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PERSONALITY DISORDERS AS BROADCAST SCRIPT
December 3, 1990

FADE UP ON LOGOS

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

FADE IN:

TEASE: KELLY: I mean before I would scratch myself; I wouldn't use a real razor. I would just use my nails and I did that when I was about 17. And then when I got to college, I would use a real razor blade. Cassette 2-19 in at 7:19 out 7:29

DEAN (A prisoner serving time for murder) I was across the street, in the Bridgewater State Hospital, the nut house, and this- this was- this is what really stands out in my mind; somebody did something to somebody else, had nothing at all to do with me.

It got me mad, I mean, really, really...and- and I felt it like building up inside of me, and I'm- I'm going to say I was 40 feet away from him, and I just ran, jumped up in the air, and kicked him in the face and smashed his head open on the floor when he hit the floor cause it knocked him over and so his head hit the- hit the ground first and that whole thing was sort of like having sex, you know. It was sort of like gratifying to do that to that guy. Cassette 2-25 in at 5:54 out 6:40.

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|---|---|
| NARRATOR: Kelly and Dean have personality disorders. | B-roll (1) Hold first sentence over end of Dean |
| They represent two examples in a group of 11 disorders that affect about 10% of the population, though not everyone with a personality disorder behaves in such extreme or damaging ways. | (2) Map of U.S.A. with faces<br>(3) Square off the 10% |
| This program will examine four personality disorders: the obsessive-compulsive, the narcissitic, the antisocial and the borderline. | (4) Square in upper left corner with OCD patient's negative image; a. add upper right narcissistic; b. add lower right antisocial; c. add lower left borderline |
| In some cases it may be easy to identify with the people featured in the program. In others, their behavior will seem worlds apart from what's considered normal. | (5) brighten upper photos<br>(6) brighten lower photos |
| DISSOLVE | |
| TITLE CARD - WHAT IS PERSONALITY | |

KNAFO: I think his biggest contribution was really the contribution to character- to character- his understanding of character disorders and his understading of the treatment. Now some people have argued some of what he ...

NARRATOR: Dr. Danielle Knafo is a psychoanalytic psychotherapist in New York City, where she teaches a course in Abnormal Psychology at the New School for Social Research. She describes the essential features of a personality, normal or abnormal.

B-roll Knafo with her students

KNAFO: When we think of somebody's character, we think of deeply ingrained, stable behavior patterns, thoughts, and ways of relating. These are referred to character traits. Relatively st- stable ways of behaving, thinking, and attitudes towards the world.

And these traits- these are the ways that we know people. These are the ways we describe people.

We describe a person through their character traits.

Dissolve to drawing of four people sitting on bench.

We say this person is shy and withdrawn;

Cut to MS of woman; Cut to CU of woman

we say this one is extrovert and assertive.

Cut to MS of second man; Cut to CU of second man

So that we expect this predictability so much that when somebody isn't behaving according to their character, we may say to them, you're not yourself today, or this isn't like you, as though there really is only one way for that person to be. Cassette 2-1 in 2:04 out 3:32. Close-up.

DISSOLVE

TITLE CARD: WHAT ARE
PERSONALITY DISORDERS

GUNDERSON (v.o.) : There's always been a recognition that

Over Title Card

DISSOLVE to Gunderson

personality can be disordered but there are inherent difficulties in defining the difference between what is a ordinary personality, everybody has them, and when a personality can be identified as disordered sufficiently so that it can get into a diagnostic system. Cassette 2-14 in at 1:11 wide shot

CHYRON: John Gunderson, Ph.D., Director -- Psychosocial Program, McLean Hospital

BUDMAN: The issue with all personality disorders is that they are in a continuum with normal behavior. So that it can be very, very difficult sometimes to differentiate, and clearly differentiate, someone with a personality disorder from someone who- who has a slight exaggeration in some aspect of their personality. Cassette 2-5 in at 4:27 out 4:49

Chyron: Simon Budman, Ph.D.

NARRATOR: A "slight exaggeration." We all know what Dr. Budman means. Someone who is a little too stingy; or a little too vain.

Dissolve from Budman to drawing of stingy

Zoom to CU of hand holding dime; Cut to MS of vain drawing

On the other hand, sometimes the differences between a personality exaggeration and a full-blown personality disorder can very easily be seen.

Cut to XCU of mirrored face

Out of focus
Cut to out of focus XCU of guy trimming beard; Focus

Take John, a patient of Dr. Knafo's with an obsessive-compulsive personality disorder. In the morning, he spends a full hour in the bathroom, and doesn't like to be interrupted and he loves to clean. He <u>needs</u> to clean.

Zoom out to WS

Cut to MS

Cut to CU John cleaning chandelier; Zoom out to MS

KNAFO (v.o.): He also labelled his food products according to the dates they were purchased, and arranged them in the cabinets or in the refrigerator accordingly. He alphabetized canned products.

Cut to WS of John labeling food products; Zoom in on food

Cut to CU of can being put in shelf; Zoom out to WS

He was so obsessive and his girl friend was not as neat and as orderly as he was so that before he would leave the house, he would

mark the sheets at the exact place where they were to be turned over so that she knew exactly how to do it. Cassette 2-1 in at 14:30 out at 16:07.

Cut to CU John marking sheets; Zoom out to WS

As a result of this very

Cut to MS Danielle

regimented schedule that John had, he constantly complained that he couldn't enjoy life and that he couldn't relax. It's not- it doesn't come as a surprise for someone who lives this way and yet to him it was surprising. He couldn't connect to the two.

He blamed other people, as many personality disorders do,

he blamed others for their lack of understanding and for their lack of perfection as the cause of his misery and his inability to enjoy.

Cut to MS John at window

Cut to CU John

Cut to XCU John

Because it is consonant with the person's own self image, these character traits are integrated into the way this person sees himself. That he'll just say this is who I am, this is the way I am. Cassette 2-3 in at :30.

DISSOLVE

NARRATOR: John's acceptence of his obsessive traits as "this is the way I am" -- especially in the face of other people's complaints about them -- is typical of people with personality disorders.

WS John trimming beard

Pan down to WS John cleaning chandelier; Pan around to WS John labeling cans

This is quite different from people with symptoms that they very much want to get rid of. The woman with panic attacks, who feels she's going crazy; the man who has a fear of crowds that interfers with his work and social life. These people want to change, and want to get rid of these symptoms.

Cut to WS woman on street looking panicked; Zoom in to CU

Cut to XCU man; Zoom out to WS of man working on bills

People with personality disorders may want to be less uncomfortable, but their habits are not seen by them as the source of their discomfort and that makes it difficult for them to change.

Cut to Square in upper left corner negative image; add others as before

Take for instance the person with the Narcissistic Personality.

Highlight upper right corner

DISSOLVE

TITLE CARD - THE NARCISSISTIC PERSONALITY

NARRATOR: It is often said that we live in a narcissistic culture. We enjoy being number one, beating the competition, standing head and shoulders above the crowd - basking in praise and adoration - secretly feeling superior to others. But behaving in a narcissistic way does not necessarily mean that we have a narcissistic personality disorder.

Cut to montage of books and magazines out of focus; focus; Pan up the montage

Cut to different montage; Pan up the montage

KNAFO (v.o.): There is a healthy narcissism and there is an unhealthy narcissism.

KNAFO: The healthy narcissism has to do with our need to love ourselves, to value ourselves, to regard ourselves as worthy human beings.

That's something that we all need and in - and a mature, normal, adult should have a sense of liking themselves and a feeling that they are important and of value.

Unhealthy narcissism or the narcissistic personality disorder is unable to develop this healthy narcissistic state where he has his own - an internal sense of value.

NARRATOR: As part of a training program for psychotherapists, Dr. Budman, a clinical psychologist at the Harvard Community Health Plan, trains actors to play the roles of people with personality disorders.

Today, he and stage director Robert Deveau are helping actor Melinda Lopez understand the narcissistic personality disorder that she will be playing.

B-roll of Budman, the actor and Bob Deveau meeting and discussing the character.

BUDMAN: For a person with a narcissistic personality disorder, there's a real issue about aging. They're- they're- they're so focused on their own perfectionism that- and- and- and being perfect in a lot of ways, sometimes around appearance, sometimes around intellectual issues, that- that as they get older, it becomes quite frightening for them.

MELINDA: So, is she coming to a therapist to have a therapist tell her it's OK? you're OK? I mean, I still am not sure what it...

DEVEAU: What do you think the response would be if- given what- what I just said and what you know about the character, what do you- what do you- when you sit down with a therapist and he says, how can I help you? Why are you here? What do you think she'd say? What- What would she say initially and what would be the impitice? Where is it coming from?

MELINDA: Well, I think initially she would say, I don't understand the world anymore. I'm very disillusioned. Why can't men behave this way? Cassette 2-7.

NARRATOR: In this scene the narcissistic woman has an argument with her boyfriend played by actor David Kieran. Her behavior may seem overly dramatic, but experts say it is not unusual.

Over the should shot of Melina voice under

MELINDA: If I had been driving the car, I would have had us in our seats but now it's 8:06. I'm not going in there. Forget it. Forget it.

[David: Just calm down now.]

It's ruined. I'll pay for the tickets. I don't care.

[David: It's not ruined. We can still see the show.]

No, no, no, no, I'm sorry. I have been standing out here, people looking at me, a single woman, feeling sorry for me, looking at me. Oh, I wonder if she's been stood up. Has she been stood up by her date?

[David: You're being unreasonable. You're being unreasonable.]

Look at that poor thing, all dressed up with no place to go. All dressed up. Look at her in all her finery waiting for her man that doesn't show up. Do you know how humiliating that is? Do you know how much that hurts me? Why do you do these things to me? Why- it's like you... Cassette 2-8.

KNAFO: So the narcissist is self-involved in that

Still showing Melinda and David arguing

he will get involved with people who will admire him, or love him, or give him this sense of positive self-regard which he lacks.

MELINDA: I won't go through that again. [David: Listen...] Don't ever do this to me again. [David: Calm down.] No, that's it. Forget it. It's over. It's over. I cannot depend on you. You are not a dependable person. I cannot live this way. I need things done a certain way. I nned to know that you will be there for me all the time when I need you. I don't think it's unjust to demand that of someone. I don't think...

NARRATOR: Dr. Knafo describes a patient with a narcissistic personality disorder whom she treated. Randi's sense of herself was completely dependent on how others perceived her.

B-Roll: Melinda and David still arguing.

Dissolve to XCU drawing of Randi; Zoom out to WS of Randi at dinner table with two friends.

KNAFO: Randi was inordinately preoccupied with herself and with how others- how she felt others perceived her. Randi would come into her therapy sessions every- every session for a long time and begin each session in a characteristic way.

She would come in put her head down as she sat, stay there for a moment of silence for a long time, for a long moment, slowly lift her head, look at me and say, showtime.

Cut to WS Randi with head down; Cut to CU hands in lap; Pan up to CU of bowed head

Cut to CU Randi, head up

So it was clear, Randi had a lot of fantasies about being a celebrity and it was clear that she was turning, she was trying to transform the therapy situation into a situation where I would be her audience and she would be the celebrity and she did this in other relationships as well and in other situations, her work situation as well.

She always had to be the star; she always had to be the center of attention.

Cut to back of head of man at dinner with Randi; Pan to Randi

When she felt that I was responding favorably to her, that she was getting good reviews, she felt fine about herself and about me. When she felt - when she perceived that I was responding negatively or indifferently, to her, she would either go into a rage or ...

...she would- she would see herself as a failure, an unworthy being, no good.

Cut to WS Randi with head down

So her sense of self-esteem was very, very shaky, very precarious,

Cut to MS Randi with head down

and was entirely dependent on how she perceived the external world was responding to her. Cassette 2-3 in at 10:02 out 11:54.

DISSOLVE

TITLE CARD: NARCISSISTIC PERSONALITY DISORDER

TITLE CARD: CAUSAL FACTORS

NARRATOR: How did Randi develop a personality disorder - was it simply normal personality development gone awry? The answers are complex and sometimes controversial.

Dissolve to CU Randi, head up

Cut to CU Randi, head down

The first to talk about personality development was Sigmund Freud. He theorized that personality develops through a series of stages early in life.

Graphic: Freud in upper left corner.
ADD: Psychosexual Stages with baby in lower left

KNAFO: For Freud, bodily sensations at different phases of one's early life become focal points for the child and organizers of behavior. He postulated a series of stages that everybody needs to go through and he called this psychosexual stages or psychosexual development.

NARRATOR: For Freud, these stages include oral, anal, phallic, and genital.

Graphics: Freud & baby
ADD: Oral, Anal, Phallic, Genital in lower left

In each there is a potential for difficulty -- the child may not complete his or her development and may become "fixated" or "stuck" at that stage.

Graphics: Arrow going from baby to word Anal

KNAFO: We all go through these stages and we all retain certain characteristics and ways of approaching life and people that are- that are derived from these early stages. Cassette 2-2 in at 1:45.

NARRATOR: In other words, Freud postulated that, later in life, the personality of the individual might be influenced by the earlier fixation.

Dissolve to Graphics: Child with arrow to Anal dissolves to woman with arrow at Anal

Unlike Freud, who believed that we are governed by the inevitability of our biological drives, the Object-Relations theorists claimed that people's behavior is governed by their earliest relationship, that there is an innate potential that needs to be activated by an empathic, caring, nurturing mother.

Dissolve to graphic: Object-Relations in upper left

ADD: Baby in center

ADD: Woman holding baby

KNAFO: And they felt this relationship and the way that this relationship either went well or didn't go well would determine how that person then developed...

... and how their character developed, how their character traits developed, how their ability to relate as adults would develop, that all of this depended on that early relationship with the mother. (2-2:07:25)

B-roll: Family of 5 walking in park

Cut to MS baby drinking bottle; Pan to include mother in shot

The mother mirrors the baby so that if the baby looks into the mother's face and sees pleasure and confirmation and validation then he will develop a sense of being good and worthwhile and want to relate more.

If, on the other hand, the baby looks into the mother's face and sees anger or absence or depression or if the mother's not even looking at the baby or is busy doing something else or gives the baby a bottle and just lets him take care of his own needs, or if there's what Spitz called a derailment of the dialogue between the mother and the infant, then the child will develop a certain lack in his own sense of self and in his later ability to relate to others. (2-2:09:?? - :10:12)

NARRATOR: Heinz Kohut, a major thinker in psychology, concentrated on narcissism, both healthy and unhealthy. He theorized that the self is whole or damaged depending on the nature of the early relationships, and that the damaged person develops a narcissistic personality disorder.

Graphics: Kohut in upper left

ADD: Baby

ADD: Mother holding baby

KNAFO: In the narcissistic personality disorder, it has been found that the self is- is what has been damaged or what is deficient. An arrest in the normal maturation of the self, according to Kohut, is due to the failure of the early nurturing environment between the child and the mother. Cassette 2-3 in at 7:20.

So again, it's very much in line with the previous theorists that this early relationship and the way the mother is emphatic or non-empathic will effect how the child later develops and what and whether he develops adaptively or maladaptively.

B-Roll: Cut to mother holding baby

Cut to mother reading to son

NARRATOR: While the Freudians and the Object Relations theorists believe that the early years are crucial, some psychologists are not so sure.

B-roll: family seen from the back walking in park

KATKIN: I would guess that whereas early psychoanalytic theory would argue that critical events in the first two to five years of life determined everything...

I think contemporary research clearly points to the fact that the development of the healthy personality or the development of the disordered personality as an ongoing process which is affected continuously from birth to adulthood and which is affected by biology as well as by social interactions. And that it is probably not the case that whatever happens in the first two to five years of life is permanent and cannot be undone.

GUNDERSON: Yes, I think that the- after you get beyond those first couple of years where a child's life is largely oriented towards and directed by the relationship with their primary care-givers enter into a larger social network, school and community and those can have major shaping influences either in aggravating problems which might otherwise not have developed into serious problems or by mollifying or ameliorating problems which were within the family by offering alterative models for identification, alternative sources of pride and self-esteem.

And then, by the time you get into your early adolescence, a large part of what you are likely to be is, I think, well established but even then these same factors within peer groups and life experience, whether you have achievements or failures, they too can affect the way your personality develops. Cassette 2-14 in at 19:56 out at 21:43.

DISSOLVE

TITLE CARD: ANTISOCIAL
PERSONALITY DISORDER

NARRATOR: People with narcissistic or obsessive personality disorders can be difficult to live with. But people with antisocial personality disorders can be dangerous.

B-roll: People walking down street, WS

Cut MS, people walking down street

And while some function within society's boundaries, others, such as the prisoners you will see in this television program, are violent people who have committed serious crimes. It is estimated that up to 4% of the population has antisocial personality disorder with men out numbering women 4 to 1.

B-roll: WS, prison footage

Cut B-Roll: Prison door being locked
Cut B-Roll: Prison yard
Cut B-Roll: Prison yard through fence

LINDSTROM: My name's Dean Lindstrom. I'm 37 years old. I'm doing a second degree life sentence with five 18 to 20 concurrent sentences with a 4 to 5 _____ after. The- the crime that I'm in on is a murder. It was - it was drug related and I've been in since - well, I came in originally in 1978 and I escaped in 1979 and I've been back since 1980. Cassette 2.24 in at 3:17 out 3:46.

GILLIGAN: (v.o.) Anti-social personality disorder...

Over Dean's face

...I think the name almost speaks for itself, is- refers to those people whose behavior is against society. And the- certainly the most important characteristic of these people from a social standpoint and a public health standpoint, so to speak, is criminal behavior and specifically criminal violence, well, as well as property crimes. Cassette 2-26 in at 11:22

Chyron: James F. Gilligan, M.D.
Harvard Medical School

LINDSTROM: I ran out of money. I wanted to go get drunk down in- in Cambridge. I lived out in the outskirts - out in a smaller town from the inner city and I ran out of money; it was late at night and- and I wanted to go down and get loaded.

And- and it was sort of along the lines of, you know, I wasn't weighing the consequences of what it was and even if I was weighing the consequences, I really didn't care. It didn't - I wasn't looking that far ahead. I certainly wasn't looking far enough ahead to say, you know, I'm going to spend the next 17 or 18 years of my life in jail. Cassette 2-24 in at 11:45

GILLIGAN: One of the most frequent symptoms, and it, it is also a diagnostic criterion for the disorder, is the abuse of alcohol and/or drugs.

These are among the most frequent characteristics of these individuals and there is also no- no question in my mind, or I think in most people's, that those drugs do, in fact, you might say disinhibit or facilitate the person's ability to engage in behavior that can be very anti-social, very violent toward other people, very dangerous to society. Cassette 2-27 in at 1:32.

LINDSTROM: Specifically, I murdered a guy in his kitchen. I shot his wife in the chest; I hit her in the face with the gun. I beat the husband prior to- to- or and during the course of this whole thing and my thoughts during that whole affair were along the lines of, you know, what the hell do you think you're doing? And when- when it came down to making a decision, the- the gun had been like going back and forth, aimed at my head, aimed at his head, aimed back at me and we were in a struggle.

And the last thought that I recall, really, really like that I can recall that I had was now, you're going to die. And- and that was it. It was sort of like a decision that was made. I was mad. I was, you know, like - it's crazy but you know, like indignant that he'd be fighting with me. Cassette 2-24 in at 14:01.

PROFIT: (v.o.) This is an individual ...

Over Dean's face

...whose basic presentation to others, who's habitual way of responding to situations, is to ignore the rights of others and to act as if there are no rules by which he or she is bound and therefore is not required to pay attention to how his behavior impacts on others.

Chyron: Wesley E. Profit, Ph.D.

And so this is someone who will engage in any sort of behavior that they consider to be appropriate and that will get them what they want...

...irrespectible of the rules or what the laws or how it impacts on other people. Cassette 2-29 in 1:25

B-Roll:Cut to prison guard tower

O'SHEA: My name is Patrick O'Shea. I'm 49 years old.

...In 1980, while engaged in a bank robbery in Massachusetts, I shot and killed a police officer. I'm now serving a natural life sentence for that crime. Cassette 2-25 in at 9:09 and in again at 13:28.

PROFIT: If you're looking at someone who, let's say, starting as a juvenile, has had brushes with the law, has had fights in school, has been truant, has begun to skip school, has engaged in early and frequent drug abuse and then that has caused them to have run-ins with the law, you can predict that if this pattern of behavior continues, then you're dealing with someone whose core personality is that of an anti-social person. Cassette 2-29 in at 3:25.

O'SHEA: I was involved in some gang activities as a juvenile. I was involved in crimes. I wound up being involved in the criminal justice system in Massachusetts and placed in a reform school. Cassette 2-25 in at 9:56.

KIT LUKAS: Did you have a bad temper as a kid, do you remember?

O'SHEA: I was probably, best describe myself, I guess, as anti-authoritarian.

KIT LUKAS: Tell me more about that, what do you mean by that.

O'SHEA: Well, I basically resented people telling me what to do.

LINDSTROM: I was constantly fighting. It seemed like that was the - that was what I wanted to do, constantly fight. It- you know, you know, what I said the proverbial- the- you know, the drop of a hat. Any reason at all was- was motivation to fight. And I'm- I'm sort of inclined to still start off in that direction now. Cassette 2-24 in at 8:09 out 8:42.

NARRATOR: The anti-social personality is also characterized by a lack of ethical or moral development. The ability to feel remorse and guilt seem to be missing.

Over MS Dean

LINDSTROM: I know the difference between right and wrong. I don't think I feel things like you feel. I don't think I ever will. Cassette 2-24 in at 16:54.

GILLIGAN (v.o.): I think Mr. Lindstrom is correctly, I assume... Over Dean

...describing himself. I have no reason to doubt his word when he says that he doesn't have the same kinds of feelings that- that you or I have and probably never will.

But let me put it this way. An inmate said to me a few years ago, you know Doc, I finally figured out what's wrong with me. I'm not mentally retarded but I am emotionally retarded.

And it struck me that actually he was right. He was correct. That what he had failed to develop was the normal range of feelings which include a capacity for love and concern and sympathy for others, a capacity for empathy with other people's suffering, and a capacity for guilt feelings when one realizes one has done, or is about to do, or is tempted to do something that would hurt other people.

All of these feelings are markedly underdeveloped in antisocial personality disorders. Cassette 2-27 in at 8:52 out 9:34.

NARRATOR: Not everyone in prison has an anti-social personality...and not everyone with an anti-social personality lands up in prison. The range of anti-social behavior is wide. If the murderer represents one extreme there are many in the middle.

B-roll: prison, cell doors

B-Roll: Cut to bars closing

B-Roll: Cut to prisoners in cell

B-Roll: Cut to row of cell bars

B-Roll: Cut to guard on terrace

GILLIGAN: Many people have been able to modulate their anti-social behavior to the degree that they keep within the law enough that they don't actually wind up in prison. They may wind up selling people, you know, defective merchandize; they may swindle people but perhaps not in a way that is quite so obvious that they can be imprisoned for it and so on. Cassette 2-8 in at 9:54.

DISSOLVE

TITLE CARD: ANTISOCIAL PERSONALITY DISORDER

TITLE CARD: CAUSAL FACTORS

DISSOLVE

PATRICK: It was an attempted bank robbery. An armored truck delivered a large sum of money to a bank. A police officer and a assistant bank manager escorted the money from one bank across the street to another bank. I intercepted the police officer on the way across the street. I was armed with an automatic rifle, a pair of handcuffs. I told the police officer to freeze; the police officer attempted to draw his weapon. I shot him. Cassette 2-29 in at 3:32 out at 4:07.

NARRATOR: There are no simple explanations for why a person develops an antisocial personality. Patrick describes his early boyhood in almost idyllic terms.

B-Roll: Prisoners coming out of building
B-Roll: Man in cell, bars open
Cut to CU Patrick

PATRICK: I'd like to think I was a real good kid. I belonged to the Cub Scouts, the Boy Scouts. I was raised a Catholic; I was an alter boy in the parish church. I went to parochial schools. I went to public schools. Basically, I would say a very normal childhood. Cassette 2-25 in at 18:31 out at 18:48

I came from a very good home. I had a very good upbringing. And a lot of discipline. I didn't resent my parents for that. I did resent police type figures though. Cassette 2-25 in at 10:45 out at 10:56.

NARRATOR: Later though there were problems. Patrick's adolescence was was anything but average.

Cut to MS Patrick

PATRICK: Back in the 50's, gangs were a- a socially acceptable thing amongst teenagers like they are, again, today, in the 90's. And to be accepted as a teenager, you kind of like had to belong. I wanted to belong. Initially, I started association, you know, with the wrong crowd type thing. And then I went on to, you know, worse type situations on my own. Cassette 2.26 in at 2:11 out at 2:46.

NARRATOR: Why did an altar boy become a juvenile delinquent and later a murderer?

Over CU Patrick

GILLIGAN: I think that to understand anti-social personality disorder...

...and how somebody can emerge from childhood with such a strong need to harm other people and such a diminished capacity to empathize with their suffering enough and- and have a capacity to feel guilty after hurting them that one could do the things he did.

I think one has to understand that these are people who had the experience in childhood and were not able to overcome it of feeling great, feelings of inadequacy, feelings of inferiority, often having been teased by other children, being exposed to feelings of shame and humiliation and that the- the tough guy stance, the tough guy facade which is typical and characteristic in personality disorders, I believe covers over deep-seeded doubts about one's own adequacy as a man. Cassette 2-27 in at 11:31 out 12:36.

PATRICK: When I left the juvenile justice system, in particular, the Institute for Juvenile Guidance here at Bridgewater, I had a big chip on my shoulder, a big chip on my shoulder.

I was determined that I was going to get even with society for the wrongs that had been done or the injustices that I felt had been perpetrated against me while I was in custody in those places and I struck out, in a very violent way. Cassette 2-25 in 12:16 out 12:43.

NARRATOR: Another factor in the development of an antisocial personality disorders may be childhood trauma and broken families.

B-Roll: Unlocking feet shackles
Cut: Unlocking handcuffs
Cut: Admittance room

Dr. Profit tells the story of a patient who was molested as a child by a member of his family and went to the local police for help.

Cut to CU Profit

PROFIT: And the police officer sort of laughed and said, oh and made a joke about the kind of molestation that he was involved in and returned him to the home. He repeatedly ran away and, of course, that became an occasion for the authorities to consider him a stubborn child and to put him into the reform school.

And once he was in the reform school, because we take people away from their families but we don't pay a lot of attention to the situations that we put them in, he was abused in the- the reform school and almost as a response to that, he started using drugs. The drugs to get away from the feelings that he had about the abuse he had undergone.

And so when I said to him, well, what can we do for you, how can we help you to get a better life, part of his response was, you know, where were you when I was getting abused and where was society when the rules were being violated around me and how is it therefore, that you expect me now to say that the rules matter and pay attention to them when no one was paying attention to them when, you know, I was the object of the rule-breaking.

Now, of course, that's a convenient excuse in some ways, and it's no excuse in other way because he's actually responsible for his behavior and he's not going to make a better situation for himself by blaming it on other people and leaving it to other people but it's not unusual to find in antisocial people that they've had experience which suggests that rules didn't work for them and so they've made up rules that give them what they think is a better chance at whatever it is that they want.

And unfortunately these rules are, you know, that these rules disregard responsibilities or rights of other people. Cassette 2-29 in at 5:52 out at 7:26.

GILLIGAN: The moral value system that the antisocial personality has is, in a way, the exact opposite of what we would call morality, in other words, the socially accepted, the Judeo-Christian, you know moral tradition which is also incorporates into our legal code and so forth, to one degree or another.

That's the, you know, the standard moral code. Certainly it's true. The antisocial personalities don't display that: they have not internalized that. They have in a sense

taken that value system and turned it exactly inside out so that what is a positive value for our moral code such as compassion for other people, is - it can be negatively valued. It can be seen as weak by an antisocial personality.

And things we would give a negative value to, such as beating somebody else up, can be seen as a positive value in the antisocial moral value code because then, that's a sign of being strong and manly and so forth. Cassette 2.27 in at 14:35 out at 15:37.

NARRATION: Some antisocial personalities exhibit especially impulsive behavior. Over CU Dean

DEAN: You know, I'm a violent guy. I was a violent guy I should say. And I brought it everywhere with me.

KIT LUKAS: Tell me about that violence. I mean, explain what you mean by being violent.

DEAN: Reactive, impulsive, lashing out, you know, one punch type of things. People do something that would -- that would offend me, do something to bother -- you know, I recall people riding around in Harvard Square on bicycles and, for whatever reason, I dug into them. And it became a thing where, you know, I just catch some poor bugger riding down the street on a bicycle, you know, and taunt him and taunt him and taunt him. And end up, you know, pulling him over with the use of my car, and- and punching him in the face. Cassette 2.24 in at 6:43 out t 7:15.

NARRATOR: With such people, psychologists are researching possible biological factors in their impulsivity. Dr. Rex Cowdry is the Chief Executive Officer of the National Institute of Mental Health Neuropsychiatric Research Hospital.

Cut to name sign of Cowdry on wall; Pan in to Cowdry at table in his office
Cut to CU Cowdry; Zoom back to MS

COWDRY: One of the interesting issues in personality disorders is whether there are traits that are exaggerated or particularly abnormal that contribute to personality disorders. One of the theories is that serotonin, which is a brain metabolite that appears to modulate a variety of drives, such as aggression of competitive behavior, may be abnormal in individuals who are prone to behave- to loss of behavioral control.

Interestingly, this is a finding that seems to cut across a variety of diagnostic groups. It's been found in depression in relation to suicidal acts. We found it in our patients with borderline personality disorder, that is the individuals who had genuine suicide attempts had lower levels of the serotonin metabolite.

It's been found in another study of borderline personality disorder; it's been found in antisocial personality disorder. In short, it seems to be associated with a behavioral abnormality that cuts across personality disorders.

NARRATOR: Dr. Gilligan discusses the possibility of heredity playing a role in the development of the antisocial personality.

Over CU Gilligan

GILLIGAN: With respect to the hereditary component, there is a- a good deal of evidence from family studies, adoptive studies and twin studies that there is at least a- an hereditary predisposition toward some types of antisocial behavior, specifically property crime.

Somewhat surprisingly, there has not been any good evidence yet, to my knowledge, and I do know of some of the best studies which really specifically don't confirm the hypothesis that there's an hereditary predisposition to violent crime. This is somewhat surprising because almost everything in human life is at least influenced by heredity but so far, at least, this has not shown up as a specific causal factor for- for violence. Cassette 2-27 in at 3:33 out at 5:00.

What has been found in one study is that if the father has a history of chronic criminal behavior, with a lot of recidivism, and the mother is an alcoholic or drug addict or has a major personality disorder, and you have that combination of disturbances on the part of both mother and father, then there is a - a threefold increase in the likelihood of violent crime on the part of the child. Cassette 2-27 in at 4:26 out at 5:07.

DISSOLVE

TITLE CARD: BORDERLINE
PERSONALITY DISORDER

LINDA: I've gotten angry enough to where ... Dissolve to CU Linda

...I've actually impulsively hit people, you know, not- not meaning to at all, you know. Or I'd punch a wall or something. You know it was just - I get that - you get that this sudden rush and you've just got to release it somehow. Cassette 2.22 in at 4:12 out at 4:41.

| | |
|---|---|
| NARRATOR: Like Dean Lindstrom, Linda has impulsively hit people, but she does not have an antisocial personality disorder. | Over Linda's face<br><br>Dissolve to Graphic: Linda upper left corner |
| For, unlike Dean, she experiences pain and remorse from her actions, she engages in self-destructive behavior, and other traits of the borderline personality disorder. | ADD: Words Pain, Remorse<br><br>ADD: Word Self-Destructive<br><br>Replace words with: Borderline Personality Disorder<br>Lose Personality Disorder |
| The term, borderline, is an early one, reflecting psychologists' belief that such people fluctuated between neurosis and psychosis. | |
| Today, it's a distinct disorder with its own constellation of character features. | Dissolve to USA map with faces |
| Up to 4% of the population has borderline personality disorder with women out numbering men 3 to 1. | Box highlighted with 4% of the population |

KNAFO: Common character traits in the borderline personality are extreme instability and unpredictability in behavior, a fear of being alone, manipulativeness in relationships, impulsiveness which we can see in promiscuous- promiscuous behavior or alcohol and drug abuse, and self-destructive, often self-mutilating behaviors. Borderlines have a defective sense of identity, and are ridden with angry feelings. Cassette 2-4 in 14:08 out 14:35.

NARRATOR: Linda and Kelly are in therapy with three other women who have also been diagnosed as having borderline personalities. They have all been in some kind of therapy for a minimum of 5 years and have made enormous progress. Inspite of the dramatic improvements they've made in their lives - their pain is still very much evident.

B-roll: Borderline group; pan around to show everyone

COREY: It just feels so bad and it just feels so painful, that- but you don't really know what you're feeling because everything's all jumbled up, you know, there's like a little ping pong game going on in your head with all these emotions going around. Cassette 2-19 in 9:28 out 10:15.

NARRATOR: This group was started almost four years ago at the Capital District Psychiatric Center in Albany.

B-roll: Zoom out from peach to include chain

Dr. Marilyn Gewacke was the director of the borderline outpatient program then. She is currently a psychologist in private practice. She talks about the first time she encountered borderlines.

Cut to MS Gewacke on phone; Zoom to CU

Cut to MS Gewacke

GEWACKE: And they acted out like no other group we ever saw. They caused more turmoil on the unit than any other patient group. Lot's of self-abusive behavior.

For instance. I've seen patients swallow tacks from our bulletin boards, break mirrors in the bathroom in order to cut themselves, throw furniture through our windows, and they found rather ingenious ways of sneaking alcohol and drugs on the unit.

So we had our hands full. And although their behavior was extreme, it didn't fit the category of schizophrenias- schizophrenia. And they, although their affects and moods at times suggested depression, that they vacillated so much that they didn't fit a major depressive disorder.

LINDA: And sometimes it's gotten to the point where I get so angry, I don't realize what I have done until after I have done it. You know. I have got this tremendous fear of getting angry now because I'm always afraid- I'm sorry- because I'm always afraid that I'm actually going to hurt somebody, whether I mean to or whether I don't and it just really scares me to get angry at times. Cassette 2.22 in at 3:20 out at 4:12.

COWDRY: Individuals with this disorder are very prone to a state that we call dysphoria and it's very hard to describe. It's, in some sense, an overwhelming sense of feeling bad and it may include elements of depression, of rage, of anxiety, but mostly it's just a state of terrible distress.

One of the intriguing things about the disorder is that this state of distress is usually triggered by specific kinds of events, a- a real or perhaps even an imagined loss, or a rejection. What then happens is equally intriguing and disturbing because these dysphoric states are so upsetting that the individual has to do something to stop them. And they take a number of different avenues to try to end this dysphoric state.

Sometimes they can find a person and the person can somehow comfort them and modulate and end this state. Another approach that's used is either taking an overdose or self-injury, wrist cutting or cigarette burns or other forms of self-injury. Cassette 2-11 in at 15:35 out at 16:56.

KELLY: I was feeling scared; I was feeling lonely. I was feeling a lot of things that I just needed a release from. I was feeling a lot of pain but I was also feeling very unreal at the same time, like I just couldn't touch reality. And that was my one way of touching reality was to cut myself and to see the blood and that always made me feel better. And to see the scars. Cassette 2-19 in at 8:02 out 8:27.

LINDA: A lot of times, it's the fact that I can be so angry, to where I just want to hurt someone else and I don't do it - to where I cut myself or [interruption] that's basically usually what I do, you know, is I cut myself. It's a way of releasing it for that moment. Cassette 2-22 in 6:00 out 6:20.

GEWACKE: They do something we call splitting, the splitting defense. They see the world in black and white. Everything is either all good or all bad. They do that to themselves. I'm either all good or I'm all bad. Most of the time it's them, they're all bad. Cassette 2-17 in at 4:39.

GEORGETTE: There's no room for any good. If there is anything to remember good, there's no room for that because you get so overwhelmed with feeling so bad, nothing helps. And I don't think I could remember anything good cause I don't.

The only good I can remember actually is my children, raising them, you know. But I can't focus. If I'm to that point, I can't focus on what's good and what's bad. I just can't do it. Cassette 2-20 in at 18:00 out at 18:44

KNAFO: This contradiction in their own self images and in the images of others is what contributes to the borderline's difficulty in establishing a consistent sense of self.

This is why they're so unstable and why their behavior is- it changes so frequently because they're constantly shifting between images of feeling great to images of feeling terrible, images of seeing you as someone they love or images of seeing you as someone who's horrible and they can't stand. Cassette 2-3 in at 17:26 out at 18:08.

GEWACKE: They have relationship problems, a lot of chaotic, intense relationships, a lot of rage, typically the rage is connected to a lot of childhood trauma. For instance, incest, physical abuse and so on. Cassette 2-16 in at 6:27 out 6:40.

DISSOLVE

TITLE CARD: BORDERLINE PERSONALITY DISORDER

TITLE CARD: CAUSAL FACTORS

NARRATOR: In fact, Dr. Gewacke says that a majority of the females in her borderline program reported a history of incest, and this may play a role in their condition.

B-Roll: XCU pan of group members

COREY: It's something nobody should have to go through. It's being so small and not being able to defend yourself against grownups that are wanting either to hurt you or molest you or do whatever they want to do. And of course when you're a child nobody listens. Cassette 2-22 in at 13:16.

LINDA: I agree with Corey, it's hard to deal with especially when you try to tell people and nobody believes you. And that just makes you wonder if it's not you. You know, if it's your fault or have you done- something, it's your fault. You've done something to bring it on.

And then you wonder, like I have two sisters, and you wonder why you. Not that I wished it on them or anything and not them, you know. I don't know what- does this sound bad? I'm not trying to say I wish it on them but you know, it really makes you wonder what you did to deserve some of the things that happened to you. Cassette 2-22 in at 15:25 out 16:42.

KELLY: Yeah, I was afraid to acknowledge it myself. I still am. I mean to this day I'll say, no, that didn't happen to me; it couldn't have. Why would anyone want to do that to me? But when I do acknowledge it, I now say, oh no that did happen to me; what did I do wrong? I can't understand it? (close-up) Cassette 2-23 in 2:00 out 2:24.

COWDRY: Recent research suggests that...

... probably 70% of individuals, at least inpatient individuals, with borderline personality disorder ...

...have had severe physical or sexual abuse early on. That figure may be high but it suggests that there is a role of trauma in the development of this disorder in some individuals. Cassette 2-12 in at 13:37 out 14:05.

Cut to XCU Corey

Cut to XCU Kelly
Pan to CU Georgette

Cut to Chris

On the other hand, not everybody who experiences this trauma develops a borderline personality disorder. So you have to go back and ask the question why are some individuals particularly vulnerable to develop this disorder when subjected to trauma, whereas other individuals make, how shall I say, a better adjustment to a terrible situation. Cassette 2-12 in at 14:41 out at 16:08.

NARRATOR: Dr. Cowdry and his colleagues at NIMH have been able to recreate the dysphoria that borderlines experience by administering a drug.

Over Cowdry's face
Cut to MS Cowdry working at desk

COWDRY: In our case we tried to use Procaine which seems to activate areas of the limbic system, and found that borderline personality disorder patients were particularly prone to experience dysphoria when they're given Procaine.

There are a number of biological hypotheses that one could formulate. One of them, for example, that the limbic system, which is a relatively primitive part of the brain, that is involved with drive states particularly, including aggression, is different in these individuals. Cassette 2-12 in at 5:23.

GEWACKE: It may be that borderline patients are born with a constitutional factor, with a biological factor, with a genetic predisposition to becoming a borderline and you put them in a certain environment, in a certain family and the whole picture blooms in to what later becomes a borderline patient. I think it's got to be an interaction.

DISSOLVE

TITLE CARD: PERSONALITY DISORDERS

TITLE CARD: TREATMENT

NARRATOR: Most people with personality disorders don't experience their character traits as distressful; they often don't seek help. When they do, treatment can be challenging, but it's not impossible.

Dissolve to CU Asian man drawing

Zoom out to include therapist

GILLIGAN: There is a myth that anti-social personalities are not interested in treatment. Actually, I would say that that is true in the community; by in large, these people often won't voluntarily come to treatment.

But if you see a population of anti-social people in a prison setting, and you're there as part of a mental health team, what you quickly discover is that there is an overwhelming desire on the part of people who have engaged in serious anti-social behavior to have somebody that they can trust, somebody who will treat them with respect, who will talk to them and help- and try to understand them and try to help them understand themselves and help them get their lives back in order. Cassette 2.28 in at 4:02 out at 4:46.

PATRICK: I suffered a period of four years in solitary confinement and a transfer to one of the harshest prisons in the United States, the Federal Prison at Marion, Illinois. And it gave me a lot of time to think about things. Cassette 2-26 in at 6:53.

PROFIT: They come to the therapy no different than they come to any other situation in their life and the first thing that they're looking for is to figure out what the therapist wants and to figure out what they want out of that situaiton. And unfortunately, many therapists are naive to that idea.

For instance, if you're going to do therapy with someone who's anti-social, you have to start out by creating a safe place, by creating a place for itself and by saying, listen, I will treat you. That is we'll have a place where we can talk about change and so on and so forth and the dysfuctional aspects of being you.

However, therapy also has to be for itself. And frequently, what contaminates the therapy and eliminates the possiblity of- of- of helping these folks is that the therapy's not for itself.

You say to someone, why are you here? Why do you want to change? Well, the parole board said, if I don't get some treatment, I can't get paroled. That's the end of therapy.

GILLIGAN: There have been amazingly few psychiatrists or psychologists who have been willing to work with this population -- well, maybe it's not amazing. You know, it's- these are potentially dangerous people but I- I do think that anti-social personality disorder and crime and violence in general, are such overwhelmingly important social problems that it is a tragedy that in this country and in most countries, we have devoted so little attention to learning what kinds of treatment approaches can work. Cassette 2-28 in at 00:57 out 1:24 in at 1:43 out at 2:16.

| | |
|---|---|
| NARRATOR: A great deal has to be learned about the treatment of the antisocial personality, but the outlook for other personality disorders appears to be more hopeful. | B-Roll: Cut to prison, metal door being slammed and locked<br>Cut to man behind grid; Zoom in |
| Dr. Knafo talks about the progress that has been made by her obsessive compulsive patient John. | Cut to CU Knafo |

KNAFO: Last week, John came into a session, and in the middle of the session suddenly looked up at me and said, you know, I am a difficult person.

Now this seemingly simple statement, was a long time coming, and reflected years of work that led up to it.

He recalled that as he would enter my office during the summer months, he would automatically turn up the air conditioning...

Cut to MS John drawing; pan down to John's hand and air conditioning

...never bothering to ask me, never bothering to consider whether I was comfortable the way things were.

Suddenly he realized that he had been inconsiderate, that was his personality, that he really didn't take others' feelings into consideration, that he would really have to work to think about these things in order to change his behavior.

Revealing his new-found understanding, he claimed, "My time is consumed by little...

... obsessivities. I don't enjoy my free time. I can't allow myself to let go. Cassette 2-4 in at 10:30.

Cut to MS John trimming beard; Pan around to dusting chandelier and to him labeling the canned food

I've been this way for a long time, this has become a pattern and this is going to be difficult to change. Cassette 2.4 in at 11:38:06.

...Now the way around that is to create a very supportive, well structured environment for the patient. One in which he is encouraged to gradually develop a sense of trust in the therapist and in the therapeutic situation in general.

Tactfully and considerately the therapist brings consistent attention to the incongruities and the inconsistencies in the patient's behavior.

The maladaptive character trait is lifted, as it were, out of the level of personality. so that the person can look at it as an isolated behavior rather than as something that all of him is invested in. Okay, he can look at it objectively and experience it as painful, ego-dystonic, foreign, a symptom, to be gotten rid of. Cassette 2-4 in at 6:36.

NARRATOR: Some therapists think that group therapy can be extremely effective in the treatment of some personality disorders. Over MS Budman

BUDMAN: Groups are the treatment of choice and the reason that groups are the treatment of choice I think, is because personality disorders most often manifest themselves in terms of interpersonal behavior, in terms of how people interact with- with one another and interact with other people.

I think what you have in a group therapy situation is the opportunity for the personality disorder patient to display the- the problematic behavior right within the group. You have a- a *in vivo* situation where the patient can, pretty much, produce that behavior right there in front of you in front of- of the other patients in the group.

And everybody can see what's going on and they also have an opportunity in that group therapy situation to- to try out new behaviors. I think that- that in an individual psychotherapy, in a one-to-one psychotherapy with the personality disorder patient, you have much more restricted opportunity for testing new behaviors; you have much more restricted opportunity for seeing the personality disordered behavior right there in front of you. Cassette 2-5 in at 18:03 out at 19:23.

If you have two narcissistic men in the same group, for example, one narcissistic man seeing another narcissistic man in the group may be able to say, my God, that guy is so self-centered;

Cut to WS group therapy

Cut to 3-shot of group; pan around group

...he never thinks about anybody but himself. And the other members may say to that- that person, that's exactly what you do.

NARRATOR: For many therapists, it's not a question of either individual or group work - both can be used together.

Over CU Gewacke

GEWACKE: One patient of mine summed it up so well, I think, when she said, in individual therapy, I learned to understand myself, but in group, I have to practice that understanding over and over again. And everything happens in group 100 times quicker because I'm doing so many things at once. Cassette 2-16 in at 13:25 out at 13:45.

NARRATOR: Along with learning how to interact with other human beings in a healthy way, groups provide emotional support and can alleviate feelings of being alone.

B-roll: 3-shot borderlines; zoom up to Kelly and Linda

COREY: Knowing that there's somebody there who understands is- it's essential for feeling better because that's, I think, what a lot of us were missing a lot of times, is because we were feeling so lonely that nobody would understand, nobody would listen, nobody would believe us. Cassette 2-23 in at 4:46 out at 5:31.

GUNDERSON: Because borderline patients often have substance abuse problems, they need to have that treated concurrently. Being involved with AA or NA proves a social support system which can be very helpful.

Borderline patients often times can profit from medications which will diminish some of the more acute distress which they feel and help them with crises. Cassette 2-14 in at 15:21 out at 16:12.

COWDRY: In a sense, the goal with medication therapy is to try to lessen the symptoms, or the degrees of distress, or the degree of chaos to- enough so that psychotherapy is possible; enough so that gradually, over time, some of these controls can be internalized through psychotherapy. So medication becomes a useful adjunct in a sense in many cases to make psychotherapy more possible or more productive. Cassette 2-13 in at 4:48 out at 5:21.

GEWACKE: I think there's a lot of work still to be done. I think mainly that's on our shoulders as mental health care-givers. We have to be open to new perspectives. I think we have to be willing to learn from our mistakes and also not be so afraid to talk about our successes and most importantly, we have to continue to listen to the people who have these disorders. It's through their stories that we'll begin to unravel this puzzle. Cassette 2-18 in at 4:00 out at 4:34.

GEORGETTE: Who am I/What is to be/Finding my identity/Yes, longing for acceptance, understanding/I want to know what love is/without experiencing horrible pain/Trusting that I hope will not hurt/a touch will not be pain/crying will not burn.

Oh, this little girl trapped in a big body/is troubled and very scared/Do I dare reveal myself/or should I stay hidden in this prison/which protects me like a knight in armor. Cassette 2-23 in at 18:20 out at 19:46.

#6

SUBSTANCE ABUSE DISORDERS
AS BROADCAST SCRIPT
May 22, 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<br>1. boy looking into camera on stomach<br>2. children in schoolroom<br>3. girl at blackboard<br>4. boy alone with group off to side - zoom in on him<br>5. two people walking under catwalk<br>6. band<br>7. older black couple hugging<br>8. man and woman at table with chins in hands<br>9. man sitting on bed with face in hand<br>10. woman in mourning with hankie over eyes |
| MAIN TITLE | The World of ABNORMAL PSYCHOLOGY (over montage of photos) |
| SERIES TITLE | SUBSTANCE ABUSE DISORDERS |

TEASE:

GREG (11-5) There was always the pot and the drinking. They were- they were interchangable. The amphetamines and the pot and the drinking were interchangable. The hallucinogenics, which I really didn't do that many of. I did, I don't know, 20, I must have done it maybe 20 times in my life, which is sufficient.

| | |
|---|---|
| NARRATOR: Abuse of drugs and alcohol in our society is rampant. The numbers are staggering. | Map |
| Over 10 million American adults show symptoms of alcoholism with another 7 million abusing alcohol in some way. | ADD: 10 Million<br>CHANGE: 7 Million |
| About five million people are using cocaine on a regular, if not compulsive basis. | |
| Despite major ad campaigns against cigarettes, current use among the young is still almost twelve percent. | CHANGE: 12 Percent |
| While these numbers may fluctuate, the negative consequences of abuse of drugs and alcohol remain serious and devastating: | B-Roll: Guy chugging beer<br>B-Roll: Ambulance |
| Over half of all fatal car accidents, homicides, and suicides occur under the influence of alcohol. | B-Roll: Crashed car w/body under sheet and gurneys w/bodies |
| Alcohol, cocaine and crack cocaine, are responsible for violent crime, and severe medical problems, sometimes leading to death. | B-Roll: Cocaine in foil<br>B-Roll: Smoking crack |
| Babies are born with Fetal Alcohol Syndrome or already addicted to cocaine. | B-Roll: Baby ward<br>B-Roll: CU Crack baby |

Finally, the adverse health effects related to smoking cigarettes are responsible for the deaths of about 350 thousand people every year.

B-Roll: Man smoking

B-Roll: Cigarette and ashtray

In the next hour, we'll learn more about substance abuse, what it feels like, what causes it, and what can be done to treat it.

Morse and group

MORSE: Just how chronic the stages are.

TITLE: USE AND ABUSE

WILLIAM GEORGE (11-18) The reality is that the use of psychoactive substances has been around since prehistoric times. People have used drugs to modify their sensations, their thoughts, their feelings and their behavior. Thus, it follows that there will always be some who ride that line between merely using psychoactive substance into abusing psychoactive substances.

NARRATOR: In this program, we'll be focusing on three of the most commonly abused psychoactive substances: alcohol, cocaine and nicotine.

GRAPHICS: Drawings of alcohol, cocaine, cigarettes

ADD: Alcohol, Cocaine, Nicotine

First, some definitions. <u>Abuse</u> involves the chronic use of a substance which results in potentially hazardous behavior, like driving while intoxicated.

ADD: Abuse

In common usage, the terms <u>dependence</u> and <u>addiction</u> are often used interchangeably and refer to a group of symptoms that may include:

ADD: Dependence, Addiction

O'BRIEN: (11-7) Focusing one's attention on getting the drug, on using the drug despite bad consequences, of having the drug interfere with normal activity, of trying to reduce the use of the drug and being unable to do so, of being unable to control the amount of the drug that the person uses.

NARRATOR: This behavioral package may also include a different type of dependence that is characterized by its physical properties. — Over O'Brien

O'BRIEN: Physical dependence is the state that exists when a person takes a drug and the body becomes adapted to the presence of the drug; when the drug is stopped the body goes into withdrawal syndrome; the body has become tolerant to the drug which means that it doesn't get a major effect from the drug any more; it's- it's adapted to it and the withdrawal syndrome when the drug is stopped consists of all of those effects of the drug in reverse.

NARRATOR: In deciding just <u>when</u> a person crosses the line from use to abuse, Dr. Dale Walker suggests it's important to look at the whole picture. — Over O'Brien / Over Walker

DALE WALKER (11-24) When we talk about symptoms for defining and diagnosing, we then have to look at social and occupational functioning, the- the- the environment in which the individual is drinking. The only way, by the way, that we can understand those terms is how that society around that individual defines drinking. Is it okay?

There are certain groups that one drink is a problem. There are other groups that have much looser definitions in out-of-control drinking's processes.

NARRATOR: Ultimately though, out of control use of substances is seen most poignantly through <u>individuals:</u> relationships ruined, health in jeopardy, dreams put on hold.

B-Roll: Scott and family

The details of the stories you'll hear may differ, but the consequences of addiction to drugs and alcohol are remarkably similar.

B-Roll: Greg on street

TITLE: COCAINE: THE EXPERIENCE

11-5 14:08

GREG: It was a 3-year addiction on cocaine. Three, three and a half years. Gosh, it was horrible. What a thing to put somebody through. She, I really created a lot of friction. And it was a lot of waste of time too because there was so many things we could have done together that we didn't do because all my money went to the drugs and all my time went to- went to using drugs.

11-3 2:55

DAVID: I look back on it and I couldn't believe the things that, I mean actually, the way I slept, the way I hung out all night in the streets and it's cold outside and I don't have nothing but a little sweater on.

11-5 11:30

GREG: The cocaine was what just got out of hand. That, there's- it's amazing. It's amazing stuff. It's amazingly uncontrollable, just whew. It just sends you head over heels into everything, everything that I had is gone.

11-4 3:24

PATRICIA: I smoked about 8 caps, they are five dollars a piece, I don't know exactly how much come in it. But I got very sick, I got nervous, I started shaking. You know, and I felt scared. And I felt like I needed help.

W.GEORGE: Initially, early on, they say just 10 or 15 years ago, cocaine was thought of as the drug of the elite. It was a glamour drug, it was a very expensive drug, it was very much used in, among celebrities, athletes and the upper-middle class.

NARRATOR: While the sort of cocaine use Dr. George is describing has actually decreased, during the 1980's, the use of crack has skyrocketed. It's cheaper, more available and provides a high that too many find irresistible.

FOOTAGE: cocaine lines snorter, smoked

Bowl of pipe

PATRICIA: (11-4) The high is very good. It's- it's- it's more different from anything I ever had. It doesn't make me feel a hangover. You know, I can smoke it and feel, you know, like in control. You know no more than like I say coming in nervousness. But the high is mellow, it's a rush, it only stays there, it used to stay 15 minutes, now it only stay about 5.

NARRATOR: Anna Rose Childress is an addiction specialist at the University of Pennsylvania.

Over Childress

ANNA ROSE CHILDRESS: (11-10) One of the ways of thinking about why cocaine is so addictive is to understand that basically it activates the same areas in the brain that all our normal pleasures and rewards do, food, sex, water, the things that keep our species going. They basically stimulate certain brain areas that we call rewards centers or pleasure areas in the brain.

Cocaine activates those same centers but does it very directly, very powerfully.

NARRATOR: Cocaine can enter the bloodstream by different routes: It can be snorted, injected intravenously or smoked.

FOOTAGE: Making lines of cocaine on mirror

Snorting with straw
Smoking cocaine

The most intense high comes from inhaling the cocaine vapor, either by freebasing--heating cocaine with flammable solvents like ether-- or using crack, pre-packaged rocklike chunks of cocaine free base.

Man snorting on street

Heating bowls

Bag of crack, bag of vial, CU vial

While cocaine that is snorted reaches the brain in 3 to 4 minutes, smoking cocaine provides the fastest and most intense high--It only takes 8 seconds for the drug to be absorbed into the brain from the lungs. The result?

Man smoking coke on street

CU: Bowl with smoke

A euphoric state so intense that patients often describe it in sexual terms.

CHILDRESS: One of the things that happens that helps cocaine cause its pleasurable effects seems to be happening through the dopamine system in the brain.

NARRATOR: All communication in the brain takes place between nerve cells. Between any two nerve cells is a little synaptic cleft, a place where the chemical message goes across from one cell to the other.

GRAPHICS: Neurotransmitters

Pull out Neuron

ADD: Synapse

Dopamine is one of the neurotransmitters involved in communicating this message from one side of the synapse to the other. One result of this communication may be a feeling of pleasure.

ADD: Dopamine

Dopamine going down into synapse

CHILDRESS: Normally, when we have a normal pleasure or arousal, dopamine would be...

...released and then part of it would be recycled back up to be ready for the next time that it's needed...

GRAPHIC: dopamine going down, coming up

...for the next time that the impulse comes down the neuron.

Cocaine has an interesting function. It prevents recycling, if you will. It basically prevents reuptake of dopamine back into this first nerve cell. That means that more of it stays in this little space between the two nerve cells producing an intensified, prolonged pleasure message, if you will.

NARRATOR: A message so strong, that it can overshadow even our most basic needs.

FOOTAGE: Man smoking coke

CHILDRESS: (11-12) And from animal data, we know that can happen in fact, that animals will use cocaine until they die and for many of our human patients, unfortunately, the same pattern is evident...

B-Roll: Over mouse at water

...it begins to take over their whole life, very very quickly.

NARRATOR: And for Patricia, that didn't take long.

Over Patricia

PATRICIA: I felt good, until the later months, you know like after a year and a half it became, started becoming where I'd spend my money for nothing. You know, just sort of like to be depressed. You know, because I knew I would be depressed coming down off of it. So basically I was- it was nice in the beginning, but it became depressing.

DAVID: You wake up in the morning; it's a normal day. But you find out you ain't go nothing to do, you sit around and you say well, figure out how to get some drugs. And once you- once you get that initial hit of, of first contact of drugs and then you go into that panic feeling where, where am I going to get the next one from or how am I going to get the next one.

PATRICIA: My son, he- he suffered; he suffered. You know there's a lot of things that he should've had that he did not have. And I couldn't perform really as a parent. But I would not admit that to myself. You know, I would not admit I was addicted either. You know, I thought that I did it 'cause I wanted to smoke today. You know, I realized later that I was addicted.

NARRATOR: Besidess the emotional damage, the physical dangers are clear. Over Patricia

CHILDRESS: (11-10) Well, physical consequences can range from if- if the person is smoking the cocaine, you know, from associated lung or membrane problems to, of course, if they're taking toxic levels of the drug, to having, you know, heart arythmias, seizures, the difficulties that you hear about in the news or with the professional sports players.

NARRATOR: One of the most highly publicized examples in recent years is that of college basketball great Len Bias.

B-Roll: Bias footage at game

JENNINGS: The Maryland Medical Examiner has now issued his report on the of the college basketball star, Len Bias. It confirms the worst suspicions; he died of heart failure because he used cocaine.

SMIALEK (Maryland Chief Medical Examiner): Leonard Bias died of cocaine intoxication.

NARRATOR: Medical examiners found no evidence that Bias had used cocaine before this incident.

FOOTAGE: Bias' press conference

They said that he inhaled a regular size but virtually pure dose of cocaine powder which within seconds was absorbed into the blood.

FOOTAGE: Bias interview

It quickly interrupted the electrical activity in his brain producing an irregular heartbeat and within minutes, death.

B-Roll: Gurney w/dead person

Even when the effects aren't so tragic, there's no mistaking the cumulative damage that cocaine use can bring on.

PATRICIA: (11-4) I started bringing up black stuff up out of my, you know, my throat, and I was aching all the time. And my heart skipped a beat, you know, and it started messing with me physically and it scared me.

GREG: (11-5) I became so thin that I used to be very, very strong. Not big, but very, very strong. I lost everything; I lost all of my weight; I lost all of my muscle.

TITLE: ALCOHOL: THE EXPERIENCE

SCOTT: (11-26) I would generally black out. So at some point I would forget a segment of the time that I had been interacting with other people or driving or doing something physical other than being passed out.

MARGARET: (11-14) It got to where instead of me drinking one time a week, I was drinking four days a week. So a quart to a fifth a day wouldn't have been any problem at all.

WALKER: (11-24) When your job, legal, social, environmental context has been changed in a negative way and drinking is related to that, then we know that there's a problem there. Does the individual know? Sometimes they don't. Sometimes they refuse to see the obvious that other people can see.

MARGARET: (11-14) My job, you could see the difference in his change of attitude with his job, with our family and friends, kinda like, we shut everybody off. It was,
I'd go to work and do what I have to and come home and fall into the bottle and that was a pattern we'd both more so get into.

NARRATOR: Often the alcohol problem has a significant effect on the family members or spouse as well.

B-Roll: Scott and family

AISHA: I kept putting this expectation on him that if he really wanted to not really destroy our relationship...

...and to not hurt his body then he could do it. And when he was sober we'd talk about it and he'd go, "Yeah, I know it's- it's a problem and I know it's not good for me and I know I lose control, and I know I don't have to do it," but then as soon as he would start drinking, it was as if he left and someone else came in instead, and there was no talking to him at all.

MARGARET: (11-14) I start to notice that my husband wasn't coming home, you know, and this of course with us drinking again. And I finally- I, you know, said to him you know, I want to know, 'Why aren't you coming home?' And this again he says, you know, "It just doesn't pay two alcoholics to be together."

| | |
|---|---|
| NARRATOR: In addition to the personal consequences of drinking, alcohol affects society as well. | Over Margaret |
| Crime statistics, research data, and patients themselves tell us that there is a strong relationship between alcohol and violence. | PHOTOS: Man being handcuffed; Police and man with woman in b-ground; Man hitting woman |
| Although the connection seems simple, experts aren't so sure just <u>why</u> these two go hand in hand. | Woman holding child; zoom in |

W.GEORGE: (11-20) What is it about alcohol ingestion that causes the increase in violence? Is it a pharmacological property of the alcohol as some have argued that's a behavioral or physiological disinhibition? Or is it a psychological disinhibition created by the expectation that alcohol allows freedom and permission to engage in behaviors that one might not otherwise engage in.

GREG: (11-6) There was never one occasion where I wasn't drinking previous to me getting in trouble. No matter what, how much the trouble was, whether it was just a ticket or whether it was being put in jail for the evening or whether it was something big.

TITLE: SUBSTANCE ABUSE:
RISK FACTORS

TITLE: MULTIPLE DETERMINANTS

W.GEORGE: (11-18) Now this is a departure from the past when it was thought that you could explain alcoholism within a single discipline or within a single level of analysis.

For example, the view that all of alcoholism could be explained through biology or could be explained though personality notions. That has since changed. Now, in trying to create an explanation, we recognize that there are multiple...

...determinants that come from different fields.

GRAPHIC: Circles

NARRATOR: Substance abuse then is a complex phenomenon, involving biological, psychological and environmental factors.

For example, biological factors such as genetics;

Biology circle alone
ADD: Genetics

Second, there are psychological factors which lead people to alcohol or drug abuse. For instance, pre-existing psychiatric disorders such as anxiety and depression.

Psychology circle

ADD: Psychiatric Disorders

Life events such as job loss that may create feelings of despondency and hopelessness;

ADD: Life Events

And there are social/ environmental factors such as peer pressure, and the simple exposure to alcohol or drugs.

Environment circle

ADD: Peer Pressure
ADD: Exposure

WALKER: (11-24) We live in a very interesting society. We authorize and sanction drinking but not too much.

SCOTT: (11-26) Well, drinking was not only popular in my peers but my parents and their brothers and sisters, which would have been my aunt and uncle, were into drinking socially. So every- everytime there was any type of gathering, there was drinking going on.

MARGARET: (11-14) Ninety percent of the people, you know, that I was around there was always a cocktail here and a cocktail there, so with my problems and with the people I was associating with, it- it just fit in; alcohol just fit perfect; it just was my escape.

O'BRIEN: When our servicemen were in Vietnam, we had a huge percentage of the enlisted men who became dependent on heroin because it was so available. It was so cheap and they were in a situation where this was just a thing that many of them did and these were people who would not have used drugs if they had not been there.

NARRATOR: It's rare that a person's substance abuse would be influenced by just <u>one</u> of these factors. It's the unique interplay of risk factors that for most people determines whether or not they'll become addicted.

GRAPHIC: Three circles

GRAPHIC: Highlighted Patricia, Scott, Greg

Despite the acknowledgement of multiple risk factors, those who believe in a biological cause of substance abuse feel that some factors outweigh others. Take the disease model of alcoholism.

Biology Circle:
ADD: Disease Model

The disease model suggests that alcoholism is a progressive disease that involves physiological malfunctioning. In this model, heredity plays an important role.

ADD: physiological malfunctioning
ADD: heredity

O'BRIEN: (11-8) I think that the way I understand a disease, alcoholism fits the definition of a disease. But a lot of people from a common sense perspective say, oh no, alcoholism couldn't be a disease like diabetes or arthritis because a person willfully picks up that bottle and drinks.

And there's a certain amount of truth to that...

...because alcoholism is a disease that's somewhat different in that behavior will at least at the beginning, the willpower is- is important...

DRAWING: Man in bar with beer

...So, you see it's a complicated sort of thing because it requires at the beginning the person to willfully start drinking but then once they start drinking they lose control.

NARRATOR: Not everyone would agree with Dr. O'Brien that alcoholism is a disease.

Over Marlatt

ALAN MARLATT: (11-22) Well, the disease model is an all or none model. You either have it or you don't have it. Proponents of the model often talk about it like a light switch. If the genetic switch is on, you have the problem whether you drink heavily or not. If it's off, you're not going to have a problem even though you drink like a fish. That's the switch model.

Our model, and I think one that's supported by more research is more like a reostat model. If you have a grandfather who's an alcoholic, that turns up the reostat risk level a little bit. If you're father is also, it turns up a lot.

Actually, you're talking, in that case, for a son, the risk factor went up by a factor of three which is quite significant. But many children of alcoholics, and you can think of some very successful ones like Ronald Reagan, don't have the disease. And so it's not like everybody that comes from that background is going to have the disease.

NARRATOR: While there is disagreement among the experts, Scott is not alone among the many alcoholics who view their alcoholism as a disease.

Over Marlatt

Over Scott and Aisha

SCOTT: (11-26) There's certain body types that have an affinity towards alcohol and I believe I'm one of those. Drinking is- well, I have fairly compulsive behavior and so when I'm choosing to drink, I drink possibly more than the average person would drink and once a certain point is reached, and I don't really have a handle on what that might be but I go into an out-of-control style of drinking.

NARRATOR: According to Dr. O'Brien, one risk factor that can't be overlooked is genetics.

Over O'Brien

O'BRIEN: (11-8) Unquestionably, you know, there is- there's evidence that alcoholism has a genetic factor and perhaps 50% of alcoholics have a genetic factor and there's a lot of data on this which we could go into. But that's not the whole story.

Even when you have identical twins who have the same genes, there's not a 100% concordance which means that there's something other than genes that make a part of a determination.

NARRATOR: Next, psychological factors.

GRAPHIC: Psychological circle

W.GEORGE: (11-18) Among those theories are the traditional Freudian, psychoanalytic view that have argued in terms of the person's inner conflicts and unresolved issues as motivating forces behind their alcoholism, there is a notion that there is an addictive personality that people who become alcoholic suffer from a particular personality constellation that causes their alcoholism...

...There is also the notion that learning theory or conditioning theory plays an important role in a person becoming an alcoholic.

DRAWING: Hand and bottle

Pan up to woman's face

In this theory, one of the assumptions is that you serve a drug, in this case alcohol...

...as a coping response. And in this case, it's a coping response that's maladaptive for the person; they use that particular response, drinking alcohol, as a way of coping with stressors in life, as a way of coping with difficulties in life.

AISHA: There was always something that you were using the alcohol for. You know, to not have to deal with certain issues.

SCOTT: Typically I would avoid problem areas in my life by drinking. Therefore I wouldn't have to be responsible to discuss certain issues with Aisha, or deal with paying certain debts to whatever members of society I owed money to; being away from my children and dealing with how I feel about that. So it was, in general, I would use the alcohol as a way to avoid being a live human being.

NARRATOR: Among social and environmental explanations, there are such influences as culture and parental models. For instance among the American Indian population.

B-Roll: Group

MAN: I'm still part of my tribe; I'm still part of my clan; I'm still part of my warrior society. So how is that going to be culturally irrellevent for me?

KERRY: (11-29) I feel, to me, that what it does for me with my indian blood, my son has always accepted that Indians always were drinkers, we drink, as a culture. Now it's up to me, now that I'm learning something here, I'm learning that I want to go back and give him this, it- it- it isn't so, you know.

That in actuality, Indians do not always have to have a drink or a bottle in their hand. Now he's been taught this by me, as I grew. As he grew up. I've always had a bottle in my hand. But now I want to go and start a new relationship with him, without him seeing the alcohol side of me.

NARRATOR: In fact, American Indians do have a disproportionately high rate of alcoholism. For this reason, some people suggest that heredity may doom them to substance abuse. Dr. Walker stresses, however, that even within one population there can be a multiplicity of factors.

B-Roll: Seattle group

Over Walker

WALKER: (11-23) I don't think we could avoid looking at genetic loading a predisposition or a vulnerability for- for alcohol problems in certain populations but remember that we just don't know that about any population let alone Indian population yet.

On the other hand, the other piece to look at is that all Indian populations or subgroups have very marked social-economic distinctions in comparison to the general population.

In other words, they don't have access to healthcare; they don't have access to social support services, high degrees of unemployment, high degrees of- of lack of support groups for the populations. All of those are the predictors for high risk populations with alcohol difficulties.

W.GEORGE: (11-18) So as you can see, as we try to come up with an all-encompassing or powerful explanation of how a person becomes an alcoholic or remains an alcoholic, we now have to draw from different disciplines and different levels of analysis and it's because of that mixture of different levels and disciplines of analysis that the term biopsychosocial model of explaining alcoholism has become prominent.

NARRATOR: When exploring the risk factors for <u>cocaine</u> use and abuse, one factor stands out--exposure to the drug.

B-Roll: Cocaine powder being poured

CHILDRESS: (11-11) The scary thing about cocaine for us is that many of the normal risk factors are sometimes absent and that exposure alone seems to be enough to get a person started down the path to compulsive involvement. And then the pharmacology of the drug seems to take over.

It may be that with cocaine, perhaps more then with any other drug that we've studied or known, that the actions of the drug, the intense pleasure followed by the intense craving, setting up this rapid, compulsive cycle may be more important as a risk factor than with many other substances such as opiates or alcohol.

DAVID: (11-3) I would say I smoked cocaine about three years on and off. At once it start out as a weekend thing or whenever my days off was. You know, I never would smoke it whiles I was working. Then, say about a year, it stretch into smoking it on the nights that I had to go to work.

CHILDRESS: (11-11) It's really alarming to us when we see folks coming in that are not remarkable psychiatrically. In other words, they don't have a lot of pre-existing psychiatric disorders; they had a job and were functioning okay...

David & tech in lab

...they had a family; they had relationships; they were pretty much like the guy next door until they bumped into this substance. And then the effects of this substance, the intense high followed by the intense craving set up a rapid, compulsive cycle.

DAVID: I kept telling my old lady that, "I can do without it, I can do without it." I started sounding stupid 'cause I knew I couldn't. And then I found out I was addicted but I didn't know what to do about it.

So I guess once I lost my job and I lost everyone there around me, you know, all my, my girlfriend, I lost her; I lost everything. I was out like, living alone and no one close to me, then I really knew I was addicted, 'cause it really didn't bother me about being that way.

TITLE: A CIGARETTE BREAK

NARRATOR: Some addictive drugs, like nicotine are common, woven into the fabric of our daily life.

B-Roll: Woman w/cigarette

A pack of cigarettes can be bought in any convenience store in the country.

Circular cigarrette display

But the medical problems related to its use are in the words of one expert, astronomical: smoking is the largest cause of both emphysema and lung cancer and a significant factor in heart disease, high blood pressure, strokes and bladder cancer.

Over CU cigarette packages

Over Surgeon General's warning

Over man with cigarette in ashtray

Smoking nicotine may be legal but as Dr. Alexander Glassman reminds us, it is still drug use.

Over Glassman

ALEXANDER GLASSMAN: (11-17) What people feel is it's a behavior, you know, that it isn't just the- if you take an antibiotic, you take a pill, you stick it in your mouth, you drink some water and you swallow it, or if somebody puts a needle in your vein and you get an antibiotic, that's a drug.

With cigarettes, there's a lot of activity that people may like or get used to and it isn't just the drug. There's a ritual, actually that's true with other drugs of abuse too and people get used to anything. People get into habits...

...There's something about holding something in your hand. Some people like something in their hand. It makes them more comfortable.

B-Roll: Bill makes coffee

NARRATOR: Bill smokes two and a half packs a day.

BILL: I started smoking in my mid-teens, like 15 or 16, at summercamp in New Hampshire and since I'm 50 now that...

...was a good 35 years ago.

It would just be nice not to have to bother with this 20 or 40 or 60 times a day. I happen to be in politics; I raise money. I just did a big campaign last November. That last month before election day I was up to 4 packs a day. I was never without a cigarette.

GLASSMAN: (11-16) When you give 100 people alcohol, about 5% of people will find it very hard to stop and they lose control of the drug. So that drugs are not addicting for everybody. With nicotine, it's really much more addicting than alcohol. If you give everybody cigarettes for a significant period of time, not for one or two cigarettes, but for months at a time, what you'll find is that about 30% of the people will become addicted to the drug...

...almost whatever you feel that's bad, whether you're anxious or angry or depressed or bored, when you light up a cigarette, the nicotine makes it a little better. That's a terrific drug.

B-Roll: Bill walks into room and lights up

And for some people, those effects are very marked and anytime, even years after they've stopped, if they get very upset they have the thought...

Over Bill smoking

...that if I light up a cigarette, it would make it a little better. But that's real; it's not like it's imagined.

BILL: It slows you down, having to light up, having to find that ashtray. In periods of high, high stress, to just constantly be going for the cigarette and smoking it and it just wastes so much, of your energy, your focus. I would love to be rid of all that.

The year I didn't smoke was an incredible year and all those cliches are true. I smelled things better, I tasted for the first time, my head was clearer at all times. And I so regret going back. I cannot tell you.

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| NARRATOR: Bill is seeking help for his smoking problem at Smokenders, one of many programs aimed at this addiction. Many people find relief in hyponosis, nicotine substitutes, and old-fashioned willpower. | B-Roll: Bill in living room<br><br>Still frame<br><br>ADD: Hypnosis<br>ADD: Nicotine Substitutes<br>ADD: Willpower |

TITLE: SUBSTANCE ABUSE: TREATMENT AND PREVENTION

PATRICIA: They ran me through I would call it a test where I saw a film, where the people were smoking the crack sort of like I would do, go sit on the side of the bed and then they- that was alright until they showed me- had a box there- to look in this box and I looked in this box and I've read that I would maybe see some things relating to drug thing.

I looked in the box and it upset me, you know. It really, really upset me but it helped me honestly because I said, I'm going to beat this.

O'BRIEN: (11-7) First of all, treatment of substance abuse <u>is</u> successful. It's just that there's kind of a notion out there in the public consciousness that it isn't because they see so many people who get into treatment and then later they see them relapse.

But in fact, this is the nature of a chronic disease. It's completely unrealistic to expect someone to go into treatment and be cured the way a person who has pneumonia can get an antibiotic and be cured.

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| NARRATOR: So, as with many psychological disorders, experts talk treatment, not cure. | Over overhead shot of group |
| The most common situation is, first, to get the drug out the person's system. | GRAPHIC: group in upper left<br>ADD: Treatment, Detoxification |
| Next, is a rehabiliation program, and finally, a maintenance period that for some, may last a lifetime. | ADD: Rehabilitation<br>ADD: Aftercare |
| The rehabilitation and maintenance programs themselves can involve: <u>medication</u>, such as disulfiram or Antabuse, used for a small percentage of patients. | CHANGE:<br>ADD: Medication |
| <u>Psychological</u> treatment, such as psychotherapy and desensitization. | ADD: Psychotherapy |
| And, by far the most widely used, <u>sociocultural</u> treatments, such as self-help groups like Alcoholics Anonymous and Narcotics Anonymous, and drug-free halfway houses. | ADD: Support groups |
| Often, treatment involves either an in- or out-patient package including all three kinds of care. | |

CHILDRESS: (11-12) If a patient comes in with a depression and you choose only to offer a self-help group but not to address that depression directly, you may be missing part of your effectiveness.

Similarly, if he comes in and has no drug-free network of friends, everybody he knows uses, and you don't refer him to a drug-free network, self-help groups, you may also be missing the boat.

So the idea is to really look at the patient as an individual with a set of problems, a profile of problems, if you will, and then try to match your interventions with his problems.

NARRATOR: What Dr. Childress is talking about is a recent development called Treatment Matching. Over Childress

O'BRIEN: (11-7) So what our research shows, and the research of many other people, is that substance abusers are very different. It's not just that we're talking about heroin addicts or alcoholics; we're talking about different kinds of alcoholics; different kinds of heroin addicts.

And they need to be assessed in an individual way and- and a determination has to be made of what kinds of problems they have and then the treatment program has to be tailored to fit the needs of the individual patient.

TITLE: TREATMENT: ALCOHOL

MARGARET (11-14) My husband agreed to see her, you know, see the doctor with me, and we did for maybe like, 8 months. You know, I started to come around. I got to the point where okay, things are changing, you know, for me here but I'm still drinking.

AISHA: One time he got so drunk that he drove off in my car and left me sort of stranded where we'd been having dinner with friends.

NARRATOR: While one could do a whole program on alcohol treatment, we've chosen to take a look at one prime example of treatment matching with the story of Meredith and his struggle to stop using alcohol.

Over Scott & Aisha

Over Group

Over Meredith

Meredith is a Sioux indian show's been drinking since he was a child. In listening to his story, it's clear that there are a great many factors that seem to be responsible for his problem.

Most of his life has been spent behind bars, a good deal of it in solitary. Meredith looks to his early years for the source of his alcohol abuse.

MEREDITH: (11-29) I started drinking at the age of 12 because I feared my father who was a Presbyterian minister, who abused me by whipping me with anything he could get his hands on. He'd blame me for something I didn't do and I feared him and I started drinking to cope with that fear that I had for him.

NARRATOR: In the late 1970's, Meredith acknowledged that he had a drinking problem.

B-Roll: Meredith in group

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| After numerous treatment programs, he finally found help at the Seattle Indian Health Board, where clients take part in one-to-one counseling and support groups that build on their shared cultural beliefs. | Over Leschi Center Ext.<br><br>Over Group |
| This is accomplished by combining 12-step AA philosophy -- which stresses complete abstinence, and the idea that you must give up control of the disease to a force larger than yourself, and accept yourself as you are -- with the concept of the American Indian Medicine Wheel. | B-Roll: 12 Step rules<br><br>PHOTO: Wheel marked in ground |
| In traditional belief, the Medicine Wheel symbolizes the cycles and changes in life from birth to deal. The Medicine Wheel is both physical and spiritual. | PHOTO: Woman with papoose<br><br>PHOTO: Indians on horses |
| It usually takes the form of a circle representing understanding of self and harmony with the universe. | PHOTO: Wheel marked in ground |
| Alcoholism or drug abuse can disrupt the harmony of the circle, and it's only by reestablishing a correct balance that healing and in this case, recovery from substance abuse, can occur. | PHOTO: Help wanted poster with indian looking at it |
| In this support group, leader Wally Morse, himself a recovering alcoholic, takes Meredith and others, both from within and outside of the Indian community, through important concepts. | Over Group |

MORSE: (11-29) What you have to understand is if that you're disease attacks you on the four major life areas and the four major life areas are basically physical, mental, emotional, and spiritual. With the use of the Medicine Wheel, it also covers the socioculture of how you're going to start fitting back into your family situations.

NARRATOR: What seems to be clear is that the Medicine Wheel's spiritual value works for Meridith in much the same way that more standard forms of therapy work for others. Over Group

MEREDITH: (11-29) The medicine wheel is very sacred amongst the Native Americans. It represents unity...

...The medicine wheel involves the spiritual, physical, the emotional and the alcoholism part, you know. And we identify that in our native way, which is very sacred.

MORSE: (11-27) When you look at the- this inner circle, it's stop the use, and one of the feelings that you're gonna start having right to begin with is there's a lot of anger that starts to come up. Does anybody relate to the feeling of being angry when you first got into treatment?

JAMES: (11-27) Each night I went to bed, I went through this scenario of who I was going to hurt, the harm I was going to do on people, who I was going to get even with.

So once that picture, that movie in my mind came to a stop, then I was able to sleep. But before then, I got rarely an hour or two of sleep at night so I was ragged that first week until I realized it was me that was causing all the problems.

MEREDITH: (11-28) I tried different ways to get rid of my anger, resentments, and searching for my higher power and I couldn't find it. I had to go by traditional way to actually know who I am. I had to go to the sacred circle of the sweat lodge for a purification ceremony.

Like you said, the fourth and fifth step, I found it in the sacred circle. This is where I had a spiritual awakening. I tried many different ways but I couldn't find it. I had to go my own traditional way of the Native Americans to really find my identity.

WALKER (11-23) The Medicine Wheel offers a chance to think about spiritual healing and integrating that belief system into the treatment process itself. — Over Group

NARRATOR: Dr. Walker, who himself is a Cherokee, knows from experience that tapping into tradition makes good treatment sense. — Over Walker

WALKER: (11-23) The first steps that I've learned in the treatment for alcohol drug problems is to look at the values, the positive things that a- that a group of people hold most dear. And you hang treatment upon those values.

For Indian people, that becomes kind of obvious. There's a very special culture identification and what the tribe believes. And if you can work upon the positives of that belief system, the treatment process is easier to understand for the people who are committed to it.

MEREDITH: (11-30) I've never held a Medicine Wheel in my hands yet. It is very sacred. I respect it. When I once hold that, I better continue on without the use of alcohol or drugs.

TITLE: RELAPSE PREVENTION

NARRATOR: Any use of drugs or alcohol once a person is in treatment is considered relapse and many people consider it failure; some experts, however, feel that this is a pessimistic notion. Over Marlatt

ALAN MARLATT: (11-21) The message is don't do it because it's a disease and if you have a first drink, you'll trigger off the disease or the addiction process and you won't be able to control it. Good, if it works.

Now, the problem is 70 to 80% of the people are actually going to experience a lapse; we know this based on treatment outcome studies or even people attending AA.

Now, what- if they do have a lapse and they really believe that the disease has taken over, it kind of gives them the message that there's nothing they can do at that point other than sort of give in or go back to the meetings or whatever.

What we're saying is that's not necessarily the case because we've found people who view it in a different way. Rather than the disease has taken over this means instead they've made a mistake in their recovery process, they went off course a little bit. They need to make a course correction to get back on track.

NARRATOR: Relapse Prevention was created to help people deal more realistically with their lapses. Over Marlatt

MARLATT: (11-21) So what we're doing is we're helping them anticipate what's going to be coming up on the road of recovery and how to deal with it at different stages.

The first stage is dealing with withdrawal; the next is what we call anticipating high risk situations for relapse. We've done a lot of studies on triggers for relapse: What causes people to go off the wagon.

And some of these have to do with what's going on in the immediate situation when they first go off the wagon and some having to do with their general lifestyle kinds of issues.

GREG: (11-6) I was always able to stay off drugs for a certain period of time. I was always good for 30 days. I could say off drugs for 30 days if I wanted to, but it was the 31st day that was really a killer.

So I tried NA and AA, and as a matter of fact, I did AA, or NA one time for 40 days. But the 41st day, I just.

MARLATT: The high risk situations, these are the triggers that tend to throw people right off the course are negative feeling states, again anger, anxiety, depression, dysphoric states that the person in the past has used the drugs or substances as a way of kind of coping are going to be a high risk triggers for, for relapse. The person is looking for the same old relief that they got in the past.

NARRATOR: Besides helping substance abusers deal with the ups and downs of recover, Dr. Marlatt and his team focus on prevention, with special attention to those crucial formative years of high school and college, where it is believed that young people may develop life-long abusive drinking patterns.

Over Marlatt

B-Roll: teens drinking

TEEN: I believe most teachers on this campus will tell you that classes on Friday are not widely attended.

INTERVIEWER: Why is that?

TEEN: That's because everybody's hung over.

NARRATOR: But alcohol abuse may begin even earlier. In one study over two-thirds of high school seniors were found to be drinkers.

B-Roll: Students walking on campus

Alcohol is a known contributor to violence such as date rape and vandalism as well as to driving accidents.

B-Roll:Bar, drinking, students

MARLATT: In this young age group and college students in particular, we see an incredible...

B-Roll: Teens drinking at beach

...increase in drinking and right now we've looked at people from high school that have just entered the University of Washington. We've seen a dramatic increase already in their drinking from high school to the freshman year.

NARRATOR: In this University of Washington course taught by Dr. George Parks, students who are moderate drinkers become more aware of <u>how</u> and <u>why</u> they drink.

B-Roll: Students in Marlatt's class

PARKS: (11-31) Imagine for me and think about in your lives, the kinds of problems that college students sometimes get into? The kind of problems that you've observed on campus that people get into with drinking? Do you know the kinds of things I'm talking about? What would be an example of a kind of a problem you've heard about or observed in your peers related to drinking?

FEMALE IN FLANNEL: Slipping of grades and not going to class as a result of hangovers...

PARKS: Okay, so that would be a negative consequence...

FEMALE IN FLOWERED SHIRT: Just becoming dependent on it? Having to have it before you go to class, before you go out in order to be social?

PARKS: Yeah, so just excessive drinking itself can become the problem...

NARRATOR: Students also participate in the BARLAB, a mock bar experience, in which they're asked to monitor their physical reactions to drinking.

BARLAB scenes

PARKS: All right folks, I just want to interrupt you for a moment. You've all had the opportunity to be drinking now for about 20 minutes or so. And I was just wondering if you're feeling any of the effects yet, the early effects, of alcohol intoxication that you spoke about earlier?

MALE: I would say a little bit because everyone's a lot more talkative. I think a lot of the anxiety is now broken down. We're able to talk to each other.

PARKS: I noticed that you guys were getting a little louder. What else? But, did anybody notice anything in their body, their thinking, any changes? Subtle; it can be subtle.

FEMALE: I feel really giggly. Laughing.

MALE: I feel a little bit warm in the cheeks, you know, but--

PARKS: Is that typical for you when you've had a drink or two?

MALE: Yeah.

NARRATOR: At the end of the drinking session, students find out that the "beer" they were served contains no alcohol. This helps them to see first-hand the power that expectations have on physical reactions.

Over Barlab

PARKS: Because a lot of the things we expect alcohol to do may be due to various myths or various kinds of things we've learned all our lives and it's called, "the myth of the magic elixir".

MARLATT: (11-22) Lots of research over the years has shown that the three things that are important in any drug effect...

Over Barlab

...would be the drug itself, the setting in which it's administered and the set, or your beliefs about how the drug is going to effect you. That's why in every, whenever they're testing a new drug, they always have a placebo drug to test for these belief factors. Well, we've found a big placebo effect with alcohol then. If people think it's going to make them more relaxed and more outgoing, it does, even when there's no alcohol in the drink...

...So the barlab is to shake people up about this. Like one young man after we told him no alcohol, he was feeling pretty loaded, he said, "What do you mean, do you think I'm doing this to myself?"...

BARLAB scenes

...And in a way, he was. I mean, because he put himself in the setting, thought he was having a real drink, and in a way, he was creating a lot of the elements that do go on with the actual drug experience.

TITLE: TREATMENT: COCAINE

NARRATOR: For cocaine as with alcohol, relapse is a major problem. As Dr. Childress points out, aftercare is essential.

Over Childress

CHILDRESS: (11-12) After this more intensive phase of treatment, that the person has some sort of maintenance care, involvement in perhaps self-help groups again, or support groups or individual therapy that would go on for a month- for anywhere from six months to two years. So that phase can really go on indefinitely.

The idea there is to maintain the person's gains, recognizing that this rehabilitation phase is really also just the beginning and that this problem, because it tends to be a chronic, relapsing problem, there is a disorder here that then tends to get better for awhile and then if you don't watch out, it will get worse again for awhile, to keep that maintenance phase in place is very, very important.

NARRATOR: Dr. Childress believes that one of the major reasons patients relapse is that cues in the environment, from granulated white sugar to a street where they bought drugs, can trigger strong cocaine craving that can lead to renewed drug use.

B-Roll: David in treatment watching film

Dr. Childress' study and treatment program at the University of Pennsylvania measures the arousal that people feel when doing cocaine-related tasks such as watching and listening to people talk about drugs.

FILM FOOTAGE & SOUND FOR ABOUT 20 SECONDS.

NARRATOR: For example, as people become aroused, peripheral skin temperature drops, producing cold and sweaty palms and fingers.

B-Roll: graph of temperature

The patient also handles drug paraphernalia using a substance that looks, smells and tastes like cocaine, but isn't.

David in box with paraphernalia

CHILDRESS: Cues in the environment had been paired with this drug for a very, very long time. Thousands of times, probably over the course of the years, and now after he's been detoxified or in a rehabilitation center, the patient goes back to his natural environment and describes seeing these cues...

...people he's used with, places that he's purchased cocaine, even paraphernalia lying in the gutter, even evening new broadcasts of the biggest drug raid of the day, finding these things causing him intense craving.

DAVID: (11-3) It makes you doubt whether you're going to ever stay off of it, you know. 'Cause if I keep running across situations like that, I either run across people that use, you know, it would put a very big doubt in my mind.

'Cause as I was simulating that I was saying, "Gosh, when can I ever do this again?" You know, I say it like this, if you ever lose a best friend and you've got the chance to get that best friend back again, then you probably will try to get it back.

CHILDRESS: (11-10) So we took our cue from that and said, what we need here is some way to try to weaken this association;

B-Roll: in lab David filling pipe

The way we do that is have a patient come into the laboratory or the clinic and show him cues that will remind him of cocaine over and over and over again but in a protected setting where he can't act on the craving and arousal of that trigger.

B-Roll: in lab David smoking

We're teaching them a number of different strategies. We beging with the simple things like teaching them the deep relaxation technique to counter the craving and arousal. We also work with them on imagery techniques, having them imagine themselves at their very worst...

B-Roll: David with tech doing tests

...withered up in a corner without clean sheets, without food, at the end of their money, without friends, family, relationship, the job having been lost, following that with a positive image of the way they can be if they don't act on this craving feeling.

NARRATOR: This controlled exposure to cues, designed to be an adjunct to a regular treatment program, is proving effective for some patients like David.

B-Roll: David heating substance

DAVID: (11-3) I've been here before but this time around, I feel much, much comfortable, much, much better about it because...

...back then I used to want to use again but couldn't use because of people watching me. You know, but now people still watching me but I don't want to go back through it again. Because I don't know, I just don't feel it. All before, I want to sneak and do it, but right now, I have no desire to sneak and do it.

TITLE: FUTURE DIRECTIONS

NARRATOR: The challenge facing experts in the field of substance abuse is formidable, how to weave through the puzzle of addiction, dependence and abuse to find out first why some people seem to have a propensity to develop vcertain addictions while others don't.

DRAWING: Alcohol

Cocaine

Cigarettes

GRAPHIC: Patricia, Scott, Greg

And second, how to treat those who do and prevent it in those who are at risk.

As is usually the case, experts aren't all in agreement about causes.

FOOTAGE: Techs in labs with DNA model

In alcoholism, for instance, some scientists have discovered a reduced amount of activity for an enzyme in the systems of alcoholics that highly inheritable and that they claim is the product of a single gene.

Looking in microscope, recording data, etc.

GRAPHIC: DNA molecule

But other disagree and lean towards that view that no single gene specific to alcoholism exists and that there are a multiplicity of causes.

Cocaine researchers too, are looking for a genetic marker, hoping it will lead to effective pharmacological treatments for cocaine addiction.

Test tube w/clear liquid

On the treatment front, the new emphasis on Treatment Matching has led to a variety of efforts, including group alternatives to Alcoholics Anonymous such as this S.O.S. or Secular Organization for Sobriety. S.O.S. believes in separating religion from recovery.

B-Roll: SOS newsletter

FOOTAGE: SOS group

Finally prevention. As many college students will eventually die of alcohol related causes, as will recieve their masters and doctors degrees.

B-Roll: Parks class

To counter this reality, experts hope that courses in safe drinking like courses in safe driving will become standard fare in classrooms across the country.

On this subject, most experts do agree. It can happen none too soon.

B-Roll: Barlab

GREG: There's nothing like being straight, clean. There's nothing like this. I'll never be square. I'll always be hip but there's nothing like being clean.