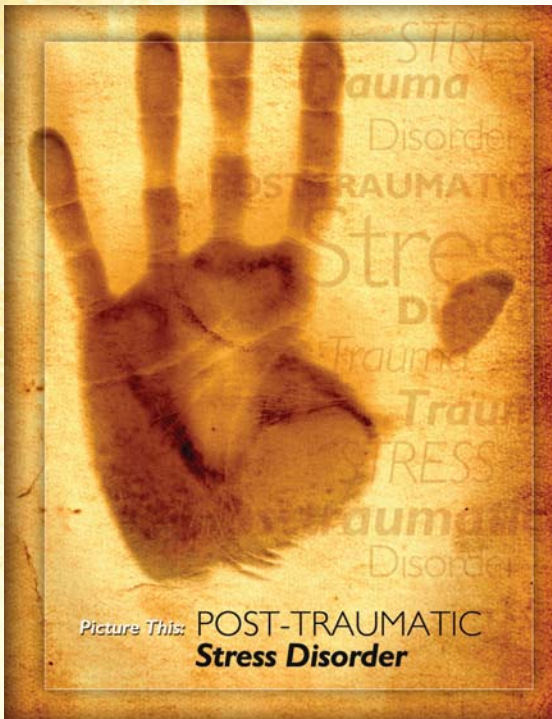




Picture This: **POST-TRAUMATIC
Stress Disorder**



*Picture This:
A Resource for Creators...*

is a guide to the key issues within the realm of post-traumatic stress disorder (PTSD), as identified by mental health experts, advocates, policy-makers, and others working to improve public awareness about and reduce the negative effects of PTSD.



www.eiconline.org



www.mentalhealth.samhsa.gov/cmhs

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TABLE OF CONTENTS

ACKNOWLEDGEMENTS	2
Our Picture This Entertainment Panelists:	3
Special Message to the Creative Community	5
Did You Know... ..	6
What is PTSD?	6
Symptoms	6
Formal Diagnosis	6
Treatment	6
PTSD vs. Other Trauma Reactions	7
PTSD and War Veterans	8
Pre-deployment Risk Factors	8
Deployment Risk Factors	9
Post-deployment Risk Factors	9
War, Terrorism and Civilian Citizens	10
Civilian Stressors	10
Effects of Stressors on Civilians	10
Relevance to U.S. Civilians	11
PTSD and Major Disasters	12
Terrorist Attacks	12
Hurricane Katrina-Related PTSD	13
PTSD and Children	14
Questions to Ask of Your Characters and Storylines Involving Trauma and PTSD	14
Depiction Priorities	15
<i>First Priority.</i> Make the signs and symptoms of PTSD clear so that audiences will understand what it is and is not.	15
<i>Second Priority.</i> Show that PTSD affects different people in different ways, and that it can devastate some people more than others	15
<i>Third Priority.</i> Show the consequences of unaddressed PTSD on the person who lives with it, as well as his or her family, friends, and community	16
<i>Fourth Priority.</i> Show that most people respond well to treatment for PTSD—it's not a lost cause, but steps need to be taken to get proper treatment	16
<i>Fifth Priority.</i> Be sensitive to viewers' own personal PTSD and consider how certain graphic portrayals of terrifying situations may trigger or exacerbate PTSD among viewers	17
Real People, Real Stories	18
PTSD Personal Stories	18
New Understanding: PTSD Clinical Trials	20
ENTERTAINMENT MATTERS	22
An Interview with <i>The L Word's</i> Cherien Dabis	22
Additional Information and Resources	24
End Notes	27

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Researching health issues can be as basic as finding research papers on the Internet or as complex as delving into public policy and the philosophical positions of interest groups. Most important is the perspective of people who, for one reason or another, make a deep commitment and dedicate their time to a cause.

*This document is a publication resulting from a formal meeting of experts in the field of mental health as well as five entertainment professionals at the National Association of Broadcasters in Washington, D.C. Numerous individuals and organizations provided insight into the complex issues surrounding post-traumatic stress disorder and related concerns as we created **Picture This: Post-Traumatic Stress Disorder.***

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Picture This: Post-Traumatic Stress Disorder was written for the Entertainment Industries Council, Inc. (EIC) by David Michael Conner with additional research by Josh Miller

OUR *Picture This* ENTERTAINMENT PANELISTS:

MATTHEW BONIFACIO – *Director/Writer/Producer, Lbs and Amexicano*
Matthew Bonifacio's directing, writing and producing debut, *Lbs.*, premiered at the 2004 Sundance Film Festival and was nominated for the Alfred P. Sloan Award. *Lbs.* screened at many festivals, winning Best Feature at the Deep Ellum Film Festival and Avignon/New York Film Festival. At the 2006 Tribeca Film Festival's first annual Tropfest@Tribeca, co-jurors Matt Dillon and Naomi Watts awarded Bonifacio's short, *The Watering Hole*, the top prize, in which he directed, co-wrote and produced. Most recently, Bonifacio directed and produced the feature film *Amexicano* which made its World premiere at the 2007 Tribeca Film Festival. Bonifacio co-founded the Brooklyn-Queens Experiment, a New York-based independent production company, with longtime *Lbs.* and *Amexicano* collaborator Carmine Famiglietti.

CHERIEN DABIS – *Co-Producer, The L Word*
Award-winning independent filmmaker and television writer Cherien Dabis has been recognized by the industry's top organizations and trade publications, including the Sundance Institute, IFF and Filmmaker Magazine, which named her one of the "25 New Faces of Independent Film." A 2004 graduate of Columbia University's Masters of Fine Arts Film program, Dabis's short films have screened at some of the world's top film festivals. Her latest, *Make A Wish*, premiered at the 2007 Sundance Film Festival, and several others. The film went on to win top awards in Dubai, Cairo and Aspen. Dabis is a Writer/Co-Producer on Showtime Network's original hit series *The L Word* and has been with the show for three seasons. As a feature film screenwriter, she has been awarded several distinguished awards in support of her screenplays including the Zaki Gordon Award for Excellence in Screenwriting, the Institute for Humane Studies Film and Fiction Scholarship and the New York Women in Film and Television Scholarship. Dabis is currently in development on *Amreeka*, her feature film writing and directing debut.

CARMINE FAMILIETTI – *Actor/Writer/Producer, Lbs and Amexicano*
"Suicide is the second leading killer of college students. We want to initiate a public dialogue to raise awareness about the prevalence of mental health issues on campus and connect students to the appropriate resources to get help. In planning for the campaign, mtvU conducted extensive research on how stress and depression are affecting college students nationwide. *Half of Us* has teamed with Mary J. Blige and identified college students to tell their stories about attempted suicides. They have also done 10 public service announcements."

SAMMY JACKSON – *Producer and Director, Vietnam: Homecoming (History Channel)*
Sammy Jackson is an award-winning producer/director of over 150 network and cable specials and documentaries. His programs have aired on PBS, A&E, Discovery, History Channel, ABC and CBS. A majority of these programs have been military related, covering veterans from WW2, Korea, Vietnam,

Desert Storm and the current conflicts in Afghanistan and Iraq. One of his most recent projects, *VIETNAM: HOMECOMING*, for History Channel and released theatrically, followed the lives of multiple families over the course of a year; during which time they traveled to Branson, Missouri, for what was billed as the largest welcome home celebration for Vietnam veterans in history. The program provides an unflinching view into the lives of these veterans, their wives, children and grandchildren, who for 30 plus years have struggled with the devastating realities of PTSD on both their families and themselves. Like a virus, the emotional conflicts spread into multiple generations within these families that continue to be fought to this day.

CHERYL HORNER SIRULNICK – *Executive Producer, MTV's True Life*

Cheryl Horner Sirulnick founded Gigantic! Productions in 2001 after several years of directing and producing at MTV. Her company has since created ten episodes of the extremely popular and critically acclaimed MTV series *True Life*, many educational/ pro-social News & Docs specials, and last year's hit two-hour documentary movie *Fat Camp*. Gigantic! Productions has also produced projects for CMT, VH1 and Apple iTunes. Her MTV News program *Hate in the Hallways* was nominated for a GLAAD Award for Outstanding TV Journalism, and her work on MTV's *Fight For Your Rights: Protect Yourself* campaign was honored with a Peabody/Robert Wood Johnson Foundation Award for Excellence in Health and Medical Programming. Her documentary *True Life: I'm Addicted to Crystal Meth* received a 2007 PRISM Award for Best Teen Series or Special. Cheryl has twice been a featured speaker at the National College Media Conference in New York. In addition to her documentary work, Cheryl Sirulnick has ten years experience producing and directing political figures such as Senator Edward M. Kennedy and former presidential candidate Howard Dean, as well as celebrities such as Adam Sandler, Justin Timberlake, and Beyonce. Prior to forming Gigantic! Productions, Ms. Sirulnick lived in Sydney, Australia where she was the Creative Director for movie channels Showtime & Encore. She also lived in Bucharest, Romania where she served as Creative Director for the launch of HBO Romania. She is originally from Florida and received a Bachelor of Arts from the highly selective New College.



SPECIAL MESSAGE TO THE CREATIVE COMMUNITY

Post-Traumatic Stress Disorder, or PTSD, is a mental disorder unlike any other. PTSD occurs in the aftermath of traumatic events—large-scale or personal disasters, sexual assault or other assaults, physical or emotional abuse, or just about anything that induces extreme panic. PTSD can devastate a person's life, as it causes persistent frightening thoughts and memories of traumatic experiences and can cause emotional numbness, detachment, anxiety and other problems. People suffering from PTSD may experience sleep problems or be easily startled.

We've all felt the effects of PTSD in one way or another. Consider how the September 11, 2001 terrorist attacks on the United States affected the entertainment industry: Immediately, people debated how much time would need to pass before it would be safe and respectful to dramatize the events in entertainment. More importantly, we had to (and still have to) consider how replaying that day's events could affect people, as many people throughout the country, and especially in New York City, Pennsylvania and the Washington, D.C. area, suffer from ongoing trauma—panic attacks, chronic worries, and other types of anxiety. For some people, any reference to the day could unexpectedly trigger severe personal PTSD symptoms.

September 11 was an isolated incident that deserves special treatment. But what about the aftermath of Hurricane Katrina? What about the school shootings at Columbine and Virginia Tech? Especially for the people immediately involved in these events, the considerations are the same: These topics must be dealt with sensitively. And in order to do so, entertainment creators need to understand the causes and effects of PTSD.

While the specific disasters named above have been responsible for many cases of PTSD, literally millions of people live with PTSD from other disastrous events—having been abused as children, in a car crash or other violent accident, having been raped or sexually assaulted, or involved in other traumatic events. First responders—police officers, firefighters, paramedics—often experience PTSD, as well.

Depicting PTSD on television and in movies—showing what it is and how it affects people's lives—makes perfect sense, as drama arises from conflict, and personal and large-scale tragedies often are sources of conflict in the stories we tell. To see a character live through the symptoms of PTSD will empower audiences with information, and may save lives, as one tragic ultimate effect of PTSD can in extreme cases include suicidal thoughts or acts.

In order to equip television and screenwriters, producers, directors and other creative professionals within the entertainment industry with the information they need to know about PTSD, the Entertainment Industries Council, Inc. (EIC), in collaboration with the Center for Mental Health Services (CMHS, SAMHSA) and the National Institute of Mental Health (NIMH, NIH), co-sponsored *Picture This: Post-Traumatic Stress Disorder*, a forum for mental health experts, as well as people who live with PTSD, to determine priorities for onscreen depictions.

Through the convening power of the entertainment industry, all of the associations and individuals listed within this publication came together for a common purpose: to determine the most pressing concerns related to depicting PTSD onscreen. A panel of entertainment professionals explained challenges and opportunities for depicting these issues onscreen, and took part in a dialogue with the experts and people with first-hand experience who were in the room. This publication is the result of that meeting.

Picture This: Post-Traumatic Stress Disorder is intended to encourage the creative process, not inhibit it. Within these pages is surprising and new information about PTSD that you may not yet know, as well as personal stories of those who have experienced PTSD first-hand, and depiction suggestions to get you thinking about ways by which you can inspire, move and possibly even help your audience.

Sincerely,

Brian Dyak, President and CEO
Entertainment Industries Council, Inc.

WHAT IS PTSD?

Post-traumatic Stress Disorder: Researchers now know that anyone, even children, can develop PTSD if they have experienced, witnessed, or participated in a traumatic occurrence—especially if the event was life threatening. PTSD can result from terrifying experiences such as rape, kidnapping, natural disasters, war or serious accidents such as airplane crashes. The psychological damage such incidents cause can interfere with a person's ability to hold a job or to develop intimate relationships with others.²

Did You Know...¹

- Approximately 7.7 million American adults age 18 and older, or about 3.5 percent of people in this age group in a given year, have PTSD.
- PTSD can develop at any age—even during childhood—but research shows that the median age of onset is 23 years.
- About 19 percent of Vietnam veterans experienced PTSD at some point after the war.
- The disorder also frequently occurs after violent personal assaults such as rape, mugging, or domestic violence; terrorism; natural or human-caused disasters; and accidents.
- There are many examples of individuals who experience the syndrome of PTSD symptoms from events which were not directly life-threatening to them, such as witnessing a physical trauma to a loved one, inflicting injury or death on another (e.g., in war) or witnessing grotesque injuries (e.g., first responders).

Symptoms

The symptoms of PTSD can range from constantly reliving the event to a general emotional numbing. Persistent anxiety, exaggerated startle reactions, difficulty concentrating, nightmares, and insomnia are common. People with PTSD typically avoid situations that remind them of the traumatic event, because they provoke intense distress or even panic attacks.³

Formal Diagnosis

Although the symptoms of PTSD may be an appropriate initial response to a traumatic event, they are considered part of a disorder when they persist beyond three months.³

In defining significant traumatic stress reactions, including PTSD, SAMHSA includes the following characteristics:

- The event is seen as a threat to the physical or psychological integrity of the individual. For example, in the Oscar-winning movie "Ordinary People," the son who was in therapy would probably meet the diagnostic criteria for PTSD, but his distress was not associated with his own near drowning, but intense guilt that he did not save his brother from drowning.
- The event overwhelms the coping capacity of the individual as indicated by such reactions as intense distress, dissociation, freezing, panic, or disorganized behavior during or following the event. This is a primary reason why individuals vary greatly in the impact of exposure to traumatic events on the course of their reactions to trauma. Coping capacity can vary depending on personal resources (e.g., intelligence), prior life experience (e.g., prior traumatic experiences) and social support and resources (e.g., family support).

Treatment

Psychotherapy can help people who have PTSD regain a sense of control over their lives. They may need a specific type of psychotherapy called cognitive behavior therapy to change painful and intrusive patterns of behavior and thought and to learn relaxation techniques. Support from family and friends can help speed recovery and healing. Medications, such as antidepressants and anti-anxiety agents to reduce anxiety, can ease the symptoms of depression and sleep problems. Treatment for PTSD often includes both psychotherapy and medication.³

PTSD vs. Other Trauma Reactions

*By Malcolm Gordon, Ph.D., Center for Mental Health Services,
Substance Abuse and Mental Health Services Administration*

PTSD is just one type of traumatic stress reaction to traumatic events. There are many other types of significant reactions to traumatic events, such as (a) exacerbation of existing mental health problems or vulnerabilities (e.g., anxious or depressed people can become more anxious or depressed, socially isolated people can become more withdrawn); (b) dissociative reactions, such as altered sense of identity or reality, (c) significant behavioral problems triggered by or resulting from trauma exposure, such as problems with hostility or interpersonal aggression resulting from experience of interpersonal violence or substance abuse problems in the aftermath of trauma exposure; (d) lasting changes in thoughts and beliefs, emotional reactions, or motivations resulting from the processing of trauma exposure, such as suspiciousness or hypervigilance, obsessive thinking about the trauma experience or associated issues, pessimism about the future, stronger distress reactions to everyday stress; (e) interruption of life course – for children and adolescents, regression to behaviors associated with earlier stages of development or failure to engage in developmental tasks children/adolescents of the same age are engaged in (e.g., peer relations in adolescence); for adults – change or retreat from life goals, such as education or partnering.

PTSD is a syndrome (i.e., cluster of symptoms) that is seen following some types of traumatic events with probabilities ranging from high (e.g., after a rape; after torture) to moderate (e.g., after a serious injury) to low (e.g., after natural disasters). The criteria for PTSD are somewhat arbitrary so that many more people have some of the PTSD criteria (e.g., obsessional thinking about the traumatic event; avoidance of the location of the trauma) than meet all the diagnostic criteria. Moreover, PTSD symptoms tend to be phasic, such that a person may meet the criteria at one point in time, fail to meet the criteria at a later time, but meet criteria again still later (possibly due to an exacerbation of symptoms due to stress or reminders).

PTSD AND WAR VETERANS

All active-duty military personnel are at an increased risk for PTSD, as these people are under constant stress and often experience traumatic situations. According to Brett T. Litz, veterans of the wars in Iraq and Afghanistan have unique risks. Litz writes, "There is much we don't know about how soldiers manage the enormous and diverse demands and traumas in these new war zones, and it is too soon to know the full extent of the need for clinical services. We also have a great deal to learn about how to help those who have a higher risk for the development of post-deployment problems. Because not all veterans require services (most adapt due to their own resourcefulness), it is important to appreciate the factors that create risk for chronic PTSD. In examining the risks for veterans of the Afghanistan and Iraq wars, we must acknowledge the socio-economic-cultural context and the personal variables that dynamically shape soldiers' adaptation across the life span."

On the following pages is information about specific acute stressors, which may for some people result in PTSD ("PTSD predictors"). Among PTSD predictors for Iraq and Afghanistan war veterans identified by Litz are:

Pre-deployment Risk Factors

- Possible genetic predisposition to chronic PTSD in some people
- Prior trauma and adversity increase the risk of PTSD among veterans:
 - 74% of soldiers studied reported being exposed to at least one potentially traumatic event separate from their time in military service-in their lifetimes, and 60% reported being exposed to more than one across their life spans, with the majority of these incidents occurring prior to military service.⁴
 - Another study found that the extent of early trauma affected development of PTSD for both men and women.⁵
 - Vietnam veterans who experienced a greater number of traumatic events before joining the military were more likely to have PTSD.⁶
 - Soldiers who were abused as children were more likely to suffer combat-related PTSD.
 - According to the Center for Disease Control's Adverse Childhood Experiences study⁷, "the short- and long-term outcomes of adverse childhood exposures include a multitude of health and social problems," which may result in or affect:
 - Alcoholism and alcohol abuse
 - Chronic Obstructive Pulmonary Disease (COPD)
 - Depression
 - Fetal death
 - Health-related quality of life
 - Illicit drug use
 - Ischemic heart disease (IHD)
 - Liver disease
 - Risk of intimate partner violence
 - Multiple sexual partners
 - Sexually transmitted diseases (STDs)
 - Smoking
 - Suicide attempts
 - Unintended pregnancies

(Note: the Adverse Childhood Experiences study primarily focused on negative health outcomes of adverse experiences in childhood. They included traumatic events, but the most prevalent were experiences of chronic family stress, such as living with an alcoholic parent, rather than acute traumatic events.)



Deployment Risk Factors

- Direct combat
- Poor diet
- Bad weather
- Poor accommodations
- Perceived life threats
- Witnessing or experiencing traumatic events (See “Civilian Stressors” on page 10.)

Post-deployment Risk Factors

- Vietnam veterans who were involved in their community were less likely to develop PTSD.⁸
- Persian Gulf war veterans whose families didn't stick together suffered more frequent incidents of PTSD.⁹
- Vietnam veterans who discussed their military experiences demonstrated decreased rates of PTSD.¹⁰
- Veterans who reported discomfort in disclosing their Vietnam service experiences to friends or family demonstrated an increased risk for developing PTSD.¹¹
- Vietnam veterans who had postwar experiences that were more stressful reported more severe PTSD.¹²
- Sexual harassment combined with other stresses after service resulted in higher PTSD among Persian Gulf veterans.¹³

WAR, TERRORISM AND CIVILIAN CITIZENS

According to the National Center for PTSD, Americans have experienced greater fear and anxiety since the September 11, 2001, attacks and since the U.S. went to war with Iraq. Civilians are at increased threat of developing PTSD whether or not they live in a war zone; however, the threat of specific kinds of trauma for people who live in war zones—including on-the-scene journalists, government contractors and others—can be especially stressful.

Civilian Stressors

- Life threat
- Being bombed, shot at, threatened, or displaced
- Being confined to one's home
- Losing a loved one or family member
- Suffering from financial hardships
- Having restricted access to resources such as food, water, and other supplies
- Torture
- Beatings
- Rape
- Forced labor
- Witnessing sexual abuse of or violence toward a family member
- Mock execution

*Effects of Stressors on Civilians*¹⁴

Refugees

Most of the research on the effects of war on civilians has been conducted on refugee samples and people who were displaced as a result of war. Compared to other war-exposed civilians, these individuals' experiences may be more traumatic not only because of the situations that led to their exile but also because of stressors experienced in refugee camps and during the process of resettlement.

- In general, refugees exhibit high rates of PTSD and depression as well as other psychiatric problems, particularly if they were tortured.¹⁵
- Among Bosnians from a refugee camp in Croatia who experienced on average more than six traumatic events, approximately one third had depression and one quarter had PTSD. Twenty percent met criteria for both disorders. Refugees with both depression and PTSD were five times more likely to report being physically disabled than refugees with no psychiatric symptoms.¹⁶

Non-refugees

PTSD and other problems are prevalent among non-refugees as well.

- An article in a 2001 issue of the Journal of the American Medical Association (JAMA) reported on PTSD in survivors of war or mass violence in four low-income countries.¹⁷
 - Rates of PTSD were 37.4% in Algeria, 28.4% in Cambodia, 17.8% in Gaza, and 15.8% in Ethiopia. These rates are considerably higher than the U.S. rate of 8%.¹⁸
 - One suggested explanation for the significantly higher rate in Algeria is that the terrorist attacks were still ongoing when PTSD was assessed. Overall, several risk factors for PTSD were identified, including torture and the experience of trauma after the age of 12.

Relevance to U.S. Civilians

Results from studies of refugees and impoverished countries may be difficult to generalize to Western cultures. However, findings from more industrialized settings such as Israel and Beirut may be more relevant to American civilians.

- Studies from the Gulf War suggest that, during the early weeks of the war, there was a marked rise in stress for people of all ages. However, the stress level dropped off within a few weeks.¹⁹
- For example, data were collected on all casualties that arrived in the emergency departments of 12 local hospitals after actual missile attacks and false alarms. Almost 75% of admissions were for stress reactions. The highest number of psychological casualties occurred during the first two missile attacks, after which the numbers declined.²⁰
- Another study found that while approximately half of the participants in a study sample reported sleep problems during the war, there was significant improvement 30 days after the war ended.²¹
- Similar results were found in a study following the 1982 Lebanon-Israel war. Almost 12,000 Israelis were interviewed regarding their mood on eleven different occasions between 1979 and 1984.
- Outbreak of war coincided with an increase in depression.
- Incidences of depressed moods peaked at the time of the Palestinian massacre at the refugee camps, and then it dropped below baseline although conflict continued.
- Thus, many civilians respond to prolonged war with various stress symptoms, but as time passes people seem to recover and stress levels return to normal.

(Note that the above information comes from one-time studies and that such information does not necessarily indicate consistent trends; further studies may contradict or confirm trends related to this information. We have included information from studies to serve as inspiration for story ideas that may help audiences have a better understanding of PTSD.)



PTSD AND MAJOR DISASTERS

Terrorist Attacks

September 11 Terrorist Attack-Related PTSD

A study published in the Journal of the American Medical Association (JAMA) concluded the following one year after the September 11, 2001, terrorist attacks on the U.S. :²²

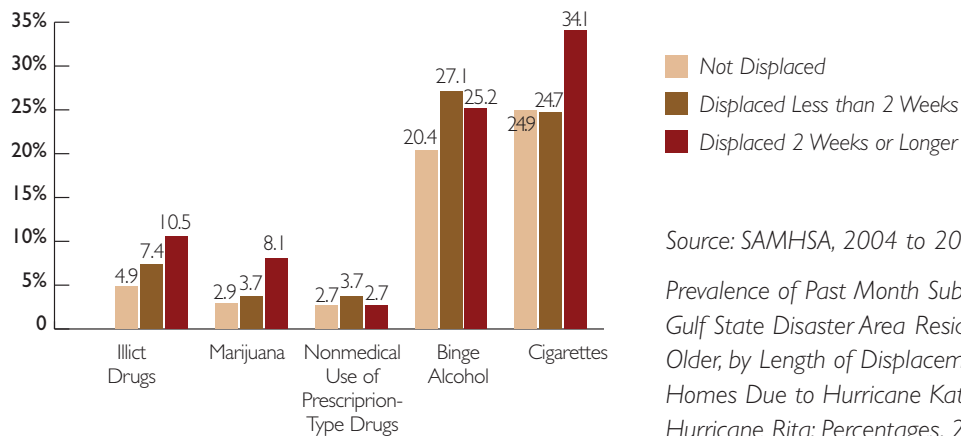
The psychological effects of a major national trauma are not limited to those who experience it directly, and the degree of response is not predicted simply by objective measures of exposure to or loss from the trauma. Instead, use of specific coping strategies shortly after an event is associated with symptoms over time. In particular, disengaging from coping efforts can signal the likelihood of psychological difficulties up to 6 months after a trauma.

Among specific findings:

- 17% of the U.S. population outside of New York City reported symptoms of September 11-related post-traumatic stress 2 months after the attacks; 5.8% did so at 6 months.
- PTSD occurred most commonly among:
 - Women
 - Separated married couples
 - People who had been diagnosed with depression, an anxiety disorder or physical illness before September 11
 - People who were most directly exposed to the attacks
 - People who avoided dealing with grief and anxiety caused by the attacks immediately after the events

Another study, also published in JAMA, found the following:²³

- The prevalence of probable PTSD was significantly higher in the New York City metropolitan area (11.2%) than in Washington, DC (2.7%), other major metropolitan areas (3.6%), and the rest of the country (4.0%).
- Sex, age, direct exposure to the attacks, and the amount of time spent viewing TV coverage of the attacks on September 11 and the few days afterward were associated with PTSD symptom levels; gender, the number of hours of television coverage viewed, and an index of the content of that coverage were associated with the broader distress measure.



Source: SAMHSA, 2004 to 2006 NSDUHs.

Prevalence of Past Month Substance Use among Gulf State Disaster Area Residents Aged 18 or Older, by Length of Displacement from Their Homes Due to Hurricane Katrina and/or Hurricane Rita: Percentages, 2006

- More than 60% of adults in New York City households with children reported that 1 or more children were upset by the attacks.
- One to 2 months following the events of September 11, probable PTSD was associated with direct exposure to the terrorist attacks among adults, and the prevalence in the New York City metropolitan area was substantially higher than elsewhere in the country.

However, overall distress levels in the country were within normal ranges.

New York, NY, September 21, 2001 – Kent Olson and his dog, Thunder, from Lakewood, Washington search through the rubble for victims of the September 11 terrorist attacks. Photo by Andrea Booher/ FEMA News Photo

Increases in Substance Abuse After September 11

A study published in the American Journal of Epidemiology found that the use of cigarettes, alcohol and marijuana in Manhattan increased after September 11, 2001.²⁴

Hurricane Katrina-Related PTSD

Increase in Substance Abuse and Mental Health Disorders Post-Hurricanes Katrina/Rita

Drug, alcohol and tobacco use and addiction often are associated with PTSD, perhaps as a form of subconscious attempts to self-medicate. New research shows that both substance abuse and mental illness related to PTSD have been on the rise in the aftermath of the Gulf State disasters of Hurricanes Katrina and Rita.

Prevalence of Past Month Substance Use among Gulf State Disaster Area Residents Aged 18 or Older, by Length of Displacement from Their Homes Due to Hurricane Katrina and/or Hurricane Rita: Percentages, 2006

Substance Use	Not Displaced	Displaced Less Than 2 Weeks	Displaced 2 Weeks or Longer
Illicit Drugs	4.9%	7.4%	10.5%
Marijuana	2.9%	3.7%	8.1%
Nonmedical Use of Prescription-Type Drugs	2.7%	3.7%	2.7%
Binge Alcohol	20.4%	27.1%	25.2%
Cigarettes	24.9%	24.7%	34.1%

Source: SAMHSA, 2006 NSDUH.

PTSD AND CHILDREN¹⁴

Most research on the effects of prolonged stress on civilians has been carried out on adults. The literature suggests that children are also affected but that the majority will not suffer from long-term consequences.

- Following the period of SCUD missile attacks in Israel during the Gulf War, children ages 10-15 were asked to describe what they thought life would be like for children their age next year. Their dominant perception was positive (73%), although children who reported greater postwar reactions held more pessimistic views.²⁵
- Several months after the war, children ages 10-15 reported that they were more concerned about traffic accidents, relations with friends, and their studies than about missile attacks.²⁶
- A one-year follow-up of children showed that high school students from high-risk areas reported no war symptoms except sensitivity to loud noises, which was reported by about one out of five children. ²⁷
- As is the case with adults, children living in refugee camps experienced more psychological problems than non-refugee children.²⁸



QUESTIONS TO ASK OF YOUR CHARACTERS AND STORYLINES INVOLVING TRAUMA AND PTSD

These questions may help with the development of storylines and characters involving PTSD. Be careful not to confuse isolated stress factors and immediate reactions to stress with the manifestation of PTSD in an individual. PTSD is a serious disorder that affects people's lives much more seriously than non-PTSD reactions to stressful events and occurrences.

- What was the character's immediate reaction to the trauma? How did it change afterward?
- How can you use flashbacks to convey that, while the event was experienced in the past, the emotional trauma is being experienced by the character in the present?
- Is there any chance that someone else involved in the traumatic event might also suffer from PTSD?
- How are the PTSD symptoms affecting the character's life?
- How do the symptoms affect the lives of his or her loved ones, coworkers, and other contacts?
- Had the victim ever received treatment for depression or any other mental disorder?
- Did the victim have a problem with substance abuse?
- Does the storyline convey that effective treatments for most conditions leading to PTSD are available (but underutilized)?

DEPICTION PRIORITIES

We asked our Picture This experts this question:

If PTSD could be addressed on television or in a film for three to five minutes, what are the most important aspects of the issue to communicate to audiences?

Following are the main points identified by our experts:

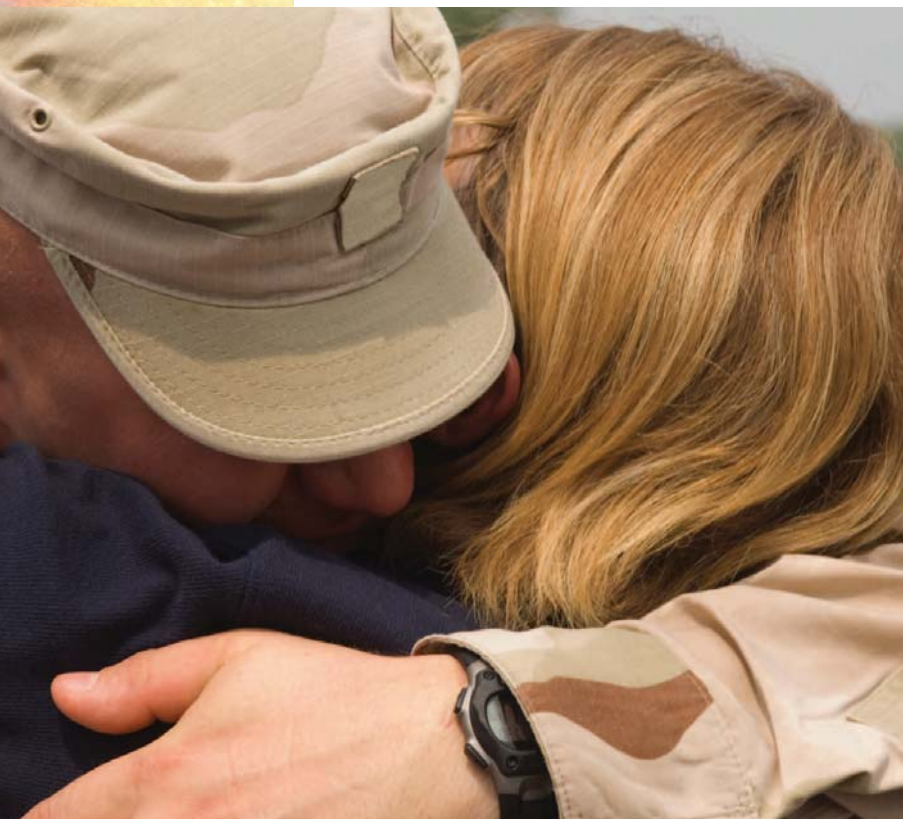
First Priority. *Make the signs and symptoms of PTSD clear so that audiences will understand what it is and is not.*

- People with PTSD sometimes relive the emotional effects of the traumatic events that cause post-traumatic stress. A storyline involving PTSD is a great opportunity for a storyline to flash back to past events in an active way, rather than with voiceover or a similar form of less dramatic exposition.
- People who live with PTSD may be numb to emotional experiences as a form of self-protection. Consider showing a character who has lived through a traumatic event becoming emotionally distant or unaffected before realizing that he or she is living with PTSD.
- Many people with PTSD also become agitated, irritable or easily frightened. Think about how your characters might act out such exaggerated emotional reactions to common events. For example, a sexual assault survivor might suffer a panic attack in intimate situations, or someone involved in a plane crash might develop phobias of flying, heights and speed that might never have existed before.

- PTSD symptoms often are triggered by sensory reminders of traumatic events. For example, a war veteran may experience a debilitating flashback when hearing a car backfire, a helicopter fly overhead, or other types of reminders of the trauma-inducing experience.

Second Priority. *Show that PTSD affects different people in different ways, and that it can devastate some people more than others*

- Consider the different ways in which people deal with traumatic events. For example, two people might be robbed together at gunpoint, and one may go on to live a relatively normal life, while the other might become reclusive and fear crowds and other public situations, or may even feel unsafe in his or her home. Think about showing how these two people might view one another, and how they might ultimately come to understand that the reactions of both are valid. Keep in mind the difference between a “normal” reaction to a stressful event and the long-term effects of living with PTSD.



- A read through the personal stories in this publication will clarify how PTSD can arise from various kinds of trauma, from harassment to battlefield injuries. Consider showing how PTSD symptoms can be similar in people who have experienced very different types of trauma, or can manifest themselves differently among people who experienced the exact same traumatic event.
- PTSD is a specific traumatic stress reaction syndrome, with the range of traumatic stress reactions that people experience acutely and chronically following exposure to a traumatic event.

Third Priority. *Show the consequences of unaddressed PTSD on the person who lives with it, as well as his or her family, friends, and community*

- Until they are diagnosed and begin to understand the source of the disruption in their lives, people who live with PTSD often are blamed by others and blame themselves for being irrationally upset, irritable, aggressive, depressed or any of the other common symptoms of the disorder. Think about ways to show how characters who seem uncomfortable in their own skin are actually living with the effects of PTSD. Also consider the possibility that one of your own existing characters who sometimes acts irrationally may be living with undiagnosed PTSD.
- While the anxiety and panic caused by PTSD is experienced only by an individual, the way it affects the individual also has effects on everyone around them. In cases of an isolated trauma, a person's anxiety might be inaccessible to friends and family members, bringing about isolation. In cases of natural disasters, terrorist attacks and other large-scale traumatic events, families and communities often become closer as a reaction to the trauma. Consider showing how such closeness might be both beneficial and negative. For example, close-knit communities are more likely to have effective evacuation routes, disaster preparedness and recovery programs; but at the same time, the fear of a man-made disaster (especially terrorism) may bring about paranoia that makes unfounded prejudices feel rational.

Consider creating PSA messages to be shown immediately after a production that addresses PTSD to offer resources and information, including Web access. EIC can connect you with the right experts to help craft a short message for such PSAs and resource Web sites.

Fourth Priority. *Show that most people respond well to treatment for PTSD—it's not a lost cause, but steps need to be taken to get proper treatment*

- PTSD treatment is better now than it ever has been. Cognitive Behavioral Therapy (CBT) appears to be the most effective type of counseling. In CBT, a therapist helps the patient understand and change how to think about trauma and its aftermath, and also to understand and cope with the emotional reactions to the event. The patient's goal is to understand how certain thoughts about his or her trauma cause stress and make symptoms worse. Consider showing how someone affected by long-repressed PTSD benefits from talking with a qualified therapist, learning to deal with trauma and live a more normal life. Remember that effective treatment of PTSD and other mental health-related conditions requires ongoing managed care; a quick cure is unlikely, if not impossible.
- Another useful form of therapy is exposure therapy. By talking about trauma repeatedly with a therapist, a patient learns to gain control of thoughts and feelings about the trauma. The patient learns that he or she does not have to be afraid of traumatic memories. This may be hard at first. It might seem strange to intentionally think about stressful things. But over time, the patient may feel less overwhelmed in the face of the memories. Consider showing how the act of recalling painful memories under the guidance of a therapist can ultimately make the memories less painful and better understood through repeated exposure.
- In group therapy, a person talks to other people who also have been through a trauma and who have PTSD. Sharing a story with others may help a patient feel more comfortable talking about personal trauma. This can help someone cope with symptoms, memories, and other parts of his or her life. Group therapy helps build relationships between people who understand each other's pain. In group therapy, people learn to deal with emotions such as shame, guilt, anger, rage, and fear. Sharing with the group also can help build self-confidence and trust. Consider showing how someone with PTSD can benefit from group therapy, and even forge long-lasting bonds in the process.

- In brief psychodynamic psychotherapy, the person with PTSD learns ways of dealing with emotional conflicts caused by trauma. This therapy helps the person understand how the past affects the way he or she feels now. A therapist can help:
 - Identify what triggers stressful memories and other symptoms.
 - Find ways to cope with intense feelings about the past.
 - Become more aware of thoughts and feelings, so a person can change his or her reactions to them.
 - Raise self-esteem.
- Showing this multi-faceted approach to psychotherapy could offer many creative opportunities for your storyline.
- Family therapy is a type of counseling that involves a person's family in the treatment process. A therapist helps the patient and his or her family communicate, maintain good relationships, and cope with tough emotions. In family therapy, each person can express his or her fears and concerns. The patient can talk about PTSD symptoms and what triggers them. He or she also can discuss the important parts of treatment and recovery. By doing this, the family will be better prepared to help. Consider showing a person with PTSD undergo individual therapy for PTSD symptoms and family therapy to help with relationships.
- Some people may self-medicate with alcohol, illegal or prescription drugs that have not been prescribed for PTSD. Consider showing how characters who self-medicate in many cases exacerbate their symptoms rather than treat them. And worse, self-medication may lead to addiction, which adds another layer of problems to the existing PTSD.

Fifth Priority. *Be sensitive to viewers' own personal PTSD and consider how certain graphic portrayals of terrifying situations may trigger or exacerbate PTSD among viewers*

- Be aware of the potential risks of portraying PTSD, especially when showing traumatic situations that often cause PTSD in real-life victims. Such situations include sexual assault (rape, incest, child molestation), combat and war scenes, and large-scale real-life disasters, such as the September 11, 2001 terrorist attacks, the Pacific rim tsunami, the post-Hurricane Katrina aftermath in the Gulf Coast states, and school shootings.
- In depictions that require showing or telling especially traumatic events, seriously consider giving out resource information during commercial breaks and at the end of the show, so that viewers who may be personally affected or know someone who is affected by the depiction will know where to go for help.



REAL PEOPLE, REAL STORIES

PTSD Personal Stories

Throughout all of EIC's Picture This series of roundtable discussions between issue experts and entertainment professionals, we've learned that one thing is extremely valuable to writers, producers, directors and other creative professionals: personal stories. This section of Picture This: PTSD gives you just that—true stories from people who are living with PTSD. We've given you the facts about PTSD. What follows is the heart.

"I started having flashbacks."

"I was raped when I was 25 years old. For a long time, I spoke about the rape as though it was something that happened to someone else. I was very aware that it had happened to me, but there was just no feeling."

"Then I started having flashbacks. They kind of came over me like a splash of water. I would be terrified. Suddenly I was reliving the rape. Every instant was startling. I wasn't aware of anything around me, I was in a bubble, just kind of floating. And it was scary. Having a flashback can wring you out."

"The rape happened the week before Thanksgiving, and I can't believe the anxiety and fear I feel every year around the anniversary date. It's as though I've seen a werewolf. I can't relax, can't sleep, don't want to be with anyone. I wonder whether I'll ever be free of this terrible problem."²⁹

The following is an excerpt from an article by Deborah Sontag, which originally appeared in the New York Times. Sontag's article, "An Iraq Veteran's Descent; a Prosecutor's Choice," examines the complex role of war-related post-traumatic stress in a murder case. For the full article, go to http://www.nytimes.com/2008/01/20/us/20vets.html?_r=1&oref=slogin.

"...One day, he snapped."

Not long after Lance Cpl. James Simmons returned from Iraq, the Marines dispatched him to Quantico, Va., for a marksmanship instructor course.

Mr. Simmons, then a 21-year-old Marine Corps reservist from Utah, had been shaken to the core by the intensity of his experience during the invasion of Iraq. Once a squeaky-clean Mormon boy who aspired to serve a mission abroad, he had come home a smoker and drinker, unsure if he believed in God.

In Quantico, he reported to the firing range with a friend from Fox Company, the combined Salt Lake City-Las Vegas battalion nicknamed the Saints and Sinners. Raising his rifle, he stared through the scope and started shaking. What he saw were not the inanimate targets before him but vivid, hallucinatory images of Iraq: 'the cars coming at us, the chaos, the dust, the women and children, the bodies we left behind,' he said.

Each time he squeezed the trigger, Mr. Simmons cried, harder and harder until he was, in his own words, 'bawling on the rifle range, which marines just do not do.' Mortified, he allowed himself to be pulled away. And not long afterward, the Marines began processing his medical discharge for post-traumatic stress disorder, severing his link to the Reserve unit that anchored him and sending him off to seek help from veterans' hospitals.

The incident on the firing range was the first “red flag,” as the prosecutor in Tooele County, Utah, termed it, that Mr. Smith sent up as he gradually disintegrated psychologically. At his lowest point, in March 2006, he killed Nicole Marie Speirs, the 22-year-old mother of his twin children, drowning her in a bathtub without any evident provocation or reason.

“There was no intent,” said Gary K. Searle, the deputy Tooele County attorney. “It was almost like things kept ratcheting up, without any real intervention that I can see, until one day he snapped.”

The following stories and more can be found on Post Traumatic Stress Disorder Today, an online community for people living with PTSD. Visit <http://www.mental-health-today.com/ptsd/story.htm> for more information

“I will be able to move on...”

“I am a 28 year old woman and I was diagnosed with Chronic PTSD last summer. I guess I have always known that there is something different about me when it comes to emotions—I have always had problems with irritability, temper, and anxiety.”

“I grew up in a very dysfunctional family. My mother was a heavy drug user, and my dad seemed to live in denial about my mothers' behavior. He gave her chance after chance to clean up, subjecting my brother and me to some pretty awful confrontations. Because of my parents' irresponsible behavior, I was often left in unsafe environments. By the time I was ten years old, I had been physically abused by four different people. Then, when I was 16, my mother was killed. She was strangled and beaten and left in an alleyway over a drug-related dispute. Shortly after this event, I began having nightmares that an intruder was sneaking into my room to do the same to me...”

“I began consistent therapy one year ago. I see a counselor once a week who I trust and admire. I still have several issues I am working through, including irritability, sexual dysfunction, anger, struggles to be perfect, self doubt, stress, and occasional panic attacks. I am working hard on these issues and am confident that with frequent therapy and stress-relief practices, I will be able to move on and overcome these obstacles that are preventing me from living to my full potential!”

“We moved to Vermont, just trying to forget...”

“About 8 years ago, my husband and I were attacked in our bedroom by an intruder. I was stabbed, and was hospitalized for weeks. After being released, my husband and I spent a month living in my parent's house. We then returned to New York to try and live and work again. Although we moved into a different apartment (one with a door man), my husband slept with a baseball bat in the bed, and I had to tour the entire apartment when I would come in to make certain no one was there. Eventually, I got fired from my job because I just couldn't concentrate anymore. We finally moved to Vermont and took new jobs, just trying to forget.

“A few years later, we moved to Connecticut as my husband was sent back to school to get his Master's Degree. My PTSD symptoms began to worsen. I started having violent thoughts, and spent a lot of time drinking. A friend recommended a therapist who specialized in PTSD and I made an appointment; I have been working with her ever since...”

“I don't know what I'm going to do...”

“When I was 25 in 1976, I moved to San Francisco. For once I had found a home as a gay male. I got a job as a nurse in a nearby hospital. By '82 there was a full-blown epidemic that seemed to be impacting, mostly, the gay population. During this time, I was forced to witness assaults from the religious right, parents who wouldn't claim their sons' bodies, and the horrors of this disease called HIV. As I slowly began to break down, I refused to be tested for HIV and became totally celibate, which I still am to this day.”

“A large number of my friends tested positive, and subsequently passed away—sometimes two in one week. I quit my job and worked for a nursing registry. For many years I had flashbacks to scenes in the hospital, of patients dying and being rejected by family. Then I encountered the survival guilt. I began to ask myself why I lived when all my friends passed on and left me alone.”

“In 1992 I thought I had recovered enough to go back to a full time job in an outpatient clinic. But in just a few months, we were hit with managed care and threats of layoffs. When nurses left and were not replaced, our work seemed to increase a hundred fold. It was a battle to keep my stress and anger under control every single day.

“I still suffer from PTSD symptoms: I can't stand large crowds, loud noises, have a horrible short term memory, and I'm insecure about trying to go out and find any kind of work. I don't know what I am going to do...”

NEW UNDERSTANDING: PTSD CLINICAL TRIALS

PTSD is a psychological rabbit hole: A person living with the disorder disappears into his or her own emotional memories and re-experiences them in a way that no one else can fully understand.

Yet, medical and psychological interventions can help people deal with the anxiety produced by PTSD, and find ways to overcome it. Medical science is concerned with finding ways to treat illnesses as well as ways to prevent them. This is where clinical trials serve an important role.

Currently, the National Institute of Mental Health (NIMH) is investigating many facets of PTSD, including the role that genetics may play in the disorder; how “nature” and “nurture” might affect treatment, and testing out various treatment methods. As with many mental illnesses, treatment for PTSD may be best accomplished through both psychoactive medicine and counseling.

Following are some clinical trials currently planned or already underway at NIMH.³⁰ By listing these, we hope to give you an inside tip on current developments surrounding PTSD, which might inspire stories, especially for legal, medical, and forensic dramas.

Cognitive Behavioral Therapy Vs. Sertraline in the Treatment of Post-Traumatic Stress Disorder.

Interventional study. This study will evaluate which parts of the brain are affected by treatment with behavioral therapy versus medication therapy in people with post-traumatic stress disorder. Ages 18-55. Location in New York, NY.

Patient-Centered Collaborative Care for Preventing Post-Traumatic Stress Disorder After Traumatic Injury.

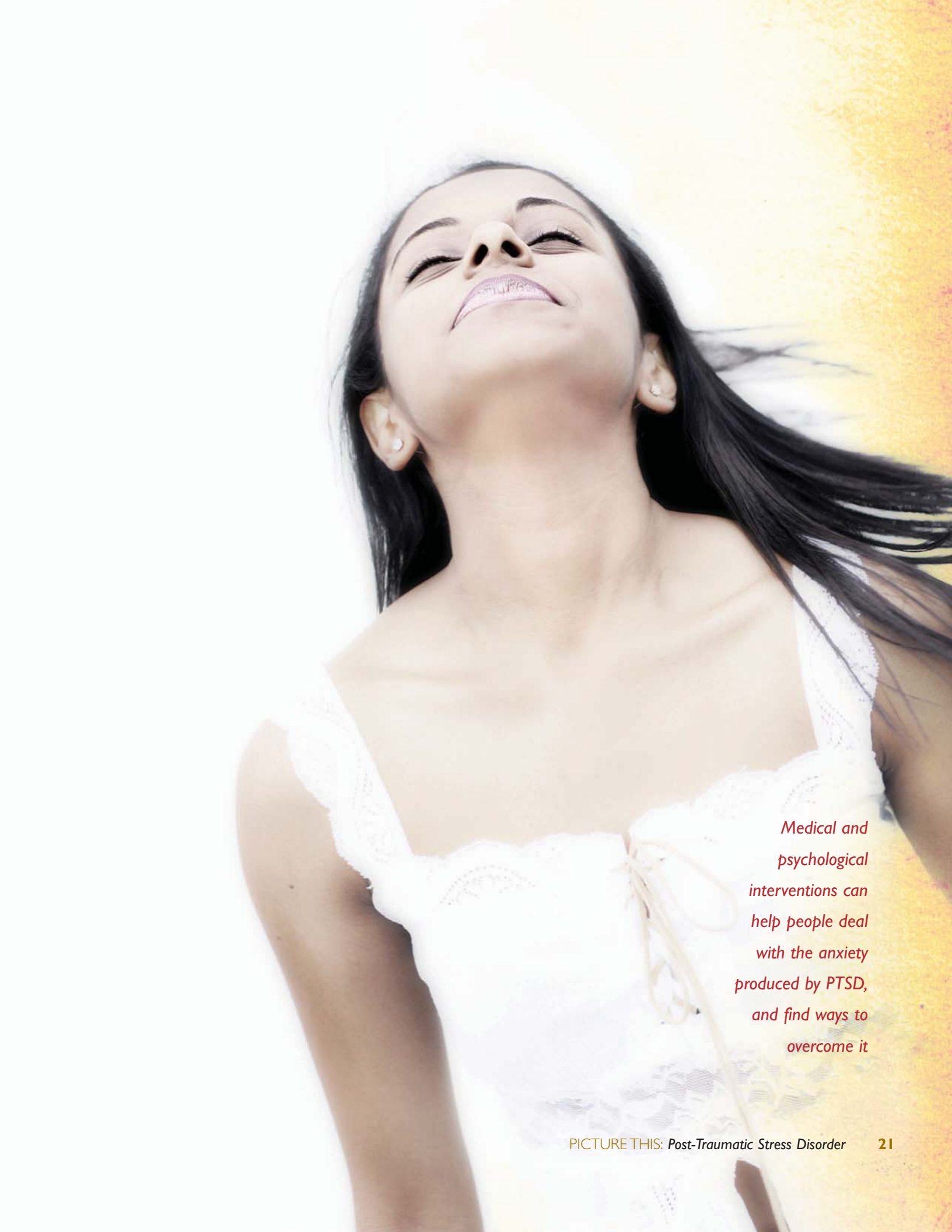
Interventional study. This study will evaluate the effectiveness of patient-centered collaborative care that combines behavioral therapy and drug therapy as compared to usual care in reducing symptoms of post-traumatic stress disorder (PTSD) in people who have survived a traumatic injury. Ages 18 and up. Location in Seattle, WA.

Prazosin for Treating Noncombat Trauma Post-Traumatic Stress Disorder.

Interventional study. This study will evaluate the effectiveness of prazosin in treating post-traumatic stress disorder (PTSD) caused by noncombat trauma in individuals taking selective serotonin reuptake inhibitors. Ages 18 and up. Location in Seattle, WA.

Treating Post Traumatic Stress Disorder in Children Exposed to Domestic Violence.

Interventional study. This study will determine whether trauma-focused cognitive behavioral therapy (TF-CBT) is more effective than child-centered therapy (CCT) in reducing post traumatic stress disorder (PTSD) in children exposed to domestic violence (DV). Ages 7-14. Location in Pittsburgh, PA.



Medical and psychological interventions can help people deal with the anxiety produced by PTSD, and find ways to overcome it



ENTERTAINMENT MATTERS

An Interview with The L Word's Cherien Dabis

by David Michael Conner

A staff writer on season three of Showtime's critically acclaimed television series The L Word, Cherien Dabis returned to season four as a Story Editor and—as she discusses in the interview that follows—will be back for the fifth season to delve more deeply into the lives of its characters, including Tasha Williams (Rose Rollins), an Iraq War veteran who has difficulty adjusting to civilian life.

Dabis was a panelist at EIC's Picture This: Post-Traumatic Stress Disorder (PTSD) meeting in Washington, D.C.

We asked Dabis to talk a little about Tasha Williams, *The L Word* character who suffers from PTSD.

“Being at EIC's Picture This meeting in D.C. has made me realize that our show can actually deal with PTSD, and maybe we can deal with the stigma a little bit more.”

David Conner: Where did Tasha come from?

Cherien Dabis: The L Word is sort of fearless when it comes to tackling issues, in a great way. That's one of the daring things that we do. Talking about gays in the military seemed the next natural progression for us. We thought the best way to talk about it was to introduce a character who had served over there, and who is a bit more conservative in nature than the characters that we usually write.

DC: You said you met with a lot of different people, people in the service, to inform yourself. Was that a large part of your research process?

CD: Yes. We began the discussion in the writers' room and right away we had a writer's assistant circulate research, articles, information, lots of general information on gays in the military and that sort of thing. Personal stories that she could pull from the Web. Afterward, we started bringing experts and real people to the writers' room to talk to us about what their lives were like and what the challenges were. Again, no one in the writer's room has ever been in the military so we needed someone to speak to that. We didn't understand the politics of a person like that. People talked to us about their personal lives, why they joined, what they did, what they saw, what it was like to be gay—and so we took avid notes, and Tasha emerged as a sort of hybrid of the people we talked to and the stories we read.

DC: As far as her PTSD, did that emerge from this composite character, or did you plan on incorporating something like that?

CD: We didn't actually plan on it. We didn't know enough. I don't think we were aware enough about it. PTSD did come up early on through our Web

research. So it became something we were aware of and that we thought needed to be incorporated into the character. You know, the first question that came up was, how do we introduce a new character in season four? Why haven't we seen this person before? So we decided that she had been on a tour of duty in Iraq and was just returning, and PTSD definitely would be something that she'd experience, as she'd be trying to get back to civilian life. It's also something that we talked to our research consultants about. One in particular—I don't think she had been diagnosed with PTSD—but she had PTSD-like symptoms for weeks, when she returned from Iraq. She fell into a depression, because suddenly there's no adrenaline rush. She said she'd rather be back in war worrying about life and death, nothing else, than be in civilian life worrying about simple things like bills and everyday things that cause stress. To her, they were really boring compared to the adrenaline rush of being on the battlefield.

DC: At the Picture This meeting in Washington, you brought up the question of violence as it relates to PTSD and you said that the writers had considered showing Tasha as violent but it just didn't feel right. Were you surprised at all to hear experts say that violence is not a big part of PTSD?

CD: We didn't know that it wasn't a big part of PTSD. We didn't know the statistics, we didn't realize [at that time] that only a small percentage of people with PTSD have violent reactions. That's what we learned later on.

I think that the challenge of writing something like PTSD is that it's very internal. I wouldn't even say we considered violence. It was discussed, and I think we quickly rejected it in the writers' room. It was brought up because of the fact that we were discussing how do we externalize so many of these internal symptoms? How do we externalize someone feeling anxious? It's so psychological.

Eventually I think we came up with more subtle ways to do it. The first time we meet Tasha is in a bar. She gets all freaked out by the lights and the noise, it's the first time she's been out with her friends since she's been back. And her friend Papi has convinced her to go out, she didn't really want to go out, but she goes, and she's freaked out because she's so claustrophobic. People are standing too close to her and they're bumping into her. The question was, how far do we go with it? Does she turn around and hit someone? Does she shove someone or is she just really jumpy? We decided on a more subtle reaction in the character. We cast someone who was strong enough to play those reactions quite clearly. We understand [through her acting] that she is feeling anxious, she is jumpy, she is angry.

DC: Obviously Papi and the other women around Tasha would be affected by Tasha's internal issues. As a writer, how do you dramatize that?

CD: In that first scene where we meet Tasha, our characters quickly dub her as 'Papi's angry friend.' We kind of brought it out in somewhat of a funny way. Their reactions show that they don't know where she's been or what she's seen. They don't even know that she's been in the Army. They just know her as 'the angry one.' And an episode later, they find out that she was in the Army and they treat her in a pretty judgmental way.

And again, this is just a way of dealing with the stigma—they're reacting more to her being in the Army and making assumptions of her politics than thinking about the PTSD. But regardless, with the PTSD, I think the only person that really gets to see it is Alice, who gets involved with the Tasha character. Alice has come across as a more frivolous, fun character who isn't that serious. With Tasha it's sort of an 'opposites attract' relationship that we set up. I think it's very illuminating for her as a character to have to face what Tasha's been through and hear about Tasha's experience.

A lot of it comes out in dialogue. But there's also an instance in which Tasha and Alice are crossing the street to go to The Planet, the café where all the characters hang out, and there's traffic on the street, people are honking, there's loud noise, screeching cars, and suddenly Tasha has a sort of reliving moment and we flash back to a sequence of war and when we come back Tasha is crouching with Alice—she's grabbed her and pulled her down next to a car where they're crouching and she's sweating, and of course Alice is going, 'What's going on, are you okay?' So I think for the other characters, it's more that they're concerned about her. I don't think they recognize what it is that she has. Or at least they haven't yet, they didn't in season four.

I don't think it will influence her behavior, but it got me thinking about the fact that we don't really talk about PTSD in a direct manner. It raised that issue for me—that it's something that we can talk about again as writers. Being at the meeting in D.C. has made me realize that Tasha can actually deal with this, and maybe we can deal with the stigma a little bit more.

For the rest of EIC's interview with Cherien Dabis, and for more information about PTSD, log into www.eiconline.org.

Cherien Dabis's official Web site is www.cherierendabis.com.

ADDITIONAL INFORMATION: RESOURCES

Active Minds, Inc.

1875 Connecticut Avenue NW, Suite 418
Washington, DC 20009
Phone: (202) 719-1177
www.activemindsoncampus.org

Active Minds is a national organization that develops and supports student-run mental health awareness, education, and advocacy groups on the college campus.

Bazelon Center for Mental Health Law

1101 15th Street NW, Suite 1212
Washington, DC 20005
Phone: (202) 467-5730
www.bazelon.org

For three decades, the Judge David L. Bazelon Center for Mental Health Law has been the nation's leading legal advocate for people with mental disabilities. Its precedent-setting litigation has outlawed institutional abuse and won protections against arbitrary confinement. In the courts and in Congress, its advocacy has opened up public schools, workplaces, housing and other opportunities for people with mental disabilities to participate in community life.

Depression and Bipolar Support Alliance (DBSA)

730 N. Franklin Street, Suite 501
Chicago, Illinois 60610-7224
Phone: (800) 826-3632
www.dbsalliance.org

The Depression and Bipolar Support Alliance (DBSA) is the leading patient-directed national organization focusing on the most prevalent mental illnesses. The organization fosters an environment of understanding about the impact and management of these life-threatening illnesses by providing up-to-date, scientifically-based tools and information written in language the general public can understand.

National Association of Social Workers (NASW)

750 First Street NE, Suite 700
Washington, DC 20002-4241
Phone: (202) 408-8600
www.helpstartshere.org

The National Association of Social Workers (NASW)'s Help Starts Here Web site provides resources, including true-life stories, which can be used to inspire story ideas. NASW also provides information on national and local resources for people looking for help.

International Society for Traumatic Stress Studies (ISTSS)

60 Revere Drive, Suite 500
Northbrook, IL 60062
Phone: 847-480-9028
Fax: 847-480-9282
www.istss.org

ISTSS is an international multidisciplinary, professional membership organization that promotes advancement and exchange of knowledge about severe stress and trauma.

Iraq and Afghanistan Veterans of America (IAVA)

770 Broadway, 2nd Floor
New York, NY 10003
p: 212-982-9699
f: 212-982-8645
www.iava.org

Founded in June 2004, Iraq and Afghanistan Veterans of America is the nation's first and largest group dedicated to the Troops and Veterans of the wars in Iraq and Afghanistan, and the civilian supporters of those Troops and Veterans.

Mental Health America (MHA)

2000 North Beauregard Street, 6th Floor
Alexandria, VA 22311-1748
Phone: (703) 838-7549
www.mentalhealthamerica.net

Mental Health America (formerly known as the National Mental Health Association) is the country's leading nonprofit dedicated to helping ALL people live mentally healthier lives. With our more than 320 affiliates nationwide, MHA represents a growing movement of Americans who promote mental wellness for the health and well-being of the nation – every day and in times of crisis.

Military OneSource

Phone: (800) 342-9647

www.militaryonesource.com

An information and referral service available 24 hours a day at no cost to military members and their families.

National Alliance on Mental Illness (NAMI)

Colonial Place Three

2107 Wilson Boulevard, Suite 300

Arlington, VA 22201

Phone: (703) 524-7600

Toll-Free: (800) 950-NAMI

www.nami.org

The National Alliance on Mental Illness (NAMI) is the nation's largest grassroots mental health organization dedicated to improving the lives of persons living with serious mental illness and their families. Founded in 1979, NAMI has become the nation's voice on mental illness, a national organization including NAMI organizations in every state and in over 1,100 local communities across the country who join together to meet the NAMI mission through advocacy, research, support, and education.

National Association for Children of Alcoholics (NACoA)

11426 Rockville Pike, Suite 301

Rockville, MD 20852

Phone: (301) 468-0985

www.nacoa.org

The National Association for Children of Alcoholics (NACoA) is the national nonprofit organization that works on behalf of children of alcohol and drug dependent parents. Because living in an environment of substance abuse during the developmental years can cause a lifetime of both mental and physical health consequences, NACoA works hard to provide help for all children and families affected by alcoholism and other drug dependencies. To accomplish this, they work to raise public awareness and provide leadership in public policy at all levels. They also provide educational materials to facilitate professional knowledge and understanding of the situations of these children.

National Center on PTSD (NCPTSD)

U.S. Department of Veterans Affairs

www.ncptsd.va.gov

Contact the NCPTSD via its Web site.

The goal of the National Center on PTSD is to provide excellence in patient care, veterans' benefits and customer satisfaction.

National Association of Social Workers (NASW)

750 First Street NE

Suite 700

Washington, D.C. 20002-4241

Rockville, MD 20852

Phone: (202) 408-8600

www.socialworkers.org

The National Association of Social Workers (NASW) is the largest membership organization of professional social workers in the world, with 150,000 members. NASW works to enhance the professional growth and development of its members, to create and maintain professional standards, and to advance sound social policies.

The National Center for Victims of Crime (NCVC)

2000 M Street NW, Suite 480

Washington, DC 20036

Phone: 202-467-8729

www.ncvc.org

The National Center for Victims of Crime (NCVC) works to help victims of crime rebuild their lives. In some cases, this means helping victims deal with the painful mental health side effects they may be experiencing.

The National Child Traumatic Stress Network

NCCTS —University of California, Los Angeles

11150 W. Olympic Blvd., Suite 650

Los Angeles, CA 90064

Phone: (310) 235-2633

www.nctsnet.org

The National Center for Child Traumatic Stress at UCLA and Duke University works with the Substance Abuse and Mental Health Services Administration to develop and maintain the Network structure, provide technical assistance to grantees within the Network, oversee resource development and dissemination, and coordinate national education and training efforts.

National Institute of Mental Health (NIMH)

6001 Executive Boulevard, Room 8184, MSC 9663
Bethesda, MD 20892-9663
Phone: (301) 443-4513 or (866) 615-NIMH (6464)
www.nimh.nih.gov

*The National Institute of Mental Health (NIMH) is one of 27 components of the National Institutes of Health (NIH), the federal government's principal biomedical and behavioral research agency. NIH is part of the U.S. Department of Health and Human Services. Its mission is to reduce the burden of mental illness and behavioral disorders through research on mind, brain, and behavior. This public health mandate demands that NIMH harness powerful scientific tools to achieve better understanding, treatment, and eventually, prevention of these disabling conditions that affect millions of Americans. NIMH's publication, *In Harm's Way: Suicide in America*, is available from the NIMH Web site.*

National Youth Violence Prevention Resource Center (NYVPRC)

PO Box 6003
Rockville, MD 20849-6003
Phone: (866) 723-3968
www.safeyouth.org

Developed by the Centers for Disease Control (CDC) in partnership with 10 other federal partners, the National Youth Violence Prevention Resource Center (NYVPRC) provides current information pertaining to youth violence that has been developed by federal agencies and the private sector. The NYVPRC is a gateway for professionals, parents, teens, and other interested individuals to obtain comprehensive information about youth violence—including suicide prevention and intervention.

The Office of Juvenile Justice and Delinquency Prevention (OJJDP)

810 Seventh Street NW
Washington, DC 20531
Phone: (202) 307-5911
ojjdp.ncjrs.org

The Office of Juvenile Justice and Delinquency Prevention (OJJDP) provides national leadership, coordination, and resources to prevent and respond to juvenile delinquency and victimization. OJJDP supports states and communities in their efforts to develop and implement effective and coordinated prevention and intervention programs. OJJDP also works to improve the juvenile justice system so that it protects public safety, holds offenders accountable, and provides treatment and rehabilitative services tailored to the needs of juveniles and their families. Their publication, "Juvenile Suicides, 1991-1998" (NCJ 196978), draws on CDC-compiled data to examine trends and characteristics of more than 20,000 juvenile suicides during that period. "Juvenile Suicides" is available from the OJJDP website.

Rape, Abuse, and Incest National Network (RAINN)

2000 L Street, NW, Suite 406
Washington, DC 20036
Phone: (800) 656-HOPE
www.rainn.org

The Rape, Abuse, and Incest National Network (RAINN) is the nation's largest anti-sexual assault organization and has been ranked as one of "America's 100 Best Charities" by Worth Magazine. RAINN created and operates the National Sexual Assault Hotline and provides important information about sexual assault prevention, recovery, and prosecution to television, radio, and print news outlets.

Substance Abuse and Mental Health Services Administration (SAMHSA)

1 Choke Cherry Road
Rockville, MD 20857
Phone: (240) 276-2130
www.samhsa.gov

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the federal agency charged with improving the quality and availability of prevention, treatment, and rehabilitative services in order to reduce illness, death, disability, and cost to society resulting from substance abuse and mental illnesses. SAMHSA's suicide prevention resources can be accessed directly at http://samhsa.gov/matrix2/matrix_suicide.aspx.

Vets4Vets

4192 E. Boulder Springs Way
Tucson, AZ 85712
Phone: (520) 319-5500
www.vets4vets.us

Founded in 2005 by a Marine Corps combat veteran of Vietnam, Vets4Vets is a place for veterans of today's wars in Afghanistan and Iraq to use peer support to help each other through speaking and listening.

ENDNOTES

¹ National Institute of Mental Health. (2008, February). "The Numbers Count: Mental Disorders in America." Retrieved from: <http://www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-america.shtml#PTSD>. Accessed February 22, 2008.

² Substance Abuse and Mental Health Services Administration. (2003, April). "Anxiety Disorders." Retrieved from: <http://mentalhealth.samhsa.gov/publications/allpubs/ken98-0045/default.asp>. Accessed February 22, 2008.

³ Litz, B.T. (2005). The Unique Circumstances and Mental Health Impact of the Wars in Afghanistan and Iraq: A National Center for PTSD Fact Sheet. Retrieved from: http://www.ncptsd.va.gov/ncmain/ncdocs/fact_shts/fs_iraqafghanistan_wars.html?opm=1&rr=rr46&srt=d&echorr=true. Accessed February 22, 2008.

⁴ Bolton, E., Litz, B.T., Britt, T., Adler, A., & Roemer, L. (2001). Reports of exposure to potentially traumatic events and PTSD in troops poised for deployment. *Journal of Traumatic Stress*, 14, 249-256.

⁵ King D.W., King L.A., Foy D.W., Keane T.M., & Fairbank J.A. (1999). Posttraumatic stress disorder in a national sample of female and male Vietnam veterans: Risk factors, war-zone stressors, and resilience-recovery variables. *Journal of Abnormal Psychology*, 108, 164-170.

⁶ Bremner, J. D., Southwick, S. M., Johnson, D. R., Yehuda, R., & Charney, D. S. (1993). Childhood physical abuse and combat-related posttraumatic stress disorder in Vietnam veterans. *American Journal of Psychiatry*, 150, 235-239.

⁷ U.S. Centers for Disease Control and Prevention. (2005). "Adverse Childhood Experiences Study: Major Findings." Retrieved from: <http://www.cdc.gov/nccdphp/ace/findings.htm>. Accessed March 11, 2008.

⁸ Brewin C. R., Andrews B., & Valentine J. D. (2000). Meta-analysis of risk factors for posttraumatic stress disorder in trauma-exposed adults. *Journal of Consulting and Clinical Psychology*, 68, 748-766.

⁹ Koenen, K. C., Stellman, J. M., Stellman, S., & Sommer, J. F. (2003). Risk factors for course of posttraumatic stress disorder among Vietnam veterans: A 14-year follow-up of American Legionnaires. *Journal of Consulting and Clinical Psychology*, 71, 980-986.

¹⁰ Green, B. L., Grace, M. C., Lindy, J. D., Gleser, G. C., & Leonard, A. (1990). Risk factors for PTSD and other diagnoses in a general sample of Vietnam veterans. *American Journal of Psychiatry*, 147, 729-733.

¹¹ Koenen, K. C., Stellman, J. M., Stellman, S., & Sommer, J. F. (2003). Risk factors for course of posttraumatic stress disorder among Vietnam veterans: A 14-year follow-up of American Legionnaires. *Journal of Consulting and Clinical Psychology*, 71, 980-986.

¹² King D.W., King L.A., Foy D.W., Keane T.M., & Fairbank J.A. (1999). Posttraumatic stress disorder in a national sample of female and male Vietnam veterans: Risk factors, war-zone stressors, and resilience-recovery variables. *Journal of Abnormal Psychology*, 108, 164-170.

¹³ Wolfe J., Erickson D.J., Sharkansky E.J., King D.W., & King L.A. (1999). Course and predictors of posttraumatic stress disorder among Gulf War veterans: A prospective analysis. *Journal of Consulting and Clinical Psychology*, 67, 520-528.

- ¹⁴ Hamblen, J., Schnurr, P. (2007, May). Mental Health Aspects of Prolonged Combat Stress in Civilians. Retrieved from: http://www.ncptsd.va.gov/ncmain/ncdocs/fact_shts/fs_civilians.html?opm=1&rr=rr71&srt=d&echorr=true. Accessed February 22, 2008.
- ¹⁵ de Jong, J., Scholte, W., Koeter, M., & Hart, A. (2000). The prevalence of mental health problems in Rwandan and Burundese refugee camps. *Acta Psychiatrica Scandinavica*, 102, 171-177.
- ¹⁶ Mollica, R., McInnes, K., Sarajlic, N., Lavelle, J., Sarajlic, I., & Massagli, M. (1999). Disability associated with psychiatric comorbidity and health status in Bosnian refugees living in Croatia. *Journal of the American Medical Association*, 282, 433-439.
- ¹⁷ de Jong, J., Komproe, I., Van Ommeren, M., El Masri, M., Araya, M., Khaled, N., van de Put, W., & Somasundaram, D. (2001). Lifetime events and posttraumatic stress disorder in 4 postconflict settings. *Journal of the American Medical Association*, 286, 555-562.
- ¹⁸ Kessler, R., Sonnega, A., Bromet, E., & Nelson, C. (1995). Posttraumatic stress disorder in the National Comorbidity Study. *Archives of General Psychiatry*, 52, 1048-1060.
- ¹⁹ Milgram, N. (1994). Stress and coping in Israel during the Persian Gulf War. *Journal of Social Issues*, 49, 103-123.
- ²⁰ Bleich, A., Dycian, A., Koslowsky, M., Solomon, Z., & Weiner, M. (1992). Psychiatric implications of missile attacks on a civilian population. *Journal of the American Medical Association*, 268, 613-615.
- ²¹ Askenasy, J. & Lewin, I. (1996). The impact of missile warfare on self-reported sleep quality. Part I. *Sleep*, 19, 47-51.
- ²² Silver, R.S., E. Alison Holman, E.A., McIntosh, D.N., Poulin, M., Gil-Rivas, V. (2002). Nationwide Longitudinal Study of Psychological Responses to September 11. *JAMA*. 288:1235-1244. Abstract available at: <http://www.medscape.com/viewarticle/440747>.
- ²³ Schlenger WE, Caddell JM, Ebert L, et al. Psychological Reactions to Terrorist Attacks: Findings From the National Study of Americans' Reactions to September 11. *JAMA*. 2002;288:581-588
- ²⁴ Vlahov D, Galea S, Resnick H, et al. "Increased Use of Cigarettes, Alcohol, and Marijuana Among Manhattan, New York, Residents After the September 11th Terrorist Attacks." *Am J Epidemiol*. 2002;155:988-996
- ²⁴ Schwarzwald, J., Weisenberg, M., Soloman, Z., & Waysman, M. (1997). What will the future bring? Thoughts of children after missile bombardment. *Anxiety, Stress, and Coping*, 10, 257-267.
- ²⁶ Greenbaum, C., Erlich, C., & Toubiana, Y. (1993). Settler children and the Gulf War. In N.A. Fox & L.A. Leavitt (Eds.), *The psychological effects of war and violence on children* (pp. 109-130). Hillsdale, NJ: Erlbaum.
- ²⁷ Klingman, A. (1995). Israeli children's responses to the stress of the Gulf War. *School Psychology International*, 16, 303-313.
- ²⁸ Paardekooper, B., de Jong, J., & Herman, J. (1999). The psychological impact of war and the refugee situation on South Sudanese children in refugee camps in Northern Uganda: An exploratory study. *Journal of Child Psychology and Psychiatry*, 40, 529-536.
- ²⁹ National Institute of Mental Health. (February, 2008). "Post-Traumatic Stress Disorder." Retrieved from: <http://www.nimh.nih.gov/health/publications/anxiety-disorders/post-traumatic-stress-disorder.shtml>. Accessed February 22, 2008.
- ³⁰ National Institute of Mental Health. (2008, February). *Clinical Trials: Post-Traumatic Stress Disorder (PTSD)*. Retrieved from: <http://www.nimh.nih.gov/health/trials/post-traumatic-stress-disorder-ptsd.shtml>. Accessed February 22, 2008.

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