DOI: https://doi.org/10.11144/Javeriana.umed64-4.vpep

Experiences of Standardized Patients in LGBTI Population and Victims of Sexual Violence: A Focus Group Study

Vivencias del paciente estandarizado en población LGBTI y víctimas de violencia sexual: un estudio de grupo focal

Received: 01 february 2023 | Accepted: 18 september 2023

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How to cite: Aguiar-Martínez L, Díaz-Amado E, Castellanos-Ochoa ME, Guerra-Murillo MJ, Pulido-Antolínez V, Perilla-Orduz A, Moreno Luna IdS, Zapata Monsalve BdS, Escobar Munévar JM. Experiences of standardized patients in LGBTI population and victims of sexual violence: a focus group study. Univ. Med. 2023;64(4). https://doi.org/10.11144/Javeriana.umed64-4.vpep

ABSTRACT

Introduction: Simulation-based education with standardized patients (SP) in high-fidelity scenarios is a tool for learning, skills development, and clinical competencies. Actors assume psychological risks when they portray these emotionally charged vulnerable patients. **Objective**: To describe the experience of the actors (as SPs) during simulation sessions where they portrayed victims of sexual violence and LGBTI population and were attended by health professionals from the district. **Methodology:**

A qualitative phenomenological study was conducted on the experience of actors who portrayed SPs in the cases described, from the interpreted patient and actor's perspective. A focus group was held with the actors after the simulation sessions. **Results**: Negative attitudes towards patients were identified, rooted in prejudices, lack of empathy and avoidance behaviors. The confluence of emotional burden and repetitive simulations rendered it arduous for actors to disentangle themselves from their roles, thereby impacting their daily activities. **Conclusions**: The need for SP simulation to sensitize healthcare staff was evident. The high emotional burden and the proximity of the cases to the actors suggests the need for psychological support. The integration of such support mechanisms contributes not only to the efficacy of simulation-based education but also to the overall well-being of actors, ensuring a more proficient and empathetic healthcare workforce.

Keywords

patient simulation; health education; simulation training; sex offenses; sexual and gender minorities.

RESUMEN

Introducción: La educación en salud basada en simulación con pacientes estandarizados (PE) en es una herramienta de aprendizaje y desarrollo de competencias tanto clínicas como de comunicación. Los actores que interpretan PE asumen riesgos psicológicos al interpretar a estos pacientes vulnerables con alta carga emocional. **Objetivo**: Describir la experiencia vivida por los actores (como PE) en las jornadas de simulación interpretando casos de víctimas de violencia sexual y población LGBTI donde fueron atendidos por profesionales de salud del Distrito de Bogotá. **Metodología**: Estudio cualitativo de tipo fenomenológico sobre la experiencia de actores que se desempeñaron como PE en los casos descritos, y desde la perspectiva del paciente interpretado y desde la del actor, se realizó un grupo focal con los actores de las jornadas. **Resultados**: Se identificaron actitudes negativas hacia las pacientes derivadas de prejuicios, falta de empatía, evitación, entre otros. Desde la perspectiva de los actores, se generó importante afectación emocional; así mismo, la carga emocional y las repeticiones influyeron en que a los actores les costará más desligarse de los roles, y se afectaran sus actividades diarias. **Conclusiones**: Se evidenció la necesidad de la simulación con PE para sensibilizar al personal de salud. La alta carga emocional y la cercanía de los casos a los actores sugiere la necesidad de acompañamiento psicológico.

Palabras clave

simulación de paciente; educación en salud; entrenamiento simulado; delitos sexuales; minorías sexuales y de género.

Introduction

Education based on clinical simulation is a pedagogical tool that enhances the learning of competencies applicable to the clinical setting (1). The standardized patient (SP) has emerged as a didactic strategy consisting of the use of trained individuals to simulate clinical scenarios to instruct, evaluate, or improve communication skills (2-4), and with the competence to represent the experience in a standardized way and allow it to be reproduced in a similar way (2,5). While SPs can be portrayed by both professional actors and non-specialist individuals (e.g., students), several studies have reported a less favorable evaluation of SPs portrayed by students, largely attributable to increased rates of anxiety and nervousness during the simulation (6-8).

The incorporation of SPs in high-fidelity scenarios enhances the pedagogical value of the learning experience (2), facilitating the acquisition and strengthening of basic, advanced, and communicative clinical skills, especially in circumstances requiring problem-solving and decision-making (9). This allows for meaningful learning by applying this knowledge to real-life cases (10).

Strategies aimed at improving competencies for the health care of the LGBTI population (11) and victims of sexual violence (12,13) pose significant challenges, which can be addressed in simulation scenarios with SP focused on fostering meaningful learning in health care personnel. There are experiences with the use of simulation with SP in cases of sexual violence (13,14) that have favorably influenced professional praxis and added value to the training program by showing changes in knowledge, awareness, and attitudes specific to trauma-informed care (14), and by highlighting the usefulness of *debriefing*, which helps to consolidate learning (13). One of the advantages is the absence of risk of harm to the actual patient, the possibility of repetition, and the decrease in anxiety of the students by improving their learning experience (15,16).

However, when the SPs assume their roles with rigor, difficulties are described for them to detach

themselves from the assumed personality (17), as well as the existence of risks of psychological damage when immersed in scenarios of high emotional charge (18). This risk increases, especially when they have any previous lived experience (19), since clinical scenarios are characterized by their precision and realism, which intensifies the emotional impact. This has been corroborated by findings showing adverse psychological effects on the actors involved (20). For this reason, several authors have highlighted the need to appropriately manage the processes of disidentification of the role played by those who assume the role of SP in simulations (21).

Although studies aimed at exploring the lived experience of SPs interpreting patients with mental illness have been described (17), to the authors' knowledge, there are no descriptions of the lived experiences of SPs who have represented patients who are victims of sexual violence and LGBTI patients and their involvement in interpreting emotionally charged cases.

This research seeks to explore how the actors characterize their experiences from their roles as well as their perception of the care received by healthcare personnel, that is, from the patient's point of view. The objective of this research was to evaluate the experience of professional actors who have interpreted the SP in simulation scenarios, both in terms of their role as actors and in their interactions with healthcare professionals, in clinical cases of victims of sexual violence and care for the LGBTI population.

Methods

The study was approved by the Ethics and Research Committee of the Pontificia Universidad Javeriana (reference FM-CIE-0270-22) and sponsored by the District Health Secretariat and the Pontificia Universidad Javeriana. The methodology used in this research is limited to a qualitative study of a phenomenological nature, whose purposes were, on the one hand, to elucidate the intrinsic meaning of the experiences lived by professional actors and, on the other hand, to describe the meaning of the experiences lived by the professional actors who interpreted the SP of clinical cases associated with the courses on care for victims of sexual violence and health care for LGBTI persons, given during the Simulation Workshops, in the second semester of 2022.

These workshops were carried out with participants who completed and passed the courses "Comprehensive Care for LGBTI Patients" and "Comprehensive Care for Victims of Sexual Violence" for healthcare personnel linked to the institutions providing services of the District Health Secretariat in Bogota (Colombia). The cases of each course were adapted and standardized in a process supervised by academics specializing in performing arts, seeking to achieve a high degree of authenticity through rigorous training. In the course of this pre-workshop training, the SPs acquired skills to simulate specific clinical conditions and maintain interpretive consistency with different cohorts of participants. They were also instructed in adaptive skills for scenarios of varying complexity.

At the end of the Simulation Workshop activities, a focus group was held in which the actors who acted as SPs signed an informed consent before the start of the activity. No sampling was carried out since the entire team of actors who acted as SPs during the workshops was convened. This dynamic was moderated by the principal investigators, who were exploring two fundamental dimensions: firstly, from the perspective of the patient being interpreted to elucidate the experience concerning the difficulties faced by these patients when being treated, and secondly, to clarify the experience and personal impact inherent in the performance of these roles as SP.

Primary information was obtained through the focus group described with SP, and recorded with the help of audiovisual media. The audiovisual information obtained from the focus group was stored with availability only for the principal investigators. Subsequently, this material was transcribed textually. NVivo software (22) was used for the storage and analysis of the transcripts, together with the

coding. An inductive analysis was carried out, seeking to discover patterns and trends in the data collected without being limited by a pre-established theoretical framework. Primary information was obtained through the focus group already described.

During the inductive process, multiple criteria were adopted to determine the categories most relevant to the object of research. Two coding cycles were carried out among four researchers, where both the relevance and the frequency of occurrence of words or phrases in the analysis executed in NVivo were weighted. Each category was defined exclusively, minimizing redundancies or similarities with others. The spectrum of data included in each category was kept exhaustive and differentiated. Flexibility was reserved to incorporate new emerging data to ensure consistency and similarity of categories. The categories defined needed to respond to the two guiding questions that constitute the core of the main objective of the present study (23).

Results

During the Simulation Workshops, 18 sessions were held, interpreted by 8 actors who were invited to participate in the focus group. Of these, 6 attended, whose average age was 26 years old (3 women and 3 men). Some of the participants identified themselves as belonging to the LGBTI community, and two did not attend due to work availability. All participants actively participated in the focus group. A quiet and trusting space was provided to develop the session, which lasted 2 hours. The moderators allowed opinions to be freely expressed based on their lived experiences.

Multiple moments of recognition and gratitude were described for the healthcare professionals, who made the SPs feel comfortable and understood, emphasizing their commitment to their patients and the provision of high-quality service in the healthcare process. However, this study sought to identify, through the focus group, mainly the experiences that could limit attention to the LGBTI population and to victims of sexual violence. For this reason, we address those impediments encountered, and the experiences of the SPs when being attended, and their impact on the actors.

Lived experiences: the actor's perspective

Regarding the experienced living as an SP during the clinical cases represented, a significant impact was evident, mainly influenced by the high emotional content of the cases, secondary to the traumatic experiences inherent in each story. The emotional impact that affected the different actors and that was most frequently expressed encompassed a variety of emotions such as sadness, anger, helplessness, and tiredness; emotional states that were recurrently projected in their daily activities, as happened with this SP: "It happened to me three Saturdays that I arrived home... I literally came home... ¡To cry! ¡To relieve myself of such a heavy emotional burden!"

Another phenomenon identified by the actors was linked to the issue of identity. The actors pointed out certain difficulties in "letting go of the character" at the end of each session. They attributed this situation to the underlying realism of the cases played, which at times generated confusion between their own identity and that of the character they were portraying. On some occasions, they felt that the temporal extension of the SP scenarios and the number of repetitions intensified this experience and led them to feel like the character and not to be acting it. At these moments, they felt that they could quickly lose themselves in the character, and the need arose to have the emotional strength to interpret these cases without being affected and to have a reference point to assist them in the process of disengaging from the role they had assumed: "In my case, Luis' identity is lost, and I become completely that character. In my particular case, well... there was a time when I had, for example, a panic attack in a consultation."

Finally, the SPs stated that the interpretation of these roles has given them a more transparent perception of the health care provider and that it has transported them to experiences close to

clinical reality. Most of the participants expressed that they forgot that they were participating in a simulation a few minutes after starting the meeting.

From the patient's point of view

Some actors stated that there were negative attitudes on the part of the healthcare personnel, which caused them feelings of discomfort and malaise during the simulated consultation. Among these attitudes, they frequently found apathy (understood as indolence) and immutability during care. They observed behaviors that denoted an absence of solidarity and sensitivity towards the patient: "And the doctor said, 'I thought it was something more serious', and I don't know why it was so hard for me. How come it wasn't so serious? I think we were two lesbian couples, and I thought... that's how they see us?"

This perception was interpreted by the actors as the product of healthcare personnel training that aims to maintain an emotional distance, "not letting themselves be affected," leading to additional barriers in care, producing distancing, and decreasing patients' trust in the healthcare professional.

Another prevalent attitude was the lack of empathy, understood as the absence of emotional identification with the patient, and a lack of interest in his or her circumstances. To a large extent, the actors related this to the fact that healthcare personnel have deficiencies in emotional self-care, expressed by them as the "lack of an emotional anchor." According to most of the SPs, if the healthcare personnel paid more attention and kindness and noticed more of the details provided by the patient, the consultation would be more effective and a quality consultation, even if it lasted only a few minutes.

In addition, some SPs also named actions that restricted health care, for example, the phenomenon of avoidance—understood as conscious or unconscious efforts to avoid activities, places, or people that bring back memories of trauma. This avoidance was manifested both in the acquisition of essential information, for example, the omission of asking the patient's gender identity, and in the deliberate interruption of their narratives to avoid emotional involvement. In this context, it was frequently observed that healthcare personnel adopted evasive behaviors, which significantly hindered the care process and induced indisposition and rejection by the patient: "... in many of the cases it will be for them to avoid themselves and to have to listen further, or to have to get involved further, or just avoid, avoid, avoid, avoid in general."

In the non-verbal language, avoidance was also evident, such as when healthcare professionals avoided eye contact with the patient; even in the roles of the LGBTI population, the actors referred in the *debriefing* that the healthcare personnel justified these actions by describing their patients as "aggressive," which allowed the care providers to remain distant and avoid the patient.

It should be clarified that some avoidance attitudes identified by the actors during the *debriefing* were attitudes secondary to the participants' own experiences, as was evidenced in the case of a health care provider who identified herself as a lesbian and during the consultation had a rather avoidant attitude in her interaction with the patient:

> Because of so many situations like this character went through, and let them leave her there or didn't listen to her, there were times when they didn't know what to do with her. Well, we have to listen to her story, so let's leave her seated, or we have to check her bodily injuries, so let's lay her down or lay her down again. It feels like a lack of respect for the integrity of the person.

Also, the SPs identified disrespectful behaviors toward the patient, for example, when some professionals used expressions and acts that the participants interpreted as aggressive and humiliating or expressed themselves with humiliating, derogatory, or arrogant phrases. These behaviors sometimes emanated from the lack of training of healthcare providers regarding

the proper handling of the impact on themselves of complex cases: "No one attends to the doctors, no one attends to the nurses and no one listens, no one helps you also to unburden yourselves."

Mental health emerged as an element raised by the actors, considering that during the *debriefing*, more personal and vulnerable aspects of the individuals who assisted them were revealed. Participants described experiences or memories related to the clinical cases and exposed the underlying reasons that conditioned their behavior in the simulated scenarios.

In this sense, the need to provide greater psychoemotional attention to healthcare professionals facing high emotional burdens was emphasized, since the lack of strategies to manage the psychological impact of the cases attended often explains the reason for their unfavorable attitudes in the consultation. Therefore, they recommend emphasizing the importance of emotional support and psychological help for healthcare personnel, especially for personnel who experience critical situations such as in the emergency department, where providers see these cases most frequently.

On the other hand, the SPs identified in the scenarios and during the debriefing that, despite having completed the online training, there was a significant gap between theoretical knowledge and clinical practice, i.e., the role they were going to play and the way they were going to proceed showed shortcomings in communication strategies, approach, and treatment of the different populations. This shortcoming was manifested in failed attempts to avoid revictimization and in the difficulty in distinguishing between the sex, gender, and sexual orientation of the patients. In addition, the SPs observed the frequent use of inappropriate and unclear linguistic expressions, such as the question "Have you already transformed?"

As for the relationship between the professional and the patient, which seeks to be based on trust, respect, and effective communication, the aim is to identify and address their health needs and, based on adequate information, facilitate consensual decision-making. The SPs documented multiple factors that affected this relationship; for example, obstacles in communication were identified, both when expressing oneself and when listening to patients. The use of crutches or recurrent phrases by habit was recognized, the use of which can be detrimental in sensitive situations, especially in the consultation context:

> They raped me, and destroyed me, and did such and such a thing to me... And they say "Perfect." I am going to die tomorrow, or my grandmother does not want to receive me in the house... And they say, "Ah, well, very good; ¡tell me more!" In other words, this kind of thing denotes that the person, even though he is there, is not fully listening to what the patient is transmitting.

Additionally, interactions with preconceived ideas were detected, which resulted in discriminatory attitudes based on the patient's sexual orientation and concepts that were unconsciously given to patients, which led to prejudice and modified the relationship between the professional and the patient by showing an attitude of indifference that made them feel judged. These actions generated frustration and guilt. There was disappointment for not receiving the expected attention, where there were expectations of greater understanding, mainly with cases of sexual violence. "Well, don't worry... You already have a warning so that next time you don't go back to those applications, because whenever you go to those applications that will happen to you."

Accordingly, the SPs expressed the need for a more holistic and humane approach during the consultation. This circumstance is observed when physicians, by focusing excessively on specialized aspects, obviate the human dimension of the patient and objectify him or her, causing the patient to feel uncomfortable.

Discussion

According to the experiences lived by the actors as SP, multiple challenges associated with health care for LGBTI populations and

victims of sexual violence were identified. Although the assistance provided was adequate in many instances, adverse behaviors on the part of healthcare personnel were detected, characterized predominantly by a lack of empathy and evasive behaviors that hindered the establishment of an effective relationship with patients. Likewise, interruptions were observed when communicating occurred events, lack of attention, and lack of listening. These observations are similar to the study by Jarosinski and Webster (17), where SPs interpreted patients with mental illness and identified a lack of empathy and a lack of relevance to the interaction. This generated feelings of disappointment; however, in the present study, the SPs, during the *debriefing*, were able to perceive that these attitudes in some participants were secondary to their own experiences that affected them.

Attitudes and comments from health professionals were also observed that denoted prejudice, discrimination, communication barriers, and lack of knowledge—situations that led SPs to feel vulnerable and disrespected, which led to a total breakdown in the doctor-patient relationship. One of the most recurrent situations was the wrong use of the name of the SP played by trans people, a situation that made them feel uncomfortable and upset. The above is consistent with what was evidenced in the study by Tyerman et al. (19), in which actors belonging to the LGBTI community were used who expressed authentic emotional reactions of anger when experiencing overt situations of discrimination such as the one previously mentioned. In this study, some actors belonging to the LBGTI community expressed a greater affectation that, as referred to, was associated with personal experiences.

Likewise, the dehumanized treatment by the healthcare personnel was repeatedly mentioned, both in the process of caring for the SPs who interpreted victims of sexual violence as well as for the LGBTI population, where they only focused on the disease that afflicted them without taking into account the emotional aspects of the patient, which at the time of the consultation they felt was the most important thing. The same is described in the article by Tyerman et al. (19), where they describe the discomfort of the actors when faced with distressing experiences in medical care, as systematic discrimination is prevalent.

As for the impact perceived by each SP, emotional affectation was mentioned to a greater extent when experiencing feelings of sadness during and after the simulation scenarios. These emotions were transported to other areas of the actors' daily lives, such as difficulties in being able to put aside the character played, and sometimes confusing self-identification. The same was documented in the study by Jarosinki and Webster (17), in which the SPs commented that the difficulty of letting go of the character is related to personal experiences that evoke their own lives or exposure to strong emotional situations that generate a great impact on the artist.

Finally, the SPs stated that by repeatedly exposing themselves to these simulation scenarios, they were able to generate learning from different areas by developing new techniques, concepts, etc. This could be observed in the course of each session, where each interpreted case was perceived as more and more authentic.

Conclusions

During the session held with the focus group, composed of the SPs (actors), key points were identified in the care process: negative attitudes frequently recognized in healthcare professionals that led the SPs to perceive dehumanized healthcare and the presence of prejudices that generated barriers in the healthcare provided to these vulnerable populations. This highlights the need to increase the preparation and practice, through simulation, of skills and strategies that allow for more sensitive care by healthcare personnel, to enable them to have a significant learning experience and thus result in a favorable outcome in healthcare of this type of patient; likewise, it is necessary to reduce these errors

identified by the actors, which are often related to problems of *showing how* and not *knowing how* of the healthcare personnel.

During the session conducted with the focus group, made up of SP, crucial elements in the health care process were identified. Recurrent negative attitudes among healthcare professionals were at the core of their observations, which induced in the standardized patients the perception of dehumanized healthcare. In addition, prejudices were detected that led to obstacles in accessing health care for these vulnerable populations. These findings underscore the imperative need to intensify training and practice through clinical simulation, aiming to sensitize healthcare personnel and foster meaningful learning that will lead to favorable outcomes in the care of this type of patient. Likewise, it is imperative to minimize the errors identified, which, on numerous occasions, are associated more with deficiencies in execution than with a lack of theoretical knowledge by healthcare personnel.

Furthermore, to the authors' knowledge, there are no studies in simulation with SP focused on victims of sexual violence and the LGBTI population, and, in the rest of the world, the existing literature on simulation scenarios focuses on the training process of undergraduate and graduate students in different areas of health. However, there is no research directed to the performance of health professionals working in health centers exposed to vulnerable populations or the need to continue training processes, so this study is useful for the implementation of educational strategies for health personnel in training in different educational institutions and graduates of Latin American countries, particularly in Colombia.

On the other hand, the SPs repeatedly expressed the emotional impact of developing characters related to victims of sexual violence and the LGBTI population. The constant exposure to discrimination and finger-pointing by the healthcare community generates sentimental lags that need to be addressed, so the need for psychological support and accompaniment for the actors during the simulation sessions is an aspect to take into account and possibly implement in future sessions.

Finally, it is necessary to recognize that health care implies a relationship between people who affect each other emotionally. Medical care is an affectionate exchange, of which the healthcare personnel know little or it is presumed that it is not in their interest to know, so strengthening this interaction is important to develop humanized and quality healthcare. It is also important to note that these clinical simulation cases are necessary for the development and continuous improvement of the actors, as their experiences and feedback are crucial components in their professional training process.

Conflicts of interests

The authors declare no conflicts of interest.

Acknowledgments

We thank the Centro de Educación e Investigación en Salud (CDEIS), of the Secretariat of Health. To Professor Jorge Luis Franco-Zuluaga, for his great help. To Admeri Acosta, who helped in the process of organizing the sessions.

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