

## COMPETENCY-BASED TRAINING: OBJECTIVE STRUCTURED CLINICAL EXERCISES (OSCE) IN MARRIAGE AND FAMILY THERAPY

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*The field of marriage and family therapy (MFT) has recently engaged in the process of defining core competencies for the profession. Many MFT training programs are adapting their curriculum to develop more competency-based training strategies. The Objective Structured Clinical Examination (OSCE) is widely used in the medical profession to assess clinical competence. These examinations involve using simulated clinical situations as a tool in conducting summative evaluations of trainee competence. This article describes an adaptation of the OSCE procedures for competency-based training of MFT students. Instead of using the procedures as a summative examination as is typical in medical education, this article proposes how to use them as formative exercises in the development of student competence. The development of the OSCE is discussed, including "blueprinting," focused competencies, procedures, and feedback protocols. The article concludes with suggestions of how to continue the development of the OSCE for evaluation in MFT education.*

### CORE COMPETENCY ORIENTATION IN MARRIAGE AND FAMILY THERAPY

There is a growing movement to define and effectively evaluate clinical competency (Miller, Todahl, & Platt, in press; Nelson et al., 2007). Great strides have been made toward articulating what constitutes core competencies in marriage and family therapy (MFT). Nelson et al. (2007) provide a detailed description of the development of MFT core competencies and how assessment of these competencies can promote the quality of service provided by marriage and family therapists. The competencies were developed to address several issues facing the profession of MFT. These issues include the increasing numbers of MFTs practicing in the United States, the impact of managed care limiting access to services (sometimes based on arbitrary evaluations of who was most competent to provide these services), and the impact of these competency evaluations on vendorship and other reimbursement legislation (Miller et al., in press).

In 2006, the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) implemented Version 11.0 of its Accreditation Standards (COAMFTE, 2006). One of the most notable differences in this version involves the incorporation of the core competencies and the shift in orientation from an input- to an output-based system. Input-based systems consider the educational and training experiences required of the student (i.e., curriculum, minimum client contact, etc.) when determining competencies. Output-based systems evaluate effectiveness by defining the outcomes expected from a competent therapist, guided by the core competency standards (Nelson et al., 2007). While the objective structured clinical examination (OSCE) has a wide acceptance as a summative assessment tool, especially in the medical field, it has only recently been introduced into MFT training as a tool for assessment of

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students (AAMFT Beta Test Group, 2006; Lesser-Bruun, Platt, Miller, & Todahl, 2005; Miller, Todahl, & Linville, 2007). Using the OSCE format described in medical training literature as a guide, this article details one method of developing OSCEs for use in training MFT students. One main difference is that this adaptation proposes using the OSCE format as a formative *exercise* instead of as a summative evaluation.

## THE OBJECTIVE STRUCTURED CLINICAL EXAMINATION

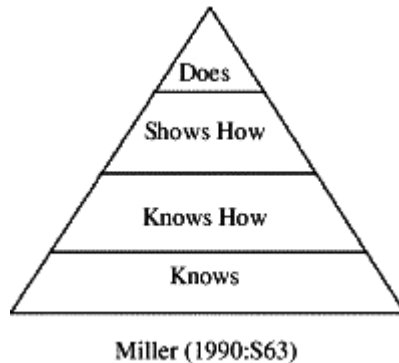
The OSCE, first described by Harden et al. in 1975, was designed to assess the clinical skills and competence of final-year medical students (Harden, Stevenson, Downie, & Wilson, 1975). Prior to this widely accepted mode of evaluation of medical students, competency was evaluated by observing their clinical intervention with a small number of real patients. Harden et al. (1975) felt this process yielded the risk of assessor bias, adversely affecting validity and reliability of the assessment. The OSCE was designed to address these issues.

The intent of the OSCE when it was first developed was to evaluate students under simulated, yet realistic and standardized conditions. The OSCE offers students the opportunity to demonstrate their competency under a variety of situations (Watson, Stimpson, Topping, & Porock, 2002). The original OSCE involved a series of 16 stations, each 5–30 min in duration. The OSCE format was designed so that students rotate through the series of stations, each station containing a mock clinical situation with a defined task the student was to complete. Students moved between stations at timed intervals, with each station involving a “standardized patient” (actors who have been specially trained to portray patients with specific medical conditions). Trained examiners stayed with each station throughout the session; thus, each student was examined by 16 different examiners. Students were assessed using standardized binary content checklists and global process rating scales (Harden & Gleeson, 1979; Harden et al., 1975).

Medical schools are increasingly relying on OSCEs as a method to evaluate their medical students’ clinical and communication skills (Humphris & Kaney, 2001). As OSCEs are becoming the method of medical licensure examinations in North America, Canada, Australia, the United Kingdom, and New Zealand, other health care professions are implementing OSCEs into their training (Reznick et al., 1998). By the mid-1990s, the use of OSCEs had spread beyond medical education to other health care professions, including dentistry (Schoonheim-Klein, Walmsely, Habets, Van der Velden, & Manogue, 2005; Zartman, McWhorter, Seale, & Boone, 2002), nursing (Alinier, 2003; McKnight et al., 1987; Ross et al., 1988), pharmacy (Austin, O’Byrne, Pugsley, & Munoz, 2003; Cerveny, Knapp, DelSignore, Carson, & Bultemeier, 1999), physiotherapy (McIlroy, 2000; Nayer, 1993; Wessel, Williams, Finch, & Gemus, 2003), podiatry (Woodburn & Sutcliffe, 1996), and radiology (Marshall & Harris, 2000; Williamson et al., 2002). These applied health professional fields have made their own adaptations to the OSCE to better evaluate the unique skills and competencies targeted for each student group.

## CONCEPTUALIZING COMPETENCE EXERCISES USING THE OSCE FORMAT

A useful construct for the assessment of competence using OSCEs is Miller’s (1990) pyramid of clinical competence (see Figure 1). In this conceptualization, the base of the pyramid consists of factual knowledge. The base level can be generally understood as competence gained by reading and studying didactic materials. One level up, the “knows how” level represents the ability to use knowledge in a particular context (i.e., applied knowledge). At a higher level, “shows how” reflects the person’s ability to act appropriately in a practical situation and describes hands-on performance in a simulated or practice situation. The “does” level refers to actual clinical work in habitual practice (Van der Vleuten, 2000). To demonstrate *clinical* competence, assessment at “shows how” and “does” levels becomes more important, but also more challenging.



*Figure 1.* Miller's pyramid of clinical competence.

Traditional modes of assessment such as written tests, essays, and multiple-choice questions are highly effective for testing “knows” (factual recall) and “knows how” (applied knowledge). Oral examinations, which do not include observations of clinical practice, also assess competence at the “knows” and “knows how” levels. While written and oral components of exams can effectively assess for factual knowledge and understanding, their uses for assessing the “shows how” level of evaluation are limited. Observations by examiners of clinicians interviewing clients and performing therapy can target the “shows how” layer of clinical competence. The original medical OSCE was designed as a tool to minimize the subjectivity and rater bias of these types of assessments while also increasing the validity of the assessment.

Assessing clinical skill and competence at the “shows how” and “does” levels requires more sophisticated methods of evaluation. The OSCE provides a standardized way of assessing clinical competence at the “shows how” level of the pyramid. Assessment of the highest level of clinical competence, the “does” level, involves evaluating the clinical performance in everyday practice. This might involve a clinical supervisor who judges the clinician’s general competence via live or videotaped supervision. The challenge many clinical training programs face is the development of training strategies to address the “shows how” level of competency. How do programs ensure that their trainees are able to “show how” they competently deal with typical clinical situations before they actually begin clinical practice? How will trainers confirm that their students can deal with specialized but common clinical dilemmas (i.e., suicidal clients, diffusing chaotic family interactions, and assessing for domestic violence) before the interns face those problems in actual practice? This adaptation of the OSCE format, focusing on its use as clinical exercises, offers one important resource to address these questions.

### ADAPTING THE OSCE FOR THE FIELD OF MARRIAGE AND FAMILY THERAPY

While OSCEs are in common use in many medical disciplines, currently, there is no known literature regarding the use of OSCEs in MFT education. Adapting the OSCE for MFT education involves a modification from the traditional summative “examination” format to its use as a formative exercise. When used as a summative evaluation, the primary goal of the OSCE is to provide an assessment of the students’ performance at the conclusion of their studies. As a formative exercise, the OSCE can provide a source of corrective (formative) feedback for the students earlier in their educational career, while there is still time to adapt to the feedback. In this way, the OSCE format can become both a method of teaching and a vehicle to provide students feedback from the instructor. The field of MFT has traditionally utilized role-play

exercises in training to demonstrate ideas, techniques, and interventions (Hodgson, Lamson, & Feldhausen, 2007). The main advantage of this technique is that it brings the focus of teaching and learning to the “shows how” level of Miller’s pyramid of clinical competency (Miller, 1990). In the proposed modification of this well-utilized modality of teaching, the clinical simulation within the MFT OSCE is more structured and intentional, targeting specific core competencies. Trainees are aware of the targeted competencies involved, yet are free to choose their own way to accomplish the tasks of the session (or station). One dilemma of the core competency orientation is that with an overly rigid application, it does not easily allow for creative or novel methods (Miller et al., in press). This adaptation of the OSCE allows for *equifinality*, a concept which states that many different origins can lead to the same results (Bertalanffy, 1968). The pressure and stress of the OSCE is hopefully lessened when used as a formative versus summative assessment of students. Student stress is often discussed as one of the main limitations of the OSCE (Bartfay, Rombough, Howse, & LeBlance, 2004; Coleman, Watson, Norman, Redfern, & Murrels, 2002). A final reason for the proposed modification of the OSCE to an exercise versus exam is the call from the field of MFT to provide new training and evaluation techniques that match the shifting orientation to core competency-based education. The core competency, output-based orientation requires training programs to identify the “outputs” in measurable, definable terms. This modified OSCE format is ideally suited to accomplish this. The following section provides a brief outline for developing MFT OSCEs as a formative exercise and evaluation tool versus a summative examination, as it has traditionally been used in the medical profession.

#### *Objective Structured Clinical Examination Blueprinting*

Variations of the OSCE have been incorporated into the training curricula of many health professions. Although there is great diversity with regard to the ways professions develop OSCE training protocols, almost all begin by developing a “blueprint” of the process. A “blueprint,” in this sense, is a template used to guide the development of OSCE stations to ensure tasks and problems depicted in simulations are relevant to competencies being measured (Austin et al., 2003). The OSCE blueprint is used to outline the parameters of the exam, evaluation, or exercise: content areas (or core competencies), knowledge, skills and attitudes, station type, and length (Hodges, Hanson, McNaughton, & Regehr, 2002). The first step is to first identify the core competencies to be focused on during the exercise, then define the specific actions students are to accomplish to demonstrate the identified core competencies.

The field of MFT has currently identified 128 core competencies, which are organized around six primary domains and five subdomains (American Association for Marriage and Family Therapy, 2004; Nelson et al., 2007). The primary domains are as follows: admission to treatment; clinical assessment and diagnosis; treatment planning and case management; therapeutic intervention; legal issues, ethics, and standards; and research and program evaluation. The subdomains are focused on types of skills or knowledge that MFTs must develop: conceptual, perceptual, executive, evaluative, and professional. Noteworthy is that the OSCE primarily targets the *executive* subdomain of core competencies. The *executive* skills are those skills that relate to what MFTs do (i.e., the behaviors, actions, and interventions performed during the therapeutic process; Nelson et al., 2007). Table 1 shows an example of one possible blueprint for the content areas of MFT core competencies with corresponding “stations,” core competency domains and subdomains, tasks, and station length. In this sample blueprint, the primary domain of “research and program evaluation” of the MFT core competencies has been left out because the corresponding competencies do not lend themselves to an OSCE modality of evaluation.

The *task* as described in Table 1 addresses the specific core competencies to be evaluated. Thus, consistent with an output-based model, instructors are interested in assessing whether students demonstrated core competencies, while also allowing students more latitude regarding how they meet the competencies.

Table 1 <i>A Sample OSCE Blueprint Template</i>					
Scenario element	Station 1	Station 2	Station 3	Station 4	Station 5
Core competency domain	Admission to treatment—executive	Clinical assessment and diagnosis—executive	Treatment planning and case management—executive	Therapeutic intervention—executive	Legal issues, ethics, and standards—executive
Task	1.3.3—Facilitate therapeutic involvement of all necessary participants in treatment	2.3.3—Apply effective and systemic interviewing techniques and strategies	3.3.1—Develop, with client input, measurable outcomes, treatment goals, treatment plans, and aftercare plans with clients utilizing a systemic perspective	4.3.7—Defuse intense and chaotic situations to enhance the safety of all participants	5.3.4—Develop safety plans for clients who present with potential self-harm, suicide, abuse, or violence
Length (min)	15	20	30	20	25

In determining the *station length*, the major factors to consider are the congruence of the station length with actual practice, the desired time frame of the entire OSCE administration, and the number of stations to be included in the OSCE. Very short stations of 5 min or less do not generally permit a complete assessment and therefore require students to be directed to one part of the interaction (Hodges et al., 2002). Stations of 15–30 min are long enough to evaluate a complete assessment of a competency and short enough to allow the use of many different scenarios. Hodges et al. (2002) suggest that stations of this length are easier to administer and require fewer instructions.

### *Creating OSCE Stations and Scenarios*

The best OSCE stations are created from real clinical cases and scenarios (Hodges et al., 2002). With this in mind, a bank of stations can be created from scenarios most common in therapy sessions. Scenarios also should be easily portrayed and tasks associated with the scenarios accomplishable within the constraints of the time limit of the station. In the OSCE literature, station length has been described as ranging from less than 4 min to over an hour. There are two main aspects to consider when determining the station length. The first consideration is the congruence of station length to the typical length of similar clinical assessments or interventions with actual practice. The second consideration is the overall length allotted for the exercise. Scenarios can be tailored to match the specific culture and ethos of the local clinical service delivery patterns. Each scenario of the OSCE can focus on one of the five primary domains of MFT core competencies (not including the research and program evaluation domain), and the tasks associated with each station can target *some or all* of the executive subdomains of the particular primary domain. Examples of five MFT OSCE stations are provided in Figure 2. Each station describes a brief therapy vignette, the core competency domain it was designed to fit, and the specific competency task that corresponds with the station.

### *Measurement Instruments*

Objective structured clinical examinations in the medical profession use measurement instruments which break down behaviors or actions into a series of discrete items or competencies. In their simplest form, they are binary in construction (i.e., require examiners to check each element from a list as either “done” or “not done”). These binary content checklists are often referred to as criterion rating tools and are designed to be unbiased (Newble, 2004). However, in MFT training, these checklists are insufficient by themselves to reveal the mastery of complex clinical skills. Instead, MFT OSCEs should include elements of global rating (i.e., ways of differentiating the relative quality of students’ performance), use more than two columns on the checklist (e.g., excellent/good/satisfactory/borderline), and offer examiners opportunities to make judgments on aspects of the students’ overall performance using Likert scales (e.g., hardly at all, not so well, fairly well, pretty well, and very well). Regehr, MacRae, Reznick, and Szalay (1998) offer evidence suggesting that global rating scales alone are actually more reliable than binary checklists alone, although they conclude that a combined approach is perhaps of greatest value. Finally, it is important to note that each unique OSCE requires the development of a new set of marking criteria. The appendix provides an example of an MFT OSCE measurement using both Likert scale checklist and global rating.

### *Procedures*

One of the main pragmatic considerations to address when designing OSCEs is the organizational cost of carrying them out. Chief among the typical expenses includes hiring actors to dramatize the OSCE scenarios. If available, one creative way around the cost is to use other trainees to serve as the mock clients. Depending on the specific scenario, one to three (or more) role players may be required per station. Non-intern MFT, counseling, or psychology students can serve as the mock clients, thus maximizing learning opportunities for both role players and interns.

**Station 1: Core competency domain—Admission to treatment**

A lesbian couple presents for therapy. During the intake session one partner is not communicative. After some prodding by her partner, she begins to question the validity of therapy, the credentials of the therapist, and the overall condition of the clinic. Her partner begins to sob, and she turns to the therapist and says, “See what you’ve done now!” This is the first interview with the couple.

*Task: Facilitate therapeutic involvement of all necessary participants in treatment (1.3.3)*

**Station 2: Core competency domain—Clinical assessment and diagnosis**

A married woman, age 27 years, with no children presents for therapy with stated goals as reducing her worries about work and to decrease her self-criticism. Recent stressors include her relative’s recent diagnosis of cancer and her own recent miscarriage and pressures on her job. Been married for 6 years. States goal is to reduce general level of anxiety. She is worried about bad things happening and worried about her worrying being out of control.

*Task: Apply effective and systemic interviewing techniques and strategies (2.3.3)*

**Station 3: Core competency domain—Treatment planning and case management**

Parents of 16-year-old girl. Ever since kindergarten parents have been getting notes and calls from teachers about child’s disruptive behavior in the classroom. She has seen psychologists and psychiatrists and has been in special education services at school. Recently, she has been hanging out with her friends and is hardly ever home. She does not tell her parents where she is going, what she will be doing, or who she is with. Parents wonder if she is starting to experiment with marijuana.

*Task: Develop, with client input, measurable outcomes, treatment goals, treatment plans, and aftercare plans with clients utilizing a systemic perspective (3.3.1)*

**Station 4: Core competency domain—Therapeutic intervention**

A divorced couple presents for therapy regarding concerns for their 8-year-old son, who has recently been acting out at school. This is one of the first times the couple has been together in the same room since the divorce. They quickly escalate, each blaming the other for the child’s problem.

*Task: Defuse intense and chaotic situations to enhance the safety of all participants (4.3.7)*

**Station 5: Core competency domain—Legal issues, ethics, and standards**

A 34-year-old married female with a history of alcohol dependence, recent death in family, childhood sexual abuse, and depression. Her current episode of depression began 2 years prior to therapy and she had been hospitalized for alcohol abuse 1 year prior to intake. She complains of depression, anxiety, procrastination, hopelessness, insomnia, and low sexual desire. Alcohol dependence in remission. Indicated she had had thoughts of suicide in the past and was still having such thoughts, but at the moment she does not have any strong intent or plans to harm herself.

*Task: Develop safety plans for clients who present with potential self-harm, suicide, abuse, or violence (5.3.4)*

Figure 2. Examples of family therapy OSCE stations.

The mock client(s) are assigned one common clinical situation that details a very specific therapy session scenario. During the mock session the intern therapists meet with the “client.” The therapist can be given the scenarios in advance. OSCEs consist of a series of stations (or mock therapy rooms) around which MFT interns who are the “therapist” rotate. The therapist is asked to undertake a well-defined task prior to entering the mock therapy room. The criteria on which performance is to be assessed are carefully defined before the evaluation takes place. Performance is scored on structured rating forms or marking sheets by an instructor or a supervisor. The instructor can observe from the observation room and meet with the “therapist(s)” during and/or after the dramatization to offer feedback and discuss the OSCE. If an observation room is not available, the instructor can observe the OSCE from the therapy room.

Feedback is organized by the OSCE form or measuring instrument, which is completed and then given to the training therapists. In this manner, the OSCE form (or measuring instrument) is more of a guide for an ongoing feedback conversation rather than a final or end report as is the typical application in medical training.

## DISCUSSION

The growing utilization of OSCE as a method of evaluating students has led to considerable debate in the literature regarding the optimal use of the OSCE in training (Carraccio & Englander, 2000; Downing & Haladyna, 2004). OSCEs have been extensively studied and have been shown to have higher reliability and validity than traditional and less structured oral examinations (Leichner, Sisler, & Harper, 1984; Schuwirth & Van der Vleuten, 2003). Some maintain that communication and interpersonal skills, ethical and professional judgment, and complex ethical problem identification and resolution skills may be assessed more effectively and efficiently through a well-designed OSCE than through other testing methods (Sloan, Donnelly, Schwartz, & Strodel, 1995).

The main strength of the OSCE is in its fundamental link between a set of core competencies and the setup of clinical situations in a simulated form that allows for the measurement of these competencies (Davis, 2002). Core competencies are broken down into specific behaviors or actions that are then used to create the checklist evaluation of the OSCE. Other perceived benefits include broader range of skills tested than with oral or written exams (Newble, 2004; Watson et al., 2002), increased consistency of experience between students (Coleman et al., 2002; McKnight et al., 1987), and high level of reliability and validity (Matsell, Wolfish, & Hsu, 1991; Schuwirth & Van der Vleuten, 2003). Indeed, it is this combination of benefits that has led some to regard the OSCE as the “gold standard” of health professional assessment (Bartfay et al., 2004; Sloan et al., 1995).

The OSCE process is, however, not without limitations. The most frequently cited disadvantage recognized in the literature is student stress (Bartfay et al., 2004; Coleman et al., 2002). Students often find the process enormously stressful, stress which could in turn adversely affect performance. However, studies attest to students’ valuing the process despite the stress involved (Bujack, McMillan, Dwyer, & Hazleton, 1991). Another limitation cited in the literature is instructor fatigue as a result of recording the performance of several students on lengthy checklists (Humphris & Kaney, 2001). Ironically, in the effort to keep track of the behaviors/actions observed and mark them onto the evaluation checklist, examiners may miss the minutia or the small details of the students’ clinical performance. An OSCE tests skills, attitudes, and knowledge in separate compartments as a way to assess core competencies. This compartmentalization is another limitation of the OSCE format. It is considered by many that breaking clinical skills into individual competencies is artificial and therefore presents little meaningful information. Fragmenting clinical care into discrete items undermines holism (Mavis, Henry, Ogle, & Hoppe, 1996; Miller et al., in press). Further, idealized “text-book” scenarios may not mimic real-life situations (Wallace, Rao, & Haslam, 2002). Finally, the complex orchestration of the OSCE process involves extensive faculty time, cost, and staffing (Bartfay et al., 2004). Developing OSCEs requires many steps that involve, but are not limited to identifying competencies to test, creating an examination “blueprint” that outlines the parameters of the exercise, and standardizing measurement instruments and scenarios (Jain et al., 1997).

## FUTURE DIRECTIONS

What is demonstrated thus far is that the OSCE offers a number of important potential strengths, alongside a range of potential limitations which need to be carefully considered in



any implementation of the OSCE process for MFT. The complexity of many family therapy cases can be more difficult to simulate than medical cases. The subtle nuances in interpersonal behavior that are necessary for a true portrayal are complex. Yet, given this limitation, the development of MFT OSCEs as formative exercises is one potentially valuable tool for core competency-based training. With this in mind, additional research is needed to determine the validity of using OSCEs to assess MFT competencies.

In 2002, the University of Oregon Couples and Family Therapy Program began experimenting with OSCEs in their COAMFTE-accredited master's-level training program. As described in this article, the OSCEs were primarily utilized as *exercises* versus summative evaluations. The exercises were carried out by student-therapists in their second year of their program of studies. The program initially employed actors to play out the scenarios, but eventually moved to using first-year master's-level students as "actors" to serve as clients for second-year student "therapists." Over the years, students have shared their impressions of the OSCE experience. Their feedback included comments about the benefits of moving beyond theory to actual clinical work without risk to clients. The following comments by second-year OSCE therapists summed up the impressions of many:

Participating in the OSCE exercise was a great experience for me as a beginning therapist. I had the opportunity to practice handling a number of situations that later came up in actual sessions with clients. Also, having the chance to roleplay while other family therapy students were playing the clients or were observing provided a nice incentive to push myself a little to demonstrate what I had learned so far, particularly in terms of my model.

I felt safe enough, since we were roleplaying, to try some things that I might not have tried with clients just yet.

The first-year student actors have also shared their thoughts about the utility of the experience for them:

It gave me the opportunity to sit where our clients will be sitting and to experience some of the questions or emotions they may feel at times. I found it very informative to see in live action various models, and in particular, how they made me feel either connected or somewhat distant from the therapist. I realized the power dynamics that are in the room and respect this much more today.

As a first year student, my roleplay was to be in open conflict with my partner. By repeating the scenario with three different student-therapists, I had the opportunity to see how the use of the model, the self of the therapist, and timing all played a crucial role in whether or not a given intervention was successful.

The primary benefits of the OSCE experience for students and faculty include the following: it provides the ability to work with clinical situations without risks to clients, the formative nature of the exercise serves to guide students, the complexities of clinical work and the small details of clinical interaction can be captured, another venue is available to explore and discuss the common clinical impasses beyond classroom demonstration and discussion, and first-year students have an opportunity to experience clinical situations as a way of easing them into clinical work. Secondary benefits included the promotion of empathy with clients as first-year students prepare and act out dramatizations as mock clients, the opportunity for first- and second-year students to interact and share information, and the opportunity for first-year

students to see the common practices of the clinic (e.g., reflecting teams, lobby intake, phone calls from supervisors in the observation room, etc.).

## CONCLUSION

The field of MFT education is changing. These changes are marked by the increasing demand for output-oriented, competency-based exercises and evaluations. The MFT OSCE is one novel strategy to assess and teach clinical competency at the “shows how” level (Miller, 1990). Many other professional disciplines have developed OSCEs to address their specific needs. This article offers one sample “blueprint” for guiding the development of MFT specific OSCEs. The diversity of different OSCE processes as described in research literature in the fields of medicine and allied health professions offers numerous exemplars of situations where OSCEs and exercises maximize training, supervision, and assessment opportunities. As this method of training and evaluation develop, it will be important to create more specialized OSCEs to reflect the unique complexities of systemic therapy. Finally, OSCEs that address specific cultural considerations and competencies need to be developed. “Cultural competency” has become a requirement for today’s clinical training programs (Kaslow et al., 2004). Culturally, specific OSCEs offer a new strategy in the effort to train culturally competent therapists. MFT OSCEs capture the complexity of teaching competencies by creating more opportunities for collaborations of learning, thus making it a very effective and meaningful contribution to MFT education. This article offers a theoretical conceptualization of how to create an MFT OSCE “blueprint,” station descriptions, and evaluation protocols as a sample for future OSCE development. These are not intended to be conclusive, but are offered as a template to guide the development of future MFT OSCEs.

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## APPENDIX

### *MFT OSCE Formative Evaluation Tool*

#### *Station #1*

A lesbian couple presents for therapy. During the intake session, one partner is not communicative. After some prodding by her partner, she begins to question the validity of therapy, the credentials of the therapist, and the overall condition of the clinic. Her partner begins to sob, and she turns to the therapist and says, “See what you’ve done now!” This is the first interview with the couple.

#### *MFT Core Competency: Admission to Treatment*

Content (MFT core competency number)	Not applicable	Hardly at all	Not so well	Fairly well	Pretty well	Very well
Gather and review intake information, giving balanced attention to individual, family, community, cultural, and contextual factors (1.3.1)						
Determine who should attend therapy and in what configuration (e.g., individual, couple, family, and extrafamilial resources) (1.3.2)						
Facilitate therapeutic involvement of all necessary participants in treatment (1.3.3)						
Explain practice setting rules, fees, rights, and responsibilities of each party, including privacy, confidentiality policies, and duty to care to client or legal guardian (1.3.4)						

*Continued*

Content (MFT core competency number)	Not applicable	Hardly at all	Not so well	Fairly well	Pretty well	Very well
Obtain consent to treatment from all responsible persons (1.3.5)						
Establish and maintain appropriate and productive therapeutic alliances with the clients (1.3.6)						
Solicit and use client feedback throughout the therapeutic process (1.3.7)						
Manage session interactions with individuals, couples, families, and groups (1.3.9)						

*Overall Assessment of Knowledge and Skills Demonstrated (Circle A, B, or C)*

A	B	C
Responds to the tasks, consistently integrating all components of theory and clinical skills	Responds effectively to some of the tasks, some development of clinical skills	Responds inappropriately and ineffectively to the tasks, indicating a lack of knowledge and/or undeveloped clinical skills