

The Art of Effectively Teaching Clinical Interviewing Skills Using Role-Playing: A Primer

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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 and macrotraining), core engagement techniques as well as 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 then can advance in intensity and complexity, including chances to practice using the skill with the supervisor playing the role of resistant clients. Practice continues until

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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, showing 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, employing 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. I personally have used role-playing for nearly 20 years as part of the Dartmouth Interviewing Mentorship Program, described elsewhere in this issue. My co-author, the creator of macrotraining, has been studying role-playing and serial role-playing intensively for almost 30 years. Together we hope to provide a user-friendly primer that introduces a variety of practical considerations for using role-playing fruitfully.

Another online article in this issue described the details of a sophisticated application of serial role-playing called "macrotraining." (Please see "Macrotraining: A 'How-To' Primer for Using Serial Role-Playing to Train Complex Clinical Interviewing Tasks Such as Suicide Assessment" at www.psych.theclinics.com, June 2007 issue). We do not intend to repeat this information here. Instead, this article focuses on the much narrower topic of how to perform one, generic role-playing 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, in which 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).

This informal article is neither a research paper 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 any new ideas you have. We hope you enjoy the article and share it to pass on clinical wisdom and technique with all those who love the power of role-playing.

Our approach in this primer is sixfold:

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 we have found to be particularly well addressed by role-playing

A BRIEF HISTORY OF ROLE-PLAYING

Role-playing has become a popular and ubiquitous method of training interviewing skills. It is used for training 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 three 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 in which 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 previously, including such remarkably diverse settings as nonmedical classrooms for distance learning in Germany [2], improving the interest and retention of students exploring careers in mental health research [3], training primary care residents in interviewing [4], trouble-shooting the cooperative function of medical teams [5], addressing patient safety issues and preventive steps by simulating situations that have gone awry [6], and evaluating sophisticated urologic procedures [7]. A nursing review offers concise cautionary notes regarding the challenges of designing effective simulations [8], and a Belgian study on teaching communication to medical students provides a candid summary after 6 years of training with a small-group format [9].

Two advances in role-playing—microtraining and macrotraining—warrant more detailed attention. In the 1960s, Ivey [10] developed a sophisticated

form of role-playing, microtraining (also called “microcounseling”), that 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 as well as 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 videotape), 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 see if 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 in which 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 interviewing technique in question. Ivey did more than speculate: he went in search of empiric 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 [11]. A review by Daniels [12] found more than 450 studies documenting its efficacy.

The next evolution in role-playing—macrotraining—was developed by Shea in the mid-1980s and is described in detail elsewhere in this issue. He noted that 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 the clinician to be able to ask questions about difficult-to-share material while simultaneously attending to and nurturing the therapeutic alliance.

Microcounseling is effective for teaching individual interviewing techniques, especially those techniques vital to engagement—such as attending behavior, communicating empathy, and using open-ended questions, reflecting statements, and summarizing statements. Shea began to wonder if 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 (see the macrotraining article in this issue) is the teaching of the widely used interviewing strategy for eliciting suicidal ideation, intent, and behaviors known as the “Chronological Assessment of Suicide Events,” the CASE approach [13]. The goal is to make sure that all trainees can demonstrate proficiency in this key clinical task before graduation.

Before closing our brief history of role-playing, we want to 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 [14].

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 will 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 videotaped 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 skill in question. Reverse role-playing lets the trainer 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 of role-playing, is that it demonstrates that the trainer is willing “to be put on the spot,” too. 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 doing 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 in which 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 into 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 my own 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 my 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 I used reverse role-playing (in 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 gotten. I tacitly demonstrated this knowledge by asking questions that could come only from a 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 in which the resident could practice the techniques. Fortuitously, in a follow-up session of supervision in which I 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, I commented on the resident's success, hoping to reinforce it so it became part of her 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, and 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 *DSM-IV-TR* 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 small number of instances role-playing can give a more accurate representation of skill competency than a videotape of a student's interview with an actual patient, a point seldom addressed in the literature. Videotapes can create artifacts. These artifacts may result from the trainee's anxiety about being taped, with a resulting loss of spontaneity or natural employment of interpersonal skills, a problem we refer to as "videotape freeze."

In other instances, specific singular issues that may have been prompted by the particular patient in the tape 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 quite stilted if this particular videotaped patient was hostile early in the interview and had thrown the student off balance. Naturally, this situation on the tape will 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 see whether the skill is truly lacking or was merely compromised with the particular videotaped subject.

Videotapes also may lead to inaccurate overestimation of a trainee's knowledge base; for example, if a frequently hospitalized patient were 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 role-playing 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 reinforcement 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 see 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 videotaped 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 to improve the student's ability to evaluate clinical situations more astutely and to problem solve 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, 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 videotape.

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 of 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 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 [10] and macrotraining (described in detail elsewhere in this issue).

Enhancing Videotape Supervision

Videotape supervision can be enhanced if the supervisor is skilled in the use of role-playing, microtraining, and macrotraining. We call such supervision “role-play-enhanced videotape supervision.” If a particular problem in which a specific interviewing technique could be useful is spotted during videotape supervision, it can be highly effective to replay the relevant tape 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 faciliic supervision (a method for spotting problems with how residents structure interviews and make transitions between topics, described in detail online in the Web Archive of this June issue at www.psych.theclinics.com) is used in conjunction with videotaping, new avenues for the productive use of role-playing arise. If the trainer sees on the videotape 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 a standard role-playing.

At times, a student’s skill deficit may be related to emotionally charged material or to countertransfereential 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 [15] can help the trainee better address the indicated clinical skills. This triadic combination of videotape, 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 do interviewing. We emphasize that we are trying to generate enthusiasm about the power and nuances of clinical interviewing in which 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 disquietening, 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, they 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 sizeable number have not, especially if they have experienced poorly done role-playing. Typical biases, as mentioned in our macrotraining article in this issue, include the idea that role-playing is silly, unrealistic, artificial, useless, or makes one feel uncomfortable [16]. That is quite a list! It is better to have these concerns out 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 the resistance 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-playing session, we also recommend asking, “How did that go for you?” Depending upon the student’s answer, we might ask, “Is there anything we might do to make this even more comfortable or useful for you?”

In my own work with trainees and with clients, I am indebted to the work of behavioral psychologist Pryor [17]. Her 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 [17] 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 in which 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, with 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 getting 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 much 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 who have 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, sometimes it is 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 that the trainee did 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, as well as 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 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 in which 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 after the problematic behavior as possible 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 [17]. 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,” and 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* [16]. 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 quite 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. These techniques and strategies 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 [18]
 - g. Validity techniques
 - Behavioral incident [19]
 - Gentle assumption [20]
 - Shame attenuation, symptom amplification, denial of the specific [18]
 - 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 [18]
- c. Effectively handling the flow of questioning while sculpting out a specific *DSM-IV-TR* 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 [13] (also see online macrotraining article in this issue)
- k. Providing psychoeducation
- l. Talking effectively with patients about their medications and addressing their concerns about side effects [21]

SUMMARY

We hope this article provides a useful introduction to the art of role-playing. Over the years, we and our students have found role-playing to be a valuable tool for improving interviewing skills. In addition, it has provided us with some of our richest encounters with our trainees and with our favorite moments of humor. We hope it does the same for you. In the long run, it is our patients who will benefit the most.

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