

SOME IMPLICATIONS OF THE USE OF VIDEOTAPE AT MENTAL HEALTH SERVICES FOR THE DEAF

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The use of videotape has been an integral part of the research, therapy and consultation at Mental Health Services for the Deaf. When we first acquired the equipment, we were among the few groups at Langley Porter Neuropsychiatric Institute to use videotape techniques. Our use of videotape grew out of the need of each of the several facets of our project. Perhaps the most outstanding result was that videotape became far more than a recording instrument; it was a positive agent for change in the psychotherapeutic process and an effective communication tool for conveying our research results.

Research

In our research study of 40 deaf children and 20 hearing control subjects, we wanted some way of measuring mother-child interaction. Researchers in the field tried making written recordings of their observations of mother and child in the home. These written observations were useful descriptions, but did not allow for reliable comparison involving multiple judges and standardized situations. To meet these problems a scenario was designed requiring the videotaping of each mother-child pair in our office studio. This scenario consisted of a twenty-five minutes, loosely structured format in which mother and child were asked to play with some toys, complete a few tasks, and have refreshments. The observer, gathering and recording data through the use of videotape, is the cameraman. Standardization of his recording techniques is just as important as that of the scenario format. How sensitively he observes and tapes the interaction certainly affects what the in-

dependent observer watching the finished tape will see. The use of the zoom lens was necessary to capture mother-child interaction at close range. Because of the number and types of rating decisions to be made later on, the camera clearly could not be left on "unattended." In the next phase of this research, three independent judges rated the 60 scenarios on 30 different items and were asked to reach agreement on 24 of these, or 1440 items. The judges were able to play back any section of the videotape they wanted, to get a better look at any part of the interaction in order to confirm their ratings. In only 19 out of the 1440 items were the judges unable to reach a consensus. This permanent record of mother-child interaction represents an ideal framework for a longitudinal study and a rich source for further study. One additional study which is proceeding, is an interaction process analysis of the scenarios, using a modified version of Bales (1950) categories. A short composite tape of several examples of mother-child interaction was made and used for orienting the judges, working with consultants and professional visitors interested in the research.

In another research study, the language acquisition of deaf youngsters was recorded on videotape at regular intervals out in the field. We were able to record each child in his home environment as well as in other settings natural to each child and his family. The videotapes can be played back as many times as needed for analysis, a particularly helpful procedure in analyzing sign language because of the individual nuances of the young child learning language. Also, instant replay affords the family feedback on what is being recorded, which often gives the family new insights and helps maintain rapport in such personal, intensive studies. In one case the video feedback was extended to include other parents of deaf children and school personnel when we videotaped in one subject's classroom. This consisted of a composite tape of the child's language development over a period of five months. The same tape has been shown to project consultees who were able to see for themselves "first hand" our research findings. Another composite tape was made of "attention getting devices" used by a deaf mother with her deaf child at age eight months through 19 months. This tape represented one of the many foci relevant to the study of language acquisition of deaf children. These tapes were useful in staff collaboration as well.

Psychotherapy

Another dimension of videotape usage developed in the course

of the Project's psychiatric services to deaf individuals and their families. Berger (1970) collected and reviewed the literature on the recent use of this medium in psychiatric services and in the training of psychotherapeutic personnel. He reported that the use of videotape techniques as a therapeutic tool in treatment "allows the development of greater awareness more rapidly and also enhances the patient's motivation to remember this awareness vividly . . ." (*ibid.* p. 168). Berger found that learning in the psychotherapeutic process is only in part intellectual and that "Before behavior changes, there needs to be learning on the emotional level, the patient must be actively (emotionally) involved in the treatment-learning process" (*ibid.* p. 57). The use of videotape, it was found, allows for that emotional involvement and the "Therapeutic impact is also made in a deeper and more effective manner through repeated opportunities to observe, perceive, and integrate the image or picture of self alone or in interaction with others over a period of time" (*ibid.* p. 120). Since our budget for videotaping was limited and primarily planned for research, the potential of such techniques in therapy was only briefly explored. Yet the results were promising enough to suggest that this is a very important area for further study. One such result was seen in the case of an eight-year-old deaf girl, J.

J. was referred by her school because of difficulties in relating to her teacher and classmates. Her parents were concerned because of J.'s sudden rages, and her preference for solitude and consequent lack of peer relationships. Although the child communicated through speech, she often used baby talk and her mother described communication as a laborious process requiring constant step by step repetition. Even though J. had lipreading skills, she would withdraw before watching anyone long enough to find out what they were saying. During the fifth month of treatment a play therapy session with J. and her therapist was videotaped. Fingerspelling had just been introduced in J.'s class and her therapist thought this might be a good time for a videotaping so J. could see herself using fingerspelling. When the therapist and J. viewed the taped therapy session together, J. had a very dramatic and positive reaction. In the therapists' words, "There was more response from that child when she was watching herself on Tv than in any other thing she does in play therapy—and it wasn't narcissistic—

she shared her pleasure with me by communicating with me more than she had ever done." Her parents reported that when J. went home after that session, she "exploded" into communication, by fingerspelling, signs, speech and writing. Watching herself on videotape seemed to be instrumental in breaking the communicative block.

Another example of the therapeutic use of videotape is in conjoint therapy.

A deaf boy, D., age 12, and his parents were referred by the school because of D.'s behavior problems. The therapist had a videotape made of the session with herself, D., and his father. Another videotape was made of herself, D., and his mother. Their therapist was able to view the tapes and analyze the communication between D. and each of his parents. Some very helpful insights emerged from these tapes. For example, the mother's style of communication was noted to be somewhat self-conscious with careful speech articulation. The therapist noted how this seemed to inhibit not only D.'s freedom of communicative style but her own as well. The tape with the father revealed a much more relaxed style, and D. had a much easier time understanding him although the father had always thought that he articulated very poorly. The therapist noticed that during the session with D.'s father, her own communicative style was more eclectic and relaxed as well.

In an example of conjoint therapy with a young deaf man and his parents, videotape feedback allowed the mother and father to notice their own behavior. The mother spontaneously commented that she introduced too much in the already strained communication between the father and son. The father, who felt very little confidence in his ability to communicate with his recently deafened son, commented that he did a much better job than he had thought and was encouraged by what he saw.

In looking at a videotape record the therapist is enabled as an observer to view and review an interaction of which he himself was at the time an involved member. He has an opportunity to recapitulate what occurred and his reasons for responding as he did and can also notice process of which he was unaware at the time. He may observe more carefully the patient's body image, expressive motion, direction of communication, use of sound and space, facial expression (the camera catches asides as well as direct views), and

the patterning of speech and play. Besides using videotape review for refining diagnostic understanding of the patient, the therapist may more closely look at himself. Sequential recordings on videotape provide for some tentative evaluation and for identification of crucial areas of improvement and of needed work. The patient also finds it helpful to be able to see his own progress recorded on videotape. Since deaf individuals rely so heavily upon visual feedback, the implications of the therapeutic value of videotape feedback should be particularly relevant both for deaf clients and for the professionals working with them.

Consultation

Another ongoing part of our project has been consultation with schools, audiologists, medical students, doctors, nurses, child psychiatrists, probation workers, teachers of the deaf, parents of young deaf children and others. Berger, discussing the potential use of videotape points out the need to convey the burgeoning scientific and medical information economically and memorably to those who require it—"in the face of a decreasing availability of psychiatrists' and educators' time and the increasing needs of students and patients" (*ibid*, p. 252)). He goes on to stress that in disseminating mental health information, ". . . videotape is a highly personal medium for the individual viewer: it demands and obtains his participation. Videotape also communicates rapidly—with refined programming and editing an hour's worth of lectured information can be televised in 10 minutes and usually with improved understanding and retention by the audience" (*ibid*, p. 254). We have produced demonstration videotapes which were composites of many hours of taping. These succinct, self-contained units have been shown to the many people with whom we consulted. Since our progress report tape encompassed all facets of our project, it was the most widely shown, to large and small groups. Furthermore, the standardized compatibility of the recent equipment permits these tapes to be viewed by anyone anywhere who has videotape equipment.

Our most recently produced composite tape of our research in language acquisition by deaf children was submitted as an adjunct to the written report to our funding agency and shows the viewer exactly what our data looks like. The actual taped record of the research subject using speech and sign language, singing, playing, and laughing, is indeed "worth a thousand words." It conveys directly and holistically in context what we have analyzed. This

videotape, like our other work with this medium, has strengthened our belief in its effectiveness in research, therapy, and research utilization through consultation.

Berger, Milton M., Editor, *Videotape Techniques in Psychiatric Training and Treatment*, New York: Brunner Mazel, 1970.