Vignettes for Teaching Psychiatry With the Arts

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In this article, six psychiatric educators will describe educational vignettes in which they incorporate the arts into teaching psychiatry. Each educator focuses upon a different aspect of psychiatric phenomena in a problem-based learning format. "The teacher's role in problem-based learning is to act as a metacognitive coach by asking questions, helping students plan their work, guiding them toward the questions they need to pursue, and assessing their progress. In this format, the teacher is more of a guide than a provider of information" (1).

Using Fairy Tales

Dr. Dianne Trumbull, from West Virginia University, uses fairy tales (Box 1) to teach development in her resident course on psychodynamic psychotherapies. Because fairy tales are repositories of archetypal experiences for children, Dr. Trumbull uses them to help residents time-travel back to the early challenges of childhood in order to see healthy and pathological solutions. Both Freud (2) and Jung (3) saw the merits of using fairy tales to illuminate aspects of early childhood. Bettelheim noted: "Which story is most important to a particular child at a particular age depends entirely on his psychological stage of development, and the problems which are most pressing to him at the moment" (4).

Dr. Trumbull asks residents to imagine a child's possible repertoire of adaptive and maladaptive responses to narcissistic injury. She asks them to step into this fairy tale a second time to write an ending in which Max returns to find no mother ready and willing to take him back. In other words, what happens if Max returns to a cold, empty space; how does he manage?

BOX 1. Summary of "Where the Wild Things Are" by Maurice Sendak

A small boy named Max is scolded by his mother. Max deals with his narcissistic injury from the empathic rupture by going on an imaginary journey. This is a temporarily satisfying solution that softens his hurt feelings and restores his wounded self-esteem. By the story's end, he seeks the comfort of real reconciliation and finds his mother ready and waiting to take him back (5).

One resident answered: "Max returned from 'Where the Wild Things Are' expecting a different outcome, in spite of the fact that his homecoming had been exactly the same the past dozen or more times. Once again, he found himself locked in his room without any supper. His mother once again left for the night, not to return until early daybreak. After a time, Human Services became involved. Soon it was a series of foster homes for Max. Some were okay, but most were bad. Max coped by maintaining his amazing ability "to go to far-away places." This resident's story goes on to show Max evolving into a someone with a personality disorder complicated by addiction and dissociative elements.

Using Script Readings

Dr. Trumbull also works with the first author, who developed a generic script (Box 2) to use in a psychotherapy course to illustrate the power of implicit communication.

The teachers ask two residents to participate, using the same script in two different readings. Although the explicit content does not change; that is, the words

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BOX 2. Generic Script

#1: It's good to see you.
#2: Is it?
#1: See that tree, down by the pond?
#2: Missing its top branches.
#1: Three hurricanes, couple of bursts of lightning, a few ice storms. It deserves to be missing a few branches.
#2: Just think if it could talk, tell what it's seen, what it's heard.
#1: Probably won't last another winter.
#2: Hm . . .
#1: Did you go to the shore this summer?
#2: Not this summer.
#1: Just stayed at home?
#2: There were things I needed to do around the farm.
#1: Things?
#2: Things.
#1: Alone?
#2: No . . . yes . . . in my own way, alone. And you?
#1: The Canadian geese are starting to arrive.
#2: Predictably on time.

remain the same, the meaning unfolds in different directions as the performers alter intentions. For the first read, a resident may be instructed to read the lines as a former lover hoping for reconciliation, but, on the second read, looking for revenge. The resident may read the lines about the tree that has been through hurricanes as a means to show compassion and sensitivity, but, on the second read, as an analogy of hurt and bitterness. The residents invariably find that when they infuse the same lines with different intentions, they alter the meaning of the explicit communications. They can apply this understanding to psychodynamic psychotherapeutic processes.

Using Written Narratives

Dr. Allan D. Peterkin, from the University of Toronto, uses written narratives to teach professionalism. Dr. Peterkin relates that all residents witness or experience clinical and academic encounters during which something "unprofessional" or even unethical happens. Many are reluctant to report or discuss such incidents, and thus their experiences remain unprocessed and may color attitudes about work, colleagues, and patients. This approach allows for shared reflection and problem-solving. Dr. Peterkin engages trainees in lively discussions about what medical professionalism "in the real world" means and to reflect on apparent breaches by having them write about specific situations.

He uses a one-time writing prompt with both family-medicine and psychiatric residents in one of their scheduled core seminars. Dr. Peterkin asks residents to: "write about an experience that felt unprofessional" and gives them 5–20 minutes to write a draft onsite. He suggests that they choose a specific incident and write a personal story, in the first person, with a beginning, middle, and end, in a way that conveys not only what happened, but how they felt about it emotionally. This instruction, informed by narrative theory, is more structured than usual assignments for "critical incident reports" (6, 7). He instructs residents to "write the way you would speak if telling this to a friend or trusted colleague" and not to worry about spelling, grammar, or syntax. He asks one or two volunteers to read their pieces aloud and to then remain silent as their peers comment, share feelings, or ask questions. This allows readers to hear and appreciate differing and sometimes surprising views and interpretations in response to what they have shared. Dr. Peterkin sets group-feedback parameters, which include not interrupting the reader, emphasizing strengths of the piece, and providing helpful edits in a respectful manner. When he invites the readers back into the discussions, they have the right to say as little or as much about the stories as they want, remaining in full control of what is elaborated. The importance of maintaining confidentiality around these written incidents is emphasized, because some of these experiences will not have yet been shared elsewhere.

Sample Discussion Questions

1. Why did you choose this incident?
2. What could have been done differently by you? By others?
3. What have you learned after reflecting on this incident?
4. What are the three teaching points about professional conduct (or confronting unprofessional conduct) that emerge from this narrative?

At the end of the session, Dr. Peterkin asks those who did not read to summarize their stories in a few lines.

Using Improvisational Theater

Dr. Jeff Katzman, from The University of New Mexico, utilizes improvisational theater to train psychiatry residents in the art of psychotherapy. The University of New Mexico invited three professional improvisationalists to a 4-hour retreat to work with psychiatry residents. The format of improvisational theater dates back to the works of Viola Spolin (8) and generally involves at least two actors without a script, who must work cooperatively to tell a story. Actors create characters together and listen actively while jointly embracing the unfolding of a tale. They are generally offered little help in this endeavor other than audience suggestions such as a location or types of relationships.

The improvisationalists follow a code:

- Listen actively to each other.
- Acknowledge the reality of fellow actors without blocking or obliterating their contributions (termed the rule of "yes, and").
- Ponder the unfolding of a story while simultaneously being a player in it.
- Facilitate the movement of the story without pushing it too quickly.
- Allow oneself to be fully engaged in an experience of the current moment.

Trainees (new therapists) often struggle with improvisations. They often sit quietly without movement in the chair, burdened as they try to be experts, removing themselves from the immediacy of the relationships. Patients often comment about the removed style of new therapists, longing for more genuine experiences from their therapists. Trainees often focus on what to say next, so busy "writing their scripts" that they miss reality as it presents itself. Trainees often respond from a place of seemingly knowing, blocking the reality of the patient as interactions unfold. Improvisationalists refer to this as slowing the story and relationship by responding with "yes, but" as opposed to "yes, and." In some sense, the art of "yes, and" as presented in the world of improvisational theater is a window to Kohut's concept of empathy. Both improvisationalists and therapists must embrace a sense of spontaneity, careful listening, openness to any material that comes forth, and an immersion in the present moment joined by the relationships in the room. Phillip Rinstrom wrote of the similarity of these processes and the potential for improvisational theater to teach therapists about the "yes, and" processes as well as an immersion in a current moment of time (9).

Using Magic

Dr. Bruce Ballon, from the University of Toronto, uses theatrical magic to teach empathy (Box 3), understanding, and professional approaches for addressing mental health conditions, including psychotic, anxiety, and mood disorders. The use of magic goes back to the dawn of time, when shamans and witch doctors used magic to promote understanding of the world around us. All human beings develop magical thinking processes as part of their development, which never completely go away and actually becomes more active in times of stress. By use of magic, trainees can travel back to childhood and reexperience what it is like to view our world with a magical eye or with the emotions and thinking of people with psychoses. The art of mystery entertainment is a form of experiential learning using simulation. Attitudinal factors have an impact on professionalism, communication, scholarship, and collaborational capacities in a learner. Providing students with the opportunity to experience what it is like to feel the perceptions of a mental health disorder without knowing the exact method (i.e., the secrets behind the magic), brings to life the unsettling nature of psychiatric conditions. In teaching about the cognitive and emotional processes within someone suffering from pathological gambling, Dr. Ballon demonstrated there is no such thing as "100%" certainty.

Besides learning about cognitive distortions, psycho-

BOX 3. Example of Using Magic to Teach Empathy

> The presentation includes having a learner choose a card randomly from a shuffled deck of cards, for example: the 7 of Clubs. The learner randomly pulls out a card, which Dr. Ballon puts on the table face-down. Dr. Ballon bets that the student's card will be exactly half the value of Dr. Ballon's card. Often, students will say "That's impossible because mine is an odd number!" As the stakes are raised, the learner notices increased anxiety that begins to make the learner second-guess his or her thought processes. Eventually, there is a final, agreed-upon bet. Dr. Ballon flips the tabled card over and it is the 3.5 of clubs!

genic needs, and the ambiguity of healthcare decision-making in general, Dr. Ballon ends with a final learning-point: "It's not wise to bet against someone who carries his own deck of cards."

With a deck of cards, one can replicate many psychiatric conditions; however, when one pulls in the art of mentalism and other magical gadgets, one can simulate or approximate experience, and create a window into what it might be like to be suffering from a mental condition. Many people assume there's "magic" at work whenever they can't explain something. Mystery immerses us in the dreaded unknown or exposes gaps in our understanding of our world. Uninvited mystery is often the key issue underlying many psychiatric conditions.

Using Video Segments

Dr. Robert Averbuch, from The University of Florida, uses video segments from movies, TV programs, and the Internet to teach about psychiatric symptoms. In the Psychiatry Clerkship and Human Behavior Course, Dr. Averbuch incorporates video clips into classroom lectures. During a Forensic Psychiatry talk, he highlights the controversies surrounding "criminal insanity."

BOX 4. First Scene From an Episode of the TV Show "ER"

A woman, clearly in hysterics, is confined in her third-floor apartment with three young children as her husband bangs at the front door, fires a gun, and threatens to break in and "kill all of you!" This clip concludes with the mother in the ER, tearful and grieving the loss of one daughter who apparently jumped from the third-story apartment window to escape.

Dr. Averbuch allows students to ponder the scene while he discusses a variety of forensic issues. The clip and discussion draw in students, setting the stage to focus students' attention on a second scene from the same "ER" episode, an episode that reveals what had actually transpired.

This concluding scene is more dramatic and powerful than the opening scene and routinely evokes strong emotions from the students. Dr. Averbuch opens the discussion

BOX 5. Second Scene From the Same TV Episode of "ER"

The mother, acting on a drug-induced delusion and vivid auditory and visual hallucinations, had forced her children out the window to prevent "unreal" violence from happening to them.

by asking, "How many people think the mother should be put in prison?" "How many believe she should not be held responsible for her actions?" He follows by introducing the full verbiage of the McNaughton Rule and Insanity Defense.

The emotional valence of the clip clearly focuses their attention; the lively discussion that ensues makes them active participants in their own learning.

Using Theater Techniques

The first author, from West Virginia University, uses both amateur and professional theater techniques for teaching psychiatry to health-science students. Dr. Fidler assigns residents to act out one-page scripts (Box 6) before a class of peers. The scripts focus on professionalism, and they are followed by discussions.

Additional scripts deal with staff conflicts, sexual-boundary issues, and financial-boundary issues.

Dr. Fidler also invites WVU Theater students to perform detailed, scripted roles of patients with psychiatric disorders (Box 7) for health-sciences students to interview in large or small classes and discuss.

Dr. Fidler encourages students to venture into asking daring questions, since the simulated patients or teachers can stop and guide students to reflect about the appropriateness of questions.

Discussion

The collective aim of the six psychiatric educators is to encourage creative thinking in a psychiatric residency culture that has become largely about the dispersal of medical information, with little room for thoughtful consideration about matters that make us human. The authors offer examples of using the arts to highlight different aspects of psychiatric phenomena in a problem-based learning format. Although the educators have consistent feedback that illustrates residents' satisfaction with these teaching

BOX 6. Professionalism: Script Two

#1: Anita? Do you mind doing me a great big favor and seeing this next patient for me? He's a new patient, a new intake?
#2: I was going to work on my charts. I'm like 15, maybe 16 dictations behind and planned to use this hour to catch up.
#1: Please.
#2: Are you ill?
#1: No, not that.
#2: Well, what's wrong?
#1: Well . . . you know my new sports car, that 20-year-old vintage MG I *just* bought, and I *just* painted?
#2: Yes.
#1: Well, this morning I parked it in front of the hospital.
#2: Yes . . .
#1: So, about 30 minutes ago, I looked out the window, down into the parking lot, and I see this guy in an old broken-down heap, pull in next to my MG. He opens his car door right into the side of my just-painted sports car!
#2: Oh, my word!
#1: So then this jerk gets out, looks at the dent, then . . .I cannot believe this. . .deliberately slams his door into my car again!
#2: That sucks. You love that car.
#1: I know. I fly downstairs and out into the parking lot, but he's gone. . .. Huge dent.
#2: Report it to the police.
#1: I'm considering it. I've got his license number. Anyway, I go out to greet my new intake, and wouldn't you know it: it's the same jerk! I just can't see him. Can you please see him?

methods, the authors need a means of formal assessment to support their hypothesis that this experiential format succeeds in its aim of enhancing creative problem-solving skills in the clinical setting.

BOX 7. Script Outline for a Simulated Patient

An actress portrays a person who was born as a phenotypic male, but lives with a female gender-identity. Students interview the actress to gather information for decisions about sexual-reassignment surgery.

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