Making Videotapes: An Activity for Hospitalized Adolescents

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Watching television is a frequent activity of adolescents (1). An occupational therapist can use this engaging, popular modality to expand the base of treatment of the hospitalized adolescent. Participation in the various aspects of a television production can provide an avenue for adolescents to express and reflect their feelings about their hospitalization and its effect. As is true with most occupational therapy activities, the use of this modality can provide opportunities for problem solving, decision making, and other related skills that contribute to a sense of competence.

The “institutionalization” within a health care environment, whether in a hospital, a residential facility, or an outpatient setting, can have many effects on clients. The effects of hospitalization and other forms of institutionalization have been documented in the literature; among the most common are: separation (2), loss of control (3), isolation (3), mistrust of staff (4), disruption of normal life patterns (3), and change in body image and function (5). One way in which adolescents can begin to cope with their health care experience is to understand, and thereby begin to master, the six most common effects of institutionalization.

Communication media such as videotape and instant pictures require integration into the user’s environment (5); that is, one needs to be in a specific environment to take a picture of that environment. Conversely, a picture reflects and is shaped by the environment. Communication media can be useful in illustrating many aspects of a situation. Some aspects of how one picture taker sees his or her environment can be exposed either intentionally or accidentally through taking pictures. Videotape and in-
stant pictures not only provide immediate visual images to a viewer, but also reveal the point of view and technical accomplishments of the picture taker that can be analyzed.

The purpose of this paper is to describe the use of a videotape project with adolescent inpatients. The same process was later used in a residential setting for developmentally delayed individuals and with a group of six developmentally delayed outpatients. The process and products that can be realized in using communication media complement other occupational therapy activities.

The Program
The program was first implemented on the 30-bed adolescent acute and chronic ward of the Children’s Hospital of Los Angeles. Clients on the ward had various acute or chronic diseases including leukemia and chronic renal failure. The goals of the video program activity were to increase client interaction and to provide opportunities to develop the clients’ skills and competencies needed to effectively interact within an institutionalized health care environment. Researchers theorized that the mastery of these skills would thus dilute the impact of the effects of institutionalization. Participants were self-selected based on interest and motivation. The initial support staff for the project consisted of a full-time activity specialist and a volunteer, two students, an instructional technologist, and an occupational therapist—all working part time. Later in the project various allied health professionals and students participated or observed. Participants met in groups. In the beginning, meetings were held twice a week and were attended by at least two staff trained in the use of videotape. The videotape project included four steps: introduction of activity, preproduction tasks, production, and final playback.

Introduction. All adolescents on the ward were “introduced” to the project concept in small group meetings that lasted for at least 1 and no more than 4 hours. Those who were confined to bed rest or needed special care were seen individually.

Because the success and immediate rewards experienced with easily mastered equipment tended to stimulate curiosity and interest in more complicated equipment and projects, familiarity with, and basic skill in using a simple camera were prerequisites to using the video equipment. Participants were given a Polaroid camera, instructed in its mechanics, and encouraged to take pictures of objects, events, and places of interest to them. Their individual control over the selection of the image to be photographed was emphasized. This was in keeping with a goal of participant control of the activity.

The essential videotape equipment needed for the project was then introduced: portable video unit including a camera, a monitor, a microphone, tripod, and a battery pack. A core group of five persons who, because of chronic medical problems would be readmitted to the hospital at varying times, were trained to use the equipment and encouraged to share their knowledge with new participants in the project. Again, to reinforce the goal of exercising control over one’s behavior, the videotape equipment and Polaroid cameras were made available to participants at all times throughout the duration of the project.

This introductory step can last 2 or 3 weeks. Among the factors that effect length of time is the course of medical treatment of the participants and the ultimate effect it has on their ability to sustain involved activity. Many adolescents completed just this introductory step during their hospitalization but, because of their chronic conditions, could continue the videotape project upon a later hospitalization.

This introductory step provides opportunities for participants in decision-making skills, for example, to make a choice and assume the appropriate responsibility for following through on the choice. Staff’s role in this step is to assist those individuals who had difficulty deciding about or initiating their involvement in the project to make a choice, to instruct in the use of the equipment, and to provide supervision when it was required.

Preproduction. During this step, participants develop specific videotape program ideas in individual and/or group “brainstorming” sessions. Ideas were written or drawn on large pieces of mounted paper that served as storyboards. Personal experiences were discussed and shared and common feelings and ideas were combined. Issues of hospitalization, loss of normal everyday life experiences, and loss of individual decision making because of illness were discussed. Then scripts were written and props assembled.

This phase generally lasted from one to four sessions. Staff’s role is to help draw out ideas and refine the client-generated topics and themes.

Videotape Production. In this step, participants were involved in several different roles in either their own or their peers’ projects. For example, one participant may be director for his or her own piece and also an actor, sound person, or wardrobe and props master for another’s
production. Or a client may be camera operator, cue card holder, and leading lady in three different videotapes. In selecting roles and tasks, attention was given to both individual interests and needs as well as to realistic physical restrictions or handicaps. For example, we explored with a blind child the appropriateness of a task as sound operator rather than camera operator. Or we guided a child on bed rest, who wanted to be an actor, into the role of master of ceremonies, a less physically demanding role.

Along with guidance, interactions and communication with staff are important during this step. Participants may wish to “interview” their doctor, favorite nurse, or lab technician, as well family members.

Many skills are practiced in this step that are part of the “normal” tasks of adolescence—mastery of an activity, or learning how to work as team members to attain a common goal (6). Where typical nonhospitalized adolescents are involved in team sports and games to develop such skills, these hospitalized adolescents worked together as a team to produce videotapes. They had to synchronize their efforts to produce the “lights, camera, and action” product. When this teamwork is experienced as positive and successful, it is reinforced and thus can be generalized to other teamwork activities encountered in their daily lives.

The production phase of the project can be the most exciting but also the most tedious time of all. Hospital treatment routines, such as special medical tests and surgical procedures, as well as low patient endurance often fragment production efforts. This triggers the need for decision making and problem solving. Because of last-minute changes and individual needs, the production phase can last anywhere from one to five sessions. Some productions were completed in 1 day, others were completed over several weeks.

Playback. During this step the videotapes are played back and discussed. The therapist draws the participants’ attention to the orderly process they followed, including the fact that the project was completed and that individual control was exercised during all phases of the production. It contrasts to the hospital experience of the illness itself, the project’s beginning, middle, and end were determined and predicted by the adolescent.

Participants were encouraged to show their videotapes in both group and individual sessions to parents, staff, and other adolescents. Among the tapes produced were: A skit about the hospital admission procedure, with patients taking staff roles and staff playing patient roles; a truth or consequences game show among patients; a documentary interview by patients or new first-year residents; and numerous skits employing role-playing situations.

The videotape program lasted 4 months and then was integrated into the general activity program. Approximately 2 to 15 adolescents were involved in any given videotape. A large number of people can participate at each step of this project. The quality of involvement is dependent upon the therapist’s knowledge and understanding of the process of using videotape. As with other activities, the therapist needs to break down large tasks into small, manageable parts based on patient needs, interests, and abilities.

Discussion

The videotape program proved to be a successful tool for increasing the interactions of hospitalized adolescents with each other and with staff. When the project was later introduced into different settings, this observation of increased interaction was noted by staff and also held true. The activity also provided clients with a sense of effectiveness in their lives in that they had to make choices and solve problems in their self-initiated project. Working in a self-directed manner within an environment that typically requires relinquishment of control helps to defer feelings of a loss of independence and helps to increase self-esteem.

As with other activities, staff had to be aware of the actions and attitudes that both discourage and promote client motivation. Once the participants perceived that they were “in control” of their project, staff effort went into supporting a successful outcome.

Several issues emerged during this project that required attention.

First, the untraditional approach to an institutional activity, that of allowing clients maximum control, was criticized by staff and made them uneasy. Yet the client control and responsibility built into this project resulted in the clients:

1. Learning about themselves, others, and their environment (e.g., as participants began working on their selected topics, as they involved hospital staff as subjects or elicited their support).

2. Improved self-esteem and socialization skills (a by-product of the client’s experiencing an accomplishment and developing new skills; being part of a production team requires cooperative behaviors, a link to developing socialization behaviors).

3. Effecting some “control” over their hospitalization experience (self-directed expressive informa-
tion about their situations combats the feeling of loss of control generated by institutionalization).

Second, a full-time project staff member who is available to answer questions, to clarify project boundaries and goals, and expectations for both clients and staff can influence the success of the project. When the program was implemented with a patient group of six developmentally delayed adolescents, the lack of daily contact with a project staff resulted in disinterest and poor follow through on productions. When the program was implemented in a residential facility for 20 developmentally disabled young men with antisocial behavior, the lack of a full-time staff resulted in unclear and therefore unfulfilled expectations—the administrator expected a commercial "advertisement" for a final product.

A third issue was that the relatively complex and sophisticated technology must be simplified for use. Even so, the project staff considered technical skill in the use of the equipment less important than the process of experiencing accomplishment through developing one's own video production from the start of an idea to the end product.

Related to this was the issue that clients were easily discouraged by their low-crafted products. At the outset participants need to be carefully prepared to expect realistic outcomes for the quality of their final production. They need to know that there will be a discrepancy between the quality of their product and what is seen on TV, and that their production cannot be compared to a fast-paced professional production made by media professionals.

A final issue was the appropriateness of some of the client-produced subject matter. By remaining sensitive to the participant's viewpoint, seemingly inappropriate matter can aid in understanding unique aspects of the client. For example, a client in the residential facility continually moved the hand-held camera from the sidewalk to a building as if he did not know how to point it. When asked about this motion, he stated that he moved the camera purposefully to avoid "looking at" strangers. Staff at the facility explored his feelings associated with this behavior and began to develop and teach appropriate people-contact skills.

Participants tended to create videotapes representing aspects of their care. For example, one person who witnessed the fixed dehumanizing hospital routines (taking pills or temperature during the early morning hours) portrayed this situation with a nurse and thus revealed clients' and nurses' feelings about the situation. This open communication on the videotape seemed to "defuse" the situation—the client was less resistant, while the nurses were more sensitive to the client's feelings. The videotape was later used for inservice training in order to introduce staff to this sensitive issue.

Cost of the project is governed by the video equipment, tapes, and staff time. Often equipment already exists in the institution and may be available for use or can be borrowed. In a 1977 survey of occupational therapy curricula and hospital clinics, "71 percent of the respondents used videotapes. Of that group, 70 percent produced videotapes of occupational therapy." (7) To economize, a year's supply of tapes may be purchased, and, if needed, used again. Finally, the activity may be integrated into an existing activity program to conserve staff time.

Conclusion

The greatest benefit of using videotape activity in an adolescent milieu is that it provides a nonthreatening, creative, client-controlled activity. It can increase staff-client communication as well as the client's self-esteem. As a result, it was observed by activity program staff, and staff at the residential facility, that clients showed improved ability to cope with separation, isolation, and changes in body image and function that result from medical or health-related institutionalization.

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The American Journal of Occupational Therapy 533