

Yale University

EliScholar – A Digital Platform for Scholarly Publishing at Yale

Yale Medicine Thesis Digital Library

School of Medicine

1-1-2023

Family Dyads, Emotional Labor, And The Theater Of The Clinical Encounter: Co-Constructive Patient Simulation As A Reflective Tool In Child And Adolescent Psychiatry Training

Isaiah Thomas

Follow this and additional works at: <https://elischolar.library.yale.edu/ymtdl>



Part of the [Medicine and Health Sciences Commons](#)

Recommended Citation

Thomas, Isaiah, "Family Dyads, Emotional Labor, And The Theater Of The Clinical Encounter: Co-Constructive Patient Simulation As A Reflective Tool In Child And Adolescent Psychiatry Training" (2023). *Yale Medicine Thesis Digital Library*. 4163.
<https://elischolar.library.yale.edu/ymtdl/4163>

This Open Access Thesis is brought to you for free and open access by the School of Medicine at EliScholar – A Digital Platform for Scholarly Publishing at Yale. It has been accepted for inclusion in Yale Medicine Thesis Digital Library by an authorized administrator of EliScholar – A Digital Platform for Scholarly Publishing at Yale. For more information, please contact elischolar@yale.edu.

Family dyads, emotional labor, and the theater of the clinical encounter:
Co-constructive patient simulation as a reflective tool in child and adolescent psychiatry
training

A Thesis Submitted to the Yale University School of Medicine
in Partial Fulfillment of the Requirements for the Degree of Doctor of Medicine

by

Isaiah Thomas, Class of 2023

TABLE OF CONTENTS

INTRODUCTION	p. 1
Critiques of patient simulation	p. 3
Co-constructive patient simulation	p. 5
Patient simulation in pediatrics and child & adolescent psychiatry	p. 8
Statement of purpose	p. 11
METHODS	p. 12
Ethics statement	p. 12
Human research subjects	p. 12
Methods description	p. 13
Student contributions	p. 17
Reflexivity	p. 17
RESULTS	p. 18
A dramaturgical approach to CCPS	p. 22
Centering the child, allying with the parent, and treating the family system	p. 27
Reflecting on dyadic challenges: role reversal and individuation	p. 32
Ambivalence in and about the parent-child dyad	p. 36
Accepting uncertainty and the unknown and focusing on the here and now	p. 41
Longitudinal narratives and change over time	p. 44

DISCUSSION	p. 50
Acting like you care	p. 52
- Embodying emotional authenticity	p. 52
- Performing emotional labor	p. 55
Parenting and the clinical encounter as holding environments	p. 60
Debriefing sessions as holding environments	p. 61
A dialogic approach to dyads	p. 63
Challenges and limitations	p. 65
Dissemination of results	p. 66
REFERENCES	p. 66
APPENDIX A	p. 73

ACKNOWLEDGEMENTS

Thank you to Andrés Martin, MD, PhD, for his editorial support throughout this project and mentorship since my first year of medical school. Thank you to Marco Antonio de Carvalho Filho, MD, PhD; Robbert Duvivier, MD, PhD; and Laelia Benoit, MD, PhD for their thorough feedback and positive encouragement. Thank you for the support and feedback from QUALab, the Qualitative & Mixed Methods Lab, a collaboration between the Yale Child Study Center (New Haven, CT), and CESP, the Centre de recherche en Epidémiologie et Santé des Populations (Paris, France). Thank you to the patient actors from the Yale School of Medicine's Simulated Participant Program for making each simulation session possible and to the Yale Child Study Center providing the space for the sessions.

INTRODUCTION

Patient simulation and the use of simulated or standardized patients have become increasingly commonplace in undergraduate and graduate medical education for the development and assessment of communication skills¹. The simulated patient (SP) may be a professional actor trained to present a history and sometimes to mimic physical signs or a patient who has received training to present his or her history in a standardized manner. According to Grau Canét-Wittkamp et al, simulation facilitates learning patient-centered care by offering the following: less complex clinical situations with decreased a cognitive load that allow learners to focus on communication; a safe environment to experiment and try new approaches without fear of harm to the patient; self-reflection through feedback from supervisors and peers; and improving learners' sense of self-efficacy². Ideally, the skills and perspectives developed during simulation will then be transferable and applicable to real-world settings. In this text, I prefer the term “simulated participant,” which I define as an actor who is trained to play one or more roles (patient or otherwise) over the more narrowly defined “standardized patient,” which refers to an actor trained to perform standardized scripts for one or more patient roles. “SP” in this text refers to “simulated participant,” rather than “standardized patient,” unless otherwise noted.

Dr. Howard Barrows, one of the pioneers in patient simulation with professional actors, began to develop the concept of standardized patients while part of the University of Southern California faculty³. Barrows sought to develop standardized evaluations for

medical students at the end of their neurology clerkship and was in part inspired by a patient's story:

As the chief resident, I had the responsibility of bringing in neurological patients from surrounding hospitals (particularly the chronic neurological patients from Montefiore Hospital) for [the board examination in psychiatry and neurology]. Following the examination, the director of the Montefiore neurology service made rounds on his patients to see how they had tolerated the numerous examinations they had had to undergo during the examination. He interviewed a patient known to everybody as Sam, who had syringomyelia. When asked about the examination, Sam remarked that there had been no particular problem except with the physician who had examined him last. Sam indicated that that physician had been quite hostile and had performed a very uncomfortable neurological examination. The director said that he was sorry to hear that, but Sam said, "Don't worry, I fixed him—I put my Babinski on the other foot and changed my sensory findings." He had simulated neurological findings.

This account makes apparent the need for more controlled clinical interactions for the sake of consistent learning and evaluation and, more importantly, for the well-being and dignity of actual patients who are employed for these purposes. In 1963, Barrows hired Rose McWilliams, an art model, to act out the first standardized patient case, or "programmed patient," named Patty Dugger, a fictionalized patient with multiple sclerosis and paraplegia⁴.

In the context of psychiatric training, Adam Brenner describes three main roles patient simulation has played: (1) Simulation provides exposure to a wider variety of patient types, especially for students and trainees at smaller medical institutions where they may encounter fewer rare or complex presentations; (2) simulation has been used as an assessment tool for medical students' and psychiatry trainees' clinical skills specific to psychiatry; and (3) simulation has been used to develop and practice psychotherapy skills given the limited opportunities at some programs for direct observation of learners by experienced clinicians and observation of experienced clinicians by learners⁵.

Critiques of patient simulation in medical and psychiatric training

Even as patient simulation has become more widespread and integrated into medical training over the past ten years, there continue to be criticisms of its efficacy as a pedagogical and evaluative tool in clinical medicine in general and psychiatry in particular. When Barrows introduced the concept of standardized patients to medical education in 1963, early critics disparaged these patient actors as “too Hollywood” and “detrimental to medical education by maligning its dignity with actors”^{3,6}. More recent critiques have questioned the reality and humanity of patient simulation. Hanna and Fins argue that patient simulation does not adequately reflect the power dynamics between a doctor and a patient⁷. The encounter has no lasting impact on either party as well, negating the power of the patient-physician relationship. Without this power dynamic, they argue that the encounter does not involve the patient experiencing “*genuine anxiety*”

nor the provider offering “*real* healing” and that simulation encounters result in “simulation doctors” who are simply performing the role of the good doctor.

In psychiatry training, some critics of patient simulation have argued that the goal of standardization is antithetical to the variable nature of clinical care⁵. For example, traditional simulation has a presumed answer and a patient who knows the “truth” of their condition and has a clearly delineated agenda. In the context of psychotherapy training, some claim that standardized patients reduce the “intrinsic ambiguity of psychotherapy situations” and therefore impede learning⁸. Additionally, Brenner questions the use of patient simulation to learn and assess empathic responsiveness:

“Are we talking about the student acting in a way that we believe would convey empathy if this was a real encounter? In that case, the student is re-creating the behavior that would follow from having an internal experience that was a response to the inner life of the patient. Or are we talking about the student actually having such an internal experience, and thus feeling moved or disturbed by the SP?”⁵

In spite of these criticisms, simulation appears to still have a place in psychiatry education; Piot et al posited simulation-based education as “particularly well-suited to psychiatry, supporting a holistic person-centered approach, reflective skills acquisition, emotional elaborations, cognitive reframing and co-construction of care”⁹.

Co-constructive patient simulation

In spite of its widespread use for learners to practice clinical and communication skills, patient simulation has, like much of medical education, traditionally been oriented toward the perspectives and priorities of instructors, at times taking the form of the *hidden curriculum*, which refers to lessons taught and learned during medical school that are not openly intended¹⁰⁻¹¹. An instructor typically designs simulations with specific objectives in mind and evaluates the learners based on their ability to meet those objectives according to the instructor's personal criteria. Schweller et al described the need to flatten the hierarchy between learner and expert in the context of medical education:

“Expertise may desensitize supervisors to the nuanced complexity and emotional nature of professional dilemmas. Therefore, residents may benefit from the opportunity to bring their own dilemmas and emotional reactions to the simulation and debriefing sessions”¹².

To address this issue, the authors developed a patient simulation series focused on challenges in the physician-patient relationship for internal medicine residents. The activity involved two innovative changes to traditional simulation: (1) Residents formulated the second and the third simulated cases together with professional actors using clinical situations that they had found challenging in the past. In the sessions with the residents' cases, a supervisor took on the role of the interviewer in the simulation but resumed as a facilitator during the debriefing session. (2) Extended debriefing sessions were implemented for discussing the emotions triggered by the professional and personal

dilemmas presented in the simulation cases. These sessions were intended to address the fact that such dilemmas are emotional experiences for both patients and providers and that an awareness of this emotional dimension is crucial to providing the best care possible. By centering the residents' experiences and voices in these cases, the authors developed and explored an innovative field in clinical simulation, "a field that offers the trainee the possibility of addressing their own needs."

Building off this foundation of self-regulated learning and critical pedagogy, Martin et al complemented the model with two additional theoretical approaches to develop the *co-constructive patient simulation (CCPS)* model:

"First *co-constructivism*, as defined in the teaching and pedagogy literature, speaks to the collaborative learning process of co-creating, negotiating, and maintaining meaning through self-reflection and dialogue in a classroom. Second, *narrative co-construction* draws on narrative theory to describe the shared sense-making, structure, and story-building [...] In the health and medical humanities, however, narrative co-construction primarily signifies the clinical encounter. Specifically, the physician's task of close listening to a patient to coauthor their illness narrative and diagnosis to both center patient agency and remediate preexisting asymmetries of power and expertise"¹³.

The authors went on to apply the CCPS model to psychiatry training and found particular effectiveness for practicing a mentalization-based approach to patients:

“By being candid and vulnerable in giving voice to both sides while naming each constraint, CCPS grounds the theory of mentalization, and prepares trainees for the daily reality of the ways in which challenging cases often force the clinician to confront the gap between their idealized and empathic clinical self and the self that acted the best they could at the time and under pressure”¹⁴.

CCPS incorporates narrative medicine approaches into patient simulation to improve its fidelity, flexibility, and empathy¹⁵. Narrative medicine emphasizes the processing of complex emotions and finding meaning in our work. As an approach that comes from a literary tradition, narrative medicine allows room for ambiguity, uncertainty, and the unknown. Additionally, narrative medicine provides room for longitudinal relationships and reflecting on how these relationships change over time. Traditional patient simulation with standardized patients tends to emphasize preparation for common, generalized clinical situations. CCPS resists the standardization that some have criticized patient simulation for promoting⁵. Given that trainees’ challenging experiences provide the source material for the simulation scenarios from their personal experiences in the clinical setting, each scenario is individualized and particularized, and no two sessions are identical. CCPS is standardized and prescriptive only in terms of the process surrounding the production of the simulation, but not in terms of the content or the trajectory of the simulated encounter. Nevertheless, the reflections and lessons from any particular simulation session are applicable to many situations, in part because of the complexity of the cases that trainees tend to develop. An additional component may be

CCPS facilitators' dedication to exploring several dimensions of each case and making learning opportunities as explicit as possible for learners. Further, because the facilitators typically do not generate the simulation scenarios themselves, there may be more room for curiosity and ambiguity in the debriefing of these cases, as the facilitator does not have an "answer key." Rather than specific diagnostic or treatment concerns, the focus tends to become exploring and reflecting upon the emotional and interpersonal work that comes with providing care in challenging clinical scenarios¹⁴.

Patient simulation in pediatrics and child & adolescent psychiatry

The CCPS model calls for emotional work and brings about emotional authenticity in participants that lend themselves to the world of child and adolescent psychiatry. If we are to take pediatric simulation seriously, this would require simulating two crucial dimensions of pediatric health care: (1) their dependence on one or more adult caregivers and (2) their dynamic developmental trajectories. Given the societal view of children as subject to adults, particularly in the realm of healthcare, attempts to simulate pediatric medicine or child psychiatry cases will be incomplete without simulating the dyadic aspect of this relationship. Recently, Buka et al outlined a number of core principles of early childhood mental health and emphasized the importance of early relational health (ERH):

A strong argument can be made for a dyadic, or a family, approach to identified emotional and behavioral difficulties in children where the family or, at a minimum, the parent-child dyad is the unit of treatment. A redesigned early

childhood mental health system needs to acknowledge the foundational nature of these bidirectional relational interactions between parents and caregivers and support interventions that serve families, not just children¹⁶.

Similarly, simulating the longitudinal dimension of care in pediatrics and child psychiatry is crucial to understanding how patients' relationships and trajectories change over time. Simulation allows one to manipulate the dimension of time such that, even during a short period of simulation sessions, learners may catch a glimpse of what the evolution of a patient over time might look like. The narrative aspect of the CCPS model lends itself to manipulating the passage of time in simulation, for pediatric and adult patients alike.

There is nevertheless a relative lack of simulation-based education involving children and adolescents as simulated patients. In their narrative review of the benefits and risks of being an SP, Plaksin et al. reported that some adolescent SPs described transient depressive feelings and needing a few minutes to get out of character after completing psychologically challenging cases¹⁷. In one study of younger SPs (ages 6 to 9), while most participants found the experience to be fun, one SP reported experiencing fear after considering the possibility that a child their own age could die for the first time because of the simulation¹⁸. Additionally, Budd et al outline some of the challenges and concerns around including children as SPs, with a focus on "middle childhood" (ages 6 to 12), which include "reports of child SPs being subject to long work hours with few breaks, limited opportunities for active involvement, and the use of coercive remuneration practices by some educational institutions"¹⁹.

Including underage actors may increase the emotional fidelity and authenticity by providing the opportunity to truly understand and incorporate their points of view and priorities into simulation. In a study exploring the employing of adolescents as SPs, Bokken et al reported that instructors commented that the adolescent actors drew attention to interesting dimensions of communication, such as “learning to deal with 2 people in a consultation (dividing attention),” “dealing with peers professionally (less formally, yet remaining serious),” “setting personal boundaries in a consultation (with a quarrelling couple),” and “asking questions/talking about sexuality”²⁰. In a study of children, ages 11 to 14, exploring what makes a good nurse, the child participants expressed a desire to be engaged with as people and a view of overly friendly approaches as off-putting or patronizing²¹. These findings indicate the assumptions and misconceptions that exist around children’s perceptions of their care and the need for children’s perspectives on their healthcare. In addition to contributing to better health care for young people at large, many adolescent SPs reported direct benefits from participating in simulation¹⁷. These SPs appreciated playing an important role in the education of health care providers, learning that adults and health care providers can make mistakes, gaining a better understanding of their own communication style and skills, and developing more self-confidence. They also reported increased empathy for others experiencing medical or psychiatric illness as well as a greater ability to discern the quality of health care providers.

In spite of potential challenges, child and adolescent patients nevertheless deserve to have their healthcare needs and experiences included in patient simulation. To minimize the risks to underage participants, Budd et al offer a series of guidelines for involving children in simulation, many of which center around ensuring that children have opportunities to provide input and feedback about the design, rehearsal, delivery, and debriefing of simulation sessions¹⁵. In a similar vein, Khoo et al emphasize the importance of ensuring underage actors are engaged as active participants in learning, rather than passive ones²². Therefore, the CCPS model offers the opportunity to both authentically simulate the provision of care to pediatric patients and to maximize the benefit to the underage participants and minimize the risk of harm to them.

Statement of purpose

The purpose of this qualitative study was to explore the use of the co-constructive patient simulation model (CCPS) as a tool for reflection among child and adolescent psychiatry trainees following the implementation of two innovations to the model:

1. The inclusion of two patient actors (including actors who were older adolescents) in the same encounter for nearly all simulation sessions to simulate child-caregiver dynamics and conflicts
2. The use of patient narratives that spanned 2 to 3 simulation sessions and allowed for a more longitudinal view of the simulated cases.

By including these two additional factors, we hope to better simulate aspects of care that are particular to child and adolescent patients and thus encourage richer reflections among participants. Given the logistical constraints (including legal restrictions at our institution limiting the recruitment of underage actors to ages 14 to 17) and potential emotional impact of taking part in difficult simulation cases, we elected to utilize older adolescent patient actors and focus on adolescent psychiatry cases. A cohort of senior fellows in child and adolescent psychiatry elected to participate in a formative educational opportunity involving a series of simulation sessions that were developed according to the CCPS model, with the modifications described above. Using a symbolic interactionist approach, which frames all human activity in terms of the inherently social processes of meaning-making, we focused our thematic analysis on the content discussed during the debriefing sessions after each simulation.

METHODS

Ethics statement

Participation in the study was voluntary; we obtained informed consent for participation and audio recording from the participants.

Human subjects research

We obtained institutional review board approval from the Yale Human Investigations Committee (Protocol # 2000026241). Trainees were encouraged to participate but informed that their participation was neither mandatory nor pertinent to their fellowship performance evaluation. They were aware that sessions would be conducted as part of a

research project and that all interviews and debriefing sessions would be audiotaped, transcribed, and deidentified toward a subsequent qualitative study.

Methods description

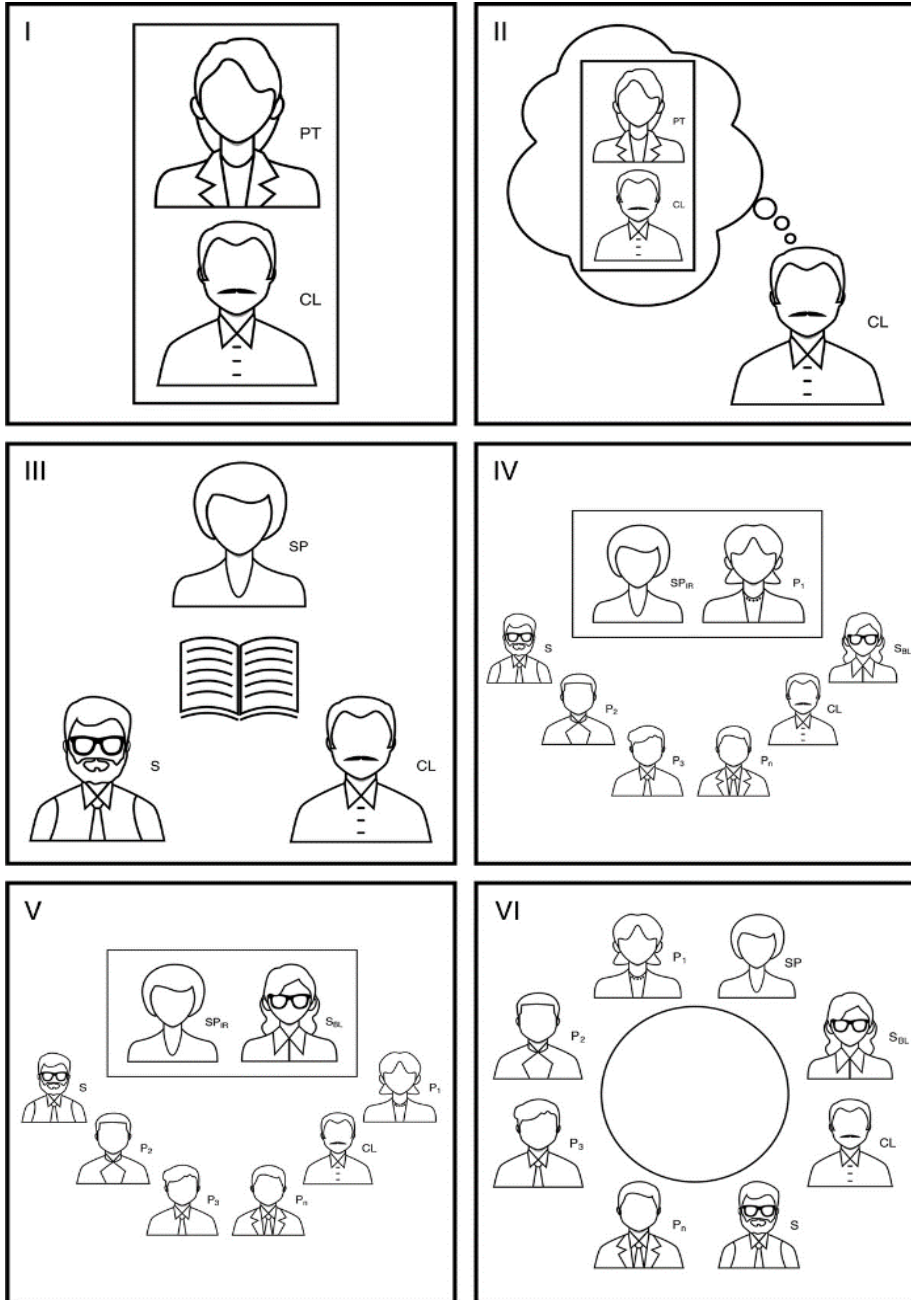
From November 2021 to June 2022, the Yale Child Study Center organized 7 patient simulation sessions as an educational opportunity for graduating child and adolescent psychiatry fellows at Yale. Six of the sessions took place in person, and one (January 2022) occurred over Zoom videoconferencing. The participants included 7 second-year CAP fellows, two research facilitators who were psychiatrists trained outside the U.S., two faculty supervisors, and one medical student.

Per the CCPS model, preparing the “script” for each simulation session began with a selected “writer” (typically one of the child psychiatry fellow participants) collaborating with facilitators and 1-2 patient actors. Together, they developed a patient profile and story based on one or more challenging clinical scenarios the writer has encountered (See **Appendix A** for example profile) and rehearsed improvising a clinical encounter based on this profile and story. During the actual simulation session, two interviewers were selected among the child psychiatry trainees and participating attending child psychiatrists. They were blinded to the case other than a “door note” that provides a brief description of the patient and the reason for the encounter at the start of the simulation. The first interviewer began the clinical encounter and interviewed the actor(s) for 20 minutes. After 20 minutes, the second interviewer stepped into the role and interviewed the actor(s) for 20 minutes and completed the encounter. We chose to include two

interviewers in each session to demonstrate two different interviewing approaches for the same clinical scenario and to maximize participants' opportunities to play the role of the interviewer while providing sufficient time for depth of interviewing. Facilitators and other participants observed the simulated encounter for its entirety. After the simulated encounter was completed, the interviewers, other participants, facilitators, and patient actors engaged in an hour-long debriefing session to reflect on the encounter. **Figure 1** summarizes the CCPS process.

We (IT, LB) first independently analyzed and coded the transcribed and anonymized recordings of the debriefing portions of the 7 simulation sessions. Additionally, two sessions from April 2021 and June 2021 with a different cohort of CAP fellows but three of the same research team members were included for partial analysis, as the patient profiles for these sessions provided the initial narrative for the two longitudinal scenarios that spanned more than one session. Data were compared between debriefing sessions to identify recurring themes, integrate new elements, and ensure triangulation and data sufficiency, that is, the point at which additional analysis only supported identified themes and did not provide new themes or insights. Once sufficiency was achieved, we constructed a complete thematic description of the experiences of the participants, organized into overarching domains linked to underlying themes, each illustrated through verbatim quotations from the debriefing sessions.

Figure 1:



Co-constructive patient simulation phases: I. Clinical encounter between CL and PT; II. Reflection. CL reflects back on the index encounter(s) and starts developing a script; III. Script writing. CL finalizes the script, working in close collaboration with an SP and a supervisor (S); IV. Simulated encounter. P1 interviews the SPIR, while P2-n and supervisors (depicted wearing glasses) observe the encounter; V. In a variation of phase IV, the interviewer is a different supervisor, not involved in phase III, and as such, blind to the clinical script (SBL); and VI. Debriefing. All participants take part in a debriefing session moderated by S; P1 is invited to share first, and CL and SP (derolled) contribute last. Note: the rectangular enclosures represent the confidential consultation spaces in which clinical encounters take place. CL, clinician; P1, first peer; P2-n, other peers; PT, patient; SBL, Simulated encounter with blinded supervisor; SPIR, SP-in-role (from Martin et al, “Co-constructive patient simulation: a learner-centered method to enhance communication and reflection skills,”¹⁴).

We conducted an inductive thematic analysis of the data from the debriefing sessions using a symbolic interactionist approach²³. As an epistemological framework, symbolic interactionism connects social structures with individual-level processes to better understand how individuals interact with one another to create symbolic worlds and how these worlds shape individual behaviors²⁴. Blumer identifies three basic premises that undergird the symbolic interactionist approach:

1. Human beings act toward things on the basis of the meanings that things have for them.
2. The meaning of such things is derived from, or arises out of, the social interaction that one has with one's fellows.
3. These meanings are handled in, and modified through, an interpretative process used by the person in dealing with the things one encounters²⁵.

In Blumer's formulation, symbolic interactionism "sees meanings as social products, as creations that are formed in and through the defining activities of people as they interact." Social interaction is "a process that *forms* human conduct instead of being merely a means or a setting for the expression of human conduct." Even a human being interacting with himself is "social—a form of communication, with the person addressing himself as a person and responding thereto."

Within this sociological tradition, Goffman's concept of dramaturgical analysis was useful in approaching and delineating the social interactions occurring in the simulation

and debriefing sessions²⁶. Dramaturgical analysis utilizes the metaphor of theater and contends that aspects of social interactions are contingent upon the time, place, and audience of the interaction. Each person is thus an “actor” performing one’s self, a process Goffman termed *impression management*, in hopes of creating specific impressions in the mind(s) of the audience, often with the implicit goal of acceptance of the actor by the audience.

Student contributions

As part of the research team, I participated in the rehearsal, simulation, and debriefing portions for all 9 sessions except for the April 2021 and June 2021 sessions. I conducted the analysis of the transcribed recordings of the debriefing sessions, which were then cross-referenced with another researcher team member. I obtained feedback from the QUALab (Qualitative and Mixed Methods Lab), a collaboration between the Yale Child Study Center and Centre de Recherche en Épidémiologie et Santé des Populations (CESP), on my thematic analysis, the structure of my results, and potential direction for the discussion, and I incorporated this feedback into the paper. I wrote the entirety of the manuscript and revised it based on feedback from members of my research team and external reviewers.

Reflexivity

I was the primary research associate who attended the rehearsal, simulation, and debriefing sessions and conducted the qualitative analysis of these sessions as part of my MD thesis. With my background in the humanities, I was interested in exploring the

interpersonal and performative aspects of the simulation and debriefing sessions. As a future child and adolescent psychiatrist, I was interested in exploring simulation of the parent-child dyad and the reflections it could bring about in CAP trainees and attendings. I was an outsider in the sense that I was not part of the CAP training program and did not have the same familiarity that the other participants had among themselves. At the same time, as a medical student, I was technically the lowest in the professional hierarchy in the room. Thus, there were unlikely to be negative repercussions from the fellows speaking frankly in front of me, despite not being familiar to them initially. As a medical student and learner, my analysis was influenced by my experiences and those of my peers in clinical learning environments. Because I am not formally part of the CAP training program, there were likely interpersonal dynamics at play between colleagues that I was unaware of. Additionally, although most of the participants were very familiar with the supervisors participating in the study, the power dynamics of the supervisor-trainee relationship likely nevertheless influenced what was said during debriefing sessions.

RESULTS

Table 1 provides a brief description of each of the cases written by participants for the simulations. In this results section, I first present our analysis of the debriefing reflections on the simulation experience via a dramaturgical perspective. I then present themes developed via a symbolic interactionist analysis of the debriefing data, summarized in **Table 2** with example quotations.

Table 1: Summaries of the simulation cases written by participants

Case number	Session date	Scenario description	Number of actors
1A	April 2021	Aiden, age 16, has been referred by his school social worker for behavioral concerns at school and home in the setting of his parents' recent divorce and one parent's gender transition. The clinician is meeting via videoconference with Aiden and his mother.	1 adolescent, 1 adult
2A	June 2021	Sonya, age 15, is currently hospitalized for suicidal ideation and self-injury. The clinician is meeting with Sonya and her father via videoconference to discuss her progress and initiating medication. Sonya has not spoken to her father in six months in the setting of her parents' divorce and strained relationship.	1 adolescent, 1 adult
1B	November 2021	A continuation of case 1A. Aiden, age 16, and his mother return to the clinic after being lost to follow-up. Aiden continues to struggle at school and home in the setting of his mother's gender transition, along with the introduction of her partner into their home life.	1 adolescent, 2 adults
2B	January 2022	A continuation of case 2A. Sonya, age 15, has been discharged from the hospital and returned to living with her mother. She was supposed to begin outpatient therapy and resume contact with her father. However, she has missed all of her appointments and has not contacted her father. The clinician is meeting with her for the first time today, along with her father, via videoconference to discuss their relationship.	1 adolescent, 1 adult
3	February 2022	Hala, age 21, has been admitted to a medical floor for altered mental status in the setting of a hypoglycemic episode; she has diagnoses of type 1 diabetes, depression, and anxiety. It is day 3 of her hospitalization and she is progressing toward discharge. However, she experienced another hypoglycemic episode the previous night. The medical team consulted the CAP consult service because they are concerned about surreptitious use of insulin for self-harm. The team searched Hala's bag and found several insulin pens; they have not yet discussed their concerns with her. They would like the clinician to evaluate Hala for safety.	1 transitional age adult
4	March 2022	Lisa, age 15, comes to the clinic with her mother. Her mother has wanted to engage in "family therapy" but has not brought her daughter to the last five visits. Previous visits have centered on the mother's feelings about her ex-husband and Lisa's father. Today, her mother hopes that her daughter will confirm her suspicions of sexual abuse by her father. Her mother would like the clinician to convince Lisa to disclose the abuse or perform an exam to determine if abuse occurred.	1 adolescent, 1 adult
5	April 2022	Toby, age 15, is hospitalized for behavioral concerns at school and at home. On the unit, he has not been allowed to participate in groups because of his use of racist language toward peers and staff. The clinician is meeting with Toby and his grandmother because she is demanding that he return to participating in groups. His grandmother is his primary caregiver; her daughter passed away when Toby was very young. Toby's grandmother is white, and Toby is mixed race; he has recently discovered that his father, who has not been present in his life, is Mexican.	1 adolescent, 1 adult
6	May 2022	Brian, age 15, and his mother come to the clinic due to worsening depression symptoms, at the suggestion of a member of their church, in the setting of his father's recent death. Brian recently joined the Nation	1 adolescent, 1 adult

		of Islam to feel more connected to his father, who was Black. He has decided to change his name to "Divine X." His mother, who is white and a devout Christian, is distraught about this decision.	
1C	June 2022	A continuation of cases 1A and 1B. Aiden, age 16, and his mother return to the clinic due to difficulties at home and at school. Aiden was recently admitted for suicidal ideation in the setting of breaking up with his girlfriend. His mother is concerned because Aiden has become more oppositional at home and has begun vaping. He has also been getting into fights with classmates at school.	1 adolescent, 1 adult

Table 2: Themes developed from debriefing data and example quotations

Theme	Example quotation
<p>Centering the child, allying with the parent, and treating the family system</p>	<p>“There are also some cases with parents with very high income and high IQ who are able to argue really well. You are balancing between ‘is the parent abusive’ or ‘are the arguments legitimate?’ Who should I protect?” (Case 2B).</p> <p>“I think that when mom does try to enter a holding space for [the patient], her hands are somewhat limited because she's still trying to hold herself” (Case 1C).</p> <p>“It shifted it from focusing on the logical piece of the story to what's the emotional meaning behind this need to protect the daughter, and ask about it” (Case 4).</p>
<p>Reflecting on dyadic challenges: role reversal and individuation</p>	<p>“He was kind of parentifying her too because he kept saying really negative things about mom. And she was placed in a situation where she constantly had to be defending mom” (Case 2B).</p> <p>“I also thought that at 15, kids begin to kind of have their own opinions, and they get into arguments with their parents as a way to separate a little bit more. We worry about what’s going to happen when he leaves and moves out in the world, if I’ll be left all alone” (Case 6).</p>
<p>Ambivalence in and about the parent-child dyad</p>	<p>“But when mom would say that okay what should I change? What should I do? He would say, oh it's not about you. So there was this ambivalence about what really was going on” (Case 1C).</p> <p>“[The father] wants to do well. So the intentions are good and the love is really there, but you can traumatize your kids, even if you love them” (Case 2B).</p>
<p>Accepting uncertainty and the unknown and focusing on the here and now</p>	<p>“I was willing to believe that she had just screwed up with the insulin pump, and maybe it's just a belief that I felt, that it's a whole story about this trust and difficulty connecting. And I was, maybe I'm just believing her and being too naive, and she will just kill herself this afternoon, but in the end, I still prefer to believe her” (Case 3).</p> <p>“[The focus] is not the [other parent], and not what happened six months ago, what happened three months ago. We're here now, we're in this session, are you hearing each other? Are you communicating? Is the message clear that you both want each other in your lives?” (Case 2B).</p> <p>“Okay, she's a grandma, a mother. And she just had her son admitted to a psychiatric hospital for the first time. That's terrible. Go work with that. Try to ignore everything else” (Case 5).</p>
<p>Longitudinal narratives and changing contexts</p>	<p>“As I was [the interviewer] in the first session, I was actually taken back for a little bit. I was like, oh well wait, these are the same people, what's going on? For a second, it took a while to realize that this was a continuation. And I will agree with you that I felt like the energy was kind of down and depressing” (Case 1C).</p> <p>“I remember I was almost crying after the first session but it was much calmer this time” (Case 1C).</p>

A dramaturgical approach to CCPS

In spite of their awareness of the “performance” aspect of sessions, participants noted a sense of *authenticity*, meaning here being true to oneself and one’s own experience, during the simulation and debriefing sessions, even if we did not achieve perfect physical and psychological *fidelity*, meaning here the degree to which the detail and quality of an original are copied exactly, in the sessions. *Sincerity*, meaning here being truthful in one’s interactions with others, may be another way of characterizing the experience of the interviewers, SPs, and the observers; the distinction here being, to be sincere is to be honest with others, and to be authentic is to be honest with oneself, as an end in and of itself or for one’s own benefit. In either case, honesty is still contingent on an audience. One arguably cannot be authentic in a vacuum. In aiming to induce some level of authenticity (or sincerity) in the sessions, the CCPS model made apparent the performative nature of authenticity, even outside of simulation or explicit performance. I observed multiple dimensions of authenticity, including the narrative authenticity of the patient cases, given their origins in real participant experiences; the emotional authenticity of the simulation sessions, with the actors’ performances evoking powerful affective responses in interviewers and observers alike; and the authenticity of participants’ reflections during the debriefing, taking the form of frank discussions around countertransference and challenging professional and personal experiences.

During the debriefing sessions, participants who had played the role of interview reported a level of awareness of performing in front of an audience with a patient actor:

When it's artificial, the light is on you. Real, the light is on the patient. We don't care about our own needs when we're talking to a patient. [...] I have a job to do. Here, we're trying to explore different ways or different styles so that we can have these conversations, and that's when we start to doubt ourselves more (Case 3).

Although there were benefits to the audience being composed of colleagues rather than strangers, an awareness of this at times resulted in a particular form of performance anxiety and social pressure:

In psychiatry, we rarely get the chance to see our colleagues with a patient. So my best friend is a surgeon, so he sees all of his friends operating and can appreciate their ability and the work that they put in. I've known [another participant] for five years, and the first time that I got to see him interview a patient was a couple of months ago (Case 1C).

Because I know a lot of you guys really well and really trust you guys and respect you guys as clinicians and therapists, there's a pressure to be like, damn, they're going to see that I suck (Case 3).

Nevertheless, participants also described becoming subsumed into the interview role and the awareness of being observed falling away. As such, some interviewers described physiologic responses to the simulated encounters:

I'm wearing my Fitbit today, so I saw what my heart rate was when I got out of the hot seat. It was 115. It was double my resting heart rate (Case 3)

I made a Freudian slip by [saying the mother was] being “overprotective,” and I was like, “Okay, you just dug your own ditch.” [...] The perspiration started coming down after that (Case 4).

The emotional tension in these simulated encounters could result in what participants described as genuine, spontaneous negative affective responses:

Dad was so good with his acting that I was two seconds away from saying, “Just be quiet, just let her finish” (Case 2B).

Beyond the immediate awareness of the individual observers in the room, participants at times referred to a kind of hypothetical or imagined observer, simultaneously distinct from and defined by the audience of colleagues present in the room. One simulation case centered around a family meeting with an adolescent in an inpatient psychiatric unit and his caregiver (his grandmother) after he was removed from group therapy for using racist language toward others on the unit. During the case, both interviewers avoided discussing the specific language used, which some participants noted during the debriefing:

Even if we are here playing [pretend], I was like, “What will happen here in this Yale community if he really starts saying what happened in the unit?” And then I

thought, “What is about to blow up in the middle of all of us?” Because I think maybe in a room where it would be just the kid, the grandma, and me, I would have said, “Okay, what did the kid say?” (Case 5).

Another observer commented on how this context of performing may have affected the interviewers’ approaches:

[The interviewer], as the white guy, has to perform and respond to all this racism in front of everyone. And I think in that way, it makes the alliance building take a backseat to feeling like, “I need to lay down the law” (Case 5).

Despite being in a “safe” space with an audience composed of familiar psychiatry colleagues, some of whom were close friends, participants did not necessarily feel safe acting as they would without an audience.

According to the dramaturgical perspective, the actor-audience relationship is a two-way street, with the audience reacting to the actor at the same time as the actor reacts to the audience. Observing participants who were interviewers in previous sessions noted how easy it was to consider different options and approaches when not in the “hot seat.” Even as they considered how they might act in a given simulated encounter, observers’ reflections tended to empathize with the interviewer:

To hear the story, maybe recounting some racial slurs being said out loud. That could throw you off. I mean, it would throw me off. It could be re-traumatic, not only for them, but also for the clinicians. [...] I don't really want to confront that myself, not only for [the child and the grandmother], but for yourself (Case 5).

For some participants, this included vicariously experiencing negative counter-transference toward some of the parents:

Well, this son of a bitch shows up 10 minutes late for this appointment, with his daughter who he calls a possession. And that angers me. I think it angers everybody. And I think it's really important to be in touch with. Yes, this is infuriating (Case 2B).

This vicarious experience extended to the emotional states of the adolescent patients as well:

I realized, in the moment, that I was spacing out, that I was becoming dissociated, and that I was like, "If I had to take care of mom, I have to dissociate. I have to space out so that I don't feel my wish to escape and that I'm here to reassure her" (Case 6).

Centering the child, allying with the parent, and treating the family system

Participants reflected on the complex and shifting nature of the answer to the question “Who is the patient?” in these simulated encounters. Many participants expressed wanting to treat the whole family unit while still trying to ensure that they were prioritizing the child:

In general, we’re child psychiatrists, but we really are treating the family. And in this case, it’s the child, the family, and then clearly, the mom has her own struggles as well (Case 1A).

Is it the parents or is it the kid? Oftentimes, I’ve always defaulted to the kid (Case 1C).

Centering the child and their needs often meant helping the parent and child hear each other, which was easier said than done. This required ensuring that the child had an opportunity to be heard and preventing the parent from taking up too much space in the dialogue:

There’s all these narcissistic injuries that this brings up. So I can see why grandma became so huge because I’m sure she’s just really fragile and really just trying to hold it together [...]. But she was too big in the room and [the patient] was way too small. And he was the one who was hospitalized and wanted to kill himself (Case 5).

One participant noted how the physical layout of the simulated encounter could impact communication dynamics and result in the literal and figurative “de-centering” of the child:

I think that [the child] is used to not having a voice. And even with the location, there was a lot of movement of the chairs. In the beginning, it was kind of like a circle, but [the child] was still on the margins, still not really having that voice. And both his chair and his grandmother’s chair eventually became linear against the wall, marginalizing [the child] even more. I liked the move of [the interviewer], moving closer. But it just made me more aware of how important location is. And still, grandmother had that seat where she was the center, and it gave the impression this was about her. And it was, in part, about her, but it was really about [the child] (Case 5).

Participants described toggling back and forth between viewing the child and the parent as two individuals and as a single dyadic unit. In order to center the child, they had to consider how the child fits into the parent-child relationship, which in turn required trying to understand the parent’s motivations and needs and how that might shape the dyad. Participants emphasized the importance of empathy for the parent, for the sake of the child:

I think that when mom does try to enter a holding space for [the child], her hands are somewhat limited because she’s still trying to hold herself (Case 1C).

It shifted it from focusing on the logical piece of the story to what's the emotional meaning behind this need to protect the daughter, and ask about it (Case 4).

When working with a parent-child dyad, the interviewers had to contend with the reality of the child and the reality of the parent and try to assemble a coherent understanding of these realities that would be meaningful to everyone involved:

I wanted to get to the root of what it meant for her daughter to be telling the truth at that moment. When she said, "This means that I'm crazy, this means that maybe I'm not a good mom," I was going to work on that and be like, "Well, it just means that you're really concerned, that you don't want anything to happen, and that you're not a crazy person, you're a good mom" (Case 4).

One case centered on an adolescent struggling in the context of his mother's gender transition. One participant described the complexity of this bereavement and the recognition of the conflicting realities of the transition for the mother and the child:

I think maybe just handling the grieving process with [the child] alone so that he can privately name what he lost very explicitly but without bringing that feeling of discomfort to [his mother]. For them to handle it together in the same room, I think that would be really, really complicated (Case 1A).

In this scenario, the same event (the mother's transition) was viewed as the start of a new life by one person and as the end of a life by another. Both realities could be simultaneously true but perhaps could not coexist in the same space at the same time. As the patient's mother put it during one of the simulations:

Let me tell you something. If I de-transition, there's a God darn good chance, you're going to end up either with a dead father or you're going to have a live trans mother. So it's up to you because that's what's going to happen (Case 1B).

However, participants could still struggle at certain points to center the patient. In a different session utilizing this same family narrative, the script called for a third actor to play the mother's new female partner. Over the course of the simulated encounter, the dynamics became emotionally charged and chaotic at times, with the SPs at times interrupting and speaking over one another. For many participants, the accounts of the two adults seemed to trump the child's experience of the situation; participants tended to frame the adolescent male patient as the aggressor in their comments. Yet during the next simulation and debriefing session (Case 2B), which involved similar challenges in a different parent-child relationship and gender constellation, participants generally came to the adolescent female patient's defense and framed her father as the aggressor. The differing responses to these two scenarios suggested that in spite of one's best efforts to center the child in the therapeutic relationship, social factors could complicate those efforts:

You had these two women, and one a trans woman, who maybe we see as even more vulnerable or whatever, and we say no, no, no, I can't push because if I push, maybe I'm a transphobic asshole (Case 2B).

Conversely, from a dramaturgical perspective (in the theatrical sense), the strong affect apparent throughout the simulation could have been in part due to the structure of this particular simulated encounter. Given that we had hired three actors to perform in the simulated encounter, each actor may have felt pressure to be seen and heard in order to effectively play their role. The "stage" may have been too crowded to accommodate all three characters. In this way, the "performance" aspect of the simulated encounter may have taken over the emotional tenor of some of the dynamics that we were seeking to simulate. In the previous session featuring the same adolescent patient and his mother (played by the same actors) but without the mother's partner present, one participant noted the empathy that the interviewer extended to the struggling patient:

When you said to [the child], "When someone transitions, it's not just them, it's everybody around them." That seemed to be like a big moment of opening for him, where he felt seen and allowed him to speak more about his experience (Case 1A).

When the dynamics were limited to only the patient and the caregiver, participants seemed to empathize with the patient more easily. More specifically, the empathy described above did not only seek to identify what the patient was feeling but also created

a space for him to experience his emotions, with an understanding that the patient had as much a right to be having a tough time as anyone else. The interviewer's comment signaled an awareness of the reciprocal nature of the parent-child relationship: In the same way that a significant shift in a child's life, positive or negative, can be difficult for a parent to process, a child can struggle to adjust when a parent's life changes radically. One recurring aspect of treating the family system in the debriefing discussions was fostering understanding by managing parents' expectations of their children, and vice versa:

Life is just kind of a steady flux of grief in one form or another. We all fantasize these relationships, we fantasize these dynamics, we create these expectations in our minds of how we want life to flow. [...] I don't think any individual, and I'm generalizing here, thinks, "Oh I'll have a child that suffers with depression," or "I'll have a child that suffers from substance use," or "I'll have a friend or mother, anyone in my life that has to suffer." That is no one's initial expectation (Case 1A).

Reflecting on dyadic challenges: role reversal and individuation

Across multiple debriefing discussions, participants noted challenges particular to the parent-child relationships, namely role reversal and the process of separation and individuation. The fact that these challenges were central to several simulation scripts developed for the sessions suggested that this was a common dynamic with which participants had struggled during their training. More interestingly, the identification of

these specific challenges specifically was made possible with the use of two actors. These dynamics would be challenging to identify and respond to if one was to interview only the child or only the parent, without observing their interactions.

Participants reflected on the expectations parents placed on children in the simulated relationships and how roles could become reversed with the child being expected to take on the responsibilities of an adult and manage the parent's emotions:

The dad has just been so occupied with his own feelings and his own career that the daughter is just a parent, where she has to deal with *his* feelings and be mindful of his feelings versus having her own (Case 2B).

[The mother] would get stuck with her own guilt. And then at one point, she said, "Should I just die?" And then [the child] responded, "Well, why are you going to put that on me?" And there was a cross just being thrown on his back (Case 1C).

The term *parentification*, or a child being forced to take on the role of an adult in the parent-child relationship (such as a confidante, mediator, or caretaker), came up during multiple debriefing sessions:

The dad placed [the daughter] in a situation where she had to constantly be like a parent in a way. He was kind of parentifying her too because he kept saying really negative things about mom. And she was placed in a situation where she

constantly had to be defending mom. [...] But dad couldn't empathize with that, that this child is really having to put up with mom's anxiety. In fact, he was saying, "It's not my fault that mom has anxiety." He wasn't recognizing how hard it is for [the daughter] to do that (Case 2B).

One participant explained how parentification could come in the form of parents asking their children to “help me to help you.” While this may be an understandable response on the part of parents, it could cause the child to “feel responsible for their relationship” (Case 1A). Along similar lines, a physically or emotionally absent parent who was attempting to re-enter their child’s life can parentify the child by expecting them to “act like an adult” and immediately be ready to rebuild the relationship:

Now I [as the parent] have gotten my act together, I’m better now, I’m not using substances, I’m out of the depression. I’m unfrozen now. And now I’m going to catch up in this relationship (Case 1A).

There’s one part when he was saying, “Nobody's perfect. What if I stopped talking to you if you were a brat.” I was like, there's parentification there again (Case 2B).

Even as the children in the simulated cases were expected to act like adults, the process of individuation and separation during adolescence was a common source of conflict between parents and children. Participants reflected on the shifting nature of the dyadic

relationship during this period and the emotional experience of parents struggling with their children growing less dependent on their relationship:

At 15, kids begin to have their own opinions, and they get into arguments with their parents as a way to separate a little bit more. We worry about what's going to happen when he leaves and moves out in the world, if I'll be left all alone (Case 6).

Even when the cases were ostensibly centered on other issues, such as a parent's gender transition or a son's exploration of a new faith, participants readily identified this process as an underlying source of the tension in the parent-child dynamics presented in the cases:

The thing that kept mom going was this idea that she'll be reunited with [her husband] in heaven, but the idea of [her son] not being there, in her mind, is just so powerfully overwhelming and upsetting (Case 6).

Mom is like, "What do I need to do?" The answer that [the child] gave was intolerable: "I need space." And for us too, I think it was intolerable. Because it's not mom's fault (Case 1C).

As participants attempted to bridge the gaps in understanding between the parent and child, they also recognized the importance of allowing space in the parent-child

relationship, especially as the child begins to mature and develop into their own person. However, creating space could be anxiety-provoking:

We could explore things around separation even if it's very frightening [...] Not because I think it would be the answer, but just because of having a safe space to be able to explore whatever is frightening even for both of them (Case 1C).

In this case, the possibility of space not only represented emotional or physical distance, but also the uncertainty of the future and the unknowability of what might become of a parent-child relationship when the child grows up.

Ambivalence in and about the parent-child dyad

Across multiple sessions, participants noted patients expressing *ambivalence*, or conflicting feelings, toward a parent, feeling simultaneously pulled in and pushed away. At times, the ambivalence could cause children and parents to question their relationships with each other, and at other times, it could cause them to question themselves:

[The child] is asking basically, "Can I be with you, dad?" I think that was a lingering question that prevented her from feeling safe seeing dad. Why is that? "Because if I'm with you, dad, am I going to hurt mom? Am I going to play a favorite?" (Case 2B).

Grandma is in such pain about it and feels such hatred towards his father around the death of her beloved daughter. And then [the grandchild] is in the middle of this horrible dilemma: I want the love of my dad. I want somebody that I can identify with, but my grandma, who I love dearly, hates him and thinks he's evil. Am I evil?" (Case 5).

My gut feeling at that time was acknowledging that mom's certainty and intensity is coming from a place of intense love and also hurt at what's happened to her, and that those are the two forces that are driving this certainty, and just to name them (Case 4).

The third quotation here brings to mind the etymological origins of the word ambivalence, deriving from the Latin words *ambo* ("both") and *valentia* ("strength") and coined by Swiss psychiatrist Eugen Bleuler in 1910, with "strength" referring to the strength of feelings.

Interestingly, participants themselves expressed ambivalence toward the parents, the patients, and the family dynamics in the simulated cases. Participants reflected on the imperative of clinicians to explore and be curious about another's way of understanding the world, their motivations, and their unmet needs, even if it is a deeply troubling one:

It's hard for us to be curious about it, and curiosity is important to be therapeutic about it. Why is he being racist as a defense? Is it not a defense? And I think his story would've fleshed that out (Case 5).

That's the difference between cutting somebody open and bleeding and one person passing out and you being a physician and being able to stitch somebody up. We will feel things, and we're supposed to have our expertise, be clinicians, and be able to see somebody's humanity. Because if you can't see them as human, you can't have therapy (Case 5).

Participants tried to focus more on the aspects of the encounter that were external to themselves as the clinicians, i.e., what the encounter is bringing to me. When faced with challenging patients, they tried to check their baggage at the door and separate themselves from the encounter:

Okay, she's a grandma, a mother—you can consider it both ways. And she just had her son admitted to a psychiatric hospital for the first time. That's terrible. Go work with that. Try to ignore everything else (Case 5).

Nevertheless, participants were aware of the difficulty of setting oneself apart from the encounter or from the emotional baggage one brings to it. Learners and instructors alike demonstrated a striking level of honesty, disclosing challenges, both in their personal

histories and currently ongoing in their lives, that could result in projection onto those around them:

I come from a place where my dad was not in my life, so I really have a negative connotation towards men in general, and it's going to be completely real. So it's almost like guilty until proven innocent for me (Case 2B).

I was ready to kind of lose my shit there and have to say, “Well, Miss Patient, let me tell you, I lost my shit because I'm kind of going through my own thing.” I was really concerned about that (Case 3).

One result of how personal the clinical encounter could become was that the “clinical gaze” of any two clinicians could differ significantly; in our study, two participants could focus on different aspects of a parent’s or child’s actions and have very different interpretations of the same actions:

I felt that the father was abusive: the thought of him hitting her sister, his response. I thought either it was sexual assault or physical abuse because of [the child’s] body language, it looked like somebody that was physically abused (Case 2B).

Contrary to a lot of people, I felt a lot of pain for the dad. I did feel anger towards the dad, but I’d say a majority of it was I felt really bad and really sorry, and

maybe a little pitiful for him. There was this sense of here's this daughter who's now living with mom and he feels like mom's pitting her against him and he wants to build a connection (Case 2B).

In these discussions, ambivalence did not necessarily reflect conflicting realities or cognitive dissonance, but in fact may have offered a truer understanding of the situation than attempting to tidily classify the involved parties:

Assholes can be good dads too. And I think that's really important. He wanted to connect that relationship or fix that relationship. I still am angry with him. I still think he did some really disgraceful things. But he wants to make that connection. It's not our job to judge, it's our job to help facilitate that (Case 2B).

“Love covers a multitude of sins” (1 Peter, 4:8). Your love for your daughter almost covered how much you were just trying to hold it together for yourself, and your love for your mom was almost covering what you were going through. I think when everybody keyed in on that, everything softened, the anger, the fear, it just softened (Case 4).

You can traumatize your kids, even if you love them (Case 2B).

The ambivalence apparent in the parent-child dyads and among the participants suggested that ambivalence may be a common dimension of dyadic relationships. In relationships

that involve a power differential, whether it is parent-child or doctor-patient, one person depends on the other and the other is depended upon, and such a dynamic seems inclined toward mixed feelings. If that is indeed the case, then perhaps one needs some amount of ambivalence to see the full picture of the other, the good and bad.

Accepting uncertainty and the unknown and focusing on the here and now

Alongside identifying and managing ambivalence, participants reflected on helping patients and families tolerate uncertainty and the unknown. In case 3, which centered on a transitional-age inpatient with type 1 diabetes being seen by the consult-liaison psychiatry team due to concerns about surreptitious insulin use, participants acknowledged and accepted the uncertainty inherent to clinical work in child and adolescent psychiatry:

It is a whole story about this trust and difficulty connecting. Maybe I'm just believing her and being too naive, and she will just kill herself this afternoon, but in the end, I still prefer to believe her (Case 3).

Because I worked a lot with adolescents, it was so important for them just to know that you are scared and that it kind of helped them in some way, just to know that someone was being scared for them in between two meetings (Case 3).

The scenario in the following CCPS session (Case 4) centered on a mother who was convinced that her daughter was being abused by her father, despite the daughter's

insistence that her father has not harmed her. Over the course of the simulation, it became apparent that it was not a case about trying to figure out whether or not the abuse occurred:

We're not lawyers, we're not court people, we're not the police. The truth isn't necessarily the most important thing for us and our purposes; it's trying to figure out what's going on between the people, the relationships, and also assessing the safety (Case 4).

Because the participants had struggled with their own uncertainty during the previous session, they appeared better equipped to understand the mother's experience and help her make peace with the uncertainty:

Essentially the dynamic is the same, it's just who you're trying to convince is different. In that situation, it was the patient convincing the doctor that she didn't do anything, and then here it's the doctor and the daughter trying to convince the mother that nothing happened. [...] Thinking about the question of, "What does it mean for you, mom, if she's telling the truth?" and thinking about if we had asked ourselves that in the doctor role in the previous session, and how we would've felt about that question (Case 4).

Like ambivalence, participants observed parents struggling with the uncertainty in the parent-child relationship, and this reflection went hand-in-hand with participants struggling with their own uncertainty in the doctor-patient relationship.

When faced with the unknown and the uncertainty of the future, participants emphasized focusing on the here and now and being present physically and psychologically. Part of this included helping families in the simulations acknowledge and experience emotions in the moment, even when they were distressing:

It was difficult for me when the snarky adolescent responded to some things and looked away. But I stayed with it and I thought, ‘Okay, this is what adolescents do. This is what somebody who is in a lot of psychological pain does. So let’s let it happen. Let it be in the room and go from there (Case 1C).

I don’t try to hide those emotions. I want the dad to see that he’s getting a reaction because I think it welcomes a space where people can show emotion, even if it’s a sad emotion or afraid. So I want him to see that. And I think it has its usefulness in some instances, as long as I don’t continue to be intimidated throughout the session, then that doesn’t help (Case 2B).

Additionally, participants reflected on the importance of helping children and parents to accept that one can’t change the past and instead focus on the present and how one moves forward:

[The focus] is not the [other parent], and not what happened six months ago, what happened three months ago. We're here now, we're in this session, are you hearing each other? Is the message clear that you both want each other in your lives? (Case 2B).

Participants noted the need for recognizing the limits of their knowledge, power, and perspective and how accepting those limits allowed them to better care for patients:

He could have said, 'You know, you don't know anything.' And I think that, yes, guilty as charged. I, of course, cannot understand. But allow me to be interested. Allow me to be interested in you. And maybe it will allow me to help (Case 6).

I think as physicians we just try to save the day. And often we can. But the terminally ill cancer patient, they still need a physician. And difficult situations that can't be solved with medication and therapy, they still need a physician to be there and to witness the hurt, the pain (Case 1C).

Longitudinal narratives and change over time

One common frustration among participants was the sense that they did not have enough time to explore the relationships and determine the best course of action. The implementation of simulation narratives that carried over across multiple sessions sought to remedy this issue:

Because I think one of the beauties in child psychiatry is there is more time usually, right? Not in this session, but in general, we're able to come back to things again and again and we don't have to force everything into one session at a time (2A).

One narrative that was carried over between two sessions (Cases 2A and 2B, June 2021 and January 2022) involved an adolescent patient who had recently been hospitalized for a suicide attempt and had not been in contact with her father for a few months in the context of her parents' complicated divorce. A different cohort of CAP fellows participated in Case 2A, but many of the facilitators were the same between the two sessions. Because of this, we were able to see how two distinct cohorts experienced the same simulated family system at two slightly different time points. In both sessions, participants noted difficulties around helping the daughter be heard due to the charismatic and at times domineering persona of the father:

The dad was a real joy, really just was hammering at his point and made it difficult sometimes to redirect, and so I almost felt like Sonya was just getting steamrolled by him. So I wanted to speak for her, but not be her voice and assume stuff (Case 2A).

That's why I stepped in and said, "Let's wait, let [the child] finish," because she expressed the fear that dad was going to take over. So at that moment, I said I

have to be the referee here, and I have to make sure everybody gets their chance to speak (Case 2B).

However, participants were split on how to view the father's role in the family drama, with some participants' opinions shifting over the course of the simulated encounter:

I did feel a push-pull where I sided with dad or sided with the daughter initially, and then there were points when I sided with dad. I personally did go back and forth between them throughout the session (Case 2A).

Additionally, participants between the two sessions had different views on re-establishing the relationship between the estranged father and daughter and what such a reunion would mean for each:

I said, "I'm confused, but you say you don't want a relationship with your dad, but you still came to the session, so help me understand that," and that moment, she said, "He's my dad, of course I want him in my life." That was an inflection point where I thought, "Got you," because that's what I wanted to get to, they're both here, it's clear what they want, they want each other in their lives (Case 2B).

I also wonder what kid doesn't want a relationship in theory with their parents? It doesn't mean it's necessarily going to be helpful. I think every kid desires a

relationship with their parent, even if they were being abused by their parent (Case 2A).

In a similar vein, participants differed in their approaches to power dynamics in this case between the parent and child. Whereas in one session, many participants cast the daughter as a victim, a participant in another session subverted the idea of what constitutes power in this context:

My parents were divorced when I was in middle school. There's this weird thing when you're a teenager and you have divorced parents where you actually have a lot of power in terms of where you decide to go. Normally, kids, when they're teenagers, can't just ghost a parent for six months. I think the kids are given that choice, and we, as clinicians, often support it (Case 2A).

For the other longitudinal case, the initial session was in April 2021 with follow-up sessions in November 2021 and June 2022 (Cases 1A, 1B, and 1C). Case 1A involved a different cohort of CAP fellows but involved many of the same facilitators. This narrative focused on an adolescent experiencing challenges at home and at school in the context of his mother's recent gender transition. All three sessions depicted the same family system with the same actors at two different time points, with Case 1B also including the mother's new partner, as described above.

Between Cases 1B and 1C, participants noted the changes in the children and their parents between sessions and how it created a more dynamic simulated family system:

We don't know what's going on exactly, but things just don't feel right. Whereas last time we could easily pin like okay these two are yelling at each other, these two are yelling at each other, these three, everybody's yelling at each other. And this was just walking into a room and you feel the depression without exactly knowing why the depression.

Between Cases 1A and 1C, I noted that interviewers and participants in each session used a similar schema (a child experiencing bullying due to a parent's minority status) to understand the conflict. However, the emotional meaning and valence given to these interpretations were very distinct and at least in part refracted through personal experiences. During Case 1A, one observing participant framed the situation in terms of bullying to make sense of it:

He could have had a low-income parent or a parent who is unemployed. And just to kind of compare it with all the situations where kids bully others because the parents are a minority. Just saying that he's dealing with the difficulties of kids who have parents from a minority group.

When the narrative was returned to for Case 1C, one interviewer, who had not been present for the April 2021 session, similarly framed the situation in terms of bullying but with a less optimistic perspective:

I feel like bullying is one of those things that seems very difficult to manage in a clinical context. And also brought up a lot of personal memories of being bullied when people found out my dad was a bus driver in middle school and high school. And just one of those things that's like no one could give me any advice about what to do about that because my dad's not going to stop being a bus driver.

Notably, in Case 1B, which continued this patient narrative, bullying was not a point of emphasis. This session involved the patient, his mother, and her new female partner. The dynamics between the male adolescent patient and the two adult women seemed to cause interviewers and observers to be less likely to frame the patient as a victim. In the first and third sessions of this narrative, which included only the patient and his mother, it became evident relatively quickly that the patient's fights at school had been in response to peers making negative comments about his mother being transgender. Participants in the first and third sessions, while recognizing the behavior as problematic, understood that it seemed to be coming from a place of wanting to defend his mother and who she is. However, in the second session, when this aspect of the fights at school came to light, it was framed as bad behavior and expression of the patient's anger toward his mother and not as him being "clearly protective of his mom," as one participant put in the first

session (Case 1A). In the third session, a synthesis of the two views emerged, recognizing that both realities could be simultaneously true:

Participant 1: [The patient] might be like, “Mom has nothing to do with this. This is the kids at school.” And so we're trying to treat two different things as the same thing there. So that makes it even more complicated.

Participant 2: Or mom does have to do with it. But it's just that she's causing the bullying. It's not her fault. He doesn't necessarily blame her for it. But he probably still feels some resentment towards her for it (Case 1C).

Longitudinal narratives in CCPS thus provide the opportunity to revisit the patients and their families, as a continuation of the narrative, but to see them with fresh eyes and hear their stories anew, rather than trying to replicate previous sessions.

DISCUSSION

In this study, we explored what kinds of reflections would be generated by CCPS cases designed to simulate the dyadic and longitudinal dimensions of child and adolescent psychiatry practice. In seeking to generate emotionally authentic responses and reflection in the participants, we elected to include older adolescent actors who were generally close in age to the patients they simulated. The depth of participant reflections during the debriefing sessions suggested the emotional authenticity and interpersonal complexity. The emotional experience of the simulations, for interviews and observers alike, provided

an opportunity to reflect on personal and professional experiences and triggered meaningful insights and connections between participants.

Did we truly simulate the clinical encounter?

We recognize that the simulation sessions described here were not perfect reproductions of an actual patient encounter and lacked physical and psychological fidelity. However, for the purposes of these sessions, which were to practice a dialogic and “holding” mindset toward the parent-child dynamics and “exercise” empathy in challenging clinical scenarios, true replication was not necessary, but rather scenarios that were sufficiently believable to evoke strong emotional responses in the participants and actors. Indeed, to successfully replicate the conditions of a real clinical encounter in its entirety would risk reintroducing the harm that simulated encounters seek to minimize or eliminate.

Did we truly create a safe space?

Even though participants were meant to feel that they were not being evaluated, interviewers and observers alike felt some pressure to perform their roles successfully for their peers as well as their supervisors. Interviewers feared making missteps while interviewing, whether failures in empathy and awareness or forgetting basic psychiatric clinical skills; some participants reported acting differently because of their awareness of being watched. The fact that there were things that a participant would say to a patient in private but not in front of an audience of colleagues suggests a space that is not truly safe, where what happens in the space may not stay in that space, even if the transgression

occurs in a simulated encounter. In a similar vein, the debriefing sessions were not immune to conflict. For example, one conflict arose around one participant using terminology to describe a marginalized group that bothered another participant who was a member of that group. In the context of the “safe space” of the debriefing, the differing needs come into conflict: can one expect freedom from harm? Or can one expect freedom of expression? It is unclear whose, if anyone’s, safety should be prioritized in a “safe” debriefing space.

Acting like you care

Embodying emotional authenticity

In spite of criticisms of patient simulation in psychiatric training, attempting to learn and practice meaningful communication via simulation does not feel fruitless, given the possibility of emotional authenticity in simulation. To suggest that acting on instinct and in-the-moment responses is the only avenue to have genuine and meaningful interactions with patients does a disservice to both providers and patients. Some critics have claimed that patient simulation fails to accurately simulate the emotional experience of a clinical encounter because it is merely a performance, rather than something with true stakes. However, I argue that a “performance” is not inherently inauthentic, particularly from an emotional perspective. Even in the controlled and “performative” space of the simulation session, participants’ reflections on the simulated encounters suggested a simulation of the emotional space that was experienced as authentic by the participants. These concerns around authenticity in simulation presume that authenticity is a moral objective in and of itself, rather than a means of achieving moral actions. Indeed, the dogged pursuit of

authenticity as an end may itself be detrimental. As Lasch argues in *The Culture of Narcissism*, authenticity as an ideal centers one's own inner feelings and experiences at the expense of the feelings and experiences of others and may be harmful to the social fabric²⁷.

Russian actor and director Konstantin Stanislavski (1863-1938) felt that an actor should "experience feelings analogous" to those of the character "each and every time you do it"²⁸. His system of acting, one of the forebears of "method acting," calls for the actor to be "thinking, wanting, striving, behaving truthfully, in logical sequence in a human way, within the character, and in complete parallel to it." The actor tries to reproduce the character's internal, affective causes of behaviors, rather than present a reproduction of the visible effects of these emotions. Stanislavski describes in a personal anecdote how one can self-induce very real emotions even in a situation known to be "unreal":

At a party one evening, in the house of friends, we were doing various stunts and they decided, for a joke, to operate on me. Tables were carried in, one for operating, the other supposedly containing surgical instruments. Sheets were draped around; bandages, basins, various vessels were brought. The "surgeons" put on white coats and I was dressed in a hospital gown. They laid me on the operating table and bandaged my eyes. What disturbed me was the extremely solicitous manner of the doctors. They treated me as if I were in a desperate condition and did everything with utmost seriousness. Suddenly the thought flashed through my mind, "What if they really should cut me open?!" Now and

then a large basin made a booming noise like the toll of a funeral bell. “Let us begin!” someone whispered. Someone took a firm hold on my right wrist. I felt a dull pain and then three sharp stabs. I couldn’t help trembling. Something that was harsh and smarted was rubbed on my wrist. Then it was bandaged, people rustled around handing things to the surgeon. Finally, after a long pause, they began to speak out loud, they laughed, congratulated me. My eyes were unbandaged and on my left arm lay a new-born baby made out of my right hand, all swaddled in gauze. On the back of my hand they had painted a silly, infantile face²⁹ (p. 284).

According to Hochschild’s reading of this account, “the ‘patient’ above is not pretending to be frightened at his ‘operation.’ He is not trying to fool others. He is really scared. Through deep acting he has managed to scare himself”³⁰.

Medical Education Empowered by Theater (MEET) offers one way of harnessing the production and performance of emotional authenticity to bring about self-reflection, personal insight, and professional growth in medical trainees³¹. MEET is based in Augusto Boal’s Theater of the Oppressed, which “brings social dilemmas to the stage and invites the audience to reflect, debate, and rehearse for changing the reality.” In Boal’s words, “theater is a rehearsal for life”³². In describing the logic behind MEET, the authors draw a comparison between actors and doctors as two types of “performers”:

Actors cannot properly perform if they are not fully present, body and mind, in their scenes. When they are not wholly present, the audience perceives the fakeness, the characters lose their strength, and the play loses its power. Actors must leave behind personal issues to focus on their characters and the play. Actors need more than understanding; they need to realize how a person, in certain circumstances, could become the character. Patients expect the same ability from a doctor. Patients perceive when their physicians are distracted or indifferent. Doctors ought to create a sense of familiarity with their patients and need to regulate and reappraise negative feelings to allow the therapeutic encounter to occur. They must realize how each person has become, also, a patient³¹.

Performing emotional labor

Given the apparent simulation of emotional authenticity, the sessions also provided opportunities for participants to practice and reflect on the emotional labor that psychiatric care and dyad-oriented care demand. In *The Managed Heart: Commercialization of Human Feeling* (1983), Hochschild argues that “nowadays most jobs call for a capacity to deal with people rather than with things, for more interpersonal skills and fewer mechanical skills”³⁰. She delineates jobs that are characterized by producing “emotional labor” by the following three criteria:

- (1) They require interpersonal contact with the public;
- (2) they require that the worker produce an emotional state in another person; and
- (3) they allow the

employer, through training and supervision, to exercise a degree of control over the emotional activities of employees.

While the demand for emotional labor in Hochschild's estimation is often a cost of doing business in the modern, service-oriented economy, the situation is a bit more complicated for certain care-oriented professions. She argues that "the social worker, the day-care provider, the doctor, and the lawyer [...] do not work with an emotion supervisor immediately on hand. Rather, they supervise their own emotional labor by considering informal professional norms and client expectations." Nonetheless, she argues that doctors do, indeed, engage in emotional work:

Doctors, in treating bodies, also treat feelings about bodies, and even patients who are used to impersonal treatment often feel disappointed if the doctor doesn't seem to care enough. It is sometimes the doctor's job to present alarming information to the patient and to help the patient manage feelings about that. In general, the doctor is trained to show a kindly, trusting concern for the patient. Ideally, he is both trusted and trusting.

However, the psychiatry trainee may, in fact, meet Hochschild's criteria for an emotional labor job, given the prominence of clinical and emotional supervision in their day-to-day experience of the role. Whether or not one is being supervised, providing child psychiatry care calls for emotional labor; rather than additional demand upon the worker, one might view it as an intrinsic dimension of the job. Much of the work of child psychiatrists is

managing the feelings of parents and helping children learn to manage their feelings while at the same time managing their own emotions. As healthcare practitioners, child psychiatrists are expected to display authentic empathy and care and to have a customer service orientation, i.e., a “love what you do” attitude. But as agents of the medical institution, they are expected to contain disruptive behaviors and feelings via the threat and force of the medicolegal apparatus and, at times, take on a cynical distance from the patient and the institution even as they act on the institution’s behalf, i.e., a “just do your job” attitude. In this way, emotional labor is not inherently positive or even ethical; just as it can mean offering warmth and comfort to ally with patients, the emotional labor of psychiatry can also mean inducing fear and discomfort to coerce patients.

Vinson and Underman frame the demand for emotional labor, i.e., clinical empathy, in the patient encounter as a product of the influence of corporatization (empathy can increase patient satisfaction for the benefit of the whole healthcare organization) and consumerism (patients have greater choice and autonomy in the care and can demand more from their providers) on medicine³³. In their qualitative analysis of interviews and ethnographic observations of medical students and residents from two U.S. medical schools, the authors describe the shift toward the standardization of empathy and emotional labor within academic and institutional medicine:

As we have shown, clinical empathy is a routinized performance that is motivated by the need to relate to patients in order to achieve strategic ends in the clinical encounter. [...] As we demonstrated, clinical empathy is taught as a set of

emotion management techniques that align with a greater institutional emphasis on the formalization of teaching and evaluating emotional expression in clinical medicine. Standardized testing is a recent phenomenon that helps to indicate that clinical empathy is becoming entrenched as an occupational requirement among physicians.

In contrast to this organizational framing, Larson and Yao conceptualize clinical empathy “psychologically” as emotional labor to better understand its components³⁴. They argue that empathy is more than an attitude, but is a dynamic process involving affective, cognitive, and behavioral components. Similarly, they define emotional labor as “the process of regulating experienced and displayed emotions to present a professionally desired image during interpersonal transactions at work.” According to the authors, emotional labor, like any form of labor, is not necessarily draining or detrimental to the laborer; it has the potential to be fulfilling and rejuvenating, even as it demands attention and effort:

The cognitive and emotional effort involved in empathy strain the already overextended psychological resource physicians have, contributing to burnout and even causing emotional pain for some. On the other hand, genuine emotional understanding of patients can bring physicians deep satisfaction from their clinical interactions and their relationships with patients.

The authors also advocate for using methods of acting to frame empathy for medical trainees. They discuss the role of surface acting, in which “individuals mainly engage in overriding automatic expressions that are not desired, fabricating expressions that are desired, and enduring the dissonance of the two,” and deep acting, in which “memory and imagination are used liberally in an effort to renovate the actor’s inner world, and the role each can play in displaying and experiencing empathy with patients. Additionally, the authors argue that such approaches can aid in avoiding burnout:

Teaching acting to physicians also enriches their reservoir of human experience and makes it easier for them to develop perspective, which, ironically, can help them achieve detachment when they become too engaged in a patient’s experience.

While such psychologizing of clinical empathy risks shifting the burden of responsibility from the organizational context onto the individual clinician, it may also offer the possibility of an internal locus of emotional control. Additionally, an interpersonal view of empathy, particularly between providers, may offload some of that individual emotional responsibility. Hardy argues for a “social extension” approach to the emotional tolls and demands of the clinical space, “rather than empathy being delegated to one empathic nurse who carries the bulk of emotional labor”³⁵. According to Hardy, socially extended empathy has the potential to “bring greater emotional solidarity to the care team and serve to make space for calm.”

Parenting and the clinical encounter as holding environments

According to object relations theory, the clinical encounter can offer the possibility of producing a “holding environment” for patients. As theorized by pediatrician and psychoanalyst Donald Winnicott, “the foundations of health are laid down by the ordinary mother in her ordinary loving care of her own baby,” particularly the active holding of the child³⁶. In Winnicott’s view, the “mother's technique of holding, of bathing, of feeding, everything she did for the baby, added up to the child's first idea of the mother,” which then allowed the child to perceive their own body as a safe place where one’s needs are met. As part of healthy development, the holding environment should expand to include the family and larger social circles. A failure to secure a holding environment at any stage could result in a rupturing of the child’s sense of integrity and agency. In line with this thinking, Winnicott viewed the role of a psychotherapist as healing through providing a holding environment: “A correct and well-timed interpretation in an analytic treatment gives a sense of being held physically that is more real...than if a real holding or nursing had taken place. Understanding goes deeper.”

The clinical encounter in child and adolescent psychiatry can potentially function as a space in which the clinician provides a holding environment for the caregiver-child relationship, to help the caregiver hold the child. In our sessions, participants noted the need to provide, as the clinician, this sort of holding environment for the adolescent patient. However, at times, parents needed to be held in order to facilitate them holding their child. Ziegler and Weidner illustrate the need for interventions for parents of children who have experienced violence to help them debrief the violence and hold the

child effectively³⁷. The authors describe the particular need in times of crisis for a holding environment, which they define by:

1. Safety and security—care, warmth, and self-control
2. Empathy—being receptive to the child's feelings, seeing the child as separate and different from themselves, appreciating the child's developmental level, emotional availability, and controlled attunement to the child
3. Facilitation—identification of resources to support and continue the child's growth, and commitment to provide these opportunities.

In order to successfully provide this holding environment for their children, the authors argue that “parents should understand the impact of the trauma on themselves as well as their child and be able to see the child's needs and emotions when they are different from their own.” They explain that parents may feel responsible for the violence and the resulting guilt and shame can interfere with their ability to empathize with the child, which must be addressed in order to fully address the child’s needs. In our sessions, participants noted the importance of providing a holding environment, with safety, security, empathy, and facilitation as described above, in the clinical space for the child, the parent, or both.

Debriefing sessions as holding environments

In the context of CCPS, perhaps the debriefing session can provide a similar sort of holding environment, to allow trainees to learn and explore with some sense of security.

In developing an in-depth debriefing session to address students' emotions and professional identity formation during simulation, Schweller et al found argued that "since we are advocating the necessity of dealing with patients' emotions in a positive and constructive way, it is mandatory that facilitators do the same with students' emotions during the debriefing"³⁸. They further analogized the debriefing session to that of an ideal clinical encounter, in which one fosters an environment that is "free, safe, devoid of judgment, and based on positive reinforcement" so that "the patient feels at ease to share his or her experiences and thoughts, and so that the doctor has the legitimacy and intimacy necessary to make suggestions and comments that make sense to the patient's life."

Palliative care, with its position typically as a consultation service for patients with particularly complex needs and circumstances, may provide insights into how clinicians can support other clinicians through debriefing sessions. Keri Brenner et al described how palliative care providers can offer a holding environment to not only patients, but also referring clinicians³⁹. The palliative care literature defines the holding environment as:

"a relational space for patients, which helps contain and normalize the extreme, often oscillating, thoughts and feelings of coping with life-limiting illness.

Palliative care clinicians foster this relational space so that patients can safely explore and process the meaning of serious illness."

When debriefing with referring clinicians, the authors outline the importance of recognizing challenges in providing care, which “may shield referring clinicians from personalizing the inevitabilities of life-limiting disease,” and establishing expectations about the patients’ possible outcomes, which “gives permission to let go of idealized expectations and concerns about others’ impressions of their clinical skills.” In this way, providing a holding environment for other clinicians may increase resilience and decrease burnout.

A dialogic approach to dyads

The metaphor of the “holding environment,” while useful, has its limits. It suggests one entity holding the other, with a unidirectional flow of care, knowledge, and resources from the “holder” to the “held,” from parent to child, instructor to learner, provider to patient. Yet, these relationships are not one-sided: as the holder changes the held, the held changes the holder. Philosopher and literary critic Mikhail Bakhtin made the concept of *dialogue* central to his ethical and aesthetic framework, describing the *open-ended dialogue* as “the single adequate form for verbally expressing authentic human life”⁴⁰. It is such a dialogue that co-construction, as embodied in CCPS, strives to generate. Bakhtin’s dialogic stance has been applied to critical pedagogy, with Paulo Freire advocating for dialogic education⁴¹. Boyd and Markarian outline how Freire characterizes the dialogic teacher:

1. Modulates his tone of voice to conversational tones rather than didactic.
2. Listens intently when students are speaking and asks other students to do the same.

3. Does not begin a reply after the student ends her or his first sentence, but asks the student to say more about the question.
4. Delays a response when students request the teacher's opinion, instead defers to other student opinions.
5. Starts next class with answers to questions/comments he could not answer during the current class.
6. Signals (as in Step 5) the importance of student statements.
7. Uses humor⁴².

According to the authors, dialogic teaching provides “supportive and substantive opportunities for engaged talk with content – to explore, challenge, reconsider, and extend ideas in ways that enhance student learning.” In considering how these tenets are conducive to the co-construction of knowledge and meaning in the instructor-learner dyad, it becomes apparent how they may also apply to the dynamics of parent-child and provider-patient dyads.

Through this dialogic process, Bakhtin argues that there is the possibility of overturning assumed orders and flattening hierarchies. In Bakhtin's conception of the *carnival*, "opposites come together, look at one another, are reflected in one another, know and understand one another"⁴⁰. The carnivalesque approach to the world is “opposed to that one-sided and gloomy official seriousness, which is dogmatic and hostile to evolution and change, which seeks to absolutize a given condition of existence or a given social order.” The body, bodily functions, and embodiment are crucial to Bakhtin's carnival, as

evidenced by its etymological roots in the Latin *caro, carnis* (flesh). Bakhtin scholar Caryl Emerson argues that such a carnal emphasis is inherently anti-elitist:

Such communal “baseness,” the vigor of *le bas corporel*, is the foundation of Bakhtin’s carnival logic. It can be fueled by denunciation and aggressive rhetoric but is apparently tainted by neither; its laughter, even when defiant, is rejuvenating. Since the grotesque body costs nothing to keep up, does not care if it wears out, has neither vanity nor fear of pain, cannot be self-sufficient, and is always “a body in the act of becoming,” it is guaranteed to triumph over classical form, institutional oppression, and individual death⁴³.

As abstract and disembodied as CAP practice and education can appear at times, we saw such embodiment in our simulation and debriefing sessions: in affective and physiological responses that occur during simulation, in the body languages of patients and providers, in the comforting touch between a parent and child. In this way, the division between mind and body collapses as well, with psychic processes influencing somatic processes, and vice-versa. By challenging the mind-body divide as a false dichotomy (and thereby a false dyad), we perhaps could then imagine the dyadic relationships discussed above as false dichotomies as well. Instead, these dyads may be understood as singular systems, interdependent and at odds with one another, unified by difference.

Challenges and limitations

I concede three main shortcomings. First, we included participants from one CAP training program in an urban academic medical center in the northeastern United States, making our findings potentially less relevant to training programs in other regions of the U.S. and outside the U.S. Second, our sample of CAP senior fellows may not have been representative of demographics of CAP trainees across the U.S. Though the participant sample was racially and ethnically diverse (with white participants being in the minority), the sample had a large majority of male participants, with only two female participants in the cohort. Third, through the format of group debriefing sessions, we may have introduced the opportunity for groupthink or participants responding in socially desirable ways, issues that individual interviews could have prevented. However, given our interest in how participants make meaning via social interactions, a group format was deemed most appropriate.

Dissemination

I plan to submit and publish these findings in a child and adolescent psychiatry journal, *Child and Adolescent Psychiatry and Mental Health*.

REFERENCES

1. Cleland JA, Abe K, Rethans J-J. The use of simulated patients in medical education: AMEE Guide no 42. *Medical Teacher* 2009;31(6):477–86.
2. Grau Canét-Wittkamp C, Diemers A, Van den Bogerd K, et al. Learning patient-centredness with simulated/standardized patients: A realist review: BEME guide no. 68. *Medical Teacher* 2022.

3. Barrows HS. An overview of the uses of standardized patients for teaching and evaluating clinical skills. *AAMC. Academic Medicine* 1993;68(6):443–51.
4. Rosen K. The History of Simulation. In: Levine A, DeMaria S, Schwartz A, Sim A, editors. *The Comprehensive Textbook of Healthcare Simulation*. New York, NY: Springer; 2014. p. 5–50.
5. Brenner A. Uses and limitations of simulated patients in psychiatric education. *Academic Psychiatry* 2009;33(2):112–9.
6. Wallace J, Rao R, Haslam R. Simulated patients and objective structured clinical examinations: Review of their use in medical education. *Advances in Psychiatric Treatment* 2002;8(5):342–8.
7. Hanna M, Fins JJ. Viewpoint: Power and communication: Why simulation training ought to be complemented by experiential and humanist learning. *Academic Medicine* 2006;81(3):5–70.
8. Coyle B, Miller M, McGowen KR. Using standardized patients to teach and learn psychotherapy. *Academic Medicine* 1998;73(5):591–2.
9. Piot M-A, Attoe C, Billon G, Cross S, Rethans J-J, Falissard B. Simulation Training in Psychiatry for Medical Education: A Review. *Frontiers in Psychiatry* 2021;12.

10. Martimianakis MA, Michalec B, Lam J, Cartmill C, Taylor JS, Hafferty FW. Humanism, the hidden curriculum, and educational reform. *Academic Medicine* 2015;90(11 Suppl):S5–S13.
11. Bächli P, Meindl-Fridez C, Weiss-Breckwoldt AN, Breckwoldt J. Challenging cases during clinical clerkships beyond the domain of the “medical expert”: an analysis of students' case vignettes. *GMS J Med Educ.* 2019;36(3):Doc30. doi: 10.3205/zma001238.
12. Schweller M, Ledubino A, Cecílio-Fernandes D, Carvalho-Filho MA. Turning the simulation session upside down: The supervisor plays the resident. *Medical Education* 2018;52(11):1203–4. <https://doi.org/10.1111/medu.13722>.
13. Martin A, Weller I, Amsalem D, Duvivier R, Jaarsma D, de Carvalho Filho MA. Co-constructive patient simulation: a learner-centered method to enhance communication and reflection skills. *Simulation in Healthcare: The Journal of the Society for Simulation in Healthcare* 2020;16(6):e129–e135.
14. Martin A, Weller I, Amsalem D, et al. From learning psychiatry to becoming psychiatrists: A qualitative study of co-constructive patient simulation. *Frontiers in Psychiatry* 2021;11.
15. Weller I, Spiegel M, de Carvalho-Filho M, Martin A. From retelling to retooling: exploring the meeting places between narrative medicine and human simulation. Submitted.

16. Buka SL, Beers LS, Biel MG, et al. The family is the patient: Promoting early childhood mental health in pediatric care. *Pediatrics* 2022;149(Supplement 5).
17. Plaksin J, Nicholson J, Kundrod S, Zabar S, Kalet A, Altshuler L. The benefits and risks of being a standardized patient: A narrative review of the literature. *Patient* 2016;9(1):15–25.
18. Woodward CA, Gliva-McConvey G. Children as standardized patients: Initial assessment of effects. *Teaching and Learning in Medicine* 1995;7(3):188–91.
19. Budd N, Andersen P, Harrison P, Prowse N. Engaging children as simulated patients in healthcare education. *Simulation in Healthcare: The Journal of the Society for Simulation in Healthcare* 2020;15(3):199–204.
20. Bokken L, van Dalen J, Rethans J-J. The case of “Miss Jacobs”: Adolescent simulated patients and the quality of their role playing, feedback, and personal impact. *Simulation in Healthcare: The Journal of the Society for Simulation in Healthcare* 2010;5(6):315–9.
21. Randall D, Hill A. Consulting Children and young people on what makes a good nurse. *Nursing Children and Young People* 2012;24(3):14–9.
22. Khoo EJ, Schremmer RD, Diekema DS, Lantos JD. Ethical concerns when minors act as standardized patients. *Pediatrics* 2017;139(3):e20162795.
23. Kiger ME, Varpio L. Thematic analysis of qualitative data: AMEE Guide No. 131. *Medical Teacher* 2020;42(8):846–54.

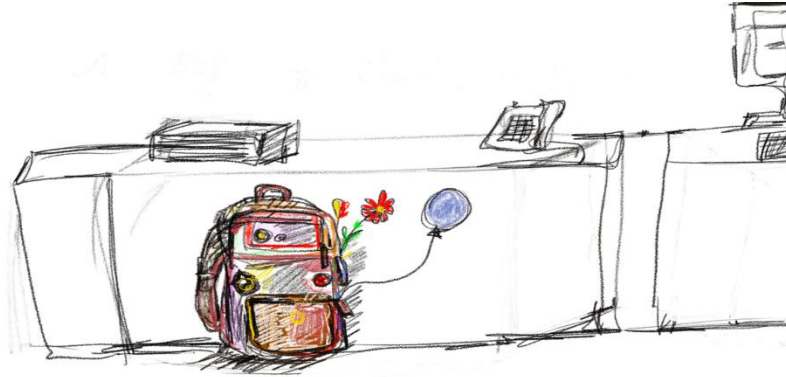
24. Hall P. Symbolic Interaction. In: Ritzer G, editor. Blackwell encyclopedia of sociology. New York, NY: Blackwell; 2007.
25. Blumer H. The methodological position of symbolic interactionism. In: Symbolic Interactionism: Perspective and Method. Englewood Cliffs, NJ: Prentice-Hall; 1969. p. 1–60.
26. Goffman E. The Presentation of Self in Everyday Life. Harmondsworth, UK: Penguin Books; 2022.
27. Lasch C. The Culture of Narcissism: American Life in an Age of Diminishing Expectations. London, UK: Abacus; 1980.
28. Stanislavsky K. An Actor's Work. London, UK: Routledge; 2010.
29. Stanislavsky K. An Actor Prepares. UK: Routledge; 1989.
30. Hochschild AR. The Managed Heart: Commercialization of Human Feeling. Berkeley, CA: University of California Press; 2012.
31. de Carvalho Filho MA, Ledubino A, Frutuoso L, et al. Medical Education empowered by Theater (Meet). *Academic Medicine* 2020;95(8):1191–200.
32. Snyder-Young D. Rehearsals for revolution? Theatre of the Oppressed, dominant discourses, and democratic tensions. *Research in Drama Education: The Journal of Applied Theatre and Performance* 2011;16(1):29–45.
33. Vinson AH, Underman K. Clinical empathy as emotional labor in medical work. *Social Science & Medicine* 2020;251:112904.

34. Larson EB, Yao X. Clinical empathy as emotional labor in the patient-physician relationship. *JAMA* 2005;293(9):1100–6.
35. Hardy C. Empathy and calm as social resources in clinical practice. *AMA Journal of Ethics* 2022;24(12):e1135–1140.
36. Winnicott, DW. The theory of the parent-infant relationship. *The International Journal of Psychoanalysis* 1960;41:585-95.
37. Ziegler R, Weidner D. Interventions with parents to support the parental holding environment to permit the debriefing of children. *Journal of Infant, Child, and Adolescent Psychotherapy* 2004;3(2):185–202.
38. Schweller M, Ribeiro DL, Passeri SR, Wanderley JS, Carvalho-Filho MA. Simulated medical consultations with standardized patients: In-depth debriefing based on dealing with emotions. *Revista Brasileira de Educação Médica* 2018;42(1):84–93.
39. Brenner KO, Logeman J, Rosenberg LB, et al. Referral relationship: Illuminating the ways palliative care creates a holding environment for referring clinicians. *Journal of Palliative Medicine* 2022;25(2):185–92.
40. Bakhtin M. *Problems of Dostoevsky's Poetics*. Minneapolis, MN: University of Minnesota Press; 1984.
41. Shor I, Freire P. What is the “dialogical method” of teaching? *Journal of Education* 1987;169(3):11–31.

42. Boyd MP, Markarian WC. Dialogic teaching: Talk in service of a dialogic stance. *Language and Education* 2011;25(6):515–34.
43. Emerson C. *All the Same Words Don't Go Away: Essays on Authors, Heroes, Aesthetics & Stage Adaptations from the Russian Tradition*. Brighton, MA: Academic Studies; 2010.

Appendix A: Sample CCPS script and illustrations by the script author

The BAGgage of good intentions:



General Objectives:

1. To explore explicit and implicit biases while providing medical treatment to patients with mental health concerns.
2. To provide experiential opportunity in navigating a complex scenario as a consult physician when patient’s privacy or rights have been ignored with “good intentions”.
3. To explore the impact of countertransference on patient care.

.....
.....

Door note:

Hala is a 21 yo female, currently admitted on the medical floor and being followed by pediatric endocrinology. She has a diagnosis of type-1 diabetes, anxiety and depression.

Hala presented to the hospital after her mother found her confused in her room. Hala got a new insulin pump recently after the battery of her previous pump failed.

It is day 3 of her hospitalization. She has been fully conscious and alert over the last 2 days. She is feeling better, and progressing towards discharge. However, she had another episode of low blood sugar last night.

You are consulted for concerns regarding surreptitious insulin injection for self-harm in the context of Hala's presentation and her psychiatric history of anxiety and depression. The medical team reports that they can not be fully certain that the incident of the low blood sugar level in the hospital was surreptitious insulin injection based on Hala's workup. She has also been nauseous and not eating much in the hospital. However, "something is not adding up".

Due to these concerns, the team searched Hala's belongings, and came to find several insulin pens in her bag. Her bag has been removed from the room and placed in the nursing station as a precaution.

When you ask if the team has discussed these concerns with Hala, they report that Hala is not aware of the bag search. They have not directly discussed their concerns with her because they want you to weigh in and evaluate her safety first.

Hala has agreed to see The Child and Adolescent Psychiatry team.



As you enter Hala’s room she looks worried and tired. After introductions, she reports that she is feeling anxious in the hospital, and wants to go home. She agreed to see psychiatry because she was “told” that she can not be discharged without psychiatric clearance; besides given her history of anxiety and depression “it would be good to talk to the consult team as they are very nice”. Hala feels that the team is not being forthright to her about why she is still in the hospital.

Two family members passed away in the hospital in their thirties due to the severity and complications of diabetes. She does not want to be here.

Hala grew up in New Haven with her parents and 2 younger siblings. She recently moved to Hartford about 7 months ago for music school. She is majoring in jazz composition and songwriting. It has been a big but very positive move for her. The pandemic has been difficult but she has made new friends. She has been able to engage in several small group activities while maintaining precautions. She recently started dating her girlfriend whom she identifies as a major support. Her girlfriend is driving down to see her today. She is excited, but would rather meet her outside the hospital.

Hala has been on an insulin pump since she was a child. Recently, her pump stopped working due to battery issues and a new one was mailed to her. She struggled with using the new pump. She shares that she had a session with a nurse to help her understand about the pump, but did not fully understand it's proper use. Hala reports that she always keeps insulin and glucagon supplies on her in case of emergencies. Especially, since her last pump malfunctioned.

Hala reports that this is the third episode of low blood sugar in the last month. The first occurred when her pump battery died and the second after she got the new pump. The latest episode occurred while she was visiting her mother's house. The last thing she remembers is reading a book in her room. Her mother told her that she found her confused in her room. She came to check on Hala when she did not come downstairs for dinner.

Hala shared that she feels worried about her health due to the recent low blood sugar levels. She has been struggling with diabetes all her life. She reports that as a child, her parents had her spend a lot of time with her aunt who also had type 1 diabetes. They wanted her to be mindful of what happens if you are not compliant with treatment. She explains that she always felt worried about her aunts as they were not as good with medication compliance or dietary precautions. Both of her aunts passed away in their late thirties due to complications. She recalls being in the hospital with her aunt Sara when she went into sepsis following a wound infection. She spent a lot of time with aunt Sara as a child. **Hala feels that though her aunt had neglected her health, in some ways, she also suffered because the severity of her physical issues were often ignored due to her history of depression. “She was eventually trying hard to do better and get better, but she also suffered due to the stigma, she was reporting too much or too little, many times symptoms she reported were not taken seriously.”** Hala narrates that some of her own anxiety and depressions stems from living with diabetes, and having lost family members due to it.

As a child she also struggled with relationship conflicts with her parents. Both her parents struggled with anxiety and depression, her father struggled with binge drinking. Being the eldest, she felt that she always had to provide emotional support to her parents and siblings, and did not have the space to voice her own fears and worries. Her parents separated when she was 14 yo. Following the separation they had joint custody. Her parents got on good terms when her father went to rehab after the separation, but did not

reconcile. Her mother lives with her boyfriend whom Hala has a cordial relationship with.

Following her parents' separation, Hala had an episode of severe depression and confided in her school counselor, she began to get therapy at that time. She was also referred to psychiatry and was put on **Prozac then switched to Zoloft due to weight gain on prozac**. She found therapy in combination of Zoloft very helpful for her mood and anxiety. She still struggles with relationship issues with her parents on and off, but things seem to have gotten better since she moved out for college. She reports that no new stressors have occurred aside from her health issues and the pandemic. Her visit home was going better than expected. She was excited to reconnect with her best friend and neighbor.

Hala has been dating her current girlfriend Sam for about 4 months. She reports that they met in music school. Sam is majoring in music production and engineering. She identifies Sam as very warm and supportive. Her family is supportive of their relationship.

Hala asks you if the team will take good care of her diabetes. If she will be able to go home. She shares that she always really respected and felt confident in her doctor. He has been working with her for a long time and has even told her about his own history of diabetes. **However, her recent struggle with her diabetes has triggered fear in her regarding possible complications and worsening of her condition. She is worried**

now that something bad is happening and the team is not telling her. She feels confused about the psychiatric consult as well, “Are you here to tell me bad news?”

She states that people in her family have not done well with the disease and in hospitals. Despite these fears, she shares that she is motivated to continue fighting for herself and recognizes that with proper management, she may not have severe complications like her aunts.

Hala reports that she discontinued Zoloft in November last year as her mood was very stable. She has been seeing her therapist regularly online. She would be happy to reconnect with a psychiatrist as her health issues have recently caused more stress. She denies any Suicidal or homicidal ideation. She is looking forward to a trip to Spain once the pandemic is over and is future oriented. She has no history of self-harm or suicide attempts. She gives consult to the team to talk to her mother and therapist for collateral.

.....
.....

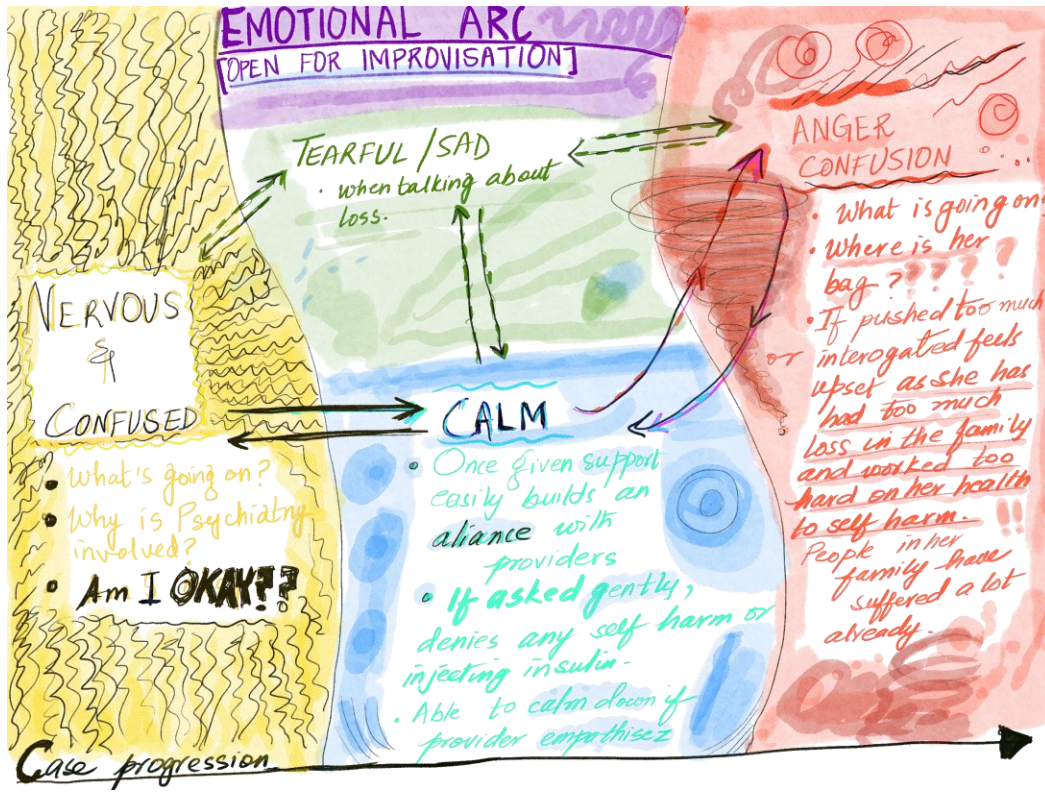
Intended directions of SP interaction:

- 1. Learners should be able to listen to and empathize with Hala’s concerns and provide support to her without being accusatory, investigative or judgmental. SP Should provide her history openly including discuss concerns**

about her health in the context of recent events. SP should discuss her concerns about her low blood sugar levels and challenges of using the new pump.

- 2. Learner should be able to recognize the concerns of invasion of Hala's property and privacy:** SP realizes during the session that her bag is missing from her room and gets upset about this. She asks the provider about this.

- 3. Learner should be able to recognize the complexity in the case and recognizing their role as a provider on the consultation team in evaluations Hala as well as advocating for her.** SP should discuss concerns about the team not being fully open with her plan and about the psychiatric consult particularly the team not discharging her without one. SP should be open about her mental health history. SP allows the team to communicate with her mother and therapist for collateral. SP should discuss history of family with severe diabetes and mental health issues. SP should discuss concerns of physical issues not being taken as seriously due to mental health history.



Initial character sketch; Hala. (to be edited with Camille)

Did hair this morning scattered, but artful.

Warm expression, though anxious about her situation (**switches appropriately**)
Tearful when discussing death of aunt.

enjoys jewelry

Strengths:

- Open about history
- hopeful about the future
- Resilient
- creative x interests
- future oriented
- In a good relationship
- Intelligent

Constant need to use hands when discussing sensitive topics such as loss of family members (plays with clothes/jewelry)

OTHER FACTORS IN PLAY:

- Chronic medical issues
- Difficult childhood experiences
- Hx of anxiety & depression
- Loss & grief
- LGBTQIA+