

ADDICTION:



FACT

and

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**HOLLYWOOD
HEALTH & SOCIETY**

Entertainment Education for Television, Movies & New Media

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CENTER

An edited transcript of a panel discussion held on January 11, 2010
at the Writers Guild of America, West



THE NORMAN LEAR CENTER

The Norman Lear Center is a nonpartisan research and public policy center that studies the social, political, economic and cultural impact of entertainment on the world. The Lear Center translates its findings into action through testimony, journalism, strategic research and innovative public outreach campaigns. On campus, from its base in the USC Annenberg School for Communication & Journalism, the Lear Center builds bridges between schools and disciplines whose faculty study aspects of entertainment, media and culture. Beyond campus, it bridges the gap between the entertainment industry and academia, and between them and the public. Through scholarship and research; through its conferences, public events and publications; and in its attempts to illuminate and repair the world, the Lear Center works to be at the forefront of discussion and practice in the field.

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ADDICTION: FACT & FICTION

As part of Hollywood, Health & Society's outreach to writers, expert panelists offered compelling stories about addiction – from substance abuse to treatment and recovery – during this lively discussion on January 14, 2010 at the Writers Guild of America, West.

A video of the program can be watched in its entirety online at:
<http://www.youtube.com/watch?v=WGxYSL1v7dA>



HOLLYWOOD, HEALTH & SOCIETY

Hollywood, Health & Society (HH&S), a program of the Norman Lear Center, provides entertainment industry professionals with accurate and timely information for health storylines. Funded by the Centers for Disease Control and Prevention, The Bill and Melinda Gates Foundation, The California Endowment and the National Institutes of Health, HH&S recognizes the profound impact that entertainment media have on individual knowledge and behavior. HH&S supplies writers and producers with accurate health information through individual consultations, tip sheets, group briefings, a technical assistance hotline, panel discussions at the Writers Guild of America, West, a quarterly newsletter and Web links to health information and public service announcements. The program also conducts extensive evaluations on the content and impact of TV health storylines.

For more information, please visit:
www.usc.edu/hhs.

PARTICIPANTS



TIMOTHY P. CONDON, PhD serves as the Deputy Director of the National Institute on Drug Abuse (NIDA), where he provides leadership in developing, implementing, and managing NIDA's research programs and strategic priorities. Drawing on a lifetime of work in neuroscience with a strong translational emphasis, Dr. Condon guides the Institute in bringing science-based findings to community treatment settings. He has initiated

enduring partnerships with multiple stakeholder groups, including other federal agencies, the criminal justice system, and the treatment and prevention practitioner communities, with whom he has been particularly effective in advancing the real-world use of evidence-based interventions. Dr. Condon regularly interacts with audiences around the country to communicate knowledge about the fundamental aspects of drug abuse—from emerging trends to how drugs work in the brain and body to promising treatment and prevention approaches. Before coming to NIDA in 1992, Dr. Condon served in several senior positions, managing research and service programs at the former Alcohol, Drug Abuse, and Mental Health Administration and directing emerging neuroscience technology assessment for the U.S. Congress, Office of Technology Assessment.



NEAL BAER, MD is a Harvard-trained physician, practicing pediatrician, and award-winning television writer and producer. Since 2000 he has been the Showrunner and Executive Producer of the NBC series *Law and Order: Special Victims Unit*. Before his tenure at *Law and Order*, he was Executive Producer of *ER*. Recently, his mentorship of a Mozambican HIV/AIDS orphan resulted in the documentary film *Home Is Where You Find*

It. He was also an adjunct professor (2001–2005) at the University of Southern California teaching in the area of health communications, health promotion and disease prevention, and sex education. He is also Co-Chair of Hollywood, Health & Society.



DAVID FOSTER, MD is an in-house medical consultant and Supervising Producer for the Emmy Award-winning drama *HOUSE*. Dr. Foster was brought on the case through his friendship with Dr. Neal Baer, a medical-school classmate. When it comes to *HOUSE*, Dr. Foster is something of a general practitioner. In addition to his writing responsibilities, he's charged with bringing authen-

ticity to the proceedings. "He's obviously indispensable to the show," said David Shore, the creator and executive producer of *House*. "He comes at the stories with a writer's point of view but with a medical expertise. And," he added, "we annoy him with all our symptoms." During the first season of *House*, Dr. Foster commuted to Hollywood from Boston, where he ran a detox clinic in an inner-city neighborhood. With the success of the series, he turned in his white coat and moved his family west.



SAM CATLIN Sam Catlin moved to New York City from Boston when he was 16. He enrolled at New York University to study acting; both as an undergraduate and then in the masters program at the Tisch School of the Arts. He moved to Los Angeles in 2000 to take his acting career to the next level. In other words, he became a writer. His first feature, *The Great New Wonderful* was produced, starring Tony Shaloub, Edie Falco, Will Arnett, Judy Greer and Maggie Gyllenhall. In television, he's worked on NBC's short-lived series *Kidnapped* starring Timothy Hutton and Jeremy Sisto, as well as Fox's even shorter-lived *Canterbury Tales* starring Julianna Margulies before joining AMC's *Breaking Bad* in 2008.



KAREN MIOTTO, MD is a Clinical Professor in the Department of Psychiatry and Behavioral Sciences at UCLA. She is also the Medical Director of the UCLA Addiction Medicine Service and the Medical Director of the Opioid Treatment Program at the Downtown Los Angeles Ambulatory Care VA. Dr. Miotto is frequently an invited speaker at local and national addiction meetings. Her research is in the area of medication development for addictive

disease.



JONATHAN M. SAMET, MD, MS is Professor and Flora L. Thornton Chair of the Department of Preventive Medicine at the Keck School of Medicine of the University of Southern California (USC), and Director of the USC Institute for Global Health. Dr. Samet received a Bachelor's degree in Chemistry and Physics from Harvard College, an M.D. degree from the University of Rochester, School of Medicine and Dentistry, and a Master of Science

degree in Epidemiology from the Harvard School of Public Health. His research has addressed active and passive smoking and the effects of inhaled pollutants in the general environment, both indoors and outdoors, and in the workplace. Dr. Samet has served as Editor and Author for Reports of the Surgeon General on Smoking and Health



LOWELL CAUFFIEL's recovery from alcoholism and drug addiction has played a major role in shaping his twenty-five-year literary career. He is the best-selling author of nine books and a former Detroit reporter who has won many awards, including citations from the Columbia Graduate School for Journalism. His New York Times best selling books *Masquerade* and *House of Secrets* have appeared on many critics' lists of the best works in American

true crime. He has appeared as an expert in many crime documentaries and also has written and produced documentaries for the Discovery Channel. In his seven years as a screenwriter in Los Angeles he's created four dramatic series pilots for CW, NBC and HBO.



SANDRA DE CASTRO BUFFINGTON, MPH is director of Hollywood, Health & Society (HH&S), a program of the USC Annenberg Norman Lear Center that provides Hollywood's entertainment industry professionals with accurate and timely information for health storylines for television, film and new media. Her research demonstrates the profound impact that entertainment media have on individual knowledge and behavior. Sandra is

known for her award-winning work in global health, entertainment education and social transformation. She has 30 years of experience working in global leadership, entertainment and emergence technologies; 20 years were spent working internationally, and five of those years were spent in residence overseas. Sandra has received numerous honors and awards including the USAID Maximizing Access and Quality Outstanding Achievement Award for her social change programs, and Brazil's Award for Leadership in developing the Bahia State Reproductive Health program.



MARTIN KAPLAN, PhD is the Lear Center founding director Martin Kaplan, a former associate dean of the USC Annenberg School, holds the Norman Lear Chair in Entertainment, Media and Society. A summa cum laude graduate of Harvard in molecular biology, a Marshall Scholar in English at Cambridge University, and a Stanford PhD in modern thought and literature, he was Vice President Walter

Mondale's chief speechwriter and deputy presidential campaign manager. He has been a Disney Studios vice president of motion picture production, a film and television writer and producer, a radio host, print columnist and blogger.

ADDICTION: FACT & FICTION



Martin Kaplan: I'm Marty Kaplan, the Director of the Norman Lear Center, which is located at the USC Annenberg School for Communication. The Norman Lear Center is named after Norman Lear because he has used the power of entertainment not only to entertain and amuse, but also to inspire and uplift and educate and provoke. That's something that we study at the Lear Center. We not only work in television and film, but also in areas like fashion and music and – believe it or not – news, politics, religion, science.

Of the Lear Center projects, tonight is a particularly special one. It's our Hollywood, Health & Society program. John Wells, the President of the Writers Guild of America, West, is the co-chair of the Board of Hollywood, Health & Society. The program looks at the ways in which the power of entertainment and the power of its storytellers – who are also here tonight – can affect health and affect the people watching shows.

So I'd like to introduce to you your "sherpa" for this evening, the Director of the Hollywood, Health & Society program, Sandra de Castro Buffington.

Sandra de Castro Buffington: Thank you Marty. Good evening everyone and welcome. I'm so glad to see all of you here. Thanks to the Lear Center and Hollywood, Health & Society staff who have organized this wonderful evening for us. A special thank you to Courtenay Singer, who's sitting in the doorway.

So Hollywood, Health & Society works with television writers to get them accurate health information from experts for their scripts. We also put on events several times a year to address the

most important public health topics of our time. Some topics of particular interest over the past year have been the medical aspects of addiction; the psychological aspects of addictive behavior and the various personal and social consequences of addiction. Writers calling us have been interested in addiction to prescription drugs, street drugs, alcohol, cigarettes and more. And tonight we have an extraordinary panel who will speak to you about the many facets of addiction.

You'll hear from a high-level addiction policy expert from the U.S. National Institutes of Health. In addition, established television writers and producers will talk about creating and writing powerful shows about addiction. Also on the panel is a well-known expert who specializes in the medical treatment of addiction and she's followed by a specialist who will talk about the enormous global problem of tobacco addiction. Last but not least, you'll hear some compelling personal stories from a recovering addict who is also a celebrated author.

To speak with us tonight about addiction and addictive behavior from a national policy perspective, I am delighted to introduce Dr. Timothy Condon. Dr. Condon is Deputy Director of the National Institute on Drug Abuse, NIDA, which is part of the National Institutes of Health. At NIDA, Dr. Condon leads NIDA's research programs and the setting of strategic priorities. And drawing on a lifetime of work in neuroscience, Dr. Condon guides the Institute in bringing science based findings to community treatment settings. He has initiated enduring partnerships with multiple stakeholder groups, including other federal agencies, the criminal justice system and treatment and prevention practitioner communities.

Dr. Condon interacts with audiences around the country to communicate knowledge about the fundamental aspects of drug abuse, from emerging trends to how drugs work in the brain and body, to promising approaches for treatment and prevention. We very much look forward to hearing his presentation, so please join me in giving a warm welcome to Dr. Timothy Condon.

“Writers calling us have been interested in addiction to prescription drugs, street drugs, alcohol, cigarettes and more.”

Sandra de Castro Buffington

Dr. Timothy Condon: Thank you very much, Sandra, for that lovely introduction and good evening everyone. Oh good, we're not in a postprandial slump, so I'll get through my comments and then everyone will start to fade a little bit.

I'm delighted to be here. I want to thank Sandra and the Lear Center for inviting me. This is a really important gig for me. I get to do this sort of thing. I'm a pocket-protector neuroscientist by training. , they don't let me carry that around anymore. The staff say, "Don't do that." Sandra told me my picture was going to be up on this screen. This is my glamour shot when I became the Deputy Director six years ago. Yeah, blame it on stress; number one reason for all kinds of things.

So I do this out of a commitment and a passion for this issue – and a family history with addiction. I wanted to start by telling you a story, because you're all storytellers. I'm a consumer of the stories you tell. I watch television a lot. We've got a dog that liked to put on elastic waist pants and sit on the sofa with us and watch TV and movies. So you are my peeps. I really enjoy what you do.

I'm gonna play a Sophia on you, from *The Golden Girls*. Picture this: 1976, newly minted bachelor degree, biologist, psychologist, can't decide whether he wants to go to medical school or go into research. Did undergraduate research in diabetes research; thought that was really very important and very interesting. Decides to go work in the Boston Veterans Administration hospital to see if he wants to go to medical school. And , if you like medicine in a VA hospital – remember, picture this 1976 – then medicine is your calling, because that was socialized medicine in 1976.

That didn't quite work out the way I had hoped, so I ended up going into a research career. Remember, the year is 1976 and our treatment of cancer has changed dramatically over the years. I worked in a laboratory on a wing of the hospital where patients had chronic diseases. You would often see the veterans – old gentlemen being wheeled to the radiation floor where they'd get



Dr. Timothy Condon, Deputy Director of the National Institute on Drug Abuse

their radiation and back. In those days they would draw with dye, purple lines on their bodies, on their faces, on their throats, so that you could identify what areas were being irradiated. I'll never forget the sight of these men, these veterans who had served their country. They were getting appropriate medical care.

But I'll never forget the sight of more than one sitting in the cafeteria smoking a cigarette through their trach tube. That's addiction. That's what we're talking about; compulsive drugs, seeking it and using it in spite of the negative health and social consequences. You can't stop. That's addiction. I won't say that it's driven me to where I am today, but that was one of the most salient things I remember about the experience working in that Veterans Administration hospital.

So I went on to a career in neuroscience – neuropharmacology – got off of the pancreas, onto the brain. This is where the action is. Then I found myself a number of years later at NIDA and I've stayed there. Remember, about 6.5 years ago I became the Deputy Director of National Institute on Drug Abuse.

I want to tell you three points. Neuroscience in the last two decades has phenomenally changed the way we think about addiction and how drugs affect the brain. Boy, neuroscience is an incredible frontier and I've been privileged to be part of the funding of those neuroscience research projects and the translating of that information into new treatments, prevention strategies and to some extent to new policies. The 1990s were the decade of the

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Dr. Timothy Condon



brain. Many of you probably didn't know that. But it really was a phenomenal time and we had so many advances.

I recently had an experience where I was talking to an audience of high school journalists. I usually show in my slide presentation the egg in the frying pan. And I say, "Well, that was popular in 1987, Partnership for Drug-Free America." And then I show them a PET scan or a functional MRI of your brain on drugs, which we have tons of now. That technological leap happened in the early '90s. I asked these high school students, "Do you remember this?" The teachers are saying, "Oh yeah, yeah, I remember that." Not a single student knew. This is the first time it ever happened. Boy, did it make me feel old.

But the point is that we had dramatic changes in the technology that catapult the science. We started to understand about the circuitry in the brain, about the neurotransmitters that are involved in addiction. For a while it was dopamine, dopamine, dopamine. Still is, because dopamine is one of the major neurotransmitters involved in reward of reinforcement in the brain. There are many other neurotransmitter systems involved as well. As you would imagine, it's a very complex system. But one thing we are able to see is that the circuitry involved in natural rewards, natural pleasures, and reinforcing behaviors are very much the same circuitries involved in drug abuse. It's the same kinds of reactions – and that's not a surprise.

Food and sex – pleasurable experiences. We wouldn't be here unless they were reinforcing experiences. Those same circuits are the ones that drugs of abuse work on, both in the nucleus accumbens and the limbic system of the brain – the older areas of the brain, the emotional centers. That's one of the reasons why people take drugs, to stimulate those areas.

It brings us to another point: Why do people take drugs? I break it down into two distinct categories. People take drugs to feel good or people take drugs to feel better. These are two very different

groups of individuals. Taking drugs to feel good, you take them for the novelty, for the fun, for the euphoria. A lot of our young people take them in social activities with others.

People who take them to feel better may be suffering from mental disorders, from depression, anxiety. They may be in despair, they may be hopeless, they may be in withdrawal. They may be taking drugs just to get through the day, to make it till tomorrow. So our prevention and treatment approaches for those two different groups of people are going to be very, very different.

For someone who is trying to make it through the night, who is in crisis, I can show all the pictures of their drugs on brain I want. It may not make any many difference at all. But you might be able to say to a young person, "Go do some bungee jumping, something safe like that, and you could get the same exhilaration euphoria, dopamine rush from that."

We have to treat these groups differently. It's not to say that people who start off taking drugs to feel good don't end up becoming people who take drugs to feel better. Many people take drugs not only to chase the high, but to chase away withdrawal. They chase away the withdrawal symptoms once they become addicted.

So who is vulnerable to become addicted to drugs? You? Me? Yes, all of us are. We all have different vulnerability quotients. It's a very complex formula. It's a combination of your genetic makeup. I can say with all honesty that everybody in this room has a different neurochemistry, so all of your brains are different and all your genetic makeups are different. And we know from research that in addiction has a very large hereditary component, or genetic load as we call it – roughly around 50 percent.

That doesn't mean that if you have a predisposition to addiction that you are going to become addicted. On the other hand, you could have a very low genetic load and you could be in environment where there are lots of drugs. It's not clear that you actually

“ *People take drugs to feel good or people take drugs to feel better. These are two very different groups of individuals.* **”**

Dr. Timothy Condon

wouldn't end up at some point having a problem with drugs. Does everybody who uses drugs become addicted? Absolutely not. The number for some drugs is very, very low; for others, again, it's a very individual thing. But no, most people who use drugs do not become addicted, do not have problems with it. But there are those who do. They are the individuals that our research is here to serve and they are the compelling stories that you tell in a lot of what you do.

One thing I wanted to tell you about neuroscience is especially what our young people are most vulnerable to these days. Here in California, people are smoking pot. We know that. Cannabis, alcohol and tobacco – those are still the big three. But coming up on cannabis and actually increasingly overtaking it is prescription drugs. We have a huge prescription drug crisis in the country. And why is this a crisis all the sudden?

In 2008, there were about 180 million prescriptions for opiate analgesics filled by pharmacies in the U.S. That's about 10 times the number that there were 15 years ago. We have a national survey that we do every year with 50,000 high school students nationwide since 2002. And since that first year, we've asked them questions about Vicodin and OxyContin. The numbers have been very consistent. I didn't believe them at first because it said that one in 10 12th graders had taken Vicodin last year. I didn't know 12th graders knew what Vicodin was. Now one in 10 had actually taken it for nonmedical purposes and that number has stayed consistent since 2002. One in twenty have taken OxyContin for nonmedical purposes. So we have a major crisis in prescription drugs in the country for our young people as well as for our adults.

Is addiction a disease? What happens after long-term exposure? Do people recover? Yes, of course, people recover from addiction. Those are the stories that are so rich, the stories of recovery. And there are so many different pathways for people to recover. There's self-help, there's treatment, of course. Some people just stop, some people never stop. I still remember the trach tube veteran;

some people never stop.

Is it a disease? Absolutely. In this country we still don't focus as much on it as a disease as we should. It is a chronic, relapsing disease, the science is clear. We still want to treat addiction as if it was a broken leg. Someone goes into rehab and 28 days later they come out and they're all fixed and it will never happen again. But that's not the way we can look at it. We have to look at it as the chronic, relapsing disease that it is, like diabetes. Diabetes also has a huge behavioral component.

I do a lot of judicial training. I was working to convince this one judge that alcoholism is a disease, like diabetes. He said, "you're never gonna convince anybody – never – that it's a disease. Everybody knows diabetes is genetic." And I knew he had that raspy voice because he was a smoker. So I asked him, "what about lung cancer?" I said, "we'll take out people's lungs, we'll irradiate, we'll use chemotherapy, we don't think twice about providing that appropriate care, as long as people need it. Yet, we don't do that with addiction. So, it is a disease."

The data's clear and we really need your help to really get that information out.

And I would thank you all for your attention today and good luck with the rest of this evening. I'm happy to be here.

Sandra de Castro Buffington: Thank you, Dr. Condon, for sharing your remarkable insights about addiction. I know we have questions for you, but I'm just going to ask you to hold off. We're going to hear from our panelists and then we'll open it up for Q&A.

I'd like to introduce our distinguished panelists. First, we have Dr. Neal Baer. Dr. Baer is a Harvard-trained physician, a pediatrician, a former Executive Producer of *ER* and he's currently Executive Producer of *Law & Order: SVU* on NBC.

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Dr. Timothy Condon



Neal Baer: At ten o'clock, as of today.

Sandra de Castro Buffington: Yes, at ten o'clock on Wednesday. Dr. Baer is also Co-Chair of our Advisory Board and makes a tremendous contribution not only to Hollywood, Health & Society, but to the health of developing countries worldwide. So thank you, Neal.

Next we have Dr. David Foster, Supervising Producer of the hit Fox series, *House*. Dr. Foster trained as an internist at Harvard Medical School. He not only writes and produces for *House*, but he also provides medical expertise that lends authenticity to the whole series.

Next up is Sam Catlin, Supervising Producer of the hit AMC series, *Breaking Bad*. Sam started out as an actor, but soon after moving to L.A. he began working as a writer. He wrote the feature film, *The Great New Wonderful*, starring Edie Falco and Maggie Gyllenhaal and he also worked on the television series, *Kidnapped* and *The Canterbury Tales* before joining AMC's *Breaking Bad* in 2008.

We look forward to hearing from these master storytellers and watching some short clips from their amazing shows.

Next we have Lowell Cauffiel, whose recovery from alcoholism and drug addiction has played a major role in shaping his literary career. He's an award-winning reporter and bestselling author of nine books. He has also written and produced documentaries for the Discovery Channel and created four dramatic series pilots for CW, NBC and HBO. His personal story of addiction is a powerful one and we look forward to hearing from him. Welcome Lowell.

We also welcome an extraordinary medical expert on addiction, Dr. Karen Miotto. Dr. Miotto is clinical professor in the Department of Psychiatry and Behavioral Sciences at UCLA. She is also the Medical Director of the UCLA Addiction Medicine Service and in the realm of research she specializes in the development of medication to



(From left): Sandra de Castro Buffington, Neal Baer and David Foster

treat addictive disease.

I'm also very pleased to welcome Dr. Jonathan Samet from USC. Dr. Samet is professor and chair of the Department of Preventive Medicine at USC's Keck School of Medicine. He is also the Director of the USC Institute for Global Health. Dr. Samet specializes in health problems related to tobacco in the US and overseas. His research has addressed smoking and the effects of inhaled pollutants in the general environment.

Please join me in welcoming all of our distinguished panelists. And with that, Neal, I'll turn it over to you.

Neal Baer: Thanks Sandra. Thank you all for coming. David, did you ever think that we'd be sitting here at the Writers Guild when we were in medical school? We were in medical school together and we used to look at all the other medical students and wonder what we were doing. Did you ever think you'd be here?

David Foster: No.

Neal Baer: Me neither. David went to Harvard Medical School and trained in internal medicine and then came onto the show, *House*. We're going to show a clip from one of the recent episodes he just co-wrote that shows *House* dealing with his Vicodin addiction for the first time.

(clip plays)

“David, did you ever think that we'd be sitting here at the Writers Guild when we were in medical school?”

Neal Baer

Neal Baer: Now we'll hear from David, speak about *House* and how he goes about writing someone who has a serious drug addiction.

David Foster: Thanks Neal. It's great to be here at the Guild. In the six years we've been writing the shows, as I think about how we thought about *House* and his use of pain medications, I've never thought of it as writing about a character who is addicted so much as writing about the gray area of several forces in *House's* life and they're sort of all in that clip.

The three things that I most frequently we think about are: one, you see someone who has real pain, debilitating pain. He's had damage to the nerves and muscle in his legs. He has real pain, which in and of itself clouds one's judgment, makes it difficult to work, leads one's personality to change, causes one to act in certain maybe irascible ways.

House is someone who clearly struggles with mental health issues. He's someone who's depressed. He's clearly someone who has a personality disorder. We can debate whether he has a narcissistic personality or an antisocial personality, but he clearly has mental health issues, which also push his personality in those directions.

The third thing that we usually think about is he takes pills – at times he's taken pills because he likes to get high. It's fun and he enjoys the high. When I think about writing those aspects of a *House* script and a *House* story, *House* lives in that gray area between all three of those things. That's his real life. The interesting thing – storytelling-wise – is life in those gray areas and how those different forces mix together and push each other differently each week through different plotlines and storylines. Different aspects win and affect his decision making, his choices and his relationships with the people in his life. We've written stories in the six years that highlight all different aspects of that.

On the more global issues – as someone who has worked as the

medical director of an inner city detox – it does my heart good to see the Guild having an event that talks about addictions because it has long been a forgotten area, an underappreciated area and an underpublicized area in the medical world. Addiction – along with mental health – are frequently ignored. I am proud that our show has been able to at least call attention to it. We can debate whether it's in a positive direction. When you say one in ten high school seniors have taken Vicodin, it gives me pause.

But it is a positive direction. Putting these stories in front of millions of people elevates the awareness and the discussion, and puts it on the radar screen. In 1994 when we were talking about health care reform, mental health didn't have a seat at the table. In 2010, thanks to the Wellstone-Domenici Mental Health Parity Act and other legislative advances, it's now part of the discussion. It's part of health care reform and that's a huge advance in 15 years.

Neal Baer: Thanks David. I think as writers we all care deeply about how our stories are viewed by the audience and what effect we may or may not have. What has your experience been hearing from the audience about *House* in terms of his use of drugs?

David Foster: We tend to hear the positive stories. We hear from a lot of people who say that they have family members who struggle with addictions or family members who struggle with mental health issues. This helps them find a way to sit and talk about these issues. We've also done quite a bit with some advocacy groups about providing people with places to turn. You may be struggling with depression but it's one thing to recognize it, it's another thing to know what to do about it. Awareness is great; action's better and so where do we turn.

Neal Baer: And what about the work that you all are doing with the National Alliance on Mental Illness? There are more ways to do things than just write the show. Tell us what you are all doing.

David Foster: We've partnered with NAMI, an advocacy group,



“*I've never thought of it as writing about a character who is addicted so much as writing about the gray area of several forces in House's life.*”

David Foster

and we've worked to raise money for them. We've also placed PSA announcements at the end of our show. For example, when we did an episode about the suicide of one of our characters, Dr. Kutner, we added a message at the end. We were concerned about dramatizing suicide on television. It's a touchy issue, and many shows worry about copycats and other ways that might encourage people to actually try and commit suicide. We put a PSA at the end telling people that if they have questions or concerns, or are thinking of this issue, please call this number – which was NAMI's national number.

Whenever we do a red carpet event, we wear NAMI T-shirts. When the press is taking our photos and asking questions of Hugh and the other stars of our show, they can respond to mental health and addiction issues and talk about how important addressing those issues are. That helps us raise awareness and have it become part of the conversation.

Neal Baer: Obviously the show is touching a lot of people. It's been a top-rated show for many years and I wonder if once he overcomes his addiction, what happens? But I'll have to keep watching.

David Foster: He hasn't taken a pill all year this year, so far.

Neal Baer: There is relapse.

David Foster: There is relapse. I appreciated your remarks about relapse because that is something we like to touch on a lot – it's a continuous struggle. There is no end zone. And even though he hasn't taken a pill all year, the show still deals with addiction.

Neal Baer: Right. It's not a switch that goes off and on and someone is suddenly better. Thanks. Sam Catlin is the Supervising Producer of *Breaking Bad*, which I'm sure you've all seen. And it deals with someone who actually makes methamphetamines. And we're going to show a clip from *Breaking Bad*.

(clip plays)

Neal Baer: Sam, please share with us what it's like to write a show about methamphetamines, and discuss the scenes that we just saw.

Sam Catlin: Dr. Kaplan was talking about the people who take drugs to feel good and the people who take drugs to feel better. The character of Jessie, at least until this point in his character development, has always taken drugs to feel good and he's a garbage head. He would smoke pot and it's working for him. He was just bored and underachieving and we took great pains to show that he wasn't from any sort of broken or neglected family or anything like that.

The sick one in the show is Bryan Cranston's character. He displays a lot more of the traditional characteristics of addiction, obsession and self-destructive behavior. At this point in season two, Jessie meets this girl who he has his first real adult relationship with. She's in recovery and obviously they feed off each other. Jessie's very much a follower. If he's around good people he's a good person. If he's around bad people he makes bad choices. This scene was towards the end of the second season. In season three, we deal a lot with his recovery, for lack of a better word. We did a lot of research into recovery and how hard would that be, how easy would that be. There are not that many recreational meth users, at least in our research. But Jessie had been that way up until this point. Then he reaches maximum capacity and basically



(From left): Sam Catlin and Lowell Cauffiel

“We’re very interested in the process of how the minutiae of people’s lives turn to crap.”

Sam Catlin

gives in to his addiction.

In terms of meth, which I knew nothing about before doing this show, Vince Gilligan’s idea behind it was to take the dirtiest, most awful drug a person could do and rationalize it as a necessary evil. The more we researched about meth and the effects it has on people, it’s just incredible.

People get disappointed when they tune in to the show initially because it has all the architecture of something that could be an escapist fantasy – a man living a dreary life, who finds excitement and empowerment. He gets to be a big bad Scarface gangster. But everything has consequences. The drug trade and drug use in our show ultimately turns out to be a bad thing for everyone.

We’re very interested in the process of how the minutiae of people’s lives turn to crap. We have an episode in season two where Jessie ends up in a tweaker house with what could be a husband and a wife and their little kid. It’s one of my favorite episodes. It’s funny in parts but there’s much about how it endangers children.

The research about this drug, I read this book called *Methland* about a small town in Iowa that was completely devastated by the drug. There are these horrific stories that I won’t go into. But the book also does talk about the macro level of the drug trade. It discusses how outsourcing created illegal immigration as agricultural companies advertised in Mexico, saying you can make \$8/hour. It’s a very effective book at explaining the giant levers of economics that help make these things possible. In season three, we begin to touch more on the larger issues of the cartels and the corruption and like that.

Neal Baer: Policymakers will argue that one of the most profound public health problems facing the United States is methamphetamine production and use. In terms of your show, it is focused on a man who’s been diagnosed with cancer and is selling meth. How do your writers deal with the consequences? How do

you deal with this when it is probably one of the most significant public health problems, particularly in small town America?

Sam Catlin: How do we deal with it in what sense?

Neal Baer: The consequences of someone selling these drugs or making meth in terms of the fact that it is a profound problem, a devastating problem in the United States.

Sam Catlin: The show’s not like *The Wire* in the sense that every week we check in with the broader effects on a community. We like to think of the show as Walt’s cancer, as in Walt is a cancer, as in everything Walt touches gets infected. As the show goes on, dealing meth turns out not to be a good thing. We certainly don’t glamorize it.

In the beginning we had some resistance from the community. The Albuquerque police were not warmly welcoming us, because it’s a show about a meth dealer. But now people in the community realize we’re certainly not championing the drug or the drug trade. We don’t have any colorful, flamboyant, “God, I wish I could be like that” drug dealers on the show. The show is very grim and the drug is very grim.

Neal Baer: It’s interesting in terms of having a major drug problem. How does a show can address that? We’ve seen clips from two different shows and they have very different approaches.

Sam Catlin: Sure.

Neal Baer: We’ll move on to Lowell Cauffiel, who is a writer and has intimate experience that he has kindly agreed to share with us – particularly about how it has affected him as a writer and how he tells stories about his life dealing with these issues.

Lowell Cauffiel: Thank you Neal. I was thinking before we started that it’s an irony to be the resident dope fiend among



such an esteemed panel. When you started talking about medical school and whether you ever thought you'd be at the WGA, I was remembering 27 years ago as I was cutting up three ounces of quality Peruvian rock cocaine with a lab scale in my office – to sell to friends – and drinking a half-gallon of whiskey, if I ever thought I'd be sitting with the Deputy Director of the National Institute of Drug Abuse. Isn't life a hoot!

In Hollywood at the Writers Guild and alls we need is a couple of DEA agents and it would be a complete mind blower.

Sandra asked me if I could talk a little bit about what happened to me, what it was like, what happened, and what it's like now in the context of addiction. I've been sober and clean for 25 continuous years. I had a lot of help.

It's hard to summarize that into five minutes so I decided to focus on the myths of experiences like mine and what people think an addict is or what recovery is like. These are myths that are held by average people who know nothing about it. But they're also reinforced by our industry, although we've gotten so much better about it with shows like *House* and *Breaking Bad*. But there are many, particularly journalists, who don't seem to understand the problem.

One of the big myths is that it's all about the drug. Is cocaine addicting? Is it psychologically addicting? Is pot really addicting? It's not physically addicting but it could be psychologically addicting. Heroin's physically addicting and there's horrible withdrawals. In my experience and in the experience of many, many addicts and alcoholics I know, the drug really isn't the issue. The issue is the person taking the drug and what the drug does for that particular person.

We always say in recovery that addiction's got three stages. There's the fun stage, which is doing it for pleasure. Then there's the fun in trouble stage and then there's the all trouble stage. Looking

back on my own life, conditions were there for my addiction long before I ever drank or used a drug. Because I always felt I'd been dropped off by aliens onto the earth and somehow I didn't fit in. Other people were having experiences in life and my insides didn't match their outsides. Now we know it gets to this dopamine issue, that there was something lacking in my brain that didn't allow me to fully experience real life and reality.



Lowell Cauffield

For me the best way to describe an addict is this joke that I've heard around in recovery circles. A couple of psychologists decide to run a test on three different people with mental disorders. The first is a neurotic, the second is a schizophrenic and the third is an alcoholic. They bring in the neurotic and say, "We have one question to answer; how much is one plus one?" And the neurotic goes, "Well, I think it's two but I have to check with my mother and see if she approves of my answer." They send him out.

They bring in the schizophrenic and they ask, "How much is one plus one?" And he says, "Well it's the color blue and green and it's got a Jimmy Hendrix solo." They send him out and they bring in the alcoholic and ask, "How much is one plus one?" And he says, "Well of course it's two but it's just not good enough."

That was the major thing for me – that there was something missing inside me. Then I discovered drugs and alcohol – pot and beer in the beginning. I became a chronic pot smoker which became problematic when I became a newspaper reporter. On drugs, I felt connected to people, to the world and I could dance. It was a lot of fun and I had a lot of good times. Then some trouble began to leak in which then became a lot of trouble. I tried to quit. And this is another myth: Why do we keep using? When we stop we become so restless and irritable and discontent with life as it is,

“ ...the drug really isn't the issue. The issue is the person taking the drug and what the drug does for that particular person. ”

Lowell Cauffield

it's just better to get high. In my experience and in the experience of many others, we don't have a drug problem. Drug and alcohol is not the addict's problem. It's the lack of drugs and alcohol that are the addict's problems. It's when you take it away, what our life becomes.

This *House* episode does a great job of illustrating that. He begins to come unnerved, even in just those clips we saw that. I never lost a job, although I rescued my job a lot of times by performing miracles after near disasters. I never lost my family, but I had a couple of – well, I don't even want to get into those details. I never crashed a car, never got a DUI. But I did crash an airplane.

The bottom for me was when I became something I didn't even recognize anymore. In the pursuit of getting the substances I needed just to feel normal, I lied, I cheated, I just had to get it. I reached a state of incomprehensible demoralization. I felt like I was living a lie while busting people as a newspaper reporter for lying and cheating and had a whole double life going. It was an emotional bottom for me.

When I got into recovery, the big wakeup call was realizing there were other people like me. Recovering from this disease means you have to change everything; the way you look at things, the way you react to things, the ability to live life on life's terms. A big part of it also too is service, going into service and helping others. That is what gave me the sense of completeness, the recovery experience that I was always looking for in the drugs and alcohol.

Neal Baer: Thanks. That is really moving and we really appreciate your honesty. As you were speaking it raised a lot of questions from about how we deal with people we know who have addictions and also how we deal with our characters in our shows. Because we're here as writers, I wanted to ask you what advice would you give to us so that we can be truer to the characters or more honest? How can writers do a better job? What should we do? How can we do this?

“*Drug and alcohol is not the addict's problem. It's the lack of drugs and alcohol that are the addict's problems. It's when you take it away, what our life becomes.*”

Lowell Cauffiel

Lowell Cauffiel: Stay away from your presumptions of what you think it's like. Get out of the coffee shop and maybe go to a couple of open Alcoholics Anonymous meetings or Narcotics Anonymous meetings. See the actual people who are experiencing it and see the families and significant others, like Alanon meetings. A lot of these meetings are open.

One of the things that makes me want to go Elvis – pulling out a weapon and shooting the TV – is when I see an Alcoholics Anonymous meeting on TV and it's all depressed people and they've got coffee cups and there's cigarette smoke everywhere and they're bitching about life and everything. Hell, I couldn't stay sober if I was in that attitude. The recovery meetings that I've been to and know of, they're raucous, they're full of dark humor, they're people celebrating surviving the Titanic. They are not negative. So do the legwork. And the National Institute on Drug Abuse is a tremendous resource as well the National Institute of Alcoholism and Alcohol Abuse. Those organizations provide a lot of insight.

Neal Baer: Thanks. That's good advice. We should do research and I think we do have a lot of preconceptions. One more question. What advice would you give us when we deal with colleagues or friends who have addictions and we're at a loss of what to do? Certainly it's likely that we all will have that happen to us at some point. How should we think about that from your perspective, having gone through it?

Lowell Cauffiel: Even those of us who suffer from this disease still have a responsibility to take care of that disease. Just like a diabetic has the responsibility to take care of his insulin. Sympathy doesn't go very far. I'm a big believer in tough love and presenting choices: get clean or you're not on staff anymore. You've got a choice.

In terms of loved ones, there's a lot of support groups available for loved ones that will help guide them through that process. Just because you don't enable someone doesn't mean that you don't





(From left): Dr. Karen Miotto and Dr. Jonathan Samet

love them or don't care about them. In fact, by enabling them, you may be killing them.

Neal Baer: Thanks Lowell. We'll move on to Dr. Karen Miotto who is an expert on the medical treatment of addiction. You've heard what the writers have said, please speak to us about how you see this problem; how you see it presented on television; what's good; what may not be good.

Karen Miotto: Thank you for the opportunity to be here. There is a quandary with prescription drug use: people use drugs to feel good and to feel better but they use them because the doctor told me so. Never before have we had a situation where we've intertwined the neurobiology of pain and addiction very well.

I had a woman who was an administrator at UCLA and hated her job and she kept getting foot surgery. She indeed had a foot disorder but she kept telling the podiatrist that she needed another surgery. It was only after she stopped using and got into recovery could she acknowledge that she forced the doctor to do surgery because she wanted more pain pills. Another woman told me, "You're telling me I'm addicted and I've never gotten high. I have pain!" When you tell your patients, "You're addicted and you never got high; that's pretty lousy." The pills become a way to cope.

If we could easily spot Vicodin addiction, it would be easy for doctors to change our prescription habits. But honestly we are

trying to treat pain in about 12 to seven minutes that we see each patient. So in those 12 to seven minutes, we're trying to identify if they have real pain. So many of the people we see have real pain, so we use real pain pills. But I've also had patients tell me that they were in real pain. One patient told me that I didn't believe she was in pain. She said, "I was in the hospital twice over Christmas." And I said, "I believe you're in pain, your father just died and December." And she said, "But I hated the guy." It's stigmatized to be depressed and to grieve and to be in pain. These pills have become the answer.

My passion now is really to reach out to the doctors to ask for sanity. But we haven't quite found it yet. We have to have a better mechanism.

Neal Baer: You have a lot of stories, so you would be a gold mine for us. David, have you met before? Because I think she has some good stories here. As writers, what would you like us to get across? What do you think are some of the issues that we don't understand? We certainly see a lot of advertisements on television for drugs. They're ubiquitous. So what would you like us to write about?

Karen Miotto: We are in generation RX and so how do you communicate the message that there are consequences to pill taking. People want a miracle cure and for them drugs are the miracle.

Neal Baer: As opposed to having to work or do whatever it takes besides taking the drug?

Karen Miotto: I'm on a college campus where you can't take a test without Adderall. By the time they become writers or doctors or lawyers they're going to need rocket fuel to function.

Neal Baer: Last week I read in *The New York Times* that Nuvigil which is a form of Provigil, which is a drug that was designed to

“My passion now is really to reach out to the doctors to ask for sanity.”

Karen Miotto

keep military personnel awake, is going to be tested by the FDA for jet lag. Suddenly there's jet lag syndrome. Can you speak to this issue of these new syndromes that are coming out that require pills? We may have taken serotonin or something, but we didn't take pills for jet lag. Tell us about this process going on.

Karen Miotto: In Europe, a pharmaceutical company can't advertise to the public. But in the United States the pharmaceutical industry has 17,000 lobbyists. The Medical Association probably has 20. We hate the companies; we love their pills. How do we change that raging tide that one is too many and a thousand is not enough?

Neal Baer: Do your patients come to you after they've seen these commercials naming all these different medications; have you seen a change in that?

Karen Miotto: I have fathers with a daughter with Attention Deficit Disorder and doing well. So they give the son the Adderall and come back and say, "He did really well this last month, give him a prescription too."

Neal Baer: What do you do?

Karen Miotto: Cry. Because we are in an era of cosmetic psychopharmacology. If you're doing well, I can enhance it with a pill. If you're a C student at the Anderson School of Business and you could be an A student, how dare I not give that pill to you? The reason I spend so much time working with doctors is that the dialog has to start with us. We're anti-pharma now, our thought leaders can't publish a paper if it's so heavily influenced by the industry that is selling the pills that the research is about.

Neal Baer: Is it a bad thing? There was a *New Yorker* article about college students taking neuroenhancement drugs – Adderall, Provigil – and doing better on them. The article didn't necessarily take a stand but it did say that this is extraordinarily common. Is

it a bad thing?

Karen Miotto: It goes back to that question of vulnerability. Who's going to do well? I have young people who take Adderall no differently than methamphetamine; they're up for three days, they crash for three days, they come and tell me that they're top of their class and I find out they're on academic probation because they're delusional. The danger is, who can get away with it and who has to just plain do their homework.

Take, for example, marijuana. Our state has this experiment with marijuana right now. The data is showing that it doesn't make people schizophrenic, but those who are vulnerable to schizophrenia get psychotic earlier in life. What's the consequence of being psychotic earlier in life? It's a heavy price to pay for marijuana smoking.

Neal Baer: I can see that there's so much here that's not easily answered that could certainly be in many television shows, in dramas, comedies and reality.

Dr. Jonathan Samet is at USC Institute for Global Health and he's going to speak to us about tobacco, both here and as a global problem.

Jonathan Samet: Thanks. Well, we left the biggest for last. That is the biggest epidemic of addiction in the world. A few numbers and they're big. There are 1.3 billion smokers in the world right now; over 40 percent of men; over 10 percent of women; seven million people are dying early each year and that number will reach a billion cumulated across this century if we proceed with business as usual in tobacco control.

I was told I couldn't have any PowerPoint so I'm feeling withdrawal. I actually brought along a writer who is writing about me taking care of his wife dying of lung cancer. This is when I was in New Mexico and the writer is a fellow named Steven Bodio who writes

“If you're a C student at the Anderson School of Business and you could be an A student, how dare I not give that pill to you?”

Karen Miotto

about the outdoors and lives down to the west of Socorro, New Mexico. We are sitting in an office with the second specialist, a neat man with prematurely gray hair. It's what we call a large cell carcinoma. It's all around the top of the lung. Betsy asks, "Will I get better, is there any treatment?" Long pause then softly, earnestly, taking pains to look each of us in the eyes, "No." And then Stephen: "You must have the hardest damn job in the world."

If China continues with business as usual, by 2020 or 2030, a million deaths a year from lung cancer. So what happens if you get lung cancer in China right now? Well, not very much, because most people don't have any health care or health insurance and they get what they can pay for. So a family making \$1,000 a year would have little resources to go seek the care you might get in the United States.

How did we get here? Well obviously the tobacco industry got us here. A little quiz question for you: What's the largest tobacco company in the world? The largest tobacco company in the world by far is China National Tobacco. China has 350 million smokers, the majority of men still smoke. Anecdotally, I started working in China about 15 years ago and when I went to see the Deputy Director of the Chinese Academy of Preventive Medicine, they offered me a cigarette. It was the norm.

After that come the real bad guys: Philip Morris, British American Tobacco, possibly one of the sleazier corporations in the world: Japan Tobacco International. It still is majority owned by the Japanese government. So imagine Japan selling cigarettes, seeking new markets, young women in Japan, the women of Asia, a big target. How do they do this? Sponsorships, advertisements, promotion, the usual stuff.

Brand stretching: When you go to India, there's Wills Lifestyle stores. Wills is the tobacco company, India Tobacco Corporation, British American Tobacco with clothing lines, Camel clothing. It's all brand stretching.

Big issues around smuggling: Until recently and maybe this will improve a third of the world's cigarettes smuggled to reach new markets. A lot of eyes are on Asia to move in and particularly to attract and addict the young women of Asia.



Dr. Jonathan Samet

But there are a couple of good things: we now have a global treaty – the world's first public health treaty – Framework Convention on Tobacco

Control hits its five-year anniversary next month. What nations haven't ratified? The United States and Indonesia. Okay, so we didn't sign treaties in the last eight years, as you will remember. So there's good news in the United States; we're down to roughly 20 percent of adults who still smoke. I suspect many of you didn't smell a molecule of tobacco smoke today, because we've made such progress in the United States. That's because we've had a lot of evidence to use.

I brought this along since it's not a PowerPoint. This is the 2006 Surgeon General's Report; it says that passive smoking kills. I edited the 1986 report that said the same thing. Just a last comment: you wonder when you work with the industry, when you testify in court, see the executive, who are they? And what do they say when they go home at night? "Gee dad, what'd you do today?" "I spent the day in court defending the tobacco industry." A lot of people do it.

Neal Baer: Thanks. I have a couple of questions. A couple of months ago I got a call from the Writers Guild and they said that somebody from Philip Morris was coming because they wanted to discuss with writers how they can stop teenagers from smoking. And as a pediatrician, I wasn't interested. It was interesting that they had made inroads here to the Writers Guild and they wanted to speak to the writers. How do you think about it and what's your

“*The largest tobacco company in the world by far is China National Tobacco. China has 350 million smokers, the majority of men still smoke.*”

Jonathan Samet

advice about dealing with these issues?

Sandra de Castro Buffington: People are looking confused, so tell them what your response was. Do you remember what you said?

Neal Baer: Oh, what did I say, because I said it to you?

Sandra de Castro Buffington: You said, just tell them to stop selling tobacco.

Neal Baer: Oh yes, well that's obvious. But I was very upset, obviously. What interesting stories are you seeing in getting people to still smoke? Because that's why they came here, to help us as writers tell the story and obviously promote the good view.

Jonathan Samet: A couple of comments. Remember Philip Morris changed their name to Altria, which they probably spent billions of dollars doing and I think Altria/altruistic, there must have been something going on there. They also tried to help kids quit smoking with campaigns that most of us did not think were effective and were a diversion.

Right now the issue in the United States is not necessarily what are they doing to get people to keep smoking. There are a variety of ways besides cigarettes to get nicotine, pharmaceutical nicotine of course, the smokeless e-cigarettes, electronic cigarettes. They're for sale everywhere. They're really not cigarettes, they should be outlawed. They're, in my view, illegal. A court decision recently said that they could be sold. It was very very disturbing.

Neal Baer: Can you describe them a little bit?

Jonathan Samet: Yes. An e-cigarette is a rod with a little heating element in it that delivers a glycerol vapor with nicotine in it and all kinds of flavoring. So talk about addicting kids. If you have an e-cigarette that's chocolate chip cookie or tangerine, this is all out

there. It's in the malls. They started off in Asia about 10 years ago and they've come in the United States and the FDA was picking them up with the borders when they could, when they could find them, but they are everywhere.

Now you can't smoke in your workplace and your employer doesn't want you to take an hour a day to go outside and smoke, so people are looking for other ways to get nicotine. Snoose, a moist snuff product that you can stick in your mouth and nobody knows you're fulfilling your addiction. Cigarette companies are after the nicotine marketplace and it does not have to be cigarettes for them to make money.

Neal Baer: It's a tough issue. I've had arguments with writers on my show about Altria and because our show is about sex crimes and Altria does donate a lot to domestic violence prevention, shelters. So it raises a lot of issues because there's not a lot of money for these important causes. How do you think about that?

Martin Kaplan: They've been major supporters of the arts too. A branch at the Guggenheim was in Philip Morris headquarters in New York. This is all image. We know we can't trust them and if you haven't looked at the tobacco industry documents, which are available online, there's a 60-year record of deception and falsehood creation of science. So we know we just can't trust them. It doesn't matter what guise they come at us. They're in it for the money. They make an extraordinary amount of money. There are few products as profitable as this one.

Neal Baer: My last question, then we'll open it up to you all. You spoke about expanding the market with women around the globe, which I find really interesting, especially since there's been a move in microfinance to empower women. We've talked a lot about this in terms of the Middle East. This may really be an approach to address issues of inequality. It may actually help in the peace process. So are you seeing anything happening in these areas that were traditionally nonsmoking areas?

“Cigarette companies are after the nicotine marketplace and it does not have to be cigarettes for them to make money.”

Jonathan Samet



Dr. Jonathan Samet: First let me take you back about 80 years. You may not know that Marlboro was a woman's cigarette. It was marketed through suffragette marches as a woman's right thing to walk down Fifth Avenue smoking a cigarette in public. In the big markets, like China, 4 percent of women smoke. Rapid urbanization, rapid image change, huge market for the tobacco industry goes along with what Neal said. I'd be very concerned that the tobacco industry will be absolutely clever enough to grab onto changing views, changing images, Westernization. You go to Beijing now and it looks like it could be L.A. I think all the groundwork, unfortunately, is there for the industry potentially to hook women, unless we're very, very careful and vigilant.

Neal Baer: Thank you. Thanks to all the panelists. It's been really, really enlightening. My experience working with NIDA was when Alan Leshner was the head of NIDA in the 1990s when I did *ER*. He said if you don't do anything, just do one thing which is to say that addiction is a brain disease and that will go a long way. I've really seen how you all at NIDA have pressed that and I think it has changed people's views in a really positive way. Thank you for coming tonight and sharing your knowledge with us.

Do you all have any questions? Yes?

Audience Member: I have a great nephew who started on marijuana when he was 10. He's now on crystal meth, has been in prisons three times. He's now 29. He doesn't want to go to Narcotics Anonymous. I brought him to live with me when he was



(From left): Dr. Timothy Condon, Sandra de Castro Buffington, Dr. Neal Baer and Dr. David Foster

16, but I was just enabling him. And my question is, is there any hope for a crystal meth addict?

Timothy Condon: The answer is, absolutely. There are lots of people in recovery from crystal meth already. There are treatments. Talk about a myth. Ground zero for crystal meth is here in California, mostly San Diego. Then it moved across the country, mostly on the interstates and just inundated the small towns in the Midwest. I actually spent some time in small town Iowa where my other half's family is from and you see the devastation there. They never had a crack cocaine epidemic like in Omaha and Des Moines, so everybody thought that you can't treat methamphetamine addicts, there's no treatment. That wasn't a correct statement. In fact, there was very little reason to believe that the treatments that were found to be effective for another stimulant, like cocaine and crack, wouldn't also be effective. What the research has shown is that they can in fact be very effective, especially things like "contingency management."

One of the hallmark treatment programs is the Matrix model which is centered here in Los Angeles at UCLA. Dr. Miotto is affiliated with the UCLA program as well. They pioneered taking and using a lot of the same cognitive behavioral, contingency management, different kinds of approaches that have been useful for cocaine. We had to test them in methamphetamine addicts, because people didn't believe it would work. They had never seen so many young people, young white males especially, who couldn't control this incredibly addictive drug.

But the answer is, yes, there are treatments. There are no medications for any stimulants at this point. We've been trying for the last 25 years to develop some medication and it's a real tough nut to crack. But there are behavioral treatments. Do they work for everybody? Well, nothing works for everybody in any kinds of treatments – whether it be for diabetes or cancer. Karen, you might have some insight on that too.

“...there was very little reason to believe that the treatments that were found to be effective for... cocaine and crack, wouldn't also be effective [for crystal meth].”

Timothy Condon



Karen Miotto: I can definitely give you some information about the programs we have. I'll look for you afterwards.

Neal Baer: Oh great, thanks. Yes?

Audience Member: I certainly don't need any convincing that addiction is terrible. Most people would agree that addiction is just awful. But the question I would like to ask is, should we as writers only be depicting addiction in a negative way? I'm interested very specifically in what the message about addiction has to do with writers and how we write stories and how we conceive stories. This is so awful, so should we keep showing how awful it is in order to make the world wake up to this problem, or not? What happens when you've got a bio-pic for example about somebody who is terribly addicted or is a terrible smoker? Are we supposed to show how awful that smoking is if the story really is about other issues in that person's life?

Audience Member: A writer could show what you could do and how that could change you for the better. I have a son who smokes cigarettes. I think we should show the good side, what happens if you stop and how it affects your family.

Neal Baer: I want to ask the writers their response. What makes things interesting, as Dr. Samet said, is that there's a lot of complexities about cigarette smoking and how it's depicted. No one wants to have a public service announcement television show

about something being bad. That's just my opinion.

David Foster: I agree. What's interesting is the complexity and the gray areas and the edges of the issue. We want to explore different aspects of someone's use over time, and all these areas are complex. There's two side to all these issues. We heard about all the pills that are on the street that are coming from doctors and then we read in the journals about how doctors ignore patients pain. We under-treat pain and we tend patients that they don't need pain medications, they just need to tough it out. What's interesting is portraying the interaction between those sides.

Neal Baer: Dr. Samet.

Jonathan Samet: Start with our current President; read his first book, in which I think smoking is mentioned roughly 50 times – and it figures centrally to him dealing with problems. One of the classics of fiction about smoking, the *Confessions of Zeno* by Italo Svevo, smoking almost becomes a side gag. He mentions that he has this little gimmick, LC, last cigarette, that comes up throughout the book. David Sedaris in his last collection of short fiction writes about this too.

You have to be moralistic about it, but I think some authors have brought deep insights into it and described addiction in very useful and insightful ways, including Obama.

Sam Catlin: I think it's a good question. We try to make as strong case as we can for why people take drugs. After-school specials were very effective in not glamorizing it. Our responsibility as writers are more ambiguous than doctor. For writers, it's not about 'do no harm.' It's about telling stories. The true story of drugs is ultimately very rarely a glamorous one, so I feel like we're pretty faithful to that.

Lowell Cauffiel: I don't think it's a matter of 'negative' or 'positive,' but accuracy. Drug addiction and alcoholism are still so stigmatized.

“We want to explore different aspects of someone's use over time, and all these areas are complex.”

David Foster





“...there are some brain imaging studies that have shown that a lot of the same areas are activated for people who are addicted to gambling as they are for drug addiction.”

Timothy Condon

It's a disease, it's a medical condition, it's brain damage. Too often in our need as writers – and I struggle with this myself – is to develop drama and to develop conflict. We look at the literary aspects and don't get to the core. It's not easy to get to the core issue. The stigmatization of it really does a disservice to the public. Those who may be suffering from addiction start to feel of weak moral character.

So it's not negative or positive, it's just its accuracy, which is why I suggested the legwork.

Audience Member: Hi. I wanted to talk about the correlation between doctors and prescription drugs. About a year ago I was diagnosed with type two diabetes. My doctor wanted to put me on metformin and I said, “No.” I picked up *Men's Health* and *Men's Fitness* and I got on a treadmill. A year later, I'm without drugs.

My question is, why wasn't that the solution in the first place? Why didn't he give me that advice to get on a treadmill? He said, “Get on a treadmill,” but he wanted to give me prescription drugs. That's the problem with this country. People want to take a pill and feel better, but they don't want to deal with the issue behind it. Why am I sedentary? Why aren't we encouraging people, when they're in pain, to look at the issue instead of prescribing a pill to feel better?

Karen Miotto: I think we do both. But changing behavior is challenging. How do we convince the other patient who says, “I don't have time,” and “I can't,” and “my knees hurt.”

Neal Baer: You bring up a good point. How many times have we all had a virus and maybe asked a doctor for an antibiotic when the antibiotic will not have any effect on the virus. It's the culture we're in.

Audience Member: I'm a writer and I'm also getting a certificate in chemical dependency. My question is, could you talk more about the changes in the brain and the different aspects of addiction? How do gambling and anorexia fit in as forms of addictive behavior?

Timothy Condon: The NIDA mantra is “addiction is addiction is addiction.” So we don't really make the distinction between physical and psychological behavioral because by definition addiction is compulsive drug seeking and use in the face of negative health and social consequences.

Audience Member: It's also repetition of a behavior.

Timothy Condon: It is.

Audience Member: Whether a drug is involved or not.

Timothy Condon: Absolutely. So we don't have all the answers about gambling but it's truly a compulsive behavior too. There are lots of compulsive behaviors. But there are some brain imaging studies that have shown that a lot of the same areas are activated for people who are addicted to gambling as they are for drug addiction. So the circuitry is pretty much the same.

One of the major advances in the last five to 10 years in addiction is understanding the circuitry of the brain. Where's the break in



the brain? That's what I call it. We know more about the prefrontal cortex of the brain and how the area is the last to develop in young people. When I went to school we thought the brain was fully developed when you were a kid. But now we know it's not fully developed until the early 20s. This is new stuff from the last five years. The last part of the brain to develop is that area that helps you with reasoning, decision making, judgment and inhibitory control. It's what tells you, "Stop, don't do it, it's not good for you." No surprise that it's the last area to develop in young people. If you have teenagers you know that already. Now we have scientific Functional MRI's showing this natural development.

In drug addicts, that area is actually compromised in people with long term drug use. It's deactivated. So you can imagine the whole system is running without breaks, or the breaks are faulty. It's a simplistic way to look at the circuitry, but it's the way I look at it.

Neal Baer: What about with anorexia, bulimia, cutting?

Karen Miotto: These activities have been shown to activate the reward pathway. But the body adapts to these activities. For example, if we give someone pain pills, the body doesn't say, "Well I guess I don't need my pain pill pathway anymore" and shuts it off. It ratchets it up to the point where things that weren't painful before now become painful. It's called opiate induced hyperalgesia. But that's another part of the pathway that actually drives the addiction and compulsion to use.



Audience Member: I wanted to introduce a cautionary note. I was trained as an engineer and about 15 years ago I decided to do an engineering analysis of the war on drugs. I would say in summary we've spent a trillion dollars on this since 1914 and we have made the problem

immeasurably worse across the board.

The only area where we've actually been successful in reducing addiction is Dr. Samet's arena, where we have reduced tobacco use among teenagers dramatically in a relatively short period of time without firing a shot. We never call the cops. We never threw anybody in the slammer.

But the horrifying fact I learned during my six years of research into the war on drugs is it is a race war. This woman's son has exactly the same probability of using drugs as my son. Blacks and whites use drugs in roughly the same percentages. Her son, however, in the identical set of circumstances is five times as likely to be arrested and incarcerated and spend considerable time in prison – five times.

There is no way that you can justify that, other than to say that it is a race war. It's very important that we address the issue of education. I'm really delighted with Dr. Condon, making the point on behalf of the United States government – that drug addiction is a disease. Under no circumstances would Dr. Condon call in the cops for a diabetic.

We need to constantly bear that in mind while we're doing these things, that the nightmare we have created for ourselves involving the corruption of all of our institutions and potentially the destruction of the Mexican government, is all related to the incredible amount of money that we have made available to the worst people on the planet.

Neal Baer: Thank you. Yes, 1 out of 100 Americans is in jail and it is a high proportion drug related.

Audience Member: You were talking about the pitfalls in terms of what makes you want to shoot the TV. You talked about AA meetings that are dreary. In writing about addicts, what else should we avoid? The research you guys did for *Breaking Bad* and

“It's not the particular drug that creates the addiction, it's the addict that creates the addiction.”

Lowell Cauffiel

“...one of the things that’s a real challenge about dramatizing addiction is the repetition and the banality of it.”

Timothy Condon

House, what did you feel was a bad path in terms of depicting addiction accurately?

Lowell Cauffiel: I want to go back to an earlier point – that it’s about the drug and there was a question here about whether there was a cure for Methedrine addiction. It’s not the particular drug that creates the addiction, it’s the addict that creates the addiction. This is very commonplace and Dr. Condon reinforced it. Someone will be recovering from heroin and then go to alcohol and then become alcoholic. We have these terms like alcoholic, drug addict, as if they’re different. Addiction is addiction.

Recovering from addiction is an inside job. It’s not a chemical job. Taking the research that the brain looks for anything to fill that gap, there’s too much focus on the drug of choice and what’s creating the problem.

Addiction is a disease and a condition and it will fuel the furnace with whatever it can find. At least that was true in my case and many of the drug addicts and alcoholics that I know. There, I’m using the term too – drug addict, alcoholic. It’s like there’s a difference, but there isn’t.

Timothy Condon: I’m sober a long time too, and one of the things that’s a real challenge about dramatizing addiction is the repetition and the banality of it. A lot of it is really not dramatic. There’s a reason why you don’t show somebody going to the bathroom on a television show; it happens all the time, but you don’t want to see it. From my own personal experience, it was the repetition and the boredom and the hopelessness. These are very hard things to dramatize especially when you’ve got to make cars explode and stuff like that.

Neal Baer: That’s a good point. We’ve struggled often in how we depict depression on television because depression is pretty boring and it’s – depressing. It’s really hard to show someone depressed for very long.

Audience Member: Writers particularly love to write a funny marijuana scene. Writers love to write a funny pot scene into a movie and the number of casual scenes that are written about pot being used in a film is extremely high. But you almost never see the people whose lives have actually been dismantled because they’re just not about to cope in society. Should we be writing a different kind of scene, at least from time to time, about marijuana? What are your thoughts on that?

Timothy Condon: That was my drug of choice and that’s why I said it was boring and repetitious. But marijuana is much more potent than it used to be and much more destructive. You’re right that it’s a challenge to show how life becomes trash because of the drug. It’s very hard to describe.

It’s a great challenge to describe it because it’s depression and it’s one of the things that’s so isolating. Marijuana addiction is has no sharp edges to it, it’s nothing dramatic. It’s all sort of fuzzy. So, I’m still waiting to see that depiction myself.

Karen Miotto: The depiction of marijuana in the developing brain in something so completely different than marijuana in an adult. I think that’s such an important story.

Audience Member: I’m a physician trained at UCLA and also at NCI. But I’m also a producer and writer. I recently pitched a show to an Emmy-winning producer about actually doing a very educational TV show and at the end of the pitch he said to



The audience at the Writers Guild of America, West

us, “Well, really, we’re not interested in education; we’re really interested in entertainment.” So we walked away with that idea..

Neal Baer: I never talk about educating or entertaining, because if I “entertain,” that can be taken as a pejorative, like it’s mindless. And if I talk about educating, it can be very pedantic. I try to do the best stories and as you saw in the two clips tonight, really gripping stories.

“Have people responded to mental illness differently from drug addiction? Is one more palatable in movies and television, or is one more funded?”

Audience member

We’re not here to educate you, but a lot of things come out of our stories that are very educational. And they may be explicit or implicit with people smoking or it may be explicit about seeing House try to conquer an addiction. But if the story is interesting and true and honest and it really develops character and it deals with complexity, then you can’t go wrong and you don’t have to worry about whether you entertained or educated or told a good story.

Audience Member: Doctors Condon and Foster both brought up the intersection of addiction and mental health. This question is for either clinicians. There’s less of a stigma against addiction and substance abuse in mass media. Have people responded to mental illness differently from drug addiction? Is one more palatable in movies and television, or is one more funded? Is there a difference?

Timothy Condon: There is a difference. I would say that the field of addiction for alcohol and drugs is probably about 10 or 15 years behind the mental health arena. Early neuroscience showed the differences in people’s brains who had depression and who had obsessive compulsive disorder and who were schizophrenic.

If you go out here on Third Street and ask somebody on the street what caused schizophrenia, very few people are going to say, “oh they had bad parents.” But that’s what was taught in school not that long ago. In fact, it’s a chemical imbalance.



Audience members in attendance.

That’s what we wanted to do in the neuroscience on addiction is go to people like Dr. Foster and the organization he works with, NAMI, National Alliance for Mentally Ill. I would say that addiction is more stigmatized than mental health, but we’re rapidly working to de-stigmatize it.

David Foster: I agree with that perspective. But it’s much harder to admit to having suffered from mental illness than to suffer from addiction. There are many reasons.

Our current President struggles with an addiction to cigarettes. Our past President was very open about his own recovery from alcohol abuse and how that almost, in fact, did ruin his life.

I can’t imagine a President of the United States saying, “when I was in my 20s I struggled with depression and I took medications for a number of years and I finally was able to lead a normal life.” I can’t imagine someone being elected President of the United States who told that story, yet we’ve elected two Presidents who struggle with addictions.

Karen Miotto: Nowadays you don’t have to be stigmatized by depression or by mental illness, because you can just have pain and get pain pills.

Neal Baer: Yes. Thank you all for coming. Thank you, panel. It was really engaging.

