

PTSD 101 for Journalists

Frank Ochberg, M.D.

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Young journalists will often encounter violence among their first reporting experiences. The effects of catastrophe and cruelty are newsworthy, particularly when victims are numerous, are famous or are symbolic of something that we all relate to and hold dear: a child killed in a schoolroom; a nurse held hostage in a hospital.

Whenever a reporter meets a survivor of traumatic events and inquires about that trauma, there is a chance that the journalist will witness - and may even precipitate - PTSD, Posttraumatic Stress Disorder. By definition, PTSD is a triad of change for the worse, lasting at least a month, occurring anytime after a genuine trauma.

My purpose in writing this is to introduce journalism students and working journalists (including you grizzled veterans) to the definition of PTSD, its impact and significance - how to anticipate it, recognize it, and report it, earning the respect of your readers and your interviewees. I do this as a victim advocate and a journalism advocate, to advance the agenda of both groups. The recognition of PTSD and related conditions enhances not only a reporter's professionalism, but also the degree of humanitarianism brought to every victim interview.

THE SYNDROME

PTSD is three reactions at once, all caused by an event that terrifies, horrifies or renders one helpless. The triad of disabling responses is:

- * recurring intrusive recollections;
- * emotional numbing and constriction of life activity; and
- * a physiological shift in the fear threshold, affecting sleep, concentration, and sense of security.

By definition in DSM IV (the 1994 edition of the Diagnostic and Statistical Manual, which is the official lexicon of psychiatric diagnoses, written and published by the American Psychiatric Association), this syndrome must last at least a month before PTSD can be diagnosed (see Appendix A, page 19). Furthermore, a severe trauma must be evident and causally related to the cluster of symptoms. There are people who are fearful, withdrawn and plagued by episodes of vague, troubling sensations, but they cannot identify a specific traumatic precipitant. (Some clinicians assume this means abuse occurred and was repressed. The pattern of PTSD reactions thus may be used, illogically and erroneously, to "prove" a hidden trauma.)

PTSD should only be diagnosed when an event of major dimension - a searing, stunning, haunting event - has clearly occurred and is relived, despite strenuous attempts to avoid the memory.

Recurring, intrusive recollections

The core feature of PTSD, distinguishing the condition from anxiety or depression, is the unavoidable echo of the event, often vivid, occasionally so real that it is called a flashback or hallucination.

The survivor of a plane crash feels a falling sensation, re-visualizes the moment of impact, then fears going crazy because his or her mind and body return uncontrollably to that harrowing scene.

A victim of the "cooler bandit," whose modus operandi was to rob urban convenience stores at gunpoint and force the clerks into refrigerated storage rooms, had nightmares for more than a year. She still has moments during the day when she sees the bandit's brown eyes above the mask that hid the rest of his face. She was sure she would be killed at the moment when he threw her to the floor. Even though no shots were fired and the robber was eventually apprehended, her sensations of terror, her feelings of impending doom, still return with sudden images of that unforgettable night.

There are important distinctions among traumatic memories. Some are clearly memories. The beholder knows this is a recollection, painful but not terrifying. Through time and (often) through telling and re-telling of the trauma story, the memory is muted, modulated and mastered. It no longer has a powerful, disruptive presence. It is a piece of personal history. On the other hand, that personal history may burst forth into awareness, and a trauma survivor may feel and act as though bombs are falling, a rapist is ready to strike or the death of a loved one is witnessed again.

Incidentally, the loss of a loved one and the consequent bereavement is not, by definition, a source of PTSD, unless the death evoked images of terror or horror. Tragic loss is often an aspect of PTSD, but shocking imagery is not usually part of natural death. Therefore, as painful as the loss of a spouse or child may be, the diagnosis of PTSD is reserved for only those losses accompanied by haunting death imagery.

Some repetitive recollections include regrettable acts by the person with PTSD. A patient of mine killed a boy in Viet Nam. It was self defense, in combat, but indelible and inexcusable in my patient's overactive conscience. Guilt - crushing guilt - was a major component of his intrusive recollection.

When the trauma reappears in the mind, some individuals experience an altered state of consciousness. They enter a trance, a dissociative disorder (see page 8) that can be dangerous to themselves or others.

The war veteran confuses his wife with a Viet Cong woman who tried to kill him many years ago, and he smothers her with a pillow. Or he leaps from the window. Or he runs from the room with a weapon and is shot by police. These are relatively rare situations and, according to most experts, beyond the boundaries of PTSD.

PTSD may include flashbacks and hallucinations, but neither is necessary for the diagnosis. When prolonged flashbacks and prolonged hallucinations, particularly auditory hallucinations that command violent activity, occur, other diagnoses may be involved, such as Dissociative Disorder and Brief Psychotic Disorder. These may co-exist with PTSD. They will be discussed later, when considering consequences of trauma that are not PTSD.

Remember, PTSD is more than a repetitive traumatic memory. It also is a form of emotional anesthesia and of generalized anxious arousal.

Emotional numbing and constriction of life activity

The emotional anesthesia, or numbing, may protect a person from overwhelming distress between memories, but it also robs a person of joy and love and hope. While participating

in a national PTSD research effort, I interviewed dozens of soldiers, decades after their service in Viet Nam. The presence of this second of the three PTSD diagnostic criteria, this loss of emotional tone, struck me as the most tragic legacy. Marriages suffered, child raising was impaired, life was hollow. To these veterans, "survivor" meant being no more than a survivor and considerably less than a fully functioning human being. Painful memories might have subsided. Anxiety attacks were tolerable. But the capacity for feeling pleasure was gone.

These PTSD victims were anhedonic, meaning not necessarily sad or morose, just incapable of delight. And they no longer participated in activities that used to be fulfilling. Why bowl or ride horses or climb mountains when the feeling of fun is gone? Some marriages survived, dutiful contracts of cohabitation, but devoid of intimacy and without the shared pride of watching children flourish - even when the children were flourishing.

These negative symptoms of PTSD, numbing and avoidance, are less prominent, less visible and less frequent than the more dramatic memories and anxieties. Early on, most survivors of trauma will consciously avoid reminders and change familiar patterns to prevent an unwanted recollection. For example, some ex-hostages from a notorious train hijacking in the north of Holland avoided all trains for weeks. Some only avoided the particular train on which the hostage incident had occurred. Others took that train, but changed to the bus for the few miles near the site of the trauma.

This aspect of PTSD, numbing and avoidance, is adaptive to a point, then becomes a serious impediment to recovery. It can also mislead an interviewer of a survivor into seriously underestimating the severity of a traumatic event. There is a popular belief that victims of rape, kidnapping and other violent crimes should be full of feeling, tearful, shuddering, even hysterical, after the assailant leaves. When feelings are muted, frozen or numb, the survivor may not be believed. When testimony in court is mechanical and unembroidered, jurors may assume that damages were minimal or never incurred. I have testified as an expert for the prosecution (or for the plaintiff in a civil suit) on several occasions to explain this phenomenon. The victims were numb or avoidant or both, and therefore did not come forward immediately. When they did come forward, they appeared, to untrained observers, to be indifferent, unconcerned and unharmed, when, in fact, they were in a state of profound posttraumatic stress.

This dimension of PTSD includes psychogenic amnesia. Along with loss of emotional tone and limited life pursuits are holes in the fiber of recollection. For example, an opera singer, battered by her husband, could not recall the most serious beatings. She was finally ready to divorce him and she needed to testify in court at a settlement hearing. After several supportive sessions, including hypnosis, she remembered him choking, almost strangling, her. Eventually, all of the memories returned, and she could joke, "He not only threatened my life but my livelihood! No wonder I put that out of my mind." A female police officer shot and killed a man who threatened her and her partner with a gun. She could remember everything vividly except for the sound of her pistol firing. Obviously, the gun went off and the sound was audible. She repressed that piece of memory for many years, eventually recalling it as her PTSD subsided.

Physiological arousal

The final dimension of PTSD is a lowered threshold for anxious arousal. This is physiological. Unexpected noises cause the person to shudder or jump. The response is automatic and not necessarily related to stimuli associated with the original trauma.

A patient of mine, a bank teller who was robbed, held hostage, then kidnapped, was not exposed to gunfire or loud sounds during her ordeal. But six months later, she was visibly startled and upset by the rumble of a train near my office.

It is as though the alarm mechanism that warns us of danger is on a hair trigger, easily and erroneously set off. A person lives with so many false alarms that he or she cannot concentrate, cannot sleep restfully and becomes irritable or reclusive. A normal sex life is difficult with such apprehension. PTSD therefore impairs the enjoyment of intimacy, and this, in turn, isolates the sufferer from loved ones - the ideal human source of reassurance and respect.

Often, the anxiety takes familiar shape: panic and agoraphobia. Panic is a sudden, intense state of fear, frequently with no obvious trigger, in which the heart beats rapidly, respirations are quick and shallow, and fingertips tingle. There is light-headedness, there may be sensations of choking or smothering, and the person feels he or she is dying or going crazy or both. It is a seizure of the autonomic nervous system. It mimics a heart attack. Panic lasts a few minutes but is so debilitating that one is upset for several hours. After experiencing a few panic attacks, a person will often avoid places where an attack would be particularly embarrassing, such as shopping malls and supermarkets.

The term agoraphobia, from the Greek words for market (agora) and fear (phobia), literally means fear of the marketplace. But it applies to many similar settings that are shunned by those with a particular pattern of anxiety. Extreme agoraphobia causes self-imprisonment in one's house or even a single room within a home.

Few PTSD sufferers reach this condition, but many of my patients have imposed dramatic restrictions on their social activity, not out of fear of a traumatic reminder, but out of embarrassment in anticipation of a panic attack that would be witnessed by others. By now it should be evident that PTSD has not only a variety of dimensions and components, but vastly different effects and implications. Some trauma survivors are continually reminded of their victimization and experience relief when they tell the details to others. Some survivors are humiliated by their dehumanization or laden with guilt for harming another person. They refuse to discuss details. Some are dazed, moving in and out of trance-like states. Some are full of fear, hypervigilant, easily startled, unable to concentrate, wary of strangers. The syndrome may be evident soon after the trauma or may emerge years later.

Acute Stress Disorder

In 1994, a variant of PTSD was added to the official list of diagnoses: Acute Stress Disorder. This term is used to describe early effects lasting more than two days but no more than four weeks. To qualify for ASD, a trauma survivor must have the PTSD triad of intrusive recollections, avoidance and anxiety, and also must have several dissociative symptoms - at least three of the following five:

- * A sense of numbing, detachment, and absence of emotional responses.
- * A reduction in awareness of surroundings, being in a daze.
- * De-realization. (The immediate environment seems unreal, as though it were a movie or a play.)
- * De-personalization. (The self is experienced as altered, unreal, an actor, a fictional character.)
- * Dissociative amnesia. (There are gaps in memory that cannot be explain by head injury, drug use or other physical causes.)

The distinction between Acute Stress Disorder and Posttraumatic Stress Disorder is important for clinical research and therapy: Why do some people have persistent

symptoms while others have only short-term effects? What treatments effectively reduce the immediate and the chronic disabilities? For journalists, however, it is enough to know that Acute Stress Disorder and Posttraumatic Stress Disorder are closely related conditions, almost indistinguishable, except for timing. ASD refers to debilitating recollections, numbing, avoidance and anxiety up to a month after a traumatic episode, and PTSD refers to the continuation of those symptoms thereafter.

Who gets PTSD?

What do we know about vulnerability to PTSD? Long before there was a PTSD diagnosis, there was a body of theory and research regarding coping. Scientists described copers as those who faced major life transitions and major life disruptions while still achieving four goals:

- * they successfully accomplished necessary tasks;
- * they maintained relationships with significant others;
- * they preserved self-esteem;
- * they kept anxiety within tolerable limits.

Populations of copers and non-copers were studied among students adapting to out-of-town colleges, children entering puberty, soldiers with extensive third-degree burns at an Army hospital, and many other populations.

The coping mechanisms that enabled some to thrive while others failed or suffered (or, in the case of the badly burned soldiers, lost their lives) included denial, role rehearsal, information gathering, positive use of fantasy or imagination and the ability to anticipate and devalue failure. For example, soldiers with 50 percent body burns who denied - who kept from conscious awareness - the realization that they would be disfigured and that their recovery would be painful, had a better rate of survival than those who, early on, recognized grim reality. Of course, there comes a time when unfortunate consequences must be accepted. Copers delayed such acceptance until their electrolytes had stabilized and physical healing had begun.

Two employees of the U.S. Information Agency were captured and held in isolation near Lebanon for 18 months by terrorists of the PFLP (Popular Front of the Liberation of Palestine). I interview both men six months later in Washington, D.C.. The one who coped well occupied his mind while in captivity by visualizing the designs for a house, down to the last detail. He categorized favorite restaurants (including the one in which our interview took place), anticipating future menus. He exercised and kept his spirits up. I recall our conversation in 1978 as pleasant for both of us.

The second interview, with his associate, was far less comfortable. This man spoke guardedly, fearing foreign agents would overhear. He had no sense of humor and smoked nervously. During captivity, he counted bricks in his cell and paced. He had no way of occupying his mind.

The men were treated equally in confinement and released the same week. One celebrated freedom. The other was disabled and diminished. I do not recall that either had flashbacks, nightmares or intrusive recollections. Probably neither would have therefore qualified for the diagnosis of PTSD, (which was defined two years later). But one was a copper and the other was not. One had conscious and unconscious coping mechanisms: denial of danger, use of fantasy, positive thinking. The other, literally a plodder, failed to cope.

Most current research shows that the intensity and duration of traumatic events correlates positively with the occurrence of PTSD. But individuals exposed to the same extreme stress will vary in their responses. Heredity could play an important role. Just as some children are born shy and others exhibit a bolder temperament, some of us are born with

the brain pattern that keeps horror alive, while others quickly recover. As a varied, interdependent human species, we benefit from our differences. Those with daring fight the tigers. Those with PTSD preserve the impact of cruelty for the rest of us.

An interesting experiential (rather than hereditary) theory posits that minor traumas, successfully resolved in childhood, protect against major psychological stressors later on, much as an attenuated virus creates immunity to full-blown infection.

Other theories emphasize the presence or absence of social supports, sustaining religious and spiritual beliefs, use of drugs and alcohol, co-existing medical and emotional disorders and the age of the trauma survivor.

When children are traumatized, they often regress. A pre-schooler will wet the bed, even though he or she has been toilet-trained for a year. A verbal child may not speak. Severe childhood traumas will disrupt personality development and therefore pose major lifelong challenges.

Reviewing the relatively high incidence of PTSD in Viet Nam compared to other conflicts, researchers noted the younger age of the soldier, the public disapproval of the war, and the fact that rotations were individual and not by unit. This meant that veterans were forced to cope with the demands of adolescence as well as those of war. Their identities were not complete; they lacked adult experience. They may have faced ridicule by war protesters back home. There were no comrades-in-arms to offer support. None of these factors cause PTSD. But each makes coping with it more difficult and compounds the impact of the disorder.

I tell patients with PTSD that there is nothing abnormal about those who suffer. It is a normal reaction of abnormal events. Anyone could have PTSD, given enough trauma.

OTHER RESPONSES

Adjustment Disorder

There are psychiatric disorders other than PTSD and ASD that follow traumatic events. Most commonly, the diagnosis is an Adjustment Disorder. This is a relatively mild, relatively brief disruption of functioning. Mood may be anxious or depressed or both. Conduct, especially in children, may be impaired. The diagnosis is often applied during marital and occupational difficulties and need not have a major trauma to justify its use. When a major trauma causes minor impairment, but enough disability to warrant psychiatric treatment, the diagnosis will be Adjustment Disorder.

At the other end of the spectrum are psychotic and severe dissociative states. These are not common.

Psychosis

Psychosis is usually defined as a break with reality. Brief psychotic disorder may include hallucinations and delusions unrelated to the trauma. Voices may order the person to harm another or to harm himself, even though the trauma had no such content. Delusions are fixed false beliefs, often of persecution or grandiosity or both. Delusions may be intricate and bizarre, with or without accompanying hallucinations.

Dissociation

Dissociation is an altered state of consciousness. One is not oneself, but not out of touch with reality. In a fugue state, people can travel long distances for no apparent reason, converse with strangers, appear normal, have no hallucination and no delusion, but

eventually return to their original self and original awareness, baffled by finding themselves in a city hundreds of miles from home. De-personalization, de-realization, psychogenic amnesia (see page 5) and multiple personality (see page 9) are also dissociative conditions.

I once evaluated a young gay man in Florida who stabbed his lover-roommate 17 times, after being attacked himself. This man had no prior history of violent behavior, no grudge against the roommate and no memory of anything between the onset of the altercation and calling the police. In my opinion, he had a brief psychotic disorder and psychogenic amnesia (a combination of psychosis and dissociation). The jury agreed.

Medical disease

Many traumatized people will develop physical diseases or exacerbate pre-existing conditions. Psychosomatic pathways are involved, so these medical problems have psychiatric labels as well. The cardiovascular system, the gastrointestinal tract and the respiratory system are well recognized by the general public as vulnerable to stress.

Hypertension, heart attack, stroke, ulcers and asthma can follow intense events.

A baffling array of symptoms follows exposure to organic compounds in war zones. The effects of Agent Orange and Gulf War Syndrome are examples. Neurologic, psychologic and other medical symptoms are difficult to diagnose and treat. We still do not know, with certainty, how various organic toxins impair brain function and why some people who may have been exposed have far more disability than others. Symptoms include short-term memory deficit, reduced intellectual function, concentration problems, fatigue, chronic pain and depression.

Multiple Personality/Dissociative Identity Disorder

A very different, well-publicized posttraumatic condition was known until recently as Multiple Personality Disorder (MPD). It is now renamed Dissociative Identity Disorder (DID). More than 90 percent of the sufferers are female and more than 90 percent were abused as children, often father-daughter incest. There are many more cases in treatment in the United States than anywhere else in the world.

I am convinced that incest is a major problem in many countries. Currently, there is a debate raging about false memories, pitting adults who recall childhood sexual abuse decades later against parents who deny being sexual abusers. Hospital records and child protective services document hundreds of thousands of cases of child sexual abuse each year in this country and roughly half involve fathers or stepfathers, so there can be no doubt that incest is occurring.

Both boys and girls are usually abused by men. The children chosen for these deviant acts are quite young, five or six being the preferred age. One way that little girls defend themselves psychologically is by going into a trance. Little Mary says to herself, "Daddy isn't doing this to me, he's doing it to Belinda." Belinda exists, at first, only during abuse episodes. She is an altered state of consciousness, or, in the language of DID specialists, "an alter." As she matures, her personality develops. She becomes a separate self who may or may not communicate with Mary. If this separation into two personalities is effective, Mary may then generate three or four - or dozens - of alters in response to abuse and other life traumas.

Why are there so few male "multiples"? It may be that men end up in prison rather than in a therapist's office. It may be that they respond aggressively rather than passively to parental abuse. There is certainly confusion and controversy in the field. But no one should doubt that father-daughter incest is a pervasive problem and that the emotional

damage is profound. The worse trauma is often the incest secret, not the sexual activity itself. Whether or not Dissociative Identity Disorder occurs, there will be problems with intimacy, self-esteem and trust. The PTSD elements of flashback and anxiety are not as prominent as the distorted relationships with father and mother and the damage to a coherent sense of self. Multiple selves are the ultimate incoherence.

Victims of cruelty

Victims of human cruelty (as opposed to victims of natural disasters) experience additional emotional difficulties which are not listed in the official diagnostic manual and are not part of PTSD. Foremost among these is shame. Although violent criminals should feel ashamed, they seldom do. Instead, the victim who has been beaten, robbed or raped is humiliated. This person has been abruptly dominated, subjugated, stripped of dignity, invaded and made, in his or her own mind, into a lower form of life.

Who cannot recall being bullied as a child, forced to admit weakness, mortified by the process? As an adult, this shame quickly becomes self-blame: Why was I there? What could I have done differently? Why did I let it happen?

Self-blame may actually be a good sign, correlating with self-reliance and self-regard. But it may also be hostility turned inward, a relentless self-criticism and downward spiral into profound depression.

Hatred is another human emotional response to trauma with no reference in the diagnostic manual. Victims of cruelty are entitled to hate their abusers, on the path to recovery and possible forgiveness. But survivors often do less hating than one might expect. Sometimes they are simply grateful to be alive. They may, ironically and paradoxically, love the kidnapper who could have killed them, but instead gave them life. This is called the Stockholm Syndrome, named for the bizarre outcome in a bank vault in Sweden in 1974 when the hostage-taker, Olsson, and the bank teller, Kristin, fell in love and had sex during the siege. Like Patty Hearst and countless others, Kristin denied that her assailant was a villain, but responded passionately to his power to spare her life. It is the Mothers Against Drunk Drivers who are MADD. The co-victims, the next of kin of the injured and dead, are more often the ones moved to rage and vengeance, if not hatred. Obsessive hatred is a corrosive condition, seldom the focus of psychiatric treatment, but of major concern to historians and journalists.

This is a good point to pause and consider the ultimate reason for a new theme in journalism education: in-depth coverage of the way victims experience emotional wounds, particularly wounds that are deliberately and cruelly inflicted.

A relatively recent area of clinical science, traumatic stress studies, teaches us that victims of violence have several distinguishable patterns of emotional response. These patterns are easily recognized once their outlines are understood. Seeing the logic in a set of psychological consequences re-humanizes and dignifies a person who may feel dehumanized and robbed of dignity. The process of recovering from posttraumatic wounds, with or without expert help, is beyond the scope of this chapter. But a sensitive explanation of the traumatic stress response aids recovery. And when we as a society pay attention to the victim as he or she heals, we are less likely to be consumed by hate, focused on perpetrators, contributing to a contagion of cruelty.

Journalists can report on victims, help victims as multi-dimensional human beings and possibly, just possibly, reduce the impulse toward vengeance in the process.

INTERVIEW ISSUES

Timing

When reporters seek a trauma survivor's comments soon after the event, they have a high likelihood of encountering one or more of the emotional states mentioned above. The reason that Acute Stress Disorder is not diagnosed until two days of symptoms have elapsed and PTSD requires four weeks of symptoms is because these symptoms are common and not indicative of a psychiatric condition in the immediate aftermath of a major life disruption. As time passes, there is a greater possibility of emotional composure. But there is also a possibility of distorted recollection, selective memory and competition from many other interviewers, each with a different agenda, each raising new questions in the mind of the person interviewed. Therefore, even from a psychiatric point of view, there is no formula for setting the ideal time for a posttraumatic interview.

Assume you have access to a clerk who was robbed at gunpoint an hour ago. She appears uninjured. You might begin, "Have you had a chance to discuss this with anyone else?" This tells you where this interview is in the predictable sequence of police investigations, insurance and management inquiries and conversations with family, friends and others, including other reporters.

It also allows you to follow up with questions about those discussions, if they occurred. An interviewee reveals a lot about conversational preferences, when given the chance. For example, he or she might indicate a desire to talk at length, to be brief and to the point, to learn about the incident from you or to get away from the scene - all in response to an open-ended question such as, "How was that previous discussion for you?"

Then you can set the stage for your interview, having assessed your subject's attitude and emotional state before he or she regards you as being responsible for his or her feelings. Have your subjects focus on how someone else made them feel.

Consider a very different interview. It is the one-year anniversary of a major catastrophe such as the Oklahoma City bombing and you are assigned to interview a survivor who now lives in your small town outside of Oklahoma. You telephone to arrange a meeting. This story, a year rather than an hour later, will deal with emotions throughout that year and on this anniversary date. The incident is less important than the impact of the incident on one individual through time. The interview may - probably will - cause vivid recollections. Do you mention this over the phone? Or do you assume that a willingness to be interviewed signifies a willingness to revisit painful memories?

The fact that this is a feature rather than a news story gives you more flexibility in arranging the time and place, meeting once or on several occasions. But you the journalist may be the cause of emotional injury, since this person was exposed to major traumatic stress and has reached some new adjustment state that you will disrupt. In a way, this is a more delicate, difficult situation.

Setting the stage

Setting the stage is important regardless of the timing of an interview. A trauma survivor should be approached with respect, neither gingerly nor casually. This is a person who has witnessed and lived through a newsworthy event outside normal experience, someone who has something to share with the community and who undertakes some re-exposure to traumatic memories by talking with you. If you convey respect for this situation, then you are off to a good start.

Consider the possibility that a survivor might be more comfortable at home or might want to be out of the family circle. Some might feel more secure with a friend or relative present.

The clerk robbed at gunpoint would probably be encountered first at the convenience store. But if she had the authority to leave, to be joined by a friend, you might get more details, more spontaneity, than if you stayed at the scene of the crime. Of course, a

deadline might preclude taking an extra hour to learn about the emotional impact of the robbery on your witness/victim. Obviously, if you can remove someone to a comfortable, secluded place, the chance of interruption is reduced and concentration is enhanced. As a psychiatrist interviewing survivors, I often find two people at my office when I expected one. The second is the mother, spouse, sister or friend. I want that person present, if my patient wants the person there. Sometimes the patient just wants the person to wait outside, to be there for the drive home. But the patient would be embarrassed to say so in front of the companion. I have found it best to ask the patient to step into the office for a moment, so that they can express their preference, then I can tell the companion to join us or wait for an hour.

Interviewing people as a Red Cross volunteer at disaster sites is more like the field conditions journalists encounter. When serving in that capacity, I set the stage as best I can, trying to assess quickly whether a person wants privacy or the proximity of others and whether the comfort level is greater with the door open or closed. One woman preferred to sit on the floor, surrounded by her soggy belongings, as she sought help at a shelter after the 1994 Northern California floods. This woman was agoraphobic before the floods, more so afterward, and I earned her trust by bringing social workers and small-business loan specialists to her, rather than having her join the crowd in the busy service center.

To set the stage for an interview, remember that the person may be in a daze, may be numb, may be easily startled, may be hypervigilant, may be confused. But they can usually tell you the setting that will suit them best. This may require a companion, an open door and several breaks for self-composure.

Eliciting or avoiding emotion

As an interviewer, you can either elicit or avoid emotion. Do you want to see and hear a person's emotional state? Or do you want the individual to describe his or her feelings without displaying them? A person can tell you, "I was very upset, crying all the time, unable to work . . ." Or they can sob as they speak.

Most reporters would prefer to have their interviewees describe rather than display strong emotions (TV talk-show hosts excepted). So would I, in initial interviews with trauma survivors. My ultimate objective is to help them master their uncontrolled feelings.

Therefore, I usually say that we can, if possible, defer dealing with the full impact of the event until we know each other better, until some progress has been made.

I explain how, several weeks hence, we will get to the central part of the traumatic experience. But that is done when I am treating PTSD, by definition a persistent problem, at least a month long, with intrusive emotional recollections. At other times, for example when de-briefing Red Cross volunteers, I want to see strong feelings, if they are present, to get them talked out before the volunteer goes home (and to show respect for the person and for his or her emotions). That is the point of the de-briefing.

But journalists are not PTSD therapists or after-incident crisis de-briefers. You are interviewing a witness who will become the subject of a story.

From an ethical point of view, you should afford your interviewee as much control as possible and as much foreknowledge as possible. You can do this by explaining your journalistic objective. For example, you might begin, "I'm really interested in the facts of the robbery. I know this may be upsetting right after it happened, but I won't be reporting on how he made you feel." However, if your intention is otherwise, you could say, ". . . and I am interested in how he made you feel, then and now. Readers need to know what kind of impact these events have, and I thank you for being willing to describe them."

It is not uncommon for tears to flow during the telling of an emotional event. Therapists offer tissues. I usually say, "I'm accustomed to hearing people while they are crying, so don't worry about me." I neither urge nor discourage someone from continuing to talk, but I do try to normalize the situation. Reporters should bring tissues if a tearful interview is anticipated.

When survivors cry during interviews, they are not necessarily reluctant to continue. They may have difficulty communicating, but they often want to tell their stories. Interrupting them may be experienced as patronizing and as denying an opportunity to testify. Remember, if you terminate an interview unilaterally, because you find it upsetting, or you incorrectly assume that your subject wants to stop, you may be re-victimizing the victim.

Some people who have suffered greatly, for example, torture victims in Chile, have benefited psychologically from the opportunity to provide testimonials, and the benefits have been substantiated by research.

Members of the Michigan Victim Alliance, who serve as interviewees for the journalism students at Michigan State University, report some PTSD symptoms (anxiety and intrusive recollections for one or two days), but an overall increase in self-esteem, because their stories have been heard. Often, the facts are told with considerable depth of feeling.

So the issue is not really should you, the journalist, attempt to control your subjects' emotions, but rather, how can you best facilitate a factual report, a full report, and give your interviewee a sense of respect throughout.

Informed consent

Should journalists offer the equivalent of a Miranda warning? "You have a right to remain silent. Anything you say can and will (especially if it is provocative or embarrassing to somebody important) be used on the front page."

That would not work. But the medical model of informed consent could be adapted for interviews with trauma victims. You might explain: "This procedure - interview and article - has benefits for the community and may benefit you. Remembering, however, may be painful for you. And your name will be used. You might have some unwanted recollections after we talk and after the story appears. In the long run, telling your story to me should be a positive thing. Any questions before we begin?"

Interviews & the stages of posttraumatic response

The first set of responses after shocking events involve the pathways of the autonomic nervous system, connecting the brain, the pituitary gland, the adrenal gland and various organs of the body. Blood is shunted from the gut to the large muscles. The pupils dilate. The pulse accelerates and the stroke volume of the heart increases.

These physiological changes, shared by all mammals, prepare us for fight or flight. We are in a state of readiness for dealing with the threats our ancestors faced on the great plains of Africa: wild beasts, sudden storms, deadly enemies. We are not adapted for fine motor movements, nor for deep conscious thought. The surge of adrenalin and pounding heart we experience when our car skids on an icy highway does not help us maneuver that modern challenge.

Our danger biochemistry is atavistic. We have to fight these bodily changes as we respond to modern mechanical dangers, such as a high-speed skid in an automobile. There are perceptual changes as well. Our focus on a source of danger, be it a wild beast or a pistol pointed at us, is intensified. Objects in our peripheral field of vision begin to

blur, a function not only of the organs of perception but the result of how impulses are received, recorded and analyzed in the brain.

Detectives, doctors and journalists all know the implications of this phenomenon: Details are notoriously distorted, except for a few central features, when eyewitnesses report from incidents of threat and sudden danger.

Sometimes, a powerful threat is prolonged, as in a hostage incident, a kidnapping, some assaults and rapes. Many natural disasters - a flash flood or hurricane - may place one in mortal danger for hours rather than seconds or minutes. Short, deadly traumas include gunshots, explosions, earthquakes and fires.

When extreme stress is prolonged (days or weeks), adaptive mechanisms collapse. This is rare. But in animal experiments, mammals suffer hemorrhagic necrosis of the adrenal gland - literally a bloody death of that organ, and, soon after, death of the organism itself. Far more frequently, humans in states of prolonged, catastrophic stress enter a second stage of adaptation. Hans Selye, the physiologist whose stress studies guide the modern era, called this a stage of resistance, following a stage of shock. Now the organism is on high gain, accustomed to the increased flow of adrenalin, consciously appraising what has previously been grasped automatically.

At this point, a crime victim knows that he or she is a victim, although the person may be thinking, "This can't be happening to me." At this point, details do become evident, particularly to the trained observer. And, in group hostage situations, there is often a ritual calm, when confusion and feelings of threat diminish. This is the time when negotiations may be successful.

Disaster workers recognize a heroic phase, a second stage after the initial bedlam, when all is shock and confusion. In the second stage, people help one another, lives are saved, lost children are found. Hope and exhilaration co-exist with fear and grief.

Eventually, there is a return to some equilibrium in the body, the mind and the community. This may be a time of depression and demoralization: The high-energy condition is gone. There is debris. There is loss. There is pain. Reality sinks in.

This is also the time when the press leaves. A survivor who might have been annoyed by too much attention could feel abandoned and forgotten.

Several authors describe stages after shocking events occur or disturbing news is heard. Kubler-Ross defined the denial, fear, anger and eventual acceptance after learning one has a fatal illness. PFLAG, Parents and Friends of Lesbians and Gays, describe similar stages, not all of them reached, by parents who are unprepared for the revelation that their children are gay. Stages are merely guidelines, not applicable to everyone who encounters unforeseen stress.

A journalist may want to consider the particular sequence of stages or phases that an interviewee has experienced, where that person is now and how each stage affects the perception of events.

A discussion of stages may help the interview process, without actually "leading the witness." Consider saying, "Sometimes people go through a stage when they act without thinking, when they don't even know what is happening," and you may elicit an interesting narrative. Some people need to be reminded that they acted instinctively. Then they can recall what occurred just before that phase and right afterward.

My patient who was thrown to the floor by the "cooler bandit" recalled months later that she hid her wedding ring under a shelf, as she lay in the fetal position, expecting to be shot. She forgot this particular event during the time that she was experiencing fear and shame and all of the PTSD symptoms listed in the diagnostic manual.

For me, it was of special note - her instinctive protection of a valuable symbol, her refusal to yield that icon to her assailant. This woman was full of self-blame for not sounding the secret alarm, for behaving like a coward. Therapy required a diligent search for evidence

to the contrary, proof that would convince her. (I was already certain that she had done what any reasonable person would have done to survive an armed robbery.) She recalled hiding her ring as we talked about the instinctive, automatic things that some people do. And she finally agreed that her instincts were correct.

THE HUMANITARIAN ROLE OF THE REPORTER

Journalists and therapists face similar challenges when they realize their subjects are at risk of further injury. Techniques may differ, but objectives are the same: to inform about sources of help. A therapist is not a lawyer or a security consultant, but a battered woman and an abused child need to know that shelters, restraining orders and a network of advocates are available. Therapy includes such referrals.

The reporter is not responsible for individual referrals, but could include sidebars about community resources when covering individuals who typify the kinds of victims who would benefit from such resources.

Journalists can also mobilize colleagues in the helping professions when they come upon problems that appear neglected. Ed Chen, a reporter for the Los Angeles Times, called me twice in recent years, not just for quotes about PTSD, but for help with neglected problems.

Ed covered the Gulf War. Before becoming the Dhahran Bureau chief, he interviewed wives of human shields. Many of these women were Middle Eastern and were sent to cities in the United States where they had no family, friends or resources. Their mental health needs were considerable and there was no federal agency equipped to respond. Several acquaintances in the helping professions, inspired in part by Ed's reporting and his requests, established an ad hoc charity, USA Give (Leslie Kern, Ph.D., director). Fifty trauma experts donated free care to 90 individuals.

Ed benefited also. Our network found him a place on the plane when a delegation of "wives of shields" flew to Baghdad to petition Saddam Hussein for the release of their husbands.

Three years later, Ed called again. He was in Oklahoma City, a week after the blast. He told me that even seasoned journalists who covered disasters and tragedies were heartsick, stunned and emotionally traumatized by this assignment.

Perhaps because he arrived a week after the others, he could see the impact on his colleagues who had been there from the start, when there was hope that children would be found alive, when the number of missing was triple that of those certified dead.

Ed's call led to an initiative from Michigan State University's School of Journalism: Trauma specialists and journalism professors who taught courses on victims and the media would meet with members of the press corps who covered Oklahoma City and wanted to reflect on the traumatic stress that they had inherited.

SECONDARY TRAUMATIC STRESS DISORDER

Journalists are candidates for Secondary Traumatic Stress Disorder, an empathic response that affects us, therapists included, when our professional detachment is overwhelmed by certain life events.

images of dead children leave an indelible mark. Firefighters, who would rather not admit that they have tender feelings, find themselves vulnerable to the haunting memory of a burnt child or the sight of a tiny form in a body bag.

The sheer numbers of unexpected dead, in one place, will penetrate the defenses of hardened rescue workers. Plane crashes rank among the most difficult assignments for American Red Cross workers who normally handle floods, earthquakes and fires. At an

air disaster, there is a concentration of death images that few doctors, nurses or ambulance drivers have ever seen.

Writing about journalists covering Rwanda, Roger Rosenblatt mused:

"Most journalists react in three stages. In the first stage, when they are young, they respond to atrocities with shock and revulsion and perhaps a twinge of guilty excitement that they are seeing something others will never see: life at its dreadful extremes. In the second stage, the atrocities become familiar and repetitive, and journalists begin to sound like Spiro Agnew: If you have seen one loss of dignity and spirit, you've seen them all. Too many journalists get stuck in this stage. They get bogged down in the routineness of the suffering. Embittered, spiteful and inadequate to their work, they curse out their bosses back home for not according them respect; they hate the people on whom they report. Worst of all, they don't allow themselves to enter the third stage in which everything gets sadder and wiser, worse and strangely better." (The New Republic, June 6, 1994, p. 16)

In one or two decades, PTSD will be universally recognized, de-stigmatized, and well treated. To be dazed at first, then haunted by horrible memories and made anxious and avoidant is to be part of the human family. When deliberate, criminal cruelty is the cause of PTSD, we often neglect the victim and become captives of collective outrage, focusing attention on crime and criminality and those who are to blame.

By discussing PTSD, we disarm PTSD. We do not prevent it, but we minimize its degrading, diminishing effects. We help victims become survivors. We help survivors regain dignity and respect.

OFFICIAL DIAGNOSTIC CRITERIA FOR PTSD

From DSM-IV - American Psychiatric Association (1994)
Diagnostic and Statistical Manual for Mental Disorders
Fourth Edition. Washington, D.C.

Diagnostic criteria for 309.81
Posttraumatic Stress Disorder

A. The person has been exposed to a traumatic event in which both the following were present:

(1) the person experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.

(2) the person's response involved intense fear, helplessness or horror. Note: In children, this may be expressed instead by disorganized or agitated behavior.

B. The traumatic event is persistently re-experienced in one (or more) of the following ways:

(1) recurrent and intrusive distressing recollections of the event, including images, thoughts or perceptions. Note: In children, repetitive play may occur in which themes or aspects of the trauma are expressed.

(2) recurrent distressing dreams of the event. Note: In children, there may be frightening dreams without recognizable content.

(3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). Note: In children, trauma-specific re-enactment may occur.

(4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

(5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

(1) efforts to avoid thoughts, feelings or conversations associated with the trauma

(2) efforts to avoid activities, places or people that arouse recollections of the trauma

(3) inability to recall an important aspect of the trauma

(4) markedly diminished interest or participation in significant activities

(5) feeling of detachment or estrangement from others

(6) restricted range of affect (e.g., unable to have loving feelings)

(7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

(1) difficulty falling or staying asleep

(2) irritability or outbursts of anger

(3) difficulty concentrating

(4) hypervigilance

(5) exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B.C. and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational or other important areas of functioning.

Specify if:

Acute: if duration of symptoms is less than 3 months

Chronic: if duration of symptoms is 3 months or more

Specify if:

With Delayed Onset: if onset of symptoms is at least 6 months after the stressor

PTSD 101

Frank Ochberg, M.D.