

JOINING FORCES



Joining Families

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REAL WORLD RESEARCH FOR FAMILY ADVOCACY PROGRAMS

FEATURED INTERVIEW

Using Standardized Clients for Problem Assessment An Interview with Lee Badger, MSW, PhD, by John H. Newby, MSW, PhD

Lee W. Badger, MSW, PhD

Lee W. Badger is the Nicholas J. Langenfeld Chair in Social Research at the Graduate School of Social Service at Fordham University, New York City. For over twenty years, she has focused on the recognition and treatment of mental disorders, particularly depression, and the develop-

ment and testing of psychosocial interventions in primary care. Her recent focus is on the patterns, types and consequences of intimate partner violence, especially within the United States Army. An author of over 40 articles and book chapters, she has received research support from the National Institute of Mental Health, the John D. and Catherine T. MacArthur Foundation, and the United States Department of Education.



In This Issue

New areas of training, assessment, and practice are emerging trends in family advocacy research and practice. This issue of *Joining Forces Joining Families* introduces these topics through two expert interviews. The first is with Lee Badger, PhD, MSW, of the Fordham University Graduate School of Social Service, New York City. Dr. Badger describes her experience using standardized clients (SCs) for training and evaluation of the assessment process in domestic violence. SCs are individuals who role-play a domestic violence victim to help in the development of education and research programs. Building Bridges to Research elaborates on the statistical requirements of research using SCs. Our second interview is with Kathleen Kendall-Tackett, PhD, of the Family Research Laboratory, University of New Hampshire who discusses emerging issues of practice from her new book, *Intimate Partner Violence*. Websites of Interest provides online resources for learning more about SC use and implications. Lastly, we welcome LTC Ben Clark, Sr., MSW, PhD, Department of the Army Family Advocacy Program Manager, to the editorial staff of *Joining Forces Joining Families*. We look forward to his contributions to this newsletter.

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JN: What led you to study standardized clients (SCs)?

Dr. Badger: When I became a member of the faculty of a medical school, I saw SCs enacting an astonishing range of roles with multiple signs, symptoms, and behaviors. I also saw the possibility of their use in research. My first project was an investigation of physicians' assessment skills in the recognition and management of depression in primary care settings (Badger et al., 1994a, b). In this study, a panel of six SCs, each with a different presentation and level of depression, were presented to about 50 primary care physicians. Although detection was related to a greater amount of information gathered, inquiry about the DSM-III-R symptoms was generally low, and in no case was sufficient information acquired to make a formal DSM-III-R diagnosis of depression. The findings suggested that the detection of depression by primary care physicians was low.

I was later approached by a group at Dartmouth Medical School to participate in a study that used undisclosed SCs to study the recognition and management of depression in primary care. Most recently, with a colleague at a school

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of social work in a study funded by the Fund for the Advancement of Post Secondary Education in the U.S. Department of Education, I applied SC methodology to the teaching of social work practice to MSW students.

JN: What do we know about the reliability and validity of SCs?

Dr. Badger: The reliability and validity of SCs are dependent on the accuracy of the case scenarios (validity) and the consistency with which the SC enacts the scenario (reliability). [Editor's note: See "Statistical Concepts in the Evaluation of Clinical Competence Using Standardized Clients" in this edition of JFJF for a discussion of reliability and validity as applied to research involving SCs.] The case scenario is the scripted narrative to be enacted. The signs and symptoms must be consistent with each other and with the disorder or problem that is being portrayed. The only way to ensure this internal validity is to select real cases. If the narrative is based on a real case, it cannot be argued that the signs and symptoms are incompatible or that the narrative has conflicting components. Reliability is also performance-related. The SC should enact the role as scripted every time in exactly the same way.

You have to decide whether you want to illustrate a case of the greatest prevalence, if you want to portray a case that is atypical, or if you want to illustrate specific risk factors.

JN: How do you train SCs?

Dr. Badger: The training of SCs is very straightforward. Coaching generally involves three people: the coach (or researcher or teacher) who is in charge of the project, the SC, and the clinician who nominated the actual case for use as an SC role. Only the clinician knows the actual behavior, tone, and affect of the client that is to be portrayed.

JN: Are there specific steps to structure case scenarios and prepare SCs for portraying their roles?

Dr. Badger: The most important thing is to be absolutely clear about the purpose of the simulation. You have to decide whether you want to illustrate a case of the greatest prevalence, if you want to portray a case that is atypical, or if you want to illustrate specific risk factors. After you are absolutely clear about the research or educational objectives and what kind of case you want to develop, you will ask clinicians to nominate cases. The next step is to develop the SC narrative from the agency or medical record, including all facts relative to the assessment and treatment. The narrative should contain a detailed social history, psychiatric and medical history, current symptoms, physical signs and anything that might be relevant to the assessment and to your educational or research purpose. Finally, use the narrative to write the SC script. It should contain a list of positive and negative cues, all extracted from the narrative, to provide the SC with guidelines for responding to questions. Other than the opening statement, SC roles are usually not verbatim scripted. If there are parts you want to script verbatim, these must be carefully crafted to sound true to the role. You want the SC to be natural in making comments. You do not want to over-script them.

JN: What are your thoughts about using professional versus non-professional actors?

Dr. Badger: I am very much in favor of using individuals who are not professional actors. I have used actors in the past and, while they are very good at learning the roles, most actors are trained to project from a stage. When you put them in a situation that would be equivalent to a therapist making an assessment, they overact. They do not seem natural; they appear to be acting. I have used professional actors on a couple of occasions for student evaluation, but I was not satisfied with them. I have used well over 40 ordinary community people in one

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Building Bridges to Research: Statistical Concepts in the Evaluation of Clinical Competence Using Standardized Clients

By James E. McCarroll, PhD

Measures of student and standardized client performance have been developed, but there is little consensus on the merit of these measures due to the complexity of the concepts, costs, and different clinical situations.

The interview with Dr. Badger in this issue of JFJF introduces the use of standardized clients (SCs) to improve clinical competence. This article will discuss the evaluation of programs using SCs.

Measures of student and standardized client performance have been developed, but there is little consensus on the merit of these measures due to the complexity of the concepts, costs, and different clinical situations.

SCs are used in both training and testing environments. The testing environments can range from examining students at various levels of training to “high stakes” evaluations such as admission to advanced training programs in medicine and licensure.

The psychometric issues required in using SCs are the same as in the development of other tests. These are reliability, validity, scoring, cut-off points, and standard setting. However, the picture becomes more complicated when using SCs because one may measure both the SC and the trainee or examinee. We will outline some of these psychometric issues.

Reliability. Reliability is the consistency of measurement. For example, a measure is reliable if a similar outcome is obtained when the measures are taken a second time under the same circumstances. [Editor’s note: See JFJF Vol. 9, No. 1, and Vol. 10, No. 1, for a further description of reliability, validity, and other concepts of test measurement in family violence assessment. Also, see Everitt, 2006.] The reliability of the SCs’ performance is the consistency with which they enact their role. Reliability can also be applied across SCs in which different SCs enact the same role with similar fidelity. When SCs rate the student’s performance using a checklist, the reliability of their judgments on a variety of tasks and interpersonal skills of the trainees can also be computed. Reliability of measures of the students refers to the consistency with which the students are ranked by their test scores if they were given a similar examination using a

different sample of cases (Vu et al., 1992). Reliability of student performance may not always be high because competence in a field may be relatively specific (e.g., for one type of case) and not generalizable (Vu & Barrows, 1994).

Finally, the consistency with which several judges evaluate the students (their inter-rater reliability) can be computed.

Validity. Validity refers to the fact that what is being measured accurately

reflects the concept that is sought. Validity is a much more difficult concept to apply in evaluations using SCs. Research has focused on standard psychometric measures of validity: *content, construct, and criterion validity*. With SCs *content* validity refers to the extent to which the case scenario enacted is a fair representation of the content of the cases to be tested (Vu et al, 1992) or to the skills shown by the clinician interviewing the SC. The latter is a skills evaluation in which the interviewer is judged on how well the essential elements of an examination are covered by the trainee in the performance with the SC. In other words, the validity of the exam is assessed by the degree to which the measure of a student’s skills accurately assesses the agreed-upon skills.

Construct validity refers to whether the measure being used accurately reflects the concept that it is meant to measure. In other words, what are the constructs that underlie the clinical skills demonstrated in the interview of an SC, and are they consistent across examinations (Vu et al., 1992). Analyses of the skills assessed across different clinical tasks have identified two separate factors: cognitive (data gathering and other examination skills) and non-cognitive factors (communication and other interpersonal skills).

Criterion validity for performing SC assessments means that the student’s assessment of the SC should be related to valid and accepted standards. In the absence of a “gold standard” such a criterion is difficult to establish. Student

The psychometric issues required in using SCs are the same as in the development of other tests.

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The true value of a standard is its ability to discriminate between those persons who are competent and those who are not.

assessments are often measured by surveying trainee supervisors. [Editor's note: See JFJF Volume 8, No. 1 for a definition and more discussion of the term gold standard. Briefly, the term gold standard denotes the highest possible level of value. A gold standard test is not infallible, just the best that is known. Unfortunately, applicable gold standards in medical practice are rare.]

Standards. In this case, a standard is a set point at which a trainee receives a pass or fail score for their performance on the assessment of an SC. Several approaches have been tried as a means to arrive at decisions (Howley, 2004). The purpose of setting standards is to support reliable decisions about the clinical performance of examinees. Ultimately, the standards have to be validated. This is an area in which there has been little research (Boulet, De Champlain, & McKinley, 2003). The true value of a standard is its ability to discriminate between those persons who are competent and those who are not. In high stakes situations, the standards are more likely to be absolute or criterion-referenced as opposed to relative standards. When the stakes are low, as early in training programs, assessment is used primarily for training and remediation. If the standard is too low, unqualified people are likely to pass. If it is too high, then programs and the

public are deprived of persons who could fulfill a need.

In considering SCs we have reviewed the concepts of reliability, validity, and standards. The use of SCs as an educational tool, like all new educational programs, requires assessment and evaluation to determine their effectiveness.

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Welcome LTC Ben Clark, Sr., MSW, PhD, Department of the Army Family Advocacy Program Manager, to the Editorial Staff of Joining Forces Joining Families

LTC Clark is the Deputy Director, Family Programs, and DA Family Advocacy Program Manager, US Army Family Morale Welfare and Recreation Command. LTC Clark has 28 years of military service in the Army and Air Force. His previous Army assignments include the Tripler Army Medical Center, Hawaii; Brooke Army Medical Center, Ft. Sam Houston, TX; 1st Cavalry Division, Ft. Hood, TX; and the 2nd Infantry Division, Korea.

LTC Clark holds a PhD in Social Psychology from Cambridge International University, Hallandale, FL, a Master of Social Work degree from Our Lady of the Lake University in San

Antonio, Texas, and a Bachelor of Arts degree from Northeast Louisiana State University. His Military schools include the Individual Leadership Education and the Combined Arms and Staff Services from the Army's Command General Staff College.

LTC Clark has received the Army Meritorious Service Medal, the Army Commendation Medal, and the Air Force Commendation Award. He is listed in the Who's Who of American Men. LTC Clark is a member of the NASW Academy of Certified Social Workers (ACSW), is Board Certified Diplomat in Clinical Social Work, and is a Licensed Clinical Social Worker.

Trends in Interpersonal Violence (IPV)

An Interview with Kathleen Kendall-Tackett, PhD

By James E. McCarroll, PhD



Kathleen Kendall-Tackett, PhD

Dr. Kendall-Tackett is a health psychologist and Fellow of the American Psychological Association in both health and trauma psychology. She is a Research Associate Professor of Psychology at the Family Research Lab and Crimes against Children Research Center, University of New Hampshire. She also serves on the editorial boards of *Child Abuse & Neglect* and the *Journal of Child Sexual Abuse*. Dr. Kendall-Tackett edits the *Trauma and Health* column for *Trauma Psychology*, and is author and editor of more than 150 articles, book chapters and other publications, and 15 books. Visit her website at www.GraniteScientific.com to learn more about her work.

Dr. Kendall-Tackett is co-editor of an important new book, *Intimate Partner Violence*.

Visit <http://www.civresearchinstitute.com/ipv.html> to learn about its contents and contributors.

JEM: Drawing upon your new and comprehensive book, what should we know about the mental health effects of IPV?

Dr. Kendall-Tackett: In our new volume, we have a section on leaving abusive relationships. What struck me about this area was how long it took people to recover from living in an abusive relationship. Women have elevated levels of depression and PTSD even a year or longer after they leave. Women leaving relationships may be substantially poorer and they may be trying to balance multiple harms. For example, they may decide that staying in an abusive relationship is less risky than becoming homeless with their children.

JEM: What is new in the way risk assessment is being approached?

Dr. Kendall-Tackett: There has been much more empirical work on risk assessment in recent years. For example, lethality is much more systematically approached than in the past. The development and validation of measures has improved over past practices, which tended to be based on what people thought would work.

JEM: What do we know about women's violence?

Dr. Kendall-Tackett: Importantly, women can be violent, but the extent and type of women's violence is argued. You may see similar rates of women committing violence, but often it is in self-defense and it tends not to be as physically injurious as violence perpetrated by men.

JEM: What have been the trends on the use of evidence-based interventions?

Dr. Kendall-Tackett: Practice is moving much more toward an evidence-based model. I think this is a good trend, but I think that sometimes we can be so evidence-based that we miss something really obvious right in front of us. The evidence is only as good as the questions we ask.

JEM: Do strength and resiliency factors add to our knowledge?

Dr. Kendall-Tackett: Many of our domestic violence models are based on a pathology approach to women in these relationships. A structured coping model may be better. Often the women are trying to balance multiple possible harms. We need to acknowledge the fact that there is some coping going on, but it may not be in the form that we are used to seeing or think is the best. Instead of focusing on "Can't this woman cope?" we need to find out why she is staying in that relationship and what are the resources we can bring to help her. Maybe she realistically knows that if she leaves this relationship she is going to be killed. Overall, she may have some positive feelings about the relationship, but just want the abuse to end.

JEM: Are the legal issues changing?

Dr. Kendall-Tackett: It is not clear that mandated arrest is a good idea. The consensus seems to be that this is not necessarily an effective policy, and can be punishing to women. Not only does mandatory arrest increase the likelihood of possible physical reprisals once the perpetrator is out of jail, but many women feel re-victimized by the system. It also does

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Women leaving relationships may be substantially poorer and they may be trying to balance multiple harms. For example, they may decide that staying in an abusive relationship is less risky than becoming homeless with their children.

Dr. Kendall-Tackett Interview, from page 5

not allow the woman's input into the decision. Sometimes these policies backfire and reinforce the powerlessness that some victims feel.

JEM: So, the solution is not exactly clear, but at least to keep the woman's point of view in mind instead of making decisions for her?

Dr. Kendall-Tackett: Yes, there is still some debate about how to put this into practice. An example is mandatory screening. I am hesitant about mandatory screening, at least in health care settings, mainly because we cannot be sure of the qualifications of the people who are doing it. It can increase the danger for women if done poorly (e.g., within earshot of the perpetrator). But screening is also an area where we can empower women. It is important to take into account *women's* assessment of their risk. Women are actually pretty accurate in their assessments about the danger they are in. We need to give the women the *freedom* to disclose in health care settings.

Another problem in health care settings is what screeners are to do with the information. Are you going to expose her to some potential danger by asking if she is being abused or if she feels safe in her own home when you do not have a plan in place to protect her? Medical personnel will not screen if they do not have some place to refer the clients. This should be considered when an institution entertains plans for mandatory screening.

JEM: What about the effects of adverse childhood experiences (ACEs)?

Dr. Kendall-Tackett: The concept of ACEs,

rather than focusing on a single type of abuse, allows you to branch out into a broader framework in considering the effects of maltreatment on children. One type of ACE is parental mental illness, including depression. Depression impairs parenting and one possible consequence is child neglect. Studies on maternal depression show that disengaging from their children is one possible response.

JEM: What do you see developing in terms of the intersection of child and spouse abuse?

Dr. Kendall-Tackett: The biggest development is that the child abuse and domestic violence communities are talking to each other. I think for a long time they have been very separate. Child protective services are developing policies in cases where there is IPV. In the past, these communities were suspicious of each other because of coming from different frameworks, but that is starting to change and people see the overlap in protecting women and protecting children.

JEM: What do we know about long-term health effects associated with maltreatment?

Dr. Kendall-Tackett: We have learned that abuse survivors have higher rates of heart disease, diabetes and other diseases. There is a lot of evidence from the immunology field that having been exposed to a traumatic event or experience, the immune system is primed to respond to ensuing, stressful situations. This has been linked to heart disease, diabetes, and even cancer. Depression and hostility also activate the immune response. These health effects can continue long after the abuse has ended.

JEM: Where do you think the field is going? What do you think is the direction for the next 20 years of research?

Dr. Kendall-Tackett: I think what we are probably going to see is more intervention studies, particularly in health care settings. I think we will also look more at the physical health effects—not only those related to current injuries, but the long-term health effects. I think we are going to have more complex, but realistic models of the victim's experience by looking at both negative outcomes and resilience factors. And I think we will see more evidence-based interventions.

JEM: Thank you

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The biggest development is that the child abuse and domestic violence communities are talking to each other.

Did You Know?

- A recent study on screening for IPV in health care settings found that women preferred self-completed approaches over face-to-face questioning (MacMillan et al., 2006).
- The risk for anxiety disorders, major depression, and substance dependence were found to be three times as high in the offspring of depressed parents as in the non-depressed parents (Weissman et al., 2006).
- Adverse childhood experiences, including child abuse and neglect and household dysfunction, seem to begin to affect a child's health even early in a child's life (Flaherty et al., 2006).
- A recent study found that posttraumatic stress disorder was significantly associated with vascular, musculoskeletal, and dermatological problems (Dirkzwager, van der Velden, Grievink, & Yzermans, 2007).

Websites of Interest

The use of standardized clients and patients has become well established in medical and legal training:

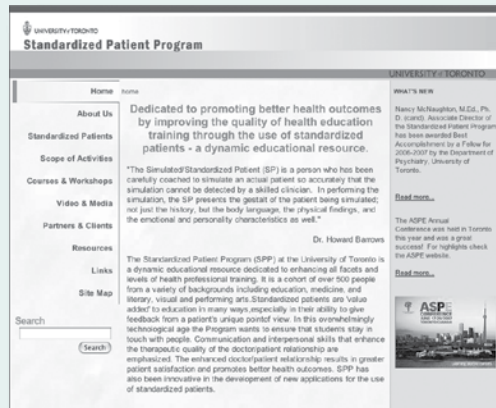


■ The Southern Illinois University School of Medicine (where Barrows conducted his original “programmed patients” work) provides a page on standardized patients (http://edaff.siumed.edu/html/standardized_patients.htm) describing their use in the medical curriculum.



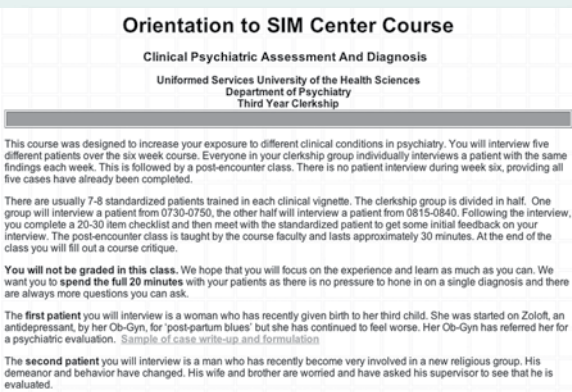
■ The Vanderbilt University Medical School website describes their Center for Experiential Learning and Assessment <http://www.mc.vanderbilt.edu/medschool/otlm/cela.php> and the benefits of simulation for medical education. Their simulations are used in a variety of fields including other health care workers, the media, and politicians.

■ The University of Toronto (<http://spp.utoronto.ca/index.php>) provides a wide range of standardized patient training and research in medicine and other fields such as pharmacy and physiotherapy, faculty development, and dispute resolution. They offer a range of educational curricula including workshops, presentations, and peer-reviewed publications. Browsing their list of topics provides a glimpse of the potential of standardized patients to enhance learning in a wide variety of topics and patient care and professional development.



■ The Georgia State University College of Law (<http://law.gsu.edu/Communication/>) website describes their pilot project using simulated clients to assess lawyer performance in the initial client interview whose goals are similar to those in a first interview in social science fields: it shapes client perception of the person conducting the interview and defines the problem and goal of the service to be provided.

■ Uniformed Services University of the Health Sciences (USUHS, the military medical school) also uses standardized patients. A description of its simulation center (Sim Center) is given at <http://simcen.usuhs.mil/>. The goals of the program for clinical psychiatric assessment and diagnosis using the Sim Center are described at http://cim.usuhs.mil/ps03001/sim_center_goals.htm and at http://cim.usuhs.mil/ps03001/sim_center_%20orientation.htm. The objectives for the USUHS medical students are to identify, through clinical assessment, the typical signs and symptoms of common psychiatric disorders as major depression, bipolar disorder, dementia, schizophrenia, and substance use disorders and develop a treatment plan. Simulated patients are also used extensively in field training exercises.



Dr. Lee Badger Interview, from page 2

project or another and they are remarkable in terms of how well they can take on a role and play another person for a day.

JN: What are the differences between role-play scenarios or other experiential instructional techniques, and using SCs?

Dr. Badger: Role-play is a very old tradition. It has been used with some success for students in developing and rehearsing their skills in the presumed safety of the classroom. However, in contrast to SC methodology, role-play really lacks authenticity and internal validity and has additional educational disadvantages. There are lots of methods of using role-play, but usually students enact roles about which they know little or nothing. Very often they do not have any of the background or experience to understand situations from the client's perspective. Even worse, they may disclose personal information that they might later regret.

JN: Would you comment on your current Army Family Advocacy Research with Dr. Mary Ann Forgey, who is also from the Graduate School of Social Service at Fordham University?

Dr. Badger: The purpose of our study is to develop and evaluate the effectiveness of a training curriculum in evidence-based spouse abuse assessment and intervention planning using SC training and evaluation methodology. The effectiveness of the curriculum will be judged by the extent to which the training program leads to the accurate identification of violence patterns, risk factors, and the development of assessment-driven differential intervention plans.

JN: How will that research improve assessments?

Dr. Badger: SCs will be useful because we want to make assessment and intervention curricula evidence-based. We searched the literature and identified risk factors and the patterns and types of abuse. We can now present SC cases that will best illustrate the empirically supported risk factors, consequences, and patterns of abuse. Through the use of SCs, we will be able to control what we present to trainees in a way that we could not using either role-play or real clients. Our purpose is to make this curriculum portable so that it can be used at any installation that would like to benefit from it. At this point we will pilot test it at Fort Bragg. During the late summer of 2007, we will recruit, coach and train our SCs before testing the effectiveness of our curriculum.

JN: Other important aspects?

Dr. Badger: SCs can simulate client-clinician interaction with a high degree of realism. SCs eliminate the threat to students or trainees of unintended personal disclosures that happen when they are asked to enact therapist and client roles. SCs can be incorporated into a wide range of curricular areas, such as assessment of mental health issues, services to children, and intimate partner violence. Very importantly, SCs offer the researcher or the instructor control over the appearance, be-

havior, and content of teaching cases. SCs can ensure diversity among racial, ethnic, age, gender, religious, sexual orientation, and socio-economic groups, and have a level of control that you cannot possibly have in using role-play only.

Another advantage of using SCs is that when the simulation is over you can ask them about their sense of the interaction and get their feedback. It gives the therapist in training an enormous advantage to get all of this feedback. The use of SCs is highly acceptable to students and trainees as a teaching tool.

JN: Thank you Dr. Badger. We look forward to your research involving the use of SC in the assessment and planning of interventions for interpersonal violence that occurs in the Army.

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