"...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