Reality Video vs. Video Modeling—A Case Study in Patient Education

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Abstract

Reality video is a promising but less studied intervention in behavioral sciences whereas video modeling has proven to be a well-validated intervention. Based on the multiple code theory (Bucci, 1997) in cognitive science, this research proposes that reality video, portraying real people in real-life situations, can connect to its audience strongly in all four domains of experience (non-verbal sub-symbolic, verbal sub-symbolic, non-verbal symbolic, and verbal symbolic) whereas video modeling, portraying models in staged settings, has a weak or absent audience connection in the non-verbal sub-symbolic domain. Reality video allows an audience self-identify as an in-group member with the video persona whereas video modeling generates only a parasocial relationship between an audience and the model. This research studies the efficacy of reality video. A qualitative case study in patient education shows that reality video can trigger positive cognitive change and even long-term positive behavioral change.

Keywords

Video Modeling, Reality Video, Multiple Code Theory, Four Domains of Experience, Health Education

Introduction

Video has been featured in research development in anthropology, sociology, education, psychology and other behavioral sciences. It is typically the method of video modeling that has been applied. Video modeling is a technical process in which a videotaped model demonstrates the behaviors required for performance, and viewers then imitate the model’s behaviors and improve their performances in practice (Burke and Day, 1986; Decker, 1982). Video modeling is a well-validated intervention in behavioral sciences (Corbett and Abdulla, 2005); however, it is expensive and its effects tend to be mostly short-term rather than long-term (Gagliano, 1988). Would reality video be a cheaper alternative to video modeling and serve as a better intervention in cognitive and behavioral changes with long-term effect?

The cost of video equipment and production, in this digital era, has become so affordable that it is no longer a major issue preventing the use of reality video as a research technique. Reality TV has boomed worldwide since the turn of the century and even established its own genres. Slocum (2016) stated that reality-based television programming is cheaper than traditional programming in virtually every line of the production budget. However, easy access to a resource or a technique does not indicate that it is needed or generates positive impact. Research on reality video is still relatively new and scarce. What are the differences between reality video and video modeling? Should data-enabled research extend to reality video? What is the role of reality video in social interactions, and for whom? What are the concerns as well as the costs and benefits of using reality video as an intervention in behavioral sciences?

First of all, reality video features real people, who may behave both positively and negatively, in real-life situations; this contrasts to video modeling which casts actors or actresses, who model only positive behaviors, in staged settings. Secondly, reality video may affect both the video personae and the video viewers; this contrast to video modeling in which it is the viewers that are typically targeted to influence (except in the special technique of self-modeling in which the model is also being studied). Thirdly, the content of reality video is mostly unstructured and unscripted; this contrasts to video modeling in which
dialogues are scripted, symbols are strategically placed, and the performances are directed and rehearsed. In sum, is reality video also a valid intervention to its participants’ cognitive and behavioral changes and are the effects of reality video differ than those of video modeling?

Melchers et al. (2015) studied the neural activation patterns in response to video clips from reality TV with fMRI and proved reality video be an ecological valid trigger for emotional responses like vicarious embarrassment. They also confirmed that reality TV as stimulus material differs from comic vignettes in such a way that the behavior depicted in the vignettes can appear scripted or further away from viewers’ experiences and hence viewers have to exert greater efforts in mental attribution (Melchers et al., 2015).

This research aims to study the effects of reality video on the cognitive and behavioral changes of its participants. It is a qualitative case study in the setting of patient education. Patient education is specifically chosen because it is expected that the distance in perspectives between a patient viewer and a patient persona in reality video with the same or similar disease is far shorter than that between a patient viewer and a model performer in medical video modeling. Extensive literature exists in the medical profession regarding the positive outcome of video modeling in doctor-to-patient (Van Vilet et al., 2011) and medical/nursing school education (Hansebo and Kihlgren 2001, Anderson and Adamsen 2001, Caris-Verhallen et al. 2000, Hardy and Brown, 2010). This research explores the efficacy of reality video in patient education by studying videos featuring real patients. It shows that reality videos exchanged among paired patients have triggered positive cognitive and behavioral changes in its participants.

**Literature Review**

Video modeling is a technical process in which a videotaped model demonstrates the behaviors required for performance, and viewers then imitate the model’s behavior and improve their performances in practice (Burke and Day, 1986; Decker, 1982). Bandura (1997)’s social cognitive theory encompassing competencies, motivations, and self-regulation states that self-efficacy could be improved by modeling. Gagliano (1988)’s meta-study concluded that video modeling has shown positive significant effects in patient education, although the patients’ increase in knowledge is mostly short-term rather than long-term. Later, more research confirmed the positive effects. For instance, Ruthman and Ferrans (2003) found a significant increase in patient preference for prostate-specific antigen testing after viewing a video educating about its importance. Wydra (2001) and Davis et al. (1998) used video methods to educate cancer patients with fatigue and women considering mammography respectively, and both studies showed measurably positive outcomes from the video components of the education (though the mammography use increase is in short term). In video modeling, the intervention typically geared towards a specific medical issue and was administered by trained medical professionals; hence, video modeling is expensive and has limited content creation and access.

<table>
<thead>
<tr>
<th>Sub-symbolic</th>
<th>Non-verbal</th>
<th>Verbal</th>
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<tbody>
<tr>
<td>Non-verbal sub-symbolic&lt;br&gt;(intuitive experiences or the emotional communication between individuals)</td>
<td>Verbal sub-symbolic&lt;br&gt;(non-symbolic aspects of language such as prosody, meter, rhythm and the phonetic qualities of language)</td>
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<tr>
<td>Symbolic</td>
<td>Non-verbal symbolic&lt;br&gt;(how images or other non-verbal forms present information)</td>
<td>Verbal symbolic&lt;br&gt;(how words are combined to present information)</td>
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Table 1. Four Domains of Experience (Bucci, 1997)

The efficacy of learning in a multimedia environment can be predicted by two fundamental theories in communication: the cue-summation theory and the dual coding theory (Jiang and Banbasat, 2007). In cue-summation theory (Severin, 1967), the more cues or stimuli, the more effective the learning is. Video is a multiple-channel communication with various combinations of textual, auditory, and visual cues and stimuli; hence video should be superior to a single–channel communication such as text. The dual coding theory (Paivio 1986) is about the nature of symbolic (verbal and nonverbal) and sensormotor (visual,
auditory, haptic, taste and smell) systems. Bucci (1985) initially extended the dual code theory by emphasizing the importance of emotional processing particularly in the nonverbal system. Bucci (1997) further developed the *multiple code* theory which not only includes the verbal and nonverbal processing, but also symbolic and sub-symbolic processing; and the intersections of these processing categories can potentially produce *four domains of experience* (see Table 1). The verbal symbolic domain concerns about how words are combined to present information. The non-verbal symbolic domain concerns about how images and other non-verbal forms present information. The verbal sub-symbolic domain concerns about the non-symbolic aspects of language such as the sounds of words. And the non-verbal sub-symbolic domain addresses intuitive experiences or the emotional communications between individuals.

As previously mentioned, Melchers et al. (2015) proved that reality video can be an ecological valid trigger for emotional responses and confirms that reality TV as stimulus material differs from comic vignettes because the behavior depicted in the vignettes can appear scripted or further away from viewers' experiences. This implies that reality video can connect to its audience much more strongly than video modeling in the non-verbal sub-symbolic domain and such strong “automatic resonance” can even be ecologically measured in neurophysiological brain activities. Video modeling, with its scripted and directed content, may make strong connections to its audience in the verbal sub-symbolic and verbal/non-verbal symbolic domains; however, video modeling falls short or is even absent in its audience connection in the non-verbal sub-symbolic domain.

Table 2 depicts the differences between reality video and video modeling in content, audience connection, and technicalities. Since many table entries are self-explanatory; only few entries are discussed.

<table>
<thead>
<tr>
<th>Reality Video</th>
<th>Video Modeling</th>
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<tbody>
<tr>
<td><strong>Content</strong></td>
<td></td>
</tr>
<tr>
<td>Has real people act in real-life situations</td>
<td>Has actors, peers, or model people with the issue at hand, act in staged settings</td>
</tr>
<tr>
<td>Has unstructured, unscripted content with free flow of information</td>
<td>Has structured, scripted content masterminded in storyboard</td>
</tr>
<tr>
<td>Can portray both positive and negative behaviors</td>
<td>Portrays positive behaviors only</td>
</tr>
<tr>
<td>May not have better selective attention and restricted field of focus</td>
<td>Has better selective attention and restricted field of focus</td>
</tr>
<tr>
<td>Is naturalistic</td>
<td>Is manipulated</td>
</tr>
<tr>
<td><strong>Connection to audience</strong></td>
<td></td>
</tr>
<tr>
<td>Connects to audience in all four domains of experience, especially with a stronger non-verbal sub-symbolic connection</td>
<td>Connects to audience mostly in three domains of experience, with a weaker or absent non-verbal sub-symbolic connection</td>
</tr>
<tr>
<td>Allows audience self-identify as an in-group members with video personae</td>
<td>Generates a parasocial relationship between audience and the model</td>
</tr>
<tr>
<td><strong>Technicalities</strong></td>
<td></td>
</tr>
<tr>
<td>May not apply professional videotaping techniques</td>
<td>Always apply professional videotaping techniques</td>
</tr>
<tr>
<td>Is cheaper</td>
<td>Is more expensive</td>
</tr>
<tr>
<td>Has a potentially large quantity</td>
<td>Has a limited quantity</td>
</tr>
<tr>
<td>Has privacy concerns</td>
<td>Has addressed or no privacy concerns</td>
</tr>
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Table 2. Reality video vs. Video Modeling

Most TV programs strive for audience to see themselves on-screen (Berman, 1987). An advantage of reality video over video modeling is that it allows the viewer to see real people in a similar life situation and gives the viewer a humanistic version rather than a tainted (often glorified), made-up Hollywood version of the issue at hand. Real people as the personae in reality video often express “unscripted” raw emotions to the camera and describe experiences that only those who have also lived through the same or similar experiences could possibly perceive and understand. The emotional contagion and the experiential resonance of such viewers are likely to be enhanced or facilitated because viewers feel personal identification with the personae who actually are real people similar to themselves. *Identification* refers to the “mechanism through which audience members experience reception and interpretation of the text from the inside, as if the events were happening to them” (Cohen, 2001). In identification, there is no
more psychological social distance between audience and media personae. Baumgartner et al. (2012) show that in-group identification activates the network of mentalizing (i.e., the ability to attribute mental states to oneself and others, as defined in Theory of Mind (Premack and Woodruff, 1978)). Hence, reality video viewers’ identification as in-group members with the reality video personae triggers more mental activities and stronger emotional resonance than those possibly triggered by a parasocial (e.g., one-sided) relationship (Tian and Yoo, 2015) between audience and a cast model in video modeling.

The naturalistic approach in reality video may result in portraying both positive and negative behaviors; in contrast, the manipulated approach in video model results in portraying only positive behaviors. Reality video can also present flaws and social norm violations by its personae in real life situations; audience can also learn from viewing with these flaws and social norm violations and from self-identifying with shame or unease. The expensive undertaking of video modeling by professionals may limit its quality of production and may attribute to its preference of reinforcing positive behaviors only.

**The Case Study**

Qualitative interviews via reality videos were conducted with actual patients, caregivers, and healthcare professionals in 2013-2016. All participants gave the written/oral consent to record/share all information disclosed; they also volunteered no need of anonymity. This indicates that patients, caregivers and health professionals are more than willing to help others when opportunities arise. Videos were recorded semi-professionally because it just happened that the researcher and some of the people interviewed are also video professionals. Nevertheless, the content generated in the videotaping process is unstructured and unscripted. The reality videos are not edited or post-produced. There was no need for the researcher to go very far to find the willing participants--patients and caregivers are often just around the corners even in the same building at the same workplace. Some patients are healthcare professionals themselves. Co-workers do not share their medical or caregiving stories with one another at work; however, many of them have experienced some illnesses and caregiving activities.

**Figure 1. Patients in Reality Videos and Video-based Interaction**

This paper focuses on the interactions among two patients only, whom were videotaped multiple times during a three-year period: Patient A is a young adult in his early twenties who was diagnosed with diabetes type I in 2013 and Patient B is in his sixties with over thirty-years of experience managing diabetes type I. Patients were generally guided by the researcher to tell their medical stories and share their knowledge about coping with the disease. Since the researcher has no knowledge about diabetes, it is the patients themselves who mainly contribute to the reality video content. The researcher manually matched this pair of patients due to the same diagnosis. Since the researcher intended to also capture the raw reactions from reality video reviewers to reality video personae, the researcher did not edit or post-produce the reality videos and personally presented the reality videos to the matched pair (see Figure 1). Each patient was shown the videos of the other and encouraged to comment on the videos.

**Result 1: Reality Video Triggered Long-term Behavioral Changes**

At the initial interviews in 2013, Patient A uses an insulin pump, and Patient B used an insulin pen (see Figures 2 and 3). After viewing an insulin pump on a real patient, Patient B would give additional thoughts on pumps:
Seeing another person actually with the pump on screen and basically listening to his endorsement of the pump makes me want to do more investigation....I thought long and hard over the past a few years about going with the pump therapy. I am much more willing to give it a shot based on what I've observed in the interview. The subject gave the demonstration how simple the pump is. I am willing to investigate and perhaps give it a try. I may have some misconceptions of the technology: the size of it, the location of it. Actually, this has spurred me to do a quick search.

After knowing Patient B’s interest in insulin pumps, in offering assistance to Patient B, Patient A said:

If [Patient B] wants to learn more about the insulin pump that I am currently wearing, I can help him understand and learn about it. If anyone needs to know, I can teach as well.

To the researcher’s pleasant surprise, after several months, Patient B actually got himself an insulin pump (see Figure 4). He stated that watching Patient A’s video has pushed him more into his investigation. He specifically mentioned that there was no live demonstration of an insulin pump even in the orientation/education program from the medical professionals and/or pump manufactures before his installation of the pump. Patient A’s video was the only source for him to see a live demonstration throughout the entire process. Patient B also mentioned that the medical professionals and/or pump manufactures did show a video about pumps; however, the video was played only once and very quickly in a clinical setting. Patient B’s comments confirmed the value of patient reality video and the limit of institutional-based health information technology to provide a complete package of technology support for patients in their quality of life. It is understandable that institutions and professionals would not ask patients to share their private uses of medical devices due to privacy concerns. Neither would they suggest patient-to-patient matching for the same reason as well as for the liability concerns.
Patient B also stated that after using the pump, his health condition got better, and he is continuing the improvement. In the subsequent few years, whenever the researcher came across with Patient B, Patient B still had the enthusiasm about the pump and volunteered offering information how he continued improving the pump use and how his blood sugar readings had improved. He continues using the pump today (see Figure 5). He is pleased about the fact that during the first year of pump use, a key index for his blood sugar health has dropped from an abnormally high 11.2 to low 7s, which are considered within the normal range by the American Diabetes Association. His last reading in Spring 2016 was 7.1, which is, in his own word, “phenomenal” for him. He also brought up a funny fact that the only issue he had with the pump is that he dropped it to the toilet once which did no damage to the pump. He has also further built the habit of observing his own health data enabled by the pump technology. Patient B’s behavioral change facilitated by reality video is a long-term change.

![Figure 5. Patient B Showed his Continuous and Better Pump User after Two Years with Improvement in a Health Indicator and Better Self-management](image)

**Result II: Reality Video Triggered Cognitive Changes**

Cognitive change can be triggered with vicarious learning. Through viewing Patient A’s reality video on testing blood sugar and Patient A’s explanations of the hygiene procedure (see Figure 6), Patient B realized that he had been lax in his own hygiene procedure (having not been swabbing adequately before administering his shots). One solvable problem that has become apparent in dealing with long-term treatment of conditions is that patients may become so proficient in treating themselves for a specific condition, for example, diabetes, that they become lax in observing all of the safety steps in the treatment process. Their doctors or other medical professionals may assume that because they have so much experience (in years) in dealing with this specific issue, that they do not need a reminder about basic treatment protocol. The patients may also assume that their years of administering self-treatment make them experts, whereas they may, in fact, be making small errors which could lead to larger problems in extreme scenarios. By watching other patients go through the same process, the patients may be reminded about these precautions, and this could influence them toward becoming more proactive and accurate.

![Figure 6. Patient A’s Reality Video on Blood Sugar Testing Hygiene](image)

Moreover, one’s cognitive change can also be triggered by self-reflection and self-evaluation of one’s own behavior. Once patients record themselves, they are then able to have a more complete view of themselves through watching the videos they have created. Patient B provides his overview on knowledge gained through the reality video project:

*What I learned from this experience...Basically, this is cool. More importantly, I learned a little bit about other people with the same issue that I have. But, maybe more importantly, to me personally, I learned a lot about myself. Maybe I need to sit back and re-evaluate how I handle my own diabetes. I think “the old dog can’t be taught the new tricks” may be irrelevant here.*
Patient A also explained how his healthcare knowledge was improved after watching Patient B’s video:

One piece of useful information is that once you are traveling, you have to be aware of the hospital and healthcare systems in other areas, whether to be a new state or a new country. [Patient B] had trouble entering Florida hospitals when he was in need because they were all privately owned. He explained what he had to do to get admitted in the hospital. He just said to be mindful of where you are going and be aware of what the laws are like and how the healthcare system is.

A limitation with general medical literature is that it is, by its nature, general. Extreme situations or extenuating circumstances, such as the medical conditions for someone traveling to a remote location, are specific instances in which anecdotal evidence can be very informative to someone facing a situation not covered by scientific or academic review. Because of this, a patient’s “life knowledge” and a good search and matching system can be instrumental in connecting a person with a situational medical issue with someone else who has experienced a similar issue. In this way, patient-to-patient advising can make up some of the gap between a patient with specific issues and doctors who may have academic knowledge of their patients’ conditions but no first-hand experience of what their patients are actually experiencing.

Result III: Reality Video Triggered the Expression of Shared Cognitive Views

Exchanging reality videos has triggered viewers to voice shared cognitive views with the video personae on certain issues. For instance, both Patient A and Patient B voiced their frustrations dealing with the information from the medical professionals. For instance, Patient A put into his own words about the lacking of competence of medical professionals in guiding patient life experiences:

The type of information like regarding how to prepare for travel, come from doctors—if they remember telling you, if they are aware of it—or other patients who already have had the experiences of traveling. I feel like that doctors may be less reliable in that regard, because he might not think to say “Oh, you are traveling, their health system is like this;” whereas, the patient, who might have already the experience of going to another hospital or was in need in another state, can tell you what was like more accurately.

Patient A further offered his own experiences in dealing with doctor-driven healthcare and discussed its limitations by saying:

Sometimes it is hard to reach a doctor on the phone immediately. You might have to leave a message; and if you miss their call, you will be back to square one. You have to wait again to talk to them; or you can schedule an appointment, which will take up to a couple of weeks.

Patient B expressed his frustrations in getting relevant information from medical professionals below:

My experience with being diabetic is getting answers from a quote “professional” educator—“I know how you feel.” As soon as I question “do you have diabetes type I” and the answer is “no,” then my answer to that is, “How do you know how I feel? You have no way of knowing how I feel,” and basically, the session is over.

Result IV: Reality Video Precluded Face-to-face Meetings

One interesting result was that though the patients learned from each other, using the reality video as a proxy precluded the need for an in-person meeting. Patient A and B are working/studying in the same building. But when asked if Patient A wanted to meet with Patient B in person, Patient A answered:

I don’t really think it is necessary. If it would be just sharing experiences, rather than helping me understand and helping him understand, cause he has almost 35 years...Rather than sharing experiences, I don’t see there will be new information that really gets out from talking to him with....I don’t have much time; all I do is run.

Patient A has a very busy schedule even though he is willing to meet with Patient B, who has a more stable
and open schedule and is only three floors up in the same building. The physical meeting of these two did not occur. Patient A was a full-time student, who was graduating in that semester when his videos were shot in 2013, and had a full time job at the same time. Since the very beginning, he was reluctant to meet Patient B in person due to his busy schedule as well as the fact that he already had a patient friend who gives him tips. He then is willing to meet with Patient B to help Patient B after knowing Patient B's interests in insulin pumps. Patients have empathy for each other. Even if a patient doesn't reach out to another for one's own benefit, a patient may be willing to go out of one's way to help another patient.

This case shows that in this digital era, one's busy schedule may prevent one from meeting with someone in person; however, many interactions can take place virtually as asynchronous virtual communication has less constraints and requires less commitment than those for synchronous face-to-face meet-ups. A caregiver in a reality video also mentioned that he would not walk into a building for a caregiving support group, but he is looking forward to the right online support group because he “has no one to turn to.”

Discussions

By mentalizing one’s own experiences in reality video, and/or observing oneself in reality video, one can have self-reflection and self-evaluation of one’s own behaviors. Reality video has shown to be effective in increasing the awareness of lacking of self-efficacy. This echoes the study of Ng et al. (1999) in which demonstrated the effects of video modeling in increasing self-efficacy. According to Horwitz et al. (2003), fibromyalgia patients who viewed themselves on videotape showed improvements in terms of body- and self-awareness. This type of a phenomenological-hermeneutic approach was also analyzed in Hansebo and Kihlgren (2001) in which caregivers were able to reflect on video-recorded interactions they had with dementia patients. This “stimulated recall” was shown to aid in the patients’ learning. Such a positive result is achieved through reality video as well.

Through videotaping real people, it has become apparent that individuals have an eagerness to share their life lessons with others in a way which makes their experiences accessible by the larger community. People are eager to help; such eagerness over-weights their concerns of privacy. They seem to enjoy the experience of being on camera because it gives them a purposefulness, which contributes to the overall experience of sharing with others who may face similar life situations. People are willing to commit their experiences to video is partially because they do not want others to repeat any negative experiences they may have had; so the opportunity to share the results of their experiences and to give others a heads-up facilitates the knowledge sharing.

One of the best assets of experienced patients is the life experience—“time shows”—their experiences are a kind of longitudinal study of a disease and its related coping strategies, and sharing this knowledge can be useful. Initially, this research’s primary focus is on the patients newly diagnosed to benefit from those who have had the diseases for a long period of time. But this case study shows that both the young and the old, the newly diagnosed and long-experienced ones, can learn from each other.

To what extent is there artificial reality in reality video? Allen Funt’s 1948 TV series Candid Camera is often credited as the first reality TV program which created artificial realities to see how ordinary people would respond. Reality TV series since 1970s have shared a dominant characteristic of the reality-soap genre: compelling storylines are identified in hundreds of hours of videotaped life and, through careful writing and editing, shape the real-life subjects into reality-show characters (Slocum, 2016). Do the reality videos on YouTube reflect the true reality? Unless the camera is hidden, there may never be true reality because a persona in reality video may have behaved differently once knowing self being videotaped.

Video is superior to other media in that it gives a visual representation of potential outcomes and can provide an insight into situations that texts simply cannot provide. For example, how posture or scarring effects from different procedures can give a very visceral presentation to patients potentially facing similar situations. Although reality video is accessible and is shown qualitatively to be an effective intervention in cognitive and behavioral changes, it is still costly in its post-production, storage, and transmission. How to best combine reality video with still images, audio and text in multimodal communication? It depends on the audience and the context. Murphy et al. (2000) has compared the effects of video modeling and
written materials in patient education for patients at low literacy levels. For a visual learner, still images or videos can deliver the messages more effectively. For a child with autism, a short attention span, and low literacy, a succinct video can attract the most attention. For illustrating a procedure, a video with audio explanations together with textual notations can provide a through tutorial that the audience can follow along. For just presenting facts, textual information may just suffice. Ultimately, it is the audience who decides what the best combination is because the audience always has the option to turn off the communication. The audience has different preferences on the modes of communication based on age, gender, education levels, motivation factors, comfort levels with technology, social-economic status, and environmental factors, etc. Patient B, who is also a health professional, emphasized the need for personalized, multimodal communication for patients below by stating:

Patient education with respect to a multi-faceted lifelong disease can be a very complex as well as a dynamic challenge for which a single methodology (reality video, in-person interactions, and print materials, etc.) may not adequately provide the level of education necessary to effectively address patients’ needs for positive outcomes….How patient best acquires the knowledge…is highly personal and is influenced by a multitude of factors….Effective education…requires a variety of methods, materials, and strategies that must be tailored to each individual personality and environment by emphasizing the critical roles that self-management and continual minute-by-minute vigilance play in successfully addressing the complexity, variability, and nuances of the disease.

Conclusion

This qualitative case study confirms that reality video, similar to video modeling, is also a valid intervention to cognitive and behavioral changes. Although the reality videos used in this study triggered some cognitive changes and even a long-term behavioral change, it is hard to identify, due to the limitations in this study, such a long-term change is caused by the reality video or whether reality video’s contribution to a long-term change is a generalizable result.

The explanations for the benefit of reality video are exploratory. Although it would have been ideal to conduct a controlled experiment comparing the effects of two interventions (reality video vs. video modeling), this research as a qualitative study with limited participants serves to provide insights rather than generalizable results. Thus, it is still unclear what specific aspects of the “reality” are necessary to be shown on video and sufficient for causing the cognitive and behavioral change in participants. Naturally, comparison between reality video and video modeling retreatments and effects through experimentations will best serve to identify the necessary and essential features of reality video that are more efficacious for cognitive and behavioral change than video modeling. This study warrants further research.

While video is the main focus of this study, video can and should also be used in conjunction with other media. Video is still relatively costly and difficult to manage. For procedural demonstrations, video is important. But for simply sharing information with “talking heads” on screens, texts could be more cost-effective. The future research continues exploring the appropriateness and costs and benefits of different media for effective and efficient knowledge sharing that may trigger cognitive and behavioral changes.

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References
