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SHOULD HAVE BEEN CALLED VIDEO BASED ASSERTIVENESS TRAINING

MEDIA THERAPY:

EDUCATIONAL CHANGE PLANNING FOR PSYCHIATRIC PATIENTS[1]

ALL DONE BEFORE ALBERTI & EMMONS

ALLEN E. IVEY[2]

University of Massachusetts, Amherst

Media therapy is a systematic video program in behavior change for psychiatric patients. Patients engage in short videotaped interactions with a consultant–facilitator. These interactions then are viewed, and the patient with consultant help identifies specific behavior that he would like to change. Further practice in these behaviors helps them to become part of the patient's behavioral repertoire. Case illustrations of individuals who participated in media therapy are presented. Implications for an educational treatment program for psychiatric patients are discussed. The role of the therapist as change agent is examined.

Despite constant reference to psychotherapy as a learning process (Dollard & Miller, 1950; Mowrer, 1953; Shoben, 1949, 1953), change has not ordinarily been conceptualized in educational terms. In a comprehensive review of the literature, Krasner (1971) has suggested that theory and research in behavior "will open the way for broad social intervention and planning that is *preventative* in nature." Media therapy (Higgins, Ivey, & Uhlemann, 1970; Ivey, 1968) had been proposed as an educational or preventative supplement to the psychotherapeutic program. This article discusses the mode of operation and potential effectiveness of a frankly educational, as opposed to therapeutic program, in the treatment of the hospitalized psychiatric patient.

Underlying the media therapy framework are three major trends in innovative treatment. The first of these is the literature on behavioral approaches to the treatment of the psychiatric patient which has been expanding logarithmically since Eysenck's (1952) classic and controversial review of the limited effectiveness of traditional methods of psychiatric treatment. Particularly important to the development of the media therapy concept have been Skinner's (1957) conception of verbal interaction in operant terms, Wolpe's (1958) systematic desensitization therapy, and Ayllon and Azrin's (1968) development of the token economy in the psychiatric ward.

Television has been used increasingly as a treatment modality in therapy. Self-observation through videotape feedback has been followed by improved behavioral changes in psychiatric patients (Boyd & Sisney, 1967; Moore, Chernell, & West, 1965; Rogers, 1968). Berger's (1970) *Videotape Techniques in Training and Treatment* summarizes the extensive literature on uses of this medium for therapeutic growth and change. While television feedback has shown considerable promise in promoting behavioral changes, it has not generally been used as the prime educational medium

[1] Discussion with Seymour L. Rudman, graduate student in the Department of Psychology, University of Massachusetts, provided the basis for implementing the self-selection of behaviors in the media therapy format. Appreciation is expressed to Russell Kraus and Robert Goshko who served as graduate research assistants on this project and to Saul Rotman, Chief of Psychology, Northampton Veterans Administration Hospital, for administrative arrangements supporting this project and for comments on the manuscript. Additional case studies and information concerning the media therapy process are available from the author.

[2] Requests for reprints should be sent to Allen E. Ivey, Human Relations Center, School of Education, University of Massachusetts, Amherst, Massachusetts 01002.

for producing behavioral change in the patient.

A major new trend in psychiatric treatment is that of Armstrong and Bakker (1971) of the Adult Development Program at the University of Washington Medical School. Combining behavioral techniques with many other alternatives to human change ranging from movement exercises to the study of myth, the Adult Development Program has developed a "curriculum" of courses of instruction in the skills of living for outpatient psychiatric treatment. Despite the promise and success of this program, it has not been widely hailed by the psychiatric profession. Educational models for treating the emotionally disturbed are relatively new and are counter to prevailing treatment modalities.

The objective of this article is to describe the combination of behavioral intervention, the video feedback learning system, and a systematic educational approach as a new treatment method for psychiatric patients.

Media Therapy

The Treatment Procedure

Within the media therapy context, the therapist operates as a facilitator or consultant to the patient and helps him to plan his own program of individual growth. In media therapy, specific skills of interpersonal living (e.g., listening, self-assertion, body language) are taught through a multimedia approach including video feedback and individualized "textbooks" or "me-kits."[3] However, single behavioral skills are taught one at a time, and the patient is not confused by the usual plethora of information supplied in the typical therapeutic session. Through organized educational programs devised by the therapist and the patient, clients have the opportunity to practice each behavioral skill until it is learned.

The therapist's prime role in media therapy is that of one who observes patient behavior and interaction, comments on what he considers to be the strengths and weaknesses of the interaction, and makes suggestions as to the alterations of the behavior that facilitates interpersonal growth. Media therapy is a derivative of microcounseling (Ivey, 1971), a systematic method of video training in counseling and therapeutic skills. Similar to media therapy, microcounseling emphasizes a consultant role for the counselor trainer and conceptualizes the therapeutic process as the art of applying specific counseling skills in harmony with patient needs.

The media therapy program is not concerned with causes of behavior but with teaching the patient that he can change his behavior if he wishes. For the "out-of-control" patient, the mastery of a simple skill of human behavior gives him a feeling that he can master his own life, albeit through small steps. Gendlin and Rychlak (1970), in a review of the behavioral literature, have stressed that this feeling of mastery is equally important to the actual behavior change.

Case Illustration[4]

John was a 20-year-old veteran who was arrested at a peace march in New York for assaulting a policeman. Subsequent to his arrest, he became hyperactive and combative and was transferred to the hospital. Unable to sit still, he demonstrated a flight of ideas and a complete inability to concentrate. Shortly after his arrival on the ward, he was introduced to the media therapy program.

The 5-minute diagnostic videotape revealed in dramatic detail the behavior discussed above. During the self-observation period, John was queried as to what he saw about himself that he might like to change. Watching himself intently, he first commented that he didn't like his beard, "It's sloppy." Then he said, "I don't listen very well. I keep interrupting." Through discussion with the consultant, John decided to set two objectives for immediate behavior change: (*a*) to start shaving once again and (*b*) to engage in training in listening skills

[3] The term "me-kit" was originated and developed by Gerald Weinstein, School of Education, University of Massachusetts, for use in psychological education courses.

[4] Cases discussed in this paper are composites so as to prevent identification.

as a first step in the treatment-educational process.

Listening was defined behaviorally as direct eye contact, attentive posture, and verbal following behavior. Since a model of behavioral listening skills was already in existence (Ivey, 1970, 1971), an adaptation was made of the counselor training program —microcounseling. John engaged twice weekly in 1-hour training videotaped sessions in which he talked in 5- to 10-minute tapings with the consultant on different topics. During these talks, he made a distinct effort to engage in the three behaviors. After each tape, counts were made of the number of eye-contact breaks and the number of "topic jumps" or interruptions, and a general rating of posture was done. Video modeling tapes of "experts" demonstrating nonattending and attending skills were shown so that John could compare his performance with that of others as well as with his previous behavior.

Eye contact proved a relatively easy behavior for this patient to master. Developing an attentive posture when listening to others was difficult due to his hyperactivity. A program of relaxation training was instituted to help John learn to control his own body. A relaxation tape was then made available in the ward nurse's office, and John took the tape out from time to time. He found it useful for going to sleep, and the tape provided a beginning wedge to help him sit still. Through videotape feedback, John quickly learned the skill of verbal following. Behavioral counts revealed a rapid decrease in the number of topic jumps. To further facilitate generalization of newly learned behavior to the ward, an audiotape cassette recorder was given to him with the assignment that he was to tape-record a 15-minute conversation every day and then listen to the tape counting the number of times he failed to listen, that is, the number of times that he caused an unnecessary topic jump.

During the third week of treatment, a small group of patients was invited to observe John's behavior. The consultant had noted that while John could now listen most effectively to relatively uncontroversial topics, the closer the topic got to authority relationships or to the police in particular, the more his behavior resembled that demonstrated on his entry to the hospital. A role-playing session was developed in which the consultant acted the part of the policemen arresting John. John became hostile and belligerent and after video feedback saw his behavior from a new perspective. With the aid of fellow patients, John was able to reenact the scene. He engaged in good listening skills but "something" in his verbalizations aroused hostility in both the consultant and in his fellow patients. Careful observation of the videotape revealed that John was engaging in good listening skills and that his comments to the "policeman" were reasonable and his nonverbal body language was no longer threatening. A second viewing of the tape, however, revealed that many of John's problems in interpersonal relations came from his speech rate and vocal tone. He spoke quickly and harshly, no matter how "good" or relevant the words, the tone and speed of his speech made him appear hostile and belligerent.

As a next step in training, John was instructed to slow down his speech rate and to notice his and others' vocal tone. With practice, supported by relaxation training, John was able to modify his behavior.

At this point, John was given a more extensive work assignment on the hospital grounds, and the media therapy efforts were reduced to occasional consultations. John was released after 6 weeks in the hospital. Just prior to his release, his first videotape was again shown and the specific behaviors learned during his stay at the hospital were reinforced. A handbook of materials and skills developed by him and the consultant during his stay at the hospital was presented to him upon leaving. This "me-kit" was designed to support generalizations to his home setting of his newly learned behavior on the ward.

Discussion

The case discussed is representative of the potential of a learning approach to behavior change for the psychiatric patient. Important in the media therapy model is

the concept of patient self-selected behaviors. In modern educational models, pupil-directed learning is recognized increasingly as vital. Rather than imposing a model of what the individual should be before he can return to society, the effort of media therapy is to facilitate each individual to become what he wants to be. This assumes that patient and societal needs will eventually coincide. On a more practical level, it is easier to teach people what they themselves want to learn.

The case presented here is representative of the media therapy educational approach to treatment. At no time did the consultants examine underlying intent or motivation; rather, they focused on directly observable behavior that interfered with the patient's immediate here-and-now interpersonal functioning. As the patient's flight of ideas disappeared and was substituted for by more effective listening and self-expression skills, the educational-therapy program moved to consideration of more unique behavioral and interpersonal problems, but still on a directly observable behavioral level.

Work with approximately 20 patients with media therapy as the central treatment modality reveals that certain behavior patterns are selected again and again, although with different emphases and in different progressions. Virtually all patients begin with emphasis on body language as a communication medium. Work with body language ranged from that discussed here to counts of hand or foot movements, to development of a more theatrical style of communication, to one patient's shock at seeing all his extraneous movements and his decision to sit on his hands as his first behavioral goal. However, after 2 weeks of sitting on his hands, he decided on a more realistic goal but by this time was able to engage in a normal pattern of body communication.

Relaxation training proved almost uniformly popular with patients. Depressed patients responded most readily and liked the good feeling associated with relaxation. Hyperactive patients found that relaxation helped to slow them down. Relaxation has long been used effectively in systematic desensitization therapy, and it requires only a slight extension to include relaxation training as part of an educational program in any psychiatric ward. The program of relaxation was so popular that the patients at one point acted as relaxation consultants themselves and would introduce new patients on the ward to the relaxation tape before the concepts were introduced by the staff.

Attending skills were found helpful with many patients. Listening skills and the ability to stay on a single topic are basic to most human communication. If one really hears what is going on in one's surroundings, he can provide social rewards to those to whom he listens, and, simultaneously, he can observe more accurately what is really happening. A few patients found training in "expression of feeling" or emotional expression useful. Highly constricted in their relationships with others, they were totally unable to express or vent emotions.

A general progression was noted in most patients. They would start their behavioral change program with nonverbal and listening skills such as those mentioned here. After fairly rapid and early success, they would turn to applications of these and other personally selected skills in role-playing sessions centered around interpersonal situations that caused them difficulty or anxiety. Practice on the ward supplemented by token reinforcement was incorporated into most treatment programs. For some patients, large scale complex behavioral hierarchies were developed.

Patients took highly individualistic routes to behavior change. One was interested in being "one-up" over other people and dominating them. At admission, he felt that he had only two alternatives for being one-up, either hitting people or leaving the room. Behavioral training increased his repertoire to include six different methods that he could use, all more socially acceptable. This was written up as a "one-up kit" and given to him when he left the hospital. Another patient complaining about headaches and antagonism from others improved markedly when television feedback revealed that the way he cocked his head

came across as hostile to others even when he didn't feel that way. The same tip of the head was a partial cause of his headaches, the tip being so extreme that the blood flow to the head was constricted.

Media therapy when combined with token reinforcement on the ward helped behavior to generalize; merely to change behavior in the educational laboratory is not sufficient. Specific provisions for behavioral generalization and rehearsal beyond the immediate setting seems required. Baer, Wolf, and Risley (1968) have pointed out that "generalization (of learned behavior) should be programmed rather than expected or lamented."

The more important issue in generalization of behavior, however, lies in transfer of the newly learned behavior to society at large. The media therapy project did not include training of families within its scope except in one pilot case. Future efforts must include family media therapy as a supplement to individual training. Many families really don't want the behavior of psychiatric patients changed. Change simply disrupts the reinforcement balance within the home. Similarly, society does not necessarily want behavior change. One patient, for example, who had shown marked improvement from depression commented that he really couldn't see any meaning in his routine assembly job. Although his behavior changed, he still saw the futility of much of his efforts. To meet this patient's needs, one can work on cognitive restructuring (Lazarus, 1971) or, better yet, work on changing the society that helped bring about the psychotic break.

An extension of the media therapy concept may be suggested here. Perhaps an additional goal of the psychiatric facility should be to train patients as change agents. Each patient might be trained in change strategies and encouraged to develop changes he would like to make in the society that sent him to a psychiatric setting. Examples of such change agent activities would be teaching one's own family how to relax systematically or to listen more effectively to one another. The change might be more at a societal level and require involvement in community action programs such as work with the poor or disadvantaged. One of the most successful programs for helping some individuals fight their own drug addiction is working to fight drug addiction in others.

The media therapy program was not uniformly successful. An occasional patient cannot stand to view himself on television, thus alternative routes to treatment must be found. With more disturbed patients, behavior may have to be broken into smaller parts and tied to concrete reinforcers such as money or tokens. Attending skills, for example, may be best taught one behavior at a time and then integrated later. When teaching relaxation skills, the patient may only be able to relax a single muscle group. With some patients, biofeedback machines such as an audible psychocal galvanometer proved useful in helping a patient learn that he can relax.

Media therapy has been presented here as an alternative treatment program. Clinical evidence indicates that it is a viable alternative since the patients described here received no other formal treatment. However, this method of behavior change may be more useful and widely implemented if regarded as a supplement to regular treatment programs. Therapists can continue regular therapy but, in addition, could refer patients for work on skill development and behavior change. The specificity made possible in the media therapy framework almost invariably results in immediate changes in the patient. These concrete changes often help the patient move through difficult parts of therapy and give specific handles that they can grasp to cope more effectively with immediate problems.

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