PROFESSOR: Today is pretty much just set aside for brainstorming. So we're probably going to do about an hour of that. Just to throw the ideas that people already have in their heads about what could be with the problem space that we're working on. This whole preparing people to deal with violence and folks suffering from an illness. And there's a whole bunch of different things that people may be working on.

And the idea is that hopefully we can get this all out and then we can spend the next half-hour, and frankly the rest of this week, trying to figure out who's in which team. Who's collaborating on a similar topic and who's interested in what. And then, anyone actually get through any of the readings? OK, great. So there's a few things up there. I realize that we don't have a lot of time to read. And there's probably more stuff up there to read that needs to be read necessarily. But it's all there as resources.

Any ideas that people thought might be interesting to work on? Andrew?

AUDIENCE: So one of the basic issues I heard from the presentation, and the papers, was communication. So this may work as a simulation, but the real world system would be communication between the psychiatrist and the patient. Along with the psychiatrist with the person above them.

PROFESSOR: Psychiatrist, patient, communication?

AUDIENCE: Yes. What do they call them? Not the patient. Patient, psychiatrist?

AUDIENCE: Orderly?

AUDIENCE: Nurse?

AUDIENCE: What function do they have?

AUDIENCE: Give us more information.

AUDIENCE: Psychiatrist-Patient for now that's fine.

PROFESSOR: You know how talking about psychiatrists there is patient. Psychiatrist, resident?

AUDIENCE: Maybe like nurse, patient, and then nurse reporting incidents to supervisors?

PROFESSOR: Three levels?

AUDIENCE: Yes, that's the one.

PROFESSOR: So it would go supervisor, nurse--

AUDIENCE: I'm sorry, guys.

PROFESSOR: --and you have the patient. Those kinds of reporting up and reporting down. All right, yeah?

AUDIENCE: So I had a couple ideas. One of them was, every idea you have a patient and there's two doctors or psychiatrists. And so one psychiatrist is trying to calm the patient while the other is doing the opposite and trying to make this patient as angry as possible. So the way I was thinking was, the psychiatrist that's trying to enrage the patient? That's training in what not to say. While the doctor who is trying to calm them down is--

PROFESSOR: So by showing what's the worst possible way? OK, I'm going to call that good cop, bad cop.

AUDIENCE: --Yeah, and then another idea I had which I thought of with [UNINTELLIGIBLE] yesterday was have a team of psychiatrists working with one patient. But interlaced in one of the psychiatrists is a saboteur trying to enrage the patient as well.

PROFESSOR: And what are the target audiences going to be like actual residents. I'm just going to say a saboteur in a group of psychiatrists. Because maybe there's an idea under that dynamic that we can play with. OK?

AUDIENCE: OK, so a few quick things. One would be, I'm not exactly sure how this fits into a game. But simulating people who are delusional schizophrenic by either having every player have a separate audio track playing in their ear as they play? So there's voices speaking to them and they have different audio experiences.

Or having just one speaker that everyone can hear that's playing audio. So incorporating audio into the experience to simulate in some way the internal thought processes and perhaps these delusional thoughts. The voice that tells you to go kill your mother and what not. Which is a documented issue.

PROFESSOR: This particular game doesn't have to be a board game, doesn't have to be a card game, you have a lot more flexibility in what you want to do. I would suggest steering away from doing anything that requires digital logic. But MP3 players would be perfect.

AUDIENCE: Exactly, something like that. So the second thing would be a board game where you're in charge of managing a ward. It's just a logistical game. Making sure that you don't leave anyone neglected or forget anyone. So your patients have their favorite nurse, and they have issues that you have to uncover and deal with. And if you leave somebody unattended and someone goes over they may become violent. So you've got to try and make sure.

And then the third idea would be to have one player play as the patient and to simulate their inability to communicate properly for whatever reason. The information of their condition is hidden from the player. And so try to create a game experience that is genuinely frustrating because the player doesn't quite know what's wrong with them and can't articulate it properly. And the other players are in charge of finding it out. And putting some kind of time-constraint things where it gets heated.

PROFESSOR: There are a bunch of improv games that are exactly that. I have something about me but can't tell you what it is.

AUDIENCE: But the players know that it can get really, yeah.

AUDIENCE: That's like the game where you have, I can't remember what it's called, but the one where you have to try to make the other person say a word. But you can't use a certain series of key words.

AUDIENCE: I'm simulating schizophrenia with audio tape. Being part of RPG's which have done that well. So like live-action role playing stuff. Which did it really well. It actually works. So I recommend that. It's been tried in a setting which I've seen before and worked really well. So I think it could work out.

PROFESSOR: You could do a refinement on that idea.

AUDIENCE: So I know one of the main things that he was talking about was knowing what to do and just going through the process of what happens when somebody does something. And so that brought to mind D & D, and how you have to prepare for the encounter and then in the encounter you have certain actions that you can do. Calm through speech, calm through

presenting some object, or some idea or whatever.

Which I think would map pretty easily into the D & D space. And then you could also have certain abilities which are natural to your character like you're very charismatic which makes some things easier and such. So simplify D & D to handle interactions with patients.

PROFESSOR: So table-top RPG style. And the kind of things you want to emphasize are things like preparation and playing up your actual skills?

AUDIENCE: Right.

PROFESSOR: Things that you're good at. So natural skills and preparation.

AUDIENCE: So I had an idea for a game that could potentially be a card game. Where the player who's playing as the patient and the player who's playing as the doctor are operating under different rules. And one of the main points of the game is they're not actually aware of the other player's rules.

So, for instance the patient could have certain goals which he is trying to achieve. But he is unaware which of these goals is completely unreasonable to the doctor. And the doctor has certain actions he can take and is unaware which of these are going to be threatening to the patient.

And so, then there could be an instance where the patient actually believes the only way he is capable of winning the game is by using violence. And so that could be one of the end conditions.

PROFESSOR: So, sure. And you have to deduce that out? Moving on to Michelle?

AUDIENCE: I like the idea that a psychiatrist has to really keep their composure when dealing with a violent person. They can't raise their voice. They have to keep at a certain distance. And they can't seem upset for whatever reason. Sort of a party game idea, you could have two people. Basically, one person would just have to be throwing insults at the other person. And the person who's receiving the insults would just have to stay calm the whole time and continue to talking. Which is really hard to do even if you know it's coming.

PROFESSOR: So keep your cool. I mean, that could be a game where you're literally insulting someone or it could be a thing where you're playing a character with a certain amount of composure points

or something and you're planning actions and maintaining notes. And different tactics to be able to increase those or decrease those.

AUDIENCE: A co-op type of game where you are a bunch of nurses trying to take care of the ward. This is a lot like Jeremy's *Diner Dash* style game. Except, you have a limitation to how you can actually do it once. So you will be forced to neglect one often.

PROFESSOR: A patient, one? Neglect one patient?

AUDIENCE: So nurses will get sick and they'll have to leave.

PROFESSOR: So, rather you have limited resources. Not quite nearly enough to deal with every single crisis that's going to happen.

AUDIENCE: So the one thing I found interesting in reading this stuff is statistically the amount of violence that happens with mental patients is not actually that different from the amount of violence that happens in the general population. And it talks about how people going through this, and deciding to go into the profession, might actually second guess themselves because they have this perception of there's more violence.

So I think incorporating something where you have life in the ward and life outside of it. So you incorporate both the things where you're trying to deal with patients but you're also reinforcing this idea that it's not significantly more dangerous than real life is.

AUDIENCE: None of your patients stab you but you get mugged on the way home.

AUDIENCE: Yeah, something like that. It's just life.

PROFESSOR: One thing that could be really attractive is that now broadens your audience to people who aren't just psychiatric residents.

AUDIENCE: So, I like the idea of the patient and doctor having different roles, rules, goals, views, et cetera. But I also like the idea of incorporating an escalation and de-escalation into the conflict between the two of them. So I feel like part of the thing which was really compelling about the role-playing scenario which they showed was there was then sense in which the doctor can say things which can escalate or de-escalate the situation. Make it more or less likely that things will go a bad way.

And one way which that could be done partially through roles would be to have hidden

keywords which the patient responds to or what have you and that moves them into a different state. And then transitioning between these two states changes the goals which the patient has so maybe the intent on trying to get Nurse-- what was the nurse's name? Dave?

AUDIENCE: John.

AUDIENCE: Nurse John. But as they get de-escalated then they just want to change their meds. But then as they get de-escalated from that then they just want to go run back out.

PROFESSOR: Just coming up with the rules that model what an unreasonable patient would do or what are you willing to give up. And actually putting somebody in the shoes of that, is essentially something to think about what I can do as a doctor.

AUDIENCE: So, there was this guy we used to play in my family where you're given a scenario and certain number of words you can't use. Essentially, you choose random words and you have a scenario. Basically what you were saying where certain keywords do certain things. But you have to somehow create the best story or the best calm-down passage to read to the patient.

And then there's some arbitrator, the GM of the game, that decides which of the three people that were playing which one had the best story out of those. To get you to have to come up with something to deal with, You need Nurse John right away.

PROFESSOR: You could do a thing where you had to create a story about a random explanation of elements or cards. But then some number of those cards, specifically the other player or maybe the game of other players specifically just saying. Those internally are supposed to be our keywords. And there's some 20 questions type of way to try and figure out what those cards are. So that would be like a doctor trying to figure out what they're dealing with while they're [INAUDIBLE].

AUDIENCE: You can make that game like *Guess Who.* Where each person draws a card and you have to give a statement to the other person or ask them something. And then you see whether they escalate or de-escalate and each individual card has a trade story. If you talk about this that's bad. If you talk about this that's good.

PROFESSOR: I'm not familiar with *Guess Who.*

AUDIENCE: OK, so it's not really that much like *Guess Who.*

AUDIENCE: 20 questions?

AUDIENCE: What I can think of is everyone just has a whole bunch of character cards and each of them have traits. Like, watch this. If you you say this they'll get upset. If you say this, it's not very fully fleshed out. But everyone just randomly draws traits. And you just take turns speaking to each other. And then the patients either will respond or get more angry.

PROFESSOR: So it's almost like your role is a collection of randomized traits or randomized behavioral rules. So, rules determined by randomized rules. For those people in the *Assassin's Guild,* or are familiar with the *Assassin's Guild,* there's the concept of assignments. Things that you as an individual player are given at the beginning of the game as things that you can do and have to do. Or if you do something you have to do it in these specific conditions.

Psychological limitations is what they're called. It could be something as simple as you have to speak in an accent all the time or you have to limp. It could be something more like every time you see blood you have to run away because there's a [INAUDIBLE]. It might be interesting to think of a collection of those things and that crafts how we play. So this makes me think I should probably do the live-action class at some point and talk about party games and role-playing games. I think you had your hands up?

AUDIENCE: No, my hands are in my pocket.

PROFESSOR: Your hands are just up, correct?

AUDIENCE: Another thing that psychiatrists do when they're talking to a patient is to try and get the story out of them as to why they're upset. So you could have a game where the patient has some set of cards that has some set of story with some keywords and the doctor has to try and get these words out of him. But the patient, himself, doesn't fully know his story so it keeps on changing. You can keep modifying your story as you go by drawing cards and putting them away. And you can only really get the full picture once you get all the cards from the patient that you can.

PROFESSOR: So, does the patient have all the cards?

AUDIENCE: The patient has his full story but it keeps changing.

PROFESSOR: So, ever-changing story and you want to stay on top of [UNINTELLIGIBLE].

AUDIENCE: Yes.

AUDIENCE: This isn't really a fleshed out idea. But as a mechanic? Say there's a doctor and a patient and the only communication is through cards. So the doctor will give the patient two cards, and then the third card is randomly inserted off of a deck and shuffled in. The patient receives all three.

So the patient might be schizophrenic and imagining things. And they get what the doctor is saying but they also get other random things as points.

PROFESSOR: So as a mechanic that would be-- man, that's hard to describe. The idea that you will be adding the randomized element.

AUDIENCE: So you get information that is both what the other person played, and something random, and you can't distinguish which is which.

AUDIENCE: You have a communication channel and you're adding random noise.

PROFESSOR: Yeah. Is that a question [INAUDIBLE]? I am running out of space, so that's a good thing. Any other ideas? That's creepy. Anyone else?

AUDIENCE: One concept I thought was interesting, though I'm not really sure how to turn it into a game immediately, is the idea of the patient and specifically the doctor or the rest of the world having at the moment irreconcilable narratives. And the goal of bringing those into some type of medium in which the patient can comfortably exist with this narrative that's in line with the rest of the world.

PROFESSOR: So the idea, again, of narrative disruption is why people get violent in the first place. So maybe even taking out the question entirely of is this person going to act violently, but can you even work together with somebody to change how they see the world until it makes sense on both sides.

AUDIENCE: So with that, something I can't actually think of a game for it right now, be something like you have the patient and doctor. One person trying to figure out the other person, the other person trying to trigger the other. But there's something in the middle that's changing everything. So it's just trying to reconcile the difference. Figuring out the connection and communication between the two.

PROFESSOR: So you have a situation where you actually have three people playing. And there's one person who's changing information on some predictable or unpredictable way.

AUDIENCE: Maybe they have their own objective in mind. The two people on the ends are trying to figure out what the other one's saying and then one person in the middle has their own agenda, representing schizophrenia.

PROFESSOR: So there's a noisy communication channel with an agenda --I like that. That could be an algorithm or that could be a person. It could be a person running an algorithm in their head.

AUDIENCE: I mean the noisy communication channel, or the actual state of mind of the patient, that is the point right? And then depending on their level of arousal, that could change how everything gets screened into being very combative. And so everything the doctor says is taken as being.

PROFESSOR: Some sort of parable that's actually going to affect how they were able to [INAUDIBLE]. OK.

AUDIENCE: This would probably only work once, the first time you play through, but again you've concealed from the players, or certain players, themselves what their goals are. Or what they believe think about the game. Say, it is in fact a delusion or not true. So you might tell them that it's about a game set in 2100 when you've been wrongly imprisoned in a psychiatric ward and you must fight your way out or something like that. And there's a voice that will guide you, or whatever.

And then you don't tell that player that they're in fact playing a schizophrenic player who will [UNINTELLIGIBLE] these things. And then you use some sort of live-action role playing or not, I'm not exactly sure, but this other guy is convinced that this is what the game is about.

PROFESSOR: I could write a [UNINTELLIGIBLE] rivals scenario. The player's don't know that going in, but folks have seen the film *The Cabinet of Dr. Caligari.* It's an old German expressionist [UNINTELLIGIBLE] film. I could spoil it? Does anyone care? It's an old 1920s.

AUDIENCE: I think you're fine.

PROFESSOR: But the basic idea comes down to the hero of the horror story is actually just a patient in a psychiatric ward. And everybody who he believes is part of the story he's conquering is somebody else in the psychiatric ward. The big villain is actually the person running the ward.

AUDIENCE: That's like Shutter Island.

AUDIENCE: Yeah, it's like Shutter Island

PROFESSOR: Not entirely unlike a lot of different stories. But similar idea of the information being given is not to be trusted.

AUDIENCE: Something to go along like that, a game mechanic for that would be everyone's assigned a different role. And one of those roles is patient. So you don't know if you're the patient or not. And so in time as you do your objectives, and as you play along you may start to realize things aren't actually as they seem. So eventually you may figure out I'm actually the patient here.

PROFESSOR: Right, almost like primeval authority in that sense.

AUDIENCE: Going along with that, I think an interesting mechanic would be like the *Battlestar Gallactica.* The person knows that they're a Cylon but they can infiltrate by doing that voting system at the end. What is that? The [UNINTELLIGIBLE]. So you know that someone's trying to sabotage you but you don't know who.

PROFESSOR: So that's who's the patient from a different way, right? One is, player knows who-- at least one person knows and the other one is trying to figure out whether they are it. [INAUDIBLE].

AUDIENCE: This is just an interesting mechanic. There was this RPG called, *Great* [INAUDIBLE] *Game* that had this really interesting mechanic for handling the dark side that each player had. Which might be relevant in this situation.

Essentially you had a different person who's also playing another protagonist also play your antagonist. And so, they would either talk to you and tell you things or they would just directly control your character like if you fail at the composure role. And taking the adversarial side of your character away from your control, it means that your character is more likely to behave in a really disruptive way. Rather than just a controllably disruptive way would be if you had a vested interest in your character.

PROFESSOR: So, open end case control of your character. And that might work really well with some of the ideas of the good cop bad cop idea that someone thought of already.

AUDIENCE: So, actually going off of the audio idea of someone is actually hearing voices? If it was the patient thing. You could actually have things where you have one player is actually playing a patient who is schizophrenic and another player is playing the voices in his head. But they don't really know that. They are playing the scenario where they have some delusion that

they're trapped in whatever. So having a person actually being the-- as you're saying-- having an actual person be the dark side of the patient.

PROFESSOR: But neither of them know who's the dark side?

AUDIENCE: The patient, yeah, you could have it.

AUDIENCE: One way you could arbitrate it is you could say, the patient player is just basically able to do as they please. But there are rules which govern whether the dark side character can take over. And that means that the patient is genuinely driven by trying to reach a compromise but they can just be overruled by the dark side.

AUDIENCE: There could also be things where it could be more like a strong role-playing thing? Where the voice is actually just trying to convince them that yes, this delusion is real.

PROFESSOR: So, do you still think you have a recorded thing? Or two different?

AUDIENCE: You could actually have two people just actually standing there talking.

PROFESSOR: So two people playing one character at once.

AUDIENCE: It would potentially require a lot of suspension of disbelief on the part of the person playing the psychiatrist.

PROFESSOR: It might be one of those things that's easier to mediate by having people talk on screen or something like that? Or a microphone in a speaker type thing? [INAUDIBLE PHRASE] I've not seen many games that are designed specifically to be played on the [INAUDIBLE] function.

AUDIENCE: I definitely like that idea, and I think it could work well in a card game as well. If you have two players sharing the same hand, and the player who actually gets to play the cards from the hand is whoever's in control of the patient. And so the state basically changes depending on what the doctor does. Different players come in control of the patient's hand.

PROFESSOR: So it seems like we actually have a lot of different options on how we could mechanic someone who's going to be unstable. And also, a bunch of ideas on how that state switch could happen or what makes it take over. So that's pretty cool.

And that's not mutually exclusive from any other ideas that are specifically about the patient and the doctor, right? So we're talking about what happens to the patient. These are the rules

a patient could be operating under. The doctor could have a different set of rules.

AUDIENCE: I was reading about this, and I think that it turns out most violence in psychiatric wards happens to the patients themselves or to other patients by patients. Much more than it actually happens towards practitioners. And I'm just noticing that I don't think any of our ideas address any of those issues.

PROFESSOR: Ward management maybe gets a little closer.

AUDIENCE: People start turning on themselves. And I was just thinking another possible way you could apply a lot of these role-playing multiple role auditory mechanics is to a situation. We should probably do research in what situations lead to patients coming in contact with each other and the encounter turning violent.

And all players be patients that have various different mental disorders, and just to help you understand as a patient what kinds of behaviors and situations would lead you to going violent on someone else. Just like one of those, be in someone else's shoes helps you understand the situation better.

PROFESSOR: So we're just putting them in an environment where everything that is necessary for a different character to become upset and violent and just see how it naturally occurs. [INAUDIBLE]. OK.

AUDIENCE: They gave a persuasion that's a cross between *BS* and *Uno.* So you have two doctors who are trying to get rid of cards in their hand, and the patient wants a certain set of cards. And he's saying, I'm looking for John. And the two doctors pull out a hard and say, oh this is John. Or they can be like, oh this isn't John but I can help you out later.

PROFESSOR: That almost seems like it's intended to teach people about lying.

AUDIENCE: Yes.

PROFESSOR: So, I'm going to say it's almost like *BS* and *Go Fish.* So we have a pretty good pile here. A lot of these can obviously be combined. And there's no reason why multiple groups couldn't attempt to do similar topics. In fact, you could take exactly the same set and I'm pretty sure you're going to [INAUDIBLE]. So that's fine.

Again, a lot of things that could probably be easier done live-action. Or easier to do a prototype live-action. The folks who were here on Monday, they are actually focused mostly on

trying to see what could be moved out to more resonant things in the future. Your games don't necessarily need to do that. But you might want to keep that in mind.

Because this assignment is a game for a client after all. And if you manage to address that need-- here's something that doesn't require one person from the original GM team. You can imagine the acting exercise that we ran through, beyond talented improvising on their feet. Requires people and requires responses that may not necessarily every gaming environment's going to have.

Something that can be turned into a very understandable set of rules or using technologies that are very accessible. They're going to play your voice and its going to be a lot easier than something like formulas or something like a phone as opposed to [INAUDIBLE].

AUDIENCE: It was a phone conversation actually going? So if it's live, and people are in different rooms, and actually talking to each other over the phone or Skype or something like that. But you're talking to someone? You have the phone-ups and then that other person can hear what you're saying and be the evil voice?

PROFESSOR: That's the thing, you don't even need to do it on Skype. You just get two cell phones with [INTERPOSING VOICES] Now, the technology just becomes that much easier for games [INAUDIBLE PHRASE].

AUDIENCE: Or you could make it like if there's some game that two people are playing. The two groups that are playing the same game but they both hear the other group. Like this group would hear the other group's playing the game. So it's not even just a random conversation. They're playing the same game you're playing but you're hearing them play games.

PROFESSOR: Wow. Wow.

AUDIENCE: That's deep.

PROFESSOR: I could say two groups eavesdropping same game.

AUDIENCE: I just wanted to say that I think the thing which is really hard if you're working with people who like don't really want to do a role-playing thing is building a level of emotional intensity and the fear of violence. Which is the point of the training. They want them to be able to deal with that kind of emotional stress on your feet. So I was just wondering. Because I don't have any good ideas. Can anyone think of something which works out?

AUDIENCE: Which could genuinely create a situation where one could be afraid of violence?

AUDIENCE: Without actually having to threaten another person.

AUDIENCE: I don't think you're going to be able to do that.

AUDIENCE: Well, if one player's role is actually not to understand but to provide the experience for the other? And they are hearing the recording that's giving them cues as to what to do? And the other player's not agreed to this, and one of their cues is like and now, grab the other player by the shoulders and shake them violently and say something. You could possibly create a situation where you're like, whoa.

AUDIENCE: The problem is you have to be able to get somebody who can do that without cracking up in the middle of it. Because people do that when they're nervous and uncomfortable. So you'd pretty much be reduced to finding professional actors. And that's a limited resource that puts a limitation on how widespread your game is.

PROFESSOR: Even people who are [INAUDIBLE].

AUDIENCE: I had a thought where you have a patient to patient interaction. So you have two people in different rooms on the phone with each other trying to negotiate something. I don't know what it would be.

AUDIENCE: And some other people in each of their rooms that are talking in their ear and trying to distract them from the conversation.

PROFESSOR: OK, so patient talks to patient.

AUDIENCE: Maybe it could be something like they're trying to negotiate [INAUDIBLE].

PROFESSOR: With voices in-person? There is a specific article on schizophrenia that I uploaded in your resources. [INTERPOSING VOICES] Patrick first, then Michelle?

AUDIENCE: So I was thinking something along the lines of *Battleship?* If you have a doctor player and a patient player and they're both looking at their own version of the same board. And if the patient wants to get from one end to the other and the doctor has to allow whether or not they can make their move.

But on the doctor's board they have different obstacles. And so the patient will say, I want to

move from here to here. And the doctor says, I can't let you do that. I can let you go from here to here. It'd be a game about compromise.

PROFESSOR: OK, so sort of a doctor mediated [UNINTELLIGIBLE PHRASE]. And the *Battleship* analogy is good to help us remember where the idea came from. Michelle?

AUDIENCE: Yeah, so just something that Owen said about trying to simulate fear. I mean, if you can add time pressure to any game then I think that strong of a stress situation can almost be fear. It can get [UNINTELLIGIBLE].

PROFESSOR: Because what you're really going for is stress in making decisions.

AUDIENCE: [UNINTELLIGIBLE] created stress without the [INTERPOSING VOICES]

AUDIENCE: So, an idea of how to take the doctor mediated board movement into the real world? We're talking about these phone to phone conversations. You could have the patient in a room but he's blindfolded. And he's trying to move through the room towards an exit in the room or something. And the doctor has some limited information about the room and has to help him navigate through the room.

And he'll say, I want to move forward. And he'll say, well I can't really let you do that because there's a pit fill of spikes in front of you. And you wouldn't necessarily actually have a real pit full of spikes in front of them. But that kind of thing where you're trying to gather information and help them through this. And you could put time pressure on it and say, well I have to make a decision now because he wants to move now. But I might accidentally move him into an obstacle and have to deal with that.

PROFESSOR: You could have a thing where there are some things that the patient needs to do that the patient can't talk about. And it might be something like the patient has to move every 10 minutes. And only the patient knows this. The doctor doesn't.

AUDIENCE: The patient has a fear of moving to the left.

PROFESSOR: Or something like that.

AUDIENCE: Things like that.

PROFESSOR: Patient has to move left, right.

AUDIENCE: I think it also emphasizes the thing they were talking about on Monday in that you are both trying to not-- if it escalates to the point where violence happens-- you're both trying to not let yourself get hurt but you're also trying to not hurt them. And I think incorporating that in some way might be cool.

PROFESSOR: Definitely a lot of these ideas are sort of mechanicing the patient's limitations are really, really, cool. But again, remember the audience is the residents. So understanding what a patient is going through is useful. But also thinking of rules that help a resident understand what they can do is also really important. So don't just think about throwing a ton of limitations on them without also given them a release. Things that they can actively do. Words that they can carry out.

AUDIENCE: So, working off the time pressure thing, I think that it might make sense for these kinds of escalation, negotiation type, situations for the person who's controlling the patient to know what their triggers are. And every time a bad thing is said, they just reduce the amount of time that the doctor has to deal with them.

And they say that, they just say minus 10 seconds. And they have a timer and it ticks down to reach the conclusion of the doctor getting them to where they want to be. And rather than like raising their voice, or being physically in some way, they just adjust a timer. And when it gets down to zero it's over.

PROFESSOR: I can see that. [UNINTELLIGIBLE PHRASE]

AUDIENCE: I'd just like to say, one way you could make your players feel pressure is to give them a really flat goal hierarchy. Right? So a good example is *Missile Command.* Does everyone know that game? *Missile Command* is just six cities. And there's missiles coming in and you have to shoot them all down. And each city is equally valuable. So if you lose one you're in a drastically reduced position.

Whereas games that tend to have a more structured goal hierarchy basically means you can afford a loss. Right? So like chess is a good example. Where you can say, OK I can afford to lose this. Whereas in *Missile Command* you can't afford to lose anything. So by really capping what the player has, what they can afford to lose, and then making sure that all of their goals have equal value, that means that every loss and every failure is felt much more strongly.

And I felt like, Dion when you were doing your role play, there was this sense, especially

coming from Caesar, that any one thing that goes wrong is really bad. There's a really thin line there.

PROFESSOR: That's especially applicable when talking about the doctor's goals, not necessarily the patient's goals.

AUDIENCE: I mean, from the doctors' position right? You can't really afford a lot of mistakes in these situations.

AUDIENCE: I'm kind of aghast, but I was listening to what you were saying and I have a thought on how to combine lots of these different ideas. I'm envisioning a game where there'd be two types of players, like you were mentioning, doctors and patients. And there'd be one doctor and multiple patients. It would be a turn based game where you go around and give each person a turn. The doctor would always be in relationship to each individual one.

And limited vocabulary I thought was important, taking that from a couple of the ideas. The patient and the doctor each have their own set of vocabularies and the clash of that would introduce mechanic there. Where the patient has their own vocabulary describing to the doctor what they like, what they don't like. They know what they like. You could extract it to describe anything the doctor would have in their vocabulary.

So, as one example the doctor could give the patient a card with a shape or some item on it. And the item has attributes like color, shape, something that somebody could like or dislike. In their list they could look at this and see one of these things clashes with something in my list of dislikes. I don't like that card. I'm going to escalate my anger, my displeasure, with the situation.

And so, the doctor has a limited amount of time to deal with each patient. As the patient's escalation increases, they have less and less time to be dealt with. After a certain point the doctor loses that patient, so you have that loss brought in. And then after all the patients have been lost the game is over.

The way that it would be won is that the doctor is discovering the profile of each patient. Because they are trying to, like in a normal setting or a real world setting, you're trying to discover the profile that allows the doctor to deal with the patient in the best possible way so that they aren't violent.

PROFESSOR: So that seems to play off the patient and doctor have different rules and triggers. You've got a

situation where, in what you're suggesting, you have one doctor and multiple patients. Which is accurate. I'm not quite sure that they'd be dealing with them simultaneously but it might not matter for the purposes of the game.

It might be like those improv games where you manage to figure out before time runs out what a person's profile is. That could be the win condition. So it's equal win [UNINTELLIGIBLE] and equal loss if you don't actually get it incorporated with something like you give a trigger and reduce the amount of time you have available, the number of turns available. It doesn't have to be real time. So you can use it with multiple patients.

So that doesn't even necessarily have to deal with talking about actual psychiatric ward situations. That could be something like objects and colors. It's more of a guessing game. That might be too abstract, possibly, because in the end you want people to be able to tie it back to the experience. To be able to make an easy connection to what it's like to be a resident or what it's going to be like to be a resident.

So this is where the theme needs to be pretty clear. But in [UNINTELLIGIBLE] talked, fear is not meaning. Meaning is also tied pretty well with your mechanics. So that's just something to keep in mind. OK?

PROFESSOR: We probably have another half-an-hour class. I think the plan was just to let everyone figure out teams you wanted to be in. This is going to be class time to talk to each other and see if there's stuff in here that people are really psyched about. Is there anyone in this class that's already like, this is something I really want to do?

AUDIENCE: Well, my preference is towards the ward advantage. To ward advantage?

PROFESSOR: I don't really have a plan [INAUDIBLE].

AUDIENCE: I'd be interested in voices and hidden information. So fooling players and that result in them behaving in erratic ways. And as from the point of view of other players, and then the point of view of player's behaving erratically, other players are behaving erratically because it's not in line with what they think is actually going on. Or voices, or both, or something like that.

PROFESSOR: So that's the general territory you're interested in going into? Who wants to?

AUDIENCE: I'm very interested in the escalation and de-escalation by hidden keywords. [INAUDIBLE].

AUDIENCE: I like basically hidden rules, goals, and keywords, and two different players playing the same character. Those are two mechanics I really like.

PROFESSOR: We have a couple of seats out there. Caffeine helps, there's a bunch. What do we have on Friday?

GUEST SPEAKER: On Friday we mostly just have brainstorming and team-building scheduled? That time is pretty flexible.

PROFESSOR: S0 what I can do maybe, if folks can plan to come into Wednesday with a team, what I'm going to do is I might move my--

AUDIENCE: You mean Friday?

PROFESSOR: --Sorry, Friday, yeah. Then I will move my live-action talk up to Friday instead. So Wednesday we can just-- since it seems like a lot of people are going in that direction. You don't have to do a live-action game, but it's one of my favorite games.