The Misconception Manual (TMM) is a deduction-based serious game designed to prompt players to question and rectify stereotypes and false assumptions about mental disorders. Misunderstandings surrounding mental health hold high historical prevalence, with behaviours deviating from sociocultural expectations frequently punished and used as a means of social control (Farreras, 2025). Historically, the prominence of religion in combination with minimal medicinal knowledge, fabricated the idea of supernatural entities (Psychology Town, 2024) leading to what we now know as problems with our mental health. Today, dramatized and inaccurate media illustrations continue to fortify these damaging misconceptions (Mind, 2017). As a Psychology student with a specific interest in Psychopathology, I chose this topic focus, due to it's social and academic relevance. Mental health is fundamental to individuals spanning all demographic groups. Given the subjects universal relevance (Kenni, 2023) TMM was intentionally designed for a broad audience of players, with no prior clinical knowledge required. The game's inclusive design is aimed at encouraging collective engagement with psychopathological content, guided by the module 'PS120:Neuropsychology & Psychopathology' taken in my first year at University. During my development of this game, I critically aligned my design choices with relevant pedagogical theories to ensure my learning objectives were met. By combining these frameworks with a socially relevant psychological topic, I propose to exhibit how TMM successfully functions as a serious tabletop game.

Learning outcomes and frameworks used

To demonstrate this, it is necessary to examine the theoretical frameworks informing TMM's design choices and pedagogical success. Firstly, Self-determination theory (SDT), proposed by Deci & Ryan (2008), emphasises the relevance of understanding human motivation,

discriminating between “autonomous motivation, controlled motivation, and amotivation” and argue these are formed by surrounding social conditions, which can either diminish or enhance performance (Kilduff 2014). This framework is particularly valuable to serious games, as “autonomous regulation” (acting by free will) is strongly associated to academic achievement (Ratelle et al., 2007).

However, it is important to acknowledge limitations on this theory. A minimal portion of literature in support of SDT focuses on adolescents, with most studies using adult samples (Perera, 2020; Leverson et al., 2012). This raises concerns on the applicability of the findings to younger learners. As TMM’s intended age range is 16 years and older, (due to cognitively challenging material and distressing content) this limitation is less concerning when applied to my specific game design.

In addition, Vygotsky’s theory of Social Constructivism emphasises how learning is fundamentally reliant on socially interactive settings (Schreiber & Valle, 2013), with supporting research from Davis (2017) who claimed successful learning is largely dependent on discussions and interpersonal interactions. This approach aligns tightly with principles of educational game design, specifically TMM as the game relies on player’s interpreting and questioning each other’s answers.

Finally, Bloom’s Taxonomy (1996) offers a hierarchal framework for understanding the cognitive processes involved in learning, outlining a progression from lower-level skills to higher-order skills, such as analysing and creating (Ruhl, 2025). Although originally created to assist curriculum leaders, the Taxonomy remains relevant to helping develop various educational materials, providing structure and clarity to educational goals. The revised model’s list of action verbs also further supports the clarification of learning objectives (Shabatura, 2014). Critically, Blooms Taxonomy is useful in refining the pedagogical value of

educational games, and defining the learning objective for my game: To analyse given psychological information and distinguish whether the information corresponds to the category of misconceptions or truths.

Mechanics and rules

TMM is built around three core mechanics: deduction, action points, and hidden information, collectively promoting engagement. Inspired by Cluedo (2023), these mechanics require players to carefully analyse missing information and strategically regulate the limited use of action points, ensuring reasoning and observational skills are prioritised. This facilitates autonomous-decision making which aligns closely with SDT, ensuring players are motivated despite the component of relatedness and teamwork being less central (Deci & Ryan, 2008). Additionally, the satisfying tension produced because of deduction and hidden information (Levi, 2025) has been consistently linked to effective experiences of learning (Howard, 2023; Rose, 2010). Therefore, the game's core objective positions deduction as central to gameplay which in theory, should result in meaningful learning. However, iterative solo playtesting proved the games educational objective was unproductive and overshadowed by the games entertainment value. To address this, I implemented a board-based progression system, permitting movement only after correct identification of misconceptions and truths. This additional mechanic refocuses attention on the educational content and ensures psychological understanding is necessary for strategic success. Moreover, this verifies the cognitively demanding experience of gameplay, and ensures the high-order learning objective, developed using Bloom's verb chart (Shabatura, 2014) can be met.

The aesthetic design of TMM is influenced by the graphic design of the mental health diagnostic manual, the DSM-5 (APA, 2022), specifically the newest addition the DSM-5-TR

(see Figure 1). Drawing from this specific diagnostic manual provided the game with a clinically recognisable visual identity. The game's colour palette, typography and line art intentionally embody the DSM's exterior while the categorisation of the disorder cards by colour, was inspired by the organisational coloured tabs used on the manual's interior (see Figure 2). I intended to colour-match the disorder cards to the tabs, however further research showed the tabs are sold via secondary sources, and do not follow a standardised colour code, resulting in me choosing my own colours. Maintaining an orderly and minimalist aesthetic was an intentional and ethically conscious decision. Visual imagery regarding mental disorders can easily fall into ambiguous or offensive areas, particularly when treatments and symptoms are being discussed. To ensure a respectful and non-stigmatising gameplay experience the visual design remains rooted in the simplistic graphics of the DSM. Additionally, though simple, this design strategy ensures minimal cognitive load for players, and ensures a fair experience for all, regardless of prior familiarity to psychological material. Overall, I feel the visual communication of the game considers all players which is essential (Shannon, 1992).

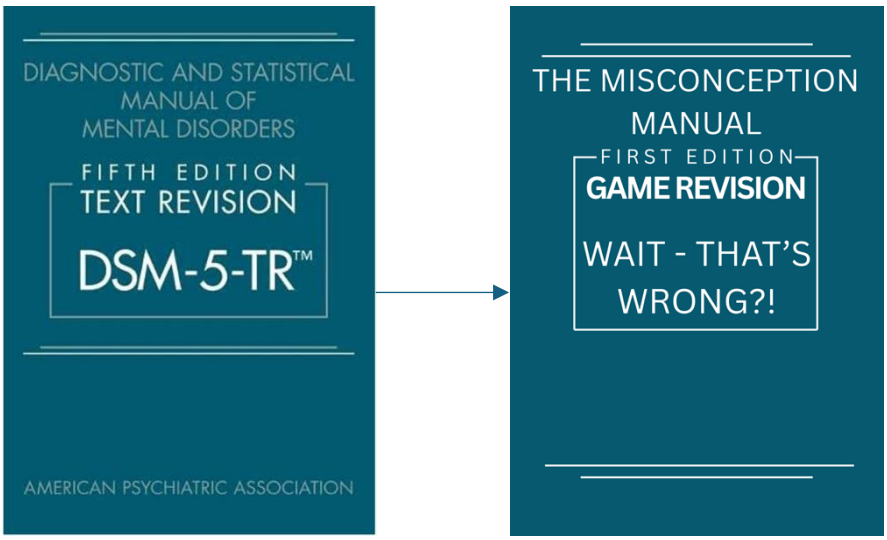

Figure 1. Inspiration from DSM-5-TR

Figure 2. Coloured tabs

Narrative & Theme:

While I acknowledge the motivational benefits roleplay provides (Lizama & Carbajal, 2024), I made a deliberate decision to exclude players embodying or performing in any means relating to their disorder card. Research indicates the choices players make during role-play games often reflect real-world behaviours and attitudes (McGreal, 2022). The aim of TMM is to challenge individuals' stereotypes, rather than provide an outlet for their reinforcement; role-play would not have aligned with the games learning objectives. Furthermore, players performing as clinicians poses the risk of over-simplifying the diagnostic process.

Additionally as mentioned, the game includes sensitive content, with mentions of suicide and abuse, distressing themes to engage with through role-play. Prioritising a respectful gameplay

experience where all ethical considerations have been addressed, contributes to a healthier experience for all (Eng, 2024).

Player roles & Interaction

Experience plays a central role in the learning process (Kolb, 1984). With consideration for the narrative and thematic design choices I made, player roles are less rooted in character identity and more mechanical, focussing on the actions they take rather than who they embody. Players primarily focus on identifying the misconceptions and truths on the information cards and later deducing who holds which disorder card. Interaction occurs through calculated information withholding and anticipation of others' decisions. This aligns with Vgotsky's principles of Social Constructivism (Schreiber & Valle, 2013) as players consistently interact. Through accessing clues, whether via landing on the space or responding to players' guesses, information feedback is consistent. This system of feedback provides the groundworks for "goal-directed action" (Kolb, 1984), further supporting the fulfilment of my learning objective and the role of TMM as a serious game.

Issues faced

During early independent play-testing several challenges emerged. Primarily, generating 60 misconceptions and 60 facts, which could be mistakenly labelled proved incredibly difficult. Although misconceptions are believable by nature, when placed alongside accurate information, the distinction was unmistakable. To achieve the perfect level of ambiguity I refined the language choices, borrowing certain phrases from the factual cards.

Although the difficulties did not stop there. I consistently encountered contradictions between the statements I used for the misconceptions and the facts (see Figure 3). Players could easily infer the correct answers through logical elimination, as opposed to genuine engagement with the content. To avoid threatening the games difficulty level and educational objective, I conducted further research to replace many of the original statements.

Blue = too obvious?

Orange = contradicts something

A shift in one's mindset is usually sufficient to overcome depressive symptoms (MDD)	Depressive symptoms are typically noticeable to friends and family (MDD)	Depression usually has a clear cause that can be identified (MDD)	Low mood during adolescence is often a part of normal development (MDD)	Depressive episodes only develop in the context of ongoing stress	**Major depressive disorder**	Depression can fluctuate in intensity over time	Many people experiencing depression delay or avoid seeking support	Clinical depression can present a wide range of emotional and physical symptoms	Depression is one of the most common geriatric psychiatric disorders	Depression is usually obvious once you pay attention to the persons behaviour
PDD is often tied to lifestyle habits as opposed to clinical factors	Medication is usually the only treatment for PDD	A lack of physical activity is often the main cause of PDD symptoms	Individuals with PDD rarely experience moments of joy	An individual can typically recover from PDD without formal treatment	**Persistent depressive disorder (PDD)**	PDD can be difficult to diagnose as the symptoms develop gradually over long periods of time	PDD can involve physical symptoms	PDD shares many symptoms with MDD	People with PDD can adapt to their symptoms so it's less noticeable to others	It can take up to 6 weeks for medication for PDD to begin working at full effect
PMDD mainly develops due to emotional or psychological factors	PMDD is viewed generally as a condition that affects emotions with little indication of broader impacts	There are several effective treatment options for PMDD	The causes of PMDD are completely unknown and unrelated to hormonal patterns	PMDD is a more intense form of PMS (premenstrual syndrome)	**Premenstrual dysphoric disorder (PMDD)**	PMDD involves heightened sensitivity to normal hormonal changes	Elevated suicide risk with PMDD is documented	PMDD is estimated to affect a small but meaningful percentage of women	Hysterectomy's (removal of ovaries) is the last line of treatment for PMDD	Surgery is the only permanent cure for PMDD
People with Bipolar I remain in one extreme mood rather than shifting between states	Bipolar I is distinguishable, and easily diagnosed as a disorder	Bipolar I follows a clinically predictable pattern of mood cycles	Bipolar I affects a small portion of the population	Manic episodes experienced with Bipolar I are classed as feelings of 'elevated happiness'	**Bipolar I**	Mania experience as part of Bipolar I is not just happiness	Bipolar I is made up of manic highs and depressive lows	Children can be diagnosed with Bipolar I	Rates of Bipolar I disorder are equal between men and women	There are multiple treatment for Bipolar I
Bipolar II does not require long-term treatment as the mood elevations are not as intense as full mania	The positive emotions felt through Bipolar II's hypomania means medication is not needed for treatment	From a biological standpoint Bipolar II does not differ from Bipolar I	People with Bipolar II experience mood fluctuations so frequently that stable periods are uncommon	?	**Bipolar II**	Bipolar II is understudied	Hypomania in Bipolar II does not reach the intensity or duration of manic episodes seen in Bipolar I	Bipolar II hypomania involves euphoric moods	Population studies suggest a small percentage of people meet the criteria for Bipolar II over the course of their life	Bipolar II can only be diagnosed via clinical interview
ASPD leads individuals to lose their complete sense of	ASPD is interchangeable with psychopathy	There are no affective treatment approaches for ASPD	People with ASPD are unable to experience/deliver	Criminal activity involvement is inevitable for people with ASPD	**Antisocial Personality Disorder**	ASPD diagnosis requires evidence from childhood	Individuals with ASPD can demonstrate forms of empathy	ASPD affects 1-4% of adults	Symptoms of ASPD often decrease with age	ASPD development is strongly linked to early trauma and neglect

moral awareness			emotional responses			(before the age of 15)				
BPD causes dramatic reactivity, as opposed to other contextual difficulties	People with BPD are unable to form and maintain long-standing relationships	The presence of mood swings in BPD makes it a variant of Bipolar Disorder	BPD is classified as a personality trait	Individuals with BPD generally show reduced empathetic engagement	**Borderline Personality Disorder**	Fear of abandonment is a core feature of BPD	BPD is strongly linked to trauma	BPD symptoms exist on a spectrum	People with BPD have heightened empathy	There is currently no single medication to treat BPD
Narcissism is mostly characterised by emotional stability	Individuals with Narcissism present themselves in an outgoing manner	Narcissistic behaviour isn't comparable to abusive behaviour	Individuals with narcissism rarely experience significant internal conflict	Individuals with narcissism fully love themselves	**Narcissism**	People with narcissistic traits can show empathy	Shame is a core experience in narcissism	Narcissism is a spectrum	External validation is central to narcissism	Narcissistic traits can fluctuate over time
Social anxiety mainly reflects a heightened reaction to ordinary social demands	People with social anxiety are generally comfortable in one-to-one settings	Social anxiety develops during adolescence and rarely persists into later adulthood	Individuals with social anxiety generally recover without formal support	Social Anxiety typically overlaps with traits such as introversion	**Social Anxiety**	Social Anxiety can occur with people familiar to an individual	Patterns of negative self-evaluation frequently accompany social anxiety	Social anxiety can be present when an individual is calm externally	Social anxiety often co-occurs with depression	Gradual exposure can retrain a person's nervous system with social anxiety
Panic attacks appear noticeably intense	The physical sensations during a panic attack can directly lead to medical harm such as heart or brain complications	Panic disorder involves individuals being in a consistent state of heightened anxiety daily	With enough determination individuals can stop panic attacks from occurring	Panic disorder is an exaggerated response to stress	**Panic Disorder**	Panic disorder involves unexpected panic attacks	Physical symptoms of panic disorder can mimic heart attacks	Panic attacks during panic disorder are time limited	The body cannot stay in panic forever (panic disorder)	Substances worsen panic disorder
Agoraphobia can be reduced through treatment but never fully resolved	If an individual was strongly motivated they can go outside (agoraphobia)	Agoraphobia is not commonly encountered and tends to be relatively rare	Individuals with agoraphobia avoid ever leaving home	Agoraphobia is the fear of open spaces	**Agoraphobia**	Agoraphobia is a situational not spatial disorder	Agoraphobia is a spectrum	Exposure therapy is the best treatment for agoraphobia	Medication is not necessary to treat agoraphobia	Physical symptoms like dizziness and nausea are often experienced (agoraphobia)
GAD tends to occur infrequently in the general population	If the feared outcome does not occur the panic experienced was not real (GAD)	GAD mainly reflects a pattern of excessive worrying with no underlying cognitive component	Reducing negative thoughts is usually enough to resolve GAD symptoms	GAD can resolve itself without treatment	**Generalised Anxiety disorder**	GAD symptoms appear across a spectrum, they are not fixed	For some individuals worrying is a coping mechanism (GAD)	GAD can begin at any age	Sleep is commonly disrupted for someone with GAD	?

Figure 3. Original Information cards

Accessibility & Representativity

During the initial design stages, the truth and misconception cards were colour-coded using red and green (see Figure 4), with monochrome front-sides to have answers revealed using colour when flipped. I later recognised this would not be inclusive for individuals with red-green colour blindness the most prevalent kind (Mangan, 2021), especially after using the 'Colour Blindness Simulator' to confirm (Colblindor, 2016). To ensure equity, the colour system was replaced with a textual code (TF = True/False, FT= False/True) allowing players to distinguish between the cards without reliance on colour (see Figure 5). Similarly, the games rulebook emphasises the games inclusive design, using strictly the gender-neutral pronouns "They/Them/Their", to avoid making assumptions and possibly offending players. Overall, I feel TMM supports an accessible and inclusive gameplay experience.

Figure 4. Old information cards

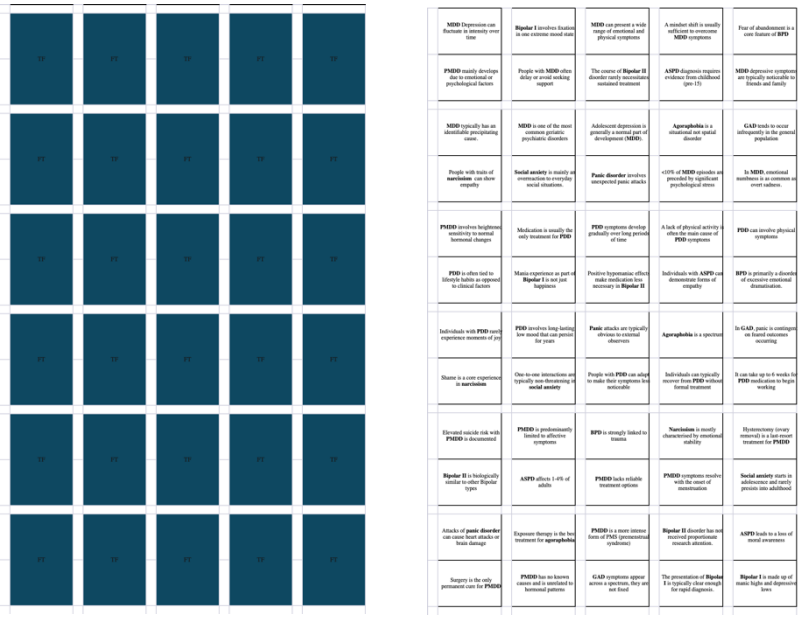

Figure 5. New information cards

Future developments

TMM being the “First Edition” (see Figure 1) draws on both the visual influence of the DSM-5-TR (APA, 2022) and it’s malleable state. The concept can be expanded to produce multiple editions, each including different selections of disorders. This design focuses specifically on selected (not all) mood, anxiety and personality disorders but by no means is limited to this content. The introduction of new disorder domains such as eating disorders, psychotic and neurodevelopmental disorders (WHO, 2025) could offer specified learning objectives, narrowing the educational focus and directing effort and attention more effectively, in turn producing higher performance (Locke et al., 1981).

To conclude, I feel TMM effectively functions as a serious tabletop game. The educational value is absolute though not at the cost of entertainment, providing the perfect integration, to create an engaging educational experience.

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Appendix A

Game Prototype Materials

Figure A1. Box cover

Figure A2. Board

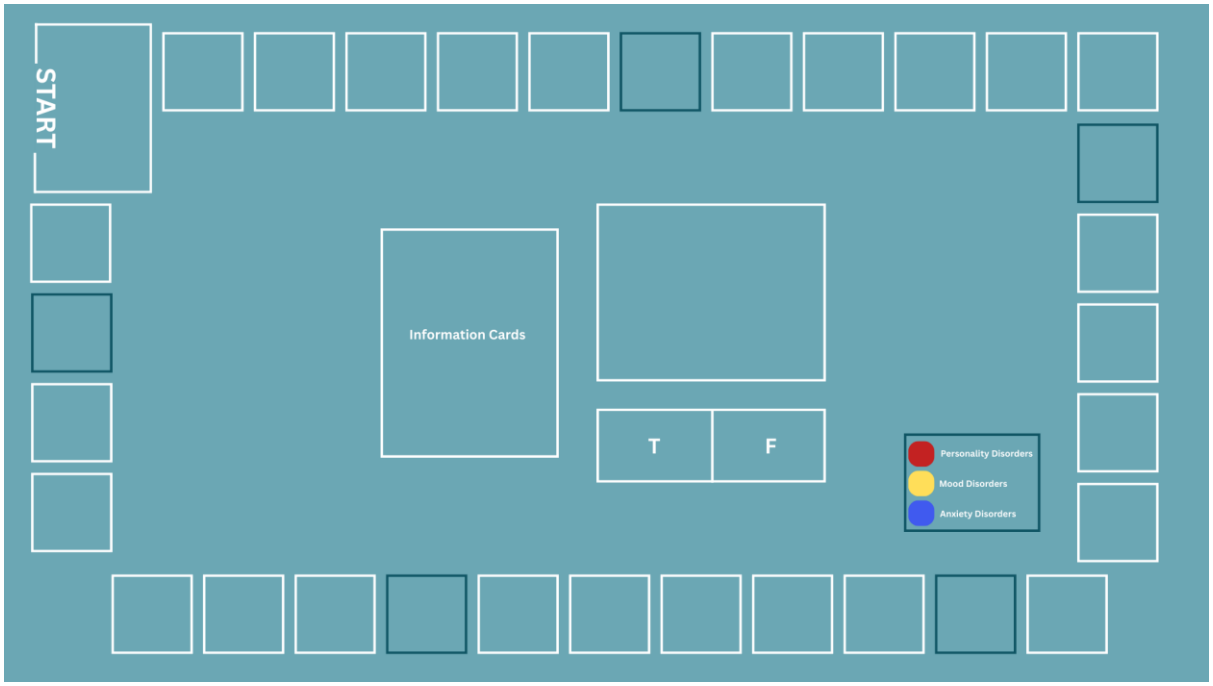


Figure A3. Disorder cards

Figure A4. Voting cards

Figure A5. Action cards

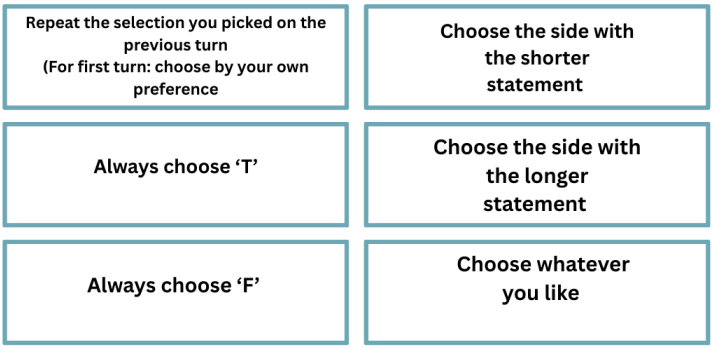


Figure A6. Player tokens

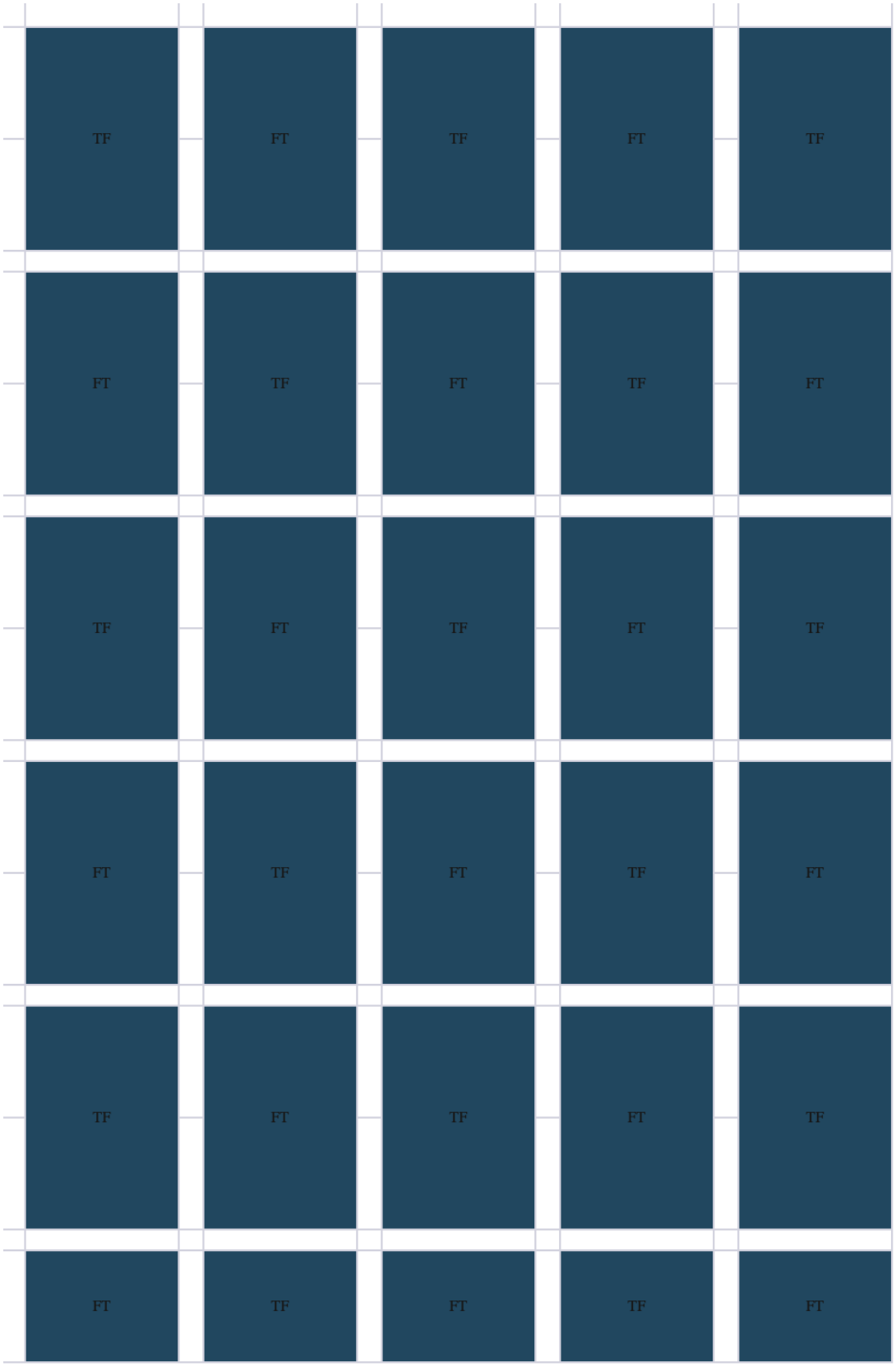
Figure A7. Tracking sheet

DISORDERS	PLAYER ONE	PLAYER TWO	PLAYER THREE	PLAYER FOUR	PLAYER FIVE	PLAYER SIX
Major Depressive Disorder (MDD)						
Persistent Depressive Disorder (PDD)						
Premenstrual Dysphoric Disorder (PMDD)						
Bipolar I						
Bipolar II						
Antisocial Personality Disorder (ASPD)						
Borderline Personality Disorder (BPD)						
Narcissism						
Social Anxiety						
Panic Disorder						
Agoraphobia						
Generalised Anxiety Disorder (GAD)						

Figure A8. Information cards

MDD Depression can fluctuate in intensity over time	**Bipolar I** involves fixation in one extreme mood state	**MDD** can present a wide range of emotional and physical symptoms	A mindset shift is usually sufficient to overcome **MDD** symptoms	Fear of abandonment is a core feature of **BPD**
PMDD mainly develops due to emotional or psychological factors	People with **MDD** often delay or avoid seeking support	The course of **Bipolar II** disorder rarely necessitates sustained treatment	**ASPD** diagnosis requires evidence from childhood (pre-15)	**MDD** depressive symptoms are typically noticeable to friends and family
MDD typically has an identifiable precipitating cause.	**MDD** is one of the most common geriatric psychiatric disorders	Adolescent depression is generally a normal part of development (**MDD**).	**Agoraphobia** is a situational not spatial disorder	**GAD** tends to occur infrequently in the general population
People with traits of **narcissism** can show empathy	**Social anxiety** is mainly an overreaction to everyday social situations.	**Panic disorder** involves unexpected panic attacks	<10% of **MDD** episodes are preceded by significant psychological stress	In **MDD**, emotional numbness is as common as overt sadness.
PMDD involves heightened sensitivity to normal hormonal changes	Medication is usually the only treatment for **PDD**	**PDD** symptoms develop gradually over long periods of time	A lack of physical activity is often the main cause of **PDD** symptoms	**PDD** can involve physical symptoms
PDD is often tied to lifestyle habits as opposed to clinical factors	Mania experience as part of **Bipolar I** is not just happiness	Positive hypomaniac effects make medication less necessary in **Bipolar II**	Individuals with **ASPD** can demonstrate forms of empathy	**BPD** is primarily a disorder of excessive emotional dramatisation.
Individuals with **PDD** rarely experience moments of joy	**PDD** involves long-lasting low mood that can persist for years	**Panic** attacks are typically obvious to external observers	**Agoraphobia** is a spectrum	In **GAD**, panic is contingent on feared outcomes occurring
Shame is a core experience in **narcissism**	One-to-one interactions are typically non-threatening in **social anxiety**	People with **PDD** can adapt to make their symptoms less noticeable	Individuals can typically recover from **PDD** without formal treatment	It can take up to 6 weeks for **PDD** medication to begin working
Elevated suicide risk with **PMDD** is documented	**PMDD** is predominantly limited to affective symptoms	**BPD** is strongly linked to trauma	**Narcissism** is mostly characterised by emotional stability	Hysterectomy (ovary removal) is a last-resort treatment for **PMDD**
Bipolar II is biologically similar to other Bipolar types	**ASPD** affects 1-4% of adults	**PMDD** lacks reliable treatment options	**PMDD** symptoms resolve with the onset of menstruation	**Social anxiety** starts in adolescence and rarely presists into adulthood
Attacks of **panic disorder** can cause heart attacks or brain damage	Exposure therapy is the best treatment for **agoraphobia**	**PMDD** is a more intense form of PMS (premenstrual syndrome)	**Bipolar II** disorder has not received proportionate research attention.	**ASPD** leads to a loss of moral awareness
Surgery is the only permanent cure for **PMDD**	**PMDD** has no known causes and is unrelated to hormonal patterns	**GAD** symptoms appear across a spectrum, they are not fixed	The presentation of **Bipolar I** is typically clear enough for rapid diagnosis.	**Bipolar I** is made up of manic highs and depressive lows

Children can be diagnosed with **Bipolar I**	**Bipolar I** follows a clinically predictable pattern of mood cycles	**Social anxiety** can occur with familiar people – not just strangers	**Panic disorder** involves being in a consistent state of heightened anxiety	Medication is not necessary to treat **agoraphobia**
People with **BPD** are unable to maintain long-standing relationships	**Narcissism** is a spectrum	**Bipolar I** is a very rare psychiatric condition	Rates of **Bipolar I** disorder are equal between men and women	Manic episodes in **Bipolar I** are classed as feelings of elevated happiness
GAD primarily involves excessive worry without a cognitive basis	**BPD** symptoms exist on a spectrum	**Narcissism** is typically expressed through an outgoing interpersonal style	**Bipolar II** hypomania involves euphoric moods	Absence of full mania in **Bipolar II** reduces long-term impairment
There are multiple treatments for **Bipolar I**	Stable mood periods between fluctuations are uncommon in **Bipolar II**	Hypomania in **Bipolar II** is defined by sub-manic intensity and duration	Individuals with **social anxiety** generally recover without formal support	Physical symptoms of **panic disorder** can mimic heart attacks
c.0.5% of people meet the criteria of **Bipolar II** at some point in life	Reducing negative thoughts is usually enough to resolve **GAD** symptoms	People with **BPD** have heightened empathy	There are no affective treatment approaches for **ASPD**	Symptoms of **ASPD** often decrease with age
Agoraphobia cannot be fully resolved through treatment	**Bipolar II** can only be diagnosed via clinical interview	**ASPD** is interchangeable with psychopathy	External validation is central to **narcissism**	**Social anxiety** is best understood as a maladaptive variant of introversion
People with **ASPD** lack the capacity for emotional responsiveness	**ASPD** is strongly linked to early trauma and neglect	Criminality is a typical developmental outcome in **ASPD**	Negative self-image with **social anxiety** is common	Contemporary classifications treat **BPD** as a maladaptive personality trait.
Attacks in **panic disorder** are time limited	People with **agoraphobia** could go out if strongly motivated to do so	Worry functions as a coping strategy in **GAD**	Mood fluctuations in **BPD** justify its classification as a bipolar variant	In **panic disorder**, the body cannot stay in panic forever
There is no single medication to treat **BPD**	**BPD** is characterised by a generalised reduction in empathy	**Social anxiety** can be present if the individual is calm externally	People with **narcissism** rarely experience significant internal conflict	Traits of **narcissism** can fluctuate over time
Agoraphobia is infrequently encountered in clinical practice	**GAD** can begin at any age	Abusive behaviour is the primary interpersonal expression of **narcissism**	Substance use worsens the clinical course of **panic disorder**	**Agoraphobia** typically results in complete home confinement
Narcissism rests on a stable and unwavering form of self-love.	**Social anxiety** often co-occurs with depression	**GAD** can resolve itself without treatment	Dizziness & nausea are often experienced in **Agoraphobia**	**Panic disorder** is an exaggerated response to stress
Sleep is commonly disrupted for someone with **GAD**	**Agoraphobia** is the fear of open spaces	Gradual exposure can retrain the nervous system in **social anxiety**	With enough determination individuals can stop **panic** attacks	In **GAD**, uncertainty is often more distressing than the feared outcomes.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