#1

ASSESSMENT AS BROADCAST SCRIPT
May 8, 1991

FADE UP ON LOGOS

NARRATION: Funding for this program was provided by The Annenberg/CPB Project.	The Annenberg/CPB Project
NARRATION: Sometimes, as we face life, we can master our experiences, sometimes we can't.	Mauve; fade up on music and pictures for open 1. boy looking into camera on stomach 2. children in schoolroom 3. girl at blackboard 4. boy alone with group off to side - zoom in on him 5. two people walking under catwalk 6. band 7. older black couple hugging 8. man and woman at table with chins in hands 9. man sitting on bed with face in hand 10. woman in mourning with hankie over eyes
MAIN TITLE	The World of ABNORMAL PSYCHOLOGY (over montage of photos)
SERIES TITLE	LOOKING AT ABNORMAL BEHAVIOR

PHYLLIS: ...I wasn't worthy to live...

NARRATOR: Phyllis has been depressed for most of her life. She went to a psychiatrist after attempting to kill herself.	B-Roll: Phyllis speaking tearfully

James was brought to a psychologist by his mother because he just can't sit still.

B-Roll: James in room banging desk

RODNEY: I came blasting through there...

NARRATOR: Rodney thought he was the second coming of Christ.

B-Roll: Rodney speaking animatedly

LaVerne suffered so much from anxiety, she couldn't leave her house.

B-Roll: LaVerne speaking

Larry's ability to think and speak clearly is being destroyed by a disease.

B-Roll: Larry talking haltingly

And Jessica was brought to a psychiatric emergency room when a voice she was hearing told her to kill her baby.

B-Roll: Jessica crying

All of these people suffer serious psychological problems. All of them came, or were brought, to professionals for psychological help.

GRAPHICS TO COME: Video wall of the six people seen above.

This help begins in a process called assessment.

B-Roll: Gines in session

GINES: Can you tell me what brought you to the hospital?

CHRIS: I still don't know. Suicidal and I was hearing voices.

NARRATOR: The careful asking of questions. Administering standardized psychological tests.

B-Roll: Person taking MMPI

Checking for medical complications.

B-Roll: Blaco and team in assessment meeting

BLANCO: We did some blood tests that show that you have an infection and we want to make sure that the infection didn't get into your brain or your nervous system which could be causing some of your symptoms now, some of your thinking difficulties and things like that.

HAMILTON: Okay.

NARRATOR: And careful listening to differentiate between those who, like most of us, need just a little support to get on with our lives, and those who may need major psychological help.

Over CU Hamilton

Cut to team meeting

BLANCO: I think the thing was to know why you came here. Just briefly. I know that you came here a week ago and we want to know what happened. Are you- you just came in or did they brought you in?

DOW: They brought me in because of my stubbornness and my inability to think more clearly I think. From being here. But, despite my horrors and sorrows and my trials and tribulations, I like it here. So, I'm happy. I'm at home again.

NARRATOR: This program is the first in a series of 13 that will explore "THE WORLD OF ABNORMAL PSYCHOLOGY." In it, we'll show how clinicians use the tools and techniques of assessment to gather information to guide decisions about diagnosis and treatment.

B-Roll: Gines and Jessica

B-Roll: Blanco and resident

How psychology defines abnormal is a question that comes up many times in this series. For most in the field, abnormality is on a continuum with normality and is related to...

Graphic: picture wall from into and The World of Abnormal Psychology

Increase in size till only words are showing

EISDORFER: ... behaviors that cripple you, they prevent you from working, things that prevent you from enjoying life to the fullest, from making a contribution, distortions, major distortions in your thinking or in your mood or in your memory and intelligence, these would all constitute what I would consider the grounds for thinking something is abnormal.

LaVERNE: I didn't see sunshine. I didn't see just like you see the green trees and hear the birds sing. I didn't see anything. I was just going through the motions. I would go to work; I'd come home and I would just- there was just nothing to smile about.

NARRATOR: Dr. Carl Eisdorfer is chief of the psychiatry service at Jackson Memorial Hospital in Miami, Florida. Over Eisdorfer

EISDORFER: In trying to assess an individual, there are several things you want to understand. One is why they're in need of help at the point at which they come to you. We call that chief complaint or principle problem. It amounts to the same thing. What's making the person upset?

It's important to broaden that context and to try to understand the home environment, the interpersonal environment, children, husband, mother, father, so on, sister and brother sometimes. And then, we need to know about their background. How were they for the years before they came to you? We need to know in many cases about their childhood. What sorts of problems a person had that may have set them up for the immediate problem that you're having to deal with.

BLANCO: You run away?

PATIENT: No.

BLANCO: How old were you when you run away?

PATIENT: 14.

BLANCO: Excuse me?

PATIENT: 14.

BLANCO: 14.

RESIDENT: Your wife doesn't live with you?

HAMILTON: No, we separated.

RESIDENT: How long ago did you separate?

HAMILTON: At least eight years. Eight or nine years now.

RESIDENT: You've been in trouble with the law before?

PATIENT: No.

RESIDENT: This is the very first time?

PATIENT: No. I didn't be in trouble this time either. They dropped all the charges. They found out I'm not guilty.

RESIDENT: You were living out of the shopping cart?

DOW: I was living with the shopping cart as my transportation moving from neighborhood to neighborhood or community, up and down...

NARRATOR: There are many techniques that a clinician uses to accumulate informaiton about a person in distress.

B-Roll: Gines and Chris

GINES: How are you doing Chris?

CHRIS: Alright.

GINES: Do you know where you are?

CHRIS: Jackson Memorial.

NARRATOR: The first assessment technique is the clinical interview in which practictioners use their expertise, experiences and insight to gather information that can lead to a judgement about the nature and seriousness of the psychological problem.

B-Roll: Gines talking with Chris

These clinical impressions can be cross-checked using standardized psychological tests, such as the Minnesota Multi-Personality Index, also called the MMPI-2. This test compares a particular patient with what is known about the population as a whole and with patients with clearly defined problems.

B-Roll: Scenes of MMPI testing

The clinician might also order a psysical examination or neuro-psychological tests to measure the functioning of the brain and nervous system.

B-Roll: Clifford taking pegboard test

This multi-disciplinary approach, making use of the skills of psychiatrists, psychologists, social workers and psychiatric nurses, has many advantages.

B-Roll: Team meeting

Dr. Bernard Brucher, Chief of the Psychology Service at Jackson Memorial, explains.

BRUCKER: In mental health, we have many different disciplines...

...that all have various areas of expertise in terms of their training, in terms of their experience. Each one of these professionals as they look at a patient are seeing that patient from a somewhat different perspective from their own specific area of training and experience. They may add to the diagnostic picture something which another discipline would miss...

...The idea of using an interdisciplinary model whereby each of the disciplines not only have an opportunity to see and evaluate the patient...

B-Roll: Over assessment meeting

... but also to also to be able to share these ideas in a common meaning and discussion will give a much truer picture of the problem, a much broader scope. This will allow us to help identify the specific problems...

...to be able to include things which might otherwise be left, to have a more accurate diagnosis and therefore, be able to put together a more specific and effective treatment program.

Group meeting in crisis center evaluating patients

NARRATOR: People in psychological pain seek relief in a variety of settings. Most often they go to community mental health clinics or the private offices of psychiatrists, psychologists and social workers.

B-Roll: exterior of Mental Health Center

Sometimes, however, people require emergency treatment.

B-Roll: People sitting in room. Pan to sign Mental Health Emergency Services

GINES: You mumbled to me earlier that you wanted to die.

In emergency room

PATIENT: Yeah. I felt suicidal to stop all this...

GINES: I can't hear you.

PATIENT: I see things.

NARRATOR: This is the crisis center at Jackson Memorial. Every day people come here in desparate need of help. Some are accompanied by a friend or family member; others are brought in by the police.

B-Roll: people in emergency center

BRUCKER: When patients are first admitted to the system, especially in the crisis unit, they come in in a...

...state where they have some very immediate needs. People who are really in pain; they need some immediate first aid treatment. The idea of determining what the problem is, the idea of at least getting the most immediate part of the pain under control becomes an essential part of the first step.

NARRATOR: Jessica came to the center in a cab, clutching her infant son, claiming that voices were urging her to kill the baby. Dr. Antonio Gines describes his first encounter with Jessica.

B-Roll: Gines and Jessica walking out of day room

GINES: When I found her in the front of the emergency room I was really flabbergasted. Voices were telling her to do this now, that is to say, to kill the children herself.

B-Roll: Gines and Jessica in consulting room

NARRATOR: Dr. Gines admitted Jessica to the crisis center and prescribed medications to calm her down, quiet the voice and relieve her psychological pain.

Cut to CU Jessica

At the same time he could get background information from members of her family and construct a part of her history.

GINES: She apparently was living with her husband in Virginia.

...They're from Nicaragua. They have not been able to find work here. They went to Virginia and it was a foreign environment for them, they were linguistically and culturally isolated. I think that contributed to the depressive episode in addition to the fact that she was embarr- pregnant at that time.

She delivered there and became increasingly depressed and began to feel some of the symptomotology at which point the husband decided to bring her down here.

NARRATOR: Once Jessica had stabilized, Dr. Gines could begin to ask her about the thoughts, feelings and actions that had brought her to the crisis center.

B-Roll: Gines, in Spanish, interviewing Jessica

(SUBTITLES):
GINES: What happened in your life five months ago to change the way you felt about yourself?

JESSICA: I don't know. Depression. I felt alone where we lived.

GINES: And had this ever happened before you had the child, your baby?

JESSICA: Never. Until now.

GINES: You gave birth to your baby and how long afterward did you begin to feel like this?

JESSICA: About a month, I think, two months.

NARRATOR: With a few simple questions, Dr. Gines has started the process of defining Jessica's problems.

Over Gines and Jessica

GINES: When I came to see you a little while ago you were crying, What was happening to you?

JESSICA (crying): I feel all alone. I feel like I'm never going to ~~be cured~~ get better. Do you think I'll ~~be cured~~ get better?

NARRATOR: Chris has been to psychiatric emergency rooms before. He has a history of psychological disturbance, drug abuse and suicide attempts.

B-Roll: Chris sitting in emergency room

GINES: Can you tell me what brought you to the hospital?

CHRIS: I was feeling suicidal and I was hearing voices.

GINES: You were hearing voices? OK. And what are these voices telling you?

CHRIS: They're telling me to kill myself and that I'm a piece of shit that I should kill myself.

GINES: Is this one voice or more than one?

CHRIS: Just one.

GINES: Is it a male or a female?

CHRIS: Male.

GINES: Is this the first time you've heard voices?

CHRIS: No.

GINES: How old are you?

CHRIS: 25.

NARRATOR: The first stage of the assessment process, often called the mental status exam, established several basic facts about the patient.

B-Roll: Gines and Chris in emergency room

The clinician is simultaneously observing many aspects of the patient's behavior.

B-Roll: Conte with patient

PATIENT: Because I didn't want to be on that medication. Ok. I'm going try the medication now but I know I'm going to into a lot of convulsions and everything. This is terrible for me. And I'm going to go through the same shit again and I'm going to end up on the street, people beating my ass, they're stronger than me because I'm on some stupid medication. That's all right. That's all right.

10-1 9:00

CONTE: This particular patient has a paranoid delusion that he thinks that his mother and his sister are poisoning his food.

The resident saw him last night and this morning I spoke with him in depth.

Over Conte and Patient

Well basically, I want to observe the behavior of the patient...

...and by speaking with him, I can get a window into his thoughts. If he's very clear and his thoughts are coherent and what he's talking about makes sense, then it indicates that he doesn't have a thought disorder.

A lot of these patients have thought disorders and they'll start saying something and one sentence won't- will not make any sense and they'll have- or they won't be talking at all.

So basically, I want to get a window into how their thought process is and the only way I can do that is by- by hearing them speak to me.

So by the way they speak, I can tell whether they're a psychotic or not. If they don't speak at all, and they're mute, I can also determine that well, why is this person mute. Is this person deaf and can't hear me. If I have a history that he's not deaf and that he was talking a day ago, then I get an idea that somehow there's something that he's preoccupied internally with to let me know that there's something going on and it's probably a psychotic process.

EISDORFER: The physical appearance of-of people is usually the first thing you see, of course. And it has with it a lot of clues. Does the person make eye contact?...

...If they make eye contact, they're feeling reasonably confident, confident in themselves and comfortable with you. If they're avoiding you, if their eyes are all over the place it may reflect anxiety, it may reflect fear...

B-Roll: Chris not looking at Gines

...It may reflect suspicion. Are they focused on somewhere else? Is there something out there that they're seeing and that they're listening to instead of listening to you?...

...How people sit, you know, their body language, is- is really very important. Depressed people you can usually tell are either sad or flat; they show no emotion as you talk to them. Or if they show an emotion, the emotion tends to be sad or down, their shoulders are down...

B-Roll: Hamilton being flat

...The way they walk into a room, the feel- you feel as if they're carrying an invisible weight and indeed they are. They're carrying a very heavy emotional weight...

...Sometimes people will come in and they'll be able to identify themselves correctly, they'll be able to identify the time and the place but they will be so off-beat in terms of their perception of- of the rest of the world, where they have a distorted sense of whom they are.

B-Roll: Group meeting

PATIENT: I was talking to Jehovah, and I said to Jehovah God, please make sure that I- that you prevent all crime because Jehovah let me know that he had prevented all crime and that with him you could be white as snow with no sins and no guilt.

Over team meeting

KATZ: What were you doing with a knife though?

EISDORFER: Sometimes people will come in a give you experiences that you think...

...are unlikely to have occurred in the form of hallucinations. They will smell things, they will see things, they will hear things...

...sometimes they'll hear them, or see them, or smell them in your presence and you're pretty sure that they don't exist.

Over Group meeting

PATIENT: But you know, ice age, stone age and all these people are still in the world too. So we're fighting against the ice age and the ice age is fighting against the stone age and the bible is fighting against Moses and Moses is fighting against Jesus....

NARRATOR: As can be seen, this process of assessment is not a simple one. Whether in a private or clinic setting, the clinician is always listening for clues to the nature and severity of the problems.

Over group meeting

EISDORFER: One of my favorite mottos is, when in doubt, shut up. Listen to the patient; let the patient use her or his own words. How do they express themselves?

Sometimes it's perfectly okay not to talk and not to ask questions. See what it is that the patient has that's bothersome enough to come to the service and the patient will very often tell you particularly if they believe that you want to hear.

If you're in such a rush that you're going to ask questions, you know, by the numbers, the patient will wait and if you hit the right question, they'll give you an answer. And if you don't get the right question, then you're going to miss that and you'll never get the flow of- of the patient. And it's almost a feeling that one gets for the kind of person that you're trying to listen to.

TITLE CARD: THE FIRST INTERVIEW

B-Roll: Eisdorfer and Barbara

NARR: When assessing a person, the initial interview is of critical importance.

To see this process in greater depth, we've asked Dr. Eisdorfer to demonstrate a first assessment interview, with a collegue taking the role of the patient. It's based on an actual case.

EISDORFER: Could you tell me why you came to see me today?

BARBARA: I just cry all the time; I cry all the time. I don't know what's the matter. I just cry.

EISDORFER: Now, how long has this been going on?

BARBARA: About three or four months, I think.

EISDORFER: Apart from crying, what else has been happening?

BARBARA: Well, I get really nervous a lot of the time. I'm nervous about my children. I'm nervous that bad things will happen to them. I don't cry a lot in front of the children but I cry a lot when they're not there.

And I worry all the time. I worry that something will happen to them, they'll get hurt; I won't be there when they need me. That I wouldn't have taught them what they neeed to know.

EISDORFER: What sort of things might harm them?

BARBARA:I'm never sure exactly but they can fall down; they could get run over. Bad things happen all the time to people.

EISDORFER: Have you ever thought that you might do something to them accidently to hurt them?

EISDORFER: Clearly she was in a depressed mood. She said she was crying, she said she was sad, said she was lonely and what we did at the beginning was to explore the breadth and to a certain extent the depth of that mood problem.

EISDORFER: You've never had an impulse to [No.] hurt them?

BARBARA: To hurt them? No.

EISDORFER: Was this a first depression? How serious was the depression? Was it sadness? Was the sadness appropriate to her situation and a lot of people caught up in kind of a lonely isolating situation, separated from their family would be sad but the question in Barbara's case is, did the sadness transcend the situation in which she found herself. That's a very important question.

EISDORFER: Do you ever get the feeling sometimes that life is hardly worth living?

BARBARA: I think I'd think that if I didn't have children. Then I think this is a terrible pressure on my children. I mean if they're all- if they're the only thing in my life that has any meaning, it has to be bad.

EISDORFER: Do you think that they might be better off without you?

BARBARA: Sometimes.

EISDORFER: Do you ever think of doing away with yourself?

NARRATOR: It is important to establish early on the potential for the patient to cause harm to herself or others.

Over Eisdorfer and Barbara

BARBARA: Sometimes.

EISDORFER: When was the last time you had that feeling?

BARBARA: Couple of weeks ago.

EISDORFER: Did you think about how you might want to do it?

BARBARA: I thought about slashing my wrists. Seeing the blood. I couldn't do it.

EISDORFER: Couldn't do it. Why not?

BARBARA: I couldn't do it because I couldn't figure out where to do it so that one of my children wouldn't be the person who found me.

EISDORFER: I wanted to find out what the potential is for actually executing this suicide. I was looking at a history of suicidal attempts which are very important people who commit suicide usually have tried it once or twice. I was looking at how serious she was in terms of looking for a specific methodology.

Was it just I'm no good and should do away with myself or I would like to do away with myself but as she pointed out, there were specific, what I would consider, potentially remediable reasons for not killing herself. It wasn't that she was sinful. It was that her children might find her.

NARRATOR: Although Doctor Eisdorfer believes Barbara's depression is serious, he does not think she is in immediate danger of harming herself or her children.

Over Eisdorfer and Barbar

EISDORFER: So what do you think about your current state? The crying, the not being able to not being able to sort of put anything together?

BARBARA: I think I would like it to stop so that I can get on with things and decide what I'm going to do and go about doing it. I just feel like this is paralysing.

NARRATOR: This first session ends with the beginnings of a plan for the future.

EISDORFER: If at the end of the session, I feel fairly comfortable that I can get her to come back soon, I may choose to do nothing except bring her back.

My hope is that by the end of an hour, very often and hour and a half will be a first session, if I can feel reasonably confident that she has gotten something positive out of it, I'd like to get to know her better before I proceed.

DOCTOR: He says the auditory hallucinations have decreased in intensity though they are still there...

NARRATOR: Time to get to know the patient better is not usually an option for the doctor in the crisis center and often, as in Chris' case the picture presented in that first examination is inconsistent and complex.

B-Roll: Staff meeting about Chris

GINES: He'll tell you that he wants to kill himself and then he smiles.

DOCTOR: And then he smiles.

GINES: So there's sort of a bizarre quality about him.

NARRATOR: Because of this, Dr. Gines admitted Chris to an inpatient unit for further evaluation by the multi-disciplinary team.

Over Team meeting

The team, headed by psychiatrist Mercedes Gonzalez-Blanco, can conduct a complete and thorough assessment combining the observations of the psychiatric nurses, social worker, psychologists and psychiatrist.

B-Roll: Team and Chris at table

BLANCO: I would like to know what happened that they brought you here.

CHRIS: I was, uh, hearing voices and feeling suicidal and I went to my outpatient clinic and I told them that I think I better go to the hospital for little bit.

BLANCO: For how long were you hearing voices, just for or few minutes?

CHRIS: On and off for about a couple of weeks.

KATZ: The purpose of the intake is to really understand what brought the patient to the hospital, what the symptoms were that preceeded the admission and to determine what their psychiatric illness is, if any.

BLANCO: When you were hearing the voices, you were hearing the voices all day long or just for a short period of time?

CHRIS: Short periods of time.

BLANCO: OK, they used to come, talk to you and ..

CHRIS: Yeah, and then stop.

BLANCO: And gone. Ok. For how long have you been hearing voices?

CHRIS: Seven, eight years.

BLANCO: Seven or eight years. So you were very young, when you started hearing voices.

CHRIS: Yeah, I was about 18, 17.

BLANCO: So you were very young, around 17 when you began hallucinating

KATZ: Usually we begin by getting a complete history which includes the chief complaint, why the patient thought they came to the hospital. They may not be able to tell us. It may be that they were brought by the police or they're too psychotic to tell us.

Then we review the history of the present illness which are the events over the preceding weeks or months that led up to the admission.

Then we review the past psychiatric history to see what their prior diagnosis was or what their prior psychiatric experiences were, along with any contributing medical problems, social history, development history.

BLANCO: What made you come down to Miami?

NARRATOR: Over the next hour and a half, Dr. Blanco and her team will begin to piece together a picture of Chris' life. They ask about his school experience, his friends, whether he has had trouble with the law, and about suicide.

B-Roll: Blanco talking to Chris

BLANCO: So you have tried. How many times you have tried to do that?

CHRIS: Couple of times.

BLANCO: Couple of times. How you have done it?

CHRIS: I tried to hang myself and uh, I jumped off a bridge up in New York.

BLANCO: And were you hospitalized then?

CHRIS: Was I in the hospital then?

BLANCO: When you tried to do that.

CHRIS: When I did that I went through a rehab.

BLANCO: A rehab?

CHRIS: A drug rehab because I was doing drugs.

BLANCO: So when you were 17 and you tried to hang yourself you were using drugs. And you went to a rehab center.

CHRIS: Right.

NARRATOR: As a foster child all his life, Chris' teenage years were particularly troubled. He moved in and out of drug rehabilitation centers and mental insitututions. These episodes began to occur after he was put up for adoption at the age of 12.

BLANCO: Do you have parents or an adoptive parent that raised you?

CHRIS: Yeah. Adoptive parents, yeah. I don't live with them though.

BLANCO: You didn't live with them, how come?

CHRIS: Because I didn't like it, I didn't like them.

BLANCO: You ran away?

CHRIS: Yup.

BLANCO: How old were you when you ran away?

CHRIS: 14.

BLANCO: 14. So for twelve years you were living with your foster parents. What happened that they gave you away at the age of 12?

CHRIS: Because I was up for adoption? I guess I really don't know.

BLANCO: How did you feel about it. Because after 12 years of being with the same family. Can you share that with us. Did they treat you well?

CHRIS: No.

BLANCO: Tell me, tell me what.

CHRIS: My father used to beat me and my brother a little bit and I didn't like that.

BLANCO: If I asked you to describe yourself, how would you describe yourself?

CHRIS: I have a lot of problems. That's basically it. That's how I can describe myself.

BLANCO: Okay, I want to hear from the team on what they think or or what they suspected from the clincial point of view about this particular patient.

Over team meeting

NARRATOR: After Chris leaves the examining room, the members of the team discuss their impressions and develop a strategy for continuing the assessment process.

RESIDENT: I don't know if he's anti-social personality but he has a lot of anti-social characteristics.

BLANCO: For example.

RESIDENT: The legal problems and the poor relations to- he seems to have poor relations to people, family, and he has a lot of legal problems as well as the drug use and the lack of relationships that he's had.

RESIDENT: I think I'd agree with Anna that I think he has a lot of anti-social traits. He- he also dropped out of school in the ninth grade and ran away from home. He's very impulsive; it doesn't seem to bother him to lie or to commit crimes. I think he has a lack of a real sense of guilt or sadness about some of his past actions. He seems to not have any sense of direction or sense of identity. He seems empty inside and I think the suicide attempts are very impulsive and motivated by a hopelessness and an emptiness that he feels.

RESIDENT: It's almost like he's failing in everything he's done in his life. I mean, he's not going to try- he says he's given up trying to kill himself because I mean, he can't even- he can't even succeed in that. I mean, that's when you get to the bottom.

Over team meeting

NARRATOR: Dr. Blanco explains that, as with many patients, it is not clear which came first, Chris' psychological problems or his intellectual problems, nor how the two interact.

10:27 @ 6:05

BLANCO: So this is a child that probably has been deprived, never met his biological parents, has been into different legal malfuntioning behavior, has a history of funcitoning very poorly in school. He- he was in a slow learner.

In question mark, this slow learner patient or child was the poor- the poor performer in the school was related to low IQ or it was related to his emotional condition. Sometimes children when they are in the school, they don't perform well because they are anxious or they are depressed, okay.

NARRATOR: Another concern of the team is that several times Chris' responses seem incongruous or inappropriate.

Over team meeting

BLANCO: When I was interviewing him I made a comment that he was talking about suicide, he was talking about jumping from the bridge and thinking about this and he smile. I will- I would consider the smile inappropriate. I don't know if you would agree with me or not.

I would speculate that this individual has been depressed and he has been depressed for a long time and we know that some patient- some people when they get depressed, they get into drugs and they get into alcohol and different drug usage- usage and I think that this young man has been depressed, deprived, all his life.

NARRATOR: Although Chris seemed to answer all of the team's questions, they are not sure that his answers were reliable. There are several other sources of information available and the team will try to make use of them.

Over team meeting

KATZ: What we need to do is really get more background from other people. We're going to call his uncle to see what his perception of Mr. Stanton functioning has been like. We're going to try to get into the court system and see whether there are any outstanding charges.

We're going to assess his behavior in the unit and see how he gets along with the other patients, whether any of the other staff members pick up anything unusual about him, whether he's observed to be hallucinating or talking about hallucinations, whether he does any self-mutilating types of behavior, whether he's really a danger to huimself.

And in addition, we'll probably do psychological testing.

TITLE CARD: THE PRACTITIONERS

BUTCHER: The mental health professionals that work with individual's that are experiencing emotional problems come from fairly diverse training backgrounds and- and have different roles in the mental health treatment process...

B-Roll: Patient going into team meeting

...Let me just mention four types of professions that get involved in the mental health treatment or mental health assessment...

NARRATOR: Dr. James Butcher is a professor of psychology at the University of Minnesota.

Butcher in lecture

BUTCHER: ...in hospitals or in clinics, you will generally find psychiatric nurses, would be working with clients...

...These are individuals who are trained in nursing but have further specialization in the area of dealing with emotional problems.

B-Roll: Psychiatric nurse talking to patient in room

NURSE: ...find that you'll have a lot fewer incidents running into people. Take your medication, keep your appointments.

BUTCHER: Similarly psychiatric social workers, these would be individuals who are trained to deal specifically with individuals experiencing emotional problems.

And one of the important things that social workers bring to the mental health setting is be able- being able to appraise and- and do a very thorough social background history...

B-Roll: Blackwell with patient, recording in notebook

B-Roll: Blackwell in group

BLACKWELL: I kind of look at the people who are referred to us and when I began to interview them...

...I want to know basically how they get along with others, what they begin to percieve as the reason for the difficulties that they're having.

Social workers tend to look at the individual from how he or she functions as a a- an entity in the social world, in the world in which we live.

And so they may not be as attuned to looking or thinking about a physical basis for the problem that the individual has incurred.

BUTCHER: The two other professionals that you would find in a mental health setting would be psychologists, would be largely responsible for the psychological evaluations, use of psychological tests in trying to bring about a clear picture of the individual's problems.

B-Roll: Psychologist and patient doing card test

BUTCHER: So it looks like a chess piece, not that they're on a chess board.

PATIENT: No, it looks like two different chess pieces.

BUTCHER: And then there is also two silhouettes in the center.

BUTCHER: And also the psychologist would probably be involved in some aspect of the treatment of the individual.

The last professional that I will mention is the psychiatrist, have medical training, have usually- they have graduated from a medical school and have obtained a residency beyond the medical school in working with individuals with emotional problems.

B-Roll: Team meeting with patients

In most instances, the- the psychiatrist on a case would be involved in the medications evaluation and monitoring the medications. They might also be involved in psychological treatment as well.

TITLE CARD: PSYCHOLOGICAL TESTING

Weinstein:

ROLL: I'm going to show you a test that requires that you use only your right hand and to put these steel pegs into these slots like so.

NARRATOR: As we pointed out, as part of the process of trying to understand or appraise the patient's personality, symptoms and functioning, the clinician may order standardized psychological tests.

Dr. Jay Weinstein is a psychologist at Jackson Memorial.

B-Roll: Weinstein with patient doing pegboard

WEINSTEIN: Many of these tests and certainly all the tests that I administer are tests that are standardized - they are widely used within the profession of clinical psychology; they have been tested on literally thousands of subjects, in different types of populations, and norms are developed so that we have scores by which we can compare one individual's performance against a group.

ROCA: I'm going to be showing you some cards, okay, that have a simple geometric design on them and what I want you to do is I'll show you one at a time, you'll look at it and all you have to do is copy it just like you see it on that sheet of paper, okay.

NARRATOR: Dr. Edie Roca administers many tests for the multi-disciplinary team.

B-Roll: Roca administerine tests

ROCA: The purpose of this type of evaluation, the psychological evaluation is to get a picture of the patient from techniques or procedures that we have points of comparison regarding normative data...

Over testing

...So basically one of the I guess the rule of thumb here is that we are at least trying to make some attempt that lifts the patient in a more objective manner versus just strict clinical picture of the patient, even though obviously the two are important in determining diagnosis and looking for those areas that may be of conflict and difficulty for the patient.

Therefore, the test allow us in a sense, if I could make the analogy of maybe it is kind of a psychological x-ray, if you will, to allow us just to see maybe a little bit more that we don't see in a clinic, just in a straight clinic interview or an intake or medical status exam.

ROCA: Dr. Blanco and Dr. Katz wanted to do some testing. Okay. And what we're going to be doing is a series of different tests...

NARRATOR: This if Clifford. He has been diagnosed with chronic schizophrenia.

Clifford taking tests with Roca

ROCA: ...from this because they want this information regarding you and how you're doing so we're going to be doing several things, alright.

10:25

ROCA: There's no question as to the fact that he suffers from schizophrenia. One of the reasons for this assessment, at least a screening is basically what we're doing, is that there was some concern that there may be some brain damage with Clifford and specifically of the frontal lobes...

...One of the things that we did with Clifford today was just kind of take a very quick look to see if there is anythings that are outstanding of any significance from a organic or brain dysfunction.

B-Roll: Roca and patient with tests

We have an array of tests or instruments to utilize.

B-Roll: Clifford taking tests

The Bender Gestalt is basically a brief screening for visual motor integration, visual motor organization in a sense.

Individuals asked to do nine geometric designs, individuals after the age of ten, eleven are able to complete this task with no errors.

So therefore from that point on any significant errors could be suggested with visual motor deficits of some sort.

If he is suffering from some frontal lobe damage, how is it effecting his functions.

B-Roll: Patient making dots

From what we did with him today on Bender Gestalt, we noticed on the second and third design that- which is the dots and the little line, the most predominant thing that we see there is the motor perceveration where in fact, there's 11 or 12 dots, it goes 11 and rhetorically just keeps going...

..In other words, there's an inability to inhibit an ongoing process...

...which is a lot of times a trademark in frontal lobe brain damage.

ROCA: What you have to do here is you have to connect the numbers in order. Okay, you'd be starting with number one, this is just a sample. You'd be starting with with one and you'd connect the line to the two, the three, the four, the five, six, seven, and eight. Okay, here it says begin, and here it says the end.

ROCA: We also gave him Trailing Making Test which is basically a test that requires visual scanning, visual motor speed. There's a complexity of functions taking place in that process.

Over Patient taking test

ROCA: Alright, now, I want you to do the same thing, this is a little bit harder, and what you need to do here is begin with number one and end up at number 25.

ROCA: Then in both of those tests, he- he scores in the mild range of possible brain damage.

So we have some indications of that. This is important. I mean some of his behavioral manifestations, his carrying a knife around and verbalizing a lot of religious themes and so forth may be in part a result of brain legion, espcially frontal lobe...

...If there's a history of aggression, I don't know if there is or not, direct, overt, hostility, it could have some correlation with the frontal lobe involvement of brain damage. So it's important to get a clear picture.

NARRATOR: This is the Wechsler Adult Intelligence Scale. It has many subtests, some to measure verabl ability and functioning by asking simple questions.

B-Roll: WAIS-R scoring form

For example, how many wings does a bird have?

ROCA: The first thing we're going to be doing is I'll be asking you some questions and then I'll be giving you something to do that will be jumping back and forth in different tests.

ROCA: The purpose of the test is to assess cognitive functioning,

Over Roca testing patient

...and as a result of the intellectual quotiant at least statistically it puts an individual on a continuum from either very superior intelligence down all the way to the levels of profound retardation.

So basically, it provides at least some estimate as to how the individual's going to fare out in society...

B-Roll: Patients taking tests

...One of the things that we look at with the Wechsler with this- with the psychiatric population is again since a lot of the problems are related to a disturbance in thinking, in a test like this which is fairly structured, affectively neutral, kind of test, the individual, it allows us to look at how the individual deals with a variety of cognitive processes.

How much does the psychiatric illness and/or the anxieties and so forth influence or have an negative impact effect on the cognition?...

...The Wechsler is also used aside very comparison of visual motor abilities and verbal abilities.

John and Roca doing Blocks

ROCA: By placing a red one here, a red one there and a white one here and a half red, half white in that position. Okay. Now, with these four blocks, make them just like that, just the top, and tell me when you have finished.

ROCA: The block design is a test also that is fairly sensitive to brain damage - individuals with some kind or organic brain dysfunction frequently may have difficulties on that test.

Patients with psychiatric disturbances may fare out fairly well on this type of test. Some who are more either accutely in a psychotic state or having considerable, say, floods of anxiety will probably do worse...

...So we have to integrate the psychiatric disorder, the psychological components, and and assess that with the intellectual assessment.

In other words we can't just provide numbers and not take into consideration all the other aspects that may be influencing cognition cognition.

NARRATOR: In addition to tests of intellictual and cognitive functioning, psychologists also assess aspects of the patient's personlaity.

Among the most widely used tests of personality is the Minnesota Multiphasic Personality Inventory, or MMPI-2.

test booklet and grid

The MMPI-2 asks people to respond true or false to hundreds of different statements. Then an individual's responses are compared with those of thousands of other people, both normal and those with various psychiatric problems.

Patterns of responses have been found to be characteristic of each diagnosis or personality style and standard profiles have been developed.

When people take the MMPI, the pattern of their answes is compared to the known patterns to create individual profiles.

B-Roll: Show test questions, filling out the answer sheet, and profile.

ROCA: Okay, John the next thing that we're going to be doing is I'm going to be showing you a set of pictures that have real figures on them and I'm going to ask you to tell me a story about what you see happening in that picutre.

NARRATOR: Tests that use pictures about which the patient is asked to tell a story, like the Thematic Apperception Test or TAT, are called projective techniques.

B-Roll: Roca and John telling story about inkblot and picture

ROCA: I want you to tell a story about what you think may be happening on there. That one, for example. What do you think may be going on in that story?

JOHN: He's confused. Like he wants to play a different instrument. He wants to play music but he doesn't want to play the violin.

ROCA: Projective technique is any any kind of task in which the the individual has to project something as to what he perceives in that test. It provides information about...

Over CU John looking at picture

...the- about to some degree of their fantasy life, their imaginative processes, the richness in which they perceive the world in general. It is a very constricted kind of perception of the world or one that is basically gloomy or depressed.

So it provides a lot of information and not only from the formal scoring system but also from the content of what is being produced in in the process...

...We kind of know what bright people produce, we kind of know what depressed people produce, we kind of know what people with significant conflicts, say for example, in sexual identify, may produce.

Over Roca taking notes of story

JOHN: He wants to play music but he doesn't want to play the violin. But his parents bought him a violin.

ROCA: The purpose is to get- to get just a greater in-depth view of the individual. Again, assuming we're having some cooperation and spontenaity in responses.

NARRATOR: Sometimes psychological tests like these show the clinician that other tests need to be performed. For example, based on the results of both the Bender Gestalt and the Trails Making Test, Dr. Roca sees the possibility that Clifford may have some type of brain damage.

B-Roll: Roca and patient and tests

WEINSTEIN: The referral was simply to administer a number of tests to help raise the question or maybe perhaps answer to some extent the question of whether or not Clifford's behaviors are the result of brain dysfunction.

So in this instance we are trying to take a look at are there any dramatic signs which would suggest to us that Clifford may have had an injury to his brain at some point.

WEINSTEIN: That was excellent. Very good. Now, we're going to run through that one more time. Only this time I would like you to use just your left hand. And we're going to do exactly the same thing...

NARRATOR: There is a test that compared how well he could sort and place pegs with each hand. This may indicate the part of the brain where any damage may be located.

B-Roll: Patient doing Pegboard test

WEINSTEIN: The Lafayette Pegboard is a simple motor test that is a pure motor test which enables us to measure if, in fact, there's any difficulty with fine motor coordination in the upper extremities. In other words, how coordinated in terms of eye hand is the patient able to perform on these tests.

This test, in particular, is a time test and it helps us to determine if there is weakness or disability on one side versus another side of the brain.

NARRATOR: Based on the results of these neuropsychological tests, Dr. Weinstein summarizes his findings this far concerning Clifford.

10-34

WEINSTEIN: He seems to be performing in a way where part of his brain anyway is less than efficient, less than effective and certainly can explain some of the possible adaptive difficulties that Clifford has found himself in...

...in his attempt to establish an adult life.

Over pegboard test

NARRATOR: If the first question in assessment is "What brings the person here?", there are two other equally important questions. What are the contributing factors that led to the disorder and what should the treatment be?

GRAPHIC: Blue of Gines and patient
ADD: What brings the person here?

ADD: What are the contributing factors?
ADD: What should the treatment be?

These two questions are often difficult to answer. Debate swirls around most matters involving care and treatment because there are many theories about how the disorders develop and what should be done about them.

Over Chris

Over person taking test

Over CU patient

TITLE CARD: THEORETICAL MODELS

NARRATOR: Edward Katkin is the Chariman of the Department of Psychology at the State University of New York at Stony Brook.

Over Katkin

KATKIN: ...And I think that there's probably reasonably good agreement that- that psychologists of all persuasions when they talk about abnormal activity, the abnormal person, are ultimately talking about behavior.

And then- then where you get into theoretical arguments is what underlies the disordered behavior. So on one extreme you'll find some people who'll say that if there's abnormal behavior then it must be because there's abnormal brain function.

And other people will say that if there's abnormal behavior its because there's an abnormal balance between the id, the ego and the superego in the famous Freudian concepts and others who would argue every argument in between.

But I don't think there'd be any disagreement among all the people in all the camps that the starting point is the observation that someone's behavior is not normal and that it's ultimately the behavior that's the driving force, the driving point for all theoretical questions about the nature of the abnormal mind, if you will.

NARRATOR: There are several models for understanding behavior, both normal and abnormal. Currently, the three most prominent ones are the biological, psychodynamic and cognitive-behavioral models.

GRAPHIC: heading: Models

ADD: Biological
ADD: Psychodynamic
ADD: Cognitive-Behavioral

By showing how these disorders models explain a disorder like depression, we will illustrate key issues between the models.

GRAPHIC: B&W photo computerized of man holding head with hand (from opening)

First the biological model. The biological model begins with the idea that our behavior is the product of our nervous system and brain.

GRAPHIC: Brain in upper left corner with title BIOLOGICAL

Abnormal behavior is a result of disruptions in normal biological functions wheter a result of genetic influence, injury or disease.

ADD: Disruptionsz

ADD: Genetics
ADD: Injury
ADD: Disease

In this model, depresison is viewed as a biological disorder resulting from an imbalance of certain chemicals in the brain called neurotransmitters.

Smash to GRAPHIC: Depression w/photo in upper rt.
ADD: Neurotransmitter Imbalance

There is also some evidence that this imbalance may be the reuslt of a genetic predisposition.

ADD: Genetic Predisposition

Second, the psychodynamic model. The experiences of early childhood are central to psychodynamic theory, the basis of which was developed by Sigmund Freud.

GRAPHIC: Psychodynamic w/Freud's photo in upper left

Freud believed that personality development is governed by biological needs and that a person's childhood is marked by conflicts over pleasure seeking drives and aggression.

ADD: Graphic baby in lower rt.
ADD: Biological needs

ADD: Conflicts

As the child grows into adulthood, these conflicts remain outside of awareness, in the so-called unconscious. But they effect daily life disguised as symptoms, with anxiety being a principle symptom.

Change baby to woman

ADD: Unconscious

Symptoms

Recently, psychodynamic theory has emphasized the social rather than the biological drives of human beings, but the idea that the origins of conflicts must be understood -- remains.

GRAPHIC: Psychodynamic
ADD: Family
ADD: Social Drives

In the psychodynamic view, abnormal patters of behavior are an expression of the ways people contort themselves to satisfy their their conflicts and other unconscious needs.

Turn family computerized

According to psychodynamic theory, depression comes about because direct awareness or grief or anger poses a threat to people's relationships. They become depressed in order to avoid awareness of those dreaded feelings.

GRAPHIC: Depression w/photo of man with head in hand in upper rt.

ADD: Threat to relationships

ADD: Avoid Awareness

Third, the cognitive-behavioral model. In this approach, the focus is on the factors in the present that are controlling and maintaining behavior. These factors can include events, thoughts, feelings, and attitudes.

GRAPHIC: Cognitive-Behavioral w/doc-pat in upper left
ADD: Woman in right

ADD: Events
ADD: Thoughts
ADD: Feelings
ADD: Attitudes

Disordered actions and distorted thinking come out of faulty learning experiences. There is no appeal to unconscious processes now is behaivor seen as symptomatic of underlying conflicts.

Lose words;
ADD: Faulty Learning

Depression may be the product of a vicious circle that begins with an environmental event;losing a job, for instance, which leads to a thought or belief 'I'm a bad person so bad things will always happen to me,' which results in giving up, which assures continued unemployement a reinforces the hopeless and passivity that are hallmarks of depression.

GRAPHIC: begin circle

at quarter mark, add: Losing a job

at half mark, add: I'm a bad person

at 3/4 mark, add: Hopelessness

at top, add: Depression

In practice, most psychologists, psychiatrists and social workers are not dogmatically attached to a particular model.

GRAPHIC: Man w/head in hand

BRUCKER: Any human behavior that we see can be explained in several different theoretical systems and actuallly quite accurately. In terms of how the treatment approach might be while some specific types of behaviors might be more ameniable to a behavior approach and others to a more dynamic approach, it is interesting that many of these abnormal behaviors are fairly successfully treated regardless of the theoretical approach.

What is more important is having a good understanding of what the nature of the problem is, being able to put that problem in a theoretical perspective so you can understand the behavior, and also have a theoretical understanding of what changes behavior.

EISDORFER: The way you pursue the examination is based on a theoretical bias. Some people already have the built-in bias and they're only interested in going down a particular funnel. I try very hard to- to ask from a range of different theoretical positions because ultimately the purpose of clinical examination is to help the patient rather than to reinforce my own ideology.

So I try to be as open as possible. The problem, of course, is that it's impossible to know everything and sometimes- sometimes you miss it. Sometimes the patient tells you important things that you really are not quite sure because you don't understand something about their culture, their language, you don't understand their particular subculture.

But the theoretical model point of view I tend to espouse is what I call biopsychosocial model. I think that...

...people's behavior, feelings and so on, are the bringing together of biologic forces, internal, psychological, and behavioral forces, and social and cultural settings.

GRAPHIC: photo of man w/head in hand

Laying three circles of Biological, Psychological, social over photo

NARRATOR: More and more practitioners are coming to accept the value of this bio-psycho-social model in dealing with abnormal behaivor.

Over circles

But even so, questions concerning the cause and treatment of psychological problems persist.

Over Chris and Gines

The goal of course, is to enable people like those we have seen in this program to function more successfully.

Over Hamilton

Over Jessica

Over patient

In the coming programs in this series we will see many other people who have had their lives disrupted by psycholoigcal disorders.

Over Fess

Over Mary

We will explore what these disorders look like and what it feels like to have them. And we will continue to discuss what brought those problems about and what can be done to treat them.

Over William

Over Team Meeting

#2

THE WORLD OF ABNORMAL PSYCHOLOGY
THE NATURE OF STRESS
As Broadcast Transcript
March 27, 1991

FADE UP ON LOGOS

NARRATION: Funding for this program was provided by The Annenberg/CPB Project.	The Annenberg/CPB Project
NARRATION: Sometimes, as we face life, we can master our experiences, sometimes we can't.	Mauve; fade up on music and pictures for open 1. boy looking into camera on stomach 2. children in schoolroom 3. girl at blackboard 4. boy alone with group off to side - zoom in on him 5. two people walking under catwalk 6. band 7. older black couple hugging 8. man and woman at table with chins in hands 9. man sitting on bed with face in hand 10. woman in mourning with hankie over eyes
MAIN TITLE	The World of ABNORMAL PSYCHOLOGY (over montage of photos)
SHOW TITLE	THE NATURE OF STRESS
NARRATOR: We all know something about stress because we all experience it.	
Like a roller coaster ride, stress in our lives can be exhilarating.	Cut to B-Roll: Roller coaster ride

But what if we really didn't want to get on the roller coaster in the first place? And what if we don't know how to get off?

Cut: CU people on roller coaster

In short, what happens when we don't have control over the events in our lives, when we feel overwhelmed?

Cut B-Roll: subjective camera on roller coaster

Cut B-Roll: roller coaster

Then we wonder: Is this stress just too much for us? Will our lives ever get back to normal?

Take the runners in a race. They may not show it, but they're under tremendous pressure to deliver. To win.

Dissolve B-Roll: Marathon runners in Slo Mo

Certain hormones pump through their bodies. Their mouths feel dry. Their hearts pound. There is increased muscle tension; blood is diverted to where it's needed.

Dissolve to Graphic: heart pumping; pan right down body to arm and hand

Dissolve: marathon runners

Often, the stress runners feel can help them win, pushing them on to victory.

Start slo mo runners

But, sometimes, stress can be disabling. And, sometimes, the runners can't go on with their race.

slo mo to still frame

Still frame

MARTHE: My stomach was literally doing cartwheels. I mean I could feel my stomach palpitating.

VET #3: I was depressed. I had incredible anxiety attacks.

GINNY: You know, sometimes I feel like really screaming, just going someplace and screaming and yelling. I haven't really done that yet.

NARRATOR: In this program we will look at people undergoing stress -- some who are adapting well, and others who are not; we'll find out how people cope with stress. And we'll answer the question: Just what is stress, anyway?

Over Widow

Over Warren

Over group session

Dr. Norman Anderson is a professor of medical psychology at Duke Unviersity.

Over Anderson

ANDERSON: And so the stress process is really a three stage process. There's a initiating event in the environment followed by our appraisal of what we think about that event, followed by our emotional or physiological responses to that event.

BAUM: The best way probably to define it is in terms of a demand placed on people. Something that requires them to act in- in more than routine ways to- to make right or to- to set the situation the way they want it to be.

That kind of definition allows us to consider events that we normally think of as stressful, losing a loved one, failing an exam, those kinds of things are obviously stressors but having a baby or getting married is also stressful.

And most people don't think of that because those are positive events but they still require us to adjust. They require us to make changes in the way we live and those changes cause stress.

TITLE CARD: BACKGROUND STRESSORS

NARRATOR: There are stressors around us all the time, so-called <u>background</u> stressors.

B-Roll: parade & band, policeman directing traffic, man getting cigarette, traffic light, traffic, gridlock sign

Situations that make a demand on us. Familiar, often of short duration, these stressors can threaten our sense of competence or our well-being or peace of mind or health or concentration.

B-Roll: band
B-Roll: jackhammer

B-Roll: policeman directing traffic
B-Roll: ambulance

And often we just don't have control over the outcome.

B-Roll: car accident, horn honking, woman in accident car

But who is most susceptible to stress?

Ann Smolin is a psycho-therapist and social worker who treats many people undergoing stress.

Over Smolin

SMOLIN: To a certain degree it's constitutional. Some people are born less able to cope with things. There have been studies with babies. Some babies are very sensitive to noise and have- have tremendous startle responses and have trouble sleeping.

Other people are born more calm and more able to roll with the punches of daily life. It also I think has to do with other things that have happened to you. If you're somebody who comes through and has experience of being able to deal with stress, being able to overcome it and things turn out pretty okay for you then you're going to be able to do that again.

NARRATOR: In addition, psychologists say three things are key: the predictability of the stressor, our control over it, and -- equally importantly -- the meaning of the stressor to us.

Over Smolin

Graphic: Box w/ambulance and word PREDICTABILITY
Smash/open: Box w/car and word CONTROL
Smash/open: Box w/policeman and word MEANING

Dr. Andrew Slaby is a practicing psychiatrist in New York who has written extensively about stress.

Over Slaby

SLABY: ...what may be stressful to one person will not be to another. If, in fact, you see a shadow looming up behind you at 12 o'clock at night and your heart begins to go rapidly and you think, my God, I'm about to be mugged, you will be very stressed.

However, if the shadows go beyond- you know the neighborhood very well and everytime you walk by a particular lamp, you see a large shadow, you don't have that same feeling. It's the same experience for two different people with a different context.

For one it's a known, familiar thing. The shadow of a lamp as you walk be it. For another, it's the potential for danger.

BAUM: The ways you interpret things is obviouly going to effect the way things affect you. People who are afraid of growing old will respond to every birthday with some sort of a stressful response whereas most of us don't respond that way. Most of us like getting presents and blowing out candles and so on.

NARRATOR: So, stress often depends on the eyes of the beholder. Is studying for exams stressful or energizing? Does noise overwhelm us or create a sense of being alive? Is being a working mother fulfilling or filled with pressure?

B-Roll: one person in student center
B-Roll: group at table in student center
B-Roll: dance/prom

B-Roll: mother with daughter in day-school

It depends on who we are.

Whether our jobs are stressful can also depend on our point of view: on whether we enjoy our work, on its meaning to us; on how much <u>control</u> we have over the way it gets done.

B-Roll: woman checking bolts

B-Roll: man talking on two phones
B-Roll: doctor and baby

SMOLIN: A lot of the time, it's the minor stresses in our life that take away our control. The phone rings, the baby cries, the dishwasher breaks; any one of a number of things happen and we are distracted from what we had planned to do with that time, with that day and it's- we're called upon to now deal with something we had no intention of dealing with and it's frustrating and it gets us angry and I think modern life is full of that kind of minor stress which keeps people really on the edge in ways that if they didn't have those stressors, they wouldn't be.

Things could get accomplished; you would feel that you had control over planning your day, planning your time and what was going to happen to you.

NARRATOR: Control or lack of control. Research has shown that, because of sudden, uncontrollable deadlines, architecture and accounting are two very stressful occupations.

Over Smolin
Black w/words Sudden Deadlines

Graphic: museum upper left
Graphic: office lower right

In a study conducted by The New York Hospital Cornell Medical Center, a rise in blood pressure in accountants and architects was discovered to be associated with especially stressful work periods.

Cut: architecture office

Theodore Beyda is an accountant who participated in that study.

Over Beyda

BEYDA: (in office to others) ...they're killing us with the forms. Just the amount of forms...

BEYDA: There aren't very many times during the course of the year where you really do...

Over Beyda in office

...have the pleasure of going home and sitting back and relaxing and saying okay, now I can sort of evaluate where I'm up to.

The pressure is really almost all year round. People think that it's only around April 15 but that's not true. It's really almost all year round.

And the anxiety of saying, wait a minute, I went in this morning to do task A and you come home and not only didn't you do task A but now task A moved down four notches and you still have to get task A done. That's the anxiety that you get.

It makes the job in one case- in one sense exciting because you're always dealing with the challenge of accomplishing things. But it's very, very difficult to keep everything in perspective.

NARRATOR: Lisa Dias also participated in the blood pressure research. In her first job after architecture school, she was with a large New York firm.

B-Roll: Lisa walking across courtyard
B-Roll: entering office

DIAS: I worked my way though school. There's a different type of stress at school than there is at work. There- at school, you have a better sense of when you're deadlines will be.

B-Roll: Lisa in office

At work, I have to coordinate a bunch of people to get a deadline met. Plus, often the deadlines pop up unannounced.

...Sometimes I get very frazzled and I feel like my brina is just going 90 miles an hour and that's it's more what I do is where I just kind of sort- it kind of- it's all running through too quickly.

NARRATOR: Both Beyda and Lisa Dias have found ways of lessening the stress in their lives. Lisa, by a change of scene...

Over Lisa

LISA: ...I walk here. I come in. It's a nice, quiet space. There are usually interesting shows here. Often they'll be lectures. It's very peaceful. It's like a gallery with the emphasis in architecture.

B-Roll: Lisa in museum

Over CU Lisa

NARRATOR: For Beyda, it's a matter of controlling when he works and when he doesn't.

Over Beyda

BEYDA: I'm orthodox so I don't work on Sabbath which is Saturday and that's my day where no matter what happens, no matter, like this afternoon come sundown, that's it, I'm- I unplug and I'm disconnected. And that's my day where I really regenerate myself for the whole week.

So whatever happens from Sunday to Friday I deal with knowing that I have the Sabbath to deal with. And other thing is I don't let any of my clients- they know as a rule they're not allowed to call me at home or anything.

Once I'm out of the office, I'm out.

NARRATOR: Psychologists already know a lot about connections between stressors and bodily responses.	B-Roll: Lisa in museum
In stressful situations, hormones, such as epinephrine and norepinephrine may increase, affecting blood pressure and heart rate. Stomach acid may suddenly be secreted.	Graphic: real brain model Zoom to neurotransmitters Back to brain with different areas lighted
The pituitary-adrenal system can cause the release of corticosteroids into the blood stream.	Add: Corticosteroids
Psychologists are constantly assessing the effect of all these body changes on short and long-term health.	Graphic: front view of body with brain Pan out to show body and beating heart
Many feel that one key issue is how stress affects the nervous system; how together they alter the endocrine system; and how the endocrine system and the brain, then, alter behavior.	Cut to word: STRESS -> NERVOUS ENDOCRINE BEHVAIOR

BAUM: Those hormones tend to do things like increase heartrate, increase the muscle tone in the skeletal muscles so that we can be stronger and act more rapidly. They also tend to reduce blood flow and reduce tone of organs that aren't needed such as the gut. We don't need to digest food while we're running from a bear and therefore blood is cut off to those- those centers so that- so that it's only going- energy is only going where it's needed.

We think it's bad for us to have these- these kinds of arousals persist long beyond the period in which they're functional.

If you think about the kinds of stressors that we experience every day, sitting behind a desk, getting up, getting- getting on the phone and finding out that the stock market just dropped three thousand points and you have no money ever again, this kind of arousal isn't going to do you any good. You're going to feel it and you going to feel your heart beating and your mouth will get dry and so on and so forth but it's not helping.

And it- there are side effects of these kinds of responses which if inappropriately prolonged, make- may make us sick.

NARRATOR: Like the Cornell researchers, Dr. Anderson is studying the effects of stress on our cardiovascular system. With an emphasis on how stress affects different segments of our society. Over Anderson

ANDERSON: One question that I've been interested in is whether black Americans show greater responses, cardio-vascular responses, to stress than white Americans given that blacks are at greater risk for developing hypertension later on.

And in fact, we have conducted a series of studies looking at this question and- and have found fairly consistent differences between blacks and whites and the magnitude of cardio-vascular response to stress.

Blacks tend to show greater blood pressure elevations when exposed to very acute, short-term stressors in the laboratory compared to- to whites.

There is a lot of research that show that people who are exposed to daily chronic stress, not the short-term stressors that we subject people to in laboratory, but daily chronic stress, are more susceptible to acute stress.

That is if you in your daily life are constantly bombarded with stressors, chronic stressors, everyday stressors, then when new stressors come about, you- you're more likely to show big responses to those stressors. Those stressors are more likely to have a greater impact on you than if you weren't exposed to daily chronic stressors. It's almost- the idea is almost that chronic stress increases you susceptability to acute stressors.

Now how does that relate to what we've been doing in the laboratory? Well, it is very clear that black Americans are exposed to more chronic stress than white Americans.

There are several different kinds of stressors in the world. There are- there are the kinds of stressors that we all experience regardless of race: divorce, loss of loved ones, job changes, etc.

But in addition to those, black Americans have a whole other set of stressors that they're exposed to that whites aren't. Particularly those that have to do with racism. Examples can be blacks, when they go into clothing stores tend to get followed around more by security guards, even blacks who supposedly well dressed.

One of the things that I'm very much interested in is why some blacks seem to adapt well to the daily stressors that they're under whereas other blacks do not. It's very clear that all blacks aren't at risk for hypertension.

While blacks experience hypertension to a higher rate and to a higher degree than whites, many blacks never experience hypertension at all and the thing that I'm interested in and one of the things that I think is a believe is a burning scientific question right now is why- why some blacks adapt well to these stressors and other do not. How have they learned to cope with the stresses of being black in American society?

TITLE CARD: HEIGHTENED STRESS

NARRATOR: There are some changes in our lives that will cause stress in most people. Take being without work. For months, these telephone employees have been on nationwide strike.

B-Roll: strikers

WARREN: Most of us are frustrated...

...You can take but so much, you know. And it's hard. I admit that. We've been on strike since August the 5th.

NARRATOR: Antoinette Warren has worked at the telecphone company for years.

B-Roll: Warren in home

WARREN: ...and they had a mediator yesterday but with the contract that they offered us is- is nothing. They want us to pay for our medical which is impossible because you have a lot of people in the picket line and a lot of women also in the company who are single mothers...

...Yes, you feel angry because I mean, you see people going in every day and they're people who are walking along saying why don't you go back to work. I say's well...

B-Roll: Warren in home

...why should we go back to work now when we're trying to prove our point.

...If it hadn't had been for prayer, I don't think I would have made it because I came home several nights and I had just- just literally cried.

Warren on couch

SMOLIN: A lot of people use prayer to deal with situations that are basically out of their control. They call it turning it over; they call it talking to the higher power in the AA kinds of programs and it feels like somebody it helping. It feels like there's somebody else there with you and that you're not totally out of control.

WARREN: (In home) I got some breakfast. Why don't have some milk or some- I brought some apple juice.

WARREN: Nicole is 12 years old. And Nicole has- had been with me on the picket line since August until school started and she understood somewhat but as you know how children are, kids want certain things and when you have to keep saying no, they don't seen to understand...

Over Warren and Nicole in kitchen

...And I said, well, I just can't take it. I said, because the bills are here and I don't know how- how we're going to pay them. And my daughter had said, mommy, don't cry. You know, and you hate to- you hate to cry in front of your children. She says, but mommy, don't cry. She says, god will work everything out. She says, you always told me that.

NARRATOR: Events that threaten to interrupt our lives in a major way can cause heightened stress. A divorce, being fired, an accident, a burglary.

Photos: man at table w/hands over face

Couple sitting at table
Man on floor dead w/cash register open

The more severe or unpredictable, the longer the stressor lasts, or the more out of our control it is, the more likely we are to have a prolonged stress reaction, of depression or anger or fear or just plain helplessness.

Black boy with cap
White girl sitting on stoop

Black man sitting in window; zoom out

One of the strongest stressors is the death of someone we love.

Family at funeral

No matter what kind of death, whether of a child, a parent, or a friend, we usually experience painful grief reactions.

Woman with hankie over eyes

Black women grieving

SMOLIN: When somebody dies, I think first you feel numb. You feel probably very little, sort of otherwordly, out of your body, it's happening to somebody else, this isn't me, you're stunned, you're in disbelief, it doesn't really hit you right away. I think then you become tearful, dejected, despondent, sad.

You can have all the kinds of symptoms that we would associate with depression. Sleeplessness, loss of appetite, loss of interest in what's going on around you, loss of ability to relate to other people around you. And this is all normal at the time that you lose somebody...

...Sometimes you don't think you're going to get over it. You feel at the time like this is going to be the way it is forever but I think you, by talking to other people, by reading about it, by finding out how other people have reacted to loss, you begin to see that this is normal; that this is something you have to go through; you have to take time out...

Photos: Man with legs crossed on bed

Black cook on break

Hospice woman comforting

Westpoint grieving

...You have to not go on with life; this is a major event that's happened to you.

And our society has perscribed many ways in which we do take that time out. There is a period you're expected not to go to work, not to take part in pleasurable things, so that society has taught us that there are normal ways of dealing with that time in your life.

NARRATOR: Each kind of death presents a different problem for those left behind. A case in point: the death of a policeman.

Photo: Man w/face in hands St. Marks Place

Officers looking at hit & run victim

SAWYER: When the word comes down that an officer has been killed and it's in your area, your blood turns to ice. I remember that from the first police death that we ever encountered when he came on the job. He happened to be on that squad and I knew he wasn't home and I knew it was in the area where he policed and I never got a call from him but when the name came out on the news media, it was like oh, my god, it's one of ours, but thank god it isn't not him.

NARRATOR: Suzi Sawyer is the wife of a policeman. She started an organization called COPS, to provide support for the families of police killed on duty.

Over Sawyer

B-Roll: Police funeral

SAWYER: Police families socialize together; police families are going to hurt together and when the line of duty death occurs, we're going to have to feel together.

NARRATOR: Ginny's husband was a policeman; he died seven months ago. Vivian's husband died over four years ago. It is clear that the amount of time since the death makes a difference about it.

Graphic: Ginny in upper left
Graphic: Vivian in lower left
Over Ginny

GINNY: And I had the feeling that I wanted to put the news on but I said no, and I just drove home and I didn't know anything about it. I mean, it had been on the news and everything. Not his name but just that an officer had been wounded.

And I remember going home and the babysitter going off and just sitting with the kids and I was eating rice at dinner and there was a knock on the door and it was dark out and I didn't really know who it was and I looked outside and the pastor was standing there and a lutinent from the department. And I guess it took me a couple of seconds and I knew immediately, you know, and I also knew immediately that he wasn't going to make it.

VIVIAN: Initially all the symptoms of intense grief were there, a sense of being outside of myself at times, many times finding myself in the house and in rooms of the house and not knowing how I got there or why I was in them. A sense of priorities changing drastically, how could I go grocery shopping when this terrible thing has happened.

Hearing him call my name at night when I knew he wasn't there and real fear, how- how am I going to take care of these children, how are these children going to cope with this critical incident. And over time, just simply time showing me we were coping.

NARRATOR: Painful as the grief may be, it's also clear that talking about it is helpful to Vivian and Ginny.

Over Graphic: Vivian
Add Graphic: Ginny and word: Coping

SMOLIN: Talking seems to be a tremendous relief- relief even when people get very upset about it. It's a way of coping with the experience. Somehow each time we experience is retold and relived, one gains a little bit of strength to go on, a little bit of putting this into perspective and of releasing some of the pent up emotions.

GINNY: You know, sometiems I feel like really screaming, just going someplace and screaming and yelling. I haven't really done that yet.

I'm also finding that it's been almost seven months now and the kids don't need me as much and a lot emotionally but you know, they're pretty much- they're back in school and they're, you know, going out and playing with their own friends and stuff like that and I find I'm having more time to reflect on what happened and I didn't in the beginning. And that's been very hard, very, very hard.

I mean, I'll just sit in the car and drive and, you know, talk to him so I think I miss that the most.

VIVIAN: Maybe people need to know it's never over. The day before my husband died, the girls and I had been at my mother's house and we'd gone to the fair, the county fair, and my husband had come- come over there for dinner and we had spent the night there. It was a break for me.

So the morning of his death we came back home and he had already gone to work and he had left two erasers for my youngest daughter; she had a brand new blackboard so she meticulously writes this note thanking him for those erasers and he never got the note.

Well about four months ago, we were riding in the car just her and I and this song came on the radio and it was Mike and the Mechanics, The Living Years, and she said mom, you've got to hear this song and you've really got to hear it. So she turns it up and the verse came on that said, I wasn't at home that morning; my father passed away; I didn't get to tell him all the things I had to say.

And I knew this was- had a profound effect on her or she wouldn't have brought it up and I really didn't know what to do and- and so I said, Sh- Heather, if you had had five mintues with your dad, what would you have said to him? And she said, well, I would have told him I loved him, I would have asked him to always, always watch over me and I would have thanked him for my erasers.

And with that she started crying and I grabbed her hand and I told her how much I loved her and I told her how proud he would have been of her and that we'd ride all night until we- you know, she was in control again. The feelings inside of me, I could have ripped that car apart.

SUICIDE SURVIVOR: My father committed suicide in January of this year and it was...

NARRATOR: One of the most traumatic ways to lose a loved one is through suicide. The stress the survivors feel is part of a normal mourning process, but often can feel out of control, never-ending.

Over survivor

Cut to 2-shot of survivor

SMOLIN: In all deaths there's some guilt. When somebody dies, you begin to feel guilty about it; I didn't call him last night or I could have sent him a card or I could have been nicer. And that's usually associated with the time of death, a few weeks or days before the person dies.

With suicide, you get to feel guilty about your whole life. People will look back and say when he was a child, I could have this or twenty years ago, I should have done that. And anybody who looks back at the way you've treated somebody, there's something we all could have done differently. Does that make the person commit suicide? I rather doubt it for the most part.

But that's where people get stuck in the guilt. What could I have done differently?

NARRATOR: As Ann Smolin suggests, survivors may wish they could have done something to prevent the suicide. They may also feel angry or they may just feel grief.

Over Smolin
Cut: group survivors

Cut: couple of survivors
Cut: CU man survivor

MAN SURVIVOR: My friend Andy, a few years ago, killed himself and at the time it- it was in a very a traumatic thing to me because he was someone I looked up to. He was a colleague of mine, and very talented, a graphic artist.

And we shared many, many things in common through school and art and during life and suddenly he's gone and it's like a hole, a void in your life.

WOMAN SURVIVOR: I lost my life partner, Paul, who I expected to spend the rest of my life with to suicide just about a year ago, October 11, 1988. And I...

NARRATOR: For every suicide there are as many as 10 survivors -- today perhaps as many as 15 million Americans are left behind to cope with the suicide of those they cared about.

Over woman survivor

Cut: WS group
Cut: woman; pan to Lisa

LISA: I'm Lisa and two years ago in May, my father committed suicide. And it had been about a three year downhill slope for him. He had serious business problems and lost- lost a lot of his money. And he had been a wealthy man for most of his life and...

NARRATOR: Sometimes survivors may shy away from dealing with their grief feelings at all and this can complicate the grieving process.

Over Lisa

Over Bob

BOB: And I guess what I personally did, it was shock to our whole family but what I did was I- I- for the first two or three years, sort of avoided the whole issue, didn't really come to terms I think with mourning as well as my brother's death.

SMOLIN: We know that if somebody doesn't talk about a traumatic experience that it's going to somehow stay inside and fester and become worse...

Over Bob

...And sometimes people just have to talk and talk and talk and talk and I think a very common reaction to a death or any kind of traumatic experience is retelling it and retelling it till the point where nobody wants to listen to you anymore but you seem to need to keep talking about it and it becomes very important to find places to do that.

WOMAN MOURNER: Three years ago in September, I lost my daughter Michelle to suicide...

NARRATOR: Usually survivors do want to talk about the suicide. But because suicide is such a taboo subject, most outsiders just don't want to hear about it.

Over grieving woman survivor

Over Bob

PETER: But there comes a point when family and friends tell you move on with your life, you have other children, you have- you have a job, you know, you know. Just turn the page on that and they don't seem to understand that it's very hard to do that.

NARRATOR: Having no one who will listen to you can increase the stress after suicide because people feel isolated and "different."

Conversely, having others who share your experience and you stress who listen to you and reflect your feelings has proven to be valuable.

This survivor group is run but a suicide hot line -- the Samaritans.

Over Peter

Cut: Group
Cut: black man survivor

Cut: woman survivor

Cut: woman survivor

Cut: Group

SMOLIN: I find that groups are very useful for having people talk about what's bothering them, for feeling that they're not alone, they're not different, that they're not isolated in the kinds of feelings that they're having and people can learn from each other...

Over Group: panning back and forth over various survivors

...One of the things they learn most is that no matter how bad something feels now, it's going to feel better a little bit later down the line, that other people have been there and other people have been able to go on and find something, find a way, to continue their lives, they they don't get stuck, that things do change.

NARRATOR: When people don't get back on track, when they show signs that stress is undermining their ability to function, if this period lasts less than six months, psychologists say they have a clinical condition called an adjustment disorder.

Dissolve to
Photos: man with head in hand

Dissolve to man on mountain

Dissolve to man, phone, and boss hanging over him

But how do we know when someone's reaction is healthy and when it's an adjustment disorder? Is the suicide survivors grief normal or abnormal? Does the widow of the policeman grieve too much and too long?

Dissolve to woman at wall; zoom out

Graphic: suicide survivors

Graphic: Vivian

And what about that man you know who's getting a divorce? Or that woman who lost her job after 12 years?

Graphic: Man at table w/head in hands
Graphic: Woman at wall

SMOLIN: You feel yourself when things aren't getting better for you, when you become incapacitated by stress, when you become dysfunctional, when your life becomes unmanageable, when things are not going the way that you want them to go, when you've given yourself some time and you still feel, I can't back to work, I can't get out of bed in the morning, I can't socialize with friends, nothing has any meaning or any interest to me, my relationships are bland and dull and I don't want to have anything to do with them and one day you say, this has gone on too long, I have to do something about this. Or somebody says it to you.

That okay. It's been X amount of time and you're still not up to speed at work or you're still not any fun to be with at home and people begin to complain about how you're doing. And then we would say that this is abnormal.

TITLE CARD: POST-TRAUMATIC STRESS DISORDER

NARRATOR: There is another clinical condition that is associated with stress. It's called Post Traumatic Stress Disorder.

There are some events which are so enormous, some events that are so life-threatening, that we would expect anyone to react to them with sizable stress.

B-Roll: tornado, emergency units, damage

NATURAL CAUSES VICTIM: I called the insurance man. He said, so sorry but everything's excluded. You have no coverage whatsoever. So here's over $100,000 and we're- we're just about wiped out...

B-Roll: damage

...I don't know what I'll do. I just don't know what I'll do.

NARRATOR: Sometimes reactions to natural or man-made disasters go beyond temporary heightened stress. Some people react with persistent anxiety, long-term nightmares, recurrent memories of the disaster, or, conversely, a numbing loss of any feelings at all.

B-Roll: woman being comforted by man

Graphic: woman being comforted by man
ADD: Anxiety
ADD: Nightmares
ADD: Bad Memories
ADD: Numbness

This is the syndrome of Post Traumatic Stress Disorder.

Dr. Mardi Horowitz is a psychiatrist at the University of California Medical School in San Francisco, and an authority on Post Traumatic Stress Disorder.

HOROWITZ: Post traumatic stress disorder has three important elements. One is that there's been a trauma, an experience that's usually extraordinary for the person and shocking very frequently. Often, terrifying or having a- a death anxiety or big terror event involved.

And the second component is often some kind of intrusive experience, whether it's of a pang of very intense emotion, recurrent visual image, repeating the perceptions.

And the third component is often a kind of numbing or denial or omiting of memories that one would expect after such a serious life event.

NARRATOR: Man-made disasters tend to create more victims of Post Traumatic Stress Disorder than do natural ones. So it was that many veterans of the Viet Nam war showed signs of PTSD after their return from war.

VET #1: You know, almost 16 months of my life was spent in a jungle. I seen a base camp only two months, you know, and that was maybe a week here and a week there. You know, but the rest of it was living with the bugs. Now, bugs bother me.

You know, loud noises. Loud noises like my- my daughter screams and that's it. I'm- I'm back, right back there again. Cause when- when you're into a flashback, you really don't have any feelings except the thoughts that are running through your mind. That's like somebody threw a vidocassette in your head and you know, you have no shut- no off button until your mind says off, but your heart starts pumping, your blood starts running.

You know, it's just like, if you're walking across the street and you don't see a car coming and he slams on your brakes and you get that (swish sound) feeling, you know. That's the kind of feeling you get, and then zip from- from there you're- you're off and running.

VET #2: It always comes back like sounds, smell, taste even. It always, always brings back a little flash. It only lasts about a second to five seconds. Sometimes it lasts longer, when a helicopter goes by I figure myself sitting at the- the gunner turret on a helicopter and letting lose and what my feelings were then is a complete fear, mostly the fear that comes over you.

VET #1: For the smell of urine, you know, because when somebody dies, you know, they- they let go. That's a very- that's one thing that will really set anybody off, you know. And you just start, you know, huffing and puffing and your mind and your blood and your heart starts pumping and your feet start shaking. You just have no control over your body and your mind and everything. You just have no control over it.

VET #3: I went through about 16 jobs; I just felt lost. I- as I say, there was alientation and I tended to isolate. I didn't deal well with relationships. I didn't deal well with people. I didn't get along with my family. I was depressed. I had incredible anxiety attacks. And to this fire, I fueled alcohol.

VET #2: When I left Vietnam, people didn't want to hear about my experiences over there. They didn't want to know about me. They just wanted to close the door on Vietnam and just forget about it. Well, I had a lot of heavy experiences inside my mind and to bury it I drank and I did drugs and to relieve the pain and the anguish and the anxiety, I had it building- building up inside of me that no one wanted to know.

NARRATOR: At the Uniformed Services University of the Health Sciences in Bethesda Maryland, Dr. Andy Baum is studying Post Traumatic Stress Disorder in veterans.

B-Roll: testing

BAUM: We bring various control group subjects into our laboratory and we ask them to watch a film which most people would consider stressful but which we suspect combat veterans may find a little bit more stressful because it's a film of combat surgery.

What we do is measure their blood pressure and their heart rate before they view the film, while they're viewing the film and after they view the film in an effort to see how reactive they are to that kind of stressful relevent stimulus.

Over testing

We ask them questions about how they feel. Whether they are experienceing a lot of symptoms, somatic problems, headaches, backaches, pains, whether they're depressed, whether they feele anxious and certain kinds of situations that seem to make them feel that way.

> ...I think that the thing that we're most interested in and that thing that I most want to- want to understand is how these acute events become such long-term albatrosses for people and- and why it is that- that while most people can deal with these things fairly effectively , why it is that some people have so many difficulties.
>
> I believe that thse long-term stress responses cause changes in our body which are bad for us and therefore I want to find out what we can do to prevent those changes from occurring for so long. Relaxation and other standard ways of stress I can't imagine working for 20 years.
>
> But if we can find some way of getting in and changing the way people think about these events or helping them to understand that if they hold on to these events too long, it's not going to be particulalry adaptive for them maybe we can prevent the whole thing from happening instead of trying to put bandaids on it once it's already there.

NARRATOR: Only some veterans actually develop Post Traumatic Stress Disorder, though many continue to undergo heightened stress.

B-Roll: testing

And the Baum study has revealed that the most important factor in determining whether they feel such stress over the long term is not how much combat they experienced, but whether they have intrusive or uncontrollable thoughts.

BAUM: And one of the things that we think is going on there is this notion that people are thinking about it a lot and reliving the experiences. And what that does is it recreates the experience for them all over again...

...and every time they experience that, they may be experiencing another one of these biological reactions. Everytime I think about that now, I'm going to experience a certain amount of stress...

Over testing

...and I may experience all these biological changes all over again and if I do that for the next ten years, I'm going to find myself in a state of arousal an awful lot and that's not necessarily good for us.

NARRATOR: Veterans are not the only people to suffer Post Traumatic Stress Disorder. Dean Kilpatrick is director of the Crime Victims Research Center in Charleston, South Carolina.

B-Roll: group

Among other matters, he is concerned with the experiencess of rape victims, many of whom suffer from Post Traumatic Stress Disorder.

Over Kilpatrick

KILPATRICK: There have been several studies of rape in the general population of women that indicate that probably at least 13% of all adult women and perhaps as much as 25% of all adult women sometime during their lifetimes have experienced a rape.

Basically a person might have recurrent memories about the bad events. For example, you might have a rape victim who finds herself constantly having memories that she can't get out of her mind like someone who has a tune that- that they keep thinking over and over and they don't want to think about it but it keeps coming back and they can't get rid of it.

Very, very disturbing memories about the assult itself and about its effect on them.

MARTHE: My stomach was literally doing cartwheels. I mean, I could feel my stomach palpitating. Hyperventilating; I could not get my breath. My throat blistered like I had strep throat. The night after I was assulted, going back into work thinking, you know, life is going to go on and this is- this is not going to effect me and I'm stronger and bigger than this.

And I can remember a young lady who had been severely sexually abused by her mother's boyfriend and sitting in isolation with her on the floor listening to her tell me her story and the whole time realizing that I was just totally decompensating.

LOU ANNE: I stayed in the apartment I think about seven or eight months after I was raped and then I couldn't take it anymore. I was scared to be there by myself. And the fear, it was very strange because the incident happened in the morning but the fear came out at night when I went to bed or if I was up doing whatever it was I had to do during the day, and working and that kind of thing, everything was fine.

When I got home from work, then I did all the little activities that you do and everything was cool but as soon as it got dark and it was time to go to bed and it was like panic all over again.

I don't- I- I guess everybody has this feeling that it's a terrible thing for it to happen but you never think it's going to happen to you. And I would go out in the streets and anytime the day or night, I didn't have a car at the time, and I lived in a small inner-city neighborhood and I was real active riding my bicycle and going out and doing whatever I wanted to.

And after I was raped, I didn't feel free to do that anymore. I felt very vulnerable.

MARTHE: It's a self-shattering experience so that you're grappling to find- to pick up the pieces. You know, so you can put it all back together. You feel like a puzzle that's been thrown and strewn and you have to start looking for bits and pieces of yourself and you tend to- you do tend to go underground to a degree so I- I avoided relationships with men. I was very cautious in any relationship with men and I- I think that I became real nervous in certain social situations.

I also tried to be, you know, the good little girl. You know, keep smiling, put up the front, pretend this didn't happen to you and it'll all go away. So I ignored it to the best of my ability but that doesn't mean that it wasn't taking it's toll the whole time.

TITLE CARD: COPING WITH STRESS

NARRATOR: What are the strategies for coping with major stress?

SAWYER: One of the major successes in the COPS program has been we've come out and told law enforcement agencies that the macho image really has to go. For years, the officer has been trained to show no emotion.

What we're telling law enforcement agencies now is those officers involved in traumatic incidents, involved in the incident where they're friend was killed have got to unwind; they've got to be debriefed; they've got to let their emotions show and by god, they've got to be allowed to cry.

Crying is extremely therapeutic.

KILPATRICK: One of the things though that has shown to be very effective in dealing with a variety of- of types of disasters and crimes and any other types of stressful event is social support and by social support, we mean, really several things, one of which is your ability to- to get the types of emotional support that you need from family, friends, neighbors, that kind of thing.

However, we also mean, social support in a real instrumental kind of sense that if you have been in a disaster let's say, and your house has been damaged, what you may need more than mental health counseling is somebody to fix your roof and somebody to cut the tree down off your house and you may need someplace to stay and you may need somebody to look after your kids. So those kinds of things, I mean, meeting your basic needs for food, shelter, whatnot are very important, just as much as meeting your emotional needs.

NARRATOR: One of the things that social support does is to allow people undergoing stress to talk about their problems; and as we've pointed out in this program, there is clear evidence that the right kind of talking helps.

Over Kilpatrick

VIVIAN: What happens is there's almost a compulsive need to talk over and over and over again about the situation. In my own case, I can remember probably drove my family about those- being notified, the trip to the hospital, all those events that surrounded that critical incident and what the trouble- trouble that most survivors have is they find nobody to talk to.

Everybody is telling them don't think about it, just go on with your life and- and pretend it didn't happen. And they need to. It seems like a healing occurs everytime you're allowed to express this.

NARR: But, sometimes, talking isn't helpful.

Over Smolin

SMOLIN: It's when the story becomes simply repetitive, word for word, over and over and over again and hooks into the same emotion and nothing seems to be changing or getting better that you're stuck in a different kind of mechanism which is this obsession and that's when you begin to wonder how come this person is stuck.

NARRATOR: And when people are stuck, psychotherapy is one often useful way of resolving feelings about stressful situations.

Drawing: Two men in therapy

SMOLIN: First you talk to them and you try to find out why this is not such an easy matter for them. What's going on? What has this loss kicked off for them? What has this stress related to in their past life either in their childhood or even more adult experiences. Why is this particular thing giving them such a hard time at this point?

And when you find out, you try to resolve the underlying kinds of issues and help them find ways to go on.

WOMAN SURVIVOR: (In group) You know, I don't do a lot of talking about her at work but if it comes up and if someone asks I say what the cause of death was.

NARRATOR: As Ann Smolin said, earlier in the program, self-help groups, where people share feelings with others who are in a similar situation, are also helpful.

B-Roll: group

JEAN: And it was very difficult and I came here and it was a great help to me. I was able to cry and say want I wanted and listen to others. And feel for the others.

SABINA: It was a complete shock and I thought at that point and weeks following that I would never be the same again. And fortunately I found support groups, this one and one in Brooklyn which has helped me tremendous.

DORIS: The connection is the support group. It's- it's really- the people in the group are the ones I want to talk to about it cause they know what I'm talking about.

SLABY: Nothing helps one as much to understand as to be understook and when you hear somebody else say the words that you have felt or thought or maybe you've felt but haven't put into words yet, tremendously gives you a sense that you are not alone; you are not isolated. There is hope. Someone else has gone through it; they've survived.

NARRATOR: There are some innovative therapies that appear to help when obsessive thinking about stressful events gets in the way. One of these cognitive/behavioral techniques is called Stress Innoculation Therapy. Over Slaby

Over Group

At the Crime Victims Research Center, Dr. Kilpatrick and Dr. Connie Best use Stress Innoculation therapy Therapy to help rape victims. In this scene, they demonstrate it with graduate students.

BEST: What we found in working with crime victims and- and other trauma victims is they really do experience anxiety and fear in each of three channels. It can be in the physical channel, it can be in the cognitive or the- their thought channel. And it can be in the behavioral channel.

KILPATRICK: One thing that's- that's true about that too is that one of the effects of crime is to really make people feel pretty helpless and powerless and so that by giving them... Over group

...an array of coping tools to use then what does is it gives them some control back over their own emotions and their own lives.

MARTHE: I wanted practical steps; I wanted to know where do I begin with addressing these reactions, the effects of this assult. I didn't have a whole lot of choice any more because it was- it effects every aspect of your life.

BEST: To address the- the- the fear and anxiety that they may be feeling physically, we do a couple of very basic techniques that we think that people find useful.

The first one is actually teaching them some deep breathing exercises. I know that some of you have- have worked with patients and have taught deep breathing so I'd like to do a little bit with you and if you have other comments about that or a different way to do that we can talk about that too...

...Breathe in. And exhale. Over group
More, the rest, all of it.

MARTHE: The breathing exercises and relaxation exercises do work and they're very practical and again very empowering because it's saying I- I can get a grip; I can figure this out; I can settle down and I can handle this.

BEST: Another kind of exercise that we teach people to help address the physi-psychiological feelings of anxiety is something Jacobsonian Deep Muscle Relaxation. Are some of your familiar with that? Okay. And basically I'd like everybody to make a tight fist, keep the- keep the tension in it, hold it, you might even feel a slight tremor, hold it, feel tension; that's what tension feels like and quickly relax.

And as you do I want you to be very aware and have your patients be very aware of the different sensation between tension and relaxation.

KILPATRICK: The next thing that we're going to turn to which is probably the- the meat and potatoes really of the stress inoculation is- is what we call guided self-dialogue.

MARTHE: It's very painful to have every wild thought that you never wanted to hear circ- circulating around in your head, especially when you're trying to go to sleep. The mind chatter can drive you crazy. And you have to exchange mind chatter for self-talk.

BEST: First of all when we talk- we would tell people that usually what happens when they think of an event that's coming up in the future, they feel overwhelmed by it. I mean, can you imagine being a crime victim and then thinking about having to go to court...

What we would try to say, well one of the things that's effective in dealing with an incoming stressor...

Over group

...is to break it down into pieces and parts, into component parts and if you can work on each part, that pretty soon, they don't feel as overwhelmed. Can they develop and you may have to work with them to help them develop, some guided self-dialogue to get them through that.

An example would be well, you know, it's going to be pretty scary but I have three or four days. I can sort of get ready for it. I can practice what I'm going to say in court. If I start feeling very, very nervous, I've learned a lot of things in the course of therapy. I know some relaxation techniques.

You know, and- and I can start working now with three days notice to prepare for it.

KILPATRICK: The important thing about this is what we're trying to do is to get them to analyse what they say to themselves before, teach them more positive self statements about each of those preparing for the stressor.

You know, actually being in the midst of the stressor and then the getting overwhelmed.

NARRATOR: The spectrum of stress is broad, and so are the ways we handle it. Though everyone probably needs some outlet for pain and grief, luckily, not everyone is faced with so much stress that they require psychotherapy.

Over Group

In fact, most of us go through life with many stressful periods which we manage to handle, in part because stress can also be a positive event, helping us avoid danger or goading us into fruitful activity, and, in part because we have our own techniques for handling mild, daily, stressful situations.

B-Roll: graduation

B-Roll: basketball game

B-Roll: student center

We complain, we make jokes, we put things in perspective, or we take time off from exposure to stressors.

Over Beyda

BAUM: There are also assets that people have and assets is the best way to say them, friends, people who have lots of friends tend to be a little bit more resistent to these kinds of problems. People who have had experiences that have taught them how to cope effectively tend to do better.

NARRATOR: Even when we're confronted with major painful stress situations, we often find that we can get control over the stress, that we have resources with which to cope.

Over disaster footage

HOROWITZ: In a disaster situation the vast majority of people are actually wonderful about their ability to cope with the event, in the immediate situation especially. People are really super, they're courageous, they help each other, they are resourceful, they come up with adaptive solutions. They rarely panic as long as they're not trapped and as long as they don't have a failure of someone seen as a leader.

The people who adapt the best in the long run are the people who have learned that they're competent, who have an abiding sense of values and who have committments to other people that sustain them in moments of sorrow and grief and rage and feeling along.

KILPATRICK: Actually I guess, kind of- kind of maybe a take home point with me is that one of the things that is important to recover from any type of traumatic event and very stressful event is that it had some meaning and that there's something that I can, you know, do about it. I can't change the past but I can change the future:

SMOLIN: I've observed that there becomes a point for many people when you can make a choice. You can say, okay, there's something else I can do when this thinking starts. It can be as simple as going for a walk, calling a friend, turning on the television set, doing something and- and there's a choice point that says, okay, either I'm going to go back and relive this experience again or I'm going to take active steps to not relive the experience.

And when you reach that time, when you recognize that you're choosing, then you have the opportunity to do something different about it.

VIVIAN: A year and a half down the road was when I went to my second COPS seminar and I could look around and I could see- I could recognize the new ones by the look in their eyes. The survivors who are new have dead eyes, like shark eyes; there's no depth and no life.

And I knew that I still looked like that and I knew I have choices to make and that I could either choose to let the anger and the grief destroy me or I could conquer it and I could strike some blows myself as far as changing attitudes.

So it was a conscious choice for me and I can look back and I can see the girls and I have made it, we weren't happy about it but it feels good to turn a negative experience into a positive action and we'll keep making it.

Stressor noises: all kinds, band, polic, sirens, whistles, horns, etc.