

## Video news

### Making a training video

This article aims to be a brief practical guide to the process of making a training video. It is based on the experience of making videos for a department of psychiatry as a research registrar and then as a senior registrar. Six different types of video are described as follows, using a classification of videos derived from Goldberg *et al* (1983): theory and fact; clinical syndromes; clinical judgements; illustrating a technique; users' or relatives' experiences; and evaluation. Each type has a rather different purpose and requires a different approach.

#### *General considerations*

There are four key areas the video maker has to address, irrespective of the type of video. Each of these areas can produce problems and needs to be clearly thought about. The areas comprise: focusing on what is important about the subject matter; defining the audience; anticipating how the video will be used as a teaching aid; and thinking about the technical limitations on style and presentation.

#### **The subject**

The subject of any video has a natural tendency to expand. For instance, a video is required to train new members of a community team for mental health in the elderly in a method of home assessment. The wider the video maker consults with others, the greater the number of key principles of home assessment are identified.

Use of an assessment method also requires an understanding of mental health problems in the elderly, interviewing skills, presentation skills, as well as the workings of a multidisciplinary team. Each of these topics could be the subject of another video.

A useful exercise is to reduce all the information to a few key points around which the subsidiary points can be grouped. The subsidiary points are then rated to see whether they should be featured, mentioned or omitted. Unless painful decisions are made at the outset, the video will be hopelessly unfocused and far too long.

#### **The target audience**

Given that videos are so time-consuming and expensive to make, it is useful for them to appeal to as wide a range of audiences as possible, without compromising their usefulness for the core audience. The

'perfect' video will work in different ways for different audiences, which is why drama is so popular since it can be interpreted at so many different levels.

#### **Training conditions**

These will affect the content of a video depending on whether its aim is to be a substitute for a teacher or an adjunct to a training session.

A commentary gives the video a 'stand alone' quality presenting clear summaries to the viewer, but it can reduce the tape's flexibility as a teaching aid because it has to be written with a particular audience in mind. It may also discourage participation and irritate the audience to the point of alienation by laying down the law. The presence of a teacher reduces the need for a commentary but problems arise when no-one is available on the day. A video has to be robust enough to be useful in suboptimal training conditions such as "Go and watch the video. You might learn something."

#### **Resources**

Although viewers are easily distracted by anything which does not conform to the standards they are used to on TV at home, they are remarkably tolerant of amateur videos, providing they are short, can be heard and the content is interesting.

With good technical assistance, it is quite possible to make low budget quality videos using relatively inexpensive equipment, although there are some caveats. The use of drama is particularly demanding from a technical point of view, and requires specialist experience. 'Special effects' are best avoided. Occasionally technical advice conflicts with the requirements of the subject matter. For instance, the long periods of extreme close-up needed to display the subtleties of a subject's affective response, conflicts with the experienced camera operator's need for rapid changes of shot.

Poor technical quality is often blamed for the failure of videos to engage medical students, but lack of clarity about the subject, the target audience and training conditions can be equally damaging.

#### *Six types of training video*

##### **Theory and fact**

Of all the different training uses to which video is put, this is the area in which it is probably the weakest.

Audiences require a change of shot every few seconds, and it is difficult, on a low budget, to provide the necessary visual distraction to engage the viewer for more than a few minutes. If conveying factual and theoretical information is the only purpose of making the video, it may be advisable to consider using another medium.

The method, used by the BBC in the Open University, is to have an expert talking to camera alternating with visual aids. It seems simple enough, but is full of dangers for the amateur videomaker. The demands of economy and precise editing points usually mean a script is necessary. Whether this is memorised or read off an autocue, the result can easily seem wooden and unnatural. Experts are not always the best presenters of their own material, and television ruthlessly exposes faults which are not apparent in a live performance. Attempts to record a live lecture are often only of historical interest, because of technical problems.

One way of trying to capture the flavour of a live performance is by an interview. It is easier to talk to another person than a camera. Provided the interviewer has structured the interview in advance, and feels able to interrupt the expert, there may be little need for editing. There are other savings in time. No script has to be written and agreed upon. Where two cameras are available, the editing can be done at the time of the recording and often the video is ready for use the moment the interview is over. Where there is only one camera, questions and reaction shots of the interviewer, (known as 'noddies') can be recorded at the end of the interview and edited in afterwards.

A videotaped interview is a dramatic event. A degree of tension between the participants, generated by differences of status, viewpoint or occupation contributes to the drama. It may be better if the interviewer has some general knowledge of the subject but is not an expert him/herself; otherwise the experiment is restricted by the awareness that the interviewer already knows the answers. The questions must be prepared in advance, but perhaps not revealed to the expert until just before; otherwise the expert has time to prepare studied answers. A useful method of finding suitably challenging questions for the expert is to make a clandestine phone call to another expert.

#### **Clinical syndromes**

Kaufman & Kaufman (1983), who assessed the use of video in the teaching of clinical neurology, found it most useful in those areas where students had not personally witnessed symptoms and signs. Student recognition was improved by seeing, hearing and sympathising with patients' experiences. When compared to 'bedside' clinical teaching, video loses out in interaction, but this can be compensated for by the adoption of a structured systematic approach (by the

use of editing) with opportunities for reinforcement (using replay) (Mir *et al*, 1984). Forgotson & Sweeney (1977) described five different ways of editing a single psychiatric interview for multiple purposes: unedited with a trainer stopping the tape at will; the interviewer's reaction to the interview; non-verbal behaviour; points of differential diagnosis; and serial interviews to demonstrate changes over time.

Interviews with different patients can also be edited together in a systematic way. In my own place of work, we have prepared a 40 minute tape structured along the lines of the Mental State Examination. It was compiled from edited highlights of clinical interviews with 36 patients.

Ethical considerations limit the use of such videos for multidisciplinary and multiagency audiences. Where an unrestricted audience is an important requirement, actors are used to great advantage. The cost, theoretically at least, can be recouped by marketing the video.

One method of improving authenticity is to show the actor a videotaped interview with the real patient. The script is prepared from an edited transcript of the real interview with details altered to protect confidentiality.

#### **Clinical judgement**

Students may have been taught the principles of the Mental Health Act, but does this particular patient meet the criteria for compulsory admission? A patient complains of feeling suicidal but how much of a suicide risk do they represent? When video is used in this way, students can and do complain they have been given insufficient information about the patient to make such judgements. Making a judgement based on incomplete information is a common clinical problem, particularly in A and E Departments, and such objections can easily be turned into useful questions, such as what else would you need to know? What steps could you take to find out?

There is rarely a 'right answer' to a clinical problem, so the aim has to be to teach a process. Golden *et al* (1980) resolved these difficulties by recording the different responses of a multidisciplinary team to a suicidal patient, including disagreements, in order to more accurately reflect the ambiguities of a suicidal evaluation.

#### **Learning a technique**

Psychotherapeutic skills can be acquired by watching 'model' interviews. The principles of the method are defined, then put into practice in the 'model' interview, and finally brief excerpts are shown to demonstrate the key details. Modelling is based on a respectable psychological theory, but 'models' can be demoralising. Trainees may identify more with

someone their own sex, age and occupation, than someone very experienced who makes it all look very easy. A range of models may be required to cater for the diversity of skills in the audience. (Hargie & Saunders, 1983).

Another problem with models is that expert practitioners do not agree about the right way to do something. There tends to be a more solid consensus about the wrong way. Shifting the focus to common mistakes has been the key to the successful output of Video Arts company, associated with John Cleese. The formula is a combination of a rigorously didactic approach and cruel humour. Key training points are identified and then reversed to dramatic effect. The result engages the viewers' emotions as well as their attention, and the points are conveyed in a striking and memorable way.

Although useful in areas like management training or professional communication, many techniques in psychiatry are too intrinsically sombre (e.g. how to give ECT) or so highly personalised and sophisticated (e.g. the psychotherapies) that they cannot be demonstrated using the stereotyped mechanical behaviour the paradoxical method requires.

#### Users' experiences

Videos of people talking about their own experience of coping with mental health problems are extremely popular with users and relatives. A typical and easily reproducible model is used in the 'So you've got . . .' series, produced by the Same Production Company for Channel 4, a company which is run by disabled people. Semi-structured interviews with a range of sufferers are recorded in close up, and then brief extracts are edited together in a structured way e.g. the onset, the impact of the diagnosis, practical difficulties, dealing with professionals and so on.

Exactly the same material is extremely useful in the training of medical students but is rarely used. Presenting a condition honestly from a user's or a relative's point of view involves realistic criticism of services and professionals which may be unpalatable. Education is only one of the functions of training videos. They have an equally important role in public relations. Professionals may become uneasy when the source of the advice and information appears to be the client group or their carers, even when this seems entirely appropriate. For instance, a consultant psycho-geriatrician may not be the best person to present advice to carers of dementing people on how to deal with incontinence. Material from the perspective of users and relatives, whether presented in documentary or dramatic form, tends to stimulate a lot of discussion.

#### Evaluation

Videotaped clinical material is now widely used in examining medical students. It has brought to the fore

conditions not previously seen in clinical examinations such as organic states. The time taken to prepare a rigorously fair tape has to be offset against the risk of its contents ever becoming public (Rix *et al*, 1985).

Complicated self-evaluation tapes involving decision trees and computer/video links are now being developed and are popular with students. They require special facilities, and are time-consuming and expensive to prepare. It is worth remembering that almost any tape prepared for training purposes can also be used for evaluation, and the benefits of preparing special tapes for this purpose need to be carefully weighed.

#### Conclusion

Some determinants of the content of training videos have been reviewed, and a number of different methods of making them have been presented. It is an advantage to use several methods within the same video for the sake of variety. Unlike a book, where a reader can skip over the less interesting pages, a video has to be consistently entertaining. Once an audience's attention is lost it is rarely recovered. There are no guarantees of success, and it has to be accepted that a proportion of training videos, however carefully prepared, will fail for unpredictable reasons. This is an important consideration at the time a request is made for funding. Is there an existing video which would do just as well?\*

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\*The Mental Health Film Council (address: 380-384, Harrow Road, London W9 2HU) has an extensive library of tapes and is a useful source of advice and information.

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