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Healing Media: A Manifesto for an Audiovisual Turn in Practices of Care

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Abstract

Emerging from the intersection of the Medical Humanities, narrative medicine, and media studies, this manifesto explores the expansion of therapeutic practice through the multisensory language of audiovisual media. By reclaiming the therapeutic agency of screens and devices, it outlines the coordinates of a transdisciplinary approach to research and training in which clinicians, artists, and patients collaborate as co-authors of meaning. Attentive to trauma, accessibility, and cultural difference, this framework situates healing within a participatory and ethical ecology that privileges collaboration and creative agency. Within this horizon, the mindful use of audiovisual and creative languages appears as the continuation of a long history in which representation, imagination, and care have always been intertwined—transforming media from mere instruments of observation into active environments of relation, empathy, and repair.

Keywords: Narrative therapy - Multisensory care - Media studies - Film Studies

Preamble

In an era marked by profound transformations in health care, education, and digital media, we call for a reconfiguration of therapeutic and clinical practices through the lens of audiovisuality. Audiovisual therapies and techniques - encompassing film, video, soundscapes, interactive media, and embodied practices of listening, viewing and touching - offer a dynamic and multisensory framework for engaging subjectivity, embodiment, and healing.

This manifesto expands the vision articulated by "Manifesto for the Medical Visual Humanities, by Fiona Johnstone (2018)", which called for greater attention to the role of images and visual culture in shaping experiences of illness, care, and the medical gaze. While Johnstone emphasized the visual, we argue that contemporary therapeutic and narrative practices must also encompass the full sensorium of audiovisual expression - mundane routine of setting up sounds, voices, silence, noise, rhythms, montage and movement, colours and shapes - as integral to embodied and affective care.

In this spirit, we assert the urgency and potential of integrating audiovisual methods into clinical, psychosocial, and artistic domains as tools of expression, recognition, and repair. Audiovisual therapies open up spaces not only for documentation or representation, but for transformation, co-creation, and renewed modes of relation.

Instead of reiterating narratives that stigmatize screens as pathological or alienating, we propose to approach audiovisual therapies and techniques as historically situated interfaces endowed with the capacity to repair, to foster empathy and sympathy, and to enable transformation. They are not to be condemned as mere vectors of distraction or estrangement in relational dynamics, but reclaimed as therapeutic devices grounded in sensory attention, narrative coherence, and affective attunement.

1. From Representation to Participation

We advocate a shift from the use of audiovisual media as tools of diagnosis or observation, toward their use as participatory and co-creative agents in therapeutic processes. Audiovisual techniques empower individuals not only to tell their stories but to reshape and re-author them, fostering agency, self-reflection, and transformation. This participatory turn requires us to move beyond models where patients are merely observed, recorded, or analysed, and toward frameworks in which they become active interlocutors, having however in mind the hierarchies and imbalance of power between medical professionals and patients, especially in institutional settings. This might be especially interesting considering that many people with disabilities or clinical issues might not have access to movie theatres due to their non-normative behaviour. Cinemas are coded spaces and set up places where an audience can only be an audience following certain rules of behaviour (no loud talking, no explicit reactions to what happens on screen, no funny sounds).

Participation does not simply mean inclusion; it implies shared authorship, dialogical exchange, and the recognition that therapeutic images are co-produced between subjects, clinicians, and media environments. Such practices disrupt traditional hierarchies of expertise and redistribute the power of narration, allowing those in vulnerable positions to exercise creative control over their own stories. Audiovisual participation creates spaces where silence, noise, fragmentation, or ambiguity can be acknowledged as valid forms of expression rather than symptoms to be corrected. In this way, moving images and sounds or sonic environments and events become catalysts for collective meaning-making, mutual recognition, and the possibility of imagining different futures of care.

2. Multisensory Engagement as Therapeutic Ground

Human experience is fundamentally sensory and affective. Audiovisual therapies embrace multisensory stimulation - image, sound, noise, silence, rhythm, movement - as a means to access non-verbal memory, regulate emotional states, and open dialogical spaces where conventional language fails. This includes the therapeutic potential of voice, breath, sound and music, montage, pacing, and gaze. Embodied and embedded, therapeutic efficacy goes beyond media specificity in se: the body is the first mixed medium. We must ask not only what therapeutic media do, but how they do it: through rhythm, framing, scale, texture, feedback, or immersive depth. The screen mediates, modulates, and reconfigures care.

3. Interdisciplinary Foundations

We propose an integrative approach that draws from clinical psychology, psychiatry, art therapy, neuroscience, film, audience and media studies, performance studies, anthropology, and visual culture. Audiovisual therapy is not the domain of one discipline but emerges through transdisciplinary collaboration and reflexivity. Its legitimacy depends on the capacity to bring together therapeutic knowledges with aesthetic sensibilities, empirical observation with creative experimentation and combine them with the embodied insight of ill, disabled body-minds. They provide tools of expression and co-creation for people in therapeutic processes, who are the experts in living with pain, anxiety, disability and other chronic conditions.

To frame audiovisual therapy as interdisciplinary means resisting reductive models that either medicalize images or aestheticize suffering. Instead, it calls for a practice attentive to media specificity and cultural difference, open to critical theory as much as to empirical research. Collaboration across domains not only enriches therapeutic protocols but fosters new languages of care, where sensory experience, symbolic imagination, and social context are held together. This transdisciplinary foundation ensures that audiovisual therapies can grow as rigorous, flexible, and ethically respon-

sive practices, capable of addressing the complex entanglements of bodies, technologies, and cultures of healing.

4. Media Histories of Healing

Audiovisual therapies must be situated within the longer history of media and healing practices. From early twentieth-century film screenings in psychiatric hospitals to the therapeutic uses of magnetic tape, television, and biofeedback experiments, media technologies have repeatedly been enlisted as instruments of (self)care, discipline, and imagination. These practices reveal how every medium carries with it the anxieties, desires, and epistemologies of its time: the promise of moral hygiene in early cinema, the dream of televisual intimacy in the postwar years, or today's promises of immersion and empathy in VR, video games and interactive environments. Historical examples abound: from the use of films to treat shell shock soldiers to videotherapy in the 1970s, and more recent VR protocols in mental health. To acknowledge this genealogy is to recognize that therapeutic media are—paraphrasing Melvin Kranzberg's famous quote—neither good nor bad, nor are they neutral —embedded in cultural narratives of normalcy, pathology, and cure. The very same screens that inspired technophobic anxieties about suggestive power and psychic damage were also mobilized as tools of moral hygiene, education, or therapeutic self-confrontation. Similarly, Renée Winter and Jonathan Rozenkrantz remind us that feedback loops and video dispositifs operate simultaneously as "technologies of the self" and as instruments of surveillance.

A historically informed understanding allows us to critically assess both the risks of technological determinism and the emancipatory possibilities of audiovisual engagement. Audiovisual therapies thus emerge not as sudden innovations, but as ongoing negotiations between bodies, machines, and imaginaries of health.

5. Digital Media, Accessibility, and Everyday Practice

Smartphones, social media, and grassroots movements and practices have increasingly broadened access to audiovisual production. At the same time the previously medicalised tools of diagnosis went mainstream as elements of wellbeing and quantify-me movements. In this perspective, we emphasize vernacular creativity and everyday therapeutic practices - from video diaries and voice memos to body mapping, first-person filmmaking, and self-monitoring - as accessible and culturally embedded tools for individual and collective care.

In this sense, acts of sharing are not only modes of distribution but also gestures of tactile sociability, activating mirror neurons and embodying a form of care enacted through audiovisual and performed exchange. The therapeutic potential of these practices lies precisely in the technological integration with everyday routines, where or-

dinary gestures of filming, posting, sharing, or listening become occasions for micro-healings, affective regulation, sociability formulae and sustained forms of relational presence and community building.

6. Trauma, Memory, and the Ethics of Exposure

Audiovisual methods must be attuned to the complexities of trauma, lived experiences of illness, and affective memory. Therapeutic work with images and sounds touches vulnerable thresholds of subjectivity: it can unlock non-verbal memories, regulate affect, and allow the unspeakable to be expressed in symbolic form. Yet such work also risks intrusion, overexposure, or re-traumatization if not approached with care. We therefore call for ethical and reparative frameworks that safeguard the dignity of participants, promote informed consent, and resist voyeuristic tendencies or the reduction of non-normative body-minds to spectacle.

Video and cinematic feedback loops have proven powerful in modulating self-image, enabling patients to "see themselves otherwise" and to reconstruct fractured narratives. At the same time, these tools inevitably carry normative frames, suggesting what counts as a "healthy" image of the self. For this reason, we urge critical awareness of the ethical, aesthetic, and ideological dimensions of audiovisual self-confrontation. Therapeutic screens must not enforce conformity but open space for difference, ambivalence, and multiplicity. In confronting trauma and memory through audiovisual means, the aim is not correction but accompaniment: the cultivation of forms of witnessing that are sensitive to fragility, attuned to silence, and responsive to the singularity of each story.

Audiovisual media may also serve as tools for narrating and healing from forms of curative violence - those coercive or disciplinary dimensions that have historically accompanied psychiatric and psychotherapeutic interventions. To acknowledge these ambivalences is not to discredit therapeutic media, but to recognize their double edge: they can wound as well as repair, silence as well as empower. A manifesto for audiovisual therapies must therefore insist on practices that transform exposure into agency, and confrontation into shared care.

7. The Audiovisual as Space for Re-imagining the Self

Audiovisual creation offers a terrain where perception, memory, and embodiment can be re-worked beyond the limits of verbal narration. When cameras, microphones, and recording and editing tools are treated not merely as instruments of self-representation but as partners in exploration, they open a laboratory for identity to be tested, fragmented, and recomposed. Crucially, the therapeutic potential lies not only in crafting these self-representations but in the repeated act of viewing them. Each playback becomes a renewed encounter with one's own gestures, silences, and affect, allowing

emotions and memories to be revisited and reenacted under changing states of mind and body.

Within therapeutic practice, this capacity for return creates a rhythm of recognition and revision. A filmed movement or a layered soundscape can be paused, slowed, or replayed, inviting participants to observe details overlooked in the first telling: the tremor of a hand, the resonance of a voice, the interplay of light and shadow. These recursive viewings transform the screen into an active site of reflection, where narratives of illness, trauma, or transformation can be reconsidered without the pressure of a single definitive account.

Through montage, rhythm, and gesture, audiovisual narrative acts provide symbolic resources for repairing personal wounds and allowing the rehearsal of alternative identities. What emerges is less the consolidation of a fixed self than the exploration of multiple perspectives and possible worlds, where audiovisual self-representation can help reconfigure the relation between experience, imagination, and care.

Owing to its portability and the relative ease of implementation, the therapeutic practice of self-modeling can and should be utilised with increasing frequency, provided it remains under the supervision of a multidisciplinary professional team and is rigorously contextualised within structured therapeutic programmes, clinical interventions, and patient-care protocols.

8. Training and Infrastructure for Audiovisual Clinicians

We call for the development of dedicated training programs that equip clinicians, therapists, and researchers with audiovisual literacy - technical, aesthetic, and ethical - while fostering sustained collaborations with artists, filmmakers, and sound designers in therapeutic contexts. Such training might take the form of interdisciplinary university modules, clinical residencies that integrate media labs, or workshops where patients, practitioners, and artists co-create audiovisual projects. These hybrid environments cultivate not only technical competence but also an ethics of listening, pacing, and co-presence that is central to therapeutic practice.

Yet literacy alone is not enough: audiovisual therapies also require infrastructures that support their practice. Devices must be embedded within dedicated spaces, shared protocols, and durable alliances. Hospitals and community centres can host media rooms equipped for video feedback, immersive soundscapes, or participatory filmmaking. Therapeutic media should not be conceived as mere gadgets, but as carefully designed and continually renewed environments of care, co-constructed by clinicians, patients, artists, and communities including family members, care collectives, allies and friends. Crucially, these practices also call for the creation of living archives, where therapeutic experiences can be preserved, shared, and reactivated across time. In this way, the infrastructure itself becomes therapeutic: a living ecology where knowledge, technology, and creativity converge in the service of healing.

9. Research, Evidence, and Critical Evaluation

We recognize the need for robust, plural, and context-sensitive research methodologies - qualitative, experimental, (post)-phenomenological, and practice-based - that evaluate the efficacy and impact of audiovisual techniques while respecting the specificity of personal and collective narratives. This means combining clinical trials with ethnographic observation, autoethnographic accounts with aesthetic analysis, and practice-based research with neuroscientific inquiry. Mixed methods allow us to capture the subtle dynamics of audiovisual healing: the ways montage regulates affect, how rhythm of sounds and silence or noise resonates with trauma, or how participatory filmmaking transforms relational bonds and allows self-expression.

At the same time, we advocate for the expansion of what counts as "evidence". Beyond the model of evidence-based medicine, which privileges standardised outcomes, audiovisual therapies also benefit from practice-based evidence, where value is demonstrated through lived experience, relational transformation, and aesthetic resonance. An archive of therapeutic media must not be restricted to medical footage and VR protocols, but should also encompass artistic experiments, activist films, patient-produced narratives, and amateur videos. Such archives preserve tacit knowledges and marginal practices, revealing how healing emerges from a plurality of voices, aesthetics, and agencies. Research in audiovisual therapies must therefore remain porous, historically informed, and ethically responsive, resisting the reduction of healing to metrics alone and affirming its cultural, affective, and ecological dimensions.

10. Decolonial, Inclusive, and Situated Practices

Audiovisual therapies must critically interrogate their own cultural assumptions and normative frameworks, striving to include marginalized voices, diverse ontologies of care, and non-Western healing traditions. Within this horizon, an ecology of media emerges—attentive to environments, infrastructures, and everyday practices—where audiovisual healing is not universal but situated, relational, and culturally mediated. Therapeutic screen practices are never neutral: they carry implicit norms regarding gender, class, race, dis/ability and definitions of sanity, reproducing power asymmetries unless actively questioned. For this reason, we call for explicitly intersectional and decolonial perspectives that challenge not only who is seen and how they are represented, but also who controls the act of seeing and the means of distribution. Decolonizing audiovisual therapies entails broadening the epistemic field of care to include ritual, oral traditions, community storytelling, and other non-Western practices, while resisting the imposition of Western aesthetic or clinical standards as universal benchmarks.

A manifesto for audiovisual therapies should therefore care not only for people, but also for the fragile media objects - scratched film reels, analog tapes, outdated formats,

equipment, technologies used for making, screening, or viewing audiovisual objects, including those that have been tinkered with to make them accessible for different/other bodies and minds and body-minds - that bear the history of therapeutic experimentation. Preserving these materials means preserving memory, marginal knowledges, and the traces of alternative ways of healing that risk being erased by dominant narratives of technological progress. From a perspective of media archaeology, such practices remind us that therapeutic media emerge within layered temporalities, where obsolete formats and overlooked devices carry their own epistemologies of care, and where the archive itself becomes a site of resistance and renewal.

11. A Politics of Listening and Witnessing

Finally, we propose a politics of listening, witnessing, and attunement: an ethics of presence that values what is not said as much as what is shown. In an increasingly mediated and distracted world, audiovisual therapeutic practices hold the potential to restore depth, slowness, and radical attention to the experience of being human. Such practices cultivate an ethics of silence, pacing, and receptivity, where the act of listening becomes as central as the act of narrating, and where witnessing creates the conditions for recognition and repair.

In the medical (but also political and propaganda) fields films were mobilized in the name of moral and mental hygiene, often reinforcing disciplinary control and normative models of health. Today, however, we propose to affirm a sensorial ethics - grounded in attunement, co-presence, and the negotiated rhythm between patient and medium. This turn resonates with Pauline Oliveros's practice of deep listening, which foregrounds attentiveness as a transformative form of relation, and with phenomenological calls for radical attentiveness as a mode of dwelling with the vulnerability of the other. In this sense, audiovisual therapies can reorient perception itself, privileging embodied resonance over correction, relational presence over surveillance, and collective witnessing over isolated interpretation. They open spaces for a more attentive, caring, and situated engagement with human fragility and capacities for transformation.

12. Personal, Collective and Creative Agencies

Building on Alfred Gell's theory of art as a system of action and social agency, we argue that therapeutic audiovisual practices are fertile grounds for enacting both personal and collective agency - not merely by reflecting experience, but by transforming it through acts of creation. In Gell's framework, art objects are not inert representations but active participants in relational networks. Similarly, in audiovisual therapy, cameras, microphones, editing software, and screens act as "secondary agents" - extensions of the self that mediate, redistribute, and augment intentionality.

Today, more than ever, the conditions for accessing such mediating agents are expanding, thanks to the ubiquity of smartphones, digital platforms, and open-source tools. This democratization of media technologies enables new forms of expressive autonomy, particularly for those historically excluded from traditional therapeutic settings. Creative agency becomes a therapeutic force when users engage with tools and practices that allow them to manipulate, reinterpret, or narrate their realities - especially when this takes place in relational contexts or collective frameworks, such as community video, activist art, or online mutual support networks.

These acts of creation blur the boundaries between artist, patient, clinician, and audience, generating distributed forms of agency across human and non-human actors. In this perspective, healing emerges not solely from introspective insight or diagnostic frameworks, but from participatory, situated, and tool-mediated processes of making. The rise of digital and post-digital art practices - ranging from therapeutic apps to immersive environments, glitch aesthetics to AI-generated imagery - further reinforces the importance of understanding agency as an emergent, shared, and often non-verbal process.

As audiovisual creation becomes a means of shaping identity, temporality, and relationality, we must develop frameworks that are attentive to how tools shape agency, how practices scaffold imagination, and how shared acts of making constitute new ecologies of care.

Conclusion

This manifesto envisions a future in which audiovisuality is not peripheral but central to care and cure. Across the principles we have articulated, a common thread emerges: audiovisual therapies invite us to move from representation to participation, shifting from images of patients to images made with them, as agents of their own healing. They call for multisensory engagement as a therapeutic ground, recognizing that voice, silence, noise, rhythm, montage and movement are not mere aesthetic devices but embodied channels of regulation, memory, and repair.

They rest on interdisciplinary foundations, where clinical psychology, art therapy, neuroscience, media and performance studies, and anthropology converge to form a shared epistemology of care. Within this frame, a longer history of therapeutic media - from early film screenings to immersive VR protocols - reminds us that every medium is shaped by cultural anxieties, technological imaginaries, and shifting models of the self. Today, digital media, social platforms, and everyday practices extend these possibilities, transforming ordinary gestures of filming, posting, and sharing into micro-practices of sociability and therapeutic presence.

Audiovisual therapies must remain attentive to trauma and memory, cultivating ethical frameworks that avoid voyeurism, protect vulnerability, and allow narrative repair. They open spaces for re-imagining the self, where audiovisual narration becomes a

means of identity play and future-making, rather than a representation of pathology. This vision requires infrastructures of training and practice: clinicians and patients equipped with audiovisual literacy, therapeutic spaces designed as environments of care, and collaborations with artists, filmmakers, and sound practitioners.

Research and evaluation must be robust, plural, and context-sensitive, embracing both evidence-based medicine and practice-based evidence to measure not only symptom reduction but also empowerment, solidarity, and cultural resonance. A decolonial and inclusive horizon demands that audiovisual therapies confront their own cultural assumptions, amplify marginalized voices and sounds, and care for the fragile media objects - scratched reels, outdated tapes - that embody overlooked histories of healing.

Finally, we affirm the politics of listening and witnessing, an ethics of presence rooted in deep listening and radical attentiveness, where silence and gesture matter as much as speech and image.

Taken together, these principles sketch an ecology of audiovisual care: historically grounded, multisensory, interdisciplinary, accessible, ethically attentive, inclusive, and oriented toward both human and media fragility. We invite clinicians, researchers, artists, and communities to pursue this ecology not as a utopia, but as a shared project of care, imagination, and creative survival.

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