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A Primer on Covering Victims

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Whenever a reporter meets a survivor of traumatic events there is a chance that the journalist will witness--and may even precipitate--posttraumatic stress disorder. Therefore it is important that working journalists (including grizzled veterans) anticipate PTSD, recognize it and report it, while earning the respect of the public and those interviewed. The recognition of PTSD and related conditions enhances not only a reporter's professionalism, but also the reporter's humanitarianism.

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

1. Recurring intrusive recollections.
2. Emotional numbing and constriction of life activity.
3. A physiological shift in the fear threshold, affecting sleep, concentration and sense of security.

This syndrome must last at least a month before PTSD can be diagnosed. 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 There are people who are fearful, withdrawn and plagued by episodes of vague, troubling sensations, but they cannot identify a specific traumatic precipitant.

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.

1. 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.

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. (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.)

Some repetitive recollections include regrettable acts by the person with PTSD. A patient of mine killed a boy in Vietnam. 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.

2. Emotional Anesthesia Constricting Life Activity

The 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 Vietnam. 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 victims were not necessarily sad or morose, just incapable of delight. 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.

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 avoided only the particular train on which the hostage incident had occurred. Others took that train, but changed to a bus for the few miles near the site of the trauma.

Numbing and avoidance are adaptive to a point, then become a serious impediment to recovery. They 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 inflicted. I have testified as an expert for the prosecution (and for the plaintiff in a civil suit) on several occasions to explain this phenomenon.

The victims were numb or withdrawn 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 his 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."

2. Lowered Threshold

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. After a few panic attacks, a person will often suffer agoraphobia, avoiding places such as shopping malls and supermarkets, where an attack would be particularly embarrassing.

Few Reach This Condition

Thus 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.

Who Gets PTSD?

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.

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

Other Difficulties

Victims of human cruelty (as opposed to victims of natural disasters) experience additional emotional difficulties that 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. On the path to recovery and possible forgiveness victims of cruelty are entitled to hate their abusers. 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 of a crime in Sweden in 1974 when a hostage-taker and a bank teller fell in love and had sex in the vault during a siege. Like Patty Hearst and countless others, the teller 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.

A Guide to Interviewing

An understanding of posttraumatic stress disorder is vital to journalists in their 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. A sensitive explanation of the traumatic stress response aids recovery. When we as a society pay attention to the victim as he or she heals, we are less likely to be consumed by hate and focused on perpetrators, thereby 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.

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. 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 outside of Oklahoma in your small town. 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 away, 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.

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 the victim 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 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 debriefing 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 debriefing.

But journalists are not PTSD therapists or after-incident crisis debriefers. 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 afterward some PTSD symptoms (anxiety and intrusive recollections for one or two days), and 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?"

Stages of 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 adrenaline and pounding heart we experience when our car skids on an icy highway does not help us maneuver that piece of machinery. 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.

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 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. Such 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 adrenaline, 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 coexist 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 of impact and recovery after shocking events or disturbing news. Elisabeth Kubler-Ross defined the denial, fear, anger and eventual acceptance after learning one has a fatal illness. 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 diagnostic PTSD symptoms.

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 selfblame 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 prisoners used as 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 therapists, 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.

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 in The New Republic:

"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."

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.

Dr. Frank Ochberg is a pioneer in the study of victims of violence. A psychiatrist, Ochberg has worked with and studied victims of war, terrorism, domestic violence rape, incest and natural disaster in many countries. When American hostages were released from 444 days of captivity in Teheran, he was the expert commentator for ABC, "Nightline" and "Good Morning America. " When human shields were held by Saddam Hussein, he helped organize a rescue mission by hostage wives. He holds adjunct professorships in psychiatry, criminal justice and journalism at Michigan State University.

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