Depression and Bipolar Disorder

First Edition, Volume 3

A resource encyclopedia for the entertainment community developed by the Entertainment Industries Council, Inc.
A resource encyclopedia for the entertainment community developed by the Entertainment Industries Council, Inc. in partnership with AstraZeneca.
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PREFACE

Message to the Creative Community

The imagination of entertainment industry writers, directors, producers, composers, and performers, along with the imagination of creative executives, combine with the knowledge base of mental health research scientists and other experts to represent a dynamic and potent combination that is capable of communicating important health information to the general public—our audiences.

Since 1983, the Entertainment Industries Council, Inc. (EIC), has been perfecting its system for encouraging the art of making a difference. Three basic elements drive our system and are at the heart of all we do: education, resources, and recognition. Education provides our creative community with a better understanding of health and social issues and the ways we can each make an impact in addressing these issues. Resources we develop provide the tools for taking action. Recognition we receive for taking action offers us encouragement to explore new ways to use our creative crafts to the benefit of society, without compromising entertainment value or commercial potential.

EIC operates a full-service, script-to-screen program that encourages the art of making a difference through accurate depiction of health and social issues, such as the ones addressed in this resource encyclopedia: bipolar disorder and related mental health diseases. Here are some of the resources EIC provides:

◆ **First Draft** provides follow-up resources in the form of a technical resource hotline linking creators and executives to scientific experts in the development and production of entertainment that addresses health and social issues. First Draft provides educational briefings to creative staffs of networks, studios, production companies, TV series, associations, guilds, and other entertainment entities.

◆ **The Entertainment & Media Communication Institute (EMCI)** is the research and strategy component if EIC. The EMCI fosters developmental, interdisciplinary activities in a variety of fields helping to promote the well-being of the public and enhancing the pro-social impact of entertainment and other media.

◆ **PRISM Awards** provide annual recognition to entertainment productions that accurately depict these issues. The PRISM Awards not only provide encouragement by “celebrating the art of making a difference,” but they also hold up our collective efforts to the world through a syndicated television special. The growth of the PRISM Awards since their 1997 inception is proof that the EIC system works and that it works well.

As I stated at the outset, the creative community and the scientific community are a dynamic and potent combination. This resource book is one outcome of that collaboration between creative production and structured research, artistic license and scientific fact—what humanity dreams and what it knows.

We take great pleasure in offering this resource to entertainment professionals, with grateful acknowledgment to our Picture This participants. To readers from the creative community, I wish you continued success in your endeavors to enlighten and entertain our audiences.

Brian Dyak
President and CEO, Entertainment Industries Council, Inc.
EIC Mission and Operating Principles

The Entertainment Industries Council, Inc. was founded in 1983 by the entertainment industry to lead the industry in bringing its power and influence to bear on health and social issues.

EIC Core Organizational Principles:

1. The entertainment industry is one small piece of the societal puzzle.
2. We recognize that members of the entertainment industry make a variety of positive contributions addressing health and social issues.
3. We utilize a nonjudgmental process respecting creative integrity.
4. We promote voluntary participation.
5. The entertainment industry sets and implements its own agenda.
In 1983, The Entertainment Industries Council, Inc. (EIC) was founded by leaders in the entertainment industry to bring the power and influence of the entertainment industry to bear on health and social issues.
the source to turn to for free research-based, fact-based, or anecdotal information on a myriad of health or social issues—when you need it, where you need it, how you need it.

Distinguished Experts
First-Hand Accounts
Script Feedback
Questions Answered
Searchable Online Database
Research Assistance
Tailored Briefings
Phone or Face-to-Face Consultation

Some of the issues EIC’s First Draft service regularly helps top television shows and feature films research:

- Aging
- Addiction
- Alcohol
- Bipolar Disorder
- Child Abuse & Abduction
- Conflict Resolution
- Depression
- Diabetes
- Disaster Preparedness
- Drug Abuse
- Eating Disorders
- Firearm Safety
- Gun Violence
- HIV/AIDS
- Human Trafficking
- Humor & Healing
- Injury Prevention
- Intellectual Disabilities
- Internet Safety
- Mental Health & Mental Illness
- Obesity
- Post Traumatic Stress Disorder
- Seat Belt Use
- Skin Cancer & Sun Safety
- Smoking/Tobacco Use
- Substance Abuse Prevention, Treatment & Recovery
- Suicide
- Traffic Safety

For more information, go to www.eiconline.org
What the Writers Said. . .

PICTURE THIS! Fade In: A large room at the National Association of Broadcasters in Washington, D.C. Three Hollywood writers sit at a rectangular table. WIDEN TO REVEAL 40 or 50 mental health professionals, psychotherapists, members of advocacy groups, research scientists, journalists; and most importantly, individuals who have or continue to struggle with bipolar disorder.

CUT TO: A very attractive moderator, let’s call her Sarah Peterson, who for the next two hours will oversee a stimulating, bi-lateral discussion on bipolar disorder.

James Kearns, Writer/Co-Producer, JOHN Q

“As a Hollywood writer, access to research is the single most critical component to my work. In order for there to be dramatic truth, a writer worth his or her salt must have access to as much factual, or in this case, psychological truth as possible.

The Entertainment Industries Council (EIC) is to be commended for opening the doors of perception and sponsoring this timely debate. As a screenwriter and a father of a 22-year-old daughter who is bipolar, I can’t tell you how liberating it was to openly discuss this much misunderstood, highly stigmatized illness.

What did I learn? That bipolar disease, true to the American spirit, is very democratic. It does not discriminate. On the contrary, it affects people from every walk of life and goes across all racial, social and economic strata. We probably all know someone who struggles and suffers from it. That despite firmly entrenched taboos surrounding mental illness; they are not and should not be treated as second class citizens.

And that, as a person and a writer, it is incumbent upon me to understand this affliction from the inside out, so that if I one day decide to write a bipolar character, I will endow that person with all the grace, humanity and dignity I can muster.”

Karen Maser, Staff Writer, ER

“The EIC’s ‘Picture This’ event was a wonderful collaborative and thought-provoking experience. The knowledge, dedication and enthusiasm of all the attendees was truly inspiring. I came away with a greater understanding of bipolar disease and, as a writer, was reminded that showing the humanity of people with this disease is not only a responsibility, but an absolute obligation.”

Lawrence Kaplow, Producer/Writer, HOUSE, M.D.

“The problem with incorporating content from health and political organizations is that as storytellers, we tell stories, not messages. But in this type of roundtable discussion, competing messages gave rise to controversy, which was when I started to pay attention, as participants began substantiating their opinions with their own experience. And since whenever there’s conflict, there’s story, I probably walked away with four or five pretty good story/character ideas. Plus they fed me.”

The Picture This: Bipolar Disorder panel of writers included HOUSE Producer-Writer Lawrence Kaplow, ER Staff Writer Karen Maser and JOHN Q Writer James Kearns.
Acknowledgments

The Entertainment Industries Council, Inc. (EIC) acknowledges the assistance and support of its Board of Directors in making this publication possible: Brian Dyak, Ralph Andrews, Gary Benz, Leroy Bobbitt, Lionel Chetwynd, Vincent DiBona, Nancy Dockry, David Goldsmith, Michele Lee, Roland McFarland, Melissa Rivers, Herman Rush, William N. Utz, Meredith Wagner, Frank Wheaton and Alan Wurtzel.

This publication was the result of countless hours of effort in the form of research, writing, editing, coordination and design work on the part of EIC leadership and staff, as well as EIC’s esteemed consultants, associates and volunteers representing both the health and entertainment fields. Information in this publication was written or compiled by David Michael Conner, Josh Miller, Lindsay Atkinson, Amanda Fink, Fallon Keplinger, Jane Kim, Marie Gallo Dyak, Larry Deutchman, Brian Keefe, Abegail Matienzo and Alissa D’Amelio.

Thanks to everyone who participated in EIC’s Picture This: Bipolar Disorder roundtable, including: National Association of Broadcasters (NAB) President and CEO David Rehr (an EIC Trustee) and NAB’s Teresa Gammon; AstraZeneca; and our Picture This entertainment panel, James Kearns, Larry Kaplow and Karen Maser.

Special thanks for the depression and suicide prevention section of this document are extended to NAB for hosting Picture This: Depression & Suicide Prevention. Thanks also to NAB President and CEO David Rehr and NAB Foundation President Marcellus Alexander; Center for Mental Health Services Director, Division of Prevention, Traumatic Stress, and Special Programs, Dr. Anne Mathews-Younes; National Institute of Mental Health (NIMH) Chief, Dissemination Research Program, Dr. David A. Chambers; Substance Abuse and Mental Health Services Administration (SAMHSA) Director of Communications Mark Weber; and our Picture This entertainment panel for the depression and suicide prevention project, Padma Atluri, Cindy Baer, EIC Board Director David Goldsmith, US Weekly’s John Griffiths, UCLA’s Dr. Reef Karim, Alexis Hyder, Rosemary Rodriguez, Darlene Lieblich Tipton, and NAB’s Stevan Johnson and Valeria West.

We appreciate NIMH, SAMHSA, the National Alliance on Mental Illness (NAMI), the Depression and Bipolar Support Alliance (DBSA) and Mental Health America (MHA) for their valuable contributions to the information contained in this document.

Thanks to AstraZeneca for sponsoring this publication and Ann Bauckman at Output Printing & Graphics for designing this document.

Finally, EIC thanks you for picking up this book and using it as a resource in the development of characterizations and storylines relating to accurate depictions of bipolar disorder and other mental health issues. Your creative work may save lives.

We invite your feedback about this publication. Please direct questions or comments to eiceast@eiconline.org.
Section I: Identifying Bipolar Disorder
Identifying Bipolar Disorder

Much of the information in this section is adapted from the following Web sites:
- www.isitreallydepression.com
- www.bridgetoabrightertomorrow.com

Signs and Symptoms of Bipolar Disorder

People with bipolar disorder have episodes of both depression and mania. The depressive phase of bipolar disorder has all of the same symptoms as major depressive disorder, commonly called depression. In contrast to major depression, bipolar disorder (until recently referred to as manic depression) also includes manic episodes and periods of “normal” or balanced moods; in other words, these are two different illnesses that require different treatments. The symptoms of both major depression and bipolar disorder include overwhelming feelings of sadness, worthlessness and hopelessness, as well as physical changes, such as difficulty concentrating and problems with appetite and sleep. Bipolar disorder also involves episodes of mania, symptoms of which may include excessive energy, extreme irritability, or “out-of-control” behavior. Major symptoms of the two sides of the disease are listed below.

Depressive symptoms vs. manic symptoms:

<table>
<thead>
<tr>
<th>Depressive Symptoms</th>
<th>Manic Symptoms</th>
</tr>
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<tbody>
<tr>
<td>Sadness</td>
<td>Inappropriate sense of euphoria (excitement)</td>
</tr>
<tr>
<td>Excessive crying</td>
<td>Reckless behavior</td>
</tr>
<tr>
<td>Loss of pleasure</td>
<td>Little sleep needed</td>
</tr>
<tr>
<td>Sleeping too much or too little</td>
<td>Excessive energy</td>
</tr>
<tr>
<td>Low energy</td>
<td>Racing thoughts; talking too much</td>
</tr>
<tr>
<td>Restlessness</td>
<td>Out of control spending</td>
</tr>
<tr>
<td>Difficulty concentrating</td>
<td>Difficulty concentrating</td>
</tr>
<tr>
<td>Irritability</td>
<td>Irritability</td>
</tr>
<tr>
<td>Loss of appetite or overeating</td>
<td>Abnormally increased activity, including sexual activity</td>
</tr>
<tr>
<td>Feelings of worthlessness and hopelessness</td>
<td>Poor judgment</td>
</tr>
<tr>
<td>Ongoing physical problems that are not caused by physical illness or injury (e.g., headaches, digestive problems, pain)</td>
<td>Aggressive behavior</td>
</tr>
<tr>
<td>Thoughts of death or suicide</td>
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</table>

Bipolar disorder is not a new disease. In *The History of Bipolar Mood Disorder*, author Julia Pesek notes that mania and depression occurring together were first described in the second century. Studies on bipolar disorder have found that it affects approximately 2% of the population.

Men and women are equally affected by bipolar disorder. The disease usually surfaces in late adolescence or early adulthood.

Mental health experts and people living with bipolar disorder agree that many misconceptions exist about bipolar disorder,
perhaps the most deceiving of which is that a person living with bipolar disorder can “fix it with will power.”

Because bipolar disorder is a disease of the brain, rather than of an organ, such as the heart or liver, some people think that it’s an imagined illness or that those suffering with bipolar disorder could put an end to their symptoms by sheer strength of will if they chose to do so. The truth is that bipolar disorder is a real physical illness—a brain-based illness. In bipolar disorder sufferers experience severe mood swings that may range from deep depression and suicidal tendencies to extreme elation, or mania. The mood swings are associated with physical symptoms, such as changes in sleep, appetite, and activity level.

**Diagnosing Bipolar Disorder**

Bipolar disorder is often misdiagnosed as major depressive disorder or depression. Although bipolar disorder and depression do have some symptoms in common, they are two different conditions that require distinct treatments. Mental health professionals experienced in diagnosing and treating bipolar disorder state that having shared symptoms can make diagnosis challenging, but it is a myth that obtaining an accurate diagnosis is impossible. Patients often seek treatment only during the depressive phase of bipolar disorder, which can obscure the manic side because the focus often is on the treatment of depression only; however, treatment professionals are now much more familiar with the symptoms of bipolar disorder than they used to be, and screening of depressed patients usually involves screening for symptoms of mania as well. These days, bipolar disorder may be diagnosed and treated with highly effective results.

In fact, the National Alliance on Mental Illness (NAMI) states that it often takes as long as 10 years to diagnose bipolar disorder in a patient correctly. Because of the difficulty of diagnosing the disorder, many people have been misdiagnosed by their physicians as having depression, schizophrenia, or another mental illness.

Some misdiagnoses of bipolar disorder occur when a patient visits the doctor during a depressive episode and may not disclose (or realize) that he or she also experiences manic episodes. Incorrect diagnoses can lead to inappropriate treatment, such as prescription of the wrong medication, which can adversely affect the patient, sometimes even worsening symptoms of the disorder and causing prolonged suffering.

Given that experts can easily overlook or misidentify bipolar symptoms, writers or actors depicting the disorder may have a “diagnostic advantage” over the medical community; creative professionals can work backwards, shaping the profile of a person with bipolar disorder whose behavior does not at first appear unusual or who has only isolated symptoms in the beginning.

A writer who is purposefully creating a character with bipolar disorder can be sure of the diagnosis while leaving other characters in the dark about it; such an approach could easily show that only through the recognition of specific overlapping symptoms would other characters, perhaps including medical professionals, ultimately be able to identify the disorder. In fact, this is how people usually become aware of bipolar disorder in real life—after finally “connecting the dots” and making sense of shared, or co-occurring, symptoms.

**How can bipolar disorder be incorrectly diagnosed?**

Because bipolar disorder involves depressive episodes at certain times in the illness, a misdiagnosis of major depressive disorder is understandable. Some of the factors that contribute to misdiagnosis include the following:

- Some individuals don’t seek help until they are deep in a depression and are entirely focused on those symptoms.
- Other individuals may not have recognized past manic episodes, or they simply don’t remember them.
• Still others may experience depression as their very first episode, and they may not have a manic episode until some time in the future.

• In general, public awareness of depression is high; people recognize the symptoms and know to look for help. In contrast, bipolar disorder—especially the symptoms of mania—is not as widely recognized.

**Antidepressants and Bipolar Disorder**

For people who are correctly diagnosed with depression, antidepressant medications are often highly effective. But in individuals who have undiagnosed bipolar disorder, antidepressants can sometimes do more harm than good. For example:

• Antidepressants may trigger manic episodes in some people with bipolar disorder.

• Antidepressants may simply be ineffective in individuals with bipolar disorder. Poor response to antidepressants could be a sign that the depression diagnosis is incorrect.

• When correct treatment for bipolar disorder is delayed (because correct diagnosis was delayed), the bipolar treatment may be less effective.

Effective medications are available for bipolar disorder, but they are different from the medications commonly prescribed for major depressive disorder. To get the right treatment, a correct diagnosis is needed.

For detailed information about treating bipolar disorder, see Section II.

**Types of Bipolar Disorder**

Doctors have identified several kinds of bipolar disorder. Each kind is defined by the length, frequency, and pattern of episodes of mania and depression. All of them share symptoms of depression and mania, to greater and lesser degrees, which usually alternate between “normal” or balanced moods.

**Bipolar I Disorder**

Bipolar I disorder is characterized by one or more manic episodes or mixed episodes (symptoms of both mania and depression occurring nearly every day for at least one week) and one or more major depressive episodes. Bipolar I disorder is the most severe form of the illness, marked by extreme manic episodes.

**Bipolar II Disorder**

In contrast to bipolar I disorder, which is characterized by one or more manic episodes or mixed episodes and one or more major depressive episodes, bipolar II disorder is diagnosed after one or more major depressive episodes and at least one episode of hypomania, with possible periods of level mood between episodes.

The highs in bipolar II, called hypomanias, are not as high as those in bipolar I (manias). Bipolar II disorder is sometimes misdiagnosed as major depression if hypomanic episodes go unrecognized or unreported. Bipolar II disorder may be diagnosed for people who have recurring depressions (episodes that go away periodically, then return) and experience periods of hypomania when they:

• Are in an especially or abnormally energetic or irritable mood (lasting four or more days)

• Feel abnormally self-confident or social

• Need less sleep or are more energetic

• Are unusually talkative or “hyper”

• Are irritable or quick to anger

• Think faster than usual

• Are more easily distracted or have trouble concentrating

• Are more goal-directed or productive at work, school, or home

• Are more involved in pleasurable activities, such as spending or sex

• Feel or have reports from others that they did or said things that were unusual, abnormal, or not like their usual selves
If your character has any of these traits, he or she might speak to a health care provider about these energetic episodes and find out if they might be hypomania. Getting a correct diagnosis of bipolar II disorder can help a sufferer find treatment that may also lift the depression. This situation would provide ongoing dramatic opportunities, while informing audiences about the symptoms and diagnosis of bipolar disorder.

Not Otherwise Specified (NOS)
Bipolar disorder that does not follow a particular pattern is called bipolar disorder, not otherwise specified (NOS). Those who receive this diagnosis might experience, for example, recurring hypomanic episodes without depressive symptoms or very rapid swings between some symptoms of mania and some symptoms of depression.

Cyclothymia
Cyclothymia is a milder form of bipolar disorder characterized by several hypomanic episodes and less severe episodes of depression that alternate for at least two years. The severity of this illness may change over time.

Rapid Cycling
Bipolar disorder with rapid cycling is diagnosed when a person experiences four or more manic, hypomanic, or depressive episodes in any 12-month period. Rapid cycling can occur with any type of bipolar disorder and may be a temporary condition for some people.

What is the difference between bipolar disorder and ordinary mood swings?
The three main characteristics that make bipolar disorder different from ordinary mood swings are:

• Intensity: Mood swings that come with bipolar disorder are usually more severe than ordinary mood swings.
• Length: A bad mood is usually gone in a few days, but mania or depression can last weeks or months. With rapid cycling, moods last a short time but change quickly from one extreme to another. With rapid cycling, “level” (euthymic) moods do not last long.
• Interference with life: The extremes in mood that come with bipolar disorder can severely disrupt the sufferer’s life. For example, depression can make a person unable to get out of bed or go to work; mania can cause a person to go for days without sleep.

Stigma: The Name Game
Given that mental illness has only recently begun to be understood by medical and psychiatric science, it is no surprise that a good deal of misinformation—or a lack of information—exists among the general public. Misinformation and ignorance often lead to inaccurate stereotypes, fears and pervasive myths that can stigmatize the illness. Words such as “crazy” and “psycho” have become common derogatory terms that many take lightly; however, these words can be extremely harmful to those living with mental illness because they perpetuate negative associations and fears.

Small changes can make a big difference. By communicating accurate information through entertainment, the industry can help general audiences gain knowledge that will lead to greater understanding, fewer fears and myths, and decreased stigma. Perhaps more importantly, this type of communication empowers members of the public to make informed decisions, recognizing symptoms and seeking treatment for themselves or their loved ones. In short, your work may save lives.

Stigma and Bipolar Disorder
The words “manic” and “bipolar” have become colloquial terms, often used in a negative sense, to describe people who behave erratically. People who live with bipolar disorder may have mood swings, but it is important to keep in mind that behavioral changes are symptoms of a disease that
they cannot control on their own. Improperly characterizing bipolar disorder perpetuates inaccurate ideas of what the disease really is.

Stigma surrounding mental illness is not exclusive to bipolar disorder. For example, people use such words as “schizo” to refer to someone who has a changeable personality. Even though this insensitive usage is often meant as a joke, such terms have perpetuated myths about schizophrenia, including the idea that it involves “multiple personalities.” In fact, the disease associated with multiple personalities is entirely different from schizophrenia and is now called dissociative disorder.

In the early 1980s, when HIV/AIDS was little understood, it was commonly considered “the gay disease.” Unbelievable as it may seem, many people at the time made insensitive jokes correlating homosexuality and the deadly disease because they felt they were immune to it. We now know better. The same is true for mental illness: Now that we understand mental illness as a spectrum of diseases, we must understand that stigmatizing mental illness only scares people away from treating their disorders, which ultimately has devastating effects on everyone. The key to changing outdated stereotypes is understanding, and that can be accomplished through compelling entertainment that incorporates accurate information about mental illnesses, including bipolar disorder.

**Stigma at Work**

Unfortunately, people living with mental illnesses often experience discrimination in the workplace. Those who are not educated about bipolar disorder may see an employee or coworker with bipolar disorder as a liability or assume that the person’s work will not be up to par because of his or her psychiatric illness. For this reason, many people with bipolar disorder do not disclose their illness to others and may feel persecuted, misunderstood, or underappreciated at work.

At the same time, many people never seek care for bipolar disorder because they fear being “outed” at work or having to face the judgments of their coworkers. The truth is that people who seek and receive treatment may be better employees than those who do not. Job performance may improve as medications take effect and the sufferer is no longer plagued by the speculation of coworkers about his or her behavior. People undergoing treatment are more likely to understand their own changeable moods and to accept their symptoms not as flaws, but as aspects of a controllable medical condition.

The most reasonable way to understand any psychiatric illness in the workplace is to view it as any other major health concern: Just as we do not look down upon people who live with cancer, diabetes, or any other physical illness, we should view people with psychiatric disorders in the same way—as ill, not “crazy.” New research has found major differences in brain function between people with psychiatric disorders and those without; this knowledge may help people understand that psychiatric illnesses, including bipolar disorder, are legitimate health concerns, just like diabetes or cancer, and people living with such illnesses should be accorded the same respect, consideration and opportunities for treatment.
Section II: Management and Treatment of Bipolar Disorder
Management and Treatment of Bipolar Disorder

Much of the information in this section is adapted from Bipolar Disorder, a booklet published by NIMH and available online at http://www.nimh.nih.gov/health/publications/bipolar-disorder/summary.shtml.

Most people with bipolar disorder—even those with the most severe forms—can achieve substantial stabilization of their mood swings and related symptoms with proper treatment. Because bipolar disorder is a recurrent illness, long-term treatment is strongly recommended and almost always indicated. A strategy that combines medication and psychosocial treatment is optimal for managing the disorder over time.

In most cases, bipolar disorder is much better controlled with continuous, rather than intermittent treatment. Even without breaks in treatment, however, mood changes can occur, but doctors may be able to prevent full-blown manic or depressive episodes by making adjustments to the treatment plan. Working closely with a doctor and communicating openly about treatment concerns and options can make a difference in treatment effectiveness.

In addition, keeping a chart of daily mood symptoms, treatments, sleep patterns and life events may help people with bipolar disorder and their families to better understand the illness and help the doctor track and treat the illness most effectively. (See Appendix B: Personal Calendar/Mood Tracking Chart from the Depression and Bipolar Support Alliance (www.dbsalliance.org)).

Disease Management

Bipolar disorder requires the same type of management as any other mental illness. The basic building blocks of disease management for mental illness are as follows:

- Medication: Doctors identify the most appropriate medication for each individual.
- Talk therapy: Patients discuss and ultimately understand their symptoms and related complications. Talk therapy also maintains support for treatment and keeps physicians informed about co-occurring problems, enabling them to monitor and adjust medications to suit the individual patient’s needs.
- Self-management skills: Patients learn to identify the warning signs of a relapse and develop the skills to maintain disease management.
- Peer support: Support from other sufferers helps patients sustain morale, combat isolation and learn effective coping skills.

Medications

Medications for bipolar disorder are prescribed by psychiatrists: medical doctors with expertise in the diagnosis and treatment of mental disorders. Although primary care physicians who do not specialize in psychiatry also may prescribe these medications; it is recommended that people with bipolar disorder see a psychiatrist for treatment. Medications known as mood stabilizers usually are prescribed to help treat bipolar disorder. Several different types of mood stabilizers are available. In general, people with bipolar disorder continue treatment with mood stabilizers for extended periods of time (years). Other medications are added when necessary, typically for shorter periods, to treat episodes of mania or depression that break through despite the mood stabilizer.
Treatment of Bipolar Depression

Research has shown that people with bipolar disorder are at risk of switching into mania or hypomania, or of developing rapid cycling during treatment with antidepressant medication. For this reason, mood-stabilizing medications generally are required, alone or in combination with antidepressants, to protect people with bipolar disorder from this switch.

Thyroid Function

People with bipolar disorder often have abnormal thyroid gland function. Because too much or too little thyroid hormone alone can lead to mood and energy changes; levels of thyroid hormone should be carefully monitored by a physician.

People with rapid cycling tend to have co-occurring thyroid problems and may need to take thyroid pills in addition to their medications for bipolar disorder. Also, certain medications may cause low levels of thyroid hormone in some people, resulting in the need for thyroid supplementation.

Medication Side Effects

Before starting a new medication for bipolar disorder, patients should talk with the psychiatrist or pharmacist about possible side effects. Depending on the medication, side effects may include weight gain, nausea, tremor, reduced sexual drive or performance, anxiety, hair loss, movement problems, or dry mouth. Patients should be sure to tell the doctor about all side effects they notice during treatment. The doctor may be able to change the dose or offer a different medication to relieve side effects. Patients should not change or stop taking their medication without a psychiatrist’s guidance.

Psychosocial Treatments

In addition to medication, psychosocial treatments—including certain forms of psychotherapy, or “talk therapy”—are helpful in providing support, education and guidance to people with bipolar disorder and their families. Studies have shown that psychosocial interventions can lead to increased mood stability, fewer hospitalizations and improved functioning in several areas. A licensed psychologist, social worker, or counselor typically provides these therapies and often works together with the psychiatrist to monitor a patient’s progress. The number, frequency and type of sessions should be based on the treatment needs of each person.

Psychosocial interventions commonly used for bipolar disorder are cognitive behavioral therapy, psychoeducation, family therapy, and a newer technique, interpersonal and social rhythm therapy. NIMH researchers are studying how these interventions compare to one another when added to medication treatment for bipolar disorder.

- Cognitive behavioral therapy helps people with bipolar disorder learn to change inappropriate or negative thought patterns and behaviors associated with the illness.
- Psychoeducation involves teaching people with bipolar disorder about the illness and its treatment and how to recognize signs of relapse so that early intervention can be sought before a full-blown illness episode occurs. Psychoeducation also may be helpful for family members.
- Family therapy uses strategies to reduce the level of distress within the family that may either contribute to, or result from, the ill person’s symptoms.
- Interpersonal and social rhythm therapy helps people with bipolar disorder both to improve interpersonal relationships and to regularize their daily routines. Regular daily routines and sleep schedules may help protect against manic episodes.

As with medication, it is important to follow the treatment plan for any psychosocial intervention to achieve the greatest benefit.
The Professionals Who Treat Bipolar Disorder

Bipolar disorder patients work with a team of health care professionals who supervise the patients’ care. For medication management, patients usually work with their psychiatrists. For psychotherapy, patients typically work with a psychiatrist or a licensed therapist or social worker. The members of the health care team maintain close contact to help ensure the patient’s continued progress.

Many people start treatment with a primary care provider. This doctor can discuss symptoms, provide guidance and recommend psychiatrists or therapists.

Even for patients who think they may be diagnosed incorrectly, it is extremely important to follow the medication plan prescribed by a doctor. Those who have concerns about prescribed medicine—or those who feel that they are doing better—should not abruptly stop treatment without the supervision of a doctor. Instead, patients should communicate openly with their doctors and discuss symptoms and possible adjustments to the treatment plan.
Section III: Myth vs. Fact
Myth vs. Fact

The following lists highlight common misconceptions about bipolar disorder in particular and mental illness in general.

Popular Myths

- Myth: People who have bipolar disorder are “crazy” or “out of control;” they need constant supervision.
  Fact: People who have bipolar disorder do not always experience symptoms; moods alternate and often the person’s behaviors and thinking are perfectly “normal,” or (preferred) balanced. Even untreated, people with bipolar disorder usually are not out of touch with reality, dangerous or completely out of control. With proper treatment, bipolar disorder is manageable and symptoms are much less pronounced, if present at all.

- Myth: People with bipolar disorder have no discretion or use poor judgment.
  Fact: This can be true during severe bouts with depressed and manic moods, but in general, people with bipolar disorder have the same discretion and judgment as people who do not have it.

- Myth: People with bipolar disorder are violent; they may even be dangerous criminals.
  Fact: Evidence suggests that people with bipolar disorder are much more likely to be victims of violent crimes than perpetrators. The most common violent thoughts of people with bipolar disorder are turned inward, as is the case with people who live with major depression.

- Myth: Only Caucasians have bipolar disorder.
  Fact: Bipolar disorder appears to affect all populations equally. This myth probably exists because Caucasian people are more likely than many minorities to seek treatment because of socioeconomic and cultural reasons. But minority communities and individuals in the U.S. are increasingly recognizing mental illness as an illness rather than a personal failing, and are finding that their communities offer mental health services that they can afford. This trend should reveal a more even distribution of diagnoses across ethnic communities nationwide.

- Myth: Bipolar disorder is a middle class disease.
  Fact: While people who have less money may have less access to health care in the U.S., there is no disease in the world that cares about how much money people have. This myth exists because some people do not believe that mental illnesses are true health conditions and that diseases such as bipolar disorder result from boredom or too much leisure time to feel sorry for oneself. The fact is, a person who has bipolar disorder needs treatment and cannot will his or herself out of having the disease.

- Myth: Bipolar disorder is not a real illness.
  Fact: While scientifically based information on mental illness is relatively new and not yet fully understood, evidence suggests that bipolar disorder and other mental illnesses often result from hormonal and chemical imbalances, brain neurotransmitter dysfunction and environmental causes. The fact that bipolar disorder responds to medicinal treatment indicates that the disruption it causes in one’s life—“the disease”—can be remedied as one can remedy the symptoms of many other illnesses.

- Myth: Having bipolar disorder is a choice; anyone with willpower can control his or her symptoms.
  Fact: This is like stating that anyone with willpower can control the symptoms and progressive destruction of cancer or HIV/AIDS. In other words, bipolar disorder is a physiologically based disorder that cannot be controlled by one’s will or wishes.
• Myth: People living with bipolar disorder suffer all the time, throughout their whole lives.
  Fact: Not true. Even untreated, people with bipolar disorder do not suffer all the time—but they do
  suffer. However, people who are properly treated can live normal or balanced lives.

• Myth: Treatment is uniform, meaning that treatment is the same for everyone.
  Fact: Because people’s biochemistry is different and because the causes of bipolar disorder may be differ-
  ent for different people, each person responds differently to treatment. This is one reason that treatments
  are thought by some to be ineffective; however, the truth is, most people can find a treatment that works
  for them without enough patience, and under the close supervision of a knowledgeable and experienced
  physician.

• Myth: Bipolar disorder is a sign of failure.
  Fact: Bipolar disorder is a sign of being a human being with a predisposition for bipolar disorder.

• Myth: Bipolar disorder is a character flaw.
  Fact: While what is or is not a character flaw is inherently a subjective question, the bottom line is that
  bipolar disorder is an illness, not an aspect of character; however, being prejudiced against people with
  health problems is a truly undesirable characteristic.

• Myth: The illness defines the person. People who suffer from mental illness have no other
  concerns or interests in life.
  Fact: Just like someone who lives with, say, HIV, treating the symptoms and the illness itself does take
  priority in a patient’s life from time to time, but with proper treatment and management of the disease,
  bipolar disorder (and any other chronic disease) takes less of a priority and the patient’s life becomes no
  different from anyone else’s.

• Myth: Those who do not “get better” are not actively engaged in the recovery process.
  Fact: No one can be blamed for the effectiveness of his or her recovery from an illness such as bipolar
  disorder. Many people work hard on finding the right way to manage the disease and continue to suffer
  the symptoms of the disorder until the best treatment is found. Assuming that a person who continues to
  suffer is not “trying” to get better is unfair and counterproductive.

• Myth: The patient is to blame for his or her mental illness.
  Fact: While incredible to most informed and intelligent people, some people still believe this myth is true.
  This incorrect belief usually stems from a lack of information or a prejudice against the mentally ill.
  With a few rare exceptions, such as people who have hypochondria or Munchausen syndrome (in which
  people have a compulsion to feign being ill), almost no one wants to be ill, and certainly no one who
  legitimately lives with bipolar disorder and suffers from its symptoms chooses to have the disorder.
Bipolar Disorder Doesn’t Discriminate

An intriguing topic that came up during EIC’s Picture This meeting was the universality of bipolar disorder. In the past, bipolar disorder was thought of as a disease that affected only Caucasians, and many people believed that bipolar disorder was a “middle-class illness,” meaning that only well-to-do people were susceptible because the disorder was thought to be a psychosomatic illness brought on by boredom.

The truth is that no one is immune to bipolar disorder.

Bipolar Disorder Affects All Groups Equally

There is no evidence to suggest that bipolar disorder affects any one group of people disproportionately. In other words, whether a person is black or white, rich or poor, educated or uneducated, any given person is equally prone to developing bipolar disorder.

Cultural and Ethnic Differences Seem to Affect Treatment

Because a large part of diagnosing bipolar disorder is observational, cultural differences and language barriers also come into play. Picture This experts from the Asian American community noted that some Asian Americans have difficulty coming to terms with bipolar disorder because they have been pigeonholed as the “model minority.” In other words, many Asian Americans feel pressure to be successful and productive, and may view bipolar disorder as an obstacle to their success. People who feel such social pressures may ignore warning signs and symptoms of bipolar disorder or may reject the idea that they or their loved ones may be susceptible to it; as a result, they never seek treatment.

An article in bp Magazine noted:

Minorities with bipolar disorder can run into a twofold problem. First, for reasons that are unclear, minorities tend to be prescribed older-generation drugs. African Americans are less likely than Caucasians and Latinos to be prescribed new-generation drugs... the older drugs have uncomfortable side effects and the risk of tardive dyskinesia (TD-repetitive, involuntary movements of the face, trunk, arms, fingers, and legs, which may be irreversible in some people) is higher in African Americans than in whites.

Another concern for minorities is the effect of differing metabolic rates. Because some ethnic minority groups metabolize drugs more slowly than Caucasians, members of these groups may absorb more of certain drugs. Physicians who are accustomed to treating Caucasian patients may not know how to regulate doses for people of varying ethnic and racial backgrounds. Improper dosages can lead to increased or heightened side effects. As a result, some people with bipolar disorder limit how often they take their medications, decreasing the effectiveness of treatment regimens and increasing the risk of side effects.

It is essential that creative professionals working with the issue of mental illness recognize that bipolar disorder affects all racial and ethnic groups and every socioeconomic level.
Section IV: Depiction Priorities
Depiction Priorities

We asked our Picture This: Bipolar Disorder experts this question: If you saw depression or suicide 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, along with depiction suggestions to facilitate the incorporation of these ideas into storylines and characterizations.

First Priority: Recognizing Bipolar Disorder

- Identifying bipolar disorder can be challenging, as symptoms of bipolar disorder (depression, insomnia, mood swings) overlap with many other mental illnesses. Consider the possibility that a character who has any of these symptoms may in fact be living with bipolar disorder—even if the writers didn’t know it when creating the character!

- Often times, some of the symptoms of bipolar disorder go “under the radar,” as patients sometimes are aware only of the most severe symptoms. Presenting only part of the symptoms to a psychiatric care provider is one of the most common reasons for misdiagnosis. Think about ways in which a characterization might be written in such a way as to show some of the subtler symptoms of bipolar disorder to audiences, while keeping the affected character unaware of these symptoms until he or she is diagnosed.

- Because bipolar disorder is such a complex illness, many people misunderstand its symptoms. In storylines involving bipolar disorder, think about briefly discussing the similarities and differences between bipolar disorder, depression, borderline personality disorder, schizophrenia and other mental illnesses so that the character and audience will have a clear idea of what makes the character tick.

Second Priority: Addressing Stigma

- Perhaps because mental illness has only recently begun to be understood by medical researchers, there is a general lack of understanding about mental illnesses such as bipolar disorder. Stigma, for the most part, is created and perpetuated by a lack of knowledge. Since people often gain a better understanding through witnessing actions rather than simply being taught, the entertainment industry has significant potential to influence public understanding of stigma-bearing illnesses such as bipolar disorder.

- People with bipolar disorder are ordinary people living in extraordinary circumstances. It may be helpful to think about it like this: A person lives with bipolar disorder; he or she is not “bipolar” or “manic.” When depicting bipolar disorder, be sure to show the humanity of the character who experiences symptoms. Think about ways to humorously, yet sensitively, depict some of the symptoms of bipolar disorder.

- People who live with bipolar disorder are thought by many to be excessively or abnormally violent; however, research shows that this is not the case. In fact, people with bipolar disorder are more likely to be crime victims than they are to be perpetrators of crimes. When depicting bipolar disorder onscreen, be sure to reflect this reality.

- Many people who live with bipolar disorder are afraid to “come out,” or disclose their illness to their employers for fear of being fired. The truth is,
everyone probably knows at least one person who has been diagnosed with bipolar disorder—but we don’t know it because the disorder can be effectively controlled with the right treatment. Consider showing the potential for discrimination among people with mental illnesses at work, which can bring about excessive stress and exacerbate symptoms.

- While headlines having to do with bipolar disorder often are negative or show the troubling aspects of the disorder, most often, people with bipolar disorder are the victims of crimes and violence rather than the perpetrators. Most people would not think twice if they read a newspaper headline stating, “BIPOLAR MAN INVOLVED IN ROBBERY.” But given that most people with bipolar disorder are not perpetrators of crimes, the headline, “DIABETIC WOMAN BURGLES BANK,” makes just as much sense—that is to say, it doesn’t make much sense at all: While criminals may suffer from various diseases, in most cases the person’s illness has nothing to do with the crime he or she commits. Consider showing the erroneousness of such headlines in scenes depicting such crimes; these headlines may attribute violence or accidents to health problems that are simply coincidental, not the cause of such violent activity.

**Third Priority: Recovery and Hope**

- Consider the opportunities to depict recovery and treatment: You might share the story of a person seeking treatment, undergoing misdiagnoses, finding treatment, coping with the side effects of medications that do work for them, and so on. Represent the whole person and the strides that can be made, showing that it is possible to regain control in life and live with bipolar disorder.

- The fact that bipolar disorder is treatable is overlooked and needs to be depicted. Bipolar disorder presents itself in many ways, and the accurate depiction of symptoms is essential to showing the disorder realistically. Reversing stereotypes in characters with bipolar disorder would be powerful and unexpected to viewers. Consider provoking new public perceptions of bipolar disorder by showing a hero or highly productive and functional person living with bipolar disorder, as often is the case in reality.

- When addressing sensitive health and social issues, such as bipolar disorder, many people have a natural inclination to become “politically correct” and always treat a matter seriously. The fact is that bipolar disorder is a health issue that involves a variety of moods, including ups and downs, that can cause tragedy, but also a great deal of laughter and elation. In direct opposition to the ultra-serious route, many of the experts and people living with bipolar disorder participating in our Picture This meeting strongly encouraged depictions of bipolar disorder that are comic and lighthearted. Several people also pointed out that dark comedy is a natural tone by which to set a bipolar-themed storyline or character, as many people with bipolar disorder are able to laugh at dark situations they encounter in life. Humor, in fact, can help make recovery easier, or at least less stressful. There is a possibility that when people see bipolar disorder depicted with sensitive humor, they will feel more comfortable discussing the disorder.

- As with any illness, from cancer to addiction, keep in mind that the most successful treatment is usually a collaborative effort among the patient, doctors, family and friends. Show the importance of relationships in achieving effective treatment for bipolar disorder.
Depicting Bipolar Disorder: When Is It Worth It?

1. Consider whether depicting a bipolar disorder, mania or depression is crucial to your storyline. If it is, try to be true to the character’s psychology and present warning signs and symptoms of depression, manic behavior and/or suicidal thoughts (see Section VII: Suicide) so that the character doesn’t misrepresent bipolar disorder.

2. Keep in mind that bipolar disorder (or “manic depression”) is not as simple as a person behaving erratically. Mislabeling unusual behavior as bipolar contributes to public misunderstandings of the disorder. If you choose to depict bipolar disorder, keep the character’s behaviors consistent with those of the disorder—both the manic and depressive states.

3. Many people have a romantic notion that bipolar disorder is linked with creativity and artistry. While there are examples of artistic and creative people who have lived with (and some who have died from) bipolar disorder or bouts with mania and depression, it is important to note that most creative people who have been treated for bipolar disorder state that they have a much better quality of life and stability, and have not lost their creative talent because of treatment.

4. Think carefully before detailing any extreme or dangerous mania-related behaviors, especially depression-related suicidal acts in a way that a viewer might be able to copy the act. (For example, in the case of a suicide by overdose, try not to indicate what pills are taken, or if a suicide is by hanging, carefully evaluate how much detail is shown regarding how to tie a slip knot.)

5. In most cases, the greatest humanity comes through characters who live through the ups and downs of life. While people who live with bipolar disorder may experience exaggerated ups and downs, which may make for engaging drama, keep in mind that a realistic story arc will eventually involve diagnosis and treatment of the disorder. That is, the highs and lows of bipolar disorder are only part of the story, and depicting only part of the story not only will skew people’s understanding of the disorder, but also will not take full potential of the drama inherent in the stories of those who live with bipolar disorder.

6. Consider incorporating actual resource information in your onscreen depiction the character may have access to, and that viewers who may recognize symptoms in themselves or a loved one can access to get help for themselves. Besides being a service to your viewer, anyone who finds help through your show will tell everyone they know that your show was responsible for changing his or her life. You can’t get better PR than that.

Questions to Ask of Your Characters and Storylines Involving Bipolar Disorder

- Has the victim ever received treatment for depression or any other mental disorder?
- Does the victim have a problem with substance abuse?
- Does the storyline convey effective treatments for bipolar disorder (but are underutilized)?
- Does the storyline acknowledge the patient’s problems and struggles, as well as the positive aspects of his or her life, to give a more balanced characterization?
- Does the audience see the realistically life-affecting aspects of untreated versus treated bipolar disorder in relatives and friends?
Special Language Concerns

- Be careful not to refer to bipolar disorder as “being manic,” “going crazy,” “losing one’s mind,” or similar derogatory statements. While these terms are common and used by many people, they contribute significantly to existing stigma that prevent people from seeking treatment and, ultimately, exacerbating problems associated with bipolar disorder and mental illness in general.

- It is important for your audience to be made aware that bipolar disorder is a mental illness and not a shortcoming, a sin, or a “fatal flaw.” Like any chronic illness, bipolar disorder may be devastating or even deadly if left untreated, but with proper treatment a person with bipolar disorder can control his or her symptoms and live a normal life.

- Be careful with diagnosing a character. One hit primetime show contacted EIC with a question about a character who was written as living with bipolar disorder, but whose symptoms didn’t seem specific to the disease. One of EIC’s mental health experts determined that the character may have a mental illness, but there was no evidence that the illness was bipolar disorder. The show changed the line referring to the character as having bipolar disorder in an effort not to mislead audiences. The point is, today’s audiences are sophisticated and many viewers seek out inaccurate information. If you write a character with bipolar disorder, be sure it’s that disorder and not one such as schizophrenia or major depression.

- Be very careful about terminology if your storyline involves suicide-related issues. See section VII: Suicide for important information about depicting suicide and suicide-related terminology.
Section V: Personal Stories
Personal Stories

Often, the best way to understand the human side of any health condition is to experience it firsthand, either personally or through someone we know.

This section of Spotlight on Depiction of Bipolar Disorder includes stories of real people living with bipolar disorder. As you read through them, keep in mind how stories like these could be shown onscreen.

Visit www.eiconline.org for more personal stories, as we continue to build our resource library for the entertainment industry’s creative community.

April’s Story

During her manic episodes, April lost the ability to sleep. She stayed up for days at a time. Her mania set off many other symptoms, including irritability and an inability to concentrate. April’s lack of good judgment and impulsive behavior took the form of impromptu shopping sprees. Alarmingly, during a depressive phase, she lost her appetite and dropped to a dangerously low 90 pounds. Extremely fortunate that she didn’t fall into debt or experience physical health problems, April found the help she needed and started taking medication. “To be honest, medications are what keep me stable, followed by coping skills. The meds alleviate most of the symptoms. It is my medicine that stabilizes my moods and helps me balance out. I wouldn’t make it without my medication.” With medication, April now has a healthy sleep cycle, better concentration and a restored appetite.

April believes that the news media have sometimes portrayed people with bipolar disorder as “crazy, homicidal maniacs.” Such portrayals, she says, reinforce negative stereotypes and perpetrate stigma. “Mental illness doesn’t have to be as destructive as it is. I was never violent; I never even had a single violent thought. If people in the community would become more educated and provide more support, people with mental illness could lead better and more productive lives.” Proving that bipolar disorder is indeed “color blind,” April is a young African American woman; as proof that people with bipolar disorder can lead normal, productive lives, she is now a medical researcher at a southern university. According to April, her strongest sources of support have been her mother, brother and grandmother. Family support often can be the saving grace for people with bipolar disorder or other mental illnesses because the stigma attached to such illnesses can lead to one of the least accepted types of discrimination—against the mentally ill.

Tom’s Story

During manic episodes, Tom lived the high life. At one point, he flew from Atlanta to Tampa and rented a Porsche, then flew to Toronto and went on a $27,000 shopping spree for new clothes. On a whim, Tom will hop a jet to New York, Ft. Lauderdale, St. Louis, or anywhere else that seems interesting. The problem is that Tom can’t afford his jet-set lifestyle—yet until recently, he had no control over it. Tom has been hospitalized seven times. He was diagnosed with bipolar disorder at age 40. At age 45, he moved in with his parents to avoid his only other option: homelessness. Only four years ago did doctors find the right combination of medications that works for Tom. As a board director for a mental health center and an advisor to the Montana State Board of Visitors, Tom points out that his struggles with finding the right treatment were not the result of improper medical care; in fact, the psychiatrists and counselors he saw over the years tried as hard as they could to treat him. Tom’s case is not atypical and highlights the difficulty of treating bipolar disorder. Often, effective treatment today is found only through trial and error—but treatment is
Section V: Personal Stories

possible and, when the right combination of medications is found, can save lives.

Linda’s Story

Linda owns and operates an Amish taxi service in Missouri. She was diagnosed with bipolar disorder at age 35. Her treatment includes a “cocktail” of seven psychiatric medications and visits to a counselor she started seeing 20 years ago, who lives 200 miles away. Mental illness isn’t just Linda’s problem. As with many cases of mental illness, she represents only one generation in her family suffering from a mental disorder. Linda’s daughter has schizoaffective disorder, which includes many of the symptoms of bipolar disorder. “We are still in the dark ages when it comes to social acceptance of mental illness,” Linda says. During one of her daughter’s hospitalizations, Linda’s coworkers confessed that they were uncomfortable with the situation and didn’t know what to do. “Do what you do when someone breaks a leg,” she told them. “Send a card, call and say you care, take food to the family, offer to babysit;” in other words, friends and coworkers should offer the same kind of support they would if someone they cared about had a seriously ill child.

Despite the complications that bipolar disorder has caused Linda throughout her life, she runs a successful business and has been married for 42 years—and while she and her daughter have mental illness in common, they also have each other to depend on. “I would without hesitation be willing to tell anyone I have a mental illness,” Linda says. “My real motivation for that is the fact that I have ended up having a very good life in spite of severe bipolar disorder...When I was diagnosed with a mental illness, I was devastated, ashamed beyond measure and greatly disappointed with myself because I had tried so hard to cope over the years.

“...I finally knew why my life had been a living hell for [the majority] of 35 years. I have also been richly blessed with an extremely supportive family. It hasn’t always been, and still isn’t, always easy for them to live with my illness. I want people to know there is every reason to have hope that life can be rich and rewarding in spite of mental illness.”

Patty Duke’s Story

One of America’s most beloved actresses, Patty (born Anna Marie) Duke, disclosed in her bestseller Call Me Anna that she lives with bipolar disorder. Like many people with this disease, Patty had to wait a long time—almost 20 years—before she was correctly diagnosed at age 35. During those years, Patty “ca-reened between periods of extreme euphoria and debilitating depression, [and was] prone to delusions and panic attacks, temper tantrums, spending sprees and suicide attempts,” according to her follow-up bestseller, A Brilliant Madness, which focuses almost exclusively on the Oscar-winning actress’s bouts with mental illness.

Patty’s battle with mental disorders began early. At age eight, she began experiencing panic attacks that she says made her obsess over thoughts of death. Around age 16, symptoms of bipolar disorder began to invade her life, including severe depression and hallucinations resulting from days without sleeping. Among hallucinations were “audio messages from beings who had passed on, and on rare occasions, she heard directly from God,” according to an article in the Winter 2006 issue of BP, a magazine dedicated to bipolar disorder and related issues.

Patty has said that “when you’re manic, nothing is scary. There were no conse-quences; therefore, it was perfectly normal for God to be talking to me.”

Patty wrote in her autobiography: “I don’t mind being thought of as someone who was crazy, because I had no control over that situation. What I don’t like is for people to think that I chose to do destructive things. I was someone who didn’t have a choice about my actions, yet I fought like a son of a bitch to get to a place where I could have one.”
That fight involved a lot of ups and downs—the downs including three failed marriages, public tantrums, excessive spending and instinctive self-medication in the form of alcohol abuse, which compounded her problems.

Fortunately for Patty, a psychiatrist who had seen her out-of-control behavior suggested she may have bipolar disorder. After finding the right treatment for her, Patty’s life improved vastly. In 1985, after decades of instability and thinking she was “crazy,” Patty was elected president of the Screen Actors Guild. That same year, she “came out” publicly as someone who lives with bipolar disorder.

Patty credits much of her adult success to her bipolar disorder diagnosis and the subsequent management of her mental illness.

In 1995, she published her best-selling autobiography, *Call Me Anna*, which helped open up public dialogue about bipolar disorder. She followed up with a second book, *A Brilliant Madness: Living with Bipolar Disorder*, which blends memoir and information on the symptoms, identification and treatment of bipolar disorder. Her Web site, www.officialpattyduke.com, has become an online meeting place for people living with bipolar disorder—a virtual community through which Patty is able to give others living with the disorder hope and understanding.

**Jimmy’s Story: From the Outside Looking In**

According to Jimmy, his girlfriend, Tessa, sometimes kept him on the phone until 2:00 a.m. as she cried, screamed, called him names and eventually broke up with him almost every week—only to apologize in the morning and ask for help. On the days when Tessa was energetic, she would talk quickly and constantly, buy Jimmy gifts, take him out to dinner and speed through homework and assignments from her office. “I just thought she was drinking too much coffee or some-

thing,” Jimmy says, “and she always claimed she had enough money to spend on gifts for herself and her friends, even though she didn’t make very much.” Then, she would crash into raging depression, described by Jimmy:

“She would call me crying for no reason at all, and I’d try and calm her down. It never worked—she just kept sobbing and then eventually would make crazy accusations at me. She would bring up things I did before we even dated, calling me a liar and a bad person...I ended up in therapy myself; I started to actually believe the things she said about me because she said them every time she was depressed.”

Jimmy became apathetic toward schoolwork and his job, overwhelmed by the lack of sleep and excessive emotional stress. After two years of extreme ups and downs, Jimmy convinced Tessa to seek professional help. She was diagnosed with bipolar disorder and prescribed daily medicine; since then, the relationship has begun to look hopeful. Jimmy says, “I can definitely tell when she isn’t on her medicine, because things go back to the way they used to be. But when she remembers to take her medication, things seem under control.”


Section VI: Co-Occurring Mental Disorders
Co-Occurring Mental Disorders

Symptoms characteristic of other mental disorders (especially anxiety) such as post-traumatic stress disorder and obsessive-compulsive disorder, also may be common in people with bipolar disorder.

Co-occurring anxiety disorders may respond to the treatments used for bipolar disorder, or they may require separate treatment. It is important to note, however, that although some anxiety disorders may share symptoms with bipolar disorder, or may occur alongside bipolar disorder, each is a distinctly different mental illness that requires specific treatment. Creative professionals should keep these distinctions in mind to avoid assigning misleading or arbitrary labels to mental illness.

The following pages give an overview of several common co-occurring mental disorders. The information in this section is adapted from publications of the NIMH available online at http://nimh.nih.gov/health/publications/index.shtml.

Because depictions of suicide are such a sensitive issue for the entertainment industry—studies show that depictions of suicide may increase suicidal behaviors among audiences—an entire chapter of this book has been dedicated to depression and suicide prevention. See Section VII for information about depression and suicide.

If you have any questions about approaches to treating bipolar disorder and co-occurring mental illnesses, call EIC’s First Draft technical assistance and referral service at (818) 333-5001 or contact us online at firstdraft@eiconline.org.

Anxiety Disorders

What Are Anxiety Disorders?

Anxiety disorders affect about 40 million American adults, ages 18 years and older (about 18%) in a given year, causing them to be filled with fearfulness and uncertainty. Unlike the relatively mild, brief anxiety caused by a stressful event (such as speaking in public or a first date), anxiety disorders last at least six months and can get worse if they are not treated. Anxiety disorders commonly occur along with other mental or physical illnesses, including alcohol or substance abuse, which may mask anxiety symptoms or make them worse. In some cases, these other illnesses need to be treated before a person will respond to treatment for the anxiety disorder.

Effective therapies for anxiety disorders are available and research is uncovering new treatments that can help most people with anxiety disorders lead productive, fulfilling lives.

Five major types of anxiety disorders are:

- Generalized anxiety disorder
- Obsessive-compulsive disorder (OCD)
- Panic disorder
- Post-traumatic stress disorder (PTSD)
- Social phobia (or social anxiety disorder)

Two other mental disorders often confused with bipolar disorder are:

- Borderline personality disorder
- Schizophrenia

This chapter provides thorough overviews of all of these mental disorders. If you are working on a script, character, or production that involves any of these disorders and need more information, call EIC’s First Draft technical assistance and referral service at (818) 333-5001 or contact us online at firstdraft@eiconline.org. First Draft offers free, fast, expert consultations for entertainment professionals.

Generalized Anxiety Disorder

People with generalized anxiety disorder (GAD) go through the day filled with exaggerated worry and tension, even though there is little or nothing to provoke it. They anticipate disaster and are overly concerned about health issues, money, family problems,
or difficulties at work. Sometimes, just the thought of getting through the day produces anxiety.

GAD is diagnosed when a person worries excessively about a variety of everyday problems for at least six months. People with GAD can’t seem to get rid of their concerns, even though they usually realize that their anxiety is more intense than the situation warrants. They can’t relax, startle easily and have difficulty concentrating. Often they have trouble falling asleep or staying asleep. Physical symptoms that accompany the anxiety may include fatigue, headaches, muscle tension, muscle aches, difficulty swallowing, trembling, twitching, irritability, sweating, nausea, lightheadedness, frequent need to go to the bathroom, feeling out of breath and hot flashes.

When their anxiety level is mild, people with GAD can function socially and hold down jobs. Although they don’t avoid certain situations as a result of their disorder, people with GAD can have difficulty carrying out the simplest daily activities if their anxiety is severe.

GAD affects about 6.8 million adult Americans and about twice as many women as men. The disorder comes on gradually and can begin across the life cycle, though the risk is highest between childhood and middle age. It is diagnosed when someone spends at least six months worrying excessively about a number of everyday problems. There is evidence that genes play a modest role in GAD.

Other anxiety disorders, depression, or substance abuse often accompany GAD, which rarely occurs alone. GAD is commonly treated with medication or cognitive-behavioral therapy, but co-occurring conditions must also be treated using the appropriate therapies.

**Obsessive-Compulsive Disorder (OCD)**

People with obsessive-compulsive disorder (OCD) have persistent, upsetting thoughts (obsessions) and use rituals (compulsions) to control the anxiety these thoughts produce. Most of the time, the rituals end up controlling the sufferers.

For example, people who are obsessed with germs or dirt may develop the compulsion to wash their hands over and over again. Those who develop an obsession with intruders may lock and relock their doors many times before going to bed. Being afraid of social embarrassment may prompt people with OCD to comb their hair compulsively in front of a mirror; sometimes they get “caught” in the mirror and can’t move away from it. Performing such rituals is not pleasurable. At best, it produces temporary relief from the anxiety created by obsessive thoughts.

Other common rituals include the need to repeatedly check things, touch things (especially in a particular sequence), or count things. Some common obsessions include frequent thoughts of violence and harming loved ones, persistent thoughts about performing sexual acts the person dislikes, or thoughts that are prohibited by religious beliefs. People with OCD may also be preoccupied with order and symmetry, have difficulty throwing things out (so they accumulate), or hoard unneeded items.

Healthy people also have rituals, such as checking to see if the stove is off several times before leaving the house. The difference is that people with OCD perform their rituals even though doing so interferes with daily life and they find the repetition distressing. Although most adults with OCD recognize that what they are doing is senseless, some adults, and most children, may not realize that their behavior is out of the ordinary.

OCD affects about 2.2 million American adults and the problem can be accompanied by eating disorders, other anxiety disorders, or depression. It strikes men and women in roughly equal numbers and usually appears in childhood, adolescence, or early adulthood. One-third of adults with OCD develop symptoms as children and research indicates that OCD might run in families.

The course of the disease is quite varied. Symptoms may come and go, ease over time,
or get worse. If OCD becomes severe, it can keep a person from working or carrying out normal responsibilities at home. People with OCD may try to help themselves by avoiding situations that trigger their obsessions, or they may use alcohol or drugs to calm themselves.

OCD usually responds well to treatment with certain medications and/or exposure-based psychotherapy, in which people face situations that cause fear or anxiety and become less sensitive (desensitized) to them. NIMH is supporting research into new treatment approaches for people whose OCD does not respond well to the usual therapies. These approaches include combination and augmentation (add-on) treatments, as well as modern techniques, such as deep brain stimulation.

**Panic Disorder**

Panic disorder is a real illness that can be successfully treated. It is characterized by sudden attacks of terror, usually accompanied by a pounding heart, sweating, weakness, faintness, or dizziness. During these attacks, people with panic disorder may flush or feel chilled; their hands may tingle or feel numb; and they may experience nausea, chest pain, or smothering sensations. Panic attacks usually produce a sense of unreality, a fear of impending doom, or a fear of losing control.

A fear of one’s own unexplained physical symptoms is also a symptom of panic disorder. People having panic attacks sometimes believe that they are having heart attacks, losing their minds, or on the verge of death. They can’t predict when or where an attack will occur, and between episodes many worry intensely and dread the next attack.

Panic attacks can occur at any time, even during sleep. An attack usually peaks within 10 minutes, but some symptoms may last much longer. Panic disorder affects about 6 million American adults and is twice as common in women as men. Panic attacks often begin in late adolescence or early adulthood, but not everyone who experiences panic attacks will develop panic disorder. Many people have just one attack and never have another. The tendency to develop panic attacks appears to be inherited.

People who have full-blown, repeated panic attacks can become disabled by the condition and should seek treatment before they start to avoid places or situations where panic attacks have occurred. For example, if a panic attack occurs in an elevator, someone with panic disorder may develop a fear of elevators that could affect his or her choice of a job or apartment and restrict where he or she can seek medical attention or enjoy entertainment.

Some people’s lives become so restricted that they avoid normal activities, such as grocery shopping or driving. About one-third of sufferers become housebound or are able to confront a feared situation only when accompanied by a spouse or other trusted person. When the condition progresses this far, it is called agoraphobia, or fear of open spaces.

Early treatment can often prevent agoraphobia, but people with panic disorder may sometimes go from doctor to doctor for years and visit the emergency room repeatedly before someone correctly diagnoses the condition. This is unfortunate, because panic disorder is one of the most treatable of all the anxiety disorders, responding in most cases to certain kinds of medication or certain kinds of cognitive psychotherapy, which helps change thinking patterns that lead to fear and anxiety.

Panic disorder is often accompanied by other serious problems, such as depression, drug abuse, or alcoholism. These conditions need to be treated separately. Symptoms of depression include feelings of sadness, hopelessness, changes in appetite or sleep patterns, low energy and difficulty concentrating. Most people with depression can be effectively treated with antidepressant medications, certain types of psychotherapy, or a combination of the two.
**Post-Traumatic Stress Disorder (PTSD)**

Post-traumatic stress disorder (PTSD) develops after a terrifying ordeal that involved physical harm or the threat of physical harm. Those who develop PTSD may have been harmed themselves, may have had a loved one harmed, or may have witnessed an event that harmed loved ones or strangers.

PTSD was first brought to public attention in relation to war veterans, but it can result from a variety of traumatic incidents, such as mugging, rape, torture, being kidnapped or held captive, child abuse, car accidents, train wrecks, plane crashes, bomb ings, or natural disasters, such as floods or earthquakes.

People with PTSD may startle easily, become emotionally numb (especially in relation to people with whom they once were close), lose interest in things they used to enjoy, have trouble feeling affectionate, become more aggressive, or even become violent. They avoid situations that remind them of the original incident, and anniversaries of the incident are often very difficult. PTSD symptoms seem to be worse if the event that triggered them was deliberately initiated by another person, as in a mugging or a kidnapping. Most people with PTSD repeatedly relive the trauma in their thoughts during the day and in nightmares when they sleep. These experiences are called flashbacks. Flashbacks may consist of images, sounds, smells, or feelings and are often triggered by ordinary occurrences, such as a door slamming or a car backfiring on the street. A person having a flashback may lose touch with reality and believe that the traumatic incident is happening all over again.

Not every traumatized person develops full-blown or even minor PTSD. Symptoms usually begin within three months of the incident but occasionally emerge years afterward. They must last more than a month to be considered PTSD. The course of the illness varies. Some people recover within six months, while others have symptoms that last much longer. In some people, the condition becomes chronic.

PTSD affects about 7.7 million American adults, but it can occur at any age, including childhood. Women are more likely to develop PTSD than men, and there is some evidence that susceptibility to the disorder may run in families. PTSD is often accompanied by depression, substance abuse, or one or more of the other anxiety disorders. Certain kinds of medication and certain kinds of psychotherapy are effective in treating the symptoms of PTSD.

**Social Phobia, or Social Anxiety Disorder**

Social phobia, also called social anxiety disorder, is diagnosed when people become overwhelmingly anxious and excessively self-conscious in everyday social situations. People with social phobia have an intense, persistent and chronic fear of being watched and judged by others and of doing things that will embarrass them. They can worry for days or weeks before a dreaded situation. This fear may become so severe that it interferes with work, school and other ordinary activities and can make it hard for sufferers to make and keep friends.

Although many people with social phobia realize that their fears about being with people are excessive or unreasonable, they are unable to overcome them. Even if they manage to confront their fears and be around others, they are usually very anxious beforehand, are intensely uncomfortable throughout the encounter and worry about how they were judged for hours afterward.

Social phobia can be limited to one situation (such as talking to people, eating or drinking or writing on a blackboard in front of others) or may be so broad (such as in generalized social phobia) that the person experiences anxiety around almost anyone other than the family.

Physical symptoms that often accompany social phobia include blushing, profuse sweating, trembling, nausea and difficulty talking. When these symptoms occur, people with social phobia feel as though all eyes are focused on them.
Social phobia affects about 15 million American adults. Women and men are equally likely to develop the disorder, which usually begins in childhood or early adolescence. There is some evidence that genetic factors are involved. Social phobia is often accompanied by other anxiety disorders or depression, and substance abuse may develop if people try to self-medicate their anxiety.

Social phobia can be successfully treated with certain kinds of psychotherapy or medications.

**Borderline Personality Disorder**

Borderline personality disorder is a serious mental illness characterized by pervasive instability in moods, interpersonal relationships, self-image and behavior. This instability often disrupts family and work life, long-term planning and the individual’s sense of self-identity. Originally thought to be at the “borderline” of psychosis, people with borderline personality disorder suffer symptoms related to emotion regulation. Although less well known than schizophrenia or bipolar disorder, borderline personality disorder is more common, affecting 2% of adults, mostly young women. There is a high rate of self-injury without suicide intent, as well as a significant rate of suicide attempts and completed suicide in severe cases. Patients often need extensive mental health services and account for 20% of psychiatric hospitalizations. Yet with help, many improve over time and are eventually able to lead productive lives.

**Borderline Personality Disorder: Symptoms**

Although a person with depression or bipolar disorder typically endures the same mood for weeks, a person with borderline personality disorder may experience intense bouts of anger, depression and anxiety that may last only hours or, at most, a day. These incidents may be associated with episodes of impulsive aggression, self-injury and drug or alcohol abuse. Distortions in cognition and sense of self can lead to frequent changes in long-term goals, career plans, jobs, friendships, gender identity and values. Sometimes people with borderline personality disorder view themselves as fundamentally bad or unworthy. They may feel unfairly misunderstood or mistreated, bored, or empty and have little idea about who they are. Such symptoms are most acute when people with borderline personality disorder feel isolated and lacking in social support and may result in frantic efforts to avoid being alone.

People with borderline personality disorder often have highly unstable patterns of social relationships. They may develop intense but stormy attachments, and their attitudes toward family, friends and loved ones may suddenly shift from idealization (great admiration and love) to devaluation (intense anger and dislike). Thus, a sufferer may form an immediate attachment and idealize another person, but when a slight separation or conflict occurs, the sufferer switches unexpectedly to the other extreme, angrily accusing the former friend or loved one of not caring at all. Even with family members, individuals with borderline personality disorder are highly sensitive to rejection, reacting with anger and distress to such mild separations as a vacation, a business trip, or a sudden change in plans. These fears of abandonment seem to be related to difficulties in feeling emotionally connected to important persons when they are physically absent, leaving the sufferer feeling lost and worthless. Suicide threats and attempts may occur, along with anger at perceived abandonment and disappointments.

People with borderline personality disorder exhibit other impulsive behaviors, such as excessive spending, binge eating and risky sex. Borderline personality disorder often occurs together with other psychiatric disorders, particularly bipolar disorder, depression, anxiety disorders, substance abuse and other personality disorders.
Borderline Personality Disorder: Treatment

Treatments for borderline personality disorder have improved in recent years. Group and individual psychotherapy are at least partially effective for many patients. Within the past 15 years, a new psychosocial treatment, dialectical behavior therapy (DBT), has been developed specifically to treat borderline personality disorder; this technique looks promising in treatment studies. Pharmacological treatments are often prescribed based on specific target symptoms shown by the individual patient. Antidepressant drugs and mood stabilizers may be helpful for depressed and/or unstable mood. Antipsychotic drugs may also be used when distortions in thinking are present.

Borderline Personality Disorder: Recent Research Findings

Although the cause of borderline personality disorder is unknown, both environmental and genetic factors are thought to play a role in predisposing patients to symptoms and traits of this disorder. Studies show that many (but not all) individuals with borderline personality disorder report a history of abuse, neglect, or separation as young children. Of borderline personality disorder patients, 40% to 71% report having been sexually abused, usually by a non-caregiver. Researchers believe that borderline personality disorder results from a combination of individual vulnerability to environmental stress, childhood neglect or abuse and a series of events that triggers the onset of the disorder in young adulthood. Adults with borderline personality disorder are also considerably more likely to be the victims of violence, including rape and other crimes. This may result from both harmful environments and impulsivity or poor judgment in choosing partners and lifestyles.

NIMH-funded neuroscience research is revealing brain mechanisms underlying the impulsivity, mood instability, aggression, anger and negative emotion seen in borderline personality disorder. Studies suggest that people predisposed to impulsive aggression have impaired regulation of the neural circuits that modulate emotion. The amygdala, a small, almond-shaped structure deep inside the brain, is an important component of the circuit that regulates negative emotion. In response to signals from other brain centers indicating a perceived threat, the amygdala marshals fear and arousal. This arousal might be more pronounced under the influence of drugs, alcohol, or stress. Areas in the front of the brain (prefrontal area) act to dampen the activity of this circuit. Recent brain-imaging studies show that individual differences in the ability to activate regions of the prefrontal cerebral cortex (thought to be involved in inhibitory activity) predict the ability to suppress negative emotion.

Serotonin, norepinephrine and acetylcholine are among the chemical messengers in these circuits that play a role in the regulation of emotions, including sadness, anger, anxiety and irritability. Drugs that enhance brain serotonin function may improve emotional symptoms in borderline personality disorder. Likewise, mood-stabilizing drugs that are known to enhance the activity of GABA, the brain’s major inhibitory neurotransmitter, may help people who experience mood swings similar to those evident in borderline personality disorder. Such brain-based vulnerabilities can be managed with help from behavioral interventions and medications, much as people manage susceptibility to diabetes or high blood pressure.

Borderline Personality Disorder: Future Progress

Studies that translate basic findings about the neural basis of temperament, mood regulation and cognition into clinically relevant insights that bear directly on borderline personality disorder represent a growing area of NIMH-supported research. Research is also underway to test the efficacy of combining medications with behavioral treatments, such as DBT, and gauging the effect of childhood abuse and other types of stress in
borderline personality disorder on brain hormones. Data from the first prospective, longitudinal study of borderline personality disorder, which began in the early 1990s, are expected to reveal how treatment affects the course of the illness. These data will also pinpoint specific environmental factors and personality traits that predict a more favorable outcome for treatment. NIMH is collaborating with a private foundation to help attract new researchers to develop a better understanding and better treatment for borderline personality disorder.

**Schizophrenia**

Many people misunderstand schizophrenia, often confusing the disease with “multiple personalities” or even bipolar disorder. Schizophrenia is a chronic, severe and disabling brain disorder that has been recognized throughout recorded history. It affects about 1% of Americans.

People with schizophrenia may hear voices other people don’t hear; they may believe that others are reading their minds, controlling their thoughts, or plotting to harm them. These experiences are terrifying and can cause fearfulness, withdrawal, or extreme agitation. People with schizophrenia may not make sense when they talk, may sit for hours without moving or talking much, or may seem perfectly fine until they talk about what they are really thinking. Available treatments can relieve many of the disorder’s symptoms, but most people who have schizophrenia must cope with some residual symptoms for the rest of their lives. Nevertheless, this is a time of hope for people with schizophrenia and their families. Many people with the disorder now lead rewarding and meaningful lives in their communities. Researchers are developing more effective medications and using new research tools to understand the causes of schizophrenia and to find ways to prevent and treat it.

**Schizophrenia Symptoms**

The symptoms of schizophrenia fall into three broad clinical categories:

- **Positive symptoms** are unusual thoughts or perceptions, including hallucinations, delusions, thought disorder and disorders of movement.
- **Negative symptoms** represent a loss or a decrease in the ability to initiate plans, speak, express emotion, or find pleasure in everyday life. These symptoms are harder to recognize as part of the disorder, and can be mistaken for laziness or depression.
- **Cognitive symptoms** (or cognitive deficits) are problems with attention, certain types of memory and the executive functions that allow us to plan and organize. Cognitive deficits can also be difficult to recognize as part of the disorder, but are the most disabling in terms of leading a normal life.

**Positive Symptoms**

Positive symptoms are easy-to-spot behaviors not seen in healthy people and usually involve a loss of contact with reality. They include hallucinations, delusions, thought disorder and disorders of movement. Positive symptoms can come and go. Sometimes they are severe and at other times hardly noticeable, depending on whether the individual is receiving treatment.

A hallucination is something a person sees, hears, smells, or feels that no one else can see, hear, smell, or feel. Voices are the most common type of hallucination in schizophrenia. Many people with the disorder hear voices that may comment on their behavior, order them to do things, warn them of impending danger, or talk to each other (usually about the patient). People with schizophrenia may hear these voices for a long time before family and friends notice that something is wrong. Other types of hallucinations include: seeing people or objects that are not there, smelling odors that no one else detects (although this can also be a symptom of certain brain tumors), and feeling things, such as invisible fingers touching their bodies when no one is near.
Delusions are false personal beliefs that are not part of the person’s culture and do not change, even when other people present proof that the beliefs are not true or logical. People with schizophrenia can have delusions that are quite bizarre, such as believing that neighbors control their behavior with magnetic waves, people on television are directing special messages to them, or radio stations are broadcasting their thoughts aloud to others. They may also have delusions of grandeur or believe that they are famous historical figures. People with paranoid schizophrenia may believe that others are deliberately cheating, harassing, poisoning, spying upon, or plotting against them or the people they care about. These beliefs are called delusions of persecution.

People with schizophrenia often have unusual thought processes. One dramatic form is disorganized thinking, in which the person has difficulty organizing his or her thoughts or connecting them logically. Speech may be garbled or hard to understand. Another form is thought blocking, in which the person stops abruptly in the middle of a thought. When asked why, the person may say that it felt as if the thought had been taken out of his or her head. Finally, the individual may make up unintelligible words, or neologisms.

People with schizophrenia can be clumsy and uncoordinated. They may also exhibit involuntary movements and may grimace or exhibit unusual mannerisms. They may repeat certain motions over and over or, in extreme cases, may become catatonic. Catatonia is a state of immobility and unresponsiveness. It was more common when treatment for schizophrenia was not available. Fortunately, catatonia is now rare.

### Negative Symptoms

The term negative symptoms refers to reductions in normal emotional and behavioral states. These include the following:

- Flat affect (immobile facial expression, monotonous voice)
- Lack of pleasure in everyday life
- Diminished ability to initiate and sustain planned activity
- Infrequent talking, even when forced to interact

People with schizophrenia often neglect basic hygiene and need help with everyday activities. Because it is not as obvious that negative symptoms are part of a psychiatric illness, people with schizophrenia are often perceived as lazy and unwilling to better their lives.

### Cognitive Symptoms

Cognitive symptoms are subtle and are often detected only when neuropsychological tests are performed. They include the following:

- Poor “executive functioning” (the ability to absorb and interpret information and make decisions based on that information)
- Inability to sustain attention
- Problems with “working memory” (the ability to keep recently learned information in mind and use it right away)

Cognitive impairments often interfere with the patient’s ability to lead a normal life and earn a living. They can cause great emotional distress.

### Schizophrenia: When does it start and who gets it?

Psychotic symptoms (such as hallucinations and delusions) usually emerge in men in their late teens and early 20s, and in women in their mid-20s to early 30s. They seldom occur after age 45 and only rarely before puberty, although cases of schizophrenia in children as young as 5 have been reported. In adolescents, the first signs can include a change of friends, a drop in grades, sleep problems and irritability. Because many normal adolescents exhibit these behaviors as well, a diagnosis can be difficult to make at this stage. In young people who go on to develop the disease, this is called the prodromal period.
Research has shown that schizophrenia affects men and women equally and occurs at similar rates in all ethnic groups around the world.

**Are people with schizophrenia violent?**

People with schizophrenia are not especially prone to violence and often prefer to be left alone. Studies show that those who have no record of criminal violence before they develop schizophrenia and are not substance abusers are unlikely to commit crimes after they become ill.

Most violent crimes are not committed by people with schizophrenia, and most people with schizophrenia do not commit violent crimes. Substance abuse always increases violent behavior, regardless of the presence of schizophrenia. If someone with paranoid schizophrenia becomes violent, the violence is most often directed at family members and takes place at home.

In fact, people with schizophrenia and other mental illnesses are more likely to be victims of crimes than perpetrators because the symptoms of their illnesses may make them more vulnerable to poor judgments than people who do not have mental illnesses.

**What causes schizophrenia?**

Like many other illnesses, schizophrenia is believed to result from a combination of environmental and genetic factors. All the tools of modern science are being used to search for the causes of this disorder.

**Can schizophrenia be inherited?**

Scientists have long known that schizophrenia runs in families. It occurs in 1% of the general population but is seen in 10% of people with a first-degree relative (a parent, brother, or sister) with the disorder. People who have second-degree relatives (aunts, uncles, grandparents, or cousins) with the disease also develop schizophrenia more often than the general population. The identical twin of a person with schizophrenia is most at risk, with a 40% to 65% chance of developing the disorder.

Our genes are located on 23 pairs of chromosomes that are found in each cell. We inherit two copies of each gene, one from each parent. Several of these genes are thought to be associated with an increased risk of schizophrenia, but scientists believe that each gene has a very small effect and is not responsible for causing the disease by itself. (It is not possible to predict who will develop the disease by looking at genetic material.)

Although there is a genetic risk for schizophrenia, it is not likely that genes alone are sufficient to cause the disorder. Interactions between genes and the environment are thought to be necessary for schizophrenia to develop. Many environmental factors have been suggested as risk factors, such as exposure to viruses or malnutrition in the womb, problems during birth and psychosocial factors, including stressful environmental conditions.

**Do people with schizophrenia have faulty brain chemistry?**

It is likely that an imbalance in the complex, interrelated chemical reactions of the brain involving the neurotransmitters dopamine and glutamate (and possibly others) plays a role in schizophrenia. Neurotransmitters are substances that allow brain cells to communicate with one another. Basic knowledge about brain cells and its link to schizophrenia is expanding rapidly and is a promising area of research.

**Do the brains of people with schizophrenia look different?**

The brains of people with schizophrenia look differently from the brains of healthy people, but the differences are small. Sometimes the fluid-filled cavities at the center of the brain, called ventricles, are larger in people with schizophrenia, overall gray matter volume is lower and some areas of the brain have less or more metabolic activity. Microscopic studies of brain tissue after death have also
revealed small changes in the distribution or characteristics of brain cells in people with schizophrenia. It appears that many of these changes were prenatal because they are not accompanied by glial cells, which are always present when a brain injury occurs after birth. One theory suggests that problems during brain development lead to faulty connections that lie dormant until puberty. The brain undergoes major changes during puberty, and these changes could trigger psychotic symptoms.

The only way to answer these questions is to conduct more research. Scientists in the United States and around the world are studying schizophrenia and trying to develop new ways to prevent and treat the disorder.

**Schizophrenia and Substance Abuse**

Some people who abuse drugs show symptoms similar to those of schizophrenia, and people with schizophrenia may be mistaken for people who are high on drugs. Although most researchers do not believe that substance abuse causes schizophrenia, people who have schizophrenia abuse alcohol and/or drugs more often than the general population.

Substance abuse can reduce the effectiveness of treatment for schizophrenia. Stimulants (such as amphetamines or cocaine), PCP and marijuana may make the symptoms of schizophrenia worse, and substance abuse also increases the likelihood that patients will not follow their treatment plans.

**Schizophrenia and Nicotine**

The most common form of substance abuse in people with schizophrenia is an addiction to nicotine. People with schizophrenia are addicted to nicotine at three times the rate of the general population (75%-90% vs. 25%-30%).

Research has revealed that the relationship between smoking and schizophrenia is complex. People with schizophrenia seem to be driven to smoke and researchers are exploring whether there is a biological basis for this need. In addition to its known health hazards, smoking interferes with the action of antipsychotic drugs. People with schizophrenia who smoke may need higher doses of their medication.

Quitting smoking may be especially difficult for people with schizophrenia because nicotine withdrawal may cause their psychotic symptoms to worsen temporarily. Smoking-cessation strategies that include nicotine replacement methods may be better tolerated. Doctors who treat people with schizophrenia should carefully monitor the responses to antipsychotic medication of a patient who decides to either start or stop smoking.

**How is schizophrenia treated?**

Because the causes of schizophrenia are still unknown, current treatments focus on eliminating the symptoms of the disease. The approach to treatment is similar to that for bipolar disorder—a combination of prescribed medication, psychotherapy performed by a qualified and experienced mental health professional and lifestyle changes that emphasize healthy living.

For information on approaches to treating schizophrenia and other mental illnesses, call EIC’s First Draft technical assistance and referral service at (818) 333-5001 or contact us online at firstdraft@eiconline.org.
Section VII: Depression & Suicide Prevention
Depression & Suicide Prevention

Suicide is a serious public health problem in this country that devastates families and causes tremendous stigma within communities.

Signs and Symptoms of Depression

People suffering from depression may exhibit the following signs or symptoms:

- Prolonged sadness or unexplained crying spells
- Significant changes in appetite and sleep patterns
- Irritability, anger, worry, agitation, anxiety
- Pessimism, indifference
- Loss of energy, persistent lethargy
- Feelings of guilt, worthlessness
- Inability to concentrate, indecisiveness
- Inability to take pleasure in former interests, social withdrawal
- Unexplained aches and pains
- Recurring thoughts of death or suicide

Risk Factors for Suicide

Risk factors for suicide fall into three categories: biopsychosocial, environmental and sociocultural. Some of the factors in each category are listed below. 24

Biopsychosocial Risk Factors

- Mental disorders, particularly mood disorders, schizophrenia, anxiety disorders and certain personality disorders
- Alcohol and other substance abuse disorders
- Hopelessness
- Impulsive and/or aggressive tendencies
- History of trauma or abuse
- Some major physical illnesses
- Previous suicide attempt
- Family history of suicide

Environmental Risk Factors

- Job or financial loss
- Relational or social loss

- Easy access to lethal means
- Local clusters of suicide that have a contagious influence

Sociocultural Risk Factors

- Lack of social support and sense of isolation
- Stigma associated with help-seeking behavior
- Barriers to accessing health care, especially mental health and substance abuse treatment
- Certain cultural and religious beliefs (for instance, the belief that suicide is a noble resolution of a personal dilemma)
- Exposure to, including through the media, and influence of others who have died by suicide

Suicide Warning Signs

The following warning signs are from the National Suicide Prevention Lifeline (www.suicidepreventionlifeline.org).

- Threatening to hurt or kill oneself or talking about wanting to hurt or kill oneself
- Looking for ways to kill oneself by seeking access to firearms, available pills, or other means
- Talking or writing about death, dying, or suicide when these actions are out of the ordinary for the person
- Feeling hopeless
- Feeling rage or uncontrolled anger or seeking revenge
- Acting reckless or engaging in risky activities—seemingly without thinking
- Feeling trapped
- Increasing alcohol or drug use
- Withdrawing from friends, family and society
- Feeling anxious or agitated, being unable
to sleep, or sleeping all the time
• Experiencing dramatic mood changes
• Seeing no reason for living or having no sense of purpose in life

Additional Indicators
• Picking fights, arguing
• Refusing help, feeling beyond help
• Showing a sudden improvement in mood after being down or withdrawn
• Neglecting appearance or hygiene
• Dropping out of activities
• Giving away favorite possessions
• Communicating with certain verbal clues (see below)
• Making a detailed plan for how, when, and where
• Obtaining a weapon
• Engaging in suicidal gestures (e.g., overdose, cutting)

Direct Verbal Clues
• “I wish I were dead.”
• “I’m going to end it all.”
• “I’ve decided to kill myself.”
• “I believe in suicide.”
• “If such and such doesn’t happen, I’ll kill myself.”

Less Direct Verbal Cues
• “You will be better off without me.”
• “I’m so tired of it all.”
• “What’s the point of living?”
• “Here, take this. I won’t be needing it anymore.”
• “Pretty soon you won’t have to worry about me.”
• “Goodbye; we all have to say goodbye.”
• “How do you become an organ donor?”
• “Who cares if I am dead anyway?”

Suicide and Mental Illness
Research seeks to clarify the connections between suicide and mental illness. Interesting findings include the following:
• Between 60% and 90% of suicide victims have significant psychiatric illnesses at the time of their deaths. These illnesses are often undiagnosed, untreated, or both. Mood disorders (such as bipolar disorder, borderline personality disorder, depression, and others), along with substance abuse, are the two most common illnesses.16,17,18,19,20
• When both mood disorders and substance abuse are present, the risk for suicide is much greater, particularly for adolescents and young adults.26,27
• Research has shown that when open aggression, anxiety or agitation is present in individuals who are depressed, the risk for suicide increases significantly.21,22

Research also shows that the risk for suicide is associated with changes in brain chemicals called neurotransmitters, including serotonin. Decreased levels of serotonin have been found in people with depression, impulsive disorders and a history of suicide attempts and in the brains of suicide victims.23

Preventing Suicide

What can be done to prevent suicide?
Research helps determine which factors can be modified to help prevent suicide and which interventions are appropriate for specific groups of people. Because research has shown that mental and substance abuse disorders are major risk factors for suicide, many programs focus on treating these disorders.

Studies have shown that a type of psychotherapy called cognitive therapy reduced the rate of repeated suicide attempts by 50% during a year of follow-up. A previous suicide attempt is among the strongest predictors of subsequent suicide, and cognitive therapy helps suicide attempters consider alternative
actions when thoughts of self-harm arise.\textsuperscript{25} Specific kinds of psychotherapy may be helpful for specific groups of people. For example, a recent study showed that a treatment called dialectical behavior therapy reduced suicide attempts by half, compared with other kinds of therapy in people with borderline personality disorder (a serious disorder of emotion regulation).\textsuperscript{26}

Research shows that older adults and women who die by suicide are likely to have seen a primary care provider in the year before death; thus, improving the ability of primary care providers to recognize and treat risk factors may help prevent suicide among these groups.\textsuperscript{27}

**Protective Factors\textsuperscript{28}**

Protective factors that may militate against suicide include the following:

- Effective clinical care for mental, physical and substance abuse disorders
- Easy access for a variety of clinical interventions and support for seeking help
- Restricted access to highly lethal means of suicide
- Strong connections to family and community support
- Support through ongoing medical and mental health care relationships
- Skills in problem solving, conflict resolution and nonviolent handling of disputes
- Cultural and religious beliefs that discourage suicide and support self-preservation

**Suicide and the Media**

A research article written by Dr. Madelyn S. Gould from the Division of Child and Adolescent Psychiatry, Columbia University and New York State Psychiatric Institute, states that newspapers, film, and television present an opportunity for indirect transmission of suicide contagion by portraying a compelling model for successive suicides. According to Gould, an individual may have a preexisting motivation to attempt suicide and repeated exposure to suicide-related themes might increase such a person’s likelihood of attempting suicide. Gould further states that studies within the past decade in the United States and abroad substantiate earlier research findings demonstrating that extensive newspaper coverage of suicide is associated with a significant increase in the rate of suicide.\textsuperscript{29} The amount of publicity given to a story and the prominence of its placement also seem to affect the magnitude of the increase in suicide behavior.

A research study that examined the impact of televised suicide stories on a cross-section of high school students found that students exposed to frequent depictions of suicides on television were more likely to attempt suicide.\textsuperscript{30} A strong association was also found between knowledge of a real-life suicide or frequent reporting of suicides on television and a suicide attempt.

Given the evidence and concern about suicide contagion, according to Gould, a recommended suicide prevention strategy involves educating reporters, editors and film and television producers about contagion to facilitate responsible stories that minimize additional harm. In addition, Gould emphasizes that news and entertainment media can serve a positive role in educating the public about risks for suicide and shaping attitudes for suicide prevention.

Recommendations for news reporting now exist in several countries, including the United States; however, none of these guidelines have been conclusively proven to be effective by scientific research. Gould believes in the importance of educating the media on the current state of empirical knowledge while simultaneously improving the knowledge base: “It is crucial that mental and public health professionals and the media develop a partnership to enhance the effectiveness of the reporting of suicide, while minimizing the risk of imitative suicides.”
Suicide Depiction Suggestions

The following depiction recommendations were adapted for the entertainment industry by EIC from a document originally developed for the news media entitled “Reporting on Suicide: Recommendations for the Media.” This document was the result of a collaborative effort by the Centers for Disease Control and Prevention, National Institute of Mental Health, Office of the Surgeon General, Substance Abuse and Mental Health Services Administration, American Foundation for Suicide Prevention, American Association of Suicidology, and Annenberg Public Policy Center in collaboration with the World Health Organization, National Swedish Centre for Suicide Research, and New Zealand Youth Suicide Prevention Strategy. The recommendations can be found online on the Suicide Prevention Resource Center site at http://www.sprc.org/library/sreporting.pdf.

Depicting Suicide: When Is It Worth It?

The following recommendations have been adapted from national recommendations for news media reports of suicide-related stories:

1. Consider whether depicting a suicide, suicidal thoughts, or attempted suicide is crucial to your storyline. If it is, try to be true to the character’s psychology and present warning signs and symptoms of depression and/or suicidal thoughts so that the character doesn’t seem to solve his or her problems with a suicidal act (which would increase the risk of audiences coming away with the idea that suicide can be a solution to problems).

2. Keep in mind that suicide is never a mysterious act by an otherwise “healthy” or “high-achieving” person. People who attempt suicide almost always are responding to significant life pressures, stresses, or trauma.

3. Be aware that suicide is most often a fatal complication of different types of mental illnesses, many of which are treatable.

4. Suicide always becomes a personal tragedy not only for the person who completes a suicidal act, but also for the friends, family and others who surround the suicide victim. If you are inclined to portray suicide as romantic, noble, or brave, try to show the reality that those around the person who attempts suicide will have to live through after the fact; in almost no case will their lives feel romantic.

5. Think carefully before detailing any methods of suicide in such a way that a viewer might be able to copy the act. (For example, in the case of a suicide by overdose, try not to indicate what pills are taken, or if a suicide is by hanging, carefully evaluate how much detail is shown regarding how to tie a slip knot.)

6. In most cases, the greatest humanity comes through characters who live through pain, suffering and other major life events. Depicting a suicidal act as the climax of your storyline doesn’t tell the whole story—what happens after a suicide attempt usually is more emotionally resonant than the events leading up to it. If a suicide is part of your storyline, think about moving the story beyond the completed suicide to show how the suicidal character’s death affected those around him or her.

7. Consider incorporating actual resource information in your onscreen depiction that the character may have access to and that viewers who may have suicidal thoughts can access to save themselves.

Suggestions for Entertainment Depictions

• Certain ways of showing suicide onscreen may contribute to what behavioral scientists call “suicide contagion” or “copycat suicides.”

• Research suggests that romanticizing suicide or idealizing those who take their own lives (i.e. a noble warrior or ritual suicide) as heroic or romantic may encourage others to identify with the victim.
• Exposure to suicide methods can encourage vulnerable people to imitate what they have seen. Clinicians believe the danger is even greater if there is a detailed description of the method. Research indicates that detailed descriptions or pictures of the location or site of a suicide encourage imitation.
• Presenting suicide as the inexplicable act of an otherwise healthy or high-achieving person may encourage identification with the victim.

Questions to Ask of Your Characters and Storylines Involving Suicide
• 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 suicidal thoughts are available (but underutilized)?
• Does the storyline acknowledge the deceased person’s problems and struggles, as well as the positive aspects of his or her life, to give a more balanced characterization?
• Does the audience see the realistically devastating effects of suicide on surviving relatives and friends?

A Couple of Concerns
• Dramatizing the impact of suicide through descriptions and pictures of grieving relatives, teachers, classmates, or community expressions of grief may encourage potential victims to see suicide as a way of getting attention or as a form of retaliation against others.
• Using adolescents on reality TV or in print media to tell the stories of their suicide attempts may be harmful to the adolescents themselves or may encourage other vulnerable young people to seek attention in this way.

Special Language Concerns
• Whenever possible, it is preferable to avoid referring to suicide as a selling point. Unless the suicide death was a true-life, high-profile event and the death took place in public, the cause of death should be embedded in the story, not in its promo or log line.
• It is preferable to describe the deceased as “having died by suicide” rather than as “a suicide” or having “committed suicide.” The latter two expressions reduce the person to the mode of death or connote criminal or sinful behavior (i.e., “committing” suicide is equated with “committing” a crime).
• Contrasting “suicide deaths” with “non-fatal attempts” is preferable to using such terms as “successful,” “unsuccessful,” or “failed.” Try not to use the terms “successful suicide,” “unsuccessful suicide,” or “failed suicide attempt.”

Suicide Contagion
Between 1984 and 1987, journalists in Vienna covered the deaths of individuals who jumped in front of subway trains. The coverage was extensive and dramatic. In 1987, a campaign alerted reporters to the possible negative side effects of such reporting and suggested alternative strategies for coverage. In the first six months after the campaign began, subway suicides and non-fatal attempts dropped by more than 80%. The total number of suicides throughout Vienna dropped as well.

Research has shown an increase in suicide by readers or viewers when:
• The number of stories about individual suicides increases
• A particular death is reported at length or several times
• The story of an individual death by suicide is placed on the front page or at the beginning of a news broadcast
• The headlines about specific suicide deaths are dramatic (i.e., “Boy, 10, Kills Himself Over Poor Grades”)
SOMETHING TO REMEMBER:
According to NIMH, the risk of copycat suicides can be minimized by “factual and concise” depictions of suicide, while prolonged exposure to details about suicide may increase the perceived appeal. Also, making sure to detail the complex feelings involved in suicidal behaviors and thoughts will reduce the likelihood that any viewer will interpret suicide as an effective solution to a temporary problem.

DID YOU KNOW?
Celebrity deaths by suicide are more likely than non-celebrity deaths to produce imitation. Although most suicides by celebrities will receive attention, it is important not to let the glamour of the individual take precedence over any mental health problems or drug use he or she experienced.

Depiction Priorities
We asked our Picture This experts this question: If you saw depression or suicide 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: Recognize that suicide is preventable and depression is treatable.
- Thoughts of suicide are complex. Depressed or suicidal characters will be much more believable—and, therefore, make more effective characters—if they are depicted with depth and profundity.
- There can be dramatic entertainment value to depicting characters who survive suicide attempts.
- Suicidal behaviors are not immediate: Many suicide attempts are driven by long-term depression. Think about this before showing a character who tries to solve a problem by attempting suicide.
- Substance abuse is often associated with depression and suicide. Consider the relationships between substance abuse and mental illnesses when depicting these issues.
- People can recover from depression and suicidal acts. Consider what stories can be told about people who have come through the bleakness of depression or a suicide attempt to find hope in the world.
- Antidepressants can be useful in preventing suicidal behaviors among people with major depression. Likewise, professional psychiatric care, psychotherapy, or a combination of the two can save lives. By showing characters seeking professional help when they need it, viewers will be cued to do the same. This simple depiction may save a real person’s life.

Second Priority: Recognize that suicide victims and survivors can be anyone. They come from different occupations, age groups, ethnic groups, etc.
- Some specific demographic populations are at a heightened risk for depression and suicide; however, depression and suicide can affect anyone.
- Consider showing people’s misconceptions that certain people—for example, those with plenty of money or in seemingly happy relationships—can’t possibly be depressed or consider suicide as an acceptable solution.
- Think about how one person’s suicide or suicide attempt affects other people. For example, suicide attempts always alarm friends and family and can even deepen existing depressive tendencies in certain people.
- Although anyone can suffer from depression or have suicidal thoughts, the stigma surrounding mental illness prevents many people from talking about it and seeking treatment (which could prevent suicide attempts). Consider showing how the stigma surrounding mental illness and help-seeking behaviors, even from specific cultural groups, can prevent diagnosis and treatment.
Third Priority: Show that Suicide has Consequences.

- Always try to keep in mind that the effects of a suicide or suicide attempt do not end with one person’s life. When someone attempts or completes a suicide, their death or near-death compounds the normal loss loved ones feel when someone dies of natural causes or becomes terminally ill. Suicidal behaviors involve guilt, shame, fear and other mental stresses and can result in PTSD among suicidal people and those around them.
- Think about the legacy of suicide within a family and its effect on family and friends. The family’s struggle to cope and the domino effect are often hidden issues.
- Family members, friends and acquaintances are often seriously affected by one person’s depression and/or suicidal behavior. Show how depression and suicide affect the friends and family of victims.

Fourth Priority: People—especially young adults—need to understand what to do if someone they know attempts suicide or shows signs of suicidal behavior.

- Suicidal behaviors almost always show warning signs. Such warning signs are nuances that will make your characters more interesting and realistic.
- Think about ways to show depressed or suicidal characters seeking help. These actions will model help-seeking behaviors for viewers and make it clear to faithful fans that characters, like real people, often keep looking for help even when seriously depressed.
- Although primary prevention is not easy to incorporate in a story arc, consider showing kids talking about suicide in an honest, helpful way and provide an opportunity for expert advice by another character—a doctor or other medical or psychiatric professional.
- Take into account visual ways to convey that someone is not alone. People can call suicide hotlines, seek out support groups and consult mental health professionals available for 24-hour intervention.
- Bring to the forefront the benefits of friends and support systems, especially peer support for young people.

Fifth Priority: Understand that current research can alleviate concerns about depictions.

- Be aware of the potential risks of portraying suicide: always relay information responsibly, employing resources to honor accuracy.
- Depictions can unfold slowly, which will allow viewers to understand the psychology of a character who might develop suicidal thoughts and behaviors. Alarmingly, sudden acts of suicide onscreen might convey the message that suicide is a solution to problems that can be resolved in other ways or by the healing effects of time passing.
- Horrific, detailed depictions of suicidal acts onscreen have been said to cause copycat behaviors in audiences. Keep this fact in mind when addressing depression and suicidal behaviors. Careful depictions of these issues can, in fact, inform viewers and make their lives better in the long run by showing how people might realistically cope with these real world issues in their own lives.
- Perhaps most importantly, realize that suicide is not a solution to any problem.

Special Suicide Risk Factors for Specific Populations

Information in this section is adapted from Fact Sheets developed by the Suicide Prevention Action Network and Suicide Prevention Resource Center. These Fact Sheets are available online at http://www.spanusa.org/index.cfm. Some information is drawn from publications of NIMH, available online at http://nimh.nih.gov/health/publications/index.shtml.

Risk and protective factors can vary
according to age, gender, ethnic group, or occupation and can vary over time. For example:

- More women attempt suicide; more men die by suicide.
- Eighty percent of completed suicides are by men.
- The elderly make up 12.6% of the population yet account for 16% of suicides.
- Older white men have the highest suicide rate of all age groups.
- According to several nationally representative studies, in any given year, about 5% to 7% of adults have a serious mental illness. A similar percentage of children (about 5% to 9%) have a serious emotional disturbance.

Veterans

An article in the *Journal of Epidemiology and Community Health*, found that veterans (regardless of when or which branch of the military they served) were twice as likely as the general population to die by suicide. However, National Violent Death Reporting System (NVDRS) data from 17 states show that 26% of the males who died by suicide in 2004 were veterans; veterans also accounted for 26% of the male U.S. population (according to the 2000 U.S. Census). Research indicates that Veterans Administration services are important venues for identifying and treating at-risk individuals.

American Indians and Alaska Natives

American Indians and Alaska Natives are at heightened risk for suicide compared with other demographic groups in the country, according to the SPAN/SPRC Fact Sheet.

General Statistics

- The suicide rate among American Indians and Alaska Natives was 10.84 per 100,000, higher than the overall U.S. rate of 10.75.
- Adults aged 25-29 had the highest rate of suicide, at 20.67 per 100,000.

- Suicide ranked as the eighth leading cause of death for American Indians and Alaska Natives of all ages.
- Suicide ranked as the second leading cause of death for those from ages 10-34.

Youth Statistics

- In 2001, 16% of American Indian/Alaska Native youth attending Bureau of Indian Affairs schools had attempted suicide in the past 12 months.
- From 1999 to 2004, American Indian/Alaska Native males in the 15-to-24-year-old age group had the highest suicide rate, at 27.99 per 100,000, compared to Caucasian (17.54 per 100,000), African American (12.80 per 100,000), and Asian/Pacific Islander (8.96 per 100,000) males of the same age.

Mental Health Considerations

- When compared with other racial and ethnic groups, American Indian/Alaska Native youth have more serious problems with mental health disorders related to suicide, such as anxiety, substance abuse and depression.
- Mental health services are not easily accessible to American Indians and Alaska Natives because of:
  - Lack of funding
  - Culturally inappropriate services
  - Mental health professional shortages and high turnover

Latinos

- Latinos, particularly Latina women, have a higher risk of suicide contemplation and attempts in the United States. They are more likely to have considered suicide, have a specific plan, and have attempted suicide than African Americans and whites.
- Overall, however, Latinos are at a lower risk for suicide than other groups.
- According to the Youth Risk Behavior Survey, 35.4% of Latino youth have felt
so sad or helpless that they have stopped usual activities almost every day for two weeks.

• Among those at greatest risk are students who perform poorly and experience negative reinforcement and those who experience less parent-child interaction.40,41

Asian Americans and Pacific Islanders

Members of this group seek support from Asian Community Mental Health Services (ACMHS) most often for depression, according to the organization’s report.

General Statistics

The Centers for Disease Control and Prevention (CDC) reports that, between 1999 and 2004, in the Asian American and Pacific Islander population:

• The suicide rate was 5.40 per 100,000, approximately one-half the overall U.S. rate of 10.75 per 100,000.42,43

• The highest rate, 27.43 per 100,000, was found among adult males aged 85 and older.52

• Suicide ranked as the 8th leading cause of death for all ages (compared to 11th for the overall U.S. population).52

• Elderly Asian American/Pacific Islander women have higher rates of suicide than Caucasian and African American people. For women 75 and older, the suicide rate for Asian Americans/Pacific Islanders was 7.95 per 100,000, compared to the Caucasian rate of 4.18 and African American rate of 1.18.44

Youth Statistics

• In the 12 months preceding the Youth Risk Behavior Survey, Asian American and Pacific Islander high school students were as likely as their counterparts to have attempted suicide.45

• Suicide ranked as the second leading cause of death among those 15-24 years old in this group.46

Mental Health Considerations

• According to SPAN USA50, one study found that Asian Americans and Pacific Islanders are significantly less likely than Caucasians to mention their mental health concerns to:
  – Friends or relatives (12% vs. 25%)
  – Mental health professionals (4% vs. 26%)
  – Physicians (2% vs. 13%)47

• Asian Americans do not access mental health treatment as often as other racial/ethnic groups do, perhaps because of the strong stigma associated with mental illness. The view of emotional problems as shameful and distressing may limit help-seeking behaviors. Asian Americans also may rely on family to solve problems rather than seeking professional help.48

• Asian American concerns that mental illness may negatively affect their social network and expectations of low effectiveness for treatment may keep them from seeking help.49

Betty Hong, ACMHS executive director, notes, “in many Asian cultures, the stigma surrounding mental illness is so extreme that it is thought to reflect poorly on family lineage. The association could thereby diminish marriage and economic prospects for other family members as well.

The stigma of mental illness limits education, prevention and treatment for our community. In addition, the labeling of Asian and Pacific Islanders with the false stereotype of the ‘model minority’—highly successful, well-educated and upwardly mobile—exacerbates the cultural stigma surrounding mental illness. The stigma is so great that it prevents those who may need support from seeking treatment altogether,” says Hong. 50

According to ACMHS:

For Asian women and girls, the stigma of mental illness is compounded because of the high standards placed on them.

In some traditional cultures, females are supposed to be perfect daughters, wives, mothers and nurturers, always putting others’ needs ahead of their own. For
Asian Americans, the “model minority” stereotype underscores that traditional expectation and adds the role of the perfect professional career woman and caretaker for both sets of elderly parents and in-laws.

ACMHS notes that some traditional beliefs and practices specific to various Asian ethnic groups can sometimes deter people of Asian origin from seeking help. To read more about this issue, go to http://www.acmhs.org/iris_chang_newsbrief.htm.

**African Americans**

African Americans once reported low rates of suicide, but that situation has changed in recent years, according to the National Organization for People of Color Against Suicide (NOPCAS).\(^{51}\) (See also http://www.sprc.org/library/black.am.facts.pdf.) NOPCAS offers the following facts:

- The rate of suicide for black teens ages 15-19 more than doubled from 1980 through 1995.
- On average, five African Americans die each day from suicide.
- African American female rates of suicide are 2 per 100,000, the lowest rate of suicide among minority groups and other populations.

**General Statistics**

- Between 1999 and 2004, the suicide rate for African Americans of all ages was 5.25 per 100,000, about one-half the overall U.S. rate of 10.75 per 100,000.\(^{52}\)
- Young males (ages 20-24) had the highest rate of suicide in the black population, 18.18 per 100,000.\(^{61}\)
- Suicide was the third leading cause of death for black Americans between the ages of 15 and 24.\(^{61}\)
- Black Americans have a lifetime prevalence rate of attempted suicide of 4.1%, similar to the general population rate of 4.6%.\(^{53}\)

**Youth Statistics**

- 7.6% of African American high school students reported having made a suicide attempt (vs. 8.4% of the general U.S. student population)\(^{62}\)
- 9.6% reported having made a suicide plan (vs. 16.9% of the general U.S. student population)\(^{62}\)
- 12.2% reported having seriously considered attempting suicide (vs. 16.9% of the general U.S. student population)\(^{62}\)
- More female youths than males reported:
  - Seriously considering suicide (17.1% vs. 7%)
  - Making a suicide plan (13.5% vs. 5.5%)
  - Making a suicide attempt (9.8% vs. 5.2%)

**Mental Health Considerations**

- Although surveys reveal that the rate of mental illness among African Americans is similar to that of Caucasians, evidence suggests that higher rates of mental illness among African Americans might be detected if researchers surveyed individuals in psychiatric hospitals, prisons, and poor rural communities, where psychiatric help is not readily available.\(^{54}\)
- One study concluded that most African Americans with major depression do not receive treatment: less than half of African Americans and less than a quarter of Caribbean (black) Americans with severe depression received treatment. Evidence shows that black Americans who do receive treatment get poorer quality care than Caucasians.\(^{55}\)

**Senior Citizens**

Senior citizens often go unrecognized as a group prone to suicide, yet suicide is quite prevalent in men over 65. According to CDC,\(^{56}\) suicide rates increase with age and are very high among those 65 years and older. Among males, adults ages 75 years and older have the highest rate of suicide (37.4 per 100,000 population).\(^{57}\) Most elderly suicide victims are seen by their primary care
providers a few weeks prior to their suicide attempts and diagnosed with their first episodes of mild to moderate depression.

Older Americans are disproportionately likely to die by suicide. The following statistics are telling:

- Although they make up only 12% of the U.S. population, people age 65 and older accounted for 16% of suicide deaths in 2004.
- Of every 100,000 people age 65 and older, 14.3 died by suicide in 2004, higher than the rate of about 11 per 100,000 in the general population.

Non-Hispanic white men age 85 and older were most likely to die by suicide. They had a rate of 49.8 suicide deaths per 100,000 persons in that age group.

Lesbian, Gay, Bisexual, and Transgender (LGBT) Individuals

People in this group have extremely high rates of depression and suicidal thoughts and attempts.

The bulk of reviews of the research on LGBT attempted suicide conclude that young LGBT people have a significantly higher risk of attempting suicide than heterosexual young people and that most attempted suicides among LGBT people occur during adolescence or young adulthood.

- Rates of suicide attempts (over the course of a person’s lifetime) range from 52.4% for 9th and 12th grade LB females to 29% for 9th and 12th grade GB males. (Compared with heterosexual suicide attempt rates of 4.6%, according to the National Comorbidity Survey.)
- According to a study by A. R. D’Augelli and S. Hersberger, LGBT youth were three times more likely to report attempted suicide than heterosexual youth.
- Russell and Joyner found that the risk of attempting suicide was twice as high among LGBT youth as among heterosexual youth.

Though specific numbers vary, the research generally agrees that LGBT youth face much higher levels of suicidal ideation than their heterosexual peers.

- One study found that 41.2% of gay men ages 17-39 reported suicidal ideation, while only 17.2% of similarly aged heterosexual men did so.
- Another study found that 47.3% of GB adolescent boys and 72.9% of LB adolescent girls reported suicidal ideation (compared with 34.7% non-GB adolescent boys and 53% non-LB adolescent girls).
- Remafedi and his colleagues found that 31.2% of GB male high school students reported suicidal ideation, as did 36.4% of LB female students. The proportions for heterosexual students were 20.1% and 34.3%, respectively.

In a literature review, Kitts discovered research revealing that the elevated risk of suicide attempts among LGBT adolescents is a consequence of the increased psychosocial stressors associated with being LGBT, including gender nonconformity, victimization, lack of support, dropping out of school, family problems, acquaintances’ suicide attempts, homelessness, substance abuse, depression, and other psychological disorders. Although risk factors are experienced by heterosexual adolescents, they are more prevalent in LGBT youth.

Youth

Youth suicide is a major public health problem in the United States. In 2004, suicide was the third leading cause of death among youths and young adults aged 10-24 years in the United States, accounting for 4,599 deaths. Although the overall rate of suicide among young people has declined slowly since 1992, the rates remain high. Psychiatric disorders, a history of abuse, substance abuse, academic problems, juvenile corrections involvement, and related problems are major contributors to suicidal behaviors among young people, and normal
adolescent stress alone will not lead otherwise healthy young people toward suicidal thoughts or actions. In spite of these pervasive emotions, not enough schools and communities have suicide prevention plans that include screening, referral and crisis intervention programs for youth.

In the aftermath of the mass murder of 32 students and professors at Virginia Tech University on April 16, 2007, debate unfolded about the commitment and availability of psychiatric services on campuses around the country. According to Dr. Jerald Kay, professor and chair of psychiatry at Wright State University in Dayton, Ohio, some universities and colleges are extraordinarily underserved and significant numbers of students who need treatment don’t take advantage of it, either because of stigma or lack of access.71

The prevalence of psychological problems among college youth is relatively widespread, according to Bruce Cohen, MD, an Associate Professor in the department of Psychiatry and Neurobehavioral Sciences at the University of Virginia in Charlottesville and director of its Forensic Psychiatry Residency Training Program. The spring 2006 National College Health Assessment, produced by the American College Health Association, said that 45% of students surveyed felt so depressed at some point in the school year that they found it hard to function. Nine percent had experienced suicidal ideation and 1.3% had attempted suicide.72

The student health director at Washington University in St. Louis stressed the importance of recognizing the signs of depression and suicidal tendencies and keeping the lines of communication open to divert a tragedy. “Depression and suicide are the largest health issues facing college students,” says Alan Glass, MD, director of Student Health and Counseling and a member of the American College Health Association’s Board of Directors. “Universities have realized that more and more resources must be focused on these areas.”73

**College Students**

College students have “increased incidence of depression,” according to a study from the Suicide Prevention Resource Center.74 In 2003, another study reported, “students experience more stress, more anxiety, and more depression than a decade ago. Some of these increases were dramatic. The number of students seen each year with depression doubled, while the number of suicidal students tripled, and the number of students seen after a sexual assault quadrupled.” 75

Factors that may contribute to suicidal behavior among college students include the following:

- Major life transitions, such as leaving home for the first time, may exacerbate existing psychological difficulties or trigger new ones.
- College campuses may contribute to the development of students’ stress disorders—including suicidal behaviors—as a consequence of perceived or real stress.
- Parental pressure to succeed and economic pressure to successfully complete a course of education and training in a shorter period of time may increase stress.
- Graduate students have the highest rates of suicide:83
  - Women in graduate school are at the greatest risk for suicide among college students.
  - Older students returning to school after a significant period of absence have high suicide rates.
  - Mounting financial burdens, worries about time away from careers and the workplace, and uncertainties about the future job market (especially for those pursuing research and academic careers) are additional stressors for grad students.

Consider creating PSA messages to be shown immediately after a production that addresses suicide and/or depression to offer resources and information, including Web access. EIC can connect you with experts to help craft a short message for such PSAs.
Section VIII: Resources
### Resources

**American Association of Suicidology (AAS)**
  5221 Wisconsin Avenue, NW
  Washington, DC 20015
  Phone: (202) 237-2280
  www.suicidology.org

The goal of the AAS is to understand and prevent suicide. Founded in 1968, AAS promotes research, public awareness programs, public education, and training for professionals and volunteers. AAS serves as a national clearinghouse for information on suicide.

**American Foundation for Suicide Prevention**
  120 Wall St., 22nd Floor
  New York, NY 10005
  Phone: (212) 363-3500
  Toll-Free: (888) 333-2377
  www.afsp.org

The American Foundation for Suicide Prevention is dedicated to advancing knowledge of suicide and its preventable nature. The foundation can provide writers with information and education about depression and suicide.

**Depression and Bipolar Support Alliance (DBSA)**
  730 N. Franklin St., Suite 501
  Chicago, IL 60654-7225
  Toll-Free: (800) 826-3632
  Fax: (312) 642-7243
  www.dbsalliance.org

DBSA is the leading patient-directed national organization focusing on the most prevalent mental illnesses. The organization, founded in 1985, 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. DBSA supports research to promote more timely diagnosis, develop more effective and tolerable treatments, and discover cures. The organization works to ensure that people living with mood disorders are treated equitably.

**Help Starts Here-National Association of Social Workers (NASW)**
  750 First St. NE, Suite 700
  Washington, DC 20002-4241
  Phone: (202) 408-8600
  www.helpstartshere.org

NASW’s Help Starts Here Web site provides resources, including true-life stories, that can be used to inspire story ideas. NASW also provides information on national and local resources for people looking for help.

**Institute of Medicine**
  500 Fifth St., NW
  Washington, DC 20001
  Phone: (202) 334-2352
  www.iom.edu

The Institute of Medicine (IOM) of the National Academies is a nonprofit organization that gives science-based guidance on matters of biomedical science, medicine and health. IOM’s mission is to serve as adviser to the nation to improve health. The institute provides unbiased, evidence-based and authoritative information and advice concerning health and science policy.

**Mental Health America**
  2000 N. Beauregard St., 6th Floor
  Alexandria, VA 22311
  Phone: (703) 684-7722
  Fax: (703) 684-5968
  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 more than 320 affiliates nationwide, this organization represents a growing movement of Americans who promote mental wellness for the health and well-being of the nation—everyday and in times of crisis.

**Military OneSource**
  Toll-Free: (800) 342-9647
  www.militaryonesource.com

An information and referral service available 24 hours a day free of charge to military members and their families.
National Alliance on Mental Illness (NAMI)
Colonial Place Three
2107 Wilson Blvd., Suite 300
Arlington, VA 22201
Phone: (703) 524-7600
Fax: (703) 524-9094
Toll-Free: (800) 950-NAMI
www.nami.org

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 that includes NAMI organizations in every state and in more than 1,100 local communities across the country that 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
Toll-Free: (888) 55-4COAS
Fax: (301) 468-0987
www.nacoa.org

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 mission, the organization works to raise public awareness and provide leadership in public policy at all levels. NACoA also offers educational materials to increase professional knowledge and facilitate understanding of the situations of these children.

National Center for Suicide Prevention Training (NCSPT)
55 Chapel St.
Newton, MA 02458-1060
Phone: (617) 618-2380 (or 877-GET-SPRC)
www.ncspt.org/courses/orientation

NCSPT currently has four Internet-based workshops available:
- Locating, Understanding, and Presenting Youth Suicide Data
- Planning and Evaluation for Youth Suicide Prevention
- Youth Suicide Prevention: An Introduction to Gatekeeping
- The Research Evidence for Suicide as a Preventable Public Health Problem

The online workshops provide educational resources to help public officials, service providers, community-based coalitions, and other interested individuals develop effective suicide prevention programs and policies.

National Center for Victims of Crime (NCVC)
2000 M St., NW, Suite 480
Washington, DC 20036
Phone: (202) 467-8700
Fax: (202) 467-8701
www.ncvc.org

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 experience after a crime. To achieve its goals, NCVC collaborates with local, state and federal partners to advocate for laws and public policies, deliver training and technical assistance to victim service organizations, and foster cutting-edge thinking about the impact of crime and the ways in which each of us can help victims regain control of their lives. The organization also works to provide direct assistance and resources to victims.
National Institute of Mental Health (NIMH)
6001 Executive Blvd., Room 8184, MSC 9663
Bethesda, MD 20892-9663
Phone: (301) 443-4513
Toll-Free: (866) 615-NIMH (6464)
www.nimh.nih.gov

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 on the NIMH Web site.

National Organization for People of Color Against Suicide (NOPCAS)
P.O. Box 75571
Washington, DC 20013
Phone: (202) 549-6039
Fax: (866) 899-5317
www.nopcas.com

NOPCAS was formed to curb the increasing numbers of suicides in minority communities. To accomplish this goal, NOPCAS works to provide new insights on depression and other brain disorders and to educate counselors, educators, and bereaved family members and friends. NOPCAS also shares information on coping methods, suicide prevention and interventions.

National Youth Violence Prevention Resource Center (NYVPRC)
P.O. Box 6003
Rockville, MD 20849-6003
Phone: (866) 723-3968
www.safeyouth.org

Developed by CDC in collaboration with 10 other federal partners, the resource center provides current information pertaining to youth violence that has been compiled 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.

Offive of Juvenile Justice and Delinquency Prevention (OJJDP)
810 Seventh St., NW
Washington, DC 20531
Phone: (202) 307-5911
http://ojjdp.ncjrs.org

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. The office 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. A publication of the office, “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 on the OJJDP Web site.

Substance Abuse and Mental Health Services Administration (SAMHSA)
P.O. Box 2345
Rockville, MD 20857
Phone: (240) 276-2130
www.samhsa.gov

SAMHSA is the federal agency charged with improving the quality and availability of prevention, treatment and rehabilitative services to reduce illness, death, disability, and the 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.
Suicide Awareness Voices of Education (SAVE)
8120 Penn Ave. S. Suite 470
Bloomington, MN 55431
Phone: (952) 946-7998
www.save.org
The mission of SAVE is to prevent suicide through public awareness and education, eliminate stigma, and serve as a resource to those touched by suicide. To fulfill this mission, SAVE works to educate people about the symptoms and warning signs of depression and suicidal thinking and teach intervention skills that may help prevent suicide.

Suicide Prevention Action Network (SPAN USA)
1025 Vermont Ave., NW, Suite 1200
Washington, DC 20005
Phone: (202) 449-3600
www.spanusa.org
SPAN USA is a national nonprofit organization that links the energy of those bereaved or touched by suicide with the expertise of leaders in science, health, business, government, and public service to achieve the goal of significantly reducing the national rate of suicide by the year 2010.

Suicide Prevention Lifeline
www.suicidepreventionlifeline.org
The Suicide Prevention Lifeline is a national 24-hour, and toll-free suicide prevention service available to all those in suicidal crisis who are seeking help. Individuals seeking help can dial (800) 273-TALK (8255) to be routed to the closest possible provider of mental health and suicide prevention services. Please DO NOT CALL THE LIFELINE FOR NON-EMERGENCIES OR FOR CREATIVE RESEARCH. Consider using the Lifeline 800 number in storylines that address suicide so that viewers who are having suicidal thoughts will know how to reach out for help.

Suicide Prevention Resource Center (SPRC) Education Development Center, Inc.
55 Chapel St.
Newton, MA 02458-1060
Phone: (877) 438-7772
www.sprc.org
The Suicide Prevention Resource Center supports suicide prevention by offering the best of science, skills and practice. The center provides technical assistance, training and informational materials to strengthen suicide prevention networks and advance the National Strategy for Suicide Prevention. SPRC has resources for members of the media to assist with onscreen depictions and messaging. (Go to www.sprc.org/news/pressroom/index.asp.)

“The Surgeon General’s Call to Action to Prevent Suicide”
Office of the Surgeon General
5600 Fishers Lane
Room 18-66
Rockville, MD 20857
Phone: (301) 443-4000
Fax: (301) 443-3574
www.surgeongeneral.gov/library/calltoaction/default.htm
This document introduces a blueprint for addressing suicide: Awareness, Intervention and Methodology (AIM). This approach is derived from the collaborative deliberations of participants at the First National Suicide Prevention Conference. As a framework for suicide prevention, AIM includes 15 key recommendations that were refined from consensus and evidence-based findings presented at the Reno conference.
Training Institute for Suicide Assessment and Clinical Interviewing
www.suicideassessment.com
This Web site is designed specifically for mental health professionals, substance abuse counselors, school counselors, primary care physicians, and psychiatric nurses who are looking for information on the development of suicide prevention skills, crisis intervention skills and advanced clinical interviewing skills.

Vets4Vets
4192 E. Boulder Springs Way
Tucson, AZ 85712
Phone: (520) 319-5500
Fax: (520) 325-0772
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 find peer support. The organization offers assistance to new veterans facing overwhelming emotional obstacles in readjusting to life after the hardships and horrors of war.
Appendix A: Interview
with General Hospital Star Maurice Benard
Interview with General Hospital Star Maurice Benard

“In the beginning, nobody knew what it was—they thought it was drugs, they thought it was alcohol and it wasn’t, and then they figured I was having a nervous breakdown, which I was.”

—Maurice Benard

ENTERTAINMENT MATTERS

An Interview with Maurice Benard
by David Michael Conner

Emmy®-and PRISM Award-winning actor Maurice Benard made his first appearance on General Hospital in 1993. Maurice has played Sonny Corinthos on the show since that time, with a year-long hiatus from August 1997 through August 1998. In 2003, Maurice received the Soap Opera Digest Award for Lead Actor and won his first Emmy® for Outstanding Lead Actor. He was nominated for a fifth Emmy in 2006.

In addition to his outstanding acting career, Maurice is committed to spreading the word about bipolar disorder, a mental illness with which he is intimately familiar. Maurice suffered his first nervous breakdown at age 22, and as he explains in the candid interview that follows, he was shortly thereafter diagnosed with manic depression, now more correctly called bipolar disorder.

Maurice credits award-winning former General Hospital Executive Producer Wendy Riche for supporting him through difficult times on the set, and in the interview he also talks about how, through treatment, people with mental illnesses can function as competently—and far beyond that, going by his multiple awards—as all other professionals.

Maurice has been very open about his bipolar disorder. In both magazine articles and personal appearances, he has been straightforward in discussing the difficulties that he’s been through, and encourages others to seek help if they need it. He is a spokesperson for the Depression and Bipolar Support Alliance (DBSA, formerly the NMDMA), and gave the closing address at the 2000 Annual NMDMA Conference in Boston. He was also honored with the Lionel Aldridge Award by the National Association for the Mentally Ill (NAMI) in 2001 and received the Didi Hirsch “Erasing the Stigma” Leadership Award in 2002. In 2003, Maurice joined forces with the National Mental Health Association (NMHA, now called Mental Health America) to campaign for bipolar disorder awareness with the “Do You Know It?” campaign.

Maurice carved out time around his busy shooting schedule to talk about his PRISM-winning depiction of Sonny’s struggles with bipolar disorder on General Hospital...
David Conner: Could you talk a little bit about your character and how he came to be diagnosed with bipolar disorder?

Maurice Benard: It’s tough, but I’m kind of proud of it because it’s given me strength. You know, your moods are up and down [when you live with bipolar disorder] and I have to take [medication] to keep my own moods from being up and down as well.

DC: So in developing your character’s bipolar disorder, did you face any challenges? Was it your idea, the writers’...

MB: I had been thinking about it for a while but I had forgotten about it, and a writer brought it up last year. We talked about it for awhile and I thought it would be great, but... It was amazing. It was over two months of having to go to those places... that I probably shouldn’t have gone to. It turned out to be too much because I had an anxiety attack.

DC: You had an anxiety attack from playing the character from the storyline?

MB: Yeah because... it was difficult to do that for so long.

DC: What made you finally decide to do it?

MB: It’s something that I had been wanting to do for a long time, so when they brought it up, I said, “Let’s do it!”

DC: A lot of people are really grateful for it. I know you won a PRISM Award—congratulations!—for that characterization. Being here at EIC, I’ve been on the receiving end of quite a bit of fan mail for you. We’ve gotten postcards from people and e-mails from people saying they’re so excited that you’re being recognized for this and that they’re really proud of you for this characterization. Actually, a couple people that have contacted us who are big fans of yours have said that they have bipolar disorder and the storyline really affected them.

MB: Well, first I have to say that I have the best fans in the world. They totally supported me in this. It’s great to have people who are bipolar help [others who have bipolar disorder]. It makes what I do worthwhile because I hope it helps people and hopefully educates people.

DC: As far as educating people, like you just said, what EIC does is try to give people incentive to address different health and social issues accurately, and that’s definitely something you’ve been able to do on General Hospital. How do you think seeing television shows, movies, and other entertainment addressing health and social issues accurately can actually affect the public?

MB: It’s simple. I got a letter once from someone who said that they thought that her husband was bipolar and she could never get him to get help. But, she sat him down to watch that storyline and afterwards he looked at her and he said, “I need help.” And that’s the way that you help people: You educate people because they see it right in front of them. You know, you can talk all you want, but unless someone visually sees something, sometimes they need to be forced to get help.

DC: We’ve seen over the year, as we’ve addressed drug abuse and different forms of substance abuse; and now that we’re branching into mental illness, we’ve seen how these types of depictions can powerfully affect people’s lives.

MB: For me, doing a character that’s bipolar; having bipolar disorder myself, I think you can bring more truth to what you’re doing.

DC: As far as daytime dramas go, what are
the advantages to doing an ongoing storyline?

MB: I think it’s amazing because you can almost get the plot in real time. For instance, we did a storyline with a kid who was dying of AIDS. We played it out for a year in real time and at the end of the year, he died. It’s amazing, it’s a phenomenon. You get to see so much more throughout a whole year than you would in a two-hour movie.

DC: And it seems like a lot of your fans feel that you’re really a part of their life...

MB: Yeah, especially with my character... [the fans] have been with me here for 15 years and I hate to be cliché about it, but it’s like a family; this relationship that I’ve had with my fans. It’s phenomenal.

DC: That’s amazing, and thank you again for speaking out about this.

MB: I’m happy to do it and I’ll continue to do it. It’s bigger than anything that I’ve done in my life.

DC: You’re a very strong person. I’ve got another question and if you don’t want to answer this, you don’t need to... we had a meeting on bipolar disorder, and a lot of people were talking about misdiagnosis being very common. On average it takes ten years, including several misdiagnoses over those years, to actually realize that somebody has bipolar disorder. Was your diagnosis along those lines, or how did you come to be diagnosed with bipolar disorder?

MB: For me, I had a nervous breakdown when I was 21 or 22. I was 22 when I had my big day in the mental institution. In the beginning, nobody knew what it was—they thought it was drugs; they thought it was alcohol and it wasn’t, and then they figured I was having a nervous breakdown, which I was. But even in the mental institution where I was at for two and a half weeks they didn’t really... you know, at that point it was manic depression, but they still didn’t know what it was. And then when I escaped from the hospital, I went home and about two or three weeks later, I met Dr. Charles Noonan, a psychiatrist who was phenomenal, and he right away looked at me—we talked for a little while— and he said, I think you’re manic depressive, and I said, what the... whatever it is, I’m glad I’m something. [Laughs.]

DC: Right. Having that identity...

MB: Right. And he just put me on [medication], man, and it worked for me, thank God. And then I would go off the medication and have a breakdown. So, needless to say, I’ve been on prescription medication for 15 years.

DC: It’s great that you’ve stuck with it. I was going to ask about that... it works that well for you?

MB: Yeah, it works that well. I mean, one time I went off [the medication] for almost two years and it took about that long for me to have another breakdown. And then it took eight or nine months, so I just don’t go off it now. Because, you know, I don’t want to have another problem. Now I have kids and it’s not good for them to see their father in that state.

DC: I think it’s really great for them too, that you’re able to speak so openly about it; because the stigma that goes along with it is so strong...

MB: I think the stigma’s kind of slowly going
away; now on prime time TV they are talking about bipolar disorder. My favorite primetime drama is Friday Night Lights and they talk about bipolar disorder... it’s hip. At least people are talking about it, and people are aware of bipolar. I think it’s good.

DC: That’s why it’s so important and commendable that you’ve been able to incorporate this into your character. Because that is what breaks down the stigma.

MB: I think so. I mean when I did Oprah, I don’t know how many men [at the time] said they were bipolar. Women, mostly women talked about it. For men, it’s a feeling of feeling weak and, you know, if you’re mentally ill it means you’re not strong or something...

DC: Well obviously that’s not true...

MB: No, because I’ll kick anyone’s...[Laughs]

DC: Have you learned anything new about bipolar disorder since you’ve done the characterization of it?

MB: That’s a good question... there’s something that I picked up, that I read. I get literature and I read it sometimes and I’m like “oh, I didn’t know that.” I just can’t remember [anything specific].

DC: Do you feel like your character before the diagnosis, looking at his behavior over the years, did you see signs of bipolar disorder in him?

MB: When I first started the show, I played the character as bipolar.

DC: You did?

MB: But nobody knew. You know, you do a little thing on the character—what is he like, so I figured it would be interesting if he was having these issues. And over the years, I had relationships with the writers and producers and they knew I was bipolar—I came out as being bipolar and all that—so I started writing it in, but never saying he was bipolar. My character would go to these dark sides; he’d have depression, but they never really said that was it. And then last year they decided to put a name to it. Let’s work it out. And we did it.

DC: That’s really cool... so going back and looking at older episodes, do you think those signs were probably all there?

MB: Well, when I started the show, about three weeks into the gig, I had a breakdown and had to quit the show. But before the three weeks was up, I had a scene with this girl and she was crying; telling me that she was abused by her father. When I was holding her, I had in my mind that my character was also abused. The audience doesn’t know; but that’s what I’m playing, so when I’m holding her you see these two people, one crying (the girl) and the other, Sonny (the character), was ready to blow—to start crying himself. But he didn’t. I think what happened with me was that I was holding all that in and then I had my third breakdown. The rest is history.

DC: Back to your real experiences and your real breakdowns; you’re actually commenting in a very strong way on mental illness, in general, in a professional setting. I think there’s still a lot of stigma about that. People wonder how dependable an employee can be in any setting, and I think that your openness about all of this, and the way you’re building this into your character is really affecting people. I hate to keep going back to it, but the fan mail we’ve gotten has been so moving.
MB: In a nutshell, what I’m able to say to everybody is, if you get treatment, if you’re on your medications, ... you can be successful, even if you’re bipolar; even with mental illness. Don’t let that stray you from achieving what you want in your life.

DC: Currently, scientific research is exploring that bipolar disorder, and other mental illnesses, is being termed the “creative disease.” A lot of people have been diagnosed as having this post-mortem.

MB: Yeah, people are saying that others like Van Gogh and Einstein may have been bipolar because their emotions became so heightened it led to manic episodes. I think you have to be emotional to begin with in order to get that high, so I think that’s why a lot of bipolar people are creative. I can imagine if I knew how to paint, I’d probably paint some abstract, cool stuff, but especially in a manic episode—I’d make a lot of money! [Laughs]

DC: Some people actually have taken themselves off of treatment, or refused treatment, because they were afraid it would get in the way of their creativity.

MB: Yeah, I’ve read about that many times but...[big sigh]...you know what? I’ve done probably the best work I’ve done. I won an Emmy® on medication. So I don’t believe that if I were off medication, that my acting would be better. What would happen is, the acting would be a little off. And probably I wouldn’t be able to get my lines. When I first started here, I had my breakdown and I was here. Now when I look back at the scenes I did during my breakdown, they weren’t great. My eyes were black. I looked intense. But there was a tightness to it. So I’d rather just stay on the medications.

DC: That’s a really strong statement.

MB: Some people ask me, “Did you ever think about getting off the medications for the breakdown story?” [Laughs.] I just think that’s way too Method. I don’t think that’s worth it.

DC: That sounds kind of dangerous.

MB: I was on medication and I still had an anxiety attack at the end. If I hadn’t been on medication... boy, it would have been ugly. [Laughs.]
Appendix B: Personal Calendar
Personal Calendar

The following mood-tracking chart is provided by the Depression and Bipolar Support Alliance. To download and print a copy of this chart, go to http://www.dbsalliance.org/pdfs/calendarforweb.pdf.

**Personal Calendar**

Print a PDF version of the monthly calendar for your use.

**TREATMENT AND PHYSICAL TRACKING - WEEKLY CHART**

1. Check the days you go to talk therapy and support group.
2. List your mood disorder medications, how many pills prescribed and how many you take each day.
3. List your medications for other illnesses and any other supplements you take.
4. Check the days when you have side effects. If you have several bothersome side effects, use a line for each.
5. Check the days when you have a physical illness.
6. If applicable, check the days when you have your menstrual period.
7. If applicable, check the days when you use alcohol and/or drugs.
8. Write down how many hours of sleep you got.
9. Write down how many meals and snacks you had.
10. Check the days when you did some kind of physical activity or exercise.
11. Check the days when you spent some time relaxing.
12. Check the days when you reached out to other people.
13. Check the days when you had a major life event that affected your mood. List the events if there are more than one.
14. Fill in the box that describes your mood for the day. If your mood changes during the day, fill in the boxes for the highest and lowest moods and connect them.
15. If you experience a mixed state, check the box.
16. Look for patterns. See how your moods relate to your treatment and lifestyle.
### Sample Calendar

<table>
<thead>
<tr>
<th>Talk therapy / support groups</th>
<th>Sun</th>
<th>Mon</th>
<th>Tues</th>
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<th>Your prescriptions</th>
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<td>Medication name</td>
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<td><strong>Medication A</strong></td>
<td>200 mg</td>
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<td><strong>Medication B</strong></td>
<td>15 mg</td>
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<th>Side effects</th>
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<td><strong>Headache</strong></td>
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<th>Physical illness</th>
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| Menstrual period              |     |     |      |     |     |     |     |
| check the days you had your period |     |     |      |     |     |     |     |

| Drank/used drugs              |     |     |      |     |     |     |     |
| check the days that you drank/used drugs |     |     |      |     |     |     |     |

| Hours of night sleep          |     |     |      |     |     |     |     |
| record the number of hours slept |     |     |      |     |     |     |     |

| Number of meals               |     |     |      |     |     |     |     |
| record the number of meals eaten |     |     |      |     |     |     |     |

| Hours of night sleep          | 8   | 5   | 5    | 7   | 8   | 10  | 8   |
| Number of meals               | 2   | 3   | 3    | 3   | 2   |     |     |
### Personal Calendar

#### Number of snacks
record the number of snacks eaten

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#### Physical activity
check the days you did a physical activity

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#### Relaxation time
check the days you spent time relaxing

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#### Helped others
check the days you helped others

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#### Major life event
check the day the event happened

<table>
<thead>
<tr>
<th>Sun</th>
<th>Mon</th>
<th>Tues</th>
<th>Wed</th>
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#### Mood tracking
shade the box(es) that reflect your mood

<table>
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<tr>
<th>Sun</th>
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<tr>
<td>Extremely manic</td>
<td>shade the box(es) that reflect your mood</td>
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<tr>
<td>Very manic</td>
<td>shade the box(es) that reflect your mood</td>
<td></td>
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<tr>
<td>Somewhat manic</td>
<td>shade the box(es) that reflect your mood</td>
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<tr>
<td>Mildly manic or hypomanic</td>
<td>shade the box(es) that reflect your mood</td>
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<tr>
<td>STABLE MOOD</td>
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<td>Mildly depressed</td>
<td>shade the box(es) that reflect your mood</td>
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<td>Somewhat depressed</td>
<td>shade the box(es) that reflect your mood</td>
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<td>Very depressed</td>
<td>shade the box(es) that reflect your mood</td>
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<td>Extremely depressed</td>
<td>shade the box(es) that reflect your mood</td>
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<td>Mixed state</td>
<td>check the box if you experienced a mixed state that day</td>
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Appendix C: EIC Profile: Hollywood Scribes, Producers Come to Washington
Hollywood Scribes, Producers Come to Washington

HOUSE Producer/Writer Lawrence Kaplow, JOHN Q Writer/Co-producer James Kearns, and ER Staff Writer Karen Maser represented television and film at PICTURE THIS: BIPOLAR DISORDER, an exclusive meeting of mental health experts.

EIC President and CEO Brian Dyak opened the meeting and delivered the goal of the event, “to identify the top three priorities concerning bipolar disorder so that EIC can convey these priorities to the entertainment industry’s creative community in a manner that is clear, engaging, accurate and national in scope.”

PICTURE THIS was held at the National Association of Broadcasters in Washington, D.C. NAB President and CEO David Rehr welcomed guests, inviting participants “to use this PICTURE THIS forum as an opportunity to engage in a vibrant dialogue for depiction suggestions that will increase coverage of bipolar disorder onscreen and help set a direction for the potential radio and television public service endeavors.” Rehr recently came onto EIC’s Board of Trustees, committing himself to EIC’s mission to bring the power and influence of the entertainment industry to bear on health and social issues.

Karen Maser discussed Sally Field’s recurring ER role as Maggie, Abby’s (Maura Tierney) mother who has been seen struggling with bipolar disorder over the years. Maser revealed that Maggie will return on the second episode of the fall 2006 ER season, and will be shown to be making great progress with her treatment. PICTURE THIS participants, including mental health experts and people living with bipolar disorder, were glad to hear that ER is showing a side of mental illness that almost always goes unseen: That successful treatment is possible, and that bipolar disorder is a real disease, however difficult it may be to diagnose.

“EIC’s ‘Picture This’ event was a wonderful collaborative and thought-provoking experience,” said Ms. Maser. “The knowledge, dedication and enthusiasm of all the attendees was truly inspiring. I came away with a greater understanding of bipolar disease and, as a writer, was reminded that showing the humanity of people with this disease is not only a responsibility, but an absolute obligation.” The new episode guest starring Sally Field is called “Graduation Day” and will air on Thursday, September 28 at 10:00pm Eastern. (Check local listings for other time zones.)

Lawrence Kaplow noted at the end of the meeting that he got a lot more out of it than originally expected; in fact, he said that he had taken a lot of notes and that the PICTURE THIS meeting gave him a lot to think about.

“The problem with incorporating content from health and political organizations,” said Kaplow, “is that as storytellers we tell stories, not messages. But in this type of roundtable discussion, competing messages gave rise to controversy, which was when I started to pay attention, as participants began substantiating their opinions with their own experience. And since whenever there’s conflict, there’s story, I probably walked away with four or five pretty good story/character ideas. Plus they fed me.”

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Sally Field’s bipolar character “Maggie” returns to ER on NBC. Make an appointment at the ER on Thursday, September 28 to see how things unfold.
Mr. Kaplow observed, to the approval of the experts in the room, that bipolar disorder, just like everything else in life, can be taken seriously while at the same time addressed with humor. It is not hard to imagine Dr. House (Hugh Laurie) taking jabs at the issue while at the same time treating it. Several participants at the meeting mentioned that people living with bipolar disorder are often highly functioning, highly productive individuals who may be overachievers—sometimes even comically so.

James Kearns, who knows something about health care having written JOHN Q, which, when produced nearly 10 years later, starred Denzel Washington and received great critical acclaim. Mr. Kearns shared personal stories about the process of writing and researching a movie based around health and social issues, and explained to attendees the great difficulties and great rewards that may come from it. Mr. Kearns noted that, “as a Hollywood writer, access to research is the single most critical component to my work. In order for there to be dramatic truth, a writer worth his or her salt must have access to as much factual, or in this case, psychological truth as possible.”

Because of Mr. Kearns’ devotion to health care, as evidenced by his work on JOHN Q, he was selected to serve as a member of the NIH Director’s Council of Public Representatives (COPR). The COPR advises the NIH Director on cross-cutting issues related to medical research and health issues of public interest that ultimately promote individual, family, and community health. Examples of such broad issues that the Council has been involved with include public trust in the research enterprise, public input and participation at the NIH, enhancing public awareness and education about the NIH, clinical trials recruitment issues, and aspects of the NIH Roadmap, such as reengineering the clinical research enterprise.

More than anything, PICTURE THIS participants stressed that people with bipolar disorder are, above all else, human, and that they should be treated as such as in storylines and characterizations. Writers, actors, directors and other creators should not be afraid to take risks with creating compelling depictions—but they should be attentive to the risks of self-inflicted injury that people with bipolar disorder are prone to, as well as the great achievements that they can make.

EIC will soon issue PICTURE THIS: BIPOLAR DISORDER, a report highlighting concerns voiced at the meeting, as well as providing more in-depth information about bipolar disorder, personal stories about those who live with it, and suggestions for creating onscreen depictions.

For more information about bipolar disorder, go to www.eiconline.org.
Appendix D: Mood Questionnaire
Mood Questionnaire

Diagnostic Questionnaires as Writing Prompts

We’ve all taken those quizzes in magazines: “Is He the Right Guy for Me?,” “What Dog Best Matches My Personality?,” “Will I Be a Billionaire?,” but have you ever thought of using these quizzes for character development?

Any good fictional character has a psychology as deep and complex as a living, breathing person, so why not apply quizzes to them to find out more about them?

The following quiz™ was developed as a diagnostic tool for people who suspect they might have a mood disorder, such as depression or bipolar disorder. If your character has had irrational mood swings or has binged on food, alcohol, drugs, or sex, just like any real-life person, he or she may be living with an undiagnosed mood disorder... which could open a floodgate of opportunities for conflict, drama and complexity; in other words, great entertainment.

Take the following quiz, just five questions, and you may find out that your characters (or you) could benefit from a visit to the doctor, diagnosis and treatment. Give it a try and find out how deep your character’s psychology goes.

About the Mood Questionnaire

Help your doctor make the right call, fill out this simple questionnaire.

If you suspect you may have had signs of bipolar disorder (recently or even in the distant past), this questionnaire is an excellent first step in exploring your symptoms. It’s quick, easy and confidential, and you can print out the results page to share with your doctor.

Of course, the Mood Questionnaire is not a substitute for a doctor’s judgment or advice. If the results suggest that you may have bipolar disorder, you should see a qualified health care professional for a complete evaluation for bipolar disorder.

This Mood Questionnaire, also known as the Mood Disorder Questionnaire (MDQ), was developed by Robert M. A. Hirschfeld, MD, as a tool to help doctors quickly and easily identify patients who may have bipolar disorder. The Mood Disorder Questionnaire was first published in the American Journal of Psychiatry.

This questionnaire is designed for screening purposes only and is not to be used for diagnosis.

Mood Questionnaire: Step 1 of 2

Instructions: Please answer each question as best you can. Upon completing this form, you will be able to print your completed form and take it to your health care professional.*

1. Has there ever been a period of time when you were not your usual self and...

   ...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got in trouble? Yes No

   ...you were so irritable that you shouted at people or started fights or arguments? Yes No

   ...you felt much more self-confident than usual? Yes No

   ...you got much less sleep than usual and found you didn’t really miss it? Yes No

   ...you were much more talkative or spoke much faster than usual? Yes No

   ...thoughts raced through your head or you couldn’t slow your mind down? Yes No
...you were so easily distracted by things around you that you had trouble concentrating or staying on track? Yes No
...you had much more energy than usual? Yes No
...you were much more active or did many more things than usual? Yes No
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night? Yes No
...you were much more interested in sex than usual? Yes No
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky? Yes No
...spending money got you or your family into trouble? Yes No

**Mood Questionnaire: Step 2 of 2**

2. If you checked YES to more than one of the previous questions, have several of these ever happened during the same period of time? Yes No

3. How much of a problem did any of these cause you—like being unable to work; having family, money or legal troubles; getting into arguments or fights? No Problem Minor Problem Moderate Problem Serious Problem

4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder? Yes No

5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder? Yes No

This questionnaire tool is designed for screening purposes only and is not to be used for diagnosis. *Derived from Hirschfeld RM. Am J Psychiatry. 2000:157(11):1873-5.*

To find out what your responses mean, take the online Mood Questionnaire at www.isitreallydepression.com.
Appendix E: Symptoms Check Talk Sheet
Appendix E: Symptoms Check Talk Sheet

The Symptoms Check Talk Sheet shown below was developed for patients and is available online at http://bridgetoabrightertomorrow.com/bridge/tools-and-resources/mood-questionnaire.aspx.

**Symptoms Check Talk Sheet for:**

Whenever you experience a symptom which causes you concern, record the date and describe the symptom and frequency. Bring this Symptoms Check Talk Sheet with you on medical visits to help you and your health care team discuss and address any symptoms you are experiencing.

<table>
<thead>
<tr>
<th>DATE</th>
<th>SYMPTOM</th>
<th>FREQUENCY</th>
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<tr>
<td></td>
<td>Describe the symptom in as much detail as you can.</td>
<td>Record how often you noticed the symptom on this day.</td>
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Appendix F: Questions to Ask Your Doctor
Appendix F: Questions to Ask Your Doctor

The following list of questions from bridgetoabrightertomorrow.com may be immensely useful to writers developing storylines in which a character wonders whether he or she has bipolar disorder. Keep this list handy to consult when you are creating a character with bipolar disorder.

Questions about exploring your symptoms:
1. Bipolar disorder is sometimes misdiagnosed as depression. Do you have any reason to suspect that I could have bipolar disorder—or that I may be at risk for developing it in the future?
2. I have taken a Mood Questionnaire. Can you interpret the results for me?
3. What types of symptoms should I be aware of or looking for?
4. If you think that bipolar disorder could be a possibility, what could you do to confirm the diagnosis?

Questions about living with bipolar disorder:
If I am diagnosed with bipolar disorder...
1. What types of medicines or other treatment might you prescribe for me? And what types of side effects might I face?
2. Would you suggest that I see other/additional health care professionals for bipolar disorder?
3. How often would I need to schedule office visits with you?
4. What would be the most important things I could do to stay physically and mentally balanced?
End Notes


14. Ibid.


38 Ibid.


46 Ibid.


End Notes


71 Ibid.


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