# Notes on Videotherapy

In 1962, when I was teaching sociology at Queens College, Lou Jacobson, then a student (now a PhD Clinical psychologist with a thesis on videotherapy behind him) invited me to come down to the video studio they had there to play with the hardware he enjoyed playing with as a student "announcer " At the time, I was busy writing my own dissertation on Plato's theory of time, and then and for years afterward I made absolutely no connection between the two. All I knew was there were these video toys and I was going to get a chance to play with them, turned on, as usual, by a hip student. I sat in a chair facing a student, and we rapped while each of us was being taped by a huge studio camera, one camera each, as it were. I remember we thought of it as instant film, were nervous, and wondered how we would look when they played it back, the same day! No developing time! Imagine our surprise when the playback turned out to have been "mixed", so that the playback experience was entirely different than the recording experience. I realized then and there that I was watching the director's experience of me, not my experience of me. And he (Lou) was sly enough even in those days of inch Phillips decks (What Gillette calls 1938 plymouths) to record our experience during the playback, and slyer still, to show us on studio monitors how he was mixing the shooting of our playback experience. To this day, I still vividly remember how hard it was to choose which monitor I wanted to watch: the playback, the live mix, or the camera monitors. It was not till a couple of years later that I got into the clinical significance of such happenings. I went home that night stoned on video, stoned on Plato, stoned on sociology, and wondered how in hell these three excitements could each give me the same feeling of being stoned yet be so different and uniquely individual experiences. Ah, the naivete of the young.

In 1964, at a conference of social psychiatry, I was presenting the results of some research on multiple family therapy I had been doing at the Creedmore state hospital. At the conference was a team from Jewish Family Service of N.Y., including the famous (now deceased) Nathan Ackerman. For some reason the team liked me and/or my work and invited me to present some of it back in N.Y. As a sociologist, I was interested in the family and as a person in psychoanalytic therapy myself, I was more than interested in doing the kind of research into families which would be useful to me as a pro as well as a patient. So, when they asked me what I wanted to do, I said I wanted to tape families in treatment (family therapy) and learn how the playback experience could be brought into the treatment setting. They thought that was cool until they found that it would require (at least) two cameras and two decks. In them days, cameras and decks cost a lot more than they do now: a camera was around three grand, a deck was about five and tapes cost a dollar a minute, by the gross. So, what happened was they bought one camera and one deck. Which meant they could make instant "films", but could not playback and "film" simultaneously. Aside from the "reservations" they had for other reasons, this severe crimp in feedback research meant I would either have to heave or get into other lines of research. I chose the latter. I needed the bread. I hoped the price of hardware would come down. I wrote the grant proposals for more hardware
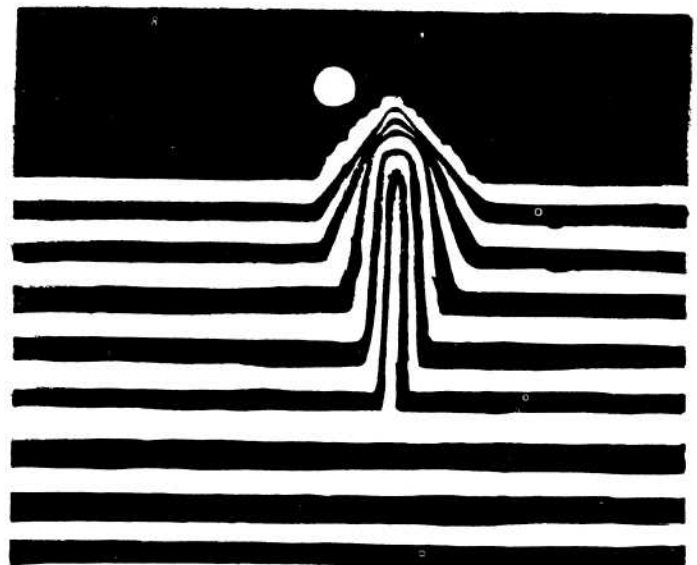
"...if we got into the epistemology from which tape

NIMH said it was a nice idea and a nice theory but I would have to come up with lots of scientific numbers and play the superscience game. I begged the administration to go for the bread. To no avail. Later (1967) when we started to put the Village project together (a sort of anti-clinic in the east village) we tried to use video playback to help people on dope see how they related to each other while badly stoned. It was again felt that "real therapy" would be better than "making movies ". When people wanted to take the camera out on the street, to get the community aspects of "the drug problem" on tape, the idea was strenuously resisted. I left soon thereafter. Not because I was no longer in need of bread, or because I was no longer interested in using tape clinically, but because that was the year the portapaks came out. I didn't need to know which portapak benefit I liked better: the relative cheapness or portability. I knew the agency wasn't going to go for something that could be used as well out of treatment room as in, since that took the definition of treatment out of their turf, if not out of their theoretical turf as well. I wish I didn't have to write now, in 1972, that many many clinicians still fiercely resist the use of tape as a clinical tool. Their "resistances" come from many sources.

For example, therapists of the psychoanalytic persuasion tend to believe that therapists are "blank screens" on which patients "project" their neurotic conflicts, and that the correct posture of the analyst is not to interfere with this projective process, but to "interpret" selectively those portions of the patients' verbalization which are unhealthy. Ideally, the analyst should remain out of sight since analysis is overwhelmingly a verbal process. Who needs pictures. Or, to phrase it in more contemporary language, the analyst is supposed to prevent any feedback from himself to the patient except those verbalizations he chooses very deliberately to engage in. Things like leg crosses, changes in posture, ANY visual clues to the patient as to where the analyst is at, are theoretically out.

Well, what about therapists who use a face to face situation? They turned out to have resistances of another kind. They thought it would be good for patients to see themselves as their therapists see them, but they weren't very happy at seeing themselves as their patients saw them. Oh, it was OK for their supervisors to see them AFTER the session was over, but being just like a patient in the playback situation, where either is free

to comment on the behavior of the other, well, that was something else.

You might think this is all ancient history. Talked to many therapists lately? Many of them think its a fine tool, great for supervision, provides very nice before-and-after documentation showing how much better patients are now than they were at the beginning. Few tapes of failures are saved, but fewer still try to playback during sessions and fewest of all know why or how to playback and/or to record and playback responses to playback.

Not that that would be so great either, since it is only another boring illustration of how right McLuhan is when he talks about rearview mirroring. Doing the same old therapy games and introducing

video into that scene is just like towing a car by horse because you understand horses and are afraid of cars. The fact is, video is the tool of an epistemology born long after the epistemologies from which most therapy derived. And, like all interfaces between past and present, it generates paradoxes. After all, who should be happier with a tool which stores the past and selectively interprets it in the present than an analyst? Which provides one with the opportunity to experience another's experience of oneself. To experience the others experience of ones experience of the other? Not to mention those sociologists who think G. H. Mead had something to say about learning selfhood by experiencing many others experience of oneself, as well as their experience of that? It does not suffice to say that we have in tape a "machine" which can visually display all those Knots, Laing magnificently portrays, in which he thinks because he doesn't know. It'll do that, sure. But the larger question is, if we got into the epistemology from which tape derives would we come up with ways to experience experience which would be therapeutic in NEW ways?

Even this question is of historical interest to those therapists who learn from the so called "communications school" of therapy. After all, Bateson wrote about double binds in 1956, long, long before anything

like portable video was around. So, another paradox: the theory of videotherapy was around long before portapaks were, yet most therapists have yet to "discover" it. We know a lot now about communication and metacommunication, and double binds (communications about communications which contradict the communications) but we're not too sure how to video them so they happen less, much less prevent them, or undo the harm they do.

There are still therapists, (probably the majority) who think that schizophrenia is a disease which individual persons have. Even Laing occasionally sounds like that's the way it is. Whereas, from a resolutely communicational viewpoint, (Haley, Speck, Auerswald, et. al.) there is no such thing as a schizophrenic: There is disordered communication, which requires a network of communicants to sustain it. So, if you wanna fix it (do therapy on it) you gotta fix the network, which means locate its channels of communication, find out where and when simultaneous contradictory messages occur, and communicate differently.

Some videofreaks have gotten that far. But then, caution to the winds, instead of figuring out what they want to do because they know why they want to do it, they sit down in their lofts and try out every last variation and configuration of hardware they can imagine. Out come the mirrors, the machines shooting the machines shooting the machines, shooting the monitor while another deck supplies it with images, producing thousands of one's right eye, etc.,etc. I got nothing against playing like this, but it ill affords therapists who say they really want to "help" people to play around like this if they don't know how easy it is to blow somebody's mind with this hardware, especially if the mind is already half-blown, in their theoretical viewpoint.

Seems to me the point of departure for videotherapy is the postulate that information is man's ecology, that information is to man what water is to fish, that it is our element, we live

in it, that is much more complicated than water and much much easier to drown in. Information ecology, as a science, is much more complex than the simple mechanical cybernetics Wiener told us about, with simple tracking and sensing devices hooked back into the trackers. There are literally billions of feedback loops characteristic of each individual's neurological system alone, not to mention chemical and/or interpersonal loops. We don't even know what most of these are, much less how to therapize them. So don't look for any quick miracles from videotherapy, especially since, even if one occurred, we wouldn't know why, or what else, it was doing.

So, finally, another paradox: lots and lots of people are looking to video feedback for sudden cures of ancient enigmas, believing they are going to be able to do things because they have the hardware. That's like turning loose a bunch of grammar school kids in the nearest nuclear reactor to see whether their ideological innocence will make it do something beneficial. There is no easy answer. Sure, lots of shrinks are afraid of video because they aren't used to seeing themselves as others see them, and they come from heads which

rely on old fashioned theories of madness. Still, videoheads are not necessarily more therapeutic just because they are not similarly brainwashed. They might just be _differently_ brainwashed.

Nor is the incredible sensitivity a genuine head brings to interaction necessarily a guarantee that he/she will be able to do anything more than understand and empathize with the suffering one (patient _means_ the suffering one). Like, if a fish is gasping for water, empathy doesn't help. If a human is gasping for some kind of validating feedback, or suffering from some kind of invalidating feedback, (or both, as in "schizophrenia") you gotta _know_ that and _know_ what to do about that. And the first step is to realize that _you_ AND your hardware constitute the patients ecology. Now, what do you know about changing past ecologies and their programs by adding on a new ecology and new program?

That's what you know about videotherapy. So be careful.

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