

# 45 BRINGING THE CLINIC INTO THE UNDERGRADUATE CLASSROOM

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*Students develop hands-on skills in problem formulation, classification of disorders, developing treatment plans, and assessing the prognoses of actual or simulated clients in this exercise. Although a film or video presentation of a clinical interview works best, you can do this activity with an audiotaped interview or even a written history. The simulation procedure generally should be introduced 4 to 5 weeks into the course, after students have been prepared in the background they will need to engage in this miniclinic assessment exercise. A full class session for the actual presentation of the interview, the assessment, and ensuing discussion is recommended. The student worksheets for completing the assessment are provided.*

**CONCEPT** Many notable teachers of psychology, textbook authors, and practicing psychologists (Benjamin & Lowman, 1981; McKeachie, 1978; Radford & Rose, 1980) have implored professors to give undergraduate students the experience of actually working at the tasks that psychologists perform. In many undergraduate lecture courses, students become oriented to what clinicians do and may even observe audiotaped or videotaped examples of clinical activities. Yet, because of ethical concerns (e.g., confidentiality problems, using untrained students to make interventions or important decisions regarding a client) or the sheer numbers of students involved, psychology students are rarely directed to attempt the hands-on exercise of clinical skills. When students are tested in abnormal psychology courses, they are often expected to make diagnostic decisions, provide a prognosis, and define the relevance of particular forms of therapy for different disorders—all based on fragments of hypothetical cases, often presented in the form of multiple-choice items. This article describes a method that involves students in the relevant simulation of a variety of clinical experiences. We have employed these techniques or "miniclinics" in several courses that contain units related to clinical assessment and intervention (e.g. abnormal, child development, and introductory psychology courses).

**MATERIALS NEEDED** Besides the three student worksheets that are replicated here, the most important element of the miniclinic exercise is the case material presented by the instructor—ideally, written background information and films or videotapes. Satisfactory but less revealing and stimulating for discussion are written case histories.

Recently, there has been an increase in both the quality and the selection of clinical vignettes (both actual and simulated productions). These are often available from book publishers for a small fee or at no charge to instructors who have adopted the publisher's text book in abnormal psychology.

The film catalogues of colleges and universities are another excellent source of such material. The film "Otto—A Case Study in Abnormal Behavior" (Film No. EC1404, 16; available from the Audio-Visual Center, Indiana University, Bloomington, IN 47405-5901) features a case enactment designed to be studied from the

basic models of psychopathology and treatment. This fine film may be ordered separately or in a series of films displaying various representative scholars discussing the hypothetical Otto from their own model of therapy.

The paper-and-pencil materials include three worksheets: (a) Intake and Problem Formulation, (b) DSM-III Classification, and (c) Treatment Plan and Prognosis. These forms should be reproduced for each student.

#### INSTRUCTIONS

Undergraduate students are assigned at random to one of several "clinic" groups representing a model or school of psychopathology (e.g., psychoanalytic, behavioral, client-centered, existential, biological). We have found that groups of 6-10 students function effectively for these exercises. During the course of the semester, as clinics are convened, students are rotated to other models. This procedure ensures that each student is exposed to the full complement of therapeutic approaches and helps each student develop ease of communication with other members of the class.

The clinic simulation procedure is generally introduced approximately 4 or 5 weeks into the semester. This timing permits the instructor to cover, in standard sequence, introductory chapters on abnormal psychology, the various models or approaches to psychopathology, the chapters on classification and assessment procedures, and at least one content chapter focusing on the disorders themselves. These chapters are usually followed by material covering the remaining diagnostic categories. The experienced instructor will frequently find that most textbooks follow this fairly standard sequence.

Critical to the success of the exercise is the effective introduction of the material in chapters about models of psychopathology and the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition* (DSM-III; American Psychiatric Association, 1980). When these chapters are taught (and they should be introduced early in the course), it is important to prepare the students for the eventual clinic exercise by demonstrating how a case can be viewed by the various models, regardless of the diagnosis agreed upon from the DSM-III. For example, depression can be viewed as resulting from a chemical imbalance, from a reduction in reinforcement, or from a symbolic loss accentuated by a fixation in the oral stage of development. Thus, before students are actually given the clinic assignment, it is important that they have understood to some degree the ideas behind the various models, the nature of the classification system, and at least one area of disorders outlined in the DSM-III.

Time requirements for the exercise vary with the depth of each instructor's involvement with the procedure. For example, some instructors may not wish to have the clinic groups complete each form for each case presented. However, after the stimulus case has been presented, at least 30 minutes of discussion and processing should be made available for the groups. Additional time for a general review of each group's findings, a discussion of agreement within and among groups, and a presentation of new material by the instructor is needed. For thorough processing of the exercise, a full hour should be allotted. Group discussion and the processing of information can be carried over from one class session to the next. However, we have found the process to be smoother when the entire exercise is completed within one class session. Problems of absenteeism, retention of the case material, and so forth are minimized when closure is achieved within one class period.

Students in each of the miniclinics are presented with an overview of the nature of the learning task. Prior to the actual presentation of case material, students in each clinic are reminded of the particular concerns and variables relevant to their dis-

pline. The psychoanalytical group is, for example, cued to look for important features of early childhood, for current defense mechanisms employed, and for the possible forms that an eventual transference might take. Similar coaching is directed toward members of other miniclinics. These instructions are provided to students in a general session so students can become further aware of the differentiation in task and approach of the various therapeutic schools.

When clinic assignments and the general review have been completed, the full case presentation is made, starting with background information provided by the instructor. Each group also receives a copy of the written case history. It is helpful to select cases with a good deal of background information so that students from each clinic have enough potential information to make a case for the relevance or efficacy of their mode. After the background information is presented, the recording of the case is played. Next, students divide into clinic groups to discuss the case and to complete the paper-and-pencil assignments. While the students are working in their groups, it is helpful for the instructor to interact with each group in progress.

The paper-and-pencil assignments consist of three worksheets: Intake and Problem Formulation, DSM-III Classification, and Treatment Plan and Prognosis. Students are instructed to tailor their observations to their assigned perspective on the Intake and Problem Formulation Worksheet. For example, under the Historical Antecedent section, behaviorists are encouraged to note possible early learning histories, psychoanalysts are told to report possible developmental trauma, and students in the physiological clinic are directed to focus on possible early signs of neurological disorder, brain injury, congenital problem, and so forth. Each student is required to complete this form, although group discussion may take place before each student has completed the assignment.

The DSM-III worksheet requires students in each of the clinics to review all five axes of the *DSM-III*. Of course, students are informed that they will rarely utilize all axes in classifying a case. As with the Intake and Problem Formulation Worksheet, each student is required to complete a form after group discussion. Students are encouraged to stick to their guns even if others in the clinic disagree. Because of this practice, reliability estimates may be made for each clinic.

The classification exercise is followed by the completion of the Treatment Plan and Prognosis Worksheet. It is here that students are able to exercise the most creativity and to display familiarity with their assigned model of practice. Interventions should be justified on the basis of problem documentation and relevance to the student's particular mode. The prognosis section is also to be completed with reference to the assigned model and with consideration of the available resources and circumstances relevant to the model (e.g., How well would an older adult with an IQ of 75 do in traditional psychoanalysis?).

With the worksheets completed, the full class reassembles to process the results of the exercise. The instructor leads a discussion of each worksheet activity, highlighting the points of view for each model represented. In addition, a discussion of agreement or disagreement on diagnosis, etiology, and treatment both within and among groups may be held. Rough estimates of percent agreement within groups may be calculated by simply dividing the number of agreements (with the correct diagnostic category) by the combined number of agreements and disagreements within each group. It should be made clear to students, however, that this number is only a rough estimate that is probably inflated because it does not account for the number of agreements that would be expected by chance. It is probably not worth the

time it would take to labor through a complete explanation of the probabilities of chance agreement for each diagnostic category.

#### DISCUSSION

The miniclinic method presents several advantages to the instructor as well as a few potential stumbling blocks. Advantages include teaching students the rigors of keeping within theoretical models, teaching the logical connection between an etiological conception of problems and interventions associated with particular models, and exploring the problem of how models relate (or do not relate) to the current classification system. Finally, students are able to learn clinical material without rote. They learn that the *DSM-III* is a real tool and enjoy exercising their diagnostic skill through safe risk taking in the miniclinic.

The problems associated with this process include the always-present possibility that passive students will remain passive and let others complete the exercise. The medical students' disease syndrome and the phenomena of the "instant expert" can also be stimulated by this activity, yet early warnings and effective feedback in class can do much to prevent these problems.

One final and nontechnical note summarizing the process is in order: Both students and instructors who use this process find it a lot of fun!

#### REFERENCES

- American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.
- Benjamin, L. T., & Lowman, K. D. (Eds.). (1981). *Activities handbook for the teaching of psychology*. Washington, DC: American Psychological Association.
- McKeachie, W. J. (1978). *Teaching tips: A guidebook for the beginning college teacher* (7th ed.). Lexington, MA: Health.
- Radford, J., & Rose, D. (Eds.). (1980). *The teaching of psychology: Method, content and context*. New York: Wiley.

#### SUGGESTED READING

- Spitzer, R. L., Skodoe, A. E., Gibbon, M., & Williams, J. B. W. (1981). *DSM III casebook: A learning companion to the diagnostic and statistical manual of mental disorders (third edition)*. Washington, DC: American Psychiatric Association.

*Intake and Problem Formulation Worksheet*

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Section: \_\_\_\_\_

Case: \_\_\_\_\_

Clinic assigned: \_\_\_\_\_

Presenting problem:

Historical antecedents:

Current observations:

Notes, Ideas, and Questions for Discussion

*DSM-III Classification Worksheet*

Name: \_\_\_\_\_  
Date: \_\_\_\_\_  
Section: \_\_\_\_\_  
Case: \_\_\_\_\_

Clinic Assigned: \_\_\_\_\_

**AXIS I: Disorders Usually First Evident in Infancy, Childhood or Adolescence**  
Assessment data:

DSM-III  
classification: \_\_\_\_\_

**AXIS II: Personality Disorders**  
Assessment Data:

DSM-III  
classification: \_\_\_\_\_

**AXIS III: Physical Disorders and Conditions**  
Assessment Data:

DSM-III  
classification: \_\_\_\_\_

**AXIS IV: Severity of Psychosocial Stressors (1-7)**  
Assessment Data:

DSM-III  
classification  
(1-7): \_\_\_\_\_

**AXIS V: Highest Level of Adaptive Functioning in Past Year (1-7)**  
Assessment Data:

DSM-III classification  
(1-7): \_\_\_\_\_

Notes, Ideas, and Questions for Discussion

*Treatment Plan and Prognosis Worksheet*

Name: \_\_\_\_\_  
Date: \_\_\_\_\_  
Section: \_\_\_\_\_  
Case: \_\_\_\_\_

Clinic Assigned: \_\_\_\_\_

Summary of needs (conditions):

Unanswered questions and further assessment needed:

Recommended interventions (with rationale):

Prognosis (related to specific problems):

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Notes, Ideas, and Questions for Discussion