Teaching About Psychological Disorders: Using a Group Interviewing and Diagnostic Approach

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We designed a cooperative learning classroom activity to enhance students’ ability to understand psychological disorders and distinguish among anxiety, mood, and psychotic disorders. We employed a group interviewing approach with the instructor (or a graduate student) serving as the pseudo-client. Students interacted with a pseudo-client to arrive at a diagnosis. Evaluations of this activity indicated that students learned about various psychological disorders as well as better understood the process of clinical interviewing and diagnosis.

In any abnormal psychology course, students need to learn the characteristics, prevalence rates, and etiologies of psychological disorders. To learn these aspects of psychological disorders, a cooperative learning approach (e.g., Marr, 1997) may prove useful. Generally, cooperative learning provides students with an opportunity to discuss and solve problems in collaborative work groups (Johnson & Johnson, 1991; Slavin, 1990). Although the educational benefits of cooperative learning are documented, its application to learning about psychological disorders has received little attention.

Instructors have used varying approaches to teach about psychological disorders. These methods include having actors portray clients (Gilliland, 1982), videotapes of clinical interviews (Lyons, Bradley, & White, 1984), and computer simulations (e.g., Lambert & Lenthall, 1988). Others have used patient role plays in medical education to depict symptoms, to provide diagnostic practice, and to develop interviewing skills (Coonar, Dooley, Daniels, & Taylor, 1991; Gordon, Regan, & Martin, 1960). However, such lengthy activities are usually impractical for undergraduate classes. The following three group interviewing activities provide students with the chance to interact with and question a pseudo-client presenting clinical symptoms through a cooperative learning environment. Our primary objectives were to (a) increase students’ knowledge of psychological disorders, and (b) increase their ability to distinguish among disorders.

Activity 1

Method

Participants. Participants were 37 undergraduate students enrolled in an abnormal psychology course at Syracuse University.

Materials. The first two authors created a script to allow for a variety of anxiety disorder symptoms to be reported or depicted within a relatively brief interview between the instructor (portraying the interviewer) and a clinical psychology graduate student (portraying the pseudo-client). (See Appendix A for a copy of the Anxiety Disorder Script.) Our goal was to depict a pseudo-client experiencing Generalized Anxiety Disorder (GAD), with hints for ruling out multiple anxiety disorders depicted during the group interview. The script we developed appeared to evidence validity based on feedback from directors of a clinical internship accredited by the American Psychological Association (APA) and a graduate training clinic. Although we did not provide students with the script itself, we gave them a list of the anxiety disorders to refer to during the interview. Once all groups had questioned the pseudo-client, students indicated the diagnosis that they believed to be very likely and indicated which diagnoses they were still strongly considering as possibilities given the information they gleaned from the group interview. Per diagnostic convention, we asked students to label diagnoses they believed to be very likely and indicated which diagnoses they were still strongly considering as possibilities given the information they gleaned from the group interview. Evaluation materials did not contain student identification.

Procedure. The activity took place following assigned readings and lectures covering anxiety disorders, but before discussion of subtle distinctions among disorders. We chose anxiety disorders for the script because different diagnostic categories can evidence similar symptoms during the initial
presentation, necessitating further interviewing to arrive at a specific diagnosis. Immediately prior to Activity 1, we provided students with a list of potential anxiety disorders and instruction in basic clinical interviewing techniques (e.g., asking open-ended questions to elicit more information). The anxiety disorders list also provided students with a common starting point for reviewing diagnostic criteria in their text as well as a standard format for choosing the pseudo-client’s psychological disorder.

We divided the class into nine groups of approximately 4 or 5 students. These small groups facilitated within-group discussion of potential interview questions and allowed for more active student involvement. After the scripted interaction between the interviewer and the pseudo-client, each group asked one question of the pseudo-client. After three groups asked their questions, each group spent 2 to 3 min discussing the pseudo-client’s responses to either develop their question for the pseudo-client or to hypothesize diagnoses. Thus, groups functioned as a group interviewer by building on each other’s questions. This process allowed for continuing participation by all students, as we instructed groups who had asked their question to discuss the new information presented by the pseudo-client to help them discern the most likely diagnosis.

When all groups had the opportunity to question the pseudo-client, students completed an anxiety disorders list to commit their diagnostic impression to paper. Once all groups formulated their diagnoses, students indicated their diagnostic impressions by a show of hands. This survey was followed by discussion of potential diagnoses, clarifying confusion regarding diagnostic criteria, exploring how changes in the pseudo-client’s presentation (e.g., mental status, cultural background) might affect diagnostic impression, and discussing possible treatment recommendations. This activity took approximately 35 min. Later class discussions also incorporated information from the activity (e.g., when discussing comorbidity issues, such as medical conditions that can mimic psychiatric disorders).

Results

GAD and Adjustment Disorder with Anxiety were the most likely diagnoses given or still strongly considered. In terms of very likely diagnoses (with rule out diagnoses [R/O] listed second), the greatest number of responses were for an Adjustment Disorder with Anxiety (n = 24; R/O n = 6) or GAD (n = 16; R/O n = 14). Additional “very likely” diagnosis responses included Acute Stress Disorder (n = 4), Social Anxiety Disorder (n = 2), and Obsessive-Compulsive Disorder (n = 1). Thus, students strongly considered GAD as a probable or possible diagnosis. They met the objective of correctly differentiating among anxiety disorders based on the information presented by the pseudo-client.

Students rated the helpfulness of Activity 1 on a series of 5-point scales ranging from 1 (strongly disagree) to 5 (strongly agree). Ratings were favorable (see Table 1), with 89% of participants agreeing or strongly agreeing that the activity helped them to understand differences among anxiety disorders (M = 4.26, SD = .74). Ninety-seven percent agreed or strongly agreed that the activity was helpful for understanding the clinical interviewing process.

Activity 2

Method

Participants. Participants were 42 undergraduate students enrolled in the same abnormal psychology course as those who completed Activity 1. Five students who had been absent from class during Activity 1 were available to participate in Activity 2.

Materials. The script (see Appendix B) and diagnostic focus were the only differences between activities. This activity dealt with differentiating between various mood and psy-

### Table 1. Evaluations of Interactive “Sessions”

<table>
<thead>
<tr>
<th>Evaluation Items</th>
<th>Activity 1a</th>
<th>Activity 2a</th>
<th>Activity 3b</th>
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</thead>
<tbody>
<tr>
<td>The activity was:</td>
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<tr>
<td></td>
<td>Anxiety M</td>
<td>Mood M</td>
<td>Psychotic M</td>
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<td></td>
<td>SD</td>
<td>SD</td>
<td>SD</td>
</tr>
<tr>
<td>1. Enjoyable</td>
<td>4.49 .66</td>
<td>4.38 .54</td>
<td>4.38 .54</td>
</tr>
<tr>
<td>4. Helpful for exam preparation</td>
<td>4.17 .62</td>
<td>3.95 .70</td>
<td>4.07 .60</td>
</tr>
<tr>
<td>5. Helpful for understanding the interviewing process</td>
<td>4.31 .53</td>
<td>4.29 .67</td>
<td>4.29 .67</td>
</tr>
</tbody>
</table>

Note. All questions are based on 5-point scales ranging from 1 (strongly disagree) to 5 (strongly agree).

Activity 1 (n = 37) and 2 (n = 42) were conducted during different class lectures with students in the same abnormal psychology course. Activity 3 (n = 20) was conducted with students enrolled in a different section of abnormal psychology.
chotic disorders, with the script depicting Schizoaffective Disorder. We again used the Activity 1 postactivity helpfulness measure for this activity.

Procedure. We used the same protocol for Activity 2, which we conducted following class instruction on mood and psychotic disorders. We timed Activity 2 in this way as our script attempted to depict a diagnosis (Schizoaffective Disorder) with both psychotic and mood-related symptoms. We presented this second script to directors of an APA-accredited clinical internship and a graduate training clinic, who found it to be a valid representation of the symptoms of Schizoaffective Disorder. The only procedural change for Activity 2 was that the course instructor portrayed the pseudo-client, whereas a graduate student was the initial interviewer. Class time for Activity 2 was approximately 30 min.

Results

We evaluated Activity 2 in the same way as Activity 1. The greatest number of very likely diagnoses were for Schizophrenia (n = 22; R/O n = 7) or Schizoaffective Disorder (n = 18; R/O n = 15). Students did not indicate any other very likely diagnoses. Similar to evaluations of Activity 1, these diagnostic response patterns indicated that students strongly considered Schizoaffective Disorder as a probable or possible diagnosis, despite the inherent difficulty in diagnosing this disorder. Thus, students met the educational objective of being able to differentially diagnose among mood and psychotic disorders based on the information presented by the pseudo-client.

Students rated the activity favorably (see Table 1). Approximately 85% of participants agreed or strongly agreed that the activity helped them to understand differences among mood and psychotic disorders, and 88% of participants agreed or strongly agreed that it was helpful for understanding the real-life difficulties clinicians encounter in distinguishing among disorders.

Activity 3

Method

Participants. Participants were 20 undergraduate students enrolled in a different abnormal psychology course from those who completed Activities 1 and 2.

Materials. We used the same materials as for Activity 1.

Procedure. Procedure was identical to that for Activity 1 with the addition of using exam performance as an outcome measure.

Results

To examine learning, we included two questions about GAD and two questions about mood and psychotic disorders on an examination. We designed multiple-choice questions to assess students’ ability to distinguish between various disorders based on presented symptoms. We used a bootstrapped paired sample test (see Efron & Tibshirani, 1993) to compare the difference in average number of correct responses for anxiety questions versus mood or psychotic questions. Results indicated that the difference between means was significant, z = -3.80, p = .00007, CI (95%): -1.30 to -.41. Thus, students demonstrated better exam performance on the questions related to the activity (GAD) than on questions not related to the activity (mood or psychotic). In addition, all students (N = 20) correctly chose GAD as the very likely diagnosis. Furthermore, students rated the activity quite favorably (see Table 1).

Discussion

Activity Strengths

This clinical interviewing activity has several advantages. First, the activity facilitated students’ ability to distinguish among possible psychiatric disorders. Second, students had the opportunity to engage in the interviewing process within an interactive and cooperative learning environment. Third, unlike other approaches that require considerable training to prepare a pseudo-client (e.g., Gilliland, 1982), the use of a graduate student or course instructor as the pseudo-client is resource efficient. Moreover, the use of a script helped present information in an efficient way, at the same time as further interviewing by the student groups allowed for hands-on practice of interviewing techniques and further clarification of the pseudo-client’s presenting concerns and symptoms. This interactive activity helped students understand symptoms of psychological disorders and processes underlying differential diagnosis. The activity also facilitated discussions throughout the semester of treatment and etiology of psychological disorders, along with the impact of cultural context and comorbidity on the case conceptualization process. This activity is similar to, although more life-like than, sample clinical casebooks typically provided in abnormal psychology courses. After the activities, we stressed the difficulty of diagnostic interviewing and underscored the need for trained professionals to use all available information to arrive at a diagnosis.

The goal of both scripts was to present a pseudo-client with a specific disorder. The student questions during each activity suggested that the initial questions (and pseudo-client responses) in each script allowed for the pursuit of various diagnoses. For example, during Activity 1, the questions asked by the nine groups covered the possibility of Panic Disorder, Posttraumatic Stress Disorder, Social Phobia, Obsessive-Compulsive Disorder, Adjustment Disorder, and GAD. Thus, the scripts accomplished our intent of providing a variety of diagnostic possibilities. This variety of possibilities could, however, be a limitation to the activity if the pseudo-client’s responses to the student questions did not ultimately
lead to the intended diagnosis. Results of the diagnostic evaluation indicated a correct or consistent diagnosis with that portrayed, suggesting that the portrayal effectively aided students’ learning. Exam performance further demonstrated the utility of this activity.

Activity Limitations

One strength of the activities is also a potential limitation. The time-limited nature of the interview precludes an extensive examination of the pseudo-client’s presenting symptoms, along with a more thorough psychosocial history and mental status examination. Stereotyping is more apt to occur whenever you make judgments about a person based on limited information. We emphasized to students that clinicians formulate their most accurate case conceptualizations based on information gleaned through multiple contacts with a client over time, in addition to incorporating other sources of information such as psychological test results and collateral interviews. However, we believe that the activities discussed here allow for a multidimensional depiction of a pseudo-client. The combination of scripted interview and group interviewing allowed presentation of sufficient information to illustrate the text material on differential diagnosis. Indeed, the feedback from students indicated that the activities were successful.

We believe that involvement in a brief clinical interview also captured students’ interest in a way that written and videotaped vignettes would not have, due to student participation in the interview. Also, the activity illustrated important aspects of the clinical interviewing process, such as the importance of using open-ended questions and using pseudo-client responses to generate follow-up questions. Moreover, the activities served as a reference point throughout the semester for discussing how changes in the client’s presentation (e.g., sex, race, ethnicity, psychosocial history, cultural background, mental status, report of cooccurring conditions) may have influenced students’ initial diagnostic impression.

Future modifications to the activities might include bringing the pseudo-client back to the class throughout the semester to illustrate the concept of a working diagnosis and how clinicians modify a diagnosis over time when they discover new information. This modification provides an alternative to using an entire class (or two) for a more comprehensive, one-time, clinical interview.

Another limitation is related to the evaluation component of the activities. Although students found the activities helpful, the question of primary interest is whether the activities facilitated student learning. Our replication in Activity 3 was aimed at providing a preliminary test of this question. We should note, however, that differential exam performance for questions related to the presence of an interview (GAD) versus absence of an interview (mood or psychotic) could be accounted for by differential question difficulty. In other words, students could have shown better performance on the GAD exam questions than the mood or psychotic questions if the GAD questions were easier than the mood or psychotic questions. Because any check on differential performance for these questions is confounded with the presence of the interview activity, we cannot know whether GAD questions were easier than mood or psychotic questions. However, the exam results fit the pattern of the activity evaluations across all three implementations and suggest that the activity did, in fact, increase exam performance. Future research might lend stronger support to the efficacy of the activities by including an item analysis of test questions and by comparing exam performance of classes who have participated in the activity with those who have used a written or videotaped case presentation instead.

Conclusions

The advantages of the activities outweigh some of the potential limitations, particularly if instructors use the activities to initiate further class discussion of the clinical interview and diagnostic formulation process. The students’ use of ongoing feedback (e.g., the pseudo-client’s responses to their questions) to distinguish among psychological disorders promoted an active learning approach, solidifying information that otherwise would be only lists of symptoms in a text. As previously noted, the scripts appear to evidence validity based on participants’ responses and feedback from directors of an APA-accredited clinical internship and a graduate training clinic. However, our activity would benefit from further examination of script validity. Thus, a future aim is to invite a practicing clinician to observe the activity and diagnose the pseudo-client to provide greater validity evidence for the scripts. In conclusion, the application of cooperative learning principles (e.g., Johnson & Johnson, 1991; Mart, 1997) to the need for interaction with a clinical pseudo-client (Gilliland, 1982) was a pedagogical success.

References


Notes
1. Thomas J. Tomcho is now at Delaware State University. Wendy L. Wolfe is now at Armstrong Atlantic State University. Rob Foels is now at Amherst College.
2. Thanks to Lawrence Lewandowski for his helpful comments on an earlier draft of this article.
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Appendix A
Anxiety Disorder Script

Interviewer (instructor) = I; Client (graduate student) = C

I: So, what brings you here today?
C: Well, I've been having difficulty falling asleep lately, and I think it's having an effect on my school performance.
I: What's going on when you have been having difficulty sleeping?
C: To tell you the truth, I've been obsessing (note: OCD) a lot about my relationship with my girlfriend. I'm awake for hours at night and then inevitably I have difficulty concentrating in class the next day.
I: Tell me more about your relationship with your girlfriend.
C: Well, she dropped a bombshell on me recently when she told me that the relationship was over. When she did that, I just started to panic. It felt like my heart was racing and I couldn't concentrate. I felt like I was losing control. And I'm sure that didn't help with the exam I had that day.
I: It sounds like this relationship is important to you. Is this your first romantic relationship?
C: This relationship was very important to me, I love her. But, this isn't my first relationship. In fact, now that I think about it, my last relationship didn't end so well either. The relationship had its ups and downs, but the most vivid memory I have of my first love was when we were mugged at gunpoint (note: PTSD). I had nightmares about that. When she ended the relationship, she offered me lots of reasons. She said things like we never did things together like going to parties and that I was always worrying about things.

Appendix B
Mood Disorders and Psychotic Disorders Script

Interviewer (graduate student) = I; Client (instructor) = C

I: What brings you here today?
C: Well, the only reason I'm here today is because my mother told me I needed to be here and she set up this appointment.
I: Why do you think that she feels you need to see me?
C: I don't know. She said I've been acting differently for a while now (note: depression time frame). She's the one that's acting weird if you ask me (note: depict irritability). During spring break she was crying (note: laugh a little to depict inappropriate affect) and saying that I wasn't the same as I used to be.
I: What do you think that means?
C: I don't know. She said I've been acting differently for a while now (note: depression time frame). She's the one that's acting weird if you ask me (note: depict irritability). During spring break she was crying (note: laugh a little to depict inappropriate affect) and saying that I wasn't the same as I used to be. But it's funny because she also gets mad because I still wear my dancing outfits. Even though I don't dance anymore my dance outfits are really special to me. I'll wear them for days at a time while I'm doing stuff (note: mania) and I won't take them off for anything. I won't even shower (note: self-care/depression). I don't know why she doesn't believe me, it's like she doesn't know that the outfits are special for me (note: magical thinking).
I: Do you have difficulties with other people understanding you?
C: Sure. It was like no one believed me when I said that I could predict the answers on the computer science exam. I know I'm the smartest person in my class, I guess they don't realize that the professor and I have a special connection. It really irritates me that they don't believe that I'm going to start my own Internet company and drop out of school like Bill Gates (note: grandiosity/bipolar disorder).