Diane Gehart, PhD, has been implementing simulation training in her MFT graduate coursework for over two years. Already considered a simulation innovator, Dr. Gehart has moved from using simulation as a fun learning exercise to applying simulation to assessment of skills and competencies. AAMFT recently caught up with Diane to observe “simulation in action.” The experience was exciting, enlightening, and opened a world of potential training possibilities in systemic education and training.

1. **If you can, tell us what your first thoughts were when you initially observed simulation?**
   
   Simulation is a gamechanger. This is going to change everything we do in MFT education.

2. **Into which courses have you integrated simulation? And now that you have incorporated simulation into your coursework, what are the different ways you are using, and can envision using, simulation with students?**
   
   Personally, I have integrated simulation with students’ in-session skills before sending them to the field. This technology has dramatically changed my theory courses to include evaluation of specific clinical skills, as well as academic knowledge.

3. **Let’s talk reality. From an instructor’s viewpoint, how real is the simulator? From a student’s viewpoint? What are some disadvantages of simulation?**
   
   One of the only complaints I have had from students is that the simulator is “too real.” Within 1-2 minutes, everyone in the room relates to the simulation with very real emotions. When working with crisis or trauma cases, we typically have to address secondary trauma issues, which has created important teaching moments for how to handle the difficult emotions therapists often experience after working with crisis and trauma clients.

4. **How do you see simulation differing from peer-to-peer role plays with your students? Compared to typical role plays what are the advantages of simulation?**
   
   There is no comparison. Peer role plays typically have unrealistic clients, and students in the therapist role do not seem to take the experience with the same seriousness as simulation. The closest experience to simulation is live supervision, with the significant difference that as the supervisor/instructor, I can freely focus entirely on the learning experience without having to put client welfare ahead of student learning outcomes. It is a liberating experience for supervisors.

5. **Simulation is dramatically superior to peer role plays, which have very little believability. Compared to hiring actors, simulation is also far more cost effective because five students can experience simulation in an hour with the same client. When using actors, typically only one to two students would go at the same time. Also, simulation actors can play any gender, age, or ethnicity and they can play two people at once, dramatically reducing the cost and increasing the training options, especially for working with diverse clients.**

6. **Can the benefits of simulation work on a scalable level?**
   
   Absolutely. We are working on systematizing the use of simulation across our curriculum, and the students love it.

7. **Is the cost of simulation a realistic expense for a program or an individual therapist?**
   
   At CSUN, we have limited institutional funding for simulation, so we charge each student $25 per two-hour simulation, with a goal of capping the costs at $125 per semester.

8. **Let’s say I want to develop a new and unique simulation for a training. Can you walk me through the basic steps of development to implementation?**
   
   Creating a new simulation takes a few hours. First, the instructor needs to define the specific learning objectives (e.g., conduct a solution-focused therapy session using solution-talk, scaling questions, and exception questions). Next, the instructor writes a client vignette (demographics, presenting problem, and relevant history). Then, more specific content/questions for the session needs to be drafted along with embedded learning events. For example, I include the following embedded learning event for solution-focused simulations: When the therapist asks, “How was your week?” the avatar will respond with a vague answer in the negative “we didn’t fight much this week.” I then grade students on how they work with that answer as a solution-focused therapist.

9. **How do you see simulation possibly influencing the profession through such means as regulation, licensing, and standards/competencies?**
   
   Because this technology is easily standardized, I anticipate it will be increasingly used to measure practitioner skills both in graduate education and eventually in continuing education and licensure. It will be a far superior approach to the current pen-and-paper tests for measuring therapist competency. And, continuing education can finally focus on skill development rather than course instruction and discussion.

10. **Are we entering a new world of systemic training or is this going to be a passing fad?**
    
    I believe this technology will significantly transform how we train future MFTs. The preliminary data we have so far indicate that it is a very effective and efficient form of instruction. Having trained MFTs for nearly a quarter of a century, I strongly believe it going to dramatically reduce the time it takes to produce competent MFTs. I think we may actually get to a place where clinicians may have to log simulation time—particularly with certain clinical populations—much like other professions. It seems the only responsible thing toward which we should aspire.
ABOUT AAMFT AND SIMULATION

The significance of integrating mixed simulation in family therapy training is that mixed simulation radically changes the training unit of focus from the client’s experience of therapy to therapist performance. With live clients, great care is taken to ensure the client is receiving the best possible treatment—at the expense of student learning. With mixed simulation, the client is a non-issue and the focal point is the student—learning and doing. The student receives immediate feedback and correction. Further, a group of students/therapists in training, the entire class is involved in the learning experience—cost effectiveness.

Moving beyond the classroom is applying mixed simulation to continuing education. Regardless of the therapy topic, simulation provides an opportunity for MFTs to engage in skill development and acquisition. Rather than learning about various clinical skills, attendees of a continuing education event can practice and receive feedback based on interactions with avatars and how well the trainee navigated an embedded learning event. Beginning in 2019, AAMFT will be making simulation available to family therapy education and training programs and interest networks.

Simulation is increasingly used in many different professions and training situations: human resources, education, hospitality, flight, and medicine. In other healthcare professions such as nursing, dentistry and medicine/surgical, simulation’s next evolution will be in regulation. Dating back to 2010, simulation-based assessments were being discussed as potentially impacting licensing and certification (Holmbke, Ruzollo, Sachdeva, Rosenberg, & Zhu, 2011). Further, Latel (2010) suggested, “Perhaps, with the adoption of simulation as a standard of training and certification, healthcare systems will be viewed as more accountable and ethical by the population they serve.” With specific regard to mental health, the nursing profession has been using simulation for years to address bias and stigma and encourage empathetic care in training (Brown, 2015). Hitchcock (2017) wrote a piece on simulation for social workers identifying how simulation provides students an opportunity to practice clinical encounters that are unlikely to be presented in a classroom.

Recognizing that simulation will likely be a standard of training in the future, AAMFT is choosing to be proactive and visionary in its adaptation and implementation. Further, as systemic skills become increasingly more sophisticated when used with specialized populations and treatment settings, it will be imperative that training incorporates some form of skill development and acquisition—didactic training will not be adequate.

Although only in its infancy, AAMFT is looking forward to the many dimensions that simulation can play in helping systemically-trained therapists with skill acquisition and competency.

REFERENCES


AAMFT’s simulation at www.aamft.org/simulation.

DEFINITIONS

Mixed Simulation: Merges real and virtual worlds to produce an environment where physical and digital objects coexist and interact in real time, providing a realistic simulation that cannot currently be replicated by purely virtual systems. The simulator uses a combination of artificial intelligence and a live person to allow students a real-life experience without real-life consequences.

Avatar: The projected image of client(s) that is a mix of artificial intelligence and a live person (actor).

Embedded Learning Event: An event within the script the avatar is working from that challenges the trainee to learn a specific clinical technique. The instructor and actor review and rehearse the embedded learning event so that the actor can execute the embedded learning event while in simulation through the avatar.

DATA NOTE

Self-care Apps Added to App Stores

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Note: A large percentage of self-care apps’ revenue is being claimed by just two apps—Calm and Headspace, both of which focus on mindfulness and meditation—casing the top grosser, earning about $1/2 the total revenue in the U.S. and worldwide, equating to roughly $4 million in the U.S. and $12.5 million worldwide. Combined with Headspace, the two generated more than 30% of the top 10 apps’ revenue last quarter.

You can learn more about AAMFT’s simulation at www.aamft.org/simulation.