#7

SEXUAL DISORDERS AS BROADCAST SCRIPT
JANUARY 4, 1991

FADE UP ON LOGOS

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

NARRATOR: Joe and Shelley are married. They met after their first spouses had died. Joe loves his new wife very much, but there is a problem in their sex life -- Joe doesn't get an erection.

Over Joe and wife

Judy grew up in a conservative family. She was taught that "good girls" do not have sex before marriage.

Over Judy

JUDY: Yes, it was definitely forbidden.

NARRATOR: But after Judy did get married she found she didn't like having sex.

Over Judy

DAVE: I would start to fantasize and think of all the other things that, you know, that were- that weren't really real.

NARRATOR: Dave gets his sexual satisfaction from watching pornographic movies, hiring prostitutes and exposing himself to women.

Over silhouette of Dave

GENE: But I was a married man. I have five children. I was just living a secret life- a total secret life.

NARRATOR: Gene is a rapist currently serving 30 years for his second sexual offense.

Over Gene

Each of these people has a sexual disorder of one type or another.

Graphic: negative images of these four people

People like Joe and Judy have physical or emotional problems that make sex difficult or sometimes undesireable.	Highlight two people on right
Sex for people like Dave and Gene is harmful either to themselves or to another person.	Highlight person on left
What is it that can make sex pleasureable for most people and yet so disabling and even destructive for others?	Three images highlighted
Like most human behavior, a person's sex drive is influenced by a number of factors. Some of these are determined biologically while others are shaped by experience.	B-Roll: couples kissing and groping
But neither biology nor personal experience alone determines a person's sex life. Rather, it is the combination that forms sexual attitudes and behaviors.	Graphic: couple having intercourse
The organ most responsible for sexual behavior is not genital. It is the brain.	Graphic: brain
Sexual reflexes like erection and orgasm, are controlled in the oldest parts of the human brain.	Highlight medulla
However, these responses are influenced to a great degree by the more complex, higher regions of the brain where intellect and emotions are processed.	Highlight the rest of the brain

Simply put, our thoughts and feelings are like management, where strategy is devised and the lower functions are the employees, who carry out the plans of the company hierarchy.

Highlight brain in same color
Add: arrows moving from outer brain to medulla

So while sexual reflexes may occur involuntarily, they are, to a great degree, enabled or inhibited by a person's beliefs, attitudes, fantasies, feelings, and experiences.

Graphic: couple having intercourse

FADE DOWN

FADE UP

TITLE CARD: SEXUAL DEVIATIONS

NARRATOR: Although there is a common biological pathway for human sexual behavior, there is also a great diversity in the way people express their sexuality.

B-Roll: Couples in park

Most people's sexual behaviors occur along a continuum that is broadly defined. This includes many permissable, if not always socially acceptable, behaviors.

Cut to Graphic: couple on bench

B-Roll: Times Square porm marquees

However, there are limits to what is ethically and legally acceptable. Those behaviors that fall outside those limits are considered sexual deviations.

Cut to montage: newspaper headlines referring to sexual abuse, child molestation, rape

Doctor Robert Carson is Professor of Psychology at Duke University.

Dissolve to Carson

CARSON: So far as I'm concerned, I'm not much interested in going around and finding abnormality and pointing it out and so forth. I don't think that that's a very useful way to- to proceed here. I'm perfectly willing to limit the notion of deviation in sexuality to practices and behaviors that are of harm to the individual himself or herself or to others.

...There is a once quite famous player in the National Football League who was a wide receiver. A very considerable talent.

Dissolve to drawing: CU football player; Zoom out to WS

He was a true golden boy who was arrested and convicted twice in two different cities for exposing himself to preadolescent girls. How can we explain such a thing?

Cut to drawing: CU player in court; Zoom out to WS

Cut to CU judge

These episodes of exhibitionism apparently occurred when the player was feeling inadequate about his masculinity, either in his role as a husband or as a football player.

Cut to CU player

...And what does that tell us? What is suggests at least is that the process of exposing- the process of flashing, was, for this individual, and act of repair, if you will, of ego repair...

...of being powerful again.

Dissolve to drawing: WS player with teammates

NARRATOR: The exhibitionism the football player displayed to compensate for his feelings of inadequacy is a type of sexual behavior known as a paraphilia, which means "beyond normal love" or deviant.

Zoom in to CU player

ADD: Paraphilia

Eli Coleman is a sex therapist and researcher. He also runs the Program in Himan Sexuality at the University of Minnesota School of Medicine.

B-Roll: Coleman coming into office
Zoom in on wall: Program in Human Sexuality

COLEMAN: I want to hear you talk about what you're doing in your therapy now, what goals that you're working on and how you evaluate your progress to date?

NARRATOR: Dr. Coleman sees many paraphilic patients at the program's clinic. One of them is a young man named Dave, who is an exhibitionist.

Over Coleman, back of Dave

DAVE: It's slow going but it's a lot better than- than, far better than when I first came here.

NARRATOR: Dave was willing to talk about his problems but asked to be disguised.

Over Coleman, back of Dave

DAVE: It's one of the things that I knew could make me feel better.

...You know, I guess- I- I used to used drugs and alcohol as a- as a- as a medicaiton think to- to help me feel better or forget my problems. And then, I- all of a sudden, I stopped using- doing those things, and my sexual things really escalated and I used that. It was always there. It was- it felt good. It was one of the reasons.

FADE DOWN

FADE UP

TITLE CARD: CAUSAL FACTORS

NARRATOR: Like the football player, a slight to Dave's self-esteem would often trigger an episode of exposing.	Over title card
This is typical of many deviant behaviors and appears to be part of a cycle of behavior.	Dissolve to heading: Loss of Self-Esteem
First, there is a perceived insult to the masculine self-image. This is then followed by a sense of depression and defeat.	Add arrow around to 1/4 circle ADD: Depression
This, in turn leads to an urge to expose. The reassurance of self-esteem that comes from the sexual sensation and the reaction of the victim are only temporary.	Bring arrow around to 1/2 circle ADD: Relief
And the original negative emotions are compounded by feelings of shame and remorse for exposing. Often this may then lead to another cycle of the behavior.	Bring arrow around to 3/4 circle ADD: Remorse Bring arrow around to complete circle

DAVE: Whether it be maybe an- an argument at home or an a rejection of some kind or from- from failure at work or something that, you know, would make it- wouildn't make me feel, you know, that I- that I couldn't handle that. I'd feel very depressed and- and then it would be the loneliness and sadness and isolative and, you know, from there.

COLEMAN: This person came in and was very, very concerned about some... Over Dave

...some compulsive sexual behavior patterns relating to the use of prostitutes, pornography, and this was causing extreme distress in himself and in his relationship with his wife.

And so one the surface this is- was the presenting complaint and we thought we were going to be treating that- that problem.

In the process of the intake, we found out that there was extensive exhibitionistic behavior, that this person was exposing himself and masturbating in public on a very, very regular basis for quite a long time.

Miraculously, he had not been caught or reported or arrested or convicted for this- this offense.

DAVE: I guess I always knew that it was, you know, it was wrong; that I, you know, that you're not supposed to do these things but it would get obsessed with that and it would- I don't think that I really could stop because I've told myself that I would stop many times.

NARRATOR: Dave came in for treatment because he wants to change his behavior. Doctor Coleman is helping him understand the origin of his problem as well as the pattern of feelings and activities that are involved.

Over Coleman, back of Dave

COLEMAN: So when you start going in to- looking for an opportunity to expose, how are you feeling then?

DAVE: Sometimes I, you know, I'm still feel sad and, you know, still feel depressed but I know that I- I- I- I know in the back of my mind that I probably really don't want to do this. But I don't know where it is- that it- that breaks off that I'm just going to do this anyways, you know, to the point where I see, you know, a woman in her car or something...

COLEMAN: He had never understood what was oging on beofre, during and afterwards and so...

Over Dave

...we've asked him to really think about his whole pattern and analyze some of the instances that he has exposed and try to identify the- the feelings before he has sought this behavior to understand what feelings stay, what's happening, what environment he is in, and to understand his whole pattern of offending so that he understands that.

COLEMAN: And then, how- how are you feeling afterwards, after this has happened?

DAVE: You know, sometimes I'm- you know, sometimes I still get excited and I'll- and I'll have to pull off to the side of the road there or, you know, or in the way of the road there or wherever my destination is and, you know, and do what I gotta do. But...

COLEMAN: Masturbate?

DAVE: Yeah, yeah, yeah.

COLEMAN: And then what?

DAVE: Sometimes I feel, you know, feel guilty and bad about it. Feeling real- yeah, what'd I just do that for, you know? I mean after- after all the good- the good feelings and good sensations are all over and done with and you feel guilty and go ah, that was kind of stupid.

FADE DOWN

FADE UP

TITLE CARD: PARAPHILIA

NARRATOR: For people withparaphilias like Dave, whose behavior stems from low self-esteem, much of the treatment is provided in a group setting.

Over Paraphilia title card
TITLE CARD: TREATMENT

COLEMAN: First of all, it really helps overcome their feelings of aloneness and shame. They feel like they're the only one that has this kind of problem and so this is very, very helpful to their very damaged self-esteem, you know, to see other people and find out that they're not monsters and terrible people, that there are other people from all walks of like that- that have this problem.

The other thing is that because of the high denial and defense system that the- the group challenges- it takes one to know one. And they can really see through each other's defense mechanisms and they can get through that better than maybe seeing them in individual psychotherapy.

NARRATOR: In addition to group therapy, many paraphilics also receive individual therapy to deal with other issues, particularly the lack of self-worth.

Over Coleman, back of Dave

S-18 @ 11:20

COLEMAN: A lot of them come from very dysfunctional families and we like to go back and deal with that dysfunction, try to resolve that as much as possible, not only for them to feel better about their family that they came from but also we're very concerned about them repeating those family- dysfunctional family dynamics in their current family that probably relates to their- their abusive behavior and also to short circuit this- this cycle that goes on from generation to generation.

DAVE: It's a battle. And sometimes it's a daily battle but through the therapy and through understanding and help here, that I, you know, I- I'm really not all alone and that I'm going to, you know, that it is a problem and that I'm going to get help for it and they're goint to- and through the people, you know, there's other people in my group that- that are like me, that have my problems and they can help me, you know, through these bad times and- and to not do these things. And I really do want to stop.

FADE DOWN

FADE UP

TITLE CARD: THE LOVEMAP

NARRATOR: Both biology and social experience influence a persons' sexual attitudes and behaviors.

Over title card

Dr. Carson hold the view that early life experiences are crucial.

Graphics: kids on beach

CARSON: I don't want to suggest that...

...neurobiological mechanisms are irrelevant to human sexuality because they aren't but huge portions of human sexuality are conditioned by social learning, by the kinds of experiences an individual undergoes in the- the course of development.

To put it another way, eroticism- human eroticism is socialized like many other kinds of characteristics of humans. And the concept that I like most that has recently been developed to refer to this kind of shaping up is the concept of The Love-Map.

NARRATOR: The concept of The Love-Map as a model for understanding human sexual development was pioneered by Dr. John Money.

Over Money

MONEY: I a way, it's- it's sort of an opportune word because there's a lot of talk these days about cognitive maps and The Love-Map really is one particular variety of a cognitive map...

...It's rather like a native language; it's something that you don't have in your head the day you're born but it eventually develops there rather early in childhood and then it gets flued in and you really have extraordinary difficulty changing it.

B-Roll: kids playing

Maybe one can assume from the point-of-view of evolution that what nature plans in two-sex soecies is that the amle and the female will meet together and create new life.

B-Roll: couples hugging, etc.

...So it makes good sense to say that's sort of the standard. Although it looks very much as though if you look over all the species, nature is also evolved a secondary standard which is to have attraction in some instances, under some conditions between two persons of the same sex.

...So a Love-Map is a template or a plan or a design that tells you what your erotic sex and your extoric sexual attraction is going to be.

Graphics: brain

And it also fills in the imagery of what will be sexually arousing to you and get your sex organs aroused and able to work and enable you to work up to the point of orgasm.

Dissolve interior of brain to Graphic: couple having intercourse

...There are many Love-Maps that are defaced or vandalized because of unhappy events-destructive events that have happened in the course of the child's life.

...Paraphilic behavior is a form of a vandalized Love-Map.

Graphic: Dave with word Paraphilics

NARRATOR: It has been estimated that more than 90% of paraphilics are men. Why should there be such an imbalance between the sexes?

ADD: 90% Male

It may be that in many others areas of life, men are exposed to and rewarded for high levels of aggressive behavior.

Dissolve Dave; scroll up graphic football picture; lose words; Add: graphic war picture; Add: CU graphic man with gun

CARSON: If you look at it, much of what we refer to as deviant sexuality involves a kind of dominance/aggression sort of thing.

Even a seemingly passive act of voyeurism, of peeping, is, in fact, intrusion into another's private apce and so forth and has this intrusive/aggressive power-driven quality.

Of course, many of the other sexual deviations, rape, I suppose being- being a- a good example, have rather obvious elements of power/aggression/domination and that sort of thing.

FADE DOWN

FADE UP

TITLE CARD: THE RAPIST

NARRATOR: One of the most prevalent forms of sexual deviation that incorporates power and domination is rape.

Over title card

Dissolve to Map

As many as one in four women in the United States will be sevxually assaulted in their lifetime, a staggering statistic.

ADD: 25% Women Sexually-Assaulted

Dr. Judith Becker, a researcher and therapist at the New York State Psychiatric Intitiute explains the complex nature of rape and the different types of rapists.

Over Becker

S-9 (01:30

BECKER: There are many reasons that individuals rape. And unfortunately, society has tend- has tended to lump every- everybody together and has- we've seen them as a homogeneous group when, in fact, there are many reasons why individuals rape.

For example, some people believe that they can have or take whatever they want, whenever they want it and we call these people anti-socials and so if they want to have sex with somebody and that person doesn't want to, then they will take what they want and it might involve being aggressive sexually to get that.

There are other indiviudal who perhaps under normal circumstances would not be sexually aggressive but under the influence of alcohol or drugs, their inhibitions are lowered and their tendency to aggress might come out.

There's a category of people who prefer to rape; that is, they need the victims' resistance and they need to feel in power and they need to dehumanize and humiliate the person in order to achieve sexual gratification. And without that, without that victim resistance in feeling very empowered, they don't get aroused.

So for those folks, even when consentual sex is available to them, they might not avail themselves of it because there is not- they don't feel in power and they don't feel that they are humiliating and they don't experience the resistance on the part of the victim.

There are other people, and we see this happening a lot in date rapes, where ideally they want consentual sex to occur but their partner is not interested in engaging in consentual sex or- or might being to be sexual and then say 'No, I don't want to quote, go all the way.' And that indiviudal will push and will push and will force sex.

So that person's different in that they are aroused by consentual sex and they want it but when it's not available to them, then they will use force.

NARRATOR: This is the Chittendon Community Correctional Center.

B-Roll: Ext. Chittendon

In addition to housing 300 inmates, it is also the home of the Vermont Treatment Program for Sexual Offenders.

B-Roll: Inmates

Gene is a repeat sexual offender. He is currently in the 16th years of a 30 year sentence for assault, robbery, and rape involving an elderly couple.

Over Gene

GENE: I had been partying and- and- and stuff, and I had a fight with my brother. Mel left me at this lake and I had just come down this road and I see this light in front of this house on a country road and I just drove up and- and walked up and kicked- and a woman come out to the door and she ran back in and I walked up and kicked the door down.

I said I'm taking over this house. I deserve a house. I never had nothing in my life and I wanted them to tell the state troopers and that they were going to kill me because I wasn't going back to prison. I went through a lot of changes.

One time I'd be- it's distorted. One time I'd be very nice like the man had some guns and he asked me not to take his special rifle. I'd put it back and said, I'm sorry and I'd go back and get it.

He asked me if I was going to kill them and I started crying and said, well, of course, I wasn't going to kill them. I wasn't like that.

And one point I laid my head on the woman's lap and be like a little boy. I was crying and then another point was I had just- I had just wanted to do things that was humiliating. I was forcing them to have sex with one another.

When that didn't work, then I took her into the parlor, and I didn't even complete the act other then- I mean, as far as ejaculation and all that. I- I stopped myself and it wasn't because I stopped myuself. It was because I was so messed up, I couldn't.

NARRATOR: What happens in men like Gene? How does extremely violent behavior combine with sex?

Over Gene

Some researchers have demonstrated a biological connection between sex drive and aggressive behavior.

Begin graphic montage of newspaper clips

Add clip

Others suggest that there are psychosocial events that can distort a person's Love-Map in such a way that rape is their preferred sexual outlet.

Add clip

Add clip

But neither explains rape since many people are violent without involving sex.

Dr. William Pithers is the founding director of the Vermont Treatment program for Sexual Offenders.

Over Pithers

PITHERS: I think to some extent, it was essential at one point in time to describe rape purely as an aggressive act. And- and I think it was important to do that in order to convince the public that what we were talking about wasn't just another form of sexual expression.

However, I think we also do a disservice to the public's understanding and to treatment professionals if we describe rape solely as an aggressive act that doesn't have a sexual component.

If rape was- if a person was wanting to engage in a purely aggressive act, why not engage in a physical assault? Why not bludgeon someone?

The type of activity that we're talking about here is a far different kind of bludgeoning involving sexual activity.

So I think what we're dealing with when we're talking about rapists is a fusion of sexuality and voilence, not either alone.

FADE DOWN

FADE UP

TITLE CARD: CAUSAL FACTORS

NARRATOR: Where does the desire to rape originate? — Over title card

According to Dr. Becker, ther are a variety of reasons. — Dissolve to Becker

BECKER: That's a complex question actually. And the motivation can differe from individual to individual.

What we have to look at are factors within each individual. That is, their ability to control their impulsive impulses. Factors within the family; were there models for aggression and not necessarily sexual aggression but violence in general and how women are treated within the families of- that they grew up in.

ANd third, we have to look to our society and to different cultures where ciolence seems to be the norm in a sense, in where women very often are not treated as equal and where we see a lot of disrespect towards women.

So when I say it's complex for each individual, we have to look within the individual, within their families and within the societies in which they grew up because there certainly is a lot, in the way of support, you know, for violence and sexual violence within our society.

NARRATOR: Gene was raised in a violent and abusive environment. He was sexually abused by several people including his father.

Over Gene

But he is learning that in spite of what others have done to him, he must bear responsibility for his own behaviors.

GENE: Maybe I was a victim as a child growing up and they may- the things that's happened to me as a child growing up may be reflections of how a lot of my life was.

But they're not excuses for my going out and raoe other people. And I accept total responsibility for that. I've learned that.

In other words, that two wrongs don't make a right and I've- I've learned that I've made choices in my life growing up, from a young age and they were my choices.

I might have- I would have had to be on alcohol and drugs when I done my crimes but I chose to go out and drink because I wanted to do my crimes.

It took me a long time to see that- that I wanted to get anger out on somebody and- and I couldn't handle the emotions of rejection from my wife and things like that and I chose to go and drink alcohol which I was always become a justifiction for me to do violence on people.

NARRATOR: Gene's violent act and his behavior leading up to it form a pattern that is common to some types of rapists.

Over Gene

Like the exhibitionist, there is a sysle of emotions and behaviors which, when amplified by alcohol or drugs, can lead up to an explosive outcome.

Graphics: Emotional Cycle: Rape, Anger, Fantasy with arrow

PITHERS: It's not uncommon for some rapists, for example, to leave an angry interaction with someone, feeling unable to express that anger to the other individual and seeking relief from this sense of rage that they feel within themselves, and in an effort to gain some relief from that rage, they will masturbate to very angry thoughts.

And for however long the refractory period lasts, experience some relief from that rage only to reexperience that rage again as their sexual gratification dissipates.

Sometimes that fantasy is followed by what we refer to as passive planning. It's a really- it's a myth that sexual offenses are impulsive acts.

In fact, in the work that we've done using the relapse prevention model, we have found that many sexual offenders will go to such lengths to plan their offenses so that they might appear impulsive when they're apprehended, that we have developed the term planned impulsiveness to refer to that phenomenon.

Sometimes offenders will decide that they will go out drinking prior to their offense, not to become drunk, but in order to have that as an excuse and to disinhibit themselves.

So we'll find offenders fantasizing about the behavior, engaging in some sort of passive planning, disinhibiting themselves through alcohol, the use of pornography or through other kinds of experiences and finally deciding to engage in the act itself.

FADE DOWN

FADE UP

TITLE CARD: THE RAPIST

TITLE CARD: TREATMENT

NARRATOR: Breaking the pattern forms the basis of treatment for sexual offenders like Gene. — Over title cards

Cognitive therapies help him understand his emotional probelms. Victim empathy training helps him grasp the consequences of his act. — Over Gene

GENE: Now, when you get into victim empathy, you have to write out exactly what you remember of your crime in detail that night or that day when it happened.

Then you also- and that could be quite lengthy. And then you also got to write out from your victim's point of view, what you think how she sees that crime.

In other words, you have to put yourself into your victim and write out what she was going through, her thoughts, her feelings, her emotions.

And then, once you get that done, you have to- each person- like there's five people in a group, each person has two weeks and we have to role play. We have to set in a chair across from each other and we- first we have to read.

First we read our testimony of the- and then we role play that.

The person in the chair next to me becomes the victim and it gets very emotional because that person plays the victim and- and then the following week, you play the victim and the other person plays the perpetrator. So you get to feel- it gets very emotional.

I know the first time I done it, I started crying.

PITHERS: It's important for offenders to have motivation to use the skills that they can acquire during the course of their treatment. Over Gene

...I don't think it's adequate though to end treatment when offenders have developed those cognitive skills.

I think it's essential to provide offenders with a form of treatment that will enhance the motivation in a very enduring fashion; one that- that's not easily forgotten.

And I think that victim empathy is possible the only kind of motivation that may have a very long half life with sexual offenders. And so we work a lot in our treatment program to enhance the empathy that offenders feel for their victims.

BECKER: When we can care and empathize with other people, then we don't do things that are against their will; we don't want to harm them; we don't want to make them suffer in any way.

But when that's lacking, when there isn't that degree of caring or understanding or empathy, you know, then people tend to take advantage of other people, whether it's sexually or non-sexually.

NARRATOR: The prevalence of rape and the devastation that sexual offenders cause their victims poses a delimna for society.

B-Roll: Exterior prison

Should sexual offenders simply be incarcerated or should they be treated for their problems?

B-Roll: Locking people in cells in prison

BECKER: The reason that I'm able to work with the population that I work with is because I see the work as I doing- I'm doing as prevention.

For every person that I see who is successfully treated, it's that many more ewomen and children who will not be at risk for being the victims of this type of crime.

As a society, as a country, we have to realize that- that is indeed an epidemic. That 25% of the women experience this act and we have to become mobilized to address the issue, to make counseling and treatment services available to victims, to provide treatment to offenders and to work out prevention strategies geared toward our society and the way women are treated.

GENE: I don't want people ever saying that they accept me and that I'm okay. I want people to hate what I done.

But I'm- I'm a personl those are thing that I've done and I don't evern want anybody to like what I've done or accept- I've had to tell that to my wife when she's forgiven me and she knows everything about my life and I want her to always hate what I done because I'll always hate what I done.

But I- the people in society should know that- that I'm a human being, that I can live a successful life with the proper treatment and with always staying in treatment for the rest of my life.

It's like an alcoholic, one day at a time. And the only thing I can do is not do it again. And maybe be involved in educating other people concerning this because I think this has really spread across the country, really heavy-duty and- and- and so I know my victims suffered that night.

I didn't physically hit my- my vict- my victims but I scared them to death and when you're 300 pounds, that's- I didn't need a weapon.

And I was a weapon and so I- I- there's- if I could change anything, that's what I would love to change is to be able to take the pain away from my victims.

FADE DOWN

FADE UP

TITLE CARD: GENDER DYSPHORIA

NARRATOR: This is a fertilized human egg. It is at teh moment of cenception that a person's genetic sex is determind.

Clip of fertilized egg

At birth, the newborn's sexual organs almost always match that genetic identity.

Clip of child just born

How personal sexual identity develops from that point on, however, is not well understood, but it is clearly influenced by social and biological factors.

Graphics: children playing

Sometimes there is a confusion between a person's physical sex and his or her personal sexual identity creating a gender dysphoria, literally an extreme unhappiness about one's biological sex.

Gender dysphoria is what led Brad here to the Program in Human Sexuality and to Dr. Eli Coleman.

B-Roll: Brad entering Program in Human Sexuality building

S-a1 @ 12:01

BRAD: I guess from the time I was very young, I couldn't understand why everyone kept telling me that I was a girl and that I should be doing things that girls do and- because as far as I was concerned, I was a boy.

And I didn't understand. It was a lot of confusion. I didn't know how to relate to anyone else. It's just very uncomfortable. It makes you feel crazy.

COLEMAN: This is a female to male transsexual who always thought of herself as a boy. Over Brad

She had extreme...

...discomfort with her body as it changed from a young girl to an adult woman and with those changes, there was increasing anxiety and discomfort about her breats, her genitalia, and also about their gender role, their role as a- as a female felt very uncomfortable.

Oftentimes, they just feel that somehow that they were just given the wrong body because in their mind, they really felt themselves to be of the other sex.

BRAD: I know that when I started going through puberty, I decided that- up until that time, I guess, I had- I had figured that everyone was wrong and in some point in time, I would prove it to them.

And as irrational and illogical as that sounds, when I got to- when I started puberty, I- I decided that they were all right and I was all wrong. And I must be crazy.

It was the only explanation I could come up with because at that point in time, I had never even heard of transsexualism; I thought I was the only one like this and I know at one point in time, I remember my mother coming into my bedroom and telling me that maybe it was time I started wearing a bra.

And I told her, no way, I'll cut them off first. And she laughed and I'm sure that no on ever knew just how serious I was about that and I did truly consider it at one point in time and I - the only reason that I didn't do it was because I decided if I did, I would probably bleed to death and everyone would know what I had done and they would- and that everyone would know how crazy I was.

So I decided that the only thing that I could do would be to try and be what everyone said that I was.

FADE DOWN

FADE UP

TITLE CARD: GENDER DYSPHORIA

NARRATOR: But that did not resolve his problem. Over title card

TITLE CARD: TREATMENT

NARRATOR: After several years of counselling Brad began taking male hormones. Over title card

They changed his body shape, lowered his voice and led to the growth of facial and body hair. Over Brad

He had a double mastectomy to remove his breasts. He had a hysterectomy to remove his fallopian tubes and ovaries.

However, Brad decided not to have a penis constructed. His female genitalia are intact and he is capable of having an orgasm.

Like most female to male transsexuals, Brad has always been sexually attracted to women.

COLEMAN: This is not an easy decision becasue it's a rather irreversible step once you go through hormonal and sex reassignment.

And this person, because of family inflence, social influence, you know, was very reluctant about pursing that and spend a lot of time trying to consider if that was really the right solution for her.

NARRATOR: Unlike Brad, many people with gender dysphoria often seek out surgery as the answer to their problem, a situation Dr. Coleman cautions against.

B-Roll: street graphic-ed

COLEMAN: Too many patients who have gender dysphoria or discomfort with their own gender have a lot of other problems that may be related to their gender dysphoria or not.

And one of the problems is that they start developing an obsessive thought that somehow this gender change is going to magically solve a lot of their problems in their life. And it's a rude awakening when they complete surgery and discover that there are still a lot of problems for them.

So in our approach here, in our clinic, we like them to resolve a lot of their psychological problems and issues before reassignment and then we have much more confidence that they are going to be successful in their reassigned role afterwards.

NARRATOR: Brad has been a man for less than a year. There are still many issues that he will confront. But this major issue in his life, whether he is male or female, has been resolved.

Over Brad

BRAD: I feel now like I'm one person. Whereas before, I always felt like I was kind of a real confusing mixture of two different people, not only two different people. I mean, generally I think when you think of yourself feeling as two different people, you think of two different people of the same sex.

I mean, I think it'd be very hard for anyyone who hasn't experienced it to imaging what it's like to feel emotionally and mentally one sex and appear to other people physically as another. I mean, it's- it's- there's no way to really explain- to explain it, I don't think.

But I do now feel like one person and I feel quite secure in who I am.

FADE DOWN

FADE UP

TITLE CARD: SEXUAL DYSFUNCTION

NARRATOR: There are times when a person is unable to satisfactorily participate in sexual activities. Sometimes this may be for emotional reasons, sometimes for physical reasons.	Over title card Dissolve to CU hands in bed
This happens to many people. But when this happens on a regular basis and the person loses the ability or the desire to have sex, this is considered sexual dysfunction.	One hand pulls away from the other

As many as one in three adults in the United States have experienced one form of sexual dysfunction or another at some time, making this one of the most prevalent of psychological conditions.	Graphic: Map ADD: 33% Experienced Sexual Dysfunctio
There are threee basic types of sexual dysfunction: a loss of desire for sex, the inability to be sexually aroused, and either a lack of orgasm or an inability to control orgasm.	Cut to nude statue with SEXUAL DYSFUNCTION ADD: Desire Problems ADD: Arousal Problems ADD: Orgasm Problems
Human sexual functioning depends on a number of factors.	Cut to Statue; pelvis up ADD: PHYSICAL COMPONENTS
On a biological level, the nervous system, the circulartory system and the endocrine system all work to produce the necessary physical components required for sexual arousal and orgasm.	ADD: Nervous System ADD: Circulatory System ADD: Endocrine System
The psychological components of fantasy and desire are equally important in achieving arousal and satisfaction.	Cut to CU statue; ADD: PSYCHOLOGICAL COMPONENTS ADD: Fantasy, Desire
Sexual dysfunction can occur when one or more of the physical or emotional elements goes awry.	Lose words Add: echo of statue Add: echo of statue
Helen Singer Kaplan is a psychiatrist and a sex therapist.	Over Kaplan

KAPLAN: A sexual disorder is a physical dysfunction. A man can not have an erection; a woman can have no orgasm or sex hurts or there's no desire. Those are physical dysfunctions. And they are the common pathway for a variety of physical stressors, psychological problems, relationship probelms, etc.

That's why I call them psychosomatic. It really mean that if a man comes into my office and can't have an erection or has a problem keeping an erection, I first have to find out, is he taking some medication, does he have a hormone problem, is he having quarrels with his wife, was he very religiously brought up and feels sex is shameful or does he have a deep neurotic problem.

NARRATOR: Dr. Carson describes a performance-related dysfunction sommon to young men: the inability to control orgasm.

Over Carson

CARSON: Hardly a year goes by that I don't have a young man show up at my doorstip looking very -- I've learned to recognize it now -- looking very scared and traumatized.

...He's at my doorstep and I say, because I've leared at this time what to expect, what happened?

Dissolve to drawing: man in Carson's doorway

Cut to CU man

Well, I don't know. I just went too fast.

Over CU man

NARRATOR: This problem, premature ejaculation, is a common sexual dysfunction occurring in approximately 35% of the male population.

Graphics: Map
ADD: 35% Report Premature Ejaculation

FADE DOWN

FADE UP

TITLE CARD: TREATMENT

NARRATOR: The treatment for premature ejaculation consists of teaching the male how to slow down his ejaculatory response.

Over title card

Dissolve to drawing: Carson and man
Zoom in to CU man

Specific exercises are used to help the man recognize and control the sensations leading up to orgasm.

Techniques such as this became popular in sex therapy as a result of the work of William Masters and Virginia Johnson in the 1970's. Their work changed much of the thinking about sexual dysfunctions.

Over photo of Masters and Johnson

KAPLAN: These methods are very interesting. They differentiate sex therapy from other forms of treatment. The behavioral aspect of sex therapy is carried out in the privacy of the couple's home. We give very specific sexual homework assignments and this is- there's never any sex in the office and patients are often disappointed and relieved to find that out but only a charlottean would have sex in the office, by the way.

We tell them exactly what to do at home. If the man has performance anxiety, impotence, we give one set of instructions. If the woman has difficulty having orgasm, we give another set of instructions, or if her vagina's very tight, we give a third set of instructions.

The patient's then come and report the results of these interventions. And very often, we find that these work but just as often there is resistance because there are also deeper problems. And these deeper problems need psychodynamic interventions.

The reasons I call sex therapy or the new sex therapy integrated is because we use- it's an integration of two modes of treatment which were always thought to be incompatible, behavioral and psychodynamic.

Very simply, and this is probably an oversimplification, we use behavioral cognitive homework assignments, instructions, redefinitions, to modify the immediate causes of sexual problems, which, by the way, are different for the different disorders.

And then if the patient feels anxiety, feels vulnerable, resists in some way, we then use psychodynamic methods of delving into the deeper problems and clarrifying and resolving these.

NARRATOR: Masters and Johnson introduced another important concept in sex therapy. They considered the couple rather than the individual as the focus of their attention.

B-Roll: couple walking down street

KAPLAN: Prior to Masters and Johnson, the patient had been seen by the psychiatrist or the psychologist as- and the focyus and if a man came into your office and complained he didn't have sexual desire, the doctor never knew, was he talking about his beautiful wife who's lovely and gracious or was he talking about a 500-pound gorilla. You couldn't tell.

So there was- and you cannot- you must consider the partner because it's an interaction so Masters and Johnson focused the interest or the attention of the field on the couple but they went too far.

We- there are some patients who would be premature or inorgasmic or impotent with any partner so you can't say that the relationship is the cause of this problem. They would simply have an inherent problem.

On the other hand, there are many patients who would be functional with other partners and are not functional with their own.

So you really have to differentiate whether this is a couple's problem or an individual problem which is expressing itself.

FADE DOWN

FADE UP

TITLE CARD: DESIRE DISORDERS

NARRATOR: One of the most common sexual dysfunctions is desire disorder- an inhibited sex drive.

Over title card

It has been estimated that one in three people who seek out sex therapy do so for this type of problem

Graphic: negative image of Judy; ADD: 1 in 3 people who seek sex therapy report desire disorder

SHOTZ: You give me the impression that you had a lot more interest in sex or desire for sex before you got married?

JUDY: Yes.

SHOTZ: And since you've gotten married, your desire has gone away?

JUDY: Absolutely.

SHOTZ: Any idea why that's happened?

NARRATOR: Judy has been married for 16 years. She has a desire disorder partly due to the fact that she was raised to believe that sex was not acceptable behavior. Her sex therapy is psychologist Fred Shotz.

Over Judy, back of Shotz
Zoom in to CU Judy

SHOTZ: This woman, based on her conservative upbringing and a denial of her own personal interest and her own personal pleasure turned into a lack of desire in sex.

Over CU Judy

SHOTZ: The desire disorders in this particular couple are one of the most destructive and one of the most common things we find in sexuality.

There is nothing more frustrating to the person who doesn't have the symptom or the problem then to have a partner who enjoys sex, who's orgasmic, who seems to have a good time, but never wants to have sex.

The interpretation of the spouse in that situation is that, and this- this case is a woman with lack of desire, is that she doesn't care for me, is the husband's statment. She doesn't desire me; she doesn't love me because when she has sex with me, she has a good time. It must be me that she doesn't want, not sex that she doesn't want.

And so this couple is as they first came in, we having real probelms in their marriage, lack...

...of intimacy, lack of communication, lots of aggravation, lots of fighting.

Over CU Judy

SHOTZ: During the whole time, during the 16 years, that you've been married, not wanting to have sex and having it anyhow whenever-- at what point would you actually agree to have sex?

Over CU Judy in therapy

Zoom out:show back of Shotz

JUDY: When he would get grouchy and the whole family would feel it.

SHOTZ: And so everything's in an uproar and you know you can fix the whole thing by- just by going to bed with him?

JUDY: Make peace. In the house.

SHOTZ: That's a lot of pressure, isn't it? The kids are being affected by it; you're being affected by it; he's being affected by it.

JUDY: Yes.

SHOTZ: And so as that dynamic continues for a while, the resentments really build.

He understandings that when she has sex with him, that she doesn't want to and so he's resentful of even the quality of the act; she's resentful of the imposition on her as she feels put upon and used but it's the only way that she can buy any tranquillity or peace in her relationship.

So this couple have been coming to see us with tremendous marital problems going on that almost overshadow the sexual problem.

DISSOLVE

TITLE CARD: TREATMENT

NARRATOR: The therapeutic approach Dr. Shotz has taken with Judy is typical for people with desire disorder.	Over title card
Cognitive therapy is used to address faulty beliefs and attitudes and sensory exercises are used to enhance the couple's sexual enjoyment as well as their communication.	Over Therapy session, Judy and Shotz

SHOTZ: In the couple sessions, in the beginning part of this kind of therapy, yo're mostly trying to maintain peace; you're trying to keep the upset spouse from venting his anger or hostility cause it just sets things back. You're trying to maintain tranquility and keep them working as a couple on a progressive path.

The sex therapy homework that I send home with a couple is basically to help the lacking desire individual engage in behaviors not compelled by the spouse by compelled by the therapist. I don't mind being the heavy.

If you want to get angry at ne because I made you go home and do your homework, that's okay. You aren't angry at your spouse that way and I don't have a problem with that.

But to help the person to realize that whether you're in the mood or not in the mood, if you get into doing it and if you make sure to keep your thinking in line, that you can have a good time and it was worth it. And we began working with how do you get in the mood and how do you make that happen.

SHOTZ: As you mentioned before, since we've been working together, things have gotten better.

JUDY: Yes.

SHOTZ: Can you help me to understand what it is that's helping you get better?

Zoom in to CU Judy

JUDY: I think it's both our attitudes, his attitude and mine mainly. I think it's- our attitudes are better. He's backed off a bit and isn't pushing and I guess I'm- I have realized that I'm a little more of a sexual person. I've realized more that I need it too.

SHOTZ: So it's becoming more important to you?

JUDY: Yes.

SHOTZ: But that's not what you were told when you were growing up? You were taught that's for him.

Pan down Judy to her hands

JUDY: Yes, definitely.

FADE DOWN

FADE UP

TITLE CARD: AROUSAL DISORDERS

NARRATOR: Not all sexual dysfunctions are due to a lack of desire.

Over title card

There are people who want to participate in sex but cannot.

Over couple sitting on couch

For example, a man who is unable to have an erection.

These problems are called arousal disorders. It was one thought that such problems were totally emotional rather than physical.

KAPLAN: There was a common misconception which was only recently corrected that the great majority, 98%, say, of sexual dysfunction had a psychologic origin, was exclusively psychogenic. That's really true among younger people bit in the over-50 population which we are now seeing more and more of, by the way, this is not true.

At least 50% of people with sexual complaints over the age of 50 have some organic or medical component. They're either taking drugs with sexual side effects or they have diabetes or arterial sclerosis or hormone deficiencies.

Now these are often correctable and they're usually only minor but if they occur in a couple who have latent or hidden marital problems or in a man or a woman who have fairly compensated but have some underlying pre-existing sexual difficulty, these rather minor or partial organic problems can escalate into a total sexual disability.

NARRATOR: Joe is unable to get an erection. That's why he and Shelly came to Dr. Shotz.

Over Joe and Shelly with Shotz in therapy

In Joe's case there appear to be both physical and emotional reasons for his problem.

SHOTZ: (Int.) This is a couple with a- just a fascinating history. Both went rhough very, very traumatic deaths of their- of their spouses and were having a very, very rough time getting over their- their widowhood.

And the closer the marriage is, the more intimate the marriage is, the more difficult it is to recover from the death of your spouse because how do you replace that type of intimacy.

SHELLY: I had said at the very beginning that I thought the reason that he had so much of a problem was because- well, first of all, we were still in the same house and in the same room that- from when he was married.

And it had been harder and harder for him to like go from there and from the past and then I would be in the future or the present.

SHOTZ: (Int.) And he was experiencing what we call, I guess is a cliche almost at this point in my professions, widower syndrome.

Widower syndrome is where a man who did love his wife up to the end, has emotional difficulty at being in love with somebody else and the betrayal of his now-deceased wife that he will experience through making love to somebody else.

SHOTZ: (Therapy) As I was getting to know you both, one of the things that came out is there's also some organic issues, some medical issues.

Over CU Joe and Shelly in therapy

SHOTZ: (Int.) His case was complicated because he's not a young man and he has a history of cardio-artery disease and of high blood pressure.

One of the biggest medical causes of erectile problems is blood pressure medication.

Over CU Joe and Shelly in therpay

...And so here I have this wonderful, loving couple with this mixed etiology. I have an organic basis to an erectile problem; I have a psychological basis to an erectile problem.

FADE DOWN

FADE UP

TITLE CARD: TREATMENT

NARRATOR: The therapy prescribed for Joe and Shelly consists primarily of a series of sensate focussing exercies.

Over title card

Dissolve to sensate B-Roll

This typically involves caressing areas of the body other than the genitals. The goal is to expand the sensual experience and help the couple become more intimate with each other.

Joe and Shelly talk about the success they have achieved with this approach.

Cut to CU Joe and Shelly in therapy

SHOTZ: (Therapy) At what point in our working together did your sex life start to improve?

JOE: Well, really after the first couple of sessions and I didn't realize it then and I guess when you say the words 'sex life', what I had to do was reorient myself as to what it- as to what that means. What- what's the definition of sex life?

And it's not just an erection, okay? It's a whole bunch of things and it's a whole bunch of getting in touch with yourself and your feelings, not just your feelings that are stimulated by a whole bunch of hormones, you know, flowing through your body but- but the stuff that's inside your brain too.

And- and- and a lot of the things that- that I guess I've learned that kept me from getting the most out of my life. And- and it's all connected. There's nothing that's separate from each other.

SHOTZ: I'm going to put you on the spot for a minute and if I put you on too much of a spot, tell me to back off, people that are going to be watching this are hearing you talk about if- if you couldn't get erections again or if your didn't get erections for awhile, that you still had a good sex life. How is that possible?

Over Joe and Shelly in therapy

Cut to WS of therapy room showing back of Shotz

JOE: Well, the- physically?

SHOTZ: Yeah.

JOE: Well, obviously there are a lot of parts of your body that have very, very sensitive feeling, your tongue, your fingers, the rest of your skin. It almost got to the point where I felt like me whole body was, you know, part of a sexual organ.

My skin- I never realized how sensitive my skin was or you know, how the feelings that- that just touching the person that you love could transmit to you.

Sometimes I, you know, when- when I'm close again and I get very close to Shelly and our skin touches and- and I- it just makes all the hair stand up on my head .

SHOTZ: What makes it better?

JOE: You better say the right thing.

SHELLY: He does.

FADE DOWN

FADE UP

TITLE CARD: SUMMING UP

NARRATOR: Human sexual behavior occurs along a very broad spectrum.	Graphic: couple making out
As we have seen, there are many factors that can effect a person's sexual beliefs and behaviors.	Over graphic B-Roll: kids playing
Some problems people have with their sexuality effect only themselves. Others are dangerous to society.	Graphic: four patients Right two highlighted Left two highlighted

All of them can have an extremely negative impact on a person's emotional wellbeing.

All four highlighted

Within the past 25 years, however, new approaches to treating these disorders have been developed which are proving to be highly effective.

Dave is learning new ways to control his sexual excesses.

Dissolve to CU Dave silhouette

Gene is being taught how to avoid repeating his sexual offenses.

Cut to CU Gene

Judy and her husband are trying to reconcile their differences.

Cut to CU Judy

And Joe and Shelly are finding different ways to enjoy sex.

Cut to CU Joe and Shelly

KAPLAN: The last 25 years or so have been a true revolution. We never could have had this program 25 years ago.

And the reason treatment of sexual disorders was so inadequate was that the scientific study of sex was simply prohibited by social morees. We've only been able to study sex scientifically in the last 25 years.

And that's why all the progress we've talked about has occurred in the last two decades. We still have a long way to go but we are so much better off.

MOOD DISORDERS AS BROADCAST SCRIPT
December 6, 1990

8

FADE UP ON LOGOS

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 1. boy looking into camera on stomach 2. children in schoolroom 3. girl at blackboard 4. boy alone with group off to side - zoom in on him 5. two people walking under carwalk 6. band 7. older black couple hugging 8. man and woman at table with chins in hands 9. man sitting on bed with face in hand 10. woman in mourning with hankie over eyes
MAIN TITLE	The World of ABNORMAL PSYCHOLOGY (over montage of photos)
SHOW TITLE	MOOD DISORDERS

FADE IN:

NARRATOR: It's part of being human to experience a wide range of moods. It's normal, for instance, to be happy or sad; elated or moderately depressed. But sometimes our moods may be inappropriate or they may interfere with our ability to function.

Drawing of four people

Zoom in on right two people
Cut to CU second person
Cut to CU first person
Cut to WS woman on street; zoom to CU

PHYLLIS: The depression was the worst part. It would just continue and continue and I know at one time about three years ago, I sat in this livingroom; for three months, I couldn't get off of the couch. I couldn't go outside; I didn't wany my neighbors to see me; I didn't want anyone to see me. I didn't want to- to dress up. I- I was afraid to go everywhere. Cassette 3.8 in in 10:51

RODNEY WESTERMAN: And- and then I went through all that and it was like that's it and, you know, it was like a Eureka! and I felt like I was overcome by this energy force and I thought, you know- it was like God, somebody had taken over and was driving. I just accelerated and- and it was like I wasn't even holding on to the wheel.

It was- there was an energy like an electricity and I accelerated and I was doing probably 120 miles an hour and there were cars- it was a two lane highway and I started to run cars off the road going head on, not backing off. I was waiting for them to veer out of the way. I mean, I was running them off the road. Cassette 3-21 in 1:46 out 2:27

NARRATOR: In this program we will show what it feels like to have mood disorders, how they disrupt people's lives. The people we will meet represent the general population of such disorders. We will also explore factors that contribute to the disorders; and examine treatments that seem to work.

B-roll: Slo mo people walking down street

Cut to Phyllis' hands sewing; pan to face

Cut to Rod in office

Cut to Margarita in deli

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 gives an example of when moods are in the normal range.

Over WS Danielle

KNAFO: I thought I would begin with a commonplace example that most people can relate to and empathize with and that is the- the moods that come as a result of feeling that one is in love.

Susan met John on a blind date, and she liked him very much and the date went very well and John...

Dissolve to WS Susan & John at dinner; Cut to CU Susan; Pan to John

...reciprocated Susan's own feelings of interest in him and he was very romantic and asked her out on a date for the following evening.

So they left, and Susan was in a very, very good mood and in high spirits, went home...

...couldn't fall asleep; she was so excited. But it didn't bother her because she was just thinking about their budding romance.

Cut to MS Susan in bed; Pan to WS

The next day, when she went to work, Susan wasn't bothered by her boss' arrogant attitude which usually annoys her quite a bit.

Cut to MS Susan at work
Cut to CU Susan at work
Cut to XCU Susan at work

She skipped lunch because she- she didn't have an appetite and she just anxiously awaited for this date of theirs the next day.

Now what happened...

...John called her at work and he canceled the date. He gave some vague excuse about his family; it wasn't clear. They re-scheduled for three days later and Susan, her elated mood dropped suddenly. She became angry, anxious, nervous and even a little, a little bit depressed. Cassette 3-1 starts at 3:26

Cut to MS John on phone; Pan to MS Susan on phone
Cut to XCU Susan on phone
Cut to WS Susan at home; Pan to CU

Susan's moods were entirely within the normal range even though they vacillated quite a bit, her- her moods were normal and we could empathize with them. These are things that everybody feels, we all know what it is to have moods, we all have felt mellow, anxious, dejected, angry, whatever. These are all moods that we know from our daily experiences. So moods are universal experiences.

When moods are not normal, they become- they- they have the tendency- the person who- who expresses pathological moods or moodiness has the tendency to be moody, to shift a lot in terms of their moods, and also to become fixated on one or the other end of the scale. Cassette 3-1 start at 9:49

DISSOLVE

TITLE CARD - WHAT IS MAJOR DEPRESSION

NARRATOR: It is estimated that 15 millions Americans - about 1 out of every 10 -- will experience what's called major depression at some point in their lives.

Dissolve to USA map with faces; Highlight square; ADD words 15 million

Lose Highlight and words

This includes symptoms such as weight loss, insomnia, a negative self-image and even suicidal thoughts. It's not the mood itself that denotes pathology but its extent, severity and duration.

ADD words: Weight Loss, Insomnia, Negative self-image, Suicidal thoughts
Lose words

ADD words: Entent, Severity, Duration

When left untreated depression can often go away by itself but for many people it persists.

Dissolve words
Graphics Cut to man on bed with squares around him; lose one square
Lose another square
Lose another square

Depression may begin as a reaction to specific life experiences such as the death of a loved one, job loss, divorce or reacting to growing old.

ADD words: Life Experiences, Death of loved one, Job loss, Divorce, Growing old.

Margarita is 28 and lives in the Bronx, New York. She had her first depressive episode last year when her husband was arrested. She is being treated with anti-depressant medication and psychotherapy and she is improving.

B-roll: Margarita & daughter walking down street

MARGARITA: Right now I'm living with my parents...

...it's their home- this is their home. I'm living here for financial reasons. Cassette 5 in at 12:24.

NARRATOR: Along with her parents, Margarita, shares this apartment with her two children, her grandmother and sometimes her brother.

B-roll: Margarita & kids in kitchen getting ice cream

Since her husband's arrest, Margarita has had plenty of time to think of their life together.

MARGARITA: We had problems. I don't really know how to describe it- he worked off and on. I think he hung out with his buddies more time than he spent more time at home. He got into things that I don't really think that I really want to get into it but things that really upset me.

And he was out here for about a year before he was arrested and he did two years in prison the first time. He came back out and he was OK for a while and then he got into his stuff and things just started going downhill again and currently he is in Sing Sing prison doing 5 years for attempted murder and that has really put it's toll on me. That has really, really hit home. Cassette 5 in at 18:07.

BAILLIET: Margarita, when she came in, she presented with an acute depressive episode which expressed itself in symptoms of... Tape 3-35 at 4:27

NARRATOR: (v.o.) Ester Bailliet, a psychiatrist who has helped Margarita.

Over CU Bailliet

BAILLIET: (con't.) ...insomnia, weight loss. She had difficulty eating and concentrating. She was attending school at the time and she had to stop briefly because she couldn't concentrate there.

MARGARITA: Cassette 3.38 in at 14:44 out at 15:25. I always wish night would come because I would fall asleep and I didn't have to think about anything.

During the day, if I had to be in the house, if would depress me even more. And why? Because after I did whatever I had to do around the house, all I had to do with either look at TV or sit down or read or whatever.

I couldn't concentrate on the TV; I couldn't concentrate on reading. And all I had to do was sit down and think and that, I didn't want to do. And- and that really bugged me.

I think somebody put me in the hole, stuck dirt, and I couldn't- I mean I felt like I couldn't get out. I thought actually that I'd never get out of this. They kept telling me well the medication this, that and I kept saying yeah right, yeah right this is not going to work. I myself was also being negative so- and I felt really- well, I can't even describe it I felt so bad. Cassette 7 in at 9:14.

NARRATOR: Phyllis is also being treated for major depression with medication and psychotherapy. But in all other respects her life is radically different from Margarita's. She is 64 years old and lives in Peoria, Illinois.

B-roll: Phyllis going to get her mail with her dog.

She began to experience devastating depressions in her twenties, but neither family members nor doctors recognized the symptoms. She was finally diagnosed two years ago.

PHYLLIS: Well, I would say that I am a middle-of-the-road person. I'm kind of traditional. I love to sew; I love to read; and I like to crochet. I used to wear the average shoe...

B-roll: Phyllis walking with dog; Cut to her and flowers

...size and the average dress. I don't think of myself in any other way.

Well, we've lived at this house 39 years.
My husband is my friend.

Cut to house ext.

We've been married 45 years in January. He's a wonderful man. I have given him a lot of problems in the years that we've been married. Cassette 3-8

Cut to CU Phyllis and husband sitting on porch swing.

NARRATOR: During the 40 years Phyllis went undiagnosed, she went to many medical doctors and had countless tests looking for an answer to why she didn't feel right.

B-roll: Phyllis sewing

PHYLLIS: And when I'd go in, they'd say but you look so good, you know. I said but I couldn't explain to him and I always felt guilty because I was taking his time up and there was nothing wrong with me because I- I was told that over and over every day. You know, forget yourself; there's nothing wrong with you. And so finally when- when it got worse and worse, I still insisted that there must be something that could help me. Cassette 3-9 in at 1:22 out 1:49

NARRATOR: Many people with major depression initially think they have only physical problems, so they seek help from a physician. And, in fact, they may never get to a mental health practioner at all.

B-roll: Phyllis

Dissolve to CU drawing black woman; pan back to doctor

So, it is not surprising that people like Phyllis can be confused about what's wrong with them. Depression can come in many forms from the mildest- that may go undetected- to the most acute requiring hospitalization.

Dissolve to Phyllis sewing

Dr. Jan Fawcett is a Professor and Chairman of the Department of Psychiatry at Rush Presbyterian-St. Luke's Medical Center in Chicago.

B-roll: Fawcett walking into building

FAWCETT: The milder forms of depression may be exemplified by a high executive who flies a corporate jet and who feels a lot of physical symptoms occurring over a period of time with a gradual onset, feels a sense of malaise, decreased energy, decreased enjoyment of life but still goes on able to work and function as far as others are concerned but as far as he's concerned is only working at 30 to 40% of his usual capacity.

This person may be very unhappy; their life may be very difficult for them but others may not even notice. And many people are working and functioning in this state. This same person may respond to treatment and feel a thousand times better once they're adequately treated but to the outside world, people who don't know them, they may look exactly the same.

That's the mildest form of the illness. Cassette 3-25 at 3:50.

KNAFO: In acute, or severe, depression, the psycho-motor retardation is even- is even more intensified. The person moves more slowly, speaks more slowly. Here the person actively withdraws from social contacts. He doesn't want to be involved with pe- with other people, just wants to be left alone.

During this- In severe depression, also, the person can no longer function as well as they could. They find they have no motivation to work, to be involved in anything. Nothing seems worthwhile. Cassette 3-2 in 3:54 out 6:05.

PHYLLIS: The depression was the worst part. It would just continue and continue and I know at one time about three years ago, I sat in this living room; for three months, I couldn't get off of the couch. I couldn't go outside; I didn't want my neighbors to see me; I didn't want anyone to see me. I didn't want to- to dress up. I- I was afraid to go everywhere.

And I think it was because I just felt like I was going to be this other person all the time and that the real person, myself, would be trapped. And- and I'd never be known again. Cassette 3-8 in 10:51 out 11:15.

NARRATOR: As bad as Phyllis' depression was, there are more severe forms.

Over CU Phyllis

KNAFO: In psychotic depression, there is a break with reality. Here the person experiences delusions, usually associated with guilt or self-blame. So you can see some of the things they just become extreme forms of what we saw in- in the milder forms of depression.

They may have hypochondriacal delusions about their bodies, that something is wrong with their bodies, that their brain is melting, that their heart has stopped, that they have- they suffer from some kind of terminal disease like cancer or AIDS.

KNAFO: Now, in the most pronounced form of depression, called a depressive stupor, all of the previous symptoms are aggravated to the nth degree.

Cut to Drawing: XXCU person in depressive stupor

Cut to CU

Cut to WS

...Here the person really does not respond to the outside world at all. Just lies mutely in bed and even has to be spoon fed to be kept alive. Cassette 3-2

In general though the- the subjective sense of the depressed person is that they're living life beneath a cloud. Cassette 3-2 in 8:55.

B-roll: Margarita reading paper; zoom in

MARGARITA: And you feel lonely, tired - sometimes you even wish you were not here.

KNAFO: One person who experienced a very severe depression told me he described it as though hurricane Hugo had gone on inside of his head and now he was left with the destruction of the hurricane.

Another patient described her years of severe depression as living in a black hole, and really the whole time believing that she would never again see the light in that hole. And so that's- that's really how depressives feel. Cassette 3-2 in 8:55.

NARRATOR: Given the intensity of major depression and the sense of worthlessness and hopelessness that often accompany it, it's not surprising that suicidal impulses may occur.

B-roll: Phyllis crocheting

PHYLLIS: I went out and I sat in my swing on the porch. That was another place that was...

...my safe place and it was 3:00 o'clock in the morning; I knew that everyone was in the house because the air was on. I knew that if I sat there, I knew what I'd do next.

All I had to do was to open the screen door into the garage, go in there, and because the air-conditioning was on, no one would hear, I would start the car and I would roll the windows up and I would go to sleep and I would never have to have that pain again. Because I wasn't worthy to live.

I wasn't a good wife, a good mother. I wasn't a good sister or a good niece. I wasn't a good daughter. I wasn't good anything. I was terrible and I didn't want anyone else to have to stay with me. I thought, I can't live if I- if everybody goes away from me, I don't want to. I thought, Lord, you just have to understand because I can't do it anymore. I can't come back and come back down here again. I don't want to ever again.

I got up and I went to the door. My husband opened the back door and he said something just told me that I should come and get you. I said let me go Eddie. I don't want you to be my husband. I don't want to ruin your life anymore; just let me go. He put his arms around me and we sat there on that porch till morning. He took me to the doctor's and they took me to the- to a psychiatrist that day. Cassette 3-9 at 7:52

FAWCETT: They're in tremendous pain and they're also hopeless that anything will take the pain away; it's like being tortured and seeing no way to get out of the torture, to get out of the pain. That's when people not only consider suicide but actually suicide seems like a merciful exit for them, a way for them to get out of what seems to be just- just a no-exit situation of pain. Cassette 3-28 in 1:45 out 3:39.

NARRATOR: It is not only depressed people who suffer with this disorder. Their loved ones are affected as well. Jan, Phyllis' youngest daughter, remembers what it was like to grow up with a depressed mother.

Over MS Phyllis & daughter sitting at the dining-room table

JAN: I had really reached the point where I was tired of it all. You want to kill yourself, kill yourself. You know, you want to run out in the middle of the street, do it. I didn't want to hear it anymore. You know, you've got problems, you're never dealt with them and there- I knew that there were problems.

I guess I had never really thought that there would be, you know, an actual medical problem where she could take a pill, you know, and straighten it out. I thought that there'd be like counseling and sessions and everything like that but I- I hated her. I hated her.

You talk about a love/hate relationship, that's exactly what- what I remember feeling is that I hated the fact that she could choose, in my mind, to live like this and be this angry and this unhappy all her life when she had a choice to get help.
Cassette 3-11 in 16:15 out 17:40

DISSOLVE

TITLE CARD - WHAT IS
BIPOLAR DISORDER?

NARRATOR: While 15 million Americans will experience a major depression during their lives, only one and a half million, like Rodney a 28 year old art director, will suffer from bipolar disorder or manic-depression, a different but related disorder characterized by mood swings. Rodney experiences both depressive and manic episodes.

B-roll: Rodney walking in the woods

Chyron: 1.5 manic-depressives (bipolar disorder) DISSOLVE

He has lived in Peoria for four years but was raised in a small farming community nearby. Last year he had his first manic episode and was put on a medication called lithium carbonate. Up until that time he had experienced severe depressive episodes.

RODNEY: I was depressed at this point and it was just- I was just slipping and...

...and- and that was kind of at an accelerated rate. My parents could see that- could see that I was depressed, could see that there was a problem.

I would sit- I would get up in the morning for breakfast and I would just sit and stare out a window, and look at a tree, you know, and they would be talking to me and I would just- I would just be a void of conversation. Cassette 3-18 in 12:11

FAWCETT: The patient with a unipolar depression can look just like a bipolar patient when they're both in a depression. Their depressions may look exactly the same but the bipolar patient at different times may have other symptomotology either at other times in the past over life space or a year or so or, in some cases, more severe cases, the patient may cycle from one mood to the other within the hour or from day to day.

So the bipolar patient has a much more complicated illness with changes in mood as opposed to the unipolar patient that may have just recurrent depressive moods. Cassette 3-25 in 1:41 out 2:21.

NARRATOR: As a result of his treatment, Rodney is doing well, but it took a while to put his life back together after a particularly severe manic episode. There is a wide range of mania from what Rodney experienced to milder forms which can go undetected.

B-roll: Rodney sitting on porch reading

FAWCETT: Mania may range from hypo-mania which is a mild form of mania...

...all the way to severe manic psychosis. Now a person who's hypo-manic may look like the American dream, they may look like a person who has it all, who has energy, attractiveness, increased sexual energy, they're optimistic, they can do everything, they're very confident people.

They may want to party; they have a tremendous sense of humor; they're generative; they- they have imagination and everybody looks at them and say, gee, I wish I could be like that and up and so optimistic and positive in this world of apathy and problems that we all function in, a person who's hypo-manic may look very healthy.

And, in fact, many people who are very successful do have hypo-manias; not all successful people but many. And- and that is almost looked at as health until a person's hypo-mania gets to the point where it starts to interfere with their judgement and they start overestimating what they can do or what others should be able to do and they make bad decisions and they- or till they cycle down into a depression and then can't function.

That goes all the way into a severe mania where an individual is psychotic or delusional, may believe they're the second coming of Christ, may believe that they control the world, may actually become paranoid, fearful that others are trying to kill them, may carry weapons, may actually commit homicide or- or- or put people at enormous risk or put themselves at enormous risk because of their behavior which is a function of their psychosis and their judgement which has been totally distorted by the process. Cassette 3-25 in 4:58

RODNEY: I went on about a seven mile trip, eight mile trip through a small community. There were people walking across the streets in this- in this small town on a Fri- Saturday- Saturday night around 6:00 o'clock and I came blasting through there at 120 miles an hour, you know, with my horn on, with my headlights on, with my hazard lights flashing, with my stereo cranked up, with my skyroof open, with my windows rolled down and I was just screaming through town. And- and- and someone else was driving. I mean, someone else was in control of the car. I was no longer- I was just a body.

And I hit two cars; I sideswiped two cars. I hit one and kept on going. It didn't even faze me. It was like it bounced me off the side of the road. I mean, it- I- I hit one car so hard, it knocked me off- I mean, it knocked me clear across another lane.

I kept on. I kept on. I didn't stop. I didn't stop. I didn't stop. And I busted a front axle on my car. It caved in the whole left side of the front of my car, shattered the windshield, my head went through the windshield; I broke the seat.

The car came to a rest on- on a- on a bridge and the music was still on; the power was still on; the lights were still on; the hazard lights were still flashing. I crawl from the wreck and it was like the phoenix from the flame.

I started ripping off all my clothes. I- I stripped down as a I was crawling- as I crawled out of the car, I thought I was Jesus Christ. I thought that- I thought, this is it; this is the dawn of a new age; that I am the second coming. Cassette 3-21 in 2:30 out 7:00.

FAWCETT: Well, Rodney showed a rather extreme form of the illness. He decribed on the tape that I saw driving his car at 120 miles an hour on windy roads, driving through a small town at that speed which obviously could kill other people or seriously kill or hurt himself. There's- there's just no limit to what this illness could have done in his state.

Chyron: Jan Fawcett, M.D.
Rush-Presbyterian-St.
Luke's Medical Center

As he describes it- he eventually his car crashed, he climbed out of the wreckage, stripped off his clothes, thought he was the second coming of Christ, and began jumping up and down, and preaching in the road in the face of traffic. You know, terrifying people because of his behavior.

He was delusional. He was in a very extreme form of the illness. I'm sure he looked like a raving maniac to people who- who saw him and yet he was in an extreme form of mania and when he was describing it, he was back to his normal state which- which shows the contrast between how sick a person can be with mania and how...

...well they can be when their illness is under control and treated adequately. Cassette 3-25 in 7:03 out 8:20.

Cut to B-Roll: Rodney on porch reading

NARRATOR: Just as there are various types of mood disorders there are various causal factors. We'll discuss bipolar disorder in a little while.

Cut to CU of book; Pan up to CU Rodney

First, we discuss major depression.

DISSOLVE

TITLE CARD - MAJOR DEPRESSION

TITLE CARD - CAUSAL FACTORS

NARRATOR: There are various theories about the factors that contribute to depression. Sigmund Freud, for instance, postulated that depression occurs when someone is in conflict about angry or hostile feelings. Unable to accept and to express the anger, the person turns it inward.

Dissolve to man on bed

Make box
Make another box
Make another box

Dr. Knafo talks about Freud's theory as it applies to major depression.

Over MS Danielle

KNAFO: Freud asserted that any relationship of consequence, of necessity, is an ambivalent one involving both hate- hate feelings and loved feelings. And the depressive person can be thought of as someone who has difficulty with the hostile side of their ambivalent feelings towards the loved one.

The relationship is very- is very important to the depressed person but they have difficulty con- expressing both sides of- of this- of their feelings.

They feel that if they express their hostile- the hostile side of their feelings, that they may lose the loved one, the love relationship and they don't want to do that, so they- they find a solution to expressing this hostility. And what this solution is according to Freud is that they take that anger that they feel towards the loved one and they turn it inwards towards themself, towards their own self-image. Cassette 3-1 after 14:14.

EDELSTEIN: We have a patient who had enormous anger built up for her husband, not only as a result of his being arrested an incarcerated. at this point, but as a result of a long history of marital conflict. And- and that anger had never really been resolved.

Chyron: Gary Edelstein, ACSW
Margarita's Psychotherapist

It was highly conflicting because she felt a certain dependency on this person and obviously was concerned about expressing this anger would interfere with their relationship and remove this person who she had become quite dependent on. Tape 3-34 at 15:10

It's that kind of psychological conflict or conflict between opposing feelings that usually results in the development of these kinds of depressions.

MARGARITA: And sometimes I would look at him and throw my hands up in the air and tell him I give up. Do what you want to do - but meanwhile I was eating all this and feeding it and not really doing anything for myself. At the time it was a love that really, really hurt- I don't know how to explain it. I think I was afraid of losing him of him leaving me or whatever. Cassette 6 in at 17:03

NARRATOR: Not all depression is a matter of anger turned inward.

Over Margarita

There are alternative ways of explaining depression.

Cut to CU Young

YOUNG: Well, I think our current thinking is that the causes of depression are mixed; there is no one cause of depression, even for the single person; it is unlikely that there is one thing that causes their depression.

And so we think of it as a risk factor model where depression develops in the context of risks and when those risks get high enough, the person goes over some threshold to develop this self-sustaining depression. And those risks might be divided into three categories, psychological, environmental, and biological.

On the biological risk side, we have genetics, other physiological conditions which give us a predisposition toward becoming depressed.

Dissolve to Biology circle upper left; ADD Genetics and other physiological factors

Dissolve words

On the psychological side, we have thinking patterns, cognitive style, personality, and various factors like that may leave us at greater risk for depression.

Dissolve to Psychology circle upper right; ADD Thinking patterns, Cognitive style, Personality

Dissolve words

Then on the environmental side, we have things like stresses and lack of social support which leave us at greater risk for depression.

Dissolve to Environment circle bottom middle; ADD Stressors, Lack of social support

Dissolve words

And when the sum total of all of these risk factors get high enough, then that pushes us over some threshold and and we go into a period of clinical depression.

Dissolve to Biology circle

Add Psychology circle

Add Environment circle

For some people, one of those three factors may be stronger than the others, but it's unlikely that there's one cause, that someone has a biological depression and nothing else in involved. It's usually some balance with different weights on the different factors. Tape 3-30 in 14:59 out 16:27

EDELSTEIN: First of all, the development of a clinical kind of phenomenon like depression is a very complex phonomenon and it involved the development psychologically and physically of the individual and then on top of that, the need to cope with the, sometimes catastrophic, social conditions that patients are exposed to. Tape 3-33 in 15:29

NARRATOR: Some of the conditions that Gary Edelstein's clients are exposed to are poverty, unemployment, drugs, homelessness, and increasing amounts of violence. But, as both he and Dr. young point out, all the risk factors have to be attended to.

B-roll: People walking down street

Cut to MS woman in bicycle accident; Zoom out

EDELSTEIN: So what we're looking at is not only the acute exposure to a particular social problem but the tendency of that individual to have been exposed to those problems all through their lives.

All of this sets up the conditions that when a real major social stressor is inflicted upon them, the patient is unable to cope and that's usually when they resent to us with- with clear diagnositc symptomology.

B-Roll: Margarita & daughter in deli

NARRATOR: Different populations seems to have different kinds of risk factors. Women, for instance, are twice as likely to suffer from major depression as men. Dr. Knafo and Dr. Fawcett discuss some of the theories about psychological, biological and environmental factors that may contribute to this difference.

Dissolve to B-Roll: street scenes

Cut to B-Roll: street scenes

KNAFO: In addition to women living in a long standing, social-disadvantaged role in our society, we know, and research has shown, that for women, relationships are more significant than for men; not just more significant and it doesn't- I'm not saying that for men relationship are not significant, but that women are more affected by relationships, by the fate of their relationships and they define themselves very much according to the relationships that they're in.

Carol Gilligan, a researcher from Harvard, has demonstrated that femininity is largely defined through relatedness while masculinity is largely defined through separateness.

So if we take this logic further, any losses or traumas, in a relationship will be- will be experienced more- more seriously by a woman than by a man, more depressing.

The woman will tend to be more depressed by a loss in the relationship or a major change in a relationship than a man will be because this is- because this is- because she defines herself and her success in life through her relationships. Cassette 3-2 in 13:24 out 15:30.

PHYLLIS: I was a failure I felt because I couldn't have my own children; that was the first heartbreak that I had. Then when we got our children, we adopted our children, I felt like I was a failure as a mother because I didn't know how to raise them. I didn't know if I was raising them properly. I was trying to copy what everyone else had done in their life. And it wasn't coming true for me. Cassette 3-8 in 14:53 out 15:16.

MARGARITA: I loved their father so much I was willing to do anything for him. It hurt. I see him now once in a while- and I tell him I love you but it's not the same. Now I know when to say "no" to you, now I know I can do for myself. I don't have to depend on you. Cassette 3-38 in at 18:19

FAWCETT: More women come in for treatment than men... Over Margarita

...It may be- it may be as high as 3 to 1 in a clinic, women to men, women accept treatment more easily or seek treatment more easily than men. Men wait till their much worse off before they'll get treatment- usually it's when they can't work. Or else- and they have a much higher rate of suicide.

Why do more women have depression than men and I think they do? It may be because less women are alcoholic than men. Men are much more likely to have alcoholism and alcoholism and depression overlap a great deal.

So many men may become alcoholic as a way of treating their depression. It's a very poor treatment for depression; it makes it worse but- but it allows the person to get by for a longer period of time. And that may be one possibility is the overlap between alcoholism and depression or alcohol abuse and depression.

The other reasons may have to do with hormonal differences between men and women. There are considerable differences and you know women frequently develop premenstrual depression, women with depression frequently get much worse premenstrually; this is not uncommon.

So there may be a hormonal difference and there may be a lot of social differences in terms of social roles that have to do with women in our society that- that exert different pressures on them than on men that account for this. Cassette 3-28 in 5:18 out 6:40.

DISSOLVE

TITLE CARD: MAJOR DEPRESSION & MANIC-DEPRESSION

TITLE CARD: BIOLOGICAL FACTORS

NARRATOR: Along with psychological and environmental factors, experts believe that biology plays a role in both major depression and bipolar disorder. There seems to be a strong genetic component especially for bipolar disorder. Rodney belongs to a support group called Mood Challenge. At a recent meeting, Rodney's mother discussed her first manic episode.

B-Roll: Mood Challenge

MRS. WESTERMAN: At age 55, I had my first one and the doctor said that that was very unusual to have it. But I had been under a tremendous amount of stress with Rodney and he had to go through and other things in our life. And I had just been under a lot of stress.

I didn't know anything unusual was happening to me. I felt, you know, there had been a few nights that I hadn't slept but not too many nights and I- I just felt like I was really into God. But during all this time, I had tried to pretend that nothing was happening, you know. And I just tried to shut it off.

I thought I have to do this because I had to work; I had to go to work. Cassette 3-14 18:57. [RODNEY: We had to really keep it in the family. You were really into God and I thought I was God, right?]

FAWCETT: The idea of genetics right now is based mainly on the observation of family transmission, that means the occurrence of an illness being more likely if there's a family history of the illness. Now that doesn't prove genetic transmission; it just suggests it.

Somebody looking at the patient's environment could say, well the environment is also the same in the family and maybe that transmits the illness.

We have reasons to believe from twin studies where the twins- identical twins have the same genetic material that the likelihood of the transmission is much greater and, of course, there have been efforts to identify the genes which have come up with findings which have not, so far, held up.

So we don't have genetic proof. So we don't have ultimate proof, but the evidence is very strong for genetic transmission in both bipolar and unipolar illness but it's the strongest in bipolar illness. Cassette 3-26 in 13:48 out 14:48.

NARRATOR: So Rodney probably inherited a predisposition for bipolar disorder from his mother. Most likely a dysfunction in the way the brain works.

B-roll: Rodney & mother at Mood Challenge

Graphics: neurotransmitters

In this hightly schematic drawing, nerve cells in the brain carry information in the form of electrical impulses - along the length of the cell.

For the impulse to cross the synapse, the space between the cells, a chemical called a neurotransmitter must be released into the synapse.

Enlarge one Synapse

ADD word: Synapse
ADD chemical dots

The neurotransmitters move across the space and lock into specific receptor sites on the next cell.

One dot divides in synapse and fill indents on other side

That's normal brain function.

FAWCETT: The theories of mood disorders- that includes both depression and mania- are dominated today- in today's knowledge base by our knowledge of neurotransmitter function in the brain. Cassette 3-25 in 12:17

NARRATOR: So, in major depression a person may not have enough neurotransmitter at the synapse. In a person who is manic, there may be too much neurotransmitter at the synapse.

Graphics: enlarged neurotransmitter and not enough divided dots to fill indentations
Wipe: enlarges neuro-transmitter and too many dots to fill indentations

Summing up. There is no <u>single</u> cause of major depression or bipolar disorder. There are various contributing factors.

Dissolve: B-Roll: street scene

Freeze Frame
ADD: Contributing Factors

1) There may be deep-rooted, unconscious conflicts.

ADD: Uncounscious conflifts

2) On the biological level, a deficit of neurotransmitters may result in depression while an excess may produce manic states.

ADD: Neurotransmitters: deficit or excess

3) There is strong evidence that some mood disorders, especially bipolar illness, may be genetically transmitted from one generation to another.

ADD: Heredity

4) Some depressions may come as a reaction to life events. So, environmental factors must be considered. Unemployment, illness, or the death of a loved one may lead to depression.

ADD: Life events

Unfreeze frame: Slo mo

All or some of these factors may be involved and it is important to assess <u>each person</u> individually to determine what the causes are and what treatments will be most effective.

DISSOLVE

TITLE CARD - MAJOR DEPRESSION

TITLE CARD - TREATMENT

NARRATOR: Some people with major depression aren't treated either because the episode runs its course, they aren't properly diagnosed, or they just don't seek help.

B-roll: street scene

For the rest there are two general forms of treatment: psychotherapy and medication. Phyllis received both.

Cut to Phyllis crocheting

The appropriate use of anti-depressant medications has helped many people with major depression.

Cut to CU Phyllis crocheting; pan to CU face

FAWCETT: The treatment for depression would be a medication which would increase the availability of certain neurotransmitters, perhaps norepinephrine, perhaps seratonin. Cassette 3-26 in 2:16

We would use medications like the tricyclic anti-depressants, for instance, Elavil or Tofranil are well known medications. Cassette 3-26 in 4:12

NARRATOR: As Dr. Fawcett notes, anti-depressants increase the level of certain neurotransmitters. There are two kinds of medications that accomplish this. The tricyclics and the MAO inhibitors.

Graphic: enlarged neuro-transmitter in upper left

ADD: Tricyclics
ADD: MAO Inhibitors

For a long-term mood disorder in which biology is a major causal component, such medications can often work wonders. The problem is they don't work for everyone who takes them. In addition, the dosage must be watched carefully; there can be dangerous physical and and psychological side effects.

Cut to B-Roll: Pill factory

BAILLIET: Any medication you- you may take will have side effects. The importance of the side effects has to be measured against the benefits of the medication and the cooperation and the motivation of the patient's extremely important. Tape 3-35 at 7:47

PHYLLIS: But my medicine, I- I depended on it too much at first. I thought I'll never be sad again; this is wonderful. I'll never have to worry again; but I was wrong. Medication can only do so much. You have to start to make your own recovery on back though the road and you have to go and you have to mend every bridge that you've broken. Cassette 3-10 in 11:52.

NARRATOR: For some people medication <u>is</u> enough, and some get better without any treatment at all. Many others need and can benefit from psychotherapy -- with or without medication. In therapy, people examine how their life experiences and early events have affected them. For a long time this has meant psychodynamic psychotherapy -- a model in which unconscious conflicts, considered to be at the heart of the depression, are uncovered.

Cut to Drawing: pan from R -¢ L on 4 people on bench

Cut to WS group therapy

Cut to CU 3rd from R; pan L

Cut to MS woman therapist and Asian man

Cut to MS Asian man

Cut to XCU Asian man

At Soundview Clinic, where Dr. Bailliet is the medical director, Margarita is being treated by Gary Edelstein, who uses psychodynamic principles.

Cut to MS Bailliet & Edelstain

EDELSTEIN: I- I would say that that depression is not only the anger turned inward but it was the result of the conflict between her anger, her aggression toward the husband and also her conflicting need, affection and dependency on the husband.

That creates a conflict which, for the patient, unresolvable and result in them just psychologically giving up and that's the clinical manifestation of depression.

Cut to MS Margarita and daughter doing homework; pan to CU Margarita

Therapy consequentially focuses on the identification of this aggressive impulse and the understanding of how it's being rechanneled and conflicted so that when the patient understands that in a more clear way, she's able to accept the feeling and understand that it's an appropriate and- and- and human feeling and doesn't mean that you will deprive yourself of that dependency object. Tape 3:34 at 17:12

NARRATOR: Today, in addition to psychodynamic psychotherapy, there are some new, short-terms psychotherapies available.

Over Bailliet/Edelstein

Cut to Fawcett

FAWCETT: Right and different individuals need different mixes and even different types of psychotherapy; we talk about psychotherapy as if it's one thing, but there are many different types of psychotherapy.

Not everybody in my opinion, should have psychoanalytic psychotherapy that has a depression. Some people need it. Some people will do better with a cognitive form of psychotherapy. I think it takes some expert judgement to decide what a person needs. And a person - anyone who evaluates people with a depression should be familiar with all the different types of therapy available and make a decision on an individual basis, what a patient needs in each case.

And again, everybody wants simple answers to these questions, one or either/or, one or the other, and that's just not how it works with human beings. They- they're so different and so individual. Cassette 3.28 in at (;28 out at 10:17.

YOUNG: There's been a lot of advancement in the past 10 or 15 years for psychotherapy in depression. The two that have emerged as being demonstrated by research to be effective in depression are cognitive or cognitive behavioral therapy and interpersonal psychotherapy.

Those are both types of therapy which were, at least originally, specifically developed for depression and were specifically developed to work in a prescribed period of time, usually two or three months. NEW OUT. Cassette 3-30 in 4:55 out 5:36.

The theory of cognitive therapy is that our feelings and our behaviors are to a large extent determined by the way we think about things.

Cut to CU notepad in therapy drawing; zoom out to two black men therapy

So, for example, if I- someone criticizes something I say, and then I might ask you, well, how do you...

Cut to CU therapist; pan to CU patient

...how am I going to feel when that happens. It's almost impossible to answer that question without knowing what I think about having been criticized.

The depressed person has negative evaluations of themselves, tends to put a negative cast on events that happen, a negative view of the world in the...

Cut to CU patient; zoom out to WS patient and therapist

...future, and therefore feels and behaves in a depressed way.

So the way we translate that into therapy is to identify with the person the thoughts that they're having, not an analysis of their- of the psychodynamics or the psychological processes underneath, like you might in traditional therapy but just what their thoughts are.

And then with them, we evaluate whether there are distortions in those thoughts, whether their are alternative ways of thinking about the situation, alternative beliefs they might have, and alternative ways of behaving that might yield different results.

And with them, we evaluate those thoughts and beliefs, look for changes that can be made, have the people do what are often called behavioral experiments where they'll go out and do something in a different manner than they usually do and see what happens as a way of changing their evaluation of what's going on, changing their thoughts, and then if their thoughts change, their feelings will naturally change in response. 3-30 in 7:29

PHYLLIS: I now know that when I start to think about something sad, that I start to say to myself- I- I try to use the coping skills that my psychiatrist has given me along with the- the help that I've had from Mood Challenges. Like, you're really not this bad person; you did this but you are able to take the responsibility for it now. Cassette 3-10 in 11:15.

FAWCETT: I don't see psychotherapy and medication as an either/or question. Some patients that have more severe depressions are not going to get better in my opinion without medication, in the more severe level.

Many patients need both psychotherapy and medication to fully recover from their depression. There are a few people who can have even severe depressions who have intact personalities who could be treated with medication and some supportive psychotherapy and recover without any further need for therapy.

There are those people. But that is not to say that you- you can replace psychotherapy with medications in patients who need both. You simply cannot do it. Cassette 3-28 in 7:28.

EDELSTEIN: I would say that, really looking at the whole person involves our not falling into a particular ideological position but utilizing all of the knowledge that's available to help our patient. Tape 3-34 at 20:32

NARRATOR: When patients are so severely depressed that they can no longer function, or they are suicidal, and haven't responded to drugs or other therapies, many professionals think that ECT, electroconvulsive therapy, may be the only option left.	Cut to Drawing: WS woman in stupor Cut to CU Cut to XXCU Go out of focus

How ECT works is not fully understood. A convulsion is produced by passing an electric current through the brain. In 80% of those who receive ECT, the depression lifts within weeks. ECT, was first use as a treatment for depression in 1938. The controversy that surrounds it is the result of its history of overuse and even abuse.

Cut to ECT drawing: CU machines; zoom out to MS

Cut to CU ECT patient

Cut to footage: CU patient

Cut to CU machine

Cut to CU forceps going on head

In the 1940's and 50's ECT was widely used in mental hospitals - often indiscriminately. Patients experienced long-term memory loss, bone fractures, and heart attacks.

Cut to chest down length of man convulsing

In the 1960's and 70's ECT fell out of favor, replaced by psychoactive drugs. But psychiatrists were faced with the problem of treating severely deprssed patients who didn't respond to medication. ECT has been making a come back.

Cut to footage: man getting on examining table

But there have been changes. The length and the intensity of the electrical charge have been reduced as have the number of treatments. Patients are now given strong muscle relaxants - to prevent (broken bones) and they are carefully monitored.

Cut to CU ECT machine
Cut to CU man; pan up to doctor

Cut to CU machine
Cut to WS ECT procedure; zoom in to CU giving man shot

Cut to BP sleeve being put on
Cut to MS man getting ECT charge; zoom back

In spite of these changes, there remain critics who think that the possibility of long-term memory loss is a high price to pay for the relief of severe depression.

The percentage of people with major depression requiring ECT is very small. For the majority, psychotherapy and medication prove effective.

Cut to WS room after ECT, wheeling patient out

DISSOLVE

TITLE CARD: BIPOLAR DISORDER

TITLE CARD: TREATMENT

NARRATOR: For bipolar disorder, the same is true; here treatment usually involves the administration of the drug lithium carbonate, and some form of psychotherapy.

Dissolve to B-Roll: Rod in office

FAWCETT: The patient who is- has manic-depressive illness, as far as we know...

Over B-Roll: Rod

...has it for life. Like diabetes or any other metabolic illness that's genetic, they have it for life, which means they could have an episode any time during their lifetime if they're unprotected.

There is protection to prevent episodes in the majority, the vast majority of cases. And the most standard protection is lithium carbonate although there are other new medications we have for patients who don't- aren't protected by lithium carbonate. Cassette 3-27

RODNEY: I think the quality of my life has never been- it's- it's never been any better. When I look back even a year ago, I didn't know what I was going to be doing and it's- it's just kind of evolved; it's been- I'm spiraling up. And it's just worked out great. I'm managing my- my illness, you know, with lithium.

I take 1200 milligrams a day. Cassette 3-22 in at 3:11 out at 3:34

FAWCETT: The likelihood of recurrence with just average treatment- when I say average treatment, that includes people that don't take their medicine- the risk of- the five years risk of recurrence is close to 80% in this illness. Cassette 3-27 in at 2:25 out at 2:36

NARRATOR: For those who take their medication as prescribed, only 20-30% will have a recurrence over a two year period. But even with medication, psychotherapy may be an important part of their overall treatment.

B-roll: Rodney in office

Dr. Knafo relates the history of Lester, a bipolar patient.

Cut to CU Knafo

KNAFO: He had a long history of depression but he also had had several manic episodes for which he had been hospitalized. So here he was hospitalized this time. He was about the age that his father was when the father committed suicide.

NARRATOR: In the hospital, Lester was treated with lithium carbonate and participated in psychodynamic psychotherapy with Dr. Knafo.

Over Danielle

KNAFO: A lot of work had to be done in terms of separating Lester's identity from that of his father's and also in allowing him to mourn the death of his father. Apparently, in his family, emotions were not tolerated so he was never allowed to grieve his father's death.

NARRATOR: Eventually Lester responded to the treatment, moved out of the hospital and back into society.

Over Danielle

In addition to medication and psychotherapy, self-help groups like Mood Challenge in Peoria can offer social support to those who are coping with mood disorders.

Cut to B-Roll: Mood Challenge

WOMAN IN ORANGE: What you have to remember is, the illness, it effects different people differently. Like, you- just because you have certain sensations and the illness effects you in a certain way doesn't mean that it effects other people the same way. Cassette 3-14 in 17:32

DON WELLS: We tend to do that. We tend to tunnel our vision from our viewpoint.

WOMAN IN ORANGE: Right. Exactly.

DON WELLS: Rod's mania may have been entirely different from mine. But the music and the lights...

ROD: There's a-there's an awful - There's an awful lot of similarities. There's a lot of similarities I think, just by talking with you about yours. (This is Rod in the group)

WOMAN IN ORANGE: My son, unfortunately isn't- isn't in as good as shape as Rod's or you. He's still struggling with trying to get this under control and right at this moment, he's in a depressed state. He's- He's functioning, going to work but that's all he's doing. He comes home from work and goes to bed. [out 3-14 at 18:23]

ROD: (from interview) The other members of the group have been through what I've been through. They know what I'm feeling. They know the questions that- that I face about the medication, about treatments, about reestablishing my life in the community because the majority of- the majority of them have been there. And- and you just can't get that anyplace else. Cassette 3-22 in 4:10

DISSOLVE

TITLE CARD: SUMMING UP

NARRATOR: We have talked about two types of mood disorders major depression and bipolar disorder.

Cut to B-Roll: Mood Challenge

For both categories the episodes can range from mild to severe. When mild, other people wouldn't know that there is anything wrong - when severe total incapacitation can occur.

Margarita, kids and ice cream with daughter

There are many theories about what causes depression and manic - depression - one dimensional explanations are inadequate.

B-Roll: Rodney in car

We must evaluate risk factors - psychological, biological and environmental - and the complex ways they interact; and then assess each person individually - to determine which treatment or treatments would be the most beneficial. The bad news is that 1 in 10 Americans will experience a mood disorder. The good news is that in most cases mood disorders can be successfully treated.

Cut to B-Roll: Phyllis & husband on porch swing

Cut to B-Roll: Phyllis & flowers

JAN: Whoa. Whoa. Night and day. That's - I mean that's a real easy way of saying that before we lived in darkness and now we live in light. That's a real easy way of saying it because it's like, okay, it's like this is- once there's a name, once there's a label, it's like okay, it's not me; it's not her. You know.

And you can let it go. You don't have to dwell on, you know, what could have been and what should have been and it's kind of like- it's kind of like a catharsis in the cocoon. It's like okay, we're free.

She's happy. I mean, I could never disagree with her at all and- and now I can disagree with her, tell her I disagree with her and she still likes me. It's like alright. You know, this is- this is I think I'll keep her, you know. Stick around.

RODNEY: Well I do a number of things. I think it- I guess it's just when the mood strikes and it's not the mood disorder, you know. You know, it's- I like to, well, just a couple of weeks ago- just two weeks ago, I went scuba diving down at my parents' lake, I did my first open water dive there. And that was a great experience.

And I like to bicycle ride and I'm involved in competitive volley ball at the "Y" and, I mean that usually carries over for about nine months. It's going to be starting up again shortly and I'm excited about that. Cassette 3.17 14:25-15:01.

I just really- I mean I love life. I have so- just such a- I think I have a positive outlook. There's- I can't think of anything I- I don't like to do. I mean, If I haven't done it, I'll try it, you know. Cassette 3.17 in at 13:53 out at 14:14.jp29