On the other side: Learning about being a service user or carer during simulation training on a clinical psychology doctorate programme

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Training clinical psychologists to be able to work with those who will use their services in ways that are not 'othering' or stigmatising and that facilitate a safe, compassionate and accepting place from where psychological therapy can be undertaken, is an essential task for trainers. Although simulation training is widely used in some healthcare professions, it is a relatively new method in clinical psychology training. In this article we describe a simulation training exercise as one effective way to achieve the goals described above.
Keywords: *Simulation; clinical psychology training; service user or carer.*

IN ADDITION to training clinical psychologists to be able practitioners and to competently conduct and be critical consumers of research, the reflective scientist-practitioner model (BPS, 2017) also encourages critical reflection and self-awareness. Although training programmes are required to have mechanisms in place to support students' personal and professional development, it is not currently a requirement to undergo personal therapy as part of training. This is despite some evidence that qualified clinical psychologists in the UK believe that personal therapy helped them to be or become more competent practitioners (Nel et al., 2012). It is also despite recent research that shows that lived experience of psychological distress amongst clinical psychologists and clinical psychology trainees are potentially common (Grice et al., 2018; Tay et al., 2018), and more worryingly, that these psychologists and trainees are often very reluctant to disclose this, including due to the fear of stigma and discrimination (Grice et al., 2018; Tay et al., 2018). As trainers of clinical psychologists, and in the absence of a requirement for personal therapy during clinical psychology, we started to think what other ways there may be for students to learn about being a client during their training. Although we accept that trainees will be working with service users and carers throughout their training and that this will give them a valuable insight into the experience of such clients, we also recognise that there is an important qualitative distinction between observing or being witness to someone's experience of an event and having first-hand experience of such an event. Furthermore, the importance of challenging 'othering' mental health stigma within our profession and break down the 'us' and 'them' divide remains an essential goal within training and has been powerfully brought to the fore again in recent research (Grice et al., 2018; Tay et al., 2018). Addressing this at a number of levels throughout training seems essential. We started to consider simulation training as a method to enable trainees to learn about and reflect on what it is like to be a service user or carer during their training.

Simulation training

Background

Simulation has been defined as the artificial representation of a real-world process to achieve educational goals via experiential learning (Flanagan et al., 2004) and is widely used in medical education through the replication of clinical scenarios (e.g. Al-Elq,

2010). One of the main aims of simulation is to create an environment that enables the participants to perform naturally, so that they can gain insights into the complexity of their actual workplace (Flanagan et al., 2004).

The University of Hertfordshire has state-of-the-art simulation facilities, a track record, and extensive expertise in simulation education. In particular, its students have access to two simulation environments including the Clinical Simulation Centre, which is one of the largest and most advanced in Europe. The Centre comprises a mock general ward, intensive care unit, home in the community, and counselling room as well as state-of-the-art audio-visual recording equipment that enhances simulation training. After the opening of the Centre in 2007 (Alinier, 2007), the Doctorate in Clinical Psychology programme at this university has started to use it for training its students (Nel, 2010). This training has expanded significantly in scope and regularity, and now includes, for example, training students to acquire clinical skills, to assess clients across the lifespan and develop formulations of their presenting difficulties, to learn intervention techniques in models such as Cognitive Behavioural Therapy and Systemic Family Therapy, to learn to manage risk, etcetera. In addition, the Centre is sometimes also used for in-vivo, formative assessment of the development of trainees' clinical competence (especially before they start working clinically on their practice placements).

Before describing the exercise, it is worth briefly noting the four theoretical concepts that underpins our work in this area (Nel, 2010): (1) that the trainees, as adult learners, actively construct their own meanings out of the same learning experience (Winitzky & Kauchak, 1997); (2) that learning occurs in social interaction with others (Vygotsky, 1978); (3) that 'good learning' occurs just above the student's current level of ability or competence in a zone of proximal development (Vygotsky, 1978); and (4) that scaffolding (Wood et al., 1976) is provided to support the trainees' learning.

The task

A simulation training event has been in operation for several years where second year trainees get an opportunity to practice working clinically with clients' systems as part of two second year teaching modules: Children, young people and families, and people with intellectual difficulties. Until recently the roles of the service users and carers in these scenarios were played by actors or members of the teaching staff. The feedback provided by these actors often included comments on how valuable an experience it was for them to be in the position of a service user or carer and, in the case of the staff, how much they have learnt for their own clinical practice. Upon reflecting on this feedback, the authors decided to consider giving first year trainees the opportunity to act as the service users in these scenarios. After some deliberations weighing up the potential advantages/disadvantages and practical implications (for example, synchronising the first and second year timetables), it was concluded that this would indeed be a useful learning opportunity for first-year trainees. The whole cohort participate as actors in client and carer roles in a simulation training event where the second year trainees develop their therapeutic skills acting as therapists. It was also agreed that their participation would not involve any form of assessment and they are informed of this when they are recruited as actors.

Aims of the task

The aims of doing this was to give the novice trainees an opportunity early on in their training (before they went on to their clinical placements) to: (1) adopt the role of being a service user in a clinical scenario; (2) to experience what it is like to be in the position of a service user; (3) to experience the professional styles and approaches of different clinicians from the position of the same service user; (4) to have the opportunity to reflect on the experience (physically, emotionally, and mentally); (5) to learn from the experience of being a client (therapeutic

relationship, process, and embodiment); and (6) to learn from observing other clinicians' work.

Setting up (scaffolding)

Staff who is responsible for facilitating one of the clinical simulation scenarios is given the task to write a brief outline of their scenario and also to draw up some brief but specific notes for each 'actor' about the service user or carer role that he or she is expected to play. These clinical scenarios are based on suitably anonymised examples from the day-to-day work life of the facilitators. This is a recent example:

> *Sophia (14) has had school-related anxiety since she made the transition to secondary school three years ago. Prior to this she had been attending a small village school and hadn't been offered a place at the secondary school that most of her friends were going to. Sophia has always found it hard to settle into new school classes, often clinging to her parents for the first half term, but her father (James) had worked as a caretaker at her primary school, so knowing he was close helped. Sophia has had some brief input from targeted child mental health services which resulted in her attending school part-time. However, at the start of term a few weeks back she started self-harming to manage her distress and stopped going out other than with huge amounts of preparation, and a lot of predictability. Sophia feels angry about her situation and that she has not been taken seriously. She frequently locks herself in the bathroom and her parents plead with her to come out. They are at a loss as to what to do. Despite her reluctance about attending the meeting with the psychologist, Sophia arrives together with her parents and their respective partners.*

A few days before the event, one of the authors then meets with the first-year trainees to introduce them to the idea of simulation training and to give a brief outline of the specific event that their participation is required for. They are presented with a list of the roles and asked to choose one role that they would be interested to play. Trainees are asked to be mindful not to select roles that they might be uncomfortable with or could potentially be distressing for them to play. Once trainees have all selected a role, they are each given the notes accompanying that role and have a few days to prepare themselves. They are encouraged to wear clothes suitable for the role and to bring along any props that could make the scenario and their experience more realistic.

On the day the trainee 'actors' are briefed that there are no right or wrong way to play their role, and that their performance will not be assessed. Instead, they are encouraged to 'live themselves into their role' to make it as realistic as possible, but also not to make it intentionally difficult for the trainee therapists who will be interviewing them. They are also informed that they will be required to give feedback to the trainee therapists after each simulation exercise has finished and are encouraged to provide constructive feedback in a clear and considerate way. They are reminded that the aim of the feedback is not to provide consultation or supervision, but rather to speak from the position of the service user or carer that they are portraying. They are then introduced to the member of staff facilitating their scenario, who supports them to set up their specific room (station) and to rehearse their scenario a few times.

Being a service user or carer

There are usually four or five different scenarios. Each trainee adopts one acting role within one practice interview scenario, and this role is then acted out three or four times with different trainee therapists (or pairs of co-therapists). Each practice interview lasts for approximately 40 minutes, with the last 15 minutes typically allocated to feedback (including feedback from the actors). All the scenarios are video-recorded for later review by the second-year trainee therapists. Following the simulation practice interviews, the first-year trainees are asked to reflect on their experiences by writing down their reflec-

tions on the day. They are encouraged to note down any emotions, thoughts, physical responses, themes, realisations and understandings for their own personal learning.

Reflecting on being a service user or carer

Within a week a three-hour teaching session takes place where the first-year trainees can reflect on their experience of being a service user or carer. The session is divided into four parts (exercises), interspersed with discussion time in the large group.

Exercise 1 (30 minutes):

To begin, the trainees are asked to reflect in silence for a few minutes by themselves, getting in touch with the emotion(s) that they experienced in their role as a service user or carer during the simulation training. They are then each given an A4 piece of paper and asked to write down the main emotion that they experienced in their role. Once they have done this, they are asked to hold the paper in front of them and walk round the room without speaking. After a few minutes the facilitators ask the trainees to reflect in the large group on the emotions portrayed in the room. The aim here is to reconnect the trainees with their emotions during the exercise, particularly in their roles as service users or carers. They are invited to share with the larger cohort how they have felt in their role and what they have learnt from this experience. Throughout this process the facilitators draw attention to themes arising across the cohort.

Exercise 2 (50 minutes):

The cohort is presented with the descriptions of the scenarios and asked to read them as if they were referral letters. In small groups they are asked to reflect (30min) as a client on (1) What beliefs, views and assumptions about the client are you invited into by this referral? How is this done? (2) What beliefs, views and assumptions about those close to the client are you invited into by this referral? How is this done? (3) What are the potential implications of these invitations (e.g. How might your therapist approach their meeting with you? How might you be inclined to respond to this approach?) The small groups then provide feedback in the large group (20 minutes), with the facilitators drawing attention to themes arising across the groups, inviting the trainees to make links between their and others' observations and to consider any learning points emerging from the discussion.

Exercise 3 (50 minutes):

After a comfort break the trainees are divided into four small groups and each group is invited to discuss one of these four themes: (1) Power, safety and emotional risk-taking; (2) Language and the construction of a service user or carer story; (3) Connections and relationships: the therapeutic relationship and alliances; and (4) The physicality of therapy: space, positions and directions. The facilitators have developed some questions to guide the group discussion around each theme.

For theme 1:

> *In your scenario, how did power play out? Who held the power? How did this change across the scenario(s)? What did that feel like? Did you feel emotionally safe as your character? What contributed to you feeling/not feeling emotionally safe? What did the 'therapist(s)' do to contribute to emotional safety? What would you have wanted them to do? Were you able to take emotional risks as your character? What allowed/did not allow you to take emotional risks? What did the 'therapist(s) do that supported/did not support emotional or relational risk-taking? What would you have wanted them to do?*

For theme 2:

> *What was the experience like to play the same scenario a number of times? How did the same story unfold differently each time? What made the difference? What reflections do you have about these differences? What influence did language have? What difference did it make which questions were asked? Did you find yourself responding differently to similar questions? What made the difference? What did you notice*

about tone of voice, body language, eye contact, and other non-verbal communication?

For theme 3:

How did emotional closeness and distance change in relation to all the people, present or not, from your scenario, including the 'therapist(s)', as the sessions unfolded? What influenced closeness and distance? How did the 'therapist(s)' establish a relationship with you? How was this different between the different times of playing the scenario? What worked for you? What did not work? Whose side was the 'therapist(s)' on? How did you know this? What influence did it have on your character?

For theme 4:

What did it feel like to have the session where you had it (home/office/hospital ward)? What impact did it have on your character? Where did you sit in relation to the 'therapist(s)'? Where did you sit in relation to the other people in your scenario? What impact did this have on your character? Were there differences between the different times you acted out the scenarios? What did you notice about physical distance between people, who you could have eye contact with or not, the direction of chairs, etc.? What was the impact on your character?

As before, each small group provides feedback in the large group (20 minutes), with the facilitators drawing attention to themes arising across the groups and inviting the trainees to make links between their and others' observations and any learning points.

Exercise 4 (30 minutes):

Drawing on the narrative therapy intervention of definitional ceremonies (White, 1997), the final exercise provides an opportunity for each trainee to consider their own learning across the whole experience, and to consider any commitments they wish to make in relation to their own clinical practice going forward. This is facilitated through a narrative therapy informed process whereby each trainee is asked to quietly reflect on and complete the following statements on a certificate: *Following the simulation exercise and reflections I wish to commit myself to the following learning points (with space given for up to three) that I hope to take with me into my life and work as a clinical psychologist.* They are then invited to individually stand up and share these commitments with the wider cohort and facilitators in a way that feels comfortable for them. This often provides a moving and transportative (White, 1997) ending to the session.

Discussion

Overall, we have been struck by the effective way in which this exercise is able to connect trainees in a meaningful way to the experiences of service users and carers, and with a reflective space to consider the implications for their own practice. It powerfully creates awareness of the impact of the choices that we make every day in our clinical practice, including how we write about, talk about, and talk to clients, and how we position ourselves and them. We have also found this exercise to be effective in challenging 'othering', stigmatising, labelling and marginalising practices and in creating a safe space for trainees who have personal experiences of distress within their cohorts. This is particularly important given the research showing the prevalence of psychological distress amongst clinical psychologists and trainees and the deep reluctance to disclose this due to the fear of stigma and discrimination (Grice et al., 2018; Tay et al., 2018).

In facilitating these sessions, it is important to consider potential pitfalls. Firstly, as mentioned before, it is highly likely that there will be trainees in any cohort who bring their own experiences of psychological distress and of accessing therapy to these sessions. Therefore, it is important to create a safe enough space for them and to be mindful of language and interactions throughout. We have also found that trainees are likely to retreat into the role of clinical psychologist and speak from this position (e.g. critiquing what the therapists in the simulation had done). Therefore, facilitators need to work

hard to keep bringing the trainees back to speaking and reflecting from the position of the service user and carer.

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