing textbook of suicide assessment and management. 2nd edition. Washington, DC: American Psychiatric Publishing; 2012. p. 29–56.
16. Shea SC, Director. Training Institute for Suicide Assessment and Clinical Interviewing. Available at: www.suicideassessment.com. Accessed January 06, 2015.
17. Harden RM, Stevenson M, Downie WW, et al. Assessment of clinical competence using objective structured clinical examination. Br Med J 1975;1(5955):447–51.
18. Shea SC, Barney C. Facilic supervision and schematics: the art of training psychiatric residents and other mental health professionals how to structure clinical interviews sensitively. Psychiatr Clin North Am 2007;30:e51–96.
19. Shea SC. Psychiatric interviewing: the art of understanding–a practical guide for psychiatrists, psychologists, counselors, social workers, nurses, and other mental health professionals. 2nd edition. Philadelphia: W.B. Saunders Company; 1998.
20. Benedek EP. Interpersonal process recall: an innovative technique. J Med Educ 1977;52:939–41.
21. Pryor K. Don't shoot the dog—the new art of teaching and training. Revised edition. Bantam Books; 1999.
22. Shea SC. Macrotraining manual. Training Institute for Suicide Assessment and Clinical Interviewing (TISA). Copyright 1997.
23. Pascal GR. The practical art of diagnostic interviewing. Homewood (IL): Dow-Jones-Irwin; 1983.
24. Pomeroy WB, Flax CC, Wheeler CC. Taking a sex history. New York: The Free Press; 1982.
25. Shea SC. Improving medication adherence: how to talk with patients about their medications. Philadelphia: Lippincott Williams & Wilkins; 2006.
26. Luoma JB, Martin CE, Pearson JL. Contact with mental health and primary care providers before suicide: a review of the evidence. Am J Psychiatry 2002;159:909–16.
27. Shea SC. The chronological assessment of suicide events: a practical interviewing strategy for the elicitation of suicidal ideation. J Clin Psychiatry 1998;59(Suppl 20):58–72.
28. Reed M, Shea SC. Suicide assessment in college students: innovations in uncovering suicidal ideation and intent (CASE Approach). In: Lamis DA, Lester D, editors. Understanding and preventing college student suicide. Springfield (IL): Charles. C. Thomas Publisher, Ltd; 2011. p. 197–222.
29. Shea SC. Suicide assessment: part 1—uncovering suicidal intent, a sophisticated art. Psychiatric Times 2009;26(12):17–9. Available at: http://www.PsychiatricTimes.com. Accessed May 9, 2011.
30. Shea SC. Suicide assessment: part 2—uncovering suicidal intent, using the chronological assessment of suicidal events (CASE Approach). 2009. Available at: http://www.PsychiatricTimes.com. Accessed May 9, 2011.
31. Knoll, J. Correctional suicide risk assessment and prevention. Correctional Mental Health Report: Practice, Administration, Law 10(5):65–80, 2009.
32. Shea SC. The practical art of suicide assessment: a guide for mental health professionals and substance abuse counselors. Stoddard (NH): Mental Health Presses; 2011.
33. Shea SC. The delicate art of eliciting suicidal ideation. Psychiatr Ann 2004;34:385–400.

34. Shea SC. Practical tips for eliciting suicidal ideation for the substance abuse professional. Counselor, the Magazine for Addiction Professionals 2001;2: 14–24.
35. Shea SC. The chronological assessment of suicide events (the CASE Approach): an introduction for the front-line clinician. NewsLink (Newsletter of the American Association of Suicidology) 2002;29:12–3.
36. Shea SC. Tips for uncovering suicidal ideation in the primary care setting. Part of the 4-part CD-ROM series titled hidden diagnosis: uncovering anxiety and depressive disorders (version 2.0). Philadelphia: GlaxoSmithKline; 1999.
37. Shea SC. The chronological assessment of suicide events: an innovative method for training residents to competently elicit suicidal ideation. Presented at the American Association of Directors of Psychiatric Residency Training (AADPRT). Puerto Rico, March 6–9, 2003.
38. Shea SC. Innovations in uncovering suicidal ideation with vets and soldiers: the chronological assessment of suicide events (CASE Approach). Presented at the Department of Defense/Veterans Administration Annual Suicide Prevention Conference. San Antonio, TX, January 12–15, 2009.
39. Shea SC. Innovations in eliciting suicidal ideation: the chronological assessment of suicide events (CASE Approach). Presented at: the Annual Meetings of the American Association of Suicidology from 1999 through 2014.
40. Shea SC. The Chronological assessment of suicide events (CASE Approach) as taught via scripted group role-playing (SGRP) for telephone crisis line providers. Presented at the Annual Meeting of LIfeLine. Washington, DC, 2009.
41. Schweickert EA, Hereen AB. Scripted role play: a technique for teaching sexual history taking. J Am Osteopath Assoc 1999;99(5):275–6.

APPENDIX 1: SAMPLE ROLE-PLAY SCRIPT FOR A SINGLE INTERVIEWING TECHNIQUE

Note to Reader: The following is an example of a role-play script for use by all the seven "A" trainees in the seven pods (if there are 28 participants split into seven groups of four each) when introducing "gentle assumption". Remember that you would need to create a unique role-play script for each of the B, C, and D participants for use when it is their turn to play the patient in the pod exercise devoted to practicing gentle assumption. You would design each role-play for the A, B, C, and D participants to illustrate a slightly different aspect of using a gentle assumption. Thus with each role-play something new about the use of gentle assumptions is learned by every member of the pod.

In a more generic sense, Appendix 1 is provided as a model to be used in designing role-plays that you create to consolidate a previously practiced interviewing technique while simultaneously teaching a new interviewing technique. In the following role-play script the interviewer must once again use a "shame attenuation" (first introduced as an interviewing technique in the immediately preceding role-play and now consolidated in this role-play through repetition). The interviewer must then use a series of "gentle assumptions" (a technique that is being introduced in this role-play for the very first time). Thus you can see the fashion in which serial repetition from role-play to role-play is often used in SGRP to simultaneously consolidate previously practiced interviewing techniques while introducing a new interviewing technique.

Note that key directions for the role-player are often printed in bold and/or ALL CAPS so as to "jump off the page" ensuring that the role player can quickly see what he or she is to do next in the role-play. Occasionally, italics are also utilized to emphasize points of protocol.

Gentle Assumption for Role-Player A

Consolidation exercise for Shame Attenuation and new acquisition RP for Gentle Assumption

Who you are: For the sake of getting into the role a bit, here is some background.

You are a 22-year-old who has developed a major depression triggered by a break-up with your boyfriend/girlfriend with whom you have had a long-standing rocky relationship. (This material will be shared by the trainer with the whole group before the role-play begins, for it represents the information garnered by the interviewer in the first 15 minutes of the interview.)

Your first response:

After the interviewer uses a shame attenuation (eg, "With all of your pain, have you been having any thoughts of killing yourself?") you will say **"yes."**

After the interviewer asks, "What have you thought of doing?" You will say, **"Hanging myself."**

After each subsequent gentle assumption by the interviewer, give **one** of the following methods starting at the top straight down.

When the list is done, after the interviewer uses a gentle assumption simply say, "No other ways" and the drill will be done:

1. Driving my car into a tree
2. Jumping off a bridge
3. Overdosing on aspirin
4. Shooting myself
5. Cutting myself

Tips for Role-Player:

1. Provide each method **ONLY** after the clinician uses a gentle assumption.
2. If clinician **does not** use a gentle assumption (eg, asks something like, "Have you thought of other ways of killing yourself?")

ANSWER WITH A SIMPLE *"NO."*

Cue Statement to Begin Role-Play: Just say, **"I don't know what I'm going to do now. I don't know if it's worth going on without him/her. I just don't know." (Interviewer will follow up with a shame attenuation.)**

APPENDIX 2: SAMPLE ROLE-PLAY SCRIPT FOR A TEACHING A COMPLEX INTERVIEWING STRATEGY SUCH AS REGION #2 IN THE CASE APPROACH

Note to Reader: The following is an example of a role-play script for use by all the seven "A" trainees in the seven pods (if there are 28 participants split into seven groups of four each) when introducing the exploration of Region #2 in the CASE Approach (Recent Suicide Events over the past two months). Remember that you would need to create a unique role-play script for each of the B, C, and D participants for use when it is their turn to play the patient in the pod exercise devoted to practicing the exploration of Region #2 (Recent Suicide Events). You would design each role-play for the A, B, C, and D participants to illustrate a slightly different aspect of the exploration of Recent Suicide Events (differing suicide methods, differing number of methods considered, different method of choice etc.). To do so, you would need to create a completely different patient for participants A, B, C, and D to play. Thus with each role-play script something new about the exploration of Recent Suicide Events is learned by every member of the pod.

Script for Role-player A: Exploration of Recent Events (Past 2 Months)

1. Who you are (What has been uncovered in the first 15 minutes of interview):

You are a 37-year-old newspaper reporter who has just lost his job because his/her newspaper has folded in the harsh economic times. You are also heavily stressed by fears that your spouse is having an affair. *(This will be read by the trainer to the whole group before role-play begins.)*

2. What has already been uncovered during "verbal video" of Presenting Event:

When exploring the Presenting Region of the CASE Approach, the clinician uncovered that, about 1 week ago, you had gone to a bridge, got up to the rail, but stopped. Looked briefly over the rail and quickly went away.

Cue Statement for Beginning the Role-Play: "I couldn't jump. I just couldn't do that to my kids, but sometimes I wonder if they wouldn't be better with me dead. The only thing I'm really good at is writing copy, and newspapers are a thing of the past."

Script:

Clinician will make bridging question about jumping thoughts over past 2 months

You will say "No."

Clinician will use Gentle Assumption

You will say, "I've thought of overdosing."

GRADUALLY SHARE THE FOLLOWING AS THE CLINICIAN MAKES A VERBAL VIDEO USING BEHAVIORAL INCIDENTS

1. **Bought some aspirin a several weeks ago**
2. **Went home (your wife was out with some friends) and drank a 6-pack of beer in your recreation room in your basement**
3. **Proceeded to put about 20 pills in your hand**
4. **Only took about 10 pills**
5. **Once again, couldn't do it because of your kids**

Clinician will use Gentle Assumption

You will say, "Nothing really."

Clinician will use Denials of the Specific

You will deny any other method UNTIL the clinician asks about a gun:

1. **Have owned a gun for protection for years**
2. **Five weeks ago, while drinking at night, you took the gun and drove to a field in an isolated section of countryside**
3. **While in the field you loaded the gun**
4. **Clicked safety off**
5. **Placed gun up against temple, placing it up and down about 5 times**
6. **Decided you could not shoot yourself, once again because, "I can't do this to the kids"**
7. **Gun is kept, "Where I can get it if I need it"**

If the clinician uses the Catch-All Question, "Are there any other ways you've thought of killing yourself that we haven't talked about?"

Simply say "No."

Clinician will use Symptom Amplification

You will say, "Not all the time, I don't know, maybe 60% of the day."

Tips for Role-Player:

1. As the clinician uses behavioral incidents to make any verbal videos, progressively share the many steps you've taken **(but only provide a step or two at a time of your actions, because you want the interviewer to learn how to use a series of behavioral incidents)**