DR. FIDLER'S PERSONAL STATEMENT

SymptomMedia
Visual Learning for Behavioral Health

Does a camera, when introduced into the environment of patients and therapists, move us away from clinical truths? If so, can excellent actors, writers, directors and editors bring us back closer to those clinical truths?

I recall thirty plus years ago when studying as a psychiatry resident at the University of North Carolina at Chapel Hill, I was assigned to interview a patient twice a week in a course (psychodynamic psychotherapy) and then presented the patient in great detail every Saturday morning to my Professor and resident colleagues. I never thought about how I was introducing something into our therapy that would distort how I behaved, much less how my patient behaved. There was not another person sitting in the room. There was not a camera or a one-way mirror in the room; however, a year into this process, my patient had a dream that the two of us were engaged in therapy with a group of people watching us. Coincidence? I don't think so. I had to have been acting, however subtle, in some manner that conveyed to the patient that every word she or I spoke, was being conveyed to an audience to study in the greatest detail.

Over the thirty years I've taught psychiatry, I've learned to not invite residents and students into sessions to observe patients whom I've seen in therapy for many years. By introducing my residents or students into these environments of great trust, the trust collapses. My patients become less open, more reserved, and more guarded. I know that in the following sessions, I shall painfully hear about how I wasted my patients' time, because with my residents and students in the room, my patients explain that they felt awkward and incapable of being truthful.

The same has been true if I invite a camera into that sacred space. The subliminal and actual presence of an audience causes a patient to feel guarded, reserved, and hide symptoms that only in the most intimate of settings could we truly get expressions, reactions and emotions. The dynamics of the conversation changes much like when a third party whether a friend, camera or stranger is introduced to a personal conversation taking place between husband and wife or good friends, intimate details intended to be shared only between trusted individuals.

For this reason, I started describing in great detail to my residents and students what happens after years of in-depth exploratory therapies. One day I decided: why not get my faculty colleagues, my residents, and my students to then act out the scenes of psychotherapy under my careful direction? They were able to portray these described sessions with amazing faithfulness. At last, I had a way to invite my residents and students into the magic, the charm, the heartbreak, and the art of what transpires in psychotherapy.

One of the greatest skills I teach in acting class is for actors to focus intensely upon the other actors on stage. Make sure your words land upon the actors on stage and look to see how they affected the other actors. Equally important: make sure you are open to respond to what other actors toss toward you. Respond. Almost daily we critique theatre students with the comment: 'concentrate on your scene partner, not the audience.' We see students make gestures or use tone of voices. This informs us that they are trying to elicit responses from audience members. No! Focus on your scene partner.

When I watch a video of clinical scenes, I do not want therapists and patients who are no longer being truthful because the cameras and implied audiences alter their responses, often quite grossly I must add for anyone who has watched reality television. (Some of my actor friends are called upon to "act" in reality television shows and take on specifically assigned personalities so those are not "reality" but "improvisation.") I prefer when clinical consultants, writers, directors, and actors work diligently to bring us more truth.

Actors do not mimic a reality but instead, recreate the truth behind it and therefore create an equally honest representation of who we are as humans. To accomplish this feat, an actor digs into the world of the individual he or she will inhabit and actively builds the context and background that creates the emotion or symptom. Their job is to understand, in all aspects, the person they will become. Unlike a real patient, who when emotionally vulnerable cannot help but change their behavior in the presence of a foreign audience, an actor is trained to simultaneously exist within the context of cameras while exposing the emotion of the created alter-ego. This is why we go to the movies and fall in love with characters, why we root for them, fear for their safety, or hope they are defeated. In essence, they have become as real as the person sitting in the next seat and we lose ourselves as we identify with them.

Finally, I return to the profound questions: does a camera, when introduced into the environment of patients and therapists, move us away from clinical truths? If so, can excellent actors, writers, directors and editors bring us back closer to those clinical truths?

For teaching purposes, it is often difficult to capture clinical truths on camera. I will admit there are times when cameras catch real human emotions, such as victims of the Japanese Tsunami (2011) being caught off guard by reporters; however, those people, unable to continue talking, walked away from the cameras. They did not want to publicly expose their deep emotions. Viewing such videos also left me with deep ethical dilemmas of feeling that many of the reporters exploited the victims. In turn, most patients when placed in front of a camera or audience with their consent are guarded or inhibited. Alternatively, we can ask patients with treated symptoms about their past experience, but they are no longer exhibiting the symptoms (as the symptoms have fortunately abated).

In scripts and actors, we can capture the symptoms. By combining real characters or case scenarios with true stories and the symptoms that these patients describe as once having, these underlying scripts performed by actors are able to convey and showcase the subtleties that we wish to highlight. The symptoms can be as overt, pronounced or nuanced as the director and clinical consultant wishes to convey.

In turn, to maintain clinically accurate performances, I have dozens of hours of patients on videos trying to capture the symptoms of one disorder. The end result is one video with one patient showing two symptoms, another patient showing one symptom, and three or four more patients showing the remaining symptoms. There will not be one patient who displays all the symptoms of one disorder. By showing those multiple videos to my actors, and condense all the symptoms I'm looking to present into one script and one patient, I am able to teach my actors the nuances of symptoms and the disorder while creating an efficient, brief, and memorable clip that my medical students will remember, understand and better able to recognize the symptoms presented.

Once we have completed the filming, it is essential to review the videos with professional clinicians to assure the reliability of what is portrayed, remembering that clinicians will differ both in their diagnosing and in describing the symptoms they observe. This also means that video is a powerful tool for striving for inter-rater reliability. I have used this technique at national conferences and the consensus was that we need to have discussions of clinicians from multiple, respected institutions and organizations to define what it is we are seeing and hearing.

Patients are reluctant to show their deeper emotions in front of classrooms of students or in front of cameras. There are plenty of research studies that show people around the world of all cultures display similar emotions to similar situations when they believe no one is watching. (As seen by hiding cameras and not giving informed consent). When people know cameras are present and that they can be observed, they censor their displayed emotions. Actors must work diligently to learn the skills to not censor their deeper human emotions upon stages and in front of a camera. Very few patients have such skills and therefore we often get tremendously censored versions of emotions and symptoms when cameras are present.