

# Models of addiction requiem for a dream



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Darren Aronofsky's second film, *Requiem for a Dream*, repeats in many ways the frenzied, tragic trajectory of *Pi*. Where *Pi*'s Max Cohen followed his mathematical obsession into insanity and self-destruction, *Requiem* now shows us the decline and fall of four individuals, Sara (Ellen Burstyn), Harry (Jared Leto), Marion (Jennifer Connelly), and Tyrone (Marlon Wayans). Sara gets hooked on diet pills, and her son, Harry, his girlfriend, Marion, and his buddy Tyrone are all junkies. Whereas the end of *Pi* leaves Max Cohen outside, smiling, looking up at the trees, the protagonists of *Requiem* all collapse in a gory heap: Tyrone ends up in prison; Harry is stuck in a hospital, his arm amputated; Marion maintains her drug habit by prostituting herself; and Sara is in a psych ward after undergoing electroshock therapy. As in *Pi*, the frenzied excitement of *Requiem for a Dream* is that of the world going to hell in a hand basket.

The movie is made out of hyperactivity and hallucination, both of which are finally judged to be absolutely wrong. The moralist of *Requiem* is, if anything, clearer than that in *Pi*. One probably cannot generalize too much from a geeky, asocial computer genius who writes a one-of-a-kind stock market program and whose work cannot be duplicated by anyone else in the world (Shultz, 2004). Max Cohen's ambitions are 'unnatural,' as we have discussed, by the film's own definitions, but the cyberpunk film can have no further moral than 'Scientist, don't go too far!'-a traditional moral that has been offered already by Mary Shelley's *Frankenstein*. *Requiem for a Dream*, however, clearly does make a generalizable antidrug statement.

The attractive young people almost kill themselves through drugs. The film communicates addiction via both arrangement (quantity of intensification)

and method (perceptual quality). As Harry and Tyrone shove the TV set around Brighton guests, 'anybody want some time?' then gives out the speed pills articulated in the jumpy cutting of party footage. The spatial warp of drugs is also forceful. Deep focus photography makes hollow, empty space a purpose correlative to the emptiness of addicts in line for their next fix. Light and reflections are utilized to express tilted states. Tyrone and Harry ignore the soft gold light quality at Brighton Beach in their eagerness to score. Paradoxically, the afternoon haze presents a visual equivalent to the state of tranquilization they seek. The harsh bare bulb in Tyrone's pad differs with the glow of sunshine from a window blocked by his back as he faces his electric predilection. When Harry and Marion thrust open an emergency exit door, it sparks white light like the drug's sudden increase of pleasure. White light also trickles in and blanks out the semi-naked image of Marion in the reflection in the mirror, flooding her in ecstasy beyond eroticism. Paradoxically, she ends up prostituting her mistreated body for heroin. Such self-absorbed fascination is common with Tyrone, who toys with mirror images of himself and pays no attention to his waiting lover.

The film reiterates stylised shots of heroin, cocaine and their 'works', or equipment for smoking, inhaling or intra-venous injection. even though the editing rhythms are quick, fast and edgy, the film strains the repetitive and ritualized nature of 'preparation' and the anticipated rush of the drug intake. A close-up eye with quickly enlarging pupil displays the consequence. The bleak white of the powder melts with the white light state it fetches. Addiction is displayed not as a physical but a perfunctory act. Physical is distinguished stridently from mechanism, which entails closed sets and is

used disapprovingly for repetition that decreases energy, creates damage and ultimately stops working. Physical connections, for example of the interlinked bodies of viewer and transcript, are potentially stimulating in its place.

The association of the viewer with cinematic methods is additionally extended in the physical grouping of projection and presentation to generate auto-productive craving machines. Rapturous with a drug rush, Tyrone dances to a hip-hop track. The rubbery motions of his legs and body winding with fluid nimbleness might appear as the unobstructed play potential to mechanical acts. As a type of force-field 'crossed by a powerful, nonorganic energy', though, this is not a body disjointed by addiction like Tyrone's. His overjoyed dance only imitates the cathartic possibilities of a BWO. In its early stage' the addictive drug happens to increase joie de vivre and incentive. Eventually, it weakens the users' creativity, whilst their plans, such as building a clothes design business, result to nothing. Tyrone's fake sense of safety is emphasized by the canting of the camera. High angle shots are employed often to create the constricted viewpoint of a trap. They give a kind of 'point-of-view' angle of the drug as imperceptible predator biding its time as the prey grows to be more trapped. Up-close imagery of Harry with Marion offer Deleuzian tactisigns. The soft warmth of their young skin is displayed in soft-focus sepia quality. The utilization of split-screen here puts side by side faces in conversation with fingers stroking skin and evokes the previous disjunction of Harry and Sara. Nevertheless close the friendly rapport of these close-ups, the screen stays worryingly split. Each lover is ensnared by his/her addiction and mutual betrayal is predicted by

composition here. Their excited conversation is splashed out as the screen overflows with blinding light. Despite their affirmation of love, a gradually spinning image places them no longer in front of each other but confronting each other. As they lie poised in the cool grey glow of a heroin high, each partner is away on a personal high.

The ' Winter' progression persistently completes the characters' downfall. Rendered helpless in a down-canted roof-top camera angle, Sara roams the snow-covered sidewalks. People haze by her in the too-fast movement of chronological dissociation. Harry and Tyrone drive south, encouraged by their dream of a Florida drug paradise, keeping Marion to take part in live sex shows that pay for her drugs. In the middle of the lush greenery and blue skies of the South, Harry takes his last shot into the decaying sore in the middle of his arm and side-steps reality. After a frightening dream about losing Marion over the perimeter of the pier Harry wakes up with his arm cut off. Marion grins in her sleep as she holds onto her heroin earnings.

Requiem for a Dream relentlessly presents an onslaught of the body provoked by the disastrous will that control all ingestions'. 128 The breaking of the surface is showed here as brief, flimsy ecstasy, pathetically small reward for physical and psychic harm. The film connects with us, by means of percepts and influences, in the whirlpool of need encouraged by the holes of injection and the inhalation. However the experimental strength of the event need not be limited to its disturbing subject matter and descending-spiraling narrative. The actualized harm of such entropy can be abstracted by art as the fundamental crack of confusion seeks more feasible, virtual pathways.

Aronofsky also wanted us to see that the ' world of the film [is] much more like a dreamland. Thus he set Requiem in Coney Island, tinted the screen, shot through filters, used split screens to show multiple subjectivities, and added pulsing, atmospheric electronic music. As in Pi, there are numerous hallucinations, almost all of which are nightmares. Even the pleasant dreams, such as when Harry imagines Marion by the ocean, burst apart to prove once again the agony of illusion. The substantial artifice of the film, in sum, is given over to distortion and insanity. There seems to be no way for Aronofsky to imagine artifice in a positive way. Even though Aronofsky speaks of art and artists relatively more often, I would say, than other young directors, there is a strong idea that nature still grounds art, in contrast to the illusions and hallucinations of artifice. In Selby's novel, Marion is a painter, and her dream is to open a store that sells clothing based on her sketches. Marion is terrifically cultured, and her mind is filled with ideas about Italian museums, Renaissance music, and light: ' All that summer and fall she painted, mornings, afternoons, evenings, then walked around the streets that were still echoing the music of the masters, and made out of interior monologues, and a film is necessarily more visual, more exteriorized.

## Section II

### Behavioral Couples Therapy:

#### Harry and Marion

It is clear from watching the movie that the extent and depravation that results from the profound acts of violence and addiction that plagues the beautiful young couple could have been saved by intervention therapies.

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However, there are a number of cautions and clarifications about BCT and partner violence in treating substance abusing patients. First, it is important to realize that BCT was not designed as a treatment method for partner violence. BCT is a couples-based treatment for alcoholism and drug abuse. We simply learned through our clinical experience treating couples and through our research that male patients seeking help for substance abuse problems are a high risk group for perpetrating partner violence, and that the violence should not be ignored.

Second, data currently available support the use of BCT for a specific subgroup of men with co-occurring problems of addiction and partner violence. BCT is recommended for married or cohabiting male substance abusing patients who have sought help for their substance abuse problem if there is not an acute high risk of severe, injurious, or lethal violence (as already described above). BCT is not recommended for substance abusing patients seeking help but not currently living with a partner. A dual-focused intervention program may be better suited to the substance-abusing, violent male who is not in a partner relationship as one means of prevention of future domestic violence (Palmer, et al 2002). BCT has not been tested on batterer clinic male patients with substance abuse problems, and is therefore not currently recommended for this population.

Third, we do not know why partner violence is reduced after BCT. Several possible explanations exist (Gorney, 2007). First, violence may be reduced because alcohol and drug use are reduced or eliminated. Second, violence may be reduced because one or both members of the couple learns constructive communication skills that prevent arguments from escalating to

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violence. Finally, a combination of these factors may explain the violence reduction associated with BCT (Giles-Sims, 1983).

Some results seem to support the importance of reduced substance use after BCT in reducing violence risk. For example, in one study for both the first and second year after BCT, violence was significantly reduced; further, the extent of violence and of clinically elevated verbal aggression levels were associated with the extent of the alcoholics' drinking (Healey, et. al 2007). Frequency of post treatment drinking was positively correlated with frequency of violence and verbal aggression, and remitted alcoholics no longer had elevated violence and verbal aggression levels when compared with matched controls, while relapsed alcoholics did. These results were observed even after baseline violence levels were taken into account (Gondolf, 2003).

Several studies that show reduced violence and an association between substance use and continued violence after individual (not couple) treatment also seem to support the importance of reduced substance use in reduced partner violence after treatment. One study of drug abusing men with comorbid alcohol problems found that partner violence was significantly reduced from the year before to the year after receiving individually-based substance abuse treatment (Shultz, 2004). This study showed the same pattern of results found with BCT. The greatest violence reductions occurred among patients who were remitted after treatment; and those remitted after treatment experienced similar levels of violence as did a nonalcoholic normative control group. Downs, (2006) also found that, in the year after individually-based treatment, the likelihood of male-to-female violence was

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18 times higher on days when the man used alcohol or illicit drugs than on days when he did not. These findings and greater violence among relapsed than remitted patients remained significant and of similar magnitude when baseline violence levels were controlled. Finally, two other longitudinal studies of partner violence after individual alcoholism treatment reported high levels of violence before treatment that were significantly reduced in the year after treatment (Shultz, 2004).

Other results suggest that couple relationship factors may be important in reduced violence after substance abuse treatment. For example, a randomized study of male drug abusing patients found that BCT was more effective than individual treatment in alleviating partner violence (O'Farrell, et al 2000). A second study, which investigated differences between partner violent and nonviolent male alcoholic patients, found that relationship distress and alcohol problem severity had independent associations with partner violence (Downs, 2006). Further, relationship adjustment remained significantly associated with partner violence, whereas alcohol problem severity did not, after controlling for demographic variables and patient antisocial traits.

Researchers have noted that BCT is contraindicated if there is an acute high risk of severe violence that is potentially injurious or lethal (Giles-Sims, 1983). However, once cases with acute risk of serious injury or death have been eliminated, it is not completely clear where to draw the line on the violence severity continuum when considering the use of BCT. For example, in two studies using the Conflict Tactics Scale (Healey, et. al 2007) definition of severe violence (i. e., kicked, bit, or hit with fist; hit with something; beat

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up; threatened with knife or gun; used knife or gun), 20%-30% of male alcoholic patients entering and accepted for treatment into BCT have engaged in severe violence toward their female partner in the year before BCT (Downs, 2006). Prevalence of severe violence is significantly reduced to 8%-12% in the two years after BCT in these studies, suggesting that some cases of severe violence can be helped by BCT.

Another issue in any form of couples' therapy is whether being in therapy has an impact on participants' perceptions regarding the integrity of the relationship and their decision-making regarding its possible dissolution, as well as how responsibility is construed. In BCT, participants do not need to have an open-ended commitment to maintaining the relationship. In fact, many couples enter BCT as a last chance to salvage their relationship; often the non-addicted spouse has made it clear that if violence or serious substance use recurs, then the relationship is over (Hardy, et al 1998).

However, in our work on BCT, participants both need to be willing to work to see if the relationship can be improved and to agree to refrain from threatening separation or divorce in anger (Gondolf, 2003). Couples promise not to continue to make threats of separation or divorce in the heat of anger at home because such threats usually sabotage the couple's progress and can lead to heightened anger than can escalate to violence or substance use. However, they also agree to discuss serious thoughts they may have about possible separation or divorce during BCT sessions where they can get help from the therapist in dealing with this issue. In this regard, BCT therapists are careful to stress that the spouse's role of assisting the male

substance abusing patient's recovery does not mean that the female partner is responsible for the male's substance use or violence.