Virtual Torment

Adventures in Video Psychiatry, Teletherapy, Image Impact, and Audio-Visual Self-Confrontation

Jeffrey Sconce

> Some day experiments will have to be carried out to determine what effects on the development of the self-image and on the general processes of maturation would result from successively exposing the developing infant, toddler, child, and adolescent to the televised image of his own nakedness in its entirety, including genitals and excretory orifices.[1]
>
> Dr. Lawrence S. Kubie

As Michel Foucault's *The Birth of the Clinic* and *Discipline and Punish* demonstrate so vividly, arcane medical practices often seem, for modern readers, indistinguishable from grueling forms of torture. A call for increasing television's role in both experimental psychology and psychiatric practice, the manifesto quoted above appeared at a time when television enjoyed a high profile as a therapeutic tool in the mental health community. Those who doubt that such videography would also constitute a form of torture are invited to imagine parents coercing a 14 year-old boy to videotape and then review images of his own anus, presumably in front of an eager medical staff waiting with clipboards to make detailed notes of his every reaction.

Why would anyone, much less a psychologist, design such a blueprint for what would no doubt prove to be a most resilient neurosis? The following pages examine psychiatry's initial infatuation with television (and videotape) in the 1960s as a mode of therapeutic intervention. We will see that psychiatrists of the era, in addition to calling for the videotaping of naked adolescents, devised an entire repertoire of televisual practices to better engage their patients, occasionally even advocating televisual interaction with their subjects over face-to-face contact. Psychiatry's incredible enthusiasm for television in this period raises a series of interesting questions related to larger cultural perceptions of television technology in the 1960s. Beyond certain logistical possibilities opened up by the new medium, for example, what other "powers" did the psychiatric community invest in television? In other words, building on larger cultural assumptions about the fundamental "nature" and status of the video image, what beneficial qualities did these doctors feel television added to the therapeutic process? For these tele-enthusiasts, finally, what special attributes did television possess beyond a mirror, a photograph, or motion pictures that made it such a favored tool of psychiatric exploration?

In many of these new therapeutic applications, physicians of the period clearly believed television

capable of unlocking unique forms of self-knowledge, insights to be gained through the medium's celebrated powers of immediacy, intimacy, and liveness. "If a method could be developed by which my own image could speak to me in my own voice, words, intonations, gestures, expressions and mimicry," pondered Kubie, "would this not introduce into analytic communications a new dimension... communications with a true image of oneself on all of one's chronological layers? It is precisely this which we seem to achieve when our own image speaks to us from a TV screen."[2] Like so many others interested in television in the 1950s and 60s, psychiatrists routinely celebrated the medium's seemingly intrinsic powers of "living" contact, frequently discussing television as if it offered a direct, unmediated, and unproblematic access to "truth" and "reality."[3] Whether using TV for educational purposes or therapeutic intervention, psychiatry often replicated the contemporaneous discourses of Marshall McLuhan, RCA executives, and television salesmen across the country, all of whom were promoting the new medium in terms of its ability to provide almost magical forms of live, intimate access. Commenting on this emerging medical trend, one doctor wrote, "as in commercial television, the impact of the screen is based on the 'immediacy effect,' the feeling that 'you are there.'"[4] This form of "vision across a distance," however, did not transport one to an evening of theater or a day at the ballpark, but instead called forth the secreted truths behind the face of the troubled neurotic or re-integrated the shattered self-image of the disassociated psychotic. Live electronic presence, in this case, was thought to be the most direct path for arriving at a form of unified "self-presence."

I am interested here in what psychiatrists (and their patients) had to say about what was then still a relatively new medium, and what their experiences with various forms of video psychiatry might tell us about the continuing negotiation of our relationships with electronic technologies. My goal, then, is not so much to explore what these televisual practices might reveal about the state of psychiatry in the 1960s as to consider what this moment in psychiatry and video therapy might say about television itself, especially in terms of the fictions of immediacy, intimacy, and liveness so often attached to it. As we will see, television's powers of liveness often presented confusing paradoxes for doctors and patients mutually invested in a fantasy of television as a mode of unmediated mediation. Other analysts, meanwhile, chose to foreground the intervention of the televisual apparatus, bringing issues of television aesthetics into the therapeutic situation. Taken together, these approaches to television as either a psychiatric "window" or a psychiatric "canvas" demonstrate that doctors of the period, like everyone else, were still coming to terms with the uncanny nature and strange modalities presented by this form of electronic contact, a process many might argue now continues in our adjustment to a variety of contemporary cybertechnologies.

"Self-Awakedness"

The growing availability of closed-circuit television systems in the early 1960s quickly led to a number of new techniques in psychiatric care and education. In the United States, remote communities lacking psychiatric resources employed the new technology for long-distance psychotherapy and family visits with relatives in distant institutions. Closed-circuit technology also allowed for the increased monitoring of patients by doctors and nurses, both in psychiatric hospitals and other medical facilities. In educational applications, doctors used closed-circuit technology to allow psychiatric residents to observe therapy sessions covertly in order to further their training.[5] Inexperienced analysts could thus watch a number of patient interviews on "live" television before they entered into the often volatile interpersonal dynamics of a psychotherapy session.

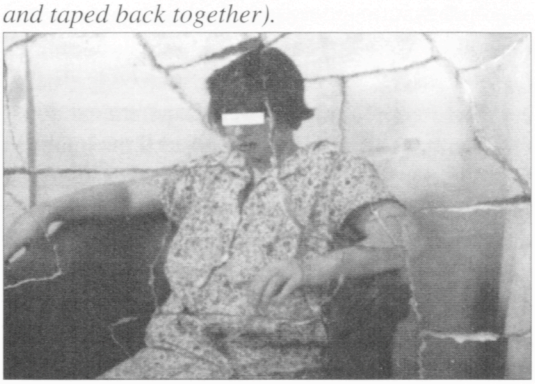
The emerging commercial availability of video cameras and videotape recorders during this same period, meanwhile, enabled a whole new form of psychiatric therapy to emerge. A 1958 study detailed

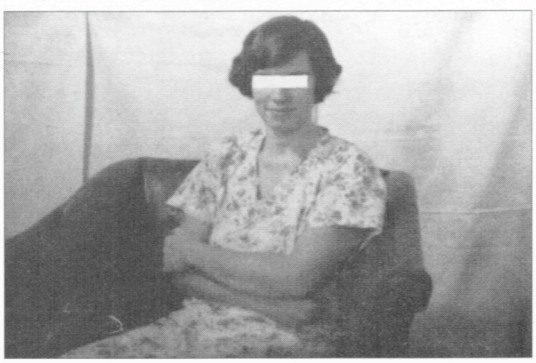
in *The Psychiatric Quarterly* presented an experiment that would serve as the conceptual foundation for much of this subsequent work in television psychiatry. In "A Study of the Response of Psychotic Patients to Photographic Self-Image Experience," doctors Floyd Cornelison and Jean Arsenian claimed that psychotic patients who were photographed and then later saw the picture of themselves in a psychotic state tended to recover more quickly than those who were not photographed and exposed to their image.[6] The study included "before and after" photographs of a female patient who became so enraged at her disengaged, psychotic appearance in the first image that she ripped the photo to shreds. A photograph taken a few weeks later displayed the patient in a more tranquil state (fig 1).

Although the practice of exposing psychiatric patients to their own image (through still and motion pictures) dated back many years, videotape allowed for the immediate recording and review of moving images by both doctor and patient. "The abnormal behavior of psychiatric patients is elicited and then recorded," wrote a doctor (and somewhat inexplicably, his dentist co-author) in 1967. "As part of therapy, the patient is made to view the tape as a measure intended to expedite their return to reality."[7] From the many imitators of this study emerged the concepts of "image impact" and audio-video "self-confrontation": the idea that television could be used for the immediate review of patient behavior as a tool for accelerating the patient's process of self-discovery and mental improvement, either to curb neurotic behaviors or even to put psychotic patients back in touch with the real world.

The practice proved especially popular in group therapy, itself a growing psychiatric trend of the decade. Here the analyst would record a group's session (at times with multiple cameras and a "switcher" for live editing) and then allow his patients to review their collective performance immediately afterwards. Some doctors even encouraged patients to interrupt and call for an "instant replay," backing up the tape to prove or disprove their contention about another group member's words or actions.[8] Another doctor was so enamored of the video process that he not only recorded his group sessions, but then taped the group as they watched the first videotape, producing a visual document of their reaction to the previous videotape (which one assumes could then itself be reviewed [and taped, and so on]).[9] Other video applications were somewhat more troubling. One doctor, for example, advocated the practice of videotaping suicidal patients in the emergency room as doctors worked to revive them. If they survived, these patients would then be forced to review themselves "receiving gastric lavage, tracheotomy,

Fig. 1 *"Before and after" photos suggest the impact of "photographic self-image experience" in the Cornelison and Arsenian study of 1958 (note that the photo on the left has been shredded by the patient and taped back together).*

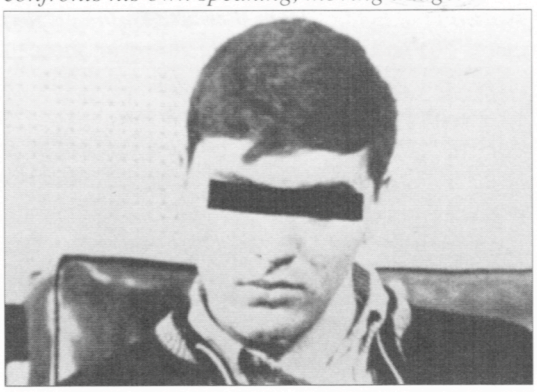




being sutured and receiving intravenous punctures," with the goal of preventing future attempts on their own lives.[10] A sex therapist, meanwhile, asked couples under his care to videotape their lovemaking so that this visual record could then be compared with each partner's narrative accounts of their sex life. "No live closed-circuit immediate feedback through a TV monitor was used in order to reduce the anxiety and factors of unnaturalness," assures the doctor, who then describes the optimal placement of cameras and microphones to best capture the session. "The couple was instructed how to start and stop the recording equipment," continues the account, noting that "the videotape was reviewed by the therapist and it was often found that the behavior seen on videotape had little in common with what the couple had previously reported."[11] Why this doctor believed a no doubt awkward sex session staged for the camera would match the couple's narrative of their private sex life is unclear, but it does suggest that the therapist, like so many of his contemporaries, believed television to be merely a "neutral" relay of vision that provided a "live" and thus "true" reality.

The therapeutic strategy that made most dramatic use of televisual liveness, however, was the practice of "audio-visual self-confrontation." Here, the patient sat alone with a video camera (or with his therapist off-screen), responding to questions or simply engaging in a monologue of free association (fig. 2). In some scenarios, the patient watched himself "live" on a monitor (or monitors) as he spoke, while in other set ups, videotape allowed patient and therapist to replay and assess the patient's "performance." As in the studies with still photographs and psychotic patients, the hope was that audio-visual self-confrontation would lead to an epiphany of some kind, what one doctor termed "'self-awakedness,' a sudden turning-on of the self."[12] Therapists believed that the televisual image had the power to compel troubled patients to reconcile their inner world and external self. "Perhaps if one could have... an opportunity to perceive one's moving, talking image on a TV screen," pondered Dr. Kubie, "and to link this image to the sound of one's own private and solitary ruminations and free associations, such a combination might [make] the controlling identifications so vivid and so haunting that it would... become impossible to bury or deny or distort them."[13]

Fig. 2 *Audio-visual Self-Confrontation: A patient confronts his own speaking, moving image.*



Such hopes, however, were often based on a paradox. For the troubled neurotic or psychotic (or even a more mentally "stable" individual for that matter), it could often be rather unclear whether the television "self-image" on the screen provoked "self-awakedness" or "self-alienation." After all, what does it mean to engage a medium that promises "you are there" when, in fact, you *are* there? "It doesn't seem real. It doesn't seem like me," responded one patient to her televised image, further describing the experience as a "weird unreality." "It seems as if I've been watching somebody else."[14] Another patient reported a similar "'incredulous' feeling about his self-perception, as if the image in front of him could not be himself...."[15] Even patients who reported success with the practice described the experience in a language of ambivalence and disassociation. Kubie, for example, details the experience of another psychotherapist engaged in self-analysis through televisual self-confrontation:

> He saw it. It was familiar and real. It was himself. Yet at the same time it was unfamiliar; or rather it seemed to have several layers of familiarity and of unfamiliarity. He felt rather than saw faces behind his own face, presences behind the image of his own presence; and he felt rather than heard voices behind his own voice.[16]

"Yet there was nothing uncanny or eerie about any of this," notes the doctor. "It was rather as a dreamer sees himself in a dream." Such disassociative reactions could be found even in the early trials with still photographs by Cornelison and Arsenian, who cited the case of a "shy schizophrenic woman," that when confronted with her photographic self-image, "smilingly objected with, 'I disagree.'"[17]

This dreamlike quality of familiarity/unfamiliarity described by so many doctors and patients in relation to audio-visual self-confrontation evokes Marshall McLuhan's commentary on the unique properties of the televisual image. McLuhan, of course, was the most visible philosopher of television in the 1960s, a theorist who frequently described television as a "spectacular electric extension of our central nervous system."[18] In *Understanding Media* (which appeared in 1964), McLuhan discussed in detail the ontology of the televisual image and the medium's seemingly revolutionary relationship to both viewer and culture. One topic of particular interest to McLuhan was the challenge of "acting" for television, and also, the actor's relationship to the viewer. Comparing the live flux and smaller screen of television with the temporality and size of the cinematic image, McLuhan observes:

> The TV actor does not have to project either his voice or himself. Likewise, TV acting is so extremely intimate, because of the peculiar involvement of the viewer with the completion or 'closing' of the TV image, that the actor must achieve a great degree of spontaneous casualness that would be irrelevant in movies or lost on stage. For the audience participates in the inner life of the TV actor as fully as in the outer life of the movie star. Technically, TV tends to be a close-up medium. The close-up that in the movie is used for shock is, on TV, a quite casual thing.[19]

For McLuhan, these characteristics of the medium combined to produce a form of defamiliarization. "The peculiar character of the TV image in its relation to the actor causes such familiar reactions as our not being able to recognize in real life a person whom we see every week on TV."[20] McLuhan supported his claims with an anecdote from actress Joanne Woodward commenting on her transition from movies to television. "'When I was in the movies I heard people say, 'There goes Joanne Woodward.' Now they say, 'There goes someone I think I know.'"[21]

Of course, the situation for patients undergoing video analysis presented an inversion of this relationship. Baffled by their self-image on a live monitor or in a video portrait taken only moments earlier, these patients often could not recognize on TV someone they saw every day in the mirror. Both forms of "defamiliarization," however, testify to television's uncanny power to "disassociate" body and image. Whereas the photographic past of cinema apparently tends to anchor identities, television's seemingly "live" and immediate image stream appears to allow subjects autonomous existences in two separate registers, the material and the electronic. This is strange enough when one encounters Jerry Seinfeld on the street; it is even more diabolical when one encounters his or herself on the television screen. Patients undergoing audio-visual self-confrontation often responded as if they saw someone they "thought" they knew (and yet did not), a familiar presence made strange by speaking "live" from a position of seemingly impossible and thus wholly uncanny otherness. How can Seinfeld be here when he should be on TV? How can I be on TV when I should be "here?"

Television's status as a live and living world (rather than a photographic record) makes such "co-presence" seemingly impossible and thus unsettling.

In his discussion of the "uncanny," Freud begins with an extended etymological meditation on the words *heimlich* and *unheimlich.* At a most basic level, *unheimlich* (the uncanny) appears to be a simple inversion of *heimlich* (the familiar). But Freud argues this relation is more complex. Heimlich, he writes, "belongs to two sets of ideas, which without being contradictory are yet very different: on the one hand, it means that which is familiar and congenial, and on the other, that which is concealed and kept out of sight." Freud later notes that *heimlich,* as the *familiar,* "is a word the meaning of which develops towards an ambivalence, until if finally coincides with its opposite, *unheimlich*" (the *uncanny* or *eerie).*[22] Such ambivalence and slippage captures perfectly the unnerving experience of audio-visual self-confrontation described by so many patients. Indeed, in reviewing patient responses to video self-confrontation, one can not help but be struck by how genuinely unpleasant the experience seemed for many subjects. "I don't recognize that guy as myself," observed one patient. "I pity the poor fool. I saw him as cold—like a Mediterranean punk, with sort of a conceit and complacency—even a blandness to him."[23] Most were uncomfortable (at least initially) with seeing themselves on a live monitor or on video playback, and many were genuinely horrified at reviewing images of themselves in discomfort and hearing confessions made in emotional distress[24] Said one participant in a videotaped family therapy session, "My God, Doc, we were all crazy. We came because Henry was called schizophrenic, but that damn machine—I looked as crazy as Henry. I should never have told you guys I was homicidal during my freshman year at college...Even Joan confessed her delusions about the Catholics being after her when she hid in her room for two weeks last fall."[25]

Psychiatric patients are, admittedly, a rather specialized audience group—but I would argue their discomfort at confronting themselves on a live monitor or seeing their activities replayed only moments later on videotape speaks to a more general sense of cultural uneasiness over the status of electronic mediation and the televisual image. Many are familiar with the way in which audio tape and phone answering machines can make one uncomfortable with the sound of their own voice. So too, apparently, does video make many uneasy at the sight of their own moving image. Inserting one's own image into an electronic world that we have learned to regard as live and in the now, and yet removed and elsewhere, is profoundly uncanny (especially since our lived body remains stubbornly behind). So common was the discomfort provoked by audio-visual self-confrontation, the phenomenon led one psychiatrist to muse on "the anxiety of television."

> The basic anxiety which underlies the experience of being videotaped is best described in existential terms as the anxiety of nonbeing.... Television anxiety is an exquisitely sensitive demonstration of nonbeing anxiety; the camera in effect removes a part of our being existence while another part proceeds in the existing living experience. One student said he experienced his first videotape recording as if he were 'being eaten up by the camera.'"[26]

These comments also recall Freud's work on the uncanny, especially his discussions of doubling and of the eerie quality associated with objects that confuse the animate and the inanimate, such as dolls and waxwork figures. In this regard, the electronically animated, live presence of television "removes a part of our being existence" in a way that film photography does not. There is a profound difference, it would seem, between viewing a moving image that "was me" versus one that "is me." Given television's spooky ability to make the self present and absent, familiar and unfamiliar, exposed and concealed, it is not surprising that

patients were reluctant to submit themselves to the process.[27] If television is an "extension of the central nervous system," as McLuhan argued, what else should we expect when individuals encounter themselves on a live monitor at the other end of their extended nervous systems? While such confrontations with self as other might eventually lead to an epiphany, it seems at first to produce only anxiety. For subjects already experiencing neurotic difficulties with self-image or psychotic confusions over boundaries of self, such an exercise could present nothing less than an existential crisis.

Transmission and Transference

Audio-visual self-confrontation was not the only way television could be used to cultivate electronically mediated anxiety in patients. A study conducted at the University of Mississippi School of Medicine in 1966 presented a particularly unsettling model for "teletherapy," indicating that some doctors found video "telepresence" so fascinating as to advocate it as an acceptable surrogate for face-to-face interaction between patient and analyst. Doctors McGuire and Stigall describe their experimental design:

> Patient and therapist are physically isolated in separate rooms which are pleasantly furnished and sound-attenuated. Visual and auditory communications is by means of a two-way, closed-circuit television system. In order to continue to see and hear his therapist, however, the patient is required to operate a footswitch at some minimal rate determined by the experimenter. Failure to maintain this operant rate results in a progressive, simultaneous deterioration of picture quality and sound intensity at the patient's television receiver. If the patient stops responding altogether, his audio reception is lost and his television picture fades to black. In order for him to recover audio and video reception he must again operate the footswitch at the programmed rate. The therapist is able to see and hear the patient optimally at all times.[28]

The article relates the case study of a suicidal housewife who served as a guinea pig for this system of video analysis. After a brief face-to-face meeting so that the therapist could recruit her for the video experiment, "Mrs. A." was then "escorted to another wing of the medical center" where an assistant wired her for sound, explained how to use the footswitch, and then left her alone. The doctor, meanwhile, seated himself before a television receiver in another room. The patient, we are told, "began to operate the footswitch and quickly learned to maintain receptive communication from the therapist."[29]

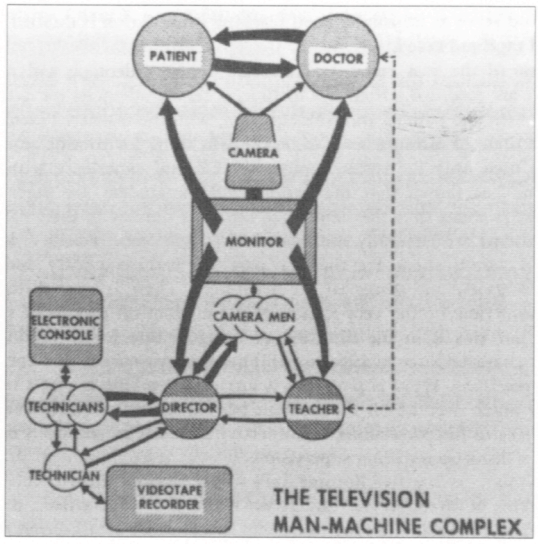
We can only imagine what this woman was thinking when her doctor, whom she had been speaking to only moments before in person, now suddenly appeared on a television screen. And why the footswitch and the continuing threat of broken contact hanging over her sessions? The authors' account of their experiment elides how they explained to the patient the necessity of televisual mediation and the footswitch, but one can certainly understand how a person in a desperate emotional condition would accept *any* form of therapy, no matter how mediated, inexplicable and bizarre. What *was* the objective of this project? In a brief conclusion, the doctors laud their procedure as "a major methodological advance in psychotherapy research."

> [I]t makes possible the systematic, experimental manipulation of specific therapist behaviors to determine their effect upon the patient's operant responding to see and hear the therapist. Continuous tracking of operant behavior across consecutive therapy sessions should provide valuable information concerning the developing interpersonal relationship in therapy."[30]

But one has to ask, 'What interpersonal relationship?' The doctors seem to ignore the fact that they are gathering data, not on a conventional form of psychotherapy, but on a wholly artificial construct involving television as an electronic relay of interpersonal contact. In other words, they are gathering data on a situation that would never have existed had they not orchestrated it in the first place. The logic is deeply flawed in that the data is specific only to therapeutic situations in which the patient just happens to be operating a footswitch to maintain contact with a televised analyst.

Despite the rather tortured circumstances of this video analysis, these doctors, like so many others, discounted claims that the use of television in therapy might present an intrusion or obstacle, arguing that television presented "no experimental distortion of the therapy relationship."[31] Not unlike documentarian Fredrick Wisemen, these doctors argued that patients soon forgot about the cameras and monitors in the room and acted "naturally" as if not being taped. As evidence, they offered the comments of Mrs. A. herself. "At first I felt like I was on 'Candid Camera,' she reflected, "now I feel fine" (and yet the patient also adds that on "one occasion...I wanted to see the doctor in his office. This was when I was very upset and felt I needed him to be in the room").[32] Ideally, such patients would be unaware, not only of the camera, but of the entire "television man-machine complex" that operated behind walls and one-way mirrors to enable video therapy to take place (fig 3).[33]

Fig. 3 *In an ideal therapeutic exchange, the patient would remain unaware of "the Television Man-Machine Complex."*



In the end, the experiment seems more a singular performance of vision and power than any form of generalizable research, a conclusion alluded to in the authors' narrative account of the ongoing tele-analysis. They observe in one session that "between minutes 50 and 55, following obvious efforts of the therapist to terminate the session, the patient appeared to become increasingly anxious and unwilling to leave the therapy situation. In the 54th minute she stated, 'Sometimes I think I should be hospitalized..." Following this rather explicit request for more direct and personal attention, the patient states, "I feel like this therapy is doing me good, but there is not enough of it. I feel like I should be somewhere where I have it all the time—any time I want it." The doctors then note that "during this same period the patient's operant rate of responding to see and hear the therapist increased slightly and remained relatively stable until the end of the session."[34] In other words, the doctors discover that a woman under the double-threat of terminated therapy (at the end of her session and on the weak side of this "interactive" televisual apparatus) makes accelerated attempts to remain in contact (via her footswitch) with a therapist who is about to vanish from the TV screen. Though this session resembles a perverse version of "Beat the Clock" ("You've got 60 seconds, Mrs. A., to comprehend the genesis of your suicidal ideation within the context of your husband's vacillations between domination and neglect, all the while maintaining the proper rate of response on your footswitch. Ready Mrs. A? Go!"), the doctors imagine the "presence" of television to be so naturalized as to serve as a wholly invisible

and benign tool for measuring "interpersonal" dynamics. So deep was the experimenters' faith in the direct, living contact of television, apparently, that they somehow forgot television figured in their therapeutic equation at all, as if the elaborate apparati involved here were invisible.

Aesthetic Analysis

Despite this early and widespread investment in television as a medium of unmediated, direct contact (either with self or therapist), some psychiatrists eventually began to foreground more elaborate production techniques to better capture (and even orchestrate) the dynamics of the therapeutic exchange. Harry Wilmer, an analyst from San Francisco, made an entire career out of giving other doctors advice on televisual aesthetics in the psychiatric clinic. In his article, "Television: Technical and Artistic Aspects of Videotape in Psychiatric Teaching," for example, Wilmer instructed fellow psychiatrists in the practices of "conventional coverage" and the basic visual language of "shot/reverse shot" structure. In lessons that will no doubt seem profoundly ironic to those versed in the psychoanalytic language of cinematic "suture," Wilmer referred to what he termed the "standard plan of sequential camera angles...programmed to orient the viewer." He instructed aspiring psychiatric directors to open with a wide-angle shot establishing the positions of analyst and patient before "tightening" to a shot framing the upper portions of the bodies. From there, the director was instructed to alternate between cameras placed behind the shoulders of each "actor" so that the cameras can tell "the story from the point of view of each participant"(fig. 4).

> The cameraman shooting over the shoulders of the individuals is directed to include in these pictures a portion of the head of the person from whose perspective he is photographing. The purpose of this is to photographically reinforce the impression of a relationship, to portray the image of seeing oneself as another sees one.[35]

Such framing, Wilmer argued, prevented excessive "narcissistic investment" on the part of the patient (and perhaps the analyst as well). To complete each therapeutic scene, finally, Wilmer advised directors, after a series of cuts back and forth, to "dolly back" for a last shot that once again framed the participants as they first appeared in the opening "establishing" shot. Thus, as in virtually every scene in the history of classical Hollywood cinema, narrative space is created and guided by the gaze, organized along a dramatic axis, and brought to a moment of temporary closure.

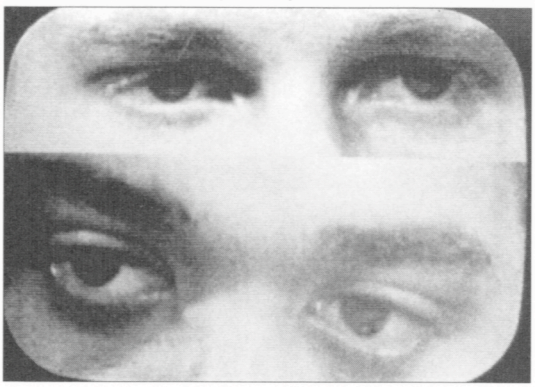
Wilmer's elaborate instructions raise a number of interesting questions related to the process of visually rendering the therapeutic exchange. Who exactly is in charge of editing such sequences, calling the cuts live as the session unfolds? Does

Fig. 4 *A photo sequence prepared by Dr. Harry Wilmer instructs psychiatrists in the basics of framing and shot/reverse structure the sequence opens with a "two-shot" of patient (left) and therapist (right) before moving into reverse close-ups.*

the role of the video director eclipse that of the analyst in such sessions? Wilmer, in fact, advised the two to work as a team, the psychiatrist following the flow of images and dialogue so as to offer advice to the director on what details should be emphasized. Working together, director and analyst could solve what Wilmer identified as the primary challenge in video therapy. "The problem in videotape participant recording is not to humanize the machinery but to diminish the depersonalized, automated role which occurs with unimaginative recording or with fixed cameras."[36] Appearing a decade or so into the history of video psychiatry, Wilmer's comments represented a significant change in philosophy. Whereas earlier therapists believed simply turning on the camera was enough to open a live portal to self or other, Wilmer understood that he was involved in "representation" rather than mere presentation.

Taking up this challenge, other techniques innovated by Wilmer were decidedly more "artful" than mere shot/reverse-shot structure. The doctor, for example, also suggested the use of "split-screen" techniques to provide extreme close-ups of the patient's and doctor's eyes at key moments in the session (fig. 5). Describing the importance of this rather Sergio Leone-esque shot, Wilmer does not shy away from the language of Hollywood dramaturgy. "Eyes are the most expressive portion of the face, as all artists, photographers and lovers know, and their reciprocal interactional relationship is dramatized in this split-screen picture." Returning to the more sober discourse of science, Wilmer hoped such shots would also provide an empirical record of "transference." "Eye movement and pupillary dilation and constriction also are clues to the transference relationship. By studying videotapes frame by frame, it is possible to measure pupillary changes." Wilmer concluded by musing on the connections between Freud's reluctance to make visual contact with his patients and the famous doctor's monumental discovery of the Oedipus Complex. "Perhaps psychoanalytic insights will broaden to include eyesights with the newer ego psychology of psychoanalysis."[37]

Fig. 5 *The eyes of a patient and doctor locked in the split-screen drama of transference.*



Wilmer also advocated the use of picture-in-picture (fig. 6), multiple images, and superimposition effects as strategies for capturing the analytic session. "In family groups," he noted, "it is often useful to superimpose one person's image over the total picture of all members so that his face will be seen in detail while the simultaneous interaction of all members in the relationship is preserved."[38] At other times, the face of the analyst could be rather imperiously superimposed in close-up over the dynamics of a group therapy session (fig. 7), a device Wilmer described in decidedly aesthetic terms. "Superimposed shots express a statement of priorities of interest and when effectively used accomplish more subtle and dramatic interpretation."[39] In a Godardian moment of colliding image and text, Wilmer also devised a system whereby the analyst could superimpose his written notes over the images of the analytic session (fig. 8). Patient and doctor could then review the doctor's written commentary on the unfolding session to better understand their therapeutic dynamics.

Joining this move toward the increased "aestheticization" of the therapeutic event, Dr. Milton Berger employed an imaging technique that seems to have produced only abject horror in his patients. Accidentally discovering the phenomenon

of video feedback, wherein a camera pointed into a monitor will produce multiple images receding into infinity, Berger immediately placed the technique into his therapeutic arsenal. Amplifying and distorting the already uncanny effects of audio-visual self-confrontation, "multi-image immediate impact," as the doctor called his technique, appears to have genuinely unnerved his patients. "As I look at the images getting smaller and smaller, it's as if I'm going back into my childhood...to being nothing," offered one patient, while another asked, "Is it possible to be possessed? I see my mother's face in my face on the monitor. I suddenly realize she never let me be myself." More ominously, one patient responded to his multi-imaged face by observing, "I see my monster. This is the monster I've always known was in me. I first felt this about myself as a child when I saw the mummy in a movie with Boris Karloff."[40]

Perhaps infatuated with their growing skills as television directors, some doctors moved beyond questions of camera and editing techniques to devise elaborate stagings of psychiatric action for the camera. Working in group therapy with drug abuse patients, for example, Wilmer hired "a member of a well-known improvisational drama troupe" to sit in during a session and "react as a spontaneous and uninhibited commentator" on the group's interaction. The patients were then invited to review by videotape their responses to the strange interloper and his antics. In another experiment/performance, Wilmer videotaped a group session while a jazz pianist in another room improvised musical responses to the group's actions (as he watched them on a monitor). The music was fed into the videotape, but the group did not hear it until the replay. Wilmer notes that the group "reacted adversely to the musical critique, largely because it made them painfully aware of their awkward, unspontaneous group behavior."[41]

With his cross-cutting, switcher effects, planted actors, and commissioned soundtracks, Wilmer clearly sought to narrativize therapy, transforming patients into actors and sessions into improvisational

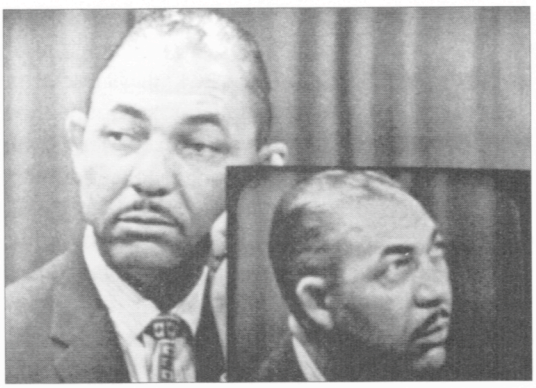


Fig. 6 *A subject contemplates himself contemplating himself on videotape.*

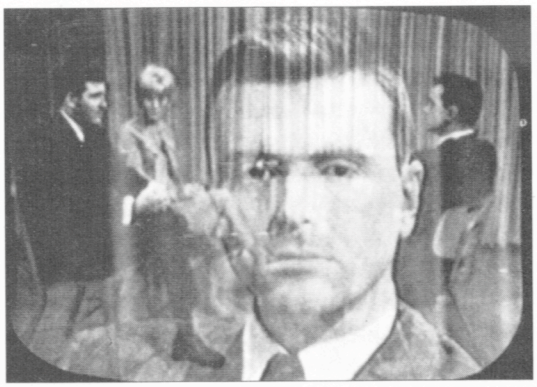


Fig. 7 *Switcher effects allow the analyst to superimpose his image over a marital therapy session.*

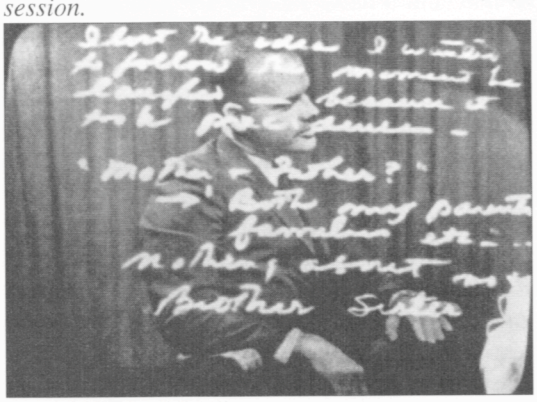


Fig. 8 *Using a white marker on black paper, the psychiatrist's session notes are superimposed over the unfolding dynamics of the therapeutic encounter.*

dramas. The doctor made no apologies for such "manipulations;" indeed, he saw such "creativity" as vital to the therapeutic environment.

> Television videotape replay is social interplay with an emphasis on sophisticated play. It mobilizes the creativity of the child's world of wonder and imagination. Eric Hoffer's trenchant aphorism is relevant: 'A nation declines when its people become too serious and reasonable and refuse to set their hearts on toys.' It is from toys that many discoveries come.[42]

Clearly, Wilmer enjoyed television, and he hoped to share the enthralling qualities of the medium with his patients (who themselves were sometimes invited to serve as cameramen and directors). Wilmer's enthusiasm for ever more stylized applications of the technology was perhaps the inevitable trajectory of psychiatry's general fascination with television. Influenced by reigning popular discourses of televisual liveness that cast the medium as a "window on the world," many analysts of the early 1960s saw television as a psychiatric "window on the self"—clear, invisible, immediate, and intimate. By the late 1960s and early 70s, however, it became increasingly difficult to maintain a naive faith in TV as a transparent medium. Writing in the mid-1970s, for example, Berger observed, "In the last decade we have moved from the reluctant acceptance of so-called 'home-movie' type videotapes to a demand for quality presentations which come closer to, if not exactly approximating, what we technically experience daily on commercial television." Berger then asked his colleagues to consider the quality of their tapes. "Does the tape maintain viewer interest? and [sic] is it aesthetically satisfying?...How is the picture quality?...Are special effects used?...How about the camera work?"[43] Though not all psychiatrists aspired, like Wilmer, to become the Cecil B. DeMille of video therapy, Berger's aesthetic checklist suggests that those who worked in the medium could no longer ignore issues of presentation.

This shift from a faith in unmediated liveness to a concern over the proper rendering of the therapeutic exchange often appears to have been driven less by medical insight than by increased familiarity with the technology and changing cultural perceptions of the medium as a whole. Reviewing the cases in this admittedly selective history of video psychiatry, one can not help but get the impression that doctors frequently had no idea what the actual "effect" of this technology would be on their patients. For example, even as Dr. Kubie advocated exposing adolescents to their own naked orifices and placing other patients before their own televisual gaze, he noted (somewhat cavalierly and even ominously): "No one can predict the effects of this." In many respects, the real subject of *analysis* here was television itself. For those doctors caught up in their enthusiasm for the medium, patients often seemed but a convenient means for learning more about this wonder technology.

Computer Attachments

Television and videotape still figure prominently in psychiatric practice. But television is clearly not the wonder technology it once was. Instead, such technophilic enthusiasm as shifted to the various applications of computer technology. Here, debates about electronically mediated forms of psychotherapy continue. In *Life on the Screen,* for example, Sherry Turkle discusses the history of therapeutic software programs such as ELIZA and Depression 2.0, analyzing the philosophical debates and popular reactions that have accompanied the rise of such computerized therapy. Turkle notes that the original debates around ELIZA centered on whether or not a machine could really replace a human being in such an intimate, interpersonal encounter. Joseph Weizenbaum, creator of the ELIZA program, steadfastly resisted the idea that computers could replace analysts, while Kenneth Colby, a psychiatrist at Stanford, worked to produce

a program that might prove useful for therapeutic applications. Turkle's own research demonstrated that many users of ELIZA enjoyed playing with the programs' quality of living sentience. "As people became familiar with the ways of ELIZA, some enjoyed purposely provoking the program to expose it as a mere machine," writes Turkle. "But many more...did the opposite. They went out of their way to speak to ELIZA in a manner that they believed would elicit a lifelike response."[44]

The initial hesitation over computer therapy continued to dissipate, argues Turkle, as the public became increasingly familiar with cognitive and psychopharmacological theories of depression. These approaches understood mental illness less as a personal (and Freudian) narrative of childhood development, than as a result of faulty neurotransmitters and bad internal programming. At the same time, proliferating representations of sentient computers in popular culture (Turkle cites *Star Trek Next Generation's* "Data" in particular) made people more comfortable with the idea of "thinking" and even "feeling" computers.

> If the romantic reaction put up a wall between computers and people, the growing acceptance of the idea of computer psychotherapy illustrates several ways in which the boundary can break down. People can come to be seen more like machines, subject to chemical manipulations and rule-driven psychotherapies. And computers can come to be imagined as more like people, as being on a path toward embodied intelligence, as being on a path toward the neurally networked Data.[45]

Turkle notes that by 1990, the intense debate fought over ELIZA between Weizenbaum and Colby was no longer an issue for her students. A well-designed computer program, it seems, could do anything.

I would argue these debates over computer psychotherapy extend the process of negotiating electronic mediation seen in the halcyon days of video therapy. Electronically animated communications technologies, it would seem, have the continuing power to call into question already fragile boundaries and definitions of self. Of course, the terms of the debate have changed. Electronic "intelligence" and "sentience" have replaced "liveness" and "immediacy" as the conceptual foundation for speculation about electronic therapy. And yet, the element of *fantasy* remains central to both forms of media analysis. Psychiatrists of the 1960s, invested in reigning discourses of televisual liveness, believed television could enable extraordinary forms of direct, seemingly unmediated contact—either with self or therapist. Software designers of the 1980s and 90s, meanwhile, worked to create the illusion of a knowing entity behind the computer screen. In both cases, therapeutic success depended on a shared set of beliefs about the technology's properties and capabilities, beliefs often based more in popular mythology than in empirical research. In the end, electronic therapy, whether by television or computer, demonstrates that what we *think* a technology can do is often as materially important as what the technology actually does. Electronic therapy, in this respect, is not unlike Tinkerbell—for it to work effectively, one must "believe" it into existence by investing in the illusions of living contact.