Police under Pressure

[A Donkey on the Edge]

By

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Dedication

For the Cops of NSW Australia

Acknowledgments

In a life that spans more than 50 years, it is of course possible to have ideas and thoughts that are your very own. However, often the seeds that germinate such ideas come from others; people who for instance share our journey. This sharing may be through books, or by our teachers and students, as well as simply those stories that are handed down. But the original authorship, or where we first heard it, has been lost. This is indeed a long-winded way of saying that, where I remember the source of some idea, I try to acknowledge it. Where I cannot remember, or perhaps I am unable to cite the quotation accurately, I acknowledge their gift to me here, with gratitude, and recognize all those people whose original ideas, concepts, or suggestions I have borrowed in writing this book.

Secondly, I would like to thank all the police I have had the privilege to serve over the last 20 or so years, either in my capacity as psychotherapist, mentor or friend.

Thirdly to Nicki, Robert, Bob, Jason, Esther, Andrew and Sr. Clare who helped with the original manuscript and gave me encouragement. I am always in your debt.

Finally, as I have before, I again also dedicate this work to my wife and life long partner Michele, who I know forgives me for the pace I set for myself, and at times unwittingly for her as well. I thank my children and grandchildren who give my life ultimate meaning.

Newcastle
February 2007

Foreword

This book is the fourth in the "Care of the Self" Series, and this edition is aimed to provide some guidance for those who work in policing. While police are the subject material throughout most of this book, the ideas and views it contains may be useful for all those who are regularly under psychological pressure of some sort, especially in dealing with and caring for others. Teachers immediately come to mind, but also psychologists, priests, nurses, in fact any profession that is regarded as a "calling", or vocation.

It is unabashedly a self-help book, which in itself was a challenge to write, given the plethora of books available. So what will hopefully make this book different is its simplicity and brevity. It seems to me, being an avid reader that the thickness of a book can however be off putting. When I wrote "Managing the Impact of Trauma" in 1999, some of the most positive feedback I received was from police who told me that it was the first book they had read from cover to cover! I suspect this was because it was little more than 100 pages and the chapters were short. I got the latter idea from author James Paterson. I am more than aware that when anxiety and or depression is high, concentration, and worse still, retention of material, is poor. Thus this book tries to bridge some of those issues.

While this book deals with some of the most defining issues in our lives, the treatment is intentionally short, it's also intentionally parochial, it's based after all on my experience with NSW cops, more than 2000 over more than 20 years. This doesn't mean that there isn't a lot more to be said, quite the contrary: any chapter of this book may deserve to be the subject matter of an entire book in itself.

In writing this book, I have some concern that fellow professionals will suggest that I have given a rather superficial cover to some profoundly vexing questions and issues. On the other hand, a person who may be a member of emergency services could think the material is in places complex and difficult to understand. My aim was always to produce a readable, common sense book that had an economy of jargon and was conversational rather than academic in style. I have avoided using a professional style of referencing such as "Harvard style", which could make the material

more like a text book, which it is not! Nonetheless, in respect to references, you will find a rich bibliography at the end of the book.

I think what also makes this book different to many others, is that it also contains stories of the lives of real people who have come into my life, both as psychotherapist and as an inhabitant of this planet. Thus, rather than simply give advice or instruct, the aim and philosophy of this book is also to share knowledge.

The final difference this book has possibly from others is that there is a realm of spirituality interwoven in all the ideas, stories and suggestions proposed, especially see Chapter 6 “Bill’s Story”. I think this helps the book to be more than just a text or another popular or “new age” psychology. It is my intention that by synthesising these two elements, i.e. of human psychology and spirituality, (not be confused with religion), that this volume will be, hopefully at least, in your life, in a category somewhat of its own.

Sans Dieu Rien

Preamble

I have been fortunate to have eight grandchildren, which means that these days our family sees a return to some healthy fun films. In one cartoon film, “Shrek”, there is a scene where Shrek is pushing his faithful donkey to the limit and the donkey replies, (without quoting verbatim), “don’t push me, I am a donkey on the edge”. This phrase became the title of a “narrative” a police officer (Jason) wrote for me. He was struggling with his mental health at the time. Jason, like most police I treat as part of psychotherapy, was asked to write an account of his life journey, in narrative form. Almost invariably, everyone gives their narrative a title; his was “A donkey on the edge”. In this book I certainly will talk further about narratives and being on the “edge”. I thought the title Jason gave his journey or narrative epitomised so many of the stories I have read, and I just couldn’t resist it. I am indebted to Jason for the idea, and thus the title to this book.

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Chapter 1

On Joining

"When I was younger, so much younger than today I never needed anybody's help in any way". Beatles (1963)

I am a psychologist and have been in private practice for more than 20 years. Having been retrenched from my position as psychologist at the local university in 1984, I considered my options, and decided that I should put my craft to good use by entering private practice. It is an interesting irony that I spent the first 5 years of my professional life teaching something I had never formally practised. I yearned for some practical experience. The local phone book in those days had three entries under "psychologists" and only one of those was a full time therapist. Today, there are three pages of entries! Does this say something of the entrepreneurial nature of psychology, or more about a community that struggles with its emotional wellbeing, or perhaps both? It's interesting that there are some statistics which suggest that unhappiness, or so called "depression" is keeping pace with and directly in proportion to, our GDP (Gross Domestic Product).

In any case, in just 20 years we have seen the phenomenal rise of psychology in Australia, especially protocols like Employee Assistance Programs. Probably we all need to get help at some stage of our lives, so, despite my misgivings about our sometimes over dependence on pills and therapy, in this book, at least, I certainly don't intend to suggest that psychology doesn't have an important role, when it clearly does. I believe it stands shoulder to shoulder with other helping professions, often with matters in common, e.g. psychology and medicine, psychology and law enforcement, psychology and teaching, to just name three complementary disciplines in the wider context of the helping professions.

Of course more people are seeking help, even though promoting this against negative mindsets about mental health still continues to face challenges; projects such as "the Black Dog Institute"

and “Beyond Blue” are very helpful in combating this. In the foreword to this book I pointed out that it is written for those in the “calling” vocations, indeed the rescuers, those who people go to in time of need. In respect to us getting help, there is an often-asked question, “who helps the helpers?” This book goes someway to addressing and answering this question.

1. Why Join?

If you are reading this and your not a police officer, but in a vocation such as teaching, then most of what follows still remains quite relevant, because I think why we do anything depends on a number of situational factors and of variables. My wife is a psychologist and we have five children, two of them are psychologists, another is married to one. This is hardly just by chance; there are, of course, any number factors, including family, that may cause a person to choose a vocation, or as we so often say “following in the footsteps”. Also there are factors of opportunity, personality, “chance”, (read fate), and monetary reasons including issues of security. For the profession of policing, power and influence may be attractive. This list is probably not endless, but I will add one more aspect, i.e., “synchronicity”, and appended to that, of course, a favourite of mine, destiny.

I just happen to believe that our lives are anything but chance. I am certainly not a reductionist who believes that every simple action by humans is set in some pre-ordained order; I certainly believe in the concept of free well. Yet I am persuaded there is an overall plan. Thus it’s easy to get drawn into what has been philosophically a long fought debate, i.e. predestination vs. total free will. As indicated earlier, this book sometimes takes a spiritual path that at times can take us too far away from the subject matter. I hoped not to do that too often when I started out writing this book, by the end of reading it you will see that I failed a number of times.

So, in short, what am I saying is that major decisions like joining the police don’t happen just by chance, there is an element of destiny. Now, it’s true that many have told me that they always wanted to be a police officer, others said that they joined because a mate joined, while others said that they really did think that they could make a difference; from my perspective, all fine motivations. Few ever say the words “I had a calling”. Yet in retrospect, after careers of 20 years, many see it as just being that. In fact, it’s a somewhat ironic statement when police say they are “in the job”, as police refer to their employment, when policing is anything but just a job. This belief in

one's vocation, as we will see later, is a critical component, but perhaps also predictive, of professional burnout.

Well motivated, as well as hopefully well skilled, even having jumped a few hoops with the "trick cyclist" (psychologist), a fitness test and a criminal check, young men and women (sometimes older these days), find themselves, at least in my state of NSW, Australia, at the Police Academy which is in Goulburn. The courses have changed over the years from being very brief (12 weeks) to quite complicated and lengthy, even university orientated training. It is not the interest of this book to discuss whether one approach is better or not. Both have created monumental success stories and, of course, abject failures. Ultimately, like a soldier, I think it all counts for very little unless the training stands the test of battle. In operational duties, Charles Figley refers to this as "Civilian Combat".

However, I do want to make some comment on the notion of the "vertical slice" selection philosophy, and that is that while this is a useful non-discriminatory approach to recruitment. I have found that some of the officers who have seen me and been subsequently prematurely discharged, apart from being smart, honest and likeable, did not actually have the temperament to serve in the expected role of an operational police officer. Moreover this is dynamically ever changing, and the desirable attributes of recruits seem to vary over time.

Likewise, there is a double edge sword that, in the issues of protecting discrimination and political correctness, has sometimes, perhaps too often, placed the safety of the officer or colleagues at risk. Moreover, in often-desperate attempts by way of political interference to increase the number of police, there has been a trade off between getting the numbers graduated, and ensuring that the skills acquisition and minimum criteria of competence are not sacrificed.

Opponents of such opinion would probably suggest that, instead, improved recruiting and more attractive conditions have created this increase in police numbers, but this is not the experience of the recipients, i.e. in local area commands (LAC). The critical problems of recruiting someone that may not have the temperament, psychological resilience and physical strength to be a police officer, is that it not only affects the ability of the police force to do its job, but may place these often

vulnerable people at both psychological and physical risk down the track; in short, there is some foreseeability of harm.

As I may say several times in this book, this is not my story as I have never been in a police force. I have, however, taught police on several occasions the Police Academy, an opportunity I might say I relished. However, in seeing so many police, now in excess of 2000, for counselling, mentoring or therapy, I have developed some ideas and I would like to share a few of those in the next few paragraphs, and of course in the chapters that follow.

Most institutions, whether the police or military, even schools, who offer live-in training programs seek to induct the recruit or novice into that particular institution's way of thinking. My wife's boarding days at a Catholic college in the 1960's give testimony to this as many of her behaviours, and indeed attitudes, so often find their roots back there in those convent days. In 1986, when I travelled overseas to study police, I visited many agencies, and despite some cultural differences I found there were similar behaviours and attitudes, making police unique and separating them from the very communities they serve. Is there one police officer in the western world who is unable to identify with the police in Joseph Wambaugh's books, "The Choirboys", or "The Onion Fields"? Despite those books having been written over 30 years ago and set in North America, there are undoubtedly common characteristics among police from all communities and all ages.

By way of a short detour this example may explain how, as an outsider, I saw the situation, at least in the 1980's. In 1988 I was in Napa Valley California presenting a paper to over 400 police present. At the opening, which was filled with pomp and ceremony, the convener introduced himself and started by saying "My fellow officers as everyone in the world knows there are two sorts of people in the world, police officers and?" With that the audience stood as one and shouted, "Assholes".

Yet there is often a resentment of this view. Challenging it, and suggesting there are massive cultural, generational and social changes that make police so different today. Yet book after book is published that give evidence to a continuing culture. Esther McKay's book released in 2006 "Crime Scene", indicates that the police experiences in 1976 and 2006 have some commonalities despite

the massive operational, scientific and legislation changes over the last 30 years. Yet, agreeably there have been some changes that have created substantial angst. I will discuss this in the next section.

2. Two Paradigms Collide

Yet from time to time there are major changes in how police may operate, as well as technological advances that alter the capabilities and operational role of how police serve and protect. One major organisational shift and change in pedagogy happened in NSW in the mid 1980's. Later, I will suggest that perhaps in NSW even at the time of writing this book the tension that was continuing to cause considerable unrest was, the clash of two quite different, and at times incompatible cultures. The first of these was from an earlier paradigm, the second from what may be viewed as an emerging paradigm of policing. While not entirely accurate, a quite obvious demarcation in terms of a time scale is in respect to those officers enlisted prior to, and after, 1988, (both with incidentally quite different entitlements in terms of employment rights and benefits – see Chapter 8). Not quite without coincidence in the mid 1980's, there was also a shift initiated by a more academic focussed Commissioner, John Avery. This change was misunderstood by some as being some mere parochial initiative but it was, in fact, part of more world wide change, and in part caused by a failure by the tax base to fund the future, i.e. more with less.

In NSW, now even some 20 years later, this unrest between the two cultures continues. A recent conversation I had with an Assistant Commissioner probably summed it up pretty well when he said, "I wish all the pre 1988s would just retire." I pointed out to him that he was a pre 1988 enlisted officer; he just replied, "You know what I mean".

Indeed, I think he felt he was being hamstrung in his region by the problem of recalcitrant, regressive and uncooperative officers, who were firmly entrenched in the past but, as you will see later, these police are certainly more than just malcontents. In fact, it is treating these officers as malcontents and reactionaries that causes only further friction and disharmony. For the most part, you see, these officers were simply trained to play by different rules. They also were burdened by

so-called "non core business issues" of other government agencies and departments; mental health and truancy are good examples.

So it's not my point to suggest that this indoctrination of police has continued uniformly over decades. Indeed, any applicant would now find the training and the culture quite different to, say, someone who joined in 1986. There has certainly been some "baton carrying", from the past into the new paradigm, because ultimately police are still formed into a body of people who understandably need to rely on each other. The need to be a team never changes, nor does of course the principles in training for "war".

3. Training

In training police for this civilian kind of war, I recently asked in a paper (Peters 2005) the following question; "does police training in fact pre-dispose police officers to PTSD, (Post Traumatic Stress Disorder)?" I originally got this idea from some comments by Nick Fothergill, a counsellor with the Vietnam Veteran Counselling Service (VVCS), a war veteran himself, as well as a clinical psychologist. Nick suggests that the military training that recruits undertake can predispose soldiers to PTSD (see "You are not in the Forces Now", 2000).

Fothergill suggests that it is well understood that the basic response of humans, as with other animals, is the so-called "fight, flight and freeze" reactions. While understood probably for hundreds of years, (I think Plato 400BC understood it) in the modern era the work of Hans Selye 70 years ago comes immediately to mind. Selye termed this phenomenon as the "General Adaptation Response or Syndrome," (GAS). What Fothergill suggests is that the soldier's training is aimed to ensure that two of these responses, i.e. the flight and the freeze response, are excluded from the soldier's repertoire whenever facing threat.

In short, soldiers are trained not to avoid the enemy, not to freeze in combat situations, but always to fight. It is the soldier who is ultimately trained to "close with the enemy and kill them"; (Infantry Training Pamphlet Volume 4 1969). Indeed it is the soldier who is trained to be "hyper-vigilant", which is, of course, a therapy in which a primary characteristic of PTSD is described. Fothergill

goes on to say that this military programming to fight is achieved by the time basic training (6 weeks) is concluded. Ultimately, the training is designed to ensure that the soldier will make the best response under battle conditions. Thus, the seemingly pointlessness of parade ground drill is better understood and makes sense. A well drilled soldier acts instantaneously to a command. It is my contention that this experience of training to "fight" is not limited to just the armed services, but is also a terminal objective of police training. Perhaps our police academies are not as regimented as military establishments, or like some of the police academies found in North America, but, nonetheless, obedience and instantaneous response to command is the ever present focus of this type of paramilitary training. A point raised here by an officer's opinion I value, when reading this replied:. "The difficulty lies in the "para" part". He further indicated that "policing involved life threatening situations one minute, followed by the need to be caring and understanding at a break - in the next, just 15 minutes later". I accept this, and pondered what our peacekeeping forces are exposed to, and I especially relate this to those soldiers I have worked with from theatres such as Namibia, Rwanda, Timor and Somalia, to name some more recent engagements.

Given this, and Fothergill's insistence that PTSD can be primed in this way, it needs to be understood that perhaps our own police are like their military counterparts, already predisposed to this condition by virtue of their training. What is also interesting, of course, is that police respond to almost all situations with the "fight" response, and this training can take precedence in many aspects of their life. They are trained to win in every scenario and of course, as I will talk about later, their gun is the last resort. Thus, it is not surprising when they are treated badly or harshly by the Department, they respond with aggression and anger. Many partners in families report this aggression, and often say to their police partners "don't treat me like one of your criminals".

Later in this book, when issues of trauma are better developed, I suggest that there may be an increased predictability in the acquisition of PTSD among police, especially when their lives are constantly in the alert or fight condition for what Charles Figley calls "civilian combat". Importantly, police training teaches the individual to harness the fight response at the exclusion of other alternative strategies. So it is not surprising that part of the syndrome that accompanies PTSD is a type of burnout phenomenon that Figley again refers to as "compassion fatigue", or when there is "no fight left in him". So many police confirm this experience, and, in addition, they often say they

feel that they have "lost their nerve". I suggest it's perhaps more that they have, in fact, got their nerve back, but more of that later. For others it can also include the inability to fully empathise, and instead cynicism too often takes over. Later I will suggest that cynicism, along with depression, are the two principle and core issues in cases of professional burnout.

4. Indoctrination

Two principle elements are indoctrinated by way of training: (a) an instinctive response as indicated above; and (b) feeling part of and belonging to a culture. The latter is achieved by a multitude of rituals, totems and language, as all humans have done for centuries. We produce, as indeed does any other academy, enthusiastic, committed and "bullet-proof" officers; the sense of pride of then being able to drink "on the other side of the bar" after graduation. Soon after, as a probationary constable, the seduction by a veteran begins on the officer's first posting, who will show him or her the ropes, explaining "how it is really done", as opposed to "the bullshit they taught you down there", (the Academy).

Young men and women, and more frequently more mature recruits, are then hitting the stations with gusto, and I remember, in one case, an officer told me that he "hated 12 hour shifts", because he explained he had so much time off and he preferred to be at work. I have never heard that from a 20-year veteran, in fact, quite the opposite.

Part of that indoctrination process includes the process of developing loyalty. In the past, this ingrained strength of character has sometimes caused officers to lie and cheat on behalf of others, because there is nothing you wouldn't do for your family, is there? In more recent years, but particularly since the "Wood NSW Royal Commission into Policing", this has been acted upon, and these actions are now regarded as misplaced loyalty, and subsequently have been well publicised; the punishment in some case has been excessively harsh.

While I may offer no excuse in the moral sense, it must be understood that this "looking after one's mates" is a critical element of loyalty for those who face combat. The downside of this is that sometimes the lines of honesty become blurry and compete sometimes, or are traded, for success.

I am sure this so often explains why some good men and women do bad things. This over emphasis on the loyalty and so-called "thin blue line", while it was never going to be completely a thing of the past, is certainly promoted differently these days, especially in what I referred to earlier as the emerging paradigm of policing.

5. Integrity at All Costs

Today the emphasis is on integrity at all costs, which often can mean, as the saying goes, "putting your mate right in it". Then of course, the down side of this is that the new culture tends to be paranoid and mistrusting. This has had an enormous impact on morale, part of which impacts upon the promotional system, and this undoubtedly has been the cause for even more discontent and, in some cases, plain simple rebellion among NSW police officers. Again, at the time of writing this book, morale seems to be suffering as a consequence of what seems to be unfair promotional systems, and the perception that you get on only if you are prepared to "put your colleagues in it".

This tension is no greater than between the earlier and emerging paradigms of policing, where the officers not only have a different view as to how policing should be done, but even more importantly the common belief by a large majority, that if you are a committed and dedicated officer, then that loyalty at some time will be reciprocated; a bank of credits if you will. This has turned out for so many to be not true and it is not reciprocated at all. The difficulty is that such a belief finds its aetiology in the early days of training at the academy. "If you do the right thing by us, we will do the right thing by you". In police talk, sadly, too many find out 20 even 30 years later it was all a "furphy".

Again, in reading this, another police officer whose opinion I value said, "You are expecting loyalty from an organisation, which by definition is unable to show this emotional trait". It was a good point, but there is in organisational psychology the notion of "emotional intelligence"; that is, that while organisations can not show emotions, like love, affection, hatred, etc, they can nonetheless act in an emotionally intelligent way. This would mean that they identify the needs of their people at an emotional level and create a culture where such affirmation is the currency of behaviour. I think by

the repeated examples historically of the NSW Police not responding to the needs of its people, in some cases outright betrayal it, has at times acted quite unintelligently.

In the next chapter I want to talk about the allostatic load of policing, i.e. the demands of the psychological type that are inherent to the vocation of policing.

Chapter 2

Trauma and Its Accumulation

"The trouble with this job is that it rips your heart out"
Det Superintendent Walker: "Trial and Retribution – the Lovers": Lynda LaPlante, (2005)

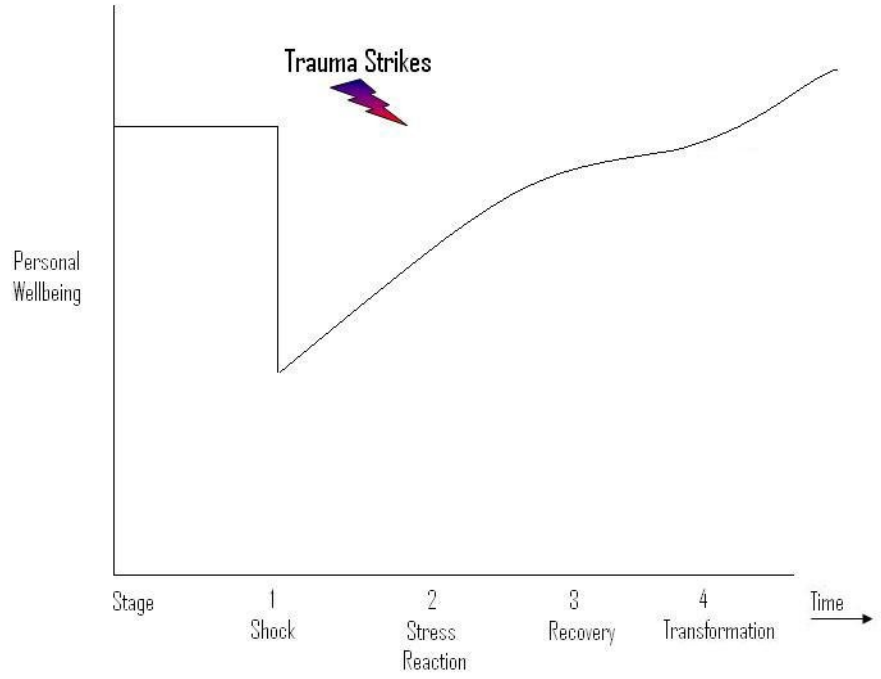
When I first wrote this chapter, I thought that it was probably too early to get down to the nitty gritty, but then that is what this book is about, i.e. being under pressure. There are all types of pressure police officers encounter; many of these have to do with administrative issues, leadership and simply dealing with a huge bureaucracy. For instance, police are probably more accountable than any other employee in Australia and have a number of agencies they are accountable to. Not least of this is dealing with the political agenda of the day, as well, as of course, with interference on a daily basis, and where the separation of powers seems just an academic item from the past. Some in fact say it is this stress more than actual policing that causes the excessive demands on our officers. Yet the work itself does of course bring its own sense of tragedy and emotional cost: Experiences that undoubtedly impact on any officer's life and, as I shall suggest later, their family as well. In this chapter I want to specifically talk about trauma, or "critical incidents" as they are sometimes referred to, and the possibility that for police these can often cause an accumulative effect that may become so great a burden on them that they question whether or not they can actually "soldier on".

The Basics

Originally, when I planned this book, I was going to take a sequential journey into policing from the very start, i.e., recruitment, to the end, whether that was through retirement, medical discharge or simply resignation. Yet the theme of this book is about "being on the edge", or under pressure. So rather than explain where this pressure comes from, which for some readers would be self evident , I want to talk more about trauma, specifically the type of trauma and how it may affect police, as so evidenced in the lives of the hundreds of cops I have seen.

In writing this chapter, I thought that perhaps I could lift something out of a past paper or even the book I wrote, "Managing the Impact of Trauma". In even thinking this I felt the guilt of laziness. Since I wrote that book in 1999, we are still learning every day more about the nature of trauma and how it impacts on humans. In fact I will be the first to admit that by the time you are reading these words science will have changed our view yet again. Also, while there has been so much written about this subject, I want to try and provide a view more orientated to the layperson. Not of course to over-simplify it, but to hopefully make it more understandable and a little less convoluted as so often it can be in scientific literature.

The word 'trauma' comes from the Greek and means "wound". So often associated with physical injury it has nonetheless a specific meaning to anyone who has become "undone", (distressed) by a significant critical incident (s). It's been said that 97% of people who are traumatised in fact recover. Often this occurs over a relatively short period of time, (not as quickly as shown in the movies), but so often in quite a short time frame, perhaps days, weeks at the most. In fact I have included here a graph that depicts this journey from trauma to recovery adding the additional factor of "transformation", which I will talk about later in this book.



In the above paragraph you will note the importance that personal well-being plays. The better a person's coping resources, or resilience, will normally predict not just that the trauma will be well managed but such psychological strength will dictate in some cases the speed of recovery. The importance of developing and maintaining psychological poise and the critical role of resilience is extensively discussed in Chapter 10.

How is a traumatic event described? It is said that it is any event or series of events that are life threatening to one's physical or psychological integrity, or even that of another. In this way an earthquake, or a tsunami are both by definition traumatic. Trauma can be based on a single or multiple events over a very short or acute period of time, such as a bank hold-up, or otherwise prolonged such as in combat operations. Traumatic events in Timor, Iraq and the Solomon Islands are good examples of continuous exposure and to multiple critical incidents; the Vietnam War was yet another.

Secondly, traumatic events expose our sense of vulnerability. Thus if a life threatening event happens to another person and we are in proximity to them, (sometimes referred to in legalese as "proximal cause") it may impact on us. We may think, "It could have been me". Perhaps in some circumstances like this a person may experience "survival guilt", i.e. "it should have been me!" or "why couldn't I stop this?" I have found some soldiers traumatised for years by the shooting of a mate, even though "the mate" went on to survive and recover not just from his physical wounds but also those wounds that are more psychological in nature. In short, the primary victim "moved on" as the saying goes, while others continued to suffer. This ties in very much with my experience with our war veteran population.

The third factor is that trauma confronts us as not being in accord with our sense of "justice". My mother-in-law died at 89 years of age, while sad and as you might expect, we used the phrase "she had a good innings". On the other hand a child killed by a drunk driver seems so unjust and unfair – in such circumstances it makes it more than just grief, it makes it of course traumatic.

How trauma and its impact affects us is not as predictive as it may at first seem. I say this because it is obvious that when several people are exposed to the same traumatic or critical incident, there is a significant variance in response, but also the duration over which the critical incident impacts upon one individual compared to another may substantially vary as well. Yet you will see that on the earlier graph "time", while important, is simply one of the dimensions.

Science suggests that 97% of people recover following exposure to trauma but this is based on the more general population. Recent research in 2006 indicated that just 6% of those involved in the destruction of the Twin Towers in New York went on to suffer PTSD. Given the cataclysm of such an event, the authors remind us of how naturally resilient humans actually are. Most people I know have never experienced such an event of anything like "September 11", and in any case would be lucky to conjure up more than half a dozen events in a lifetime that could meet the full criteria of a traumatic incident. Sure people die and that can be traumatic, but the grief process is separate yet again and should not be confused with the more unusual event of trauma and being traumatised.

There needs to be some separation, for instance, between those who have been traumatised and the event of trauma, as not all traumatic events lead to traumatisation. Again there is for those who are experiencing traumatic stress an almost mantra saying among psychologists, i.e. that a reaction of grief is a normal response to a normal, even if an unfortunate, occurrence, while traumatic responses are normal responses to a highly abnormal event.

Police by the nature of their work of course confront traumatic incidents not just 6 times or 7 times in a lifetime, but for many as often as 6 times or more a week! I propose that this has an accumulative effect. As research suggests that the number of emergency service workers that go on to develop PTSD is more like 20%, it is thus some 6 -7 times more likely than found in the general population. Given that the stereotypes, of the "warrior" or "rescuer" form the body of our emergency services, a high morbidity rate may be seen as even more confronting and dramatic.

In the landmark precedential case of Fairfax County Vs Mottram (Lindahl 2005) the notion of accumulative trauma was successfully argued. The defence pursued an argument that claimed that post-traumatic stress disorder, (the inability to fully recover from trauma), must be caused by an

identified single catastrophic event. The applicant, a fire chief (Mottram), argued that his PTSD was due to an accumulation of events, and moreover he could not particularise where "the wheels fell off". He could of course recall when he went off work, but it was unlikely that the final incident caused his final incapacitating level of distress. While a contemporary event, it was little more than just another incident, but as you might expect, though, it was the proverbial straw that broke the camels back! An officer described it to me as follows, "my hull just kept gathering weed from each job then a tiny thing just pulled me under".

Furthermore, and I will take this up later, his counsel argued that PTSD was not just a paradigm or a simple disorder, but a disease, because there is evidence to suggest that there are significant changes in brain architecture. This idea of actual brain changes is not new, and a wonderful psychologist Basel van de Kolk was prolific in researching this area more than 20 years ago. In particular he studied the locus ceruleus, or the brain's "smoke detector". Interestingly, this structure is found in the limbic system, which is of course the seat of our emotions. You may see immediately the connection, between say our sense of smell and emotions. This is a critical reflex and one in fact that allows us to survive and protect ourselves from harm, but more of that later.

Mottram's arguments were upheld, i.e. the cause in his case was an accumulation of traumatic events which led to a diagnosis of PTSD. Furthermore, it was in fact a disease of the mind! This decision has changed the way many now view trauma, and I hope that along with that the next few paragraphs will do the same for you.

2. Common Myths and Misunderstanding of trauma and its impact

Myth 1

Only the weak suffer from traumatic responses.

Fact 1

Trauma is actually a physiological reaction where the so-called "symptoms" are in fact normal physical reactions (dictated by the endocrine and limbic systems) to what are abnormal events. It is true that the impact trauma has can vary between individuals. The reality is that the level of impact

in someway is connected to resilience, (see the earlier graph and especially the principle components of human resilience, i.e. the individuals' coping resources).

I have encountered police who had attended the most gruesome of scenes and yet be seemingly unaffected, or simply just shocked: many simply recover almost immediately. Whereas, on the other hand, even seemingly lesser events others experience in a catastrophic way. In such circumstances the victim may be treated by others with suspicion, or even worse, considered malingering, (in police speak that is "shonk") with the comment being made that, "it was no big deal" or even worse "just get a grip". Obviously there are subtleties in traumatic or critical events that can only be interpreted by an individual and within the context of their own lives. A police officer who is also a father undoubtedly may be more likely to be traumatised by the death of an infant than say perhaps an officer without children. The problem of identifying with the victim is a major factor in determining whether or not the person may be more or less traumatised, certainly a factor as to whether they go on to develop some posttraumatic syndrome.

It is true of course, as indicated above, that the more resilient the person is then the better equipped they will be to manage not only their traumatic events, but also to manage stress more generally, sometimes referred to as "allostatic load". Obviously if a person feels drained, emotionally empty, even burnt out, then continued exposure to traumatic events can only have a deleterious impact on their psychological wellbeing. This is not however a sign of weakness, yet any inability to cope is too often used in a pejorative manner ("if the kitchen's too hot"). In fact hitting the so-called "wall" says very little about the strength or general weakness of the person, but instead illustrates how we need to better understand the impact, eroding nature and complexity of traumatic events on an individual's ego strength, often referred to as ablative armour, i.e. it simply wears away.

It also needs to be understood that a high level and frequent exposure to traumatic events such as those that police may regularly experience, may not just lead to subsequent psychopathology, but it subsequently leaves the individual up to nine times more likely to be re-traumatised, and in fact increases the chances of relapse. This was eloquently expressed in a report I read by a psychologist from HealthQuest (the state government's advisor on matters of health), when she

said, “This officer is no longer fit for operational duties, as there is some foreseeable risk of relapse”. Sometimes the adage “what doesn’t break me makes me stronger”; isn’t always true!

Of some interest is that the comment from the psychologist indicated in the previous paragraph affirms the permission clients have to get better. To explain, you see there are times when there may be an agenda by a person suffering from psychological ill health to stay unwell and thus avoid returning to the “frontline”. For some war veterans the need to stay unwell may in fact ensure their continued pension. How does a person get really well in such circumstances? Perhaps, like the ungrateful leper in the “Life of Brian” this is explained when he said, “bloody do-gooder, he’s taken away my whole livelihood; you think he could have at least left me with a limp!” In the determination mentioned above the psychologist insightfully suggests that despite the fact that the patient had recovered from his previously poor psychological health, he was in fact still unfit to return to operational duty due to the high risk of relapse. That final part of the determination importantly emphasises that his employer then had a duty of care (because of the foreseeability) in such circumstances, not to place him at risk again.

Myth 2

The more serious the event, the more likely the trauma will cause long lasting effects.

Fact 2

As tempting as this myth is, and as much as common sense may make it seem evident, this is not necessarily true at all. Perhaps to explain this I could use a personal example here. My daughter, a nurse, was fascinated by the murder some time ago, where the victim was “skinned” and decapitated, and the victim’s skin left hanging on a door. (Incidentally, of the three cops first at the scene only one suffered longer-term effects, albeit his condition was delayed some 5 years and only triggered when he read about it and himself in a published book on the murder). This was probably the most gruesome murder in the history of my local region. Yet people like my daughter had an interest not for its gruesomeness, or a morbid curiosity, but because of its clinical interest. Do you see how perceptions, rather than simply the event itself, are critical here?

It has been pointed out to me that my daughter wasn't actually there and perhaps she would have had a quite different reaction had she been, say, first to the scene! While this is true, the facts of the matter are that if gruesomeness is a criterion then everyone who experiences a gruesome situation, even first hand, will be adversely affected in the long term, and that is not consistent with what happens. Let me explain perhaps why this may seem to be the case. It is not unusual for an officer who suffers the effects of accumulative trauma to be asked, "Tell me of the worst traumatic experiences that you have had". Not surprisingly this question implies that somehow a person's condition in respect to post traumatic stress can be explained by a series of events in order of gruesomeness. This is not what I have discovered in therapy, although later I will suggest that the seriousness of such events need to be taken into account with a view that is just plain common sense.

Perhaps I can explain this better by an illustration. A 63-year-old officer saw me some 5 years after he had retired. He had not recorded his traumatic history, but was seeing me because he was worried by intrusive thoughts, which had been more regular in recent times. I enquired as to what the theme of these thoughts was. He said that the most prominent of these involved a particular scene. He explained that 20 years ago he attended an accident where an 8-year-old girl had been killed by a truck when she was crossing the road. He recalls seeing her then, and later in hospital where, he said she seemed "peaceful" with a rose in her hands. A tragic and pathetic scene, but you see these were not the basis of his intrusive thoughts, but instead the doctors and nurses who were standing helplessly crying, certainly not gruesome but most definitely as I said tragic.

The failure for events to cause a unilateral response in everyone disposes of this myth quite adequately. It is true that the gravity of the event may be one factor in why a police officer can go on to develop PTSD, but not the sole reason. The problem is that if an organisation for instance accepts this myth it may lead to the inappropriate treatment of police officers. For instance, Critical Incident Stress Debriefing (CISD) was introduced into the NSW Police Force, in about 1987-88. Whether a CISD was conducted originally depended on a list, i.e. included in the "Commissioners Instructions" [Section (23)]. This outlined the types of critical incidents where debriefing had to be mandatorily conducted.

Yet such lists can expose a poor mindset that in some way there is some objective scale of "seriousness" in respect to traumatic events that allows them to be arbitrarily and independently gauged. Here the point that in fact I am making is that critical incidents are very much subjectively experienced, and I suggest that police have their own unique and highly personal list, not just in respect to the traumas they are exposed to, but how particular critical incidents more or less affected them. However, in counselling officers, many feel that to isolate a particular event is unrealistic and talk of their multiple exposures and as I mentioned before the accumulative effect that can lead to a complex form of pathology

Myth 3

Traumatic stress is simply a psychological reaction and people should just get over it.

Fact 3.

It's true that most people recover from traumatic stress, but such a myth that suggests that it's only a psychological reaction betrays a lack of understanding among other things of psychoendrochrinology. To be frank, I don't expect most to understand the complexities of the endocrine system. However when the symptoms that accompany traumatic stress are examined, there are four domains, not just one, which together influence how we experience traumatic stress. These include:

a) Emotional Reactions

These are often experienced as intermittent changes in one's emotional state. These include strong and unfamiliar feelings such as;

* Repetitive and intrusive recollections of the event (flashbacks), not only of images of the event but also a reliving of the emotions, causing distress and anxiety.
* Nightmares concerning the event itself or similar themes such as death, danger or feeling out of control.
* Apprehension about the recurrence of a similar event.
* Emotional numbness and fluctuations.
* Feelings of panic, anxiety, depression and anger.

(b) Psycho-physiological Reactions

These reactions include changes in bodily responses;

* Heightened arousal, hypersensitivity and nervousness
* sleep disturbances including insomnia, disturbed or poor quality sleep
* Loss of appetite, gastrointestinal upsets.
* Muscle tension problems - headaches, fatigue and exhaustion.

(c) Cognitive Effects

Often thought processes and mental abilities are affected for some weeks afterwards. These can be manifested as;

* impaired concentration
* Short term memory problems
* Impaired perception, decision making and judgment
* Preoccupied thoughts

(d) Behavioural and Interpersonal Effects

Various changes are commonly observed in the victim's behaviour and their relationship with others. These involve:

* Restlessness and irritability
* Apathy and disinterest and poor motivation.
* Social withdrawal
* Alcohol and or substance abuse

Incidentally, many of these symptoms are explained by an understanding of the various glands of the endocrine system, sleep disturbances implicate the pineal gland, difficulty concentrating, agitation involve the pituitary gland, similarly depression. The adrenal glands account for anxiety and fear. Lowered "T" cell production of the thymus may of course lead to ill health. So, as you can see, while we most definitely experience significant psychological reactions following traumatic stress, there are in addition some profound physical symptoms. The trick of course in assisting recovery is to alleviate these symptoms and so return to normal. This normalcy is referred to as "homeostasis" or simply put, balance or, psychological poise. In an interesting study Greg Wilkins (2006) suggested that trauma throws out the cerebellum, which is responsible for integrating fine-tuning and also fine motor co-ordination. In a novel experiment, he had people complete a number

of balancing exercises (eg standing on one foot with the eyes closed), and found a remarkable improvement in wellbeing and a significant reduction in symptoms for those diagnosed with PTSD. As odd as this may seem at first glance, similar results have been achieved with the use of a particular discipline of yoga.

I think it's safe to say that while the mysteries of how trauma affect us in all of these four domains indicated above remains at times puzzling, there are of course numerous theories, all of which are worth listening to, but no absolutes: To think there is in any case a teleological explanation is a myth.

In concluding this section I would say that there are a number of other myths not included in this chapter. The notion of traumatic responses is as old as human kind; it's not a new phenomenon, but one better understood, recognised and certainly talked more about in recent times. Trauma will strike all of us at some stage in our life, some more often than others. It involves physical, psychological, emotional and behavioural changes in how we think and react. However with some useful strategies such as talking it through, maintaining a fitness regimen along with a healthy and strong optimistic attitude, most people, including police manage these adverse effects, and while the world seems topsy turvy for a while, in the fullness of time, we do return to normal.

3. But what happen when the noises in my head don't stop?

As indicated above there are times when a full recovery doesn't follow a traumatic event and some become "stuck". After 12 weeks of persistent symptoms the psychiatric nomenclature suggests the patient may meet the criteria for Post Traumatic Stress Disorder (PTSD). For the clinician the criteria are simplified to just three features. The first is hypervigilance, where typically the patient is experiencing clinical levels of anxiety. This may include emotions such as anger and or behaviour such as hyperactivity, phobias and obsessional behaviours are also noted. PTSD is fundamentally a condition of anxiety. Whereas the initiating anxiety may be a normal response to an abnormal event if it persists and fails to fully ameliorate over time, a diagnosis may be warranted. For my professional colleagues reading this chapter, I do not intend to complicate my explanation with references to Acute Stress Disorder (ASD).

Thus a war veteran who still has profound anxiety 30 years later, especially in the absence of there being a war and no longer a soldier, may be said to meet the first criteria, as I said in such circumstances they are regarded as being stuck. What confuses us a little is the fact that many who suffer from PTSD have a "triggered" form of it. There seems to be two types here, where a person at first appears to be symptom free for years and then there is either (a) sudden; or (b) gradual onset. Typically in (b) there may have been some evidence of symptoms for some time, which perhaps close friends and relatives may notice, even if the patient doesn't. Their family and friends may say later when the person actually publicly speaks out, "you haven't been yourself for a long while". The reason for this delay is complex and there are a number of psychobiological theories.

One explanation may be, especially for older war veterans, is that their lives may have been hitherto a process which has allowed the process of repression to occur and their busy lives have provided a diversion. Coming home from a war, but with a young family, a home and a career to build, traumatic events that were experienced may be pushed aside. Retirement, or older age may give the opportunity to reflect. For my own part I think it has to do with our developmental path, i.e., that in older age, we become firstly a little wise, (I never met a WWII Veteran who wasn't a pacifist), but also I suggest our resilience somewhat diminishes with age, for instance anxiety actually increases as we get older! Subsequently if PTSD is a condition of anxiety, then it's not surprising we see the delayed onset among not just our police, but war veteran population as well. I will discuss this again later.

The triggers can be obvious such as the case of the veteran who had worked in the Atlantic Ocean in WWII, retrieving bodies from sunken ships, who had a triggered response, (and was later diagnosed with PTSD) by seeing on television the more recent sinking of the Russian submarine, then some 60 years later! Or another client of mine who served on the HMAS Voyager in the 60's which sunk after a collision with the HMAS Melbourne who had no symptoms for 40 years, until he saw on television a news flash of the supply ship the Westralia catching fire with lives being lost. Again symptom free for nearly 40 years! Yet from that trigger he experienced the typical and indeed full brunt of symptoms consistent with PTSD including panic and social phobia.

The second criterion of PTSD is intrusivity of thought. It is of course absolutely normal for a person who has just been traumatised, to ruminate and even have flashbacks of the event. These may be auditory flashbacks where they seem to actually hear the noise created at the time of the trauma, or a smell and even imagine they are back there again. However in time this should pass, not just because of time but in particular after the person has had a chance to have more and more "sleeps" the event should fade (the particular role of the REM or rapid eye movement phase of sleep in resolving trauma and grief will be discussed later). So over time the emotional salience of the event for most should lessen. Our memories are in fact only distressing when they are tagged to our emotions. The strongest memories we all have (good or bad) are those with powerful emotions. The bane of the PTSD sufferer is that they have not just strong intrusive memories, often years after the event, but memories that force them to think in tears, often leading to repeated breakdowns. A simple dictum: if there are no emotions then there has been no traumatic experience. Thus when our emotions fade, so too our memories of traumatic events, they become less frequently intrusive and, more importantly, less significant.

Intrusive thoughts (and emotions) come to us quite involuntarily and so often without warning. They are frightening and cause us to often re-experience the trauma again and again; leaving us feeling that it will never go away. This is exactly what I referred to earlier as being "stuck".

The third criterion of PTSD is that of avoidance. It's normal in the first few days to want to avoid the scene or places that might remind the survivor of the terror and horror of a particular event; we need to feel safe again. Bank officers who return to work the day after a robbery would undoubtedly do so with some fear and trepidation. Of course it's again simply a normal expected response, which in time (and of course the absence of further bank robberies) will heal. The power of being safe again, as a positive reinforcement, cannot be under-estimated. However, this is the kernel of psychotraumatology and our understanding of how a normal response may become pathological. If a person is profoundly traumatised, aside from recording the event in a structure of the brain, (I refer here to the limbic system), there is a hard-wired imprint of this so as to remind us that life can be dodgy and risky. This is not just in respect to a specific situation and circumstance where the

trauma occurred, but a powerful reminder that similar circumstances could be likewise risky. In fact in this way trauma is a useful survival mechanism, making us aware of our vulnerability.

However, if this warning is overly generalised it may become problematic. To explain, say a teller in a bank is robbed; they need of course to remember that men with balaclavas and guns are dangerous. But what if this is over generalised and instead of just being frightened of people with guns, they become suspicious of everyone? The person is then not just fearful of the teller's box, but then the bank, and then more generalised to the shopping centres and so go on to develop agoraphobia where they cannot even leave their own home! This is a hyperbolae of simple avoidance and, sadly, too common an experience of PTSD sufferers!

There is an additional and even further interesting phenomenon in respect to this criterion of avoidance. Trauma occurs to people, thus people more generally can be then seen as the primary source of potential conflict. The avoidant response is one strategy for a person who suffers from PTSD. This may explain why so many who suffer PTSD tend to become withdrawn and isolated. Simply put avoid people avoid conflict. Conflict causes anxiety, anxiety is the root cause of PTSD, and thus the process of avoidance is reinforced, because it leads to a reduction in anxiety. Paradoxically of course, it's actually contact and reaching out to people that is one important component or the panacea. It's not unusual for war veterans to become isolated from the community. During a recent war veterans' course, which had several men with PTSD as participants, I asked during the "ice breaker session", among other questions; "who would you like to be marooned on a tropical island with? Many said just themselves, several said "and a fishing rod"! I think even in that trivial game, their inner fears of others and conflict was betrayed.

So too with police, they avoid. Not surprisingly, this includes their work. They also isolate themselves from their families. They become increasingly anxious and avoidant and, in so doing, I think at least in their minds, remove themselves from an environment where they don't have to "deal with it any more". The downside of this is that in being isolated there is even a greater chance of rumination and talking themselves deeper into their neurosis. [Moreover this undoubtedly impacts adversely on those around them]. While their diminishing self esteem and self worth then deleteriously impacts on them, and in turn further reduces their ability to cope. [They may be then

ostracised by the people they care about the most, i.e. other police, or in the case of armed forces, other veterans.]

Two further issues in respect to the development of this pathology are (a) the adverse additional impact of co-morbidity and (b) the problem of co-dependence. Co morbidity simply means an illness that goes with another. For instance, 60% of marijuana users are said to have some co morbid mental health condition, usually either depression or psychosis. Among amphetamine users it's 71%! Among PTSD sufferers the three most frequently found co morbid conditions are substance abuse, (primarily alcohol), anxiety based conditions and depression.

Anxiety is no surprise because PTSD is, as I mentioned earlier, ultimately an anxiety based condition. In fact no anxiety, no PTSD. However, the anxiety at the source of PTSD can further develop to include panic disorders, the phobias, the obsessive compulsive behaviours and, of course, Generalised Anxiety Disorder, (GAD). These anxiety conditions are caused by the over stimulation of the physiological systems that govern our activity patterns. Thus blood pressure, poor sleep patterns, as well as poor concentration may all be outcomes as well. I am tempted to spend some time explaining the psychobiology of this, but I think it's more of an interest of my own than it would be for most readers. However there is a more recently discovered phenomenon that gives some insight into the complexities of PTSD and anxiety conditions.

It's well understood that cortisol and a hormone from the adrenal gland are responsible for the stress response. For instance, a recent study, to be published while writing this book, found that a group of stressed women in the first trimester, when compared to a non-stress group, found 50% miscarried compared to the non-stressed group. Stress was measured by elevated levels of cortisol. Interestingly, common sense would then suggest that PTSD sufferers who have an excess of stress or anxiety would have elevated cortisol levels. However, recent research has suggested that it is in fact the opposite, that cortisol among PTSD sufferers is in fact depleted! There is of course a quite complex technical explanation that I could include here, but instead I refer you to my web page, www.heas.com.au. I have written a review article in respect to this paradoxical phenomenon. I make mention of it here to suggest how complex the neurobiology is in respect to

PTSD. Anxiety is nonetheless a frequent co-morbid condition of PTSD. In some cases it presents often almost out of control, even to the point where hospitalisation may be necessary.

Alcohol is a useful substance to calm us down in times of stress. However it in itself is a depressant and the more we use the more we need over time to get the same effect. Thus, the development of dependence is easily understood. Alcohol will cause what George Everly, a world authority on PTSD, said was the "dampening down affect". In short ,it reduces the hyperactivity brought about by PTSD and brings some solace, albeit for just one or two hours. Alcohol and self-medication, in fact using any drug to deal with anxiety, is patently dangerous. It's easy to understand how so many cops and indeed war veterans start to develop an over dependence on alcohol. Moreover alcohol so much mimics psychopathology, it then becomes difficult to see, and it often masks what is in fact the problem. Importantly, as most medications used in the treatment of conditions of anxiety do not mix with alcohol, the answer for most is to be found in abstinence. In fact, I know of some psychiatrists who will not see patients if they continue to drink.

Depression: imagine if you will, a person who was unhappy, not for days, but years. A person who is angry a good deal of the time is not happy. It's impossible to be relaxed and stressed at the same time. I mentioned earlier that our bodies have a clever process of homeostasis, or restoring of balance. What do you think happens when a person is unhappy for a long period to that process? Simply put, it is just possible that you may adjust psychobiologically, as if being unhappy was the norm. In psychology we refer to this as "set point". We know we learn to get fat; we also learn to get blood pressure! I want to propose we can learn to get depressed. I realise that current science suggests depression is caused by a chronic drop in serotonin from the pituitary gland, but what causes that drop? Simply put when I am happy I have a buoyant mood and serotonin is responsible for that, when I feel sad, there is a consequential drop in serotonin levels and even for some time, but afterwards there is a return to balance. In this way Serotonin is responsible for governing our appropriate moods in response to exogenous and endogenous information. But what would happen if you were low or depressed all the time? You see I think current thinking suggests that you may retrain your pituitary to regard this depressed mood as a normal state of affairs. Subsequently, serotonin drops permanently and, simply put, the set point is readjusted. Then even when you wish your mood would improve it resists as if you now see the world through what I refer

to clients as "grey coloured glasses". I think it's the chronicity of the PTSD response, the unhappiness of the sufferer that predictably so often leads to the co-morbid condition of depression. I think this is why there have been some successes in treating PTSD with anti-depressants.

This is singularly the most frequently found co-morbid condition and by assisting in elevating mood changes, and thus improving perception, the person will be helped to move on. Medication in this way can provide a better mind environment in which to engage in psychotherapy.

Co-dependence: I want to say that this is a frequently found phenomenon among families. PTSD can be experienced by those without PTSD, by simply having a relationship with someone who does. This is the circumstance where a person who has a level of psychopathology "infects" others, and they too develop some level of anxiety or similar pathology themselves, referred to as "Le folie au deux". I am in fact going to discuss and develop this further in Chapter 8 in respect to relationships and in the last chapter of this volume, i.e. on resilience. For now, it's sufficient to simply suggest that when one person suffers from a psychological condition, such as PTSD, it can become a significant problem for entire families. Many family members eventually experience not the actual behaviour and difficulties associated with PTSD like their suffering partner or parent, find nonetheless find an adverse impact on their own health and psychological wellbeing. What, for instance, are the implications for a partner who stops being a lover but becomes instead a carer? What are the implications for the future of a marriage based on intimacy, when one partner is austere, seemingly aloof and has no interest in lovemaking? Importantly, it's clear that conditions like PTSD are not just an individual's problem, but a couples or families concern. In fact I have written a paper "PTSD and Partners" just recently, and I have included this as an appendix. Some of the views may seem to some quite controversial, but when there is an option to save a marriage or savage a career, I recommend choosing the former.

In the next chapter I will explore the interventions that can lead to an improved chance of recovery from trauma. Then in Chapter 4 I will discuss a particular treatment protocol that is efficacious in the treatment of conditions such as PTSD.

CHAPTER 3

Getting Help and early interventions following traumatic and stressful events.

"And now those days are gone and I am not so self assured, I need to change my mind and open up the door!" The Beatles 1965

I want to start this chapter by relating to you a short story: A prison officer came to see me some years ago. He hobbled into my room. I asked him if he had trouble with his feet (that's the thing about us psychologists, we are terribly insightful). The officer told me that he did and that his organisation had recommended he wear a running shoe that they had placed on order.

About a month later he came to see me for a second visit. His problems incidentally were not directly related to his problems of podiatry, but in respect to a particular trauma that occurred while working at a local prison some weeks before. But again on this occasion he limped into my room and I enquired as to the running shoes that we previously spoke about. He told me that they were still on order and, he added quite indignantly, that he still hadn't received them. I then asked why he just didn't go to the local shop and buy himself a pair. He told me that "it wasn't his responsibility".

You may be amazed by the self harm that such an attitude had, but I have found this so commonplace, not just amongst police officers, but amongst many employees who simply refuse to reach out to get available help when they really need it. I think there is a belief by all of us that justice is naturally provided, when in fact it often has to be sought out. Of course, adjusting this mindset requires some significant and further cultural change. Part of the problem is, how do you explain to someone who is "bulletproof" during training, and even for some years after, that they may need help one day? However, if there is to be a paradigm shift, the message has to be simple and repetitive. In fact this message, of the importance of getting help early and reaching out, is the reason for writing this book.

This may seem an odd way to start this particular chapter, but I think it is important because what this chapter aims to do is emphasize that help is almost always in fact available, but, if you require it, you have of course to be motivated to go out and get it. As I say in one of my courses, you have heard the commandment "love your neighbor as yourself"; another commandment could be "let your neighbor love you". In short, the reaching out process is an important part of self responsibility, not just making things easier on your "feet", but certainly in respect to mental health. However, I understand, probably as well as anyone, that when someone is feeling anxious and depressed, that person may develop a substantial level of learned helplessness. This in fact regularly proves to be a major barrier to many getting the help that they should.

In the NSW Police, with whom I am familiar, I suspect the availability of various agencies to assist police are similar to those in others within Australia. Later in this chapter I want to focus on three particular initiatives: These are (a) peer support; (b) critical incident stress debriefing; and (c) employee assistance programs (EAPs). Before discussing these three important initiatives I would like to discuss the principle services available to police. I will use, as I have throughout this book, NSW Police as a model.

The NSW Police, in 1987, recruited their first psychologist. It is difficult to believe that in the face of most agencies in the western world having psychology sections prior to that time, the NSW Police had none. In fact, the first psychologist, John Raue, was appointed following a study tour that I completed that was in part sponsored by the NSW Police. I returned home to point out that all the agencies that I visited had active, and for that matter pro-active, psychology sections while NSW, having one of the largest police agencies in the world as I said, at that time had none.

Thus, the development of the psychology branch in the NSW Police has a history of less than 20 years. It's important to understand that it was formed at a time when any matter relating to stress or anxiety was treated with great suspicion. Indeed, as you might imagine, the section itself had trouble asserting itself in such a culture. However, today with several psychologists now employed, and the handing of the psychological baton down through four chief psychologists, the section has developed into a credible and well experienced team. However, due to the level of under-funding and under-resourcing, the NSW Police Psychology Branch does not enjoy a particularly good

reputation among police. This is not through any direct fault of their own but, I would suggest, again bound more to cultural issues of distrust. The psychologists I have met over the years have all been credible, well meaning, and highly professional, as well as generally motivated people, yet the police I see are quite critical of them. On the positive side, over the years their reputation has improved, even if still a long way to go.

I think this perhaps negative view of the psychology branch has developed more from the poor regard that the police have for their organization as a whole. I will mention more of this when talking about critical incident stress debriefing and the effectiveness of such programs as the EAP.

Psychology Branch is responsible for fitness for duty reports, and should an officer be concerned about his/her level of fitness, then the Psychology Branch might be the point of first contact. They are also involved in providing wellness programs such as alcohol and other drug education, as well as healthy lifestyles. The psychology section coordinates other activities that are necessary to ensure the psychological wellbeing and betterment of serving members.

Along with the Psychology Branch, and within the scope of welfare, is Welfare Branch. In addition, there are several rehabilitation coordinators located through the state. In the case of rehabilitation coordinators, their responsibility is, in the main, to coordinate rehabilitation rather than simply initiate it. In more recent times this has been achieved with some assistance by private rehabilitation agencies that have been contracted to assess and provide services for injured officers, (commonly referred to as outsourcing). Few officers understand the process or their entitlements.

It is important for police to understand that they do not have to work with the assigned rehabilitation provider; they can choose their own. This will vary slightly, based on whether you are an officer recruited before or after 1988. I will explain more about these differences next.

The execution of rehabilitation policies have not been particularly smooth, especially given that the NSW Police is divided into two groups with quite different entitlements, depending on simply the date of their recruitment, i.e. pre 1988 versus post 1988. For pre 1988 officers, their rehabilitation, if

ever attempted in the first place, ceases once they are medically discharged. This is not true for post 1988 officers, and these officers are often pressed to take on non-operational roles within the police department. Some have suggested that in this way an injured officer is penalized for simply being injured. It is not appropriate in this chapter to discuss the various issues relating to workers' compensation, pensions and other entitlements. To quote a good Australian saying, "It's a dog's breakfast", would be to understate the issue. In fact the poor response times, delays, and rejection of claims all form part of a gruelling process that simply adds more "pain" in respect to not just poor options of rehabilitation, but also to the tortuous process of medical discharge.

While this all sounds very negative, I am of the opinion that, in the main, rehabilitation officers seek to provide assistance in a professional and supportive way. Again, any negative view is more a reflection of the organisation rather than the character and well-meaning of those who work for it. I will, however, make a strong suggestion for the situation if an officer believes their rehabilitation provider is not providing an adequate service. Then, rather than sit back and just take a learned helplessness approach mentioned earlier, with comments such as "This is typical of this mob", police can actually demand an improved and more efficient service. As I indicated earlier, many officers I believe simply resist being interactive and pro-active with rehabilitation, more to fulfill a self-fulfilling prophecy, i.e. "the system is hopeless, just look at me". However, there is at least one more slant I can place on this: I will make the comment later, given that police officers are taught to obey orders, if there are no orders then no action. Thus, if rehabilitation doesn't contact them and give them "orders", then they are most likely not to engage. I know this is a simple, perhaps an almost naïve analysis, but I have found especially in the psychotherapeutic setting, that police respond much better when they are given "orders". In fact I am not the first to notice this, and it was Anthony Kidman, a Sydney based psychologist, who I recall introduced the idea of a "behavioural prescription pad", on which he wrote down some agreed target behaviour and had the client agree to do them for "homework". I have done something similar with my Workbook and Journal booklet, and achieved some good results.

A third area of support is the chaplains. The chaplains have been involved with the NSW Police for decades. Like any other support agency, these people provide a wonderful service that assists officers in times of need. While my experience is only of the local region, I can attest to the care

and professionalism of chaplains. One of the things we in the general community appreciate about the Salvation Army, for instance, is that they don't try to convert us to some religion, but rather support us in the time of crisis. In a disaster, it might be a warm mug of coffee and a blanket. So too with the multi-denominational police chaplains; they are not there to convert police to their particular way of theological thinking, but to provide them with care and support.

I guess in reading this so far you could take the position that I have nonetheless still put a negative slant on these resources. Quite the contrary, that would be a mistake. I am suggesting that the negative outcome is not just because the agencies are under-staffed and under-promoted, but rather because too often officers themselves don't bother to access them. Getting help is a shared responsibility, not just a duty of an organisation; in fact it's this reciprocity that is the focus of any initiative in respect to occupational health and safety. In order to put a proper balance in this, I also know that so many officers I have spoken with have had poor experiences, with poor continuity of contact or no response at all, with the result that it doesn't take long or much for a "stressed out" officer to give up.

To put this into some practical purpose, if you are suffering from a psychological condition as a result of your work and seek the assistance of a psychologist or psychiatrist, you should also seek to gain the help of a rehabilitation officer. The quicker that is done, the quicker rehabilitation can take place. At the time of writing this book the NSW Police virtually have, in the case of most officers, taken a "watch and wait" policy. In short, in the first few weeks you may not be contacted by anyone. I am suggesting you need to think about this carefully and ask in whose best interests it is to do this is. Again, if this hits a cord with you, then perhaps you need to reach out!

The chaplains, for instance, are available 24 hours a day, as too is the Psychology Branch. Again, they are only a phone call away, and you will be able to access some of the most experienced and professional people that you will find in Australia.

I am aware that many police often have negative experiences in connecting with professionals, but one of the things that I suggest to you is that if at first you don't succeed, then try and try again. In

short, if you don't like the help you are getting then change where you are getting help, rather than simply giving up.

I apologise if this overview of the resources available to police may seem superficially addressed, but I want to spend time discussing three major initiatives where I believe people may also gain substantial help and support. The first of these is the employee assistance program, (EAP).

Employee Assistance Program (EAP)

In addition to trying to understand trauma I have probably spent most of my professional life developing Employee Assistance Programs (EAPs). It is not the purpose of this part of the chapter simply to praise, or even describe, the development of programs in Australia, but rather to suggest to police officers, or for that matter any employee, how they might gain the best benefit from such a program.

However, I feel it necessary to place the EAP's in some type of context, and given that I have been using the NSW Police as a model, I will refer to how EAPs have developed within the NSW Police Force.

In 1986 I returned from my overseas trip absolutely enthused that EAPs were, along with the other two components that complete this chapter, critical incident stress debriefing (CISD) and peer support, in fact an important initiative. The NSW Police, of course, had to first of all develop a psychology section, which as I indicated above was first headed by John Raue. Despite this, from 1986 to 2001, there was no formal EAP. Instead, there was an "employee assistance branch" (read Psychology Branch) and this was the closest to an EAP. Using partly their own resources, but chiefly psychologists from the private sector, they provided what I would regard as a defacto EAP. Since that time, at the turn of this century, an EAP was developed into what is now a formal program one currently available to all police and their families throughout the state in New South Wales. Historically, EAPs are a relatively new concept in Australia, with their original roots here sometime in the 1980's. Today there is a professional body, EAPPA, (of which I was founding President), and in addition, an international body, EAPA, of which I am also a member. In fact, I

was fortunate enough to be asked to co-author the internationally accepted guidelines for the provision of EAPs.

EAPs have proven to be a useful mental health intervention; with 4 million workers and families covered it certainly complements what has been hitherto an abysmal lack of mental health services in Australia. In short, employers have been blocking up gaps in the mental health system by paying for their employees and their families to attend psychologists, where the employee would otherwise have to pay professional fees for themselves. Given the substantial cost of fees, i.e., between $75 &$185 per clinical hour, without this support by the EAP industry there could only have been an adverse impact on mental health in this country. I will return to a more recent initiative later in this chapter.

Basically an EAP provides free confidential help. Usually organisations have a limit to the number of sessions an employee may have, and in the case of NSW Police it is just six. I will not bore you with definitional terms or any more of a historical overview, but it may be sufficient to say that the EAP is aimed at assisting employees with work or non-work related problems, and, in addition, acts as an appropriate referral service. Thus, a person who has gambling or financial worries may attend an EAP not only to deal with their anxiety, but also to receive a referral to an appropriate agency to assist them with the focus of that problem.

40% of clients who attend EAP counselling seek assistance for difficulties in a relationship. This compares to the general provision of EAPs, with approximately 20% who present with work related problems. However among police, while there is some consistency in terms of the volume seeking relationship counselling, more than 50% who are referred have work related issues. I suggest this sizeable difference is because of the excessively demanding and stressful nature of policing and, in particular, the ubiquitous nature of trauma.

What is interesting in NSW is that, once a police officer has made application to have their psychological injuries recognised as hurt on duty, i.e., under the provision of workers compensation, then they are not permitted to continue to use the EAP. This has a major

consequence for the way in which the EAP operates and is provided, and perhaps more importantly, how it may in fact then be accepted by police.

Again, like other initiatives, the EAP has not enjoyed an overwhelming positive response. However, I want to refer to an earlier part of this chapter when I suggested that it is the nature of the environment in which these initiatives are provided that is a critical linchpin as to whether this, or any initiative, is seen as worthwhile or otherwise. Thus you may understand it is not necessarily the EAP that is poorly regarded, but rather the organisation. That perhaps that poor regard for the organisation is generalised in respect to anything that it provides. As one officer said to me, "I wouldn't use anything that was paid for, or promoted by, this organisation". A limiting view but well understood in a culture with which he regards with suspicion. Another said to me, "you get what you pay for, and once, again we chose the lowest bidding contractor".

These comments may or may not be valid. For instance, while I have seen the request for tender I have not been privy to the actual tendering process itself. However I would make one observation that an annual fee system, such as that preferred by the NSW Police, has vulnerability perhaps not fully appreciated by everyone. For instance, in bidding for an EAP for a large organisation such as police, it's impossible for one EAP provider to fulfill its contractual obligations without the use of sub contractors.

Aside from the question of quality of provision, this is connected with a potentially serious further problem. Any EAP provider is undoubtedly in the business to be profitable. In fact, one major provider is the owner of a major hotel chain, while another is owned by a merchant bank. Thus when EAP sessions are limited to say 6, one approach to increase profitability is to ensure that sessions are minimized. You might see my point immediately, but to explain further, if an EAP provider quotes on an expected usage of 5% and that, after the contract has been commenced in fact becomes 10%, the quoted cost is significantly compromised. One strategy to overcome such a compromise may be for the EAP provider to initiate a policy that reduces the number of sessions from say 6 to 3, perhaps even introduce screening of the type of referral accepted, and even the actual duration of the session. If this happens it's easy to understand how an EAP that promises so

much doesn't live up to its reputation, and thus gains the type of comments of the two officers earlier, which sadly I would regard as typical.

Despite such criticisms, the facts are that if you are reading this chapter and need help, it is important to realise that this particular initiative is a wonderful and useful, cost effective, way to obtain assistance, or importantly, to be referred to the right agency that can assist you the best. I repeat; if you find you do not relate to the EAP counsellor, change counsellor. Do not stop getting help.

A number of people misunderstand what happens in an EAP counselling session. Counselling means to "guide", and therapy means to "heal". It is important to understand that EAP counselling simply provides some guidance, and generally is only a short term intervention (the national average is 3.4 sessions per client). Thus, the idea of going to an EAP for a lengthy period of time is a misnomer, Counselling should address some answers to the fundamental questions, e.g., where are you now? Where are you going? How do you want to get there? This is the basis of all counselling. Typically, in counselling, a cognitive behavioural approach is the primary intervention, but so too is problem solving. Counselling often includes some relaxation and of course stress management techniques are taught.

Importantly, all EAPs by definition are available to the entire family, or sometimes these days referred to as "those under your emotional umbrella". Elsewhere in this book I emphasise the connection between one partner having a psychological condition and the impact that it might have on the other, even the entire family.

Finally many people suggest that by seeking counselling via the EAP, confidentiality is at risk. While again understandable, the almost paranoid belief in relation to this is actually a bit of a furphy. The facts are that psychologists make their living by reputation, thus no reputation no income. Secondly, as a profession, we are also vulnerable to litigation. The most likely complaint would be in respect to confidentiality. A breach of that code of ethics would mean de-registration. Thus if you are reading this, I emphasise it's not a matter of giving lip service to confidentiality, but seeing it as our investment. While not guaranteeing confidentiality, I can give some pretty strong

assurances. A fellow from another organisation was complaining and suggesting that confidentiality was the reason that he wouldn't access an EAP. I suggested to him that he should have reported any breach. But as you might guess this actually hadn't happened to him but to a friend of a friend! Again, I suspect this is said more about the lack of respect he had for his employers than it did, in real terms, about the EAP.

In the summer of 2006/2007 the Australian Government introduced some legislation in relation to Medicare. Clients of registered psychologists (with a Medicare registration) may claim a substantial rebate, in some cases the entire fee. To enable this rebate to be paid, the client simply requires a referral with a provisional diagnosis provided by their general practitioner. The importance of this may not at first seem transparent, but the impact this will have on the delivery of EAP's will be substantial.

EAP's have previously provided free, easy to access, counselling for Police; in NSW, as I indicated, this includes a maximum of 6 sessions per year. Obviously, EAPs provide an attractive option with no cost to the officer. The Commonwealth Government, however, in providing all Australians with 12 sessions for psychological counselling a year, offering a substantial rebate, even bulk billing, has provided a sound alternative. I believe that the suspicion in respect to breaches of confidentiality in the provision of EAP services, as indicated by the type of adverse view in the earlier paragraph, is, sadly, one held by many officers, and I might say is, in fact for the most part, unwarranted. However, this may represent a substantial minority of police who avoid getting assistance for this. The alternative represents a substantial new avenue for assistance.

Peer Support

In the 1980's Jeffery Mitchell, from Maryland USA, developed a critical incident stress management protocol. There has been some considerable tension in our profession; sadly, more because Jeff was not a psychologist but an educationalist. However, Jeff worked with one of the most outstanding and foremost respected psychologists in developing this package, i.e. George Everly. George Everly, a psychoneurobiologist, has written extensively in the area of trauma.

Together they formed the Critical Incident Stress Foundation, adding later the title "International, (ICISF). The Foundation's aims are to provide support to emergency service workers at the time of critical or traumatic incidents, by what they referred to as "Critical Incident Stress Management (CISM)". Thousands of emergency service workers, as well as mental health professionals, have been trained using this model of intervention, including myself.

Later, in the final part of this chapter, I will discuss the essential component of CISM, i.e. critical incident stress debriefing, (CISD), which is just part, even if the most talked about component, of the critical incident stress management protocol.

One of the most interesting initiatives that came from the development of this protocol was the idea of peer support. Originally finding its roots in critical incident stress debriefing, the peer supporter was used in debriefing to provide the facilitator (referred to as a clinician) with an emergency services worker who was part of the organisation and so to help interpret what occurred, prior to and during the debrief. You might imagine that when a psychologist comes into an organisation and perhaps has little understanding of the culture, or even the type of work the people may be involved in, there could be a level of resistance or downright antipathy by those taking part.

What the peer supporter did in the case of CISD was to provide an opportunity for the psychologist conducting a debrief to be inducted, and to also brief the psychologist of the actual operational issues together with the sometimes sensitive cultural matters, all of which can influence how a CISD is conducted.

Paralleling this important role, peer supporters have taken a broader role and, in most organisations, typically act as a conduit between the agency, its people, and the psychology branch, the employee assistance program provider branch, chaplains, etc. By a conduit, I refer to the fact that with some useful training, especially in communication, as well as the ability to recognize and assist people that may be struggling, these peer supporters can advise in relation to getting help. Peer supporters are not qualified counsellors, but simply represent what in psychology we regard as "a peer referent other". In short, someone respected by staff and management alike who, with some formal training, is tasked to assist people in times of crisis. To simply be there!

Peer supporters are also invaluable in promoting critical incident stress debriefing (often doing the organising) and employee assistance programs, and enthusiastically advertise other strategies such as alcohol and other drug education. At present a set of standards, or "best practice" guidelines, are being developed by Australia's leading peer support trainer Michael Tunnecliffe. Like so many initiatives, protocols need to be validated and outcomes need to be measured. In so doing, firstly some consistency in service delivery needs to be established. (For further information on this contact: michael@emergencysupport.com.au).

In the NSW Police, peer support has been established for nearly two decades. Peer support certainly was promoted very shortly after the establishment of an Employee Assistance Branch, (EAB), but years before the introduction of employee assistance programs. Normally, in organisations I work with the reverse is true; first the EAP, then initiatives such as CISM are developed, and with that the establishment of peer support programs. There seems little point in explaining why or particularly what the effect of this has been, other than to say, how does an effective peer support program thrive without an employee assistance program? You might understand an EAP should be independent from the organisation. This was not true for so many years for the NSW Police, and thus peers were often left with the circumstance where they had to refer police to the very organisation in which they had no trust. Yet there were other reasons why Peer Support has struggled.

The NSW Police, however, took one other approach that I think in hindsight may have been regrettable. This was to have peer supporters not necessarily selected by their colleagues, but rather selected by management. This as you might expect created some suspicion from the outset and, to be blunt, many were rightly or wrongly seen as "spies" for management. Thus, the NSW Police peer support program was, and even today, is still treated with some suspicion by many officers. For instance, consider this comment by one officer, "Unfortunately, the alternate position was that when they were chosen by their peers, Police Association representatives pushed themselves to the front and usurped the peer support role and related everything back to a union perspective."

As a consultant to the NSW Police, and having the opportunity to observe peer support first hand, I can categorically say that the peer supporters I have met have always had the best of intentions, and at least in my mind have always attempted to provide a confidential and credible service.

A third obstacle that peer supporters had to overcome was the suspicion that they were merely completing peer support training and being peer supporters to put themselves in a "good light" for future promotion. As you may understand, in such an environment, this has again proven to be a difficult challenge. At the time of writing this book, I think peer support has not been as effective as it could have been, principally because of the difficult history that has made it hard to promote.

I would say this to you – if you are thinking of speaking to a colleague, then you wouldn't do better than to speak to a peer supporter. The peer support officer is trained to listen, not so much to just give good advice, although that is usually the case, but more importantly to get you in touch with the best help when you really need it.

Peer support, as I have emphasized several times in this chapter, suffers in an organisation where there is a lack of trust, lack of morale, and a great deal of suspicion This should, however, not distract you from using this wonderful initiative, or perhaps volunteering to be a peer supporter yourself.

Critical Incident Stress Debriefing

When I returned to Australia in 1986 I wrote up a study that was partly sponsored by Jack Avery, the then Commissioner of Police in NSW. I returned with the idea of helping the NSW Police develop a psychology branch, fitness for duty reports, employee assistance programs, and critical incident stress debriefing as well as critical incident stress management. In the above section I have briefly discussed the role of peer support. This was very much a part of a critical incident stress management protocol that Jeff Mitchell, as I mentioned earlier, had developed in Maryland USA.

As I also mentioned earlier, many people have been in fact trained using the so-called "Mitchell Model" of critical incident stress management. Probably the most known part of this protocol was critical incident stress debriefing, (CISD).

I would like to now give some background into critical incident stress debriefing before explaining how you might access it, how it might benefit you, and of course the limitations in regard to what this particular intervention can accomplish.

It is so tempting to write much of the dissent that has been ubiquitous among members of my profession. It's hard to believe that such in-fighting in any profession could have been as hostile and embarrassing as it has been in mine. Most of it was sadly about ownership and territory. An old saying a psychologist once said to me was that; "dogs just piss in corners, psychologists piss on each other". It's little wonder why user organisations, and for that matter, the public consumers have been confused. Some of the papers I have on my web site might give you some idea of the various issues, but now at least I want to discuss some basic issues that may be important if you are involved in a critical incident stress debriefing (CISD), or if you think you should organise one. Certainly as a reader, you hardly need me to write about the public "washing of our dirty laundry".

Firstly, and of paramount importance, CISDs were never designed for non emergency personnel and as a general rule, they aren't for secondary victims, and as a mandatory rule, never for primary victims or survivors of critical incidents. They are for tertiary victims, that is to say normally emergency service workers. They are not designed for the primary or secondary victims, thus they were not designed for staff involved in a robbery in a bank, or for school teachers who say loose a pupil in a MVA. They have of course been used in this way, but such an abuse of the CISD protocol is a risky practice. In short, I think it's safe to say that measuring the successful outcomes of CISDs, needs to be based on homogenous groups and preferably emergency service workers. I advise you to be cautious in reading any research that examines the efficacy of CISDs with any other type of victim population.

The second factor that is important in critical incident stress debriefing is that they need to be provided immediately, not delayed, and ideally within the first 72 hours. They need to involve

everyone who was involved, but not necessarily everyone in altogether. Thus it's unwise to mix non-emergency service workers with emergency service workers. It's also unwise to have large groups, or groups that have differing experiences. For instance, the suicide of a much loved police colleague should not involve his close friends, i.e. primary victims. Likewise, it should not involve the first hand work colleagues with others who barely knew them. I have likened the design of debriefing to concentric circles; first those that I refer to as intimate contacts (these should not be debriefed, but provided by way of one on one counselling). The second "circle" should include, say, those that worked with them and had a professional only relationship. The third involves significant others that may be involved in the investigation, the removal of the deceased, etc. In this way the focus of the CISD, i.e. a particular experience, can be maintained and, importantly, the debrief is respectful of the group then being debriefed.

The NSW Police have often failed abysmally in this. The worse experience I personally encountered was to have two separate groups attend the one debrief; one following the drowning of a child, the second a MVA including the deaths of two young adults. As the debriefer, when I asked my host to explain why they were all in the same room, I was told that time was an "issue" and, as the saying goes, "time is money!"

In any case, the protocol used should have been a uniform step by step, stage by stage process, and I refer in particular to the protocol described by Mitchell and Everly (1993). It is not my intention to outline this protocol here, but despite the controversy surround CISD and debriefing more generally, it is an intervention that has some substantial merit and executed effectively by a trained clinician can have a benefit to police.

While you are reading this I think you have an idea of what a debriefing might be, i.e. "a talk" or a "chat". This is one description, perhaps though it is more a "structured" talk, and follows a series of phases in which the participants are encouraged to discuss the critical incident, not only in terms of what they saw, and what they did, but also what they thought and how they felt. Importantly a debrief allows a number of psychological process to occur, including providing the opportunity for mutual support between colleagues in a safe environment. It emphasises the shared but differing experiences of those who have been involved in the event. It allows the ventilation of feelings and

as well as thoughts with a view to reducing the strength of the later emotional responses that can so often inevitably accompany a tragic circumstance.

The debrief is aimed to normalise and legitimise the feelings of participants. The CISD is aimed to assist an accelerated return to normal and, importantly, provide helpful information that may assist that process. Finally, and probably most importantly, a CISD provides an opportunity for workers involved in a critical incident to be monitored, followed up, and then be provided with further help if necessary. The later point becomes critical because this is too often where police and other emergency service workers can be forgotten and be left floundering alone.

Conclusion

So what do the principle messages of this chapter say to you? Hopefully the first is to get help when you need it. Secondly, realize what's available and seize the opportunity when it is available. For all my frustration and discontent with regard to the resources that can sometimes for police be so inadequate or lacking, ultimately I believe that police need to take better care of themselves. This, I believe, has been the essential message throughout this chapter, if not the whole book. When you need help, you will need to reach out and get it.

So what happens if none of this works? What if the stress and traumatic experiences that come with policing continue to place pressure on an officer? In the next chapter I propose to explore how a psychologist might help using a particular style of psychotherapy.

Chapter 4

Treating PTSD – Cognitive Behavioural Therapy

Do not cling to the events of the past or dwell on what happened long ago. Isaiah 43:18

Introduction

This book is aimed to assist not only emergency service workers, especially police, but also health professionals who work with police. As indicated in the previous chapter, most recover from traumatic events, or what have become termed "critical incidents". However, in the previous chapter I also suggested that some don't, and given the ubiquitous nature of trauma in emergency work, it's not surprising that such repeated exposure puts them at higher risk than the general population. At the time of writing this chapter, a young police officer was shot while alone in a Sydney police station. She survived and just 5 weeks later she was back at work. Asked about counselling, she said that, "it was offered but I didn't think I needed it". I will not suggest for one moment that she has not recovered, but there is, at times, some pressure to be seen by others as having put these events behind you. Certainly she has increased her profile, and when the opportunity comes for promotion, I am sure her courage and resilience will provide for a recognition. Yet the problem of delayed onset and the accumulation of traumatic events leading to complex PTSD needs to be clearly understood. Our war veterans stand testimony to this condition. I am sure that the Police will have conducted a fitness for duty assessment, and this is probably the best that can be done. It will be an interesting case and one that should be followed up over the months to come.

There are countless officers who have just "jumped back on the bike" who later came to psychological grief, where previously the police agency has accepted the great Australian disclaimer, "she will be right mate", when, in fact, in the longer term; it was proven that everything was anything but right!

Importantly, for those that find some difficulty in recovering, help is available. As you will see in the later part of this chapter, Cognitive Behaviour Therapy (CBT) has been shown to be superior to most other treatment protocols. While I support the use of medication in some cases, and especially when co-morbid conditions (say of depression) are diagnosed. I remind all my clients that the leaflet that comes with medication invariably says words to the effect, "this medication works best in conjunction with psychotherapy".

I am often asked to provide a description of the type of treatment protocol that I use in the treatment of Post Traumatic Stress Disorder (PTSD). The purpose of this chapter is to explain the six stages in the treatment of PTSD, using the widely accepted intervention of CBT.

So often when a patient attends my practice, they are hopeful that I will be able to work some kind of magic in helping them remove the pain that they are experiencing. Quite often they hope that I will be able to make them as they were before. I am indebted to a fellow psychologist, Mark Creamer, who in talking about this particular subject provided the following useful quote:
Macbeth consults a doctor about his wife being…troubled with thick coming fantasies that keep her from rest…and demands of the doctor:
Cure her of that:
Canst thou not minister to a mind diseased?
Pluck from the memory a rooted sorrow,
Raze out the written troubles of the brain,
And with some sweet obvious antidote
Cleanse the stuffed bosom of that perilous stuff
Which weighs upon the heart?
The doctor replies: Therein the patient must minister to himself

The problem I had in writing this chapter was to question how much technical and clinical information I should include. Incidentally it was Mark Creamer who is currently writing, with his team, from Melbourne "Best Practice Guidelines in the Treatment of PTSD and ASD". Mark presented a workshop that I attended in Melbourne in 2006: "Advances in CBT Treatments for

PTSD". I am indebted for his ideas and the eloquent simplicity of how explained to everyone what this involves.

I showed a police officer this and he said; "perhaps there is too much detail here if you want it to be read by cops in crisis". So I sweated over this and decided that "crisis" is a short term situation and this book has import for longer term care. Moreover, I think cops when they are out of crisis, should understand what works and why it does. Finally, of course, this book is not just aimed at cops in crisis, so here goes.

Returning to Macbeth for a moment, obviously, the answer then, as it is today, is that successful treatment inevitably lies with the patient, but the critical role of appropriate and effective therapy cannot be underestimated in facilitating such recovery. I believe that cognitive behavioural therapy provides the best intervention with the most likely successful outcomes of any therapy. In treating post traumatic stress disorder using cognitive behavioural therapy there are six stages of the treatment process. These include:

1. Stabilization and engagement
2. Education and information
3. Anxiety management
4. Trauma exposure
5. Cognitive restructuring
6. Relapse prevention and maintenance

Stabilization & Engagement

(a) A time of attending to the client's practical needs and current crisis.

When a client first comes to see us, they are often in crisis and have many concerns that do not immediately warrant just psychological intervention, but more intervention of a practical kind. They are worried about their pay; they are worried about what is happening to them; they are worried

about the future; they are worried about their family; they are worried about the fact that they are feeling they are going mad; all of which are issues that need to be addressed prior to any psychotherapeutic intervention. Simply put, as Abraham Maslow identified in his "hierarchy of needs," we have a series of ascending needs, starting with our physical health and safety. Thus, the old saying "you don't count the deck chairs when the Titanic is sinking," is a humorous attempt to point out that we need to first get the basics right, and this is what crisis intervention does. It provides not only immediate support and reassurance but best of all, hope. At this point the officer may be seeing the smaller picture, even in minute detail. The therapist is to show immediately that there are choices. Here the therapist reassures the client that the crisis like all others passes, so often the question is "will I get better?", "will it ever go away?" the answer to both questions is most likely yes!

(b) Substance Abuse

The next question that needs to be addressed in these early stages is whether there is a problem of substance abuse. This might include illicit drugs or prescribed drugs, but too frequently, it involves alcohol. With 80% of people drinking on a regular basis, alcohol can quite often be the drug of choice to reduce and dampen down the effects of anxiety. This may lead to an abuse problem, and furthermore, this abuse problem may lead to a range of psychological difficulties, including depression and anxiety.

One of the great difficulties has been to break a cultural mindset among police, especially those recruited prior to the 1966 Wood Royal Commission in NSW. The idea of a debrief down the pub was accepted practice. While some substantial arguments can be made for there being various positive outcomes from this activity, good science would generally suggest otherwise. Clearly alcohol is a depressant, it's a drug that may cause significant dependence, and in fact there are too many horror stories to think this is otherwise. While there has been some substantial change in the last decade, both in attitude and practice, we now face the problem among police of the impact of so called "recreational drugs", a phrase that has always struck me as an oxymoron.

A psychiatrist friend of mine once referred to alcohol as being the mimicker of all psychiatric illnesses. What she was saying was that alcohol is an aggravating and exacerbating factor that needs to be taken into account, then dealt with when treating people who have PTSD, or for that matter, any presenting clinical condition. Clients need to agree and contract to minimization or abstinence during the period of treatment. If this cannot be obtained immediately, then it needs to be worked on during therapy.

(c) Engage In Treatment

Treatment is part of a cooperative and collaborative plan. It cannot be just "done" by the therapist, it needs to be accepted and responded to by the client. In order to do this, treatment must be fully explained and, in the early stages, the broad ideas behind cognitive behaviour therapy (CBT) should be outlined to the client. This enhances their knowledge base, while at the same time providing them with an opportunity to ask questions and become involved with the process right from the outset.

Education & Information

(a) Explaining common responses to trauma

Quite often after being traumatised, a person will experience a range of symptoms that they associate with being out of control, or even going mad as outlined in chapter 2. During this time, it is a matter of high priority to ensure that the patient understands that for the most part their reactions have been a normal reaction to an abnormal situation. Even though these symptoms may have persisted for some time - days, even weeks - it is not helpful to diagnose at this stage. It is important to remember that these symptoms can be addressed, and while they may indeed represent Acute Stress Disorder or PTSD, they need to be the first concerns in counselling. Symptoms at this time are manifest by way of four core elements, i.e., physiological, behavioural, emotional, and psychological, (see chapter 3). At this early stage the therapist attempts to normalize the symptoms, help if possible to accelerate recovery, and of course validate the client's

experience. Keep in mind that 95-97% of people recover from traumatic experiences and are responsive to counselling and coaching at this stage.

In this early stage of intervention it is important that the client understands that these four primary areas of effect indicated above may, however, continue and in fact are indicative of a typical recovery. At this stage it may be appropriate, and certainly it's my practice, to provide educational material such as a book ("Managing the Impact of Trauma"), or handouts similar to that included in the appendices. A failure to move on after some weeks may well be indicative of psychopathology. Both client and therapist at the completion of this counselling phase of intervention need to understand that therapy may be necessary.

(b) Providing a rationale for the client's symptoms and the proposed treatment

At this point the therapist should go back over what happened in more detail, and help the person to incorporate what did happen, and why it happened, in some world-view or schemata. To this end I often ask the person to write a narrative, where they not only include the incident which led to their referral to me, but perhaps a more general overview of their life and other traumatic experiences. These narratives tend to be somewhere between four and sixteen pages, and often provide an insight into literally where the patient is coming from. Knowing this, I am in a better position as therapist to develop a therapeutic plan.

Incidentally, there is some recent research (Ireland 2004) that suggests that police officers who keep a diary and write of their experiences following traumatic events, simple as a matter of routine, develop better coping and resilience. In this way they are less likely to suffer the "accumulative effect" so often experienced by those who work in stressful occupations such as emergency services.

At this point the patient should also be given some further explanation of cognitive behavioural therapy and a quick cheat sheet on CBT in order for them to get the essential ingredients (see appendices). These days, with almost everyone having access to the World Wide Web, this information can easily be accessed.

Anxiety Management

(a) Teaching clients strategies in physiological, cognitive and behavioural domains

All psychopathology has a root cause, i.e. anxiety, or at least that is the opinion of scholarly research. Thus it makes sense at this point to introduce various strategies for reducing anxiety. This has the added benefit of lowering a client's more general anxiety, and allows for better absorption of information, certainly a more receptive cognitive state, in which to listen and thus learn better ways of management. The first and obvious technique is physiological. Here relaxation might be taught simply by some breathing exercises. Secondly, it is useful to introduce a technique such as guided imagery exercise into the patient's repertoire. This will be useful later if exposure therapy, or even eye movement desensitization reprocessing therapy, (EMDR) is introduced.

There are other ways we teach clients to gain a reduction in general arousal, and this often includes behavioural techniques such as physical exercise, yoga, tai chi and the like. In addition, cognitive strategies or behavioural techniques such as checking against faulty thoughts, irrational thinking, etc may also be introduced at this point. For hard to manage anxiety, which can include panic, some discussion by the therapist with the client's GP in respect to medication may be warranted at this time.

(b) Activate naturally occurring support networks

This is an important issue because many people who suffer depression, PTSD and the like become quite isolated, when in fact quite clearly established support networks are important. These networks provide support in between sessions, and at times, when the client may feel that no one particularly cares, or even feels abandoned, an anchor point. It is also understood that a lack of support, (real or otherwise) is one of the key predictors in the development of PTSD conditions. Thus, people who feel they are not supported by the workplace, for instance, will often go on to have more entrenched and chronic conditions.

(c) Educate and support the Carers

Quite often at this point, it may be the second or third session, I ask the partner of the client to attend where I discuss with them the full implications of their partner's condition and ways in which they may help. I also point out that it is possible that the partner can experience similar symptoms; for instance, anxiety in one person can cause anxiety in the other, (especially if the other has a weapon).

I also check the partner's more general psychological wellbeing, because I have often found that the psychological wellness of the client's partner clearly drives the psychology of the client. This is much in the same way that a healthy and integrated partner may have a positive impact. Sadly, so often the reverse is true, i.e. a partner who is unbalanced and suffers from pathology may exacerbate and worsen my client's anxiety. Who knows what may be the actual cause!

Confronting the Memories

(a) Imaginable and, where possible in vivo (real life) exposure.

This is an important and critical, even central, part of cognitive behavioural psychotherapy. In this phase the client is engaged in confronting in an imaginary way, or in a real life situation (if possible), e.g. the phobias, and their traumatic memories. This is achieved by a graduated and desensitizing approach, one that sees a slow but purposeful discussion and investigation of the memory (s) that seems to be the centrepiece of their traumatic response.

There is nothing new in this, and while I am not trained in psychoanalysis I note that Breuer and Freud as far back as 1893, about the psychical mechanism of hysterical phenomena, said:

"…. each individual hysterical symptom immediately and permanently disappeared when we had succeeded in bringing clearly to light the memory of the event by which it was provoked and in arousing its accompanying affect, and when the patient had described that even in the greatest possible detail and had put the effect into words."

So it has been known for some time that prolonged and repeated exposure to confronting the memories, even in the imaginings, or as indicated earlier, in vivo, the client can experience a reduction in painful memories, and in doing so reduce their overall anxious state. I take the view that this is why relaxation is important throughout therapy, because the more relaxed the client feels, then the less experience of anxiety they have. The less anxious a person is means their painful and traumatic memories will likewise be lessened, or at least experienced not on an all day everyday basis.

Measuring these changes, like many therapists, I have found the SUDS (Subjective Units of Distress Scale) as being helpful and if used at the beginning of this section of therapy and thereafter, changes and lowered levels of distress can be recorded. Likewise the IES ("Impact of Event Scale) may achieve the same quantitative estimate of change. [I was going to include a copy as an appendix, but like many questionnaires are available from the World- Wide-Web – simply type in "Impact of Event Scale", using most search engines and you will find several versions].

These while perhaps providing only a rough gauge, will normally help to show the impact of psychotherapeutic intervention, especially if repeatedly measured over sessions. Clients who work with me also receive a "Therapy Workbook and Journal". Here I have clients record their levels of anxiety over a period of time, sometimes just days, other times months. It's important to understand that mostly psychological change comes as an evolution, rather than suddenly or revolution. Keeping track of where we have been and just noticing small improvements over time is really important, so both the client and therapist can gauge the benefit of any psychotherapeutic alliance.

It is at this stage that the EMDR (Eye Movement Desensitization Reprocessing Therapy) may be introduced as another way of desensitizing the client in respect to the evocative aspects of their traumatic memories. This particular therapy certainly has proven to be successful in any number of cases. On the other hand, like all things (including medication), it has been found not to always be successful.

It is important that the therapist uses some clinical commonsense as to when to introduce exposure into a treatment plan. It is not advisable to use exposure in the first two sessions. However the

patient may take, even in the first session, that direction and it may be appropriate to deal with some pressing components of their traumatic experience. To do this prematurely may be especially distressing in the early stages and cause a failure to commit. It needs to be remembered that avoidance is a pillar of PTSD, thus any conflict may be dealt with by avoidance and the client may simply cease therapy. Structurally, exposure is best done, I believe, in the third session. By this session both trust and rapport should be established and the health, personality and clinical background of the client more fully understood.

Sandra: A brief case study.

Sandra was a police officer who was referred by her general practitioner. As part of therapy we focused on some inevitable triggers from a terrible accident she attended that involved a crane. She explained that some 13 years ago two men had fallen about 60 metres from a crane. One man had been immediately killed on impact, the other died in her arms waiting for the ambulance. Perhaps using the criteria for traumatic incidents indicated earlier, this event certainly qualified. Sandra had many other traumatic events that had accumulated, and she had been diagnosed by a psychiatrist as having PTSD (complex). However, one psychological legacy she had from this event was that she avoided passing cranes whenever driving, she would always take a quite convoluted journey to do so. Not only was this inconvenient, but it also resulted in panic and significant anxiety for hours afterwards.

The classical conditioning of this is self evident. We developed a strategy whereby she would first "Google some images" and then form a power point slide presentation using about 30-40 images of cranes, with exposure of about 5 seconds each. The slides increased in similarity, until the type of crane she saw at the original scene was being presented. While watching the presentation of these slides, Sandra was instructed to play a CD which we had previously recorded for this purpose in my rooms. This was a mixture of positive affirmations and some restive music she liked.

Then, in the follow up session, I actually produced a large, but toy, crane on my desk and she focused on it, while I used a basic but deep relaxation script. While Sandra reported almost immediate improvement, you might imagine the final test of our success. It wasn't, of course, to be

able to be actually elevated physically in a crane, as that was not the target behaviour. Instead, she went to a yard where cranes were garaged and, from outside, but from a short distance, she could clearly see the cranes. In her parked car, she again listened to the CD produced in my office. This proved to be the closing segment of what was a successful therapeutic technique.

What had happened was that the conditioned response of fear and panic was diffused and replaced, and she was then able to deal successfully with not only her fears, but also her avoidant behaviour. I should make somewhat of a disclaimer here; not all cases are as easy as this.

Cognitive Restructuring

This is an important stage that sees the client move from a passive role to develop strategies and cognitive plans in dealing with their world. Here, ideas of a "just world" should be challenged together with other such faulty thinking, including irrational beliefs of the type introduced in reality therapy or rational emotive therapy. (Why did this happen to me? If only things had been different, what have I done wrong?). My favourite challenge is that originally said by Jesus, when he indicated "that it rains on good men and bad men alike"(Matthew 5.45), or to put it another way using popular jargon, "shit happens".

(a) Identifying maladaptive assumptions and beliefs about self and the world.

This can be done as a written homework exercise, and this is where I often introduce a unique resource, i.e. mood gym (www.moodgym.anu.edu.au). This is a six-week program that the client can undertake, and as a result, report back with their homework book each week. This is particularly useful in relation to challenging misassumptions about the world. It is important to understand that a sense of injustice and unfairness are two primary drivers of PTSD. The therapist should ideally assist the client to check these assumptions and replace them with more reasonable expectancies. For instance, De Botton (2004), in his book "Status Anxiety", says, that our self-esteem is dependent upon our success over our expectations. This is to say that the higher our expectations and/or the more unrealistic those expectations are, the less likely that success is

possible. He argues that this failure of our expectations reduces the individual's self-esteem and self worth; he suggests that this is the basis of modern anxiety.

Again it is important to understand that reducing anxiety more generally will reduce the impact and the level of post-traumatic stress a person may experience.

Importantly, cognitive restructuring includes assisting the client adjust real world information, re-evaluating things on the basis of evidence. CBT attempts to challenge and replace maladaptive automatic thoughts and beliefs. It is during this particular phase a therapist may introduce the "(a), (b) and (c)" of cognitive behaviour restructuring. With (a) being the event, (b) being the thoughts, and (c) being the outcome or behaviour. What happens, so often, is that in many circumstances our thought process is non-existent and our reactions are automatic, so we move from (a) to (c) without thinking (b). When we think (b) and interpret the world more rationally, then our behaviour at least can move from a simple automatic to a more cognitive or analytical process.

Relapse Prevention

(a) Identify high risk situations

Obviously in working with clients with PTSD it is important that they understand that as a result of suffering PTSD, they may be then more prone not just to relapse, but experiencing PTSD again, (some suggest as high as 9 times more likely). The client needs to have an acute awareness of high-risk situations, and (perhaps as unrealistic as this may first seem in the case of police) have a set of strategies to deal with that. Many police officers realise that they can no longer do what they promised themselves they would do, and as a result resign, or are medically discharged, or pensioned off by the police.

It is important to ensure that the patient understands the notion of choice, and, despite their mistaken belief that we do not have choices; realize that there is a choice almost to everything. What I think makes it difficult is actually the consequences of those choices, not the choice itself. For instance, a highly addictive person still has choices even if the choice is not to use.

(b) Developing Coping Strategies

While this may have been introduced before, the five coping strategies should be re-introduced with perhaps more emphasis at this stage. The coping strategies are: (a) good self-esteem, (b) social support, (c) emotional strength, (d) physical wellbeing, and (e) spiritual wellbeing. These five coping resources are the basis of resilience, the subject matter of Chapter 10.

Conclusion

Does cognitive behaviour treatment for PTSD work? The research is quite outstanding in this regard, especially Resick et al. (2002) and Bryant et al. (2003). CBT seems to be effective in 60-80% of individuals with PTSD, but it needs to be kept in mind that these figures have been mainly sexual assault or accident survivors. Police and emergency services probably don't have as sound an outcome, but the theory and the practice of CBT still pays dividends, especially for those police officers after they have made the decision to exit the police force.

The question has been raised as to whether CBT is better than say another modality such as EMDR, which I mentioned earlier in this chapter. It is quite clear by Delvelly et al (1999) that CBT is superior to EMDR, and on that basis EMDR might be seen as a complementary therapy rather than the primary therapy. What is interesting in Taylor et al (2003) is that relaxation alone, without exposure therapy or EMDR, produces significant reduction in PTSD. For instance, Taylor showed a reduction in PTSD symptoms from 100 to 60 after treatment by relaxation, and 60 to 50% in a follow-up 6 months later. The exposure therapy however showed a variance of 100% to 32%, and a 6-month follow-up showing again the advantageous results of cognitive behavioural therapy.

It is important to enhance CBT treatment by understanding that the co-morbidity of such conditions as substance abuse, and associated features of anxiety such as guilt, anger and even dissociative reactions, can all be actively managed while using CBT for PTSD. Secondly, the approach that I take is highly motivational and directional, which I have found particularly useful for police officers and military personnel. These people not only take orders on a regular basis, as well as check list training, but also feel more in control (in a paradoxical sense) when they are in a controlled environment.

Professor Mark Creamer is currently developing best practice guidelines in the treatment of PTSD and Acute Stress Disorder for the National Health and Medical Research Council (NHMRC). These guidelines, which are in draft form at the time of writing this book, are available via the working party's web site, www.acpmh.unimelb.edu.au. They represent a major contribution to the treatment

of this complex disorder. They concluded (Section 2.3.7) with "the course of PTSD is often chronic without treatment and sometimes a chronic condition with treatment (Section 2.5.)." Further, they state that "PTSD is less likely to follow a chronic course with effective treatment". On the basis of several studies, it is reasonable to assume that around one third will make a good recovery following effective treatment, one third will do moderately well, and one third are unlikely to benefit". It is my belief, and the belief of many others, that appropriate and timely intervention by way of psychotherapy may alleviate not just the distress of trauma, but also the collateral damage and what seems to be an epidemic of burnout in the helping professions. Burnout is the subject matter of the next chapter.

Chapter 5

Burnout

"Is characterised by physical depletion, by feelings of helplessness and hopelessness, by emotional drain, and the development of a negative self concept and negative attitudes toward work, life and other people", (Pines and Aronson, in Farber (1983)

1. Introduction

In the previous chapters I have expressed some ideas about the inherent psychological hazards of working as a police officer. Essentially there are two categories of hazard: the administrative type, which may be compounded by poor morale, or as some refer to as a toxic work environment; the second are operational issues that may include an individual traumatic event or, on the other hand, an accumulation of psychologically demanding, as well as traumatic, events. Persistent, un-remitting pressure can often lead in the longer term not to specific psychological responses such as anxiety and depression, but a more pervasive condition referred to as occupational burnout.

Interestingly it has been put to me several times, that while any officer may suffer from a specific psychopathology, either due to constitutional factors, or as a result of the work they do, burnout is unlikely to occur in the more junior officers. It has been suggested by one officer that perhaps it takes up to 5 years for the average police officer to fully understand the administrative and political issues of a police agency. He went on to say that it is, within this context, not just the accumulation of critical incidents, but also an increase, and to use his words, of "the donkey load". That was an insightful observation and especially interesting when a previous Commissioner, Peter Ryan, I believe told a graduating class, "just give me five years". One can ask, as I have done many times, including in other parts of this book, "what is the 'shelf life' of the average cop?", and "is it critical for both police and the organisation itself to think about different vocational targets, such as 15 years?" but perhaps thats for another time.

Burnout is a phenomenon that needs some attention both from an experiential and theoretical point of view, if for no other reason than because of the ubiquitous nature of it among caring and emergency professionals. Burnout is singularly the most frequent description of what ails police, and afflicts those most committed and those that have been for many years under pressure by the circumstances of the work they do. Unlike PTSD which may be accounted for by operational demands, burnout has been repeatedly shown to be due to the demands made upon them from both an operational and administrative perspective.

The introduction into the Diagnostic and Statistical Manual of Mental Disorders (DSMIV) and International Classification of Disorders (ICD 10) in the 1980's of (a) Post Traumatic Stress Disorder and (b) the expanding of "adjustment disorder" to include periods of impairment greater than 3 months, provided a useful way to diagnose some police patients. It is clear that both of these disorders may develop following excessive stress in the workplace, and of course as a consequence of critical incident stress, indeed an occupational hazard for emergency service workers. In a paper I mentioned in Chapter 2, i.e. Lindahl (2004), highlighted the importance that single traumatic events, while sufficient to cause PTSD, were not the common circumstance among emergency service workers, but instead, or at least in addition to, an accumulation of evocative events, sometimes over decades. These, as a totality, were more likely to be the cause of PTSD. Lindahl (2004) cites research that suggests as many as 20% of emergency service workers may ultimately be diagnosed with some type of accumulative post trauma psychopathology. I will pick this up again later in this chapter.

PTSD is in fact often integral to police burnout. One difficulty that PTSD has had, at least in respect to a clinical diagnosis, is that it has at times been missed entirely on the one hand, or overly diagnosed on the other. Instead of being based on a sound and thorough clinical assessment, the DSMIV criteria has been used as a score or tally card and, simply put, if there are enough "points" scored, a diagnosis is made. Of course patients are able to fake or exaggerate their symptoms presumably to score sufficiently so as to warrant diagnosis. Unhappy thoughts become flashbacks, poor motivation becomes poor concentration, simply being malcontent becomes anger and being anxious and unhappy becomes depressed. On the other hand clients feel humiliated that even the previous year they were able to cope, but not this year. As one client said, "am I just a sook?"

At different times this has placed some question as to the credibility of PTSD as a discrete psychiatric entity and, as I once heard a very senior academic in psychology scornfully suggested, "Everyone's got it these days". This devaluing of PTSD is unfortunate for, when correctly diagnosed, it needs to be understood that it can be a highly debilitating condition, with serious ramifications for the patient in every facet of his or her life, as well as their family. While its origins as a distinct entity finds its roots in the war veteran population, it is a condition that is particularly identified in police, ambulance personnel and fire officers. The diagnosis has the additional "attraction" in that it can provide sufficient and necessary cause for an officer to be medically retired. The payoff is of course access to not just workers compensation entitlements, but, especially in the case of some NSW police, an attractive pension. Thus secondary gain has been of some manifest concern.

Likewise, another diagnosis i.e. Adjustment Disorder, (again see the DSMIV) has also been used as a fairly low-key diagnosis, one that is more likely to be cited when referring to what was colloquially called "stress". Certainly, in most cases of adjustment disorder, recovery is predictable, and, in fact it, was this very predictability I think that caused the original inclusion of Adjustment Disorder in the DSM and to be viewed as a transient condition of fairly short duration, i.e. weeks. While chronic has since been introduced to the psychiatric nomenclature, it is a diagnosis that is generally not considered as typically causing a more permanent condition.

What seems to have happened is that, these days, chronic adjustment disorder is used to diagnose those patients who don't quite meet the criteria for PTSD, but have symptoms that seem to be more severe and chronic than, say, Acute Stress Disorder, (ASD). This is yet sometimes "beefed up", with additional descriptors of "anxious" and/or "dysthymic mood". The emphasis here being that a patient may have some symptoms of depression, but not severe enough to warrant a diagnosis of clinical depression. Again, they may be sufficiently anxious to warrant clinical attention, yet insufficient to warrant a diagnosis of Generalised Anxiety Disorder.

I think many emergency service workers, and others who come to their occupation by way of a vocation or "calling", do of course experience psychological problems, even pathology such as

PTSD, depression, chronic adjustment problems and mood disorders, but at times I believe these conditions stem instead from a deeper down root cause i.e. “burn out”. Burnout, and indeed its metaphors, does not represent a medical condition in as much as they are not included in the psychiatric nomenclature as defined by the DSMIV or the ICD10. For instance, “compassion fatigue” as Charles Figley describes it , is again a colloquialism and not a diagnosis, even though it may more eloquently say more about the patient’s condition than, say, simply adjustment disorder.

In writing this Chapter, I will try and develop our understanding of the psychopathology of emergency service workers, especially police officers within the broader paradigm of professional burnout.

2. Defining Burnout

Pines and Aronson (1981) noted that burnout is “characterised by physical depletion, by feelings of helplessness and hopelessness, by emotional drain, and by the development of negative self-concept and negative attitudes towards work, life and other people...It is a sense of distress, discontent, and failure in the quest for ideals” (p 15). Freudenberger and Richelson (1980) described burnout as a “state of fatigue or frustration brought about by devotion to a cause, way of life, or relationship that failed to produce the expected reward”, (p 13). Edelwich and Brodsky (1980) defined burnout as a “progressive loss of idealism, energy, purpose, and concern as a result of conditions of work” (p 14).

Burnout is of course subjectively experienced, but is as a state of physical, emotional, and mental exhaustion caused by long-term involvement in situations that are emotionally demanding. The emotional demands are most often caused by a combination of very high expectations and chronic situational stresses. Burnout is accompanied by an array of symptoms including physical depletion, feelings of helplessness and hopelessness, disillusionment, and the development of a negative self-concept and negative attitudes towards work, people involved in the work, and life itself. In its extreme form burnout represents a breaking point beyond which the ability to cope with the environment is severely hampered.

Burnout tends to afflict people who enter their professions highly motivated and idealistic, expecting their work to give their lives a sense of meaning. It is a particular hazard in occupations in which professionals tend to experience their work as a kind of "calling." Burnout involves the painful realisation that we have failed – to make the world a better place; to help the needy; to have a real impact on the organisation – that all our efforts were for nothing, and we no longer have the energy it takes to do what we promised ourselves to do, we have nothing left to give. This realisation makes us feel that our whole lives have had no purpose. In this respect burnout represents the failure of work as a solution to the existential dilemma.

On the other hand Compassion Fatigue as discussed by Figley (1999) [in Violanti and Paton (1999)], offers a different emphasis in respect to burnout and uses a slightly different focus or schemata. So here, rather than cite a definitional approach to compassion fatigue as earlier, with burnout the following descriptive table aims to provide what Figley (1999) meant. It also indicates some of the similar characteristics, seen in the definitional terms of burnout.

Probably one of the most compassionate public statements I have heard in recent times was made by Superintendent Bruce Lyons, speaking at a funeral on the North Coast of NSW for just one of four boys who were killed in a MVA. Tyler, the driver who survived was at the service. Bruce Lyons said, "Young man on behalf of many, may I say God bless you. I know in the past days you must be asking yourself a number of what-ifs and perhaps you haven't been able to answer them" he said" You need to know that Mitchell and Bryce and Corey and Paul are in a peace and tranquillity that none of us are yet to know about". Indeed, Bruce Lyons, some days are harder for coppers than others are they not?

Police Compassion Fatigue (PCF)

Cognitive	Emotional	Behavioural	Spiritual	Personal Relations	Physical/ somatic	Work Performance
Lowered concentration, decreased self-esteem, apathy, rigidity, *disorientation*, perfectionism, minimization, *preoccupation with trauma, thoughts of self-harm or* harm to others.	Powerlessness*, anxiety, guilt, anger, range, survivor guilt,* shutdown, *numbness, fear, helplessness, sadness, depression, emotional roller coaster,* depleted, *overly sensitive*.	*Impatient, irritable, withdrawn, moody,* regression, *sleep disturbance, nightmares, appetite changes, hypervigilance, elevated startle response, accident* proneness, losing things.	Questioning the meaning of life, loss of purpose, *lack of self satisfaction, pervasive* hopelessness, anger at God, questioning of prior religious beliefs, loss of faith in a higher power, greater *scepticism* about religion.	*Withdrawal, decreased interest in intimacy or sex, mistrust, isolation from others, over protection as a parent, projection of anger or blame, intolerance, loneliness, increased interpersonal conflicts.*	*Shock, sweating, rapid heartbeat, breathing difficulties, aches and pains, dizziness, increased number and intensity of medical maladies, other somatic complaints, impaired immune system.*	*Low morale, low motivation, avoiding tasks, obsession about details, apathy, negativity, lack of appreciation, detachment, poor work comm., staff conflicts, absenteeism, exhaustion, irritability, withdrawal from colleagues*.

I think it's important to note that when the characteristics indicated above in italics are compared with other conditions, say anxiety and or post-traumatic stress syndromes, that the symptoms are similar. Yet our professional full acceptance of burnout as a psychological condition is hampered by the lack of recognition in the psychiatric nomenclature. Of interest, though, is that the key - accepted when establishing the existence of any condition - is that it should cause impairment in functioning. In this respect, even just evidenced by the table above, burnout certainly causes that.

The idea of impairment in an individual's functioning is a critical element in evaluating claims for compensation. The NSW government, for instance, introduced the Psychiatric Impairment Rating Scale. While psychometric nonsense, the scale makes it clear enough that without impairment there is no injury. Likewise when the Victims Compensation Legislation was reconstructed some 5 or 6 years ago with the purpose of reducing the victims compensation budget, the criteria that was ultimately deemed important was not based on the "medical label" applied, but rather, how did the condition impair the victim, e.g. in terms of social, familial, academic and or work functioning. To put it bluntly it establishes that if you are a victim of crime but your life doesn't change substantially, irrespective of the diagnosis, there is no compensation. I recall one tragic case of a developmentally challenged fellow who was attacked in his housing commission home, he was forced to move and he no longer could socialise at the local club. Basically, what the assessor determined was that as his life was of such poor standard before the attack, there was therefore no significant further impoverishment, and his claim for victim's compensation was therefore rejected. I have always wondered since how that assessor slept at night! Simply stated, burnout causes impairment in functioning and thus needs to be considered as a disorder.

There is a dilemma in measuring police and the accumulative impact of traumatic and stressful events in their lives. Certainly regarding them as burnt out makes clinical sense, but as a psychiatric entity not particularly useful in making a claim for workers compensation, or seeking a medical discharge. I want to illustrate this by way of two cases. The first, an ambulance officer, the other a chief inspector of police to emphasis the difficulties that can arise. In these cases PTSD and or adjustment disorder were in fact diagnosed, but irrespective of the medical diagnosis, undoubtedly burnout was the underlying cause for their failure to "soldier on".

Case 1: Russell

Russell was first referred to me in May 1996, having joined the NSW Ambulance Service some 15 years earlier. Now 9 years ago, he gave an account quite typical for emergency service workers, which included a range of traumatic incidents, all of which I suspected contributed to what can be referred to previously as "allostatic load". This accumulation is a quite well understood phenomenon among emergency workers, and is likely to provide the very contextual or psychological environment that causes these workers to burn out.

Certainly an incident in 1995 seems to have provided the watershed, or turning point, for Russell. While working as an ambulance officer, Russell was threatened by a man who threatened to kill him. He found that he "lost it", and from there seems to have struggled with the symptoms consistent with Post Traumatic Stress Disorder (PTSD). A second incident where he was again threatened saw him referred to a psychiatrist. Even nearly a year later when I saw him in 1996, it was clear to me he wasn't coping particularly well. He later applied for, and was successful in gaining, a position as a dispatcher. However, I suspect that his motives in moving from on road duties to dispatching was as much about his avoidance, and his inability to cope, as well as a lack of confidence to operate as a frontline operative, than anything else.

Again, in 2004, there was an operational incident, which involved a procedural concern that jeopardised a speedy and timely response by the ambulance on call. This was the subject of an investigation. It's not my intention to outline the issues here. Nonetheless, it's clear to me that, in pointing blame, Russell felt betrayed and let down by the Ambulance Service. Russell believed that he had been a committed officer for many years and deserved better. Again you may note that reciprocated loyalty issue which is preached to every officer in basic training. After "remedial training", he returned to work back in the co-ordination centre. Yet Russell reported feeling even more stressed than ever and said he felt overwhelmed by the volume of work and poor procedures. [This type of claim, I might add, has been repeatedly featured in numerous articles about the NSW Ambulance Service in the popular press over the last 30 years].

Poor communication, misunderstanding and some assumptions created yet a further incident and Russell's performance was again seen as wanting. According to Russell, his superintendent attributed his so-called poor performance to his psychological difficulties that stemmed back some 10 years earlier. Russell on the other hand regarded this as a "cop out", and argued that it was in fact the lack of resources that caused the problem. Later that day he experienced chest pains and attended at the local hospital.

Russell did not return to work and was later retired on medical grounds due to a reoccurrence of PTSD. I would first like to make some further observations in respect to the condition referred to as posttraumatic stress disorder (PTSD). Like any condition that becomes "popular" and diagnosed, PTSD has become also frequently misunderstood. I would like to clarify among other things as to why, despite the passing of time and apparent recovery, so many sufferers can continue to episodically experience relapses for a lifetime.

While even seemingly intractable, PTSD may temporarily remit, unfortunately, however, relapse rates are high. In fact, some research indicates that a person who has suffered PTSD will have nine times the chance of suffering similar episodes of PTSD, compared with a person who has not. While indeed that makes some logical sense, it's interesting that, because a person returns to work and seems to be effective, the PTSD is often regarded by some as being cured. The simple dictum that *"PTSD is managed not cured"* is sensible. Incidentally, Russell's claim for workers compensation was rejected based on the fact that his anxiety was seen as being directly related to a work performance issue and a specific part of the workers compensation legislation was invoked, i.e., Section (11a) of the NSW Workers Compensation Act.

The second is a misunderstanding that it's *only* a single particular traumatic event which accounts for subsequent PTSD. While individual events, of course, alone may provide the aetiology of such conditions, it is well recognised that accumulative critical incidents may also account for PTSD. This is especially true among emergency service workers. Not only may it be accumulative, but it may not be, as I mentioned elsewhere, a "big time event". The trigger can be something far more subtle. An example I will use is Gary, a 62 year old police officer who came to see me 5 years out of the job, who had not submitted a hurt on duty claim for workers compensation. I figure I can

exclude the cynics at this point who may believe he was setting up a basis for a pension increase. A MVA some 20 years before had stayed in his mind but it wasn't that the child involved was just 8, nor the fact that when he got to the hospital they had her "laid out", with a rose between her hands. It was in fact his reoccurring memory that the doctors and nurses were openly crying. This was to be the basis of years of intrusive thoughts that he could not shake. You see my point earlier about "gruesomeness"; it just doesn't work like that.

As I indicated earlier in this and previous chapters, the idea of accumulation of trauma has, especially, been more accepted recently in North America in Fairfax County v Mottram case (Lindahl 2004). In that case, an experienced fire officer claimed that his disorder was caused more by an accumulation of events rather than a single event. I think the reason that the single event explanation for PTSD is attractive is that it is often a specific incident that prefaces a "breakdown". I would suggest instead that this, in emergency services work, is normally just the proverbial straw than anything else. Unfortunately in the case of police officers this single event explanation too often becomes the attributed cause, but worse still, may become the overemphasis in therapy.

The third misunderstanding is that PTSD is not a real medical condition. It is true that the notion of PTSD is regarded as a "paradigm", but to suggest it's not a physical condition is to ignore the substantial research available in science, especially neurobiology. Research clearly indicates there are substantial physiological and neurological alterations in patients with PTSD. For example, there are significant alterations to the Hypothalamic Pituitary Axis (HPA), as well as significant changes to the limbic system in patients diagnosed with PTSD. For instance, Yahunda (2004) among others found that there are lowered levels of 17-Hydroxicorticosteroids among PTSD patients. This may be seen as an astonishingly (see Chapter 2) finding given that elevated corticosteroids are normally a marker of anxiety.

These physiological changes are, according to some, permanent, which suggests a strong support that PTSD is more than just a paradigm but as well a disease. The case mentioned earlier (Lindahl 2004) was also argued on the merit that PTSD is *"an occupational disease"* (p546).

I was surprised that Russell's claim for compensation was rejected as it was his own employer who thought that his present circumstances were the consequence of his original PTSD. While Russell disagreed and placed the responsibility of his condition on inadequate systems and resources, I think that his employer's account had some merit. I am sure that Russell can better see that now. I suspect that when it was first argued, he saw it as simply abrogating their responsibility to implement proper work practices in place and, as such, I have no doubt it attracted some ire from him. However, from a psychological perspective, if those work practices were inadequate and, as he says, the workload unreasonable, it is somewhat predictable that a person, who had also had PTSD may break down and this of course, is exactly what happened.

It's interesting how communications centres are the most often thought of places to provide retreat from front line operations. Yet dispatching or communications has been the subject of some significant research, especially overseas, which has suggested such places are stressful places to work. This, including the fact that there are often many people in a confined environment under tense conditions, only increases the stress levels of those that work there. In the communications centre of the NSW Police in Newcastle, over the period I saw Russell, more than 16 people were retired on medical grounds. In this regard, I think this was at least partly caused because the job is in fact inherently stressful, but, in addition, quite often, injured officers had been placed in the unit on restricted duties. Subsequently and due to their injuries, both physical and psychological, their wellbeing has suffered and many have experienced what is referred to as "burnout". This, in my opinion, like PTSD, burnout, remains a ubiquitous problem for emergency service workers.

In one sense, this is what I think eventually happened to Russell. While he applied for the dispatching position in good faith, it was, I suspect his need to "escape" the stress of day-to-day roadwork and his increasing levels of anxiety and depleted levels of coping. The facts, in hindsight, I think suggest that his pre-disposing psychological condition contributed to his poor behaviour and then subsequent inability to work as effectively as he might have otherwise. Undoubtedly his psychological injuries and impairment could be seen as being duty related, but obviously his condition can be described as burnout.

Case 2: Bob

Bob was a 32-year veteran police officer aged 54 when he first came to see me. He had been off work for some 11 months and was faring much better than he had when he first sought therapy for a psychological condition in 2004. However, it was clear to me that no one particular incident that he experienced as a police officer caused his condition, which had been diagnosed as PTSD. Rather there were multiple events, all of which individually and severally together were sufficient to cause PTSD. It's interesting that the chances of recovery from a traumatic incident are estimated as good at 97%. This figure refers to the general population who, as I indicated earlier, if unlucky, may experience less than a dozen traumatic incidents. In a lifetime, police, like other emergency service workers may have as many experiences in one month. The odds of PTSD, of course, increase as the multiplicity of events carry their allostatic load. This accumulation factor makes identifying a particular traumatic incident to be the basis of PTSD more problematic. In fact I think the accumulation or wearing away of the psychological resilience of the officer is the key, not just to the type of PTSD emergency service workers suffer, but also the rate of burnout.

In Bob's case, and since being on leave for some 11 months, it's easy to understand how PTSD could remit. After all, if work was a primary cause, then perhaps the absence of work should predict an improvement. This, along with treatment and medication, certainly provides a reasonable prognosis. However, to suggest that a person who has suffered from PTSD can, when recovered, simply return to full time operational duties is perhaps akin to suggesting that a person who is in remission from lung cancer can return to smoking.

What we do know, of course, is that there is some foreseeable risk in returning officers like Bob back to the workplace. A useful hypothetical I use in such cases goes as follows: If the officer (like Bob) decides in the process of treatment to resign, but at the end of treatment decided that had he been imprudent and then seeks to re-join, would his application be accepted? The answer is obvious, and one firmly in the negative. In a paper I wrote, ("Pre Therapy Schemata") which again is available via my website, I emphasise the point made by others that one of the four so called predictors of relapse is being exposed to further trauma. This is why I have shifted my view, and I

have the belief today that police officers who suffer PTSD should not be returned to full time operational duties.

The diagnosis of just PTSD alone may, however, be less than accurate and, in fact, perhaps it is a way of providing some medical reason as to why an officer should not return to work. Rather than PTSD, I suspect their anxiety is more aligned with the fact that they are at the point of burnout. Yet, today as much as ever before, we persist with seeking diagnoses using medical labels of the psychiatric nomenclature. Without them there is no medical condition, so in turn there can be no dignified medical exit and as a result there can be no just and sensible financial closure.

Conclusion

I suppose the absurdity in Bob's case and others like it is that the so-called "independent" psychiatrist (who may have thought his role was one of an adversary) saw Bob's return to good health as indicating he was capable of full fitness for duty. The analogy, however, would be to suggest that an asymptomatic asthmatic therefore no longer suffers asthma. His decision was of course nonsense. One major fault among health professionals can often be the absence of a real understanding of the exact nature of police work. It amazes me when psychiatrists, instead of psychologists, are asked to make vocational or occupational assessments. Again, I have heard any number of medical partitioners say, "well, surely they can find him or her some work to do, in an organisation as big as that", when referring to the NSW Police. This naivety is obviously faulted, but especially so in respect to two industrial principles.

Firstly, all officers in NSW Police Force, unless they have been able to apply and successfully gain a restricted duties position, must otherwise demonstrate they are fit to be fully operational, (85% or better in terms of fitness), or face being retired. This seems to some outsiders as somewhat harsh, but given the nature of police work, it is potentially dangerous to both the officer and or their colleagues for this criterion to be otherwise. I recall an orthopaedic surgeon who made the recommendation that a police officer was deemed fit to return to operational duties following significant spinal surgery. I took the opportunity to then ask the surgeon whether or not the officer was therefore able to play football in the local competition. He indignantly replied that of course it

wasn't and to do so would put him in grave danger. So, you see that type of misunderstanding typifies the real lack of insight into what policing often involves, i.e., running, tackling and fighting.

A second principle worth noting is the dictum that a person should not be disadvantaged because of their injury in returning to work. The analogy I regularly use is that if a neurosurgeon looses the gift of performing surgery they cannot then be then expected, as a reasonable employment alternative to manage the hospital car park. While I realise this example is somewhat of a hyperbolae, I think it emphasises the importance that any return to work duties should always be commensurate with the officer's pre-injury ability and training. It should also necessarily include the notion of dignity. I am forever frustrated by return to work plans that take high effective operational police officers and place them in mind numbing jobs simply for the sake of it. Any rejection of an offer of employment is seen instead as being due to the officer's lack of co-operation and indeed ungratefulness! Burnout officers should then find a different career path and certainly not one within the occupation in which they suffered burn out.

Finally, burnout is at least an adjustment disorder. This disorder is so often a "wastebasket" diagnosis as indicated earlier. Its so often used when the symptoms for PTSD don't quite meet the criteria and a more heavy duty diagnosis such as depression or anxiety are also perhaps not warranted. It is usually diagnosed when there is some variance in mood, outside that of day-to-day alterations, and where this adverse level of mood seems to predominate. It is also used when there are significant deleterious effects on performance. As you may see from the earlier table "Police Compassion Fatigue", these are also similar to those found with patients who suffer problems of adjustment. However, as I also pointed out earlier, adjustment disorder was included in the DSM with a view that these symptoms and impairment in functioning would be brief, i.e. less than 3 months.

Burnout certainly tends to be occupationally specific and produces chronic symptoms of so-called stress or adjustment. Thus the inclusion of "chronic" in respect to adjustment disorder in the DSMIV actually improved the alignment with burn out which, of course, has been useful to diagnosticians. The difficulties arise however, generally speaking, when a person has an adjustment disorder, if they are removed from the source of stress, given some therapy and sometimes medication, and

their symptoms ameliorate. In Bob's case above, this was sufficient for the psychiatrist to say he was fit for work again.

Now it seems to me that two matters in respect to that situation are in my view at least, after more than 20 years of treating police, transparently clear: The first is that the experience of burnout is more or less permanent in respect to a particular occupation. In short, the definition of burnout has some circularity, i.e. burnout should only be confirmed when the patient is unable to return to their previous occupation! Secondly, to suggest that a person who is burnt out but no longer has the expressed symptoms of PTSD or Adjustment Disorder should then be put back into an environment where they may be further exposed is undoubtedly negligent. It is true that some stress can make us more resilient, but chronic periods can make us predictably much more susceptible to stress responses than we were before the original exposure. This is where the concept of burnout is especially useful and perhaps more superior as a clinical entity than simply adjustment disorder, especially in assisting us all to understand the patient's potential for rehabilitation.

In this chapter I have attempted to suggest that the day-to-day diagnosis of psychiatric labels of PTSD and Adjustment disorder have not always been helpful in adding to our complete understanding of the depth and destructive nature of career burnout among emergency service workers. Moreover, an improvement in the patient's wellbeing that will then supposedly lead to a return to that type of work is unrealistic, at least in most cases. It has been suggested that psychiatric or medical labelling remains essential, if not so much for the purpose of treatment but certainly necessary to augment the recognition of such injuries and prove to be helpful in facilitating the medical discharge process. However, this labelling often ignores, and perhaps even deflects our attention from, what sits as the underlying cause, i.e. burnout.

My concerns about the acceptance of burnout as a psychiatric entity, separate to a diagnosis of adjustment disorder and PTSD is, I agree, somewhat wasted given that it is unlikely that any consideration in respect to the inclusion of it within the psychiatric nomenclature is likely to be addressed in the next decade. However, from a therapist's perspective the treatment of clients who suffer from occupational burnout need to be considered and treated within a broader and more

holistic approach, rather than just being dismissed as a colloquialism. Finally because burnout seems as much an existential crisis, then usually separation from the cause of burn out will invariably mean that the person will return to a normal level of functioning and wellbeing, sadly the same can not be said by those who suffer PTSD, at least if our war veteran population are anything to go by.

In the next two chapters I want to tell two stories. I indicated from the earliest parts of this book, that I intended to make this book certainly different from other “self help” books. It seems that it is appropriate that given we are about half way that perhaps I provide you with two stories that touch on many of the issues of the previous 5 chapters.

Chapter 6

Bill's Story: A Case for Tragic Optimism

"It is surprising that in those depths we again found human qualities which in their very nature were a mix of good and evil?" (P94), (Victor Frankl- Man's search for Meaning)

Bill was a 44-year-old veteran police officer of some 23 years standing when I first met him. He was married to Anne, aged 42, and they had three children, a son now aged 23, and two daughters 19 and 20 years. Bill and Anne owned their home. Anne had worked part time, but mostly they lived on his wage in a pleasant suburb of the city in which I live.

Bill liked a drink, go to the footie (he loved the Knights football team), and also had a passion for collecting die cast miniature models of American cars. Most of all, he loved being a cop. He joined at just 21 years of age and, due to the lifestyle he had chosen, i.e. to live on the coast and away from the city, promotion had eluded him. After all these years he remained a senior constable in general duties, a "street" cop, yet he had the knowledge and capacity that could have seen him achieve so much more.

He found, like most police that I have met over the past 20 years, the work both demanding and challenging. Bill received two commendations for bravery and was well respected by his peers. His relationship with his family had struggled at times; not just due to shiftwork, but also, the prolonged and repeated exposure to grief, trauma and other people's pain, which had all taken its toll. Bill drank a little too much, and could be quite avoidant of his family, especially when, as they use to say, "He was in one of his moods". His wife Anne told me that at times it was like walking on eggshells, but she loved him and believed that it was all worth it; they were still together, and she felt that the good times had outweighed the bad.

I have taken some time to set this background because what happened to Bill was to see all of what they valued placed at risk, and I thought you should know just what that "all" was, i.e. his family, his vocation, and indeed, his good standing as a member of the community.

In fact his story, for the most part, could be one told of just about any officer. Importantly, as he narrated it, it was typical of so many I have been therapist to. I have had to vary the facts only a little to protect confidentiality, as much of what I say in this chapter could be told many times over, again just changing the main character and only marginally changing the background.

So Bill, of course, is not his real name and I might say that while the story is truthful, it's not actually factual. This rightly protects Bill's identity and, of course, his right to confidentiality.

While the day-to-day work that police officers do, sometimes referred to as "civilian combat" naturally takes its toll, probably the worst nightmare, but sadly so often part of the job, are allegations of wrongdoing or misconduct. Obviously the more serious the allegation, the more it impacts on the officer and their family. Bill's nemesis was a vexatious and malicious complaint by way of comeback, made by a person he had previously arrested. I will not go into the details here but if her claims were true, then, if proven, they would undoubtedly lead to him serving a long custodial sentence.

The actual circumstances and the "facts" are not as important as the journey. Bill had to take a journey that caused them all to be terrified of the outcome, and sadly, irrespective of the findings, there would be a "death", at least of his career. For Bill understood as a veteran that investigations of this type often lead to discipline because of issues of the administrative type, i.e. matters arising from the investigation. So often despite innocence or at least guilt not being proven, there may be some failure to follow procedures as described by the Commissioners Instructions, i.e. Standing Operating Procedures. I will return to this later in the story. Or in Bill's case, as he told me more simply, some "mud" always sticks.

The allegations, as outrageous as they were, saw the case get to a court of law. Some years before there had been a royal commission into policing. In an effort to demonstrate that corruption would be rooted out, quite often, severe penalties were handed out for relatively minor infractions. Moreover, the view was that if it costs a few officers their careers, then that was the cost of restoring public confidence and demonstrating their favourite mantra, "transparency".

Thus, officers accepted that they were in fact guilty until proven innocent. The second problem was that many believed that, even when they were innocent, their employer treated them like they had cheated rather than beat the system. Moreover, the inquisitional nature of the enquiry (in the initial stages officers investigated other officers) was often cruel in itself, often referred to as a "witch hunt". This was often then followed by an effort to convict by the DPP who, at least during Bill's prosecution, seemed more obsessed by the fact he was a police officer than in establishing the truth of the matter.

As I said earlier, I don't want to explain the facts here, or the actual process, but instead superimpose the "stations" on Bill's painful journey, one that ultimately saw the end of his career, his "death" and "burial" as it were, but then to show that there was finally a resurrection and transformation.

If these terms are familiar and, have a religious ring, then of course they should. In fact I am going to use by way of analysis a mechanism I have used before and is found in a paper on suffering I wrote last year, i.e. "Stations of the Cross for Atheists and Others". In that paper, I suggested that despite the centrality of Christianity to the "Stations of the Cross", it is also a useful metaphor for our own human suffering, and that unless it ultimately leads to a transformation, it is benign. Indeed many resist the transformative process of suffering and so stay caught, often for a lifetime. In saying this there is in suffering a case to be made for what Victor Frankl refers to and mentioned at the start of the chapter, a "case for tragic optimism".

1. The Condemnation

If you have ever been wrongly accused of something, (its unlikely you got to adulthood without such a circumstance happening to you), then you would have experienced the frustration of being vilified. There is in us all, I think, a tendency to think the worst of someone, as demonstrated by the ease at which gossip spreads. The myth becomes the fact, facts themselves become distorted and they may be seen as having some truth, even in humour.

The allegations against Bill were so vile that they could otherwise be seen as preposterous. Even more, there seemed to be an obvious agenda by the complainant, a story that she would repeat with increasing inconsistencies and contradictions. Yet the police, in their desire to demonstrate that all allegations are always strenuously investigated, and if necessary prosecuted, saw Bill fairly well condemned from the outset. Firstly he was the subject of an internal enquiry, and the complaint was ultimately referred to the DPP. In all this time, of course, Bill was suspended from work.

The often-heard statement, "where there is smoke there is fire", was a commonly heard analysis at the time around town. Bill, in the meantime as I say, had been suspended and faced some fairly difficult questions from his family, especially his children. His drinking increased and his mood was "black". He was condemned as an officer that could not be trusted.

2. The Cross

We all have crosses to bear, some are crosses that we must carry because of our bad luck, others are those that we bare because we have responsibility, there are those that are thrust upon us, deceitful and mischievous and malevolent crosses, such as that carried by Christ as an agitator against Rome, or even Plato who was supposed to have corrupted the minds of the youth of Athens several centuries before Christ. And so it was that Bill had this cross, people in the street would point to him and whisper, friends from work were found to be scarce. In fact, no one paid him a visit after word had got out that Bill was trouble.

His wife Anne tried to talk with him, but Bill described himself as feeling numb. It was then his anxiety levels got to the stage where he was referred to me. I noted his medication seemed to be doing more harm than good. He was avoidant and withdrawn, he often failed to keep appointments with me, and continued to drink heavily. Bill was pessimistic about the outcome, he pondered the inevitable that when this process was over his career would be in ruins, so too his reputation and he faced gaol. Bill told me that he would kill himself before he went to prison.

3. The fall for the first time

Bill's mood continued to spiral downward, and he felt dreadfully alone. He started to experience panic attacks, but was able to overcome these by decreasing his drinking. Alcohol is an antagonist to depression and anxiety. In the short term it has specific beneficial gains, but there's a cost to that window of just 2-3 hours of relief, as it is often paid for by hours of even more severe anxiety, loss of sleep and depression. Thus the cycle for many is this: First anxiety, then intoxication, followed by panic, depression (normally between 2am and 5am), then anxiety and back to intoxication. The pattern has to be broken. Bill broke this pattern, and while in one respect the journey wasn't easier, the monkey was at least off his back. Then he knew that at least his feelings were real and not an artefact of alcohol.

Kids are often the casualties of these types of processes. There is an understanding by psychotherapist that anger is often just a manifestation of anxiety. Bill's son was in many ways immature for his age, although I don't know what that quite means these days! Yet in a paper written by my own son "Le Folie au deux", a study of co morbidity between police officers' anxiety and their partners, he posited that psychopathology experienced by an officer has the effect of causing anxiety and depression among other members of the family. I am going to deal more with this in both the next chapter on relationships and in the final chapter on resilience.

4. The fall for the second time

For some time during all of this, his son used and abused drugs, mainly cannabis. I guess the argument could be made, so what's new, what kid doesn't? Indeed I often explain away such circumstances myself. Yet the pattern was so predictable – Bill's son was 21 and had not used drugs, including alcohol, at any time during those years that I think are the most vulnerable for kids. Yet the onset of drug use was after Bill was suspended and ceased two years later after making a pact with his father, to look after his mother. Was it rebellion, anger or something else? Bill's pain was made so much worse seeing his son in the grasp of such toxicity, but also feeling responsible, and indeed taking the blame for his son's circumstances.

5. The fall for the third and yet a fourth time

Bill's style had been, in the past, one of avoidance, a matter that his wife Anne had been frustrated with for many years. She realised that men often used this strategy to ease the pain and avoid further conflict. It does little to increase the bond; rather it caused them to drift apart. Anne's daughters remained close and supportive of her, but were stunned when their mother disclosed she had formed a relationship with another woman. Anne and her friend just started off by keeping company, Anne describing Bill as being impossible to live with and her friend so supportive. Anne later thought that it was true that she had taken advantage of the friendship, and her friend had taken advantage of Anne's vulnerability. The girls found out when Anne's estranged partner rang home and told them about it, after Anne had tried to cease the relationship: They were shattered. Her son, despite loosing it to drugs, but still attended university and said that it was O.K with him and that his father was an "asshole".

6. The end near

At this very time Bill's defence counsel told him he should "cop a plea"; in this case the lesser charge of aggravated assault instead of sexual assault. The offer of a plea bargain was tempting enough, at least to his counsel, as the difference in penalty was about 10 years. I was at last seeing Bill a little more regularly and my clinical notes recorded, "Bill is at his lowest- I am fearful of self harm". I alerted a number of supporting agencies and his entire family came in for an extended session. Bill had agreed to this and, while he wasn't talking to his wife, they were still living in the same house.

The family session seemed to help a little and many issues were aired by each of them. Painfully, Bill heard his children's doubts (remember earlier I mentioned "where there is smoke there is fire"). Anne, on the other hand, saw that her relationship with this other woman was a cry for help. Bill was angry and said he "couldn't give a fuck, and that if she wanted to sleep with a woman, then she had literally made her own bed, etc". However, by the end of the session, aside from the tears, and recriminations, there was a new agreement. Firstly, their son would get help (this was to prove

to be a slow process over the next two years), Anne said she would sever the relationship with the woman entirely and work on what I called "re-inventing" their relationship, agreeing to some couple counselling. Doubts were put aside and family loyalty came to the fore.

As crude as it was stated, they agreed that, "no one fucks with their family". They effectively had, in fact, used the threat to their family to be a galvanising issue rather than the fragmenting issue it had been. I realise people say that families stick together in times of crisis, but the reality is that it's rarely the crises alone that undermines family resilience and resolve, but rather the wear and tear of time.

Meantime, the court case continued against Bill: a trial and a mistrial led to a delay of six months; then another mistrial; to 9 months later, finally a "no bill". You see, as I suggested earlier, the evidence given by the complainant kept changing, in fact making a conviction impossible, but instead of having his day in court there was an empty and rather a "Clayton's" verdict, one that had taken 3 years 7months and 6 days to be, at last, concluded.

7. The Death and Burial

Yet you may recall a comment earlier about "matters arising from". This is a finding in the process of the investigation where there are matters found wanting in terms of how the officer being investigated followed proper departmental procedures. Bill was, in fact, found in breach of so-called "Commissioners Instructions". These allegations were pitiful but damaging to Bill. I will not include them here as in doing so I may betray the identity of the actual officer. These breaches, rather than the alleged offences which went to court, turned out to be the basis of his dismissal – the "death of his career".

Bill was proven right; they were going to crucify him. Often police officers are not seen to beat the charges but cheat them. The sacking was the ultimate betrayal; having survived his journey this far they drove the nail in and watched on while his career finally died. It's important to point out here, that despite being some years later, the industrial matter was eventually tried in front of an Industrial Court judge who was brutal in his condemnation of Bill's employer, saying that Bill had

been wrongfully dismissed. This was little succour for Bill of course, whose career, as they say, had well and truly been "dead and buried" for some time. So what was it all about one could ask? It is not the purpose here to point to wrongdoing, or the failure of justice, (because in the end it was served), but more importantly to show that all you have read so far is resurrection story.

8. Resurrection and Transformation

As you can see, Bill almost lost more than a job and his standing in the community, but also his life partner, and his children as well. It is safe to say that Bill's family, in fact, were the beneficiaries not just of Bill's suffering but indeed of their own. To explain, his son learned to respect his father, and learned that the abyss of drugs could be stepped back from, despite his sense of helplessness and hopelessness during his worst period. Likewise, his daughters learned about relationships, communication and loyalty, while his wife Anne recalled a line from a corny Hollywood film (The Story of Us), telling me that she and Bill had "a history and that was worth fighting for".

In fact they reinvented their relationship, not just once but twice; once during the "crucifixion" and then after it during the "resurrection". It was Anne who gently tended to Bill's needs emotionally and otherwise, during the court cases and ultimately his dismissal, comforting him and bringing him a sense of hope for the future; we all need "mothering", that's the aetiology of attachment. They both learned to communicate better. They also learned to respond to each other rather than react.

Yet, there was always going to be life after the cops; what sort of life was just, at first, unknown. I think that too often we try to think of a resurrection as things going back to being the same ("I just want things to be the way things were!"). That is neither possible nor desirable. You see, what is the point of suffering if it's not been about learning and improving? Isn't this the basis of almost any plot, in almost any movie ever made, or book written? i.e. "walking off into the sunset" at the end, so as then to start a new life. Some say this is schmaltzy and unrealistic, but isn't this exactly what happens when we successfully make the leap from death and instead choose to live.

For instance, had Bill stayed angry and destroyed his relationship, instead becoming bitter and angry at the world, do you see that the suffering would have been simply destructive, not restorative?

Instead, Bill ditched his anger, learned to communicate better, started to read, lost some weight and took up exercising (which I had tried to lure him into during therapy). He established new and better friendships, (our friends are the folk you have home for dinner – the rest are acquaintances – it is after all in the breaking of the bread together that we all truly recognise each other!).

Those who knew him as a cop then hardly recognised him. He and Anne certainly had a different relationship together, taking weekends away without the kids, even though money was tight (remember in the early days his case had yet to be settled in the industrial relations court). Anne worked some extra shifts and Bill started and completed a TAFE course. He started in a new profession, and found new meaning in his life and was in everyway transformed.

Conclusion

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In Bill's story I have perhaps not so subtly used some headings that represent some of the Stations of the Cross. Ultimately, as I indicated, Bill could have destroyed everything, including himself. Yet not only did he salvage what ultimately is the most important thing (his family), he also chose to take on a new life and meaning. As I say, he was transformed!

In a previous book about police i.e. "And pigs might fly" (which has never been published), I included a dozen stories like Bill, but I wrote it more as a catharsis of my own experience of the vicarious pain I experienced because of the mistreatment and appalling lack of compassion in so many matters, where ultimately so many innocent police and families suffer by a system of rough justice that is a major cause for everyone involved with police. Indeed, I could write so many simple chapters, but Bill's was a story of true survival and I couldn't resist it. One area of Bill's life that did improve of course was his relationship with his family, especially with Anne. And as a relationship so often suffers, it deserves a chapter on its own, which follows in Chapter 8.

However there was another story that could be told and one I wrote several years ago. I wanted to publish it in the ill-fated book on police welfare mentioned in the above paragraph that never made it to print, this is Barry's story.

Chapter 7

Barry's Story

"It's a long and winding road" – Paul McCartney 1970

Barry's story as a policeman is again quite unremarkable. His work was typical of that encountered by most police officers. He joined the job in 1973, just 22 years old, and by 1974 was working in Highway Patrol (HWP). While he loved the work, (and was good at it), Barry found that, from the outset, he was somewhat different from many of his contemporary officers: He didn't swear, or smoke, is offended by dishonesty, and most importantly he didn't drink. A common view held then (by at least some) – *"you can't trust a man who doesn't drink*". Barry was often ridiculed for his participation in the Police choir; he regrettably left it in November 1974.

Later Barry developed a good working relationship with a policewoman and was then scandalised by rumours for two years from March 1979 to 1981. The effect was to cause his marriage to break down. His wife was obsessed with the quite false belief that he was having an affair, and left him taking with her their two children. The relief nicknamed him "Frank", after Frank Burns in the "MASH" television series. [You might recall Frank was a bumbling fool who was besotted by "hot lips" Houllahan and found every opportunity to have intimate contact]. Barry has always been a man of great integrity and honesty; you only need to talk with him briefly and you will quickly and clearly establish in your mind the character of the man.

Thus these problems weighed heavily on Barry and he first sought psychological help in 1982, and as a result, was absent from work for about three months. He made the difficult decision at that time not to see his children any further, concerned about the pain the acrimonious relationship he was having with his wife was causing his children. They probably never knew what an effort of self sacrifice this was, rather instead, thinking he had just abandoned them.

Barry tried, some time later, to re-establish a healthy relationship and make a go of a relationship with a policewoman through to mid 1985. He again was subject to station gossip and innuendo

that, at one stage, ended in a fight with another officer. He again experienced depression and after a brief period of treatment, felt improved, returned to work, and was posted to a station in the Hunter Region in 1986.

From the outset Barry says he was treated with absolute contempt and disdain by his supervisor. He felt isolated and thus excluded from the group. Barry sought therapy for recurring depression late in 1986. It was during that period his supervisors collaborated to have him moved and Barry was subsequently transferred (banished) to the radio room, a punishment for simply not having been liked.

When Barry came to see me, I regarded him as suffering from a clinical depression, sometimes referred to as an "endogenous depression", and I sought to act as co-therapist with a local psychiatrist. It was clear to me that the hostile treatment, including a spiteful, and what Barry regarded as an unfair, appraisal ultimately caused his "banishment" to the radio room, and sat at the seat of his depression. In today's work place this "treatment", as it was called then, would be regarded as bullying, or what Mann (1996) refers to as "sustained degenerative abuse."

In 2003 I wrote about 50,000 words towards a book "And pigs might fly". A family member, also a psychologist, said it was a "negative, cynical and painful" start. I abandoned the project because it was not my own catharsis that was important, but rather that the lessons learned are passed on, and we as a community try to stop replicating them. I had finished the first draft of this book when I remembered "Barry's story". Barry of course as you might have guessed was not his real name. Yet, despite this story's harsh reality, it's worth telling if for nothing else than to demonstrate the triumph of the human spirit. I am indebted to Barry for the relationship we had over nearly 20 years.

I will digress for a moment. In reading this account so far, you may say; "well he had been battling depression for years, how was Barry's condition the responsibility of the then NSW Police? I think that can be argued against quite effectively. You see I am not sure that it was his depression they were arguing about, it went more like, "This bloke is different to everyone else, he doesn't drink, he is too serious by far, he has a 'black and white mentality to honesty', and he just doesn't fit in, so lets get rid of him". To be blunt, he didn't fit the culture. However, to justify their actions of

ostracism, at the very least they needed to have a more formal reason, and one that would somehow legitimise their "treatment" of him. Their strategy was faulting his performance and thus the invention of adverse appraisals. These appraisals were, as subsequent court cases proved, in fact quite at odds with all previous appraisals. Is that any surprise, especially given that their agenda was subversive? In fact if previous appraisals were accurate then to the contrary, his work was always of the highest quality. Barry received commendations about his work and was recognised as having those qualities needed to supervise. For instance, in 1982, an appraisal said, *"would make an excellent traffic Sgt"*, and that he was *"well suited"* and *"a keen and enthusiastic member who performs his duties in an excellent manner"*. This vindictive and punitive strategy to undermine and sink officers who were not liked, was well understood at that time. Is it still a strategy to deal with those who don't fit in?

At least in Newcastle at that time there was a phrase, the "80 wheeler" transfer; known as such because it assumed that the Newcastle train that travelled to Sydney had eighty wheels. This threat was regularly used against officers who were well established in this region but were viewed as "troublemakers", and especially those that didn't conform. The threat was a choice; firstly the officer could travel to Sydney, but that would require leaving home at 4am and returning at 9pm or, on the other hand, to move to Sydney where houses for the last three decades have been twice as expensive as the same houses in this locality. In North America I found a similar tactic employed, there this threat was referred to as a "freeway" transfer.

Another tactic for presumed recalcitrants was the transfer of a police officer from operational duty to a desk job. The radio room was just one choice. This tactic we now know today may have constituted a "constructive dismissal". For instance Bill Dodson (The Sharp End) says: "*As part of the reform process following the Wood Royal Commission, New South Wales Commissioner Peter Ryan revised the policy on "permanent restricted duties" police officers and announced they had no future in the job. As a result of this policy I was contacted by the personnel officer for Northern Region and offered a job on the new Police Assistance Line (PAL). Commissioner Ryan had sanctioned the PAL as the only alternative area of employment for permanently restricted duties' police."* Dodson then says; *"The prospect of spending the rest of my career sitting behind a desk with a headset and a computer terminal certainly wasn't what I had signed on to do. It was a case*

of horses for courses and with no disrespect to the people at PAL, given my background, it would have utterly bored me and in the process sent me round the bend" p263.

Barry's transfer to the radio room was undoubtedly punitive and aimed solely as punishment for not fitting in. Moreover, if such a duty could have the potential to send someone "round the bend" like Dodson, (about whom I make the tenuous assumption, was not previously suffering any psychological condition), then what would it do to someone who was so predisposed and with a fairly lengthy psychiatric history such as Barry?

So, in returning back to those who want to suggest that Barry's problems predated his posting to the Hunter Region, I would remind them that the ridicule at being in the police choir, the barrage of gossip and rumour that persisted for two years which caused the breakdown of his first marriage, was by any standards unacceptable harassment, and in as much his original breakdown was work related. Yes, of course he was then predisposed and thus vulnerable. It is the very nature of depression for those who suffer it to recover but then be more predisposed to further episodes. This doesn't, however, abrogate the Police Service responsibility in any way. Further, it could be expected that the bullying treatment at the hands of his supervisors, not just by their transfer of him, but their construed humiliation by way of an adverse appraisal, clearly could have caused the depression that initiated his referral to me.

This opinion is not just my own, but one shared and supported later in 1998 and 2000 by the decisions of two judges in both Industrial Relations Commission and Workers Compensation Court of NSW.

In returning to Barry's story, I need to point out that up until the point that Barry applied for workers compensation, I am convinced there was some hope that he would recover. But I would now like to explain what happened to him between 1989 and 2001, in all then a thirteen-year period from when he first went off duty and saw me until early 2001, when he received his police pension.

Believing his injury was work related Barry submitted an application for his condition to be recognised as Hurt on Duty. During 1989, when it was clear that he was not going to be able to return to work, he made a further application for medical retirement.

The Police Service historically has found ways to deal with all types of "troublemakers", recalcitrants, non-conformists, etc. For instance, Sgt Tom Arantz is a good example of retribution played out by the Service, having him found mentally ill. Likewise, even as recently as 1999 when the Service tired of William Dodson, they regarded him as having some type of personality defect or, as Dodson describes it, an *"authority problem"*. The NSW Police, for at least as long as I have been involved in treating police officers, too often attempts to find, not something wrong with themselves, but something wrong with the claimant, all of which may seek to cast the officer in the role of perpetrating his own illness, or otherwise simply malingering.

So in Barry's case too, the Police Service regarded that it was not the years of harassment, the combat fatigue generated by the nature of his work as a frontline operational police officer, nor was it the fact that he had lost a wife and two children, all of which was caused by malicious and vexatious gossip. Nor was it the fact that he was ostracised here in Newcastle because he was not deemed to fit in by his supervisors. Instead, his distress was deemed to be caused by his own fault, by way of his poor performance. In addition, his circumstances were derived because of a personality disorder. I would like to now outline how they mischievously went about proving that, and then clinging to that same story for over a decade.

Their treatment and subsequent assessment of his hurt on duty claim was an exercise in victim blaming. Dodson, again from "The Sharp End", says about victim blaming; *"it's more subtle these days*", but is it? It's too easy for someone reading this to suggest that I have caught a substantial dose of paranoia from the officers I have treated. But is what I am saying so unusual, and worse still, it's not just confined to policing. For instance in a brain storming session at a local engineering firm in 2001, managers were asked to come up with some ideas about how they would downsize their workforce. These are some of the suggestions leaked to the press. "*Departure lounges, where workers are given no work in the hope they will become so bored, they will leave. Transfer workers to horrible places, sack poor performers, create in-group and out group hostility that will force*

workers to leave". The list in fact went on further with over a score of these types of suggestions. In reading it, I am sure that some found it hard to believe in 2001; let me say this tactic was definitely evident in 1988.

I mentioned the process of gaining a hurt on duty approval earlier; such an assessment requires three reports aside from that made by the claimant. First, an opinion is sought from the supervisor regarding the legitimacy of any claim made. Secondly, the Police Service commissioned a report from the treating doctors, and also thirdly gained an "independent' opinion from, in the case of psychological injuries, a psychiatrist. It's quite obvious that the psychiatrist's report about Barry, and of course my own, supported him and suggested that Barry was suffering from depression, a condition that related to his work as a police officer. However, there were two hurdles that were then placed in front of Barry, and for that matter other officers, from the outset. Firstly, his supervisor's report was hardly going to be supportive. Even one from his local area commander would depend on the information given to him by his supervisors as he presumably had no knowledge of Barry's performance, behaviour or for that matter his well-being.

Armed with this report, the Police Service HOD Section sent him to a psychiatrist for an opinion, whom likewise conveniently, but not surprisingly, failed to identify any work related injury, but rather suggested the cause was a defect in Barry's personality, which she referred to as a "personality disorder", and thus a non work-related condition. While Barry's HOD Claim was rejected, his supposed personality disorder was regarded as sufficient to exclude him from carrying out his duties. Barry was then retired, not on a pension, but a gratuity representing two years pay. Nice, neat, clear cut, and rejected.

The Police Association then provided funding and legal counsel to appeal this decision, and what follows is the tortuous path that his claim took just to gain a redress of wrongs, a battle that took over thirteen years to resolve.

Despite a claim by Barry that the diagnosis of personality disorder was inaccurate and his counter claim that he was suffering a depressive illness, the Commissioner refused to accept such a claim and the matter was referred to the Industrial Relations Commission, where it was not heard until

1998. One can only wonder how it could have possibly taken a decade to get to a court to be heard. In the meantime, Barry had desperately tried to get on with his life. For work, he managed a block of flats for about ten months, but returned to Newcastle after the owner returned home to Australia and wanted to manage them himself. In that time Barry also met his second wife. While hopeful of a happy life together, it fell to pieces, when, to be frank, I think she found the going tough, living with a depressed person. By then, of course, the monies originally provided by his gratuity on separation from the Police Service had long since diminished; he applied, and was given, an invalid pension, based on chronic morbidity of endogenous depression.

After his marriage ended, Barry returned to live with his mother, where he continues to live although his mother sadly passed away last year. To say that Barry's life was difficult is to state the obvious, especially trying to live on less than $200.00 per week for ten years. In all of this he continued to pursue his claim. When this first started in 1988, the Police Service was not happy with just one opinion and sent him for at least three other opinions by psychiatrists. His own counsel sent Barry for as many others, and not surprisingly, when they were all compared, there was a substantial difference of opinion.

Over the next ten years aside from being isolated and alienated, Barry complained that he felt he had been hijacked into leaving his job, one that he loved, and the "only thing I have ever been good at". Barry resented being in the position he was in and, despite our claims that the diagnosis was unfair and that he did not suffer a personality disorder, the Police Service argument was otherwise. I think their argument was; how was it that someone who did no more and experienced no more than anyone else could suffer from work related depression, without it being in fact simply a constitutional disorder and thus not work related? They would not even accept he was depressed whether it was work related or otherwise. This was frustrating, and I once wrote to his solicitor and said, *"Well, lets even accept for a moment that he does have a personality disorder, could they not see that such normal circumstances of employment as they ascribe, in such a predisposed person, in fact could cause a psychological injury"?* Further, in a no fault system of workers compensation as it is in this State, Barry's condition, irrelevant of any issues concerning personality, should be regarded as work related, irrespective of any claimed predisposed personality. This comment, and one other I made in the intervening years, was to come back and bite years later while under cross-

examination. I might add that when this analysis was challenged by the NSW Police the Industrial Relations Commissioner could thankfully see through their attempt to discredit me, but I will return to that a little later.

What I noticed about Barry, and in fact many others who I was treating at the time, was a commonality of symptoms that related not just to whatever they had been originally suffering from and subsequently diagnosed, but then a collection of symptoms that developed following isolation and subsequently invalidity. The effect of the harassment and discrimination over time waned, but in Barry's case the depression continued. Clinically this is understandable as the depression becomes more bound up in distinct chemical changes in the brain. Thus, even in the absence of the initiating stressors the depression may continue, some refer to it as a "depressive neurosis". Of course that all makes sense, but then I realised the process of making a claim, and the appeal, was in itself an extremely stressful and at times a traumatic process. In a paper I wrote for "Forensic Issues in Mental Health", in 1991 titled "Twenty Pieces of Silver", I said the following about what I termed the "Hettinger Syndrome";

"I found out after coining the term that in fact there is a medical syndrome already related to RSI called the Hettinger Syndrome, so I have recently called it more accurately the "Karl Hettinger Syndrome". You may recall Joseph Wambaugh's book, "The Onion Field". In it he describes a critical incident where two police officers are abducted, one is shot dead; the other – Karl Hettinger – escapes. He develops some classic symptoms of posttraumatic stress, becomes dysfunctional and unwell. As a result of this, and some considerable time later, he applies for the police pension. I describe in my paper that the development of his symptomology from that point on are somewhat altered as he faced literally dozens of psychiatrists as the LAPD attempted to abrogate their responsibility. Eventually, for twenty pieces of silver one psychiatrist assessed him as not traumatised but suffering from a predisposed illness, an important determining legal issue in the USA. Despite this, Karl eventually won his case at court but not until after he had been through an experience that was humiliating and excessively distressful, an experience that reinforced his sense of loss of control, abandonment and disillusionment toward an organisation to which he was dedicated. The symptoms were in fact an exacerbation of and creation of a secondary disorder, which did not relate directly to the actual disorder for which he claimed compensation. Remarkably

when I was in Houston in 1986 completing some research on stress and policing, I found that workers had in fact taken out secondary claims for "stress" caused by treatment of them in making a claim of work related stress.

I believe that the delay in getting Barry's case to an industrial court some ten years later was in fact an object lesson to him served up by the Police Service. This delay, where justice was in fact denied, was just another form of the "treatment" that I have come to expect from the NSW Police. If someone reading this chapter could explain and justify such a delay, other than through shear malice, I would be happy to hear such an alternate view. If you are reading this and you were part of that malevolence you should know that it was this delay that I believe provided the basis for Barry's despair and subsequently contributed to his lifetime battle with depression. It was all so bloody preventable.

By 1998, almost a decade after he first lodged a claim, an industrial court judge heard the case and made the following observations about Barry. Firstly that, *"He was very careful to be accurate in his recall of events and gave evidence in a responsive, clear and balanced manner without exaggeration or any attempt to put a gloss on the facts. I accept his evidence."* P8. His Honour noted that prior to the adverse assessments and subsequent diagnosis of personality disorder Barry was, to quote from three previous appraisals *"an efficient and effective Member who obtains good work results and has a pleasant manner".* What his Honour had to do was to try and reconcile these quite desperate descriptions of Barry from several performance appraisals over a number of years, but also reconcile the type of observation in relation to his performance and his life more generally with the Police Service's allegation that he was suffering from a personality disorder. His Honour was thankfully not able to, (not just from the evidence that was given), but he made an informed deduction from a psychiatric manual, i.e., the Diagnostic and Statistical Manual of Mental Disorders.

From that he was able to differentiate the notion of a personality disorder and simply traits of personality. He noted, quite rightly, that in a personality disorder, *"the personality feature must be evident by early adulthood"*, at least, for instance, by the time Barry had joined the NSW Police Service. Further, he noted that the disorder should be manifest over time and across different

situations, and that these disorders must be distinguished from characteristics that emerged simply in response to specific situational stressors or more transient mental states. This was a critical understanding by his Honour and one that Barry's psychiatrist and I had argued for years.

Of interest and of concern was that both Barry's psychiatrist and I saw the underlying condition as depression in the broad sense, but saw it against a dysthymic personality, one that we were able to separate from a personality disorder. To explain, according to Theodore Millon, we all have weak points in our personalities, or as he refers to them as a "diathesis". These are somewhat akin to our physical weak points, where we may be more susceptible to certain ailments, eg asthma, migraine, dermatitis. In short, like people who suffer these ailments, we may be more prone to be more psychologically affected by different types of stress. If all people with personality diatheses were to be regarded as having personality disorders, then everyone would have a personality disorder, an obvious nonsense, but a nonsense argued by the Police Service, a position we were unable to penetrate for over a decade.

I mentioned earlier that some of my comments to Barry's solicitor in trying to assist them came back to haunt me. In my evidence, counsel for the police suggested I had become no more than an advocate for Barry, in this way impugning my evidence. This attempt was rebutted by his Honour when he said as follows: "*I might comment at this stage that there was some adverse comment by counsel for the respondent that Dr. Peters was more an advocate for the appellant that an objective witness offering professional opinion. I can understand that criticism being levelled against Dr. Peters, but, on balance and after reviewing his various reports, and particularly having had the benefit of observing him in the witness box, I am satisfied as to Dr. Peters' professional objectivity and of the opinions expressed by him. After all, he has had a long association with the appellant in the context of treating him for his illness and I think Dr. Peters was concerned, perhaps overly so, to ensure all the facts were known to enable a proper decision to be made as he saw it. I do not discount his evidence for that reason.*

Dr. Peters said that from the outset he did not believe the appellant had a personality disorder because he did not meet the criteria laid down in either DSM IIIR or DSM IV"

Before turning to the findings in the Industrial Court of NSW, I want to recount some evidence from the hearing that was later used in the judgement. When the first psychiatrist, on behalf of the Police Service, originally assessed Barry, he was given a psychometric assessment. I gave evidence that the independent psychometric assessment, initiated by the psychiatrist 10 years before, actually provided her with the necessary evidence that Barry was not suffering from a personality disorder, but she chose to ignore that. I have relied on the transcript, and only varied it so as to not include any of the names for the defendant, otherwise it is verbatim.

His honour commented as follows: "*As to his own views based upon psychometric testing of the appellant, Dr. Peters gave the following evidence*":

Q. I refer you to your most recent report dated 24 September 1997. You said on page 3 of that report the following, "It is interesting that when any psychometric tests have been completed … there is no psychometric evidence that Barry has a personality disorder."
You then go on to comment about Dr "Smiths", "blind interpretation" of an MMPI. In relation to that comment, can you, first of all, tell this Court what constitutes psychometric evidence and psychometric testing?

A. Psychometric testing is a manner of asking people a series of questions and, depending on their response, examining those responses against a normative base, that is, a group, a population, in the case of the MMPI, tens of thousands, and comparing their personality with this form and personalities within the normative group.
This allows independent "blind" assessment – in other words, the psychiatrist does not necessarily see the patient beforehand, and in fact the psychometrician can actually deliver this questionnaire sight unseen, can get an interpretation and then compare that interpretation with their clinical observations, thus providing testing oversight. In 1988 in the prestigious journal "Science", Faust and Ziskin said that the average psychiatrist on 45-minute interview diagnoses no better than the layperson.

Consequently, since that time there has been a frequent use of psychometrics to assess people, to test the diagnosis of the clinician. That is why I suggest that the defendant's psychiatric expert, used Dr Smith, a neuropsychologist.

Q. Is it common for psychiatrists to refer the issue of psychometric testing or psychometric evidence to psychologists?

A. It is not as usual as it should be but the defendant's psychiatrist, in fact, was one of those people who, prior to that, used a psychologist by the name of Jones. Some refer to it some don't. I would suggest that the preponderance of psychiatrists do not still use psychometric testing.

Q. Do you consider psychometric testing to be more the field of psychologists or psychiatrists?

A. Invariably they have been tested by psychologists and researched by psychologists, so of course I guess it is the area of psychology.

Q. What is the MMPI referred to in your report?

A. Minnesota Multi-Personality Inventory.

Q. Is this a form of psychometric testing?

A. It is indeed.

Q. You yourself conducted psychometric tests on Barry?

A. That is correct.

Q. Are psychometric tests a good means of identifying personality disorder?

A. Excellent. In fact the Australian Defence Force uses them entirely throughout recruiting, as does the New South Wales Police and many others.

Q. The New South Wales Police use them now. Are you aware whether they used them at the time?

A. They didn't use anything at the time of Barry's recruitment.

Q. Did the psychometric tests you carried out indicate the presence of a personality disorder in Barry?

A. Certainly not.

Q. Do you recall what they did indicate, if anything?

A. They indicated that Barry was suffering from a high level of anxiety, severe level of depression.

Q. You have seen the report of Miss Smith in relation to her interpretations of the psychometric tests she did. Is there anything in that report that leads you to the conclusion that her psychometric tests disclosed a personality disorder?

A. In fact quite the contrary. What her tests showed was Barry's personality traits and styles that were all unique to him of course, but nonetheless just a mere style and the characteristic way in which he behaved under certain circumstances.

Then again his Honour, in relation to the defendant's psychiatrist evidence, notes that *"In my view from the evidence of the psychiatrist in diagnosing the appellant as suffering from a personality disorder, has contrary to the criteria laid down in DSMIV and the evidence of Dr Chenoweth, Dr Klug, Professor Raphael, Dr Steele and Dr Peters failed to distinguish between a personality disorder and personality traits or characteristics.* In fact His Honour was critical of both the defendant's psychiatrists, and said the following *"Therefore I do not accept any opinion that supports a diagnosis of personality disorder"* p 39.

His Honour was also critical of another of the defendant's psychiatrists, another "hired-gun" for the NSW Police Service, and said about him; *"In the real sense it seems to me, he does not discount the fact the appellant may have had a major depression but rather he grouped such a condition with personality disorders as mental illnesses genetic in origin",* p43 In addition he said, " *It troubled me in reviewing the doctor's evidence that he related the appellant's maladaptive response to being unable to live in reasonable harmony with a female, whereas over the same period of time the work as a police officer was considered to have no relevance. Having in mind the terms of the DSMIV and the opinion expressed by the medical specialists for the appellant I am quite unable to accept that logic"*, p44-45.

His Honour ordered the appeal be allowed.

Thus Barry thought his journey was over, but it was anything but. However, rather than accept the simple decision, which was to have his psychiatric condition accepted as depression caused by work related stressors and the infirmity of personality set aside, they chose to deny him his right to a police pension for a hurt on duty injury. To emphasise the clarity of His Honour's decision, he

said; *"It is certified that the appellant was incapable from the infirmity of major depressive illness of discharging his duties of his office as a Senior Constable of Police as at 25 May 1989 and at all other relevant times in consequence of why he was discharged from the NSW Police Service on June 8th 1989".*

I am not sure a clearer decision could have been given, yet the Police Service refused to provide a certificate of infirmity that would allow his pension to be paid. Barry was then forced to take his matter to The Workers Compensation Court and it was finally listed some two years later, and again resolved in his favour many months later. The case was heard by Judge Ashford. What was interesting here was that the Police Service sought to gain no new evidence and, while a simplistic explanation of their position, I think their argument went something like this. Despite Coram Hungerford's decision, we think he was suffering a personality disorder and even if he was suffering from depression it wasn't work related.

So poor was their preparation, so benign their claim, the matter was heard mainly by way of submissions rather than a full hearing. Judge Ashford's opinion was as follows: *"It is my view that the applicant suffered psychological injury from his employment and I am satisfied this was not a mere emotional impulse. Clearly there has been a major depressive illness and the balance of probabilities I am satisfied this was a result of his employment with the respondent. He has been certified as unfit for the work of a police officer and has required treatment. I accept the opinions of his treating psychologist, Mr Peters, of Dr Chenoweth and Professor Raphael in that regard."* P12. "*I set aside the decision of the Commissioner and find the condition of major depressive illness was caused by the applicant having been hurt on duty." P12*

So after 13 long years Barry's injuries were accepted, and some months later he received a superannuation payout. However, a failure to submit a particular document by his solicitors in 1989, one that would have seen him paid by the NSW Police Service, resulted in a financial loss to him. I estimated that to be in excess of $300k. This meant that in all of this, aside from the astronomical legal fees the total I am unaware of, (paid for by you and me); the Police Service paid Barry nothing more than his medical fees that had accumulated over that time. However, the superannuation payout was substantial and the recommended legal action against his solicitors for negligence,

(interestingly enough suggested by a clerk from the police HOD section) was considered but not proceeded with. You may well ask why the appropriate papers were not lodged in 1989. I think that negligence is a too simplistic explanation. I really believe that his counsel at that time did not expect him to be successful.

There is a postscript to this story, one that sadly continues. The first part is did the money make any difference to Barry? As he points out, what's the point of money if there is no one to share it with? His life style has changed little, but we both thought that the settlement would be also a symbolic win against the years of malevolence the Police Service had perpetrated against him, but secondly and importantly also provide closure on a painful chapter in his life. Sadly this was not to be the case. Some time afterwards the Police Superannuation Committee wrote to Barry and explained that more than two-thirds of the settlement has been made by way of over-payment and sent a letter of demand. I wouldn't say that Barry didn't take it in his stride, but who would? However he has continued to manage with depression, did he fight that decision? You can bet your bloody life he did, and won!

The purpose of this chapter is not to suggest this is typical, nor was it aimed to detract from the positive sentiment that should be the main message of this book. I asked a question whether it could happen today; sadly I think the bullying might be of a different nature, but I think issues of bullying and harassment should remain high on the Police occupational health and safety agenda. It's unlikely that such a protracted legal process could occur again, but then, nor should it. However, reading any police journal, especially the Police News (NSW Police Association) "Mailbag" section, the type of reluctance to recognise work related injuries and the inordinate time to resolve cases such as Barry's still features strongly in the letters published. The financial cost to the taxpayers is immeasurable, while the cost psychologically to the officers and their families is nothing short of tragic.

In fact, the cost to families in this type of circumstance is often enormous, and may threaten the very survival of a couple's marriage, and of course, Barry paid the ultimate price, as Bill in chapter 7 almost did as well. Thus it is appropriate to move now to the issue of relationships, in particular how to best protect them and the subject matter of the next chapter.

Chapter 8

Relationships

"Our house wasn't a house it was a home, because mum and dad loved each other" - Dale Kerrigan (The Castle – A film)

As I indicated in the introduction of this book, I wanted to make it a book with a difference. Certainly the following chapter may seem, in part, incongruent with the themes and other ideas developed so far. Yet relationships are so often the casualties of the work we do. I have raised the idea of co-dependence several times in previous chapters, along with a concept I refer to as "Le folie au deux", hopefully emphasising the point that when one person is suffering from anxiety, it can have a contagious effect; just look at Bill's family as a case in point in chapter 6.

Importantly, when a relationship struggles and work is overly stressful, even traumatic, then it can be said to be fighting a "war" on two fronts. I use this analogy with clients, pointing out that history is checkered with some catastrophic outcomes when generals have tried to fight battles on two fronts. So too, if you think you can "fight" your personal life on two fronts. Simply put, a happy home frees us to tackle the stress and strain we may experience at work, while on the other hand if we are struggling with our personal relationship, then work may provide us somewhat of a sanctuary. The following chapter stems from some work I do with couples; i.e. my program "Reinventing Relationships". Also, the basic elements are taken from a segment of this program, and I hope it will provide some valuable insights into our relationships, even save yours if you are presently struggling.

There are some commonalities in the types of challenges most relationships face. There is an almost cliché single comment that most grab on to i.e. communication. If resolving relationship difficulties were that simple (as anyone can learn to better communicate) then most relationships could be and would be, saved. The facts of the matter are that I think it is a tad more complex.

Background

If fact, while I am the first to cite communication as an important factor in the wellbeing of a relationship, I am also aware that, over time, our relationships with our "better half" change. The period of falling in love is probably hormonal, and I can even give you the likely culprits; oxytocin in women and vasopressin in men. The half life of these chemicals is probably no more than two years, from then on our relationships need to grow and take on some different characteristics, from an almost infantile stage to adulthood. Sometimes this shift is difficult to make and can cause confusion. So that, not feeling as we once did, we may feel that we are "no longer in love", simply because that "it" factor we recall from our youth is not quite the same, or is even absent. But nor should it be!

Love grows and changes in its dimension and character over time, thus we not only need to recognize this, but grow with it. Importantly, we need to realise that life changes within marriage cause us to think differently, not just about each other, but about the world in general. For instance, there is a major change when children come along, but so too when they go to school, then leave school, and even leave home. The title of my course "re-inventing our relationships" was coined because it is important to understand that how we were together at one stage of our marriage, will not do at another stage. People often say in coming to relationship counselling, "I wish we could go back to the way we were". This is not only impossible, but not prudent; after all, as I explain, "how you were got you to being ultimately here!"

John Gottman is a favourite author of mine, and he has spent many years examining relationships. John some time ago took me away from a rather myopic focus on communication, to one that emphasises friendship instead. That is not to say that communication is not important, and I will come back to that shortly, but John emphasises that friendship is ultimately the key to happy couples. John derived a good deal of his theory from his so-called "love shack" experiments in Northern America over the last 20 years. He asks people to spend a weekend in this pleasant retreat while he films them. You will be happy to know that this isn't in the bedroom or the toilet. Like most who study human behaviour, it's not very long before couples, despite being filmed, start

to behave the way they normally would. Some of us who have been unfortunate enough to view reality television have seen the evidence for that.

The end result of viewing thousands of hours of video footage of couples led him to the conclusion that friendship, rather than simply communication, is the key to a good relationship. It is this notion of friendship I want to return to later

More on Communication

Most of us have had the experience of participating in courses that have been aimed to improve our ability to communicate. Easy, perhaps in the classroom, and to some extent, in our more general lives, but I fear much more difficult in our life as a couple. The dictum, "when in stress we regress", is a phrase I coined in the 80's when conducting management training. I suggested then that we can train people to change their communication style, but predictably, under pressure or in crisis, a person's personality and fundamental style is likely to return to the fore, almost no matter what techniques have been taught.

However, I would again refer to my "Building Resilience" workshop, of which you will find a copy on my website. I suggest there that there are in fact no bad personalities, simply creative or destructive ways in which we use them. Oddly enough, this always seems to be much more obvious when we are involved with people we love. How many times have I heard one partner say; *"You wouldn't speak to one of your employees like that"*. I am quick to point out that they are hardly likely to be passionately in love with an employee, or indeed have the same sense of responsibility or concern for an employee as they might have for their children. When emotions are involved, how we communicate changes!

"The Story of Us" and returning yet again to Communication

A further technique that we developed during our lifestyle program was to introduce a popular film to demonstrate some of the key points in healthy communication, and how quickly good communication can deteriorate into an argument, and worse. In the "Reinventing Relationships"

module there is a reference to the film, "The Story of Us", staring Michele Pfeiffer and Bruce Willis. We show two segments of that film; one part is towards the beginning of the story, the other at the end. Bruce Willis and Michelle Pfeiffer are acting out the role of a couple who have just returned home from Rome, and are having a simple conversation in bed, which should have ended in a rather splendid way, instead it deteriorates. They use almost every single destructive strategy of communication including:

- Escalation
- Invalidation
- Negative interpretations
- Withdrawal and Avoidance

Of course, the argument they have proves to be a watershed in their relationship and, shortly thereafter, leads to their separation. Of course, it is a film of redemption, and towards the end both realise that they have a history together and that they want to keep that history, not just because of the kids, but because they worked so damn hard on it over the years.

A glitzy, perhaps even "gooey", film for some, but I have never seen anything like the bedroom scene that within a few minutes encapsulates all the negative and destructive aspects of communication. So, even if you don't watch the whole film, I think just scene 17 on your DVD will give you three minutes that you will undoubtedly (as all of us do) identify with.

This has led me to hope that I could find more films like "The Story of Us", because quite interestingly, yet not surprisingly, it seems when I show the film people are able to learn a lot more from the descriptive portrayal than simply words, even perhaps more than these words in this document.

It may not be just your marriage and relationship you are harming! Research in the latest 2005 issue of the Archives of General Psychiatry showed that the stress of a half-hour domestic dispute is enough to slow down the body's ability to heal itself from physical wounds by an entire day. The study included 42 healthy married couples, aged 22 to 77, who had been married for an average of 12.6 years. Couples made two 24-hour visits to a hospital research unit. On the first visit, they were instructed to interact with each other in a supportive way, while on the second visit, they discussed

a marital disagreement such as money, communication or in-laws. A vacuum pump was used to produce blisters on each partner's arm, and the wounds were examined several times over the following 12 days. Researchers found that couples' wounds healed more slowly following the argument than after the supportive discussion, and couples who were highly hostile towards each other in both sessions healed 60 per cent more slowly than couples with low levels of hostility.

The Foundation of Marriage is Friendship

In the "Reinventing Relationships" sessions I conduct for couples, I point out that there are four hallmarks in any sound relationship. These are: a) feeling safe; b) shared responsibility; c) intimacy; and d) planning. (See: www.heas.com.au) These four hallmarks are critical if a relationship is to survive.

This chapter is primarily based on my encounter with John Gottman's ideas about friendship. By way of background I want to first explain, just for a moment, an experience that Michele, my partner, and I had when presenting a lifestyle course for a war veteran population.

We decided, as an "ice breaking" exercise, (it was a week-long course) that we would use something rather typical to help everyone get to know each other. A lot of these people had not met before, but in the main they were there with their partners. You may be familiar with "ice breaker" techniques; these allow a facilitator to introduce a non-threatening strategy for introducing and getting to know his or her audience. This particular exercise involves five questions – your favorite film, your favorite book, your favourite food, the most inspiring person you can think of, and who would you like to be trapped on a tropical island with. On this occasion, however, we used a slightly different strategy and we asked each couple to respond for the other.

We had conducted six courses when the pattern became clear (we have since run 31) i.e. the average score to these quite trivial questions for couples on the courses, was just three. Making this result even more surprising was that these were not people who had been married for a short period of time, but, by our 'guesstimate' was at least 25 years.

With these results in mind, it got Michele and me to thinking, "what is it that these people talk about to each other" and what does that imply about friendship?" You see, I think the key to friendship knows the other person, their concerns, their worries, their likes, their dislikes, etc. Surely this is what friendship is about. You may not know things about acquaintances, but really good friends should know many of their most intimate details and their biographical stories.

So it struck us that this poor score may be reflective of some inadequacy in their relationship, or, at least the way in which their friendship has developed. For instance, one of the reasons that they didn't know all the answers to the above five simple questions was perhaps because they had simply gotten into the habit of not talking or, worse still, ignoring each other? We decided that if this lack of awareness was true in respect to these rather simple and trivial quiz questions, then how true may it be in relation to the deeper and more profound issues indeed that may never be discussed? Again on my website you will find two of John Gottman's questionnaires, i.e. "Building Blocks for Relationships" and "How well do you know your partner".

These are certainly worth completing, and perhaps sharing with your partner. For friendship is undoubtedly the key to sound relationships. Friends would and should know the answers, not just to all the simple questions, but as a result, they would also feel affirmed and appreciated by the other.

Friendship is Affection and Affirmation: The ultimate two elements

There are two ingredients that I have learnt after being married for over 37 years, and I believe these are common elements that are true for women and men. The first of these things is "affirmation", and the second is "affection". Fortunately, I was able to find an Australian film for my course, i.e. Reinventing Relationships", that demonstrated these two elements repeatedly. Most Australians have seen the Australian film 'The Castle', which involved the Kerrigan family. I would like you, at some stage, to watch that film together, because I think you can ask yourself "to what extent can we identify with the Kerrigans?"

The film is, of course, a comedy, and unless you are particularly eccentric like Darryl Kerrigan, and you have children who are certainly intellectually challenged, you may think that there is little you have in common. Bill Collins, an Australian film critic, says we should always watch good films at least three times. I invite you to watch this film, not for the story line, but to understand the family dynamics and what it is to have unconditional love for each other.

The comedy aside, the story betrays some real issues, cultural and social, as to what it is to be an Australian. The film also highlights the critical elements of all successful relationships, not just between partners, but between children as well.

While this two-element theory of successful relationships may seem at first for too simple, feedback has indicated that the practical application of both can make substantial changes to a relationship. These elements, I believe, are the fundamental core values found in all successful friendships, and consistently desired by all of us, i.e. we just want to be valued and loved.

Affection and Affirmation Portrayed

In “The Castle”, young Dale Kerrigan tells us at the beginning of the movie that his “dad is the back bone” of the family. He says, “That mum is the other bone”. Steve later says “The only reason I love that house is because it had mum and dad in it”. Can you say that about your home, your parenting? Is dad the backbone of the family? Is dad the leader, because that’s what the word “father” means? Do you tell stories to your kids? In the film, Yvonne tells how Darryl and she first met while she was on a date with someone else. Examine closely next time why she was struck by him. She called him “lanky”, but as a man who had “obvious principles”. Dale, Darryl’s son, tells us “Dad just loves us kids to death”. Steve talks about present giving as being important, he reminds us that after one particular father’s day Darryl said, “That was the best father’s day ever”. Do you remind your children that you are appreciative of them?

Darryl waits for his son Wayne to return home, he still unconditionally loves Wayne, who is in gaol for an armed hold up. One of Darryl’s biggest concerns is how he will tell Wayne (the son that must have let them down so much), that their home is going to be compulsorily acquired by the

government, and that there won't be a home for him to come home to. This level of unconditional love is an exemplar of how we as parents should love our children. (By the way, someone once said, "conditional love is an oxymoron").

However, I want to go back to the way in which Darryl and Yvonne relate to each other in this movie. There is, throughout the film displayed a continued and open affection between them. They show and tell each other how much they mean to one another, but more importantly, they touch. It would seem to me that Yvonne couldn't see the flaws and the often stupidity of Darryl, even when he buys a chicken coop, jousting sticks, or invests money in dogs that haven't won in years. What kind of tolerance and affection do you show each other? And what kind of affection do your kids see? What kind of lessons about marriage and family are your kids learning as a result of your relationship?

The second of these almost ridiculously simple strategies is that of affirmation. From the beginning of the film to the end, almost irrespective of Darryl's concerns, he finds the ability to affirm his wife. There is one point in the movie where his son said "He was so down he even stopped complimenting mum on her cooking". Ultimately, it's not what you do occasionally in terms of your relationship; it's more what you consistently and persistently do that ultimately makes the difference. Darryl consistently and persistently affirms his wife. For instance, Darryl in the kitchen, "And what do we call this darling?" Yvonne's reply is it's a "sponge cake". Darryl says "And on the top", Yvonne says "icing". Darryl says, "Well kids, why would you want to go out when this comes up night after night?" Later, when she is giving him a beer stein for his father's day, Yvonne says, "I should do pottery". He says, "You would be good at that". How many times have we missed an opportunity like that and, rather, said instead something sarcastic like "What would you want to do that for?"

Another example of Darryl Kerrigan's ability to affirm is "This is a beautiful dish, what do you call them again?" Yvonne (smiling graciously) says, "Rissoles, everyone knows that". So even in the minor every day mundane matters, Darryl reminds Yvonne that she is not just loved, but affirmed in everything she does. As I say, if you haven't seen the film, I suggest you do.

You see at the conclusion of all of my study, and more than 37 years of marriage, I am convinced that these key elements remain, i.e. affirmation and affection, the most important. I use, by way of a vehicle here, the film "The Castle", because I think, in all its simplicity, the film demonstrates what I have found so lacking in too many relationships. I have, for instance, tried to encourage couples to try and give up criticizing and directing each other (directions can sometimes be an implied criticism, i.e. you doubt the person knows what they are doing!), but quite frankly most find this too difficult, (even for a day). Indeed it is hard to change our behaviours, all of which are so entrenched and almost involuntary. However, adding some new behaviour rather than stopping old behaviour may be simpler. So my challenge to you is, to show your partner more affection every day, and to offer some random acts of affirmation as often as you can, on a daily basis.

Trauma and marriages

As much as it's tempting to stay on this subject of relationships, I think it's important to relate it back to the subject matter of this book, i.e., Police under Pressure. As you can see in Bill's story, one of the casualties of Bill's fall from grace was his family. Like many men, he hid in "his cave" (as John Gray talks about in "Men are from Mars and Women are from Venus"), yet Anne entered the "cave" only to have "her head bitten off". Their relationship was, as she said in chapter 6, "like walking on eggshells". The children resented Bill's mood and his poor control of anger, which was too often directed at them. Ultimately though, Anne and Bill were friends, they had endured a lot together and as mentioned earlier, "they had a history", which they both cherished. When Bill and Anne got to communicate and, more importantly, explore their friendship, they became galvanized and the family was protected and became the beneficiaries.

I have lost count of the number of police who suffer from conditions of Post Traumatic Stress disorder, and have inadvertently damaged their relationships, some permanently and fatally. If you are struggling with your relationship, if anxiety and depression is causing you to be withdrawn, avoidant and isolated, you must fight it. You must find a way to break down the barriers. It's interesting, but earlier I mention Basel van de Kolk a psychoneurobiologist, one of his remarkable findings, now more than 20 years ago, is that when a person is traumatized, often an area of the brain, i.e. Brocca's region, is inhibited. This is the region of the brain that governs speech and

language; it's interesting that people so often use the jargon, after being traumatized, "I can not talk about it". Basel found that by allowing an opportunity to ventilate and actually talk about the trauma helped. His topographical studies of the brain, not surprisingly, found that after talking, Brocca's area was then dis-inhibited!

Quite often when I diagnose a police officer with PTSD, I ask the partner to come in for a session where I discuss the implications of this condition for them as a family and their relationship. I explain the issues relating to anxiety, the impact on libido, and moody behaviour that may be some cause for concern. Likewise, I try to establish that while their partner may need compassion and understanding, they may at times need to be dealt with firmly. For instance, its not O.K. to drink excessive amounts of alcohol, with or without their medication! No, they may not feel up to going to a farewell or "send off", but they can and should attempt to take you, say, to a local restaurant. In fact as I mentioned earlier I have prepared a small brochure, i.e.,"Partners and PTSD", which is an appendix to this book and also available on my website. You may find that helpful if you are a partner or, even if you are a member of the police, it might be a useful brochure to share with your partner

A final comment on this chapter on relationships is to express, from a male's point of view, how the lack of communication can create a worse understanding. When I am stressed, I quite often prefer to be quiet, not articulating my concerns; my wife calls this "brooding", but I think otherwise. Another problem I have when I am stressed is that I don't like to be touched, "just keep your distance", "don't bother me", etc. The problem with this is that my lack of intimacy can be misunderstood. For instance, this lack of intimacy, if it persisted, could say to my wife, "you are not attractive", even "I don't love you". A woman regards touch and talking as critical to intimacy. Thus, for many men no sex, then there is no other intimacy. It's easy to understand how this can then be misconstrued. Perhaps from the woman's point of view, I am not loveable or attractive, but perhaps worse, that there is someone else.

Fear and foreboding means these issues and these matters are never addressed and are left to fester. Nagging may start in the relationship, and small issues are then blown out of all proportion! Perhaps a man's reaction to that is to avoid, even, as indicated in Bill's case from the previous

chapter, begin to drink more heavily, and then almost to the point of separate lives. Anne, in the previous chapter, sought solace elsewhere and, regrettably, in hindsight, made some poor personal choices and was exploited.

How is your relationship? The almost superficial treatment I have given this topic is little more than the ideas I have developed over the years. I wrote Chapter 3 to highlight interventions and resources available, i.e. the chaplaincy service, the Employee Assistance Branch, as well as agencies outside your police agency. Here in Australia "Relationships Australia" can provide couples expert counselling service. In fact, at the time of writing this book, the federal government is providing funding specifically to allow couples to get help. With the marriage attrition rate probably at 50%, the cost socially, culturally and financially is a significant burden. If you are under pressure and you need assistance, it's available. Is your relationship going to become the vicarious victim of the work you do?

In fact so many police when they decide to leave policing explain that it was much easier when they understood it was the police or their family. Some recognised this in hindsight, too late, while others realised before and before they got a “tap on the shoulder”, the topic of the next chapter.

Chapter 9

A tap on the shoulder

If you've got to go, better go now, go now…….. Moody Blues (January 1966)

A great mate of mine is Michael Hagan, and for me he is in fact one of the finest men I have ever met, though I might say he has had some pretty tough competition for that accolade, after all I have had some 60 years on the planet. In fact I dedicated one of my previous publications, "Sporting Body Sporting Mind", to him. I might say it brought his wife, Sue, to tears when she read it, but she likewise is as in the Kerrigan family, (see previous chapter) the "other bone" to their family. Michael spoke to me just before his retirement from professional football and said, "Rog, I just need to know when to go – I would hate to get a tap on the shoulder".

I start this chapter with this brief story to say that ultimately police need to know when to stay and when to go. One of my previous books, "Managing the Impact of Trauma", starts with the words of a police officer of some 13 years standing who came to see me. You see, I am convinced that police have a so called "shelf life" in terms of their career, and knowing when that is approaching, and then doing something about it, is critical as to whether they will go on to live normal and healthy lives.

So where are you? Here are four distinct phases. Starting with the last, are you John, who conducted an orders group at his local police station and then went to the toilet and blew his brains out? That's the last stage and far too many cops have got to there. Are you Peter, who they found in the foetal position, sobbing like a baby, who then spent 6 weeks in a psychiatric unit? That's the third stage. Or are you the officer that is so cynical and bitter that the check list in Chapter 5 on Burnout is an inventory of your wellbeing, or rather should I say your poor health? Or are you at the first stage, wondering how you can escape from the overwhelming pressure you feel, still loving the job, but unsure how long you can endure it? Those last two stages are indicative of "burnout" (stage 2), and "brown out" (stage 1).

So at what stage are you? If you are not even at stage 1, I suggest you keep working but use the resources outline in Chapter 3 and certainly some ideas from the final chapter of this book, i.e., build your resilience.

For those suffering burnout, but not yet at the 3rd and final stages, this chapter is addressed to you. There are at the time of writing this book somewhere between 20-21 million people in Australia, all but between 17,000 are doing other things other than being in the NSW Police Force and some, if not more than most, are happy. I use this to emphasise right from the outset, that your happiness is not contingent on being a cop.

Mark Franklin, one of the most charismatic CEOs I have ever met of any organisation, in his case Energy Australia, at the time said that "I only want people who want to come to work to be here". He said that, "If you say you 'have to go to work', give up and do something else". Thus the first test for a cop is to work out whether they still have a vocation. Is it still a sacred trust? If not, then all the money (which is indeed substantial) will not sustain motivation. Again many officers claim that they are locked in and compelled to work because of the good income that cops receive. It is true that police are paid better they were 20 years ago. However there are so many jobs that pay well. I think this claim, i.e. an income protection issue, is a fake, or sometimes just used as an excuse for so many to do nothing.

To help develop your vocational goals and keep focussed on what's best, it's important to seek help. A mentor is a good idea; in fact, we can all do with one of those. This is a person you respect, with whom you can discuss a range of issues, including your career. In the old days (and perhaps rightly treated with suspicion) was the idea of having a "sponsor". Whereas this has some overall implication in respect to perverting the promotional system, i.e. looking after one's mates, the idea of someone to help you guide your career makes sense. I read in a book recently "Jesus and Leadership by Wilkes (2005), he suggests that we all need a St Paul, as a guide who has trod the path before, a Barnabas, someone who loves us but is not overawed by us, and a Timothy, who we can pass the baton on to.

So many cops wait impatiently for the Police Force to change; even more fancifully, that it will somehow change to how they think it should be run. To them I say good luck! This belief is one of the reasons that many police see the "old and bold" as "dinosaurs", or simply malcontent.

In fact, as I suggested in chapter 1, they are simply representative of the previous paradigm of policing, rather than from the emerging paradigm. Those from the previous paradigm have a wish or desire to return to old methods, and of course their view is often romanticised, which is common place not just among those police I have worked with, but I suspect this is a world wide phenomenon. Added to this is that older police officers who have been overlooked for promotion may feel threatened, even cheated, by the younger and "upwardly mobile" new generation of duty officers, (Incidentally two moments of insanity in NSW Policing were the introduction of duty officers and "leading senior constable"; in what military or para-military organisations is there such rank?). A further point that I have noticed among the NSW Police; many officers who could rightly be expected to move on through the ranks at some stage take a career option to remain where they are, coined "a desirable location", often to bring up their family. This is indeed their choice, but they then become frustrated by the lack of recognition by way of their experience, ultimately (and unhappily) being often subordinate to a supervisor they see as - to use police speak- incompetent "bosses".

This causes a high level of discontent and more general unhappiness. Such a negative, even hostile, work environment obviously sets the scene for a greater risk of occupational burnout among this particular group of officers.

Police come to see me in any one of the stages mentioned above; thankfully, normally well before stages 3 & obviously Stage 4 referred to, but sadly over the last 25 years, not always! As I write these lines one police officer's anniversary occurs, the fifth. When he killed himself, he chose a permanent solution to a temporary problem, you see 5 years later whatever it was that so concerned him, would have no longer mattered. Gilbert (2006) in his wonderful book "Stumbling on Happiness", points out that humans are unique, in that we can see or at least imagine the future; in fact, we are so good at it, he says we spend 12% of our thinking time there. The problem is that we can not actually see ourselves other than how we are today in that future. Simply put, today will be

irrelevant in the future; we will look back perhaps with sadness and regret, happiness, even romanticise the "good old days", but they will no longer matter and we will be someone different. Thus a person who is depressed perhaps sees the future as depressed or hopeless – remember we can only see ourselves as we are today in the future. Keeping that in mind, we need to do a retrospective analysis of the past. Yes, there were times of trouble, but ultimately we pulled through. So too it will be the case in the future. If you imagine you will be taking baggage into the future, remember that you will not require it when you ultimately arrive there.

When police come to see me, I point out they are at a "T" intersection. On the left of that intersection is to go back to work and face what they face daily for many more years. On the right is to exit the NSW Police and do something different with their lives. At times it has been suggested that my name should be "Dr Pension". I have broad shoulders, so it doesn't actually worry me, but it is in fact a misnomer. Firstly, I don't have the authority to grant pensions. Secondly, most who see me, in fact choose to go back to their work as police. However, it needs to be also understood that by the time a person sees me, it is possible that they have already encountered a major crisis and thus have already been thinking of leaving, by whatever means, as soon and as practically as possible, in fact, "if you've got to go better go now". My philosophy in psychotherapy is based on making the best choices, and there are always choices!

I was once asked when will I retire, and I used the Mick Jagger response, "creative people don't retire". What I say to people is that there is life after policing; you just have to grab it by the throat and maintain a positive and optimistic attitude. In closing one career, as much as you may have loved it, you open up exciting opportunities. Too many Police only see the dangers.

In the next chapter I will be specifically talking about those people who decide to return, or continue to work as police officers. Many of them ask the question "how can I do 20 years more of this?". I am quick to point out that it is not 20 more years; if they don't get promoted and stay where they are it is the same year 20 times over! This is an absolutely daunting prospect for many young police officers and one, which when confronted, sees them leave policing. It is important that they realise when they are in this stage, i.e. Stage I or II, between brownout and burnout, that they can still make clear decisions either way. Too often, when they get to stage three and end up in

psychiatric wards, it is usually too late. Thus, if you are reading this chapter and believe you are somewhere between stage one and two, you have some major decisions to make.

If you return to the NSW Police, or for that matter, any police agency, you have to accept one major factor, and that is that it is unlikely the organisation will always behave like an organisation. There will, of course, be changes in administration and leadership, and yes, there will be changes in legislation, but simply put, large organisations like the NSW Police, The Department of School Education and the Department of Corrective Services, just to name three, provide complex and challenging environments in which to work, some say ”toxic”. Places where there is power may also attract people who are sociopaths, even psychopaths, who want nothing more than to gain promotion and power, (See John Clark (2005) “The Corporate Psychopath”). This is often the type of challenging work environment that many police will have to continue to work in if they choose to remain police. In policing it has often been suggested that 50% of an officer’s stress comes from the operational role, the other 50% from the administration.

It is accepting this and realising the part that you play, and the ability you have to change things about your own personal life, that becomes critical as to whether or not you will “survive”. If you live in anticipation that this environment will one day improve and become a benevolent organisation that generally cares for its people, then I think you are overly optimistic. Worse, if you persist with that hope, it becomes painfully obvious over the years that what you seek is never going to happen. This is the stuff and basis of burnout; burnout is not just about the operational duties of police alone, but importantly the type of environment in which they occur. You see, the complaints I heard in 1986 from police were the same in 1996, and now in 2006. I asked myself the question, how can we effect change when we keep doing the same thing? It’s of some considerable irony as I say elsewhere that a Deputy Commissioner once used the term “TJF” (The Jobs Fucked) to me, but it’s an acronym that is at least 35 years old!

While it is probably not anywhere near as relevant, but you may be interested, given at the time of writing this book is the question of why Generation Y is regularly in the press. While I think the idea of emerging versus older paradigms of policing is a useful methodology for looking at differences in how police work, so too is the fact that at any time there are three generations working side by side

in any work place. Naming them as we do at present, i.e. the baby boomers, Generations X and Y, certainly has some merit in terms of differences, but the reality is it's a matter simply of which epoch we are in. Socrates complained, did he not, that the children of his day were not civil; they gobble their food and are rude to adults. Likewise, the story of the "prodigal son" from St Luke's Gospel sees the three generations illustrated, but especially, given how we view Generation Y, is the youngest son, who wanted it now! So Heath (2006) "F#@k off its our turn", shows once again that 2000 years later there is still an impatience and impetuosity among the younger that is well understood. A matter, I might point out, that produces regular conflict between the "dinosaurs" as the younger police call them, and the "wet behind the ears university types" as the older police refer to them. I warned you, I might wander off!

Now perhaps all of this sounds extremely pessimistic, but I guess in writing this book I have tried to add some sense of reality to what is both a very difficult occupation and work environment. You see, when I wrote "Managing the impact of trauma" in 1999, I thought the so called shelf life of operational non commissioned cops was somewhere between 15 and 20 years. I believe it's about 10 years at the time of writing this. I think there are only three choices. Our ability to recruit more resilient cops is not likely to be achieved, when numbers becomes the political agenda of the day. Moreover I think the environment is more demanding than ever, with some suggestion we are not going to see more burnout, but perhaps that it will happen in the future earlier than it has in the past.

Can I just again go off the track a little? Generation Y who I mentioned earlier, now make up 28% of the Australian population, and we will see them have an increasing role in policing. In fact, policing, very shortly, will be left to just Generation X and Y. Probably the big difference between these two generations is in fact the difficulty of home ownership. It's true that the age for, say, marriage has increased over the three generations, but the age of property ownership, on the other hand, is decreasing. In fact, houses are the only commodity (including petrol) that is more expensive than it was, based on income since 1984. In fact housing is three times more expensive.

The result of this in society is to see that more people will rent, in which case they will be more mobile than any recent generation before it. How many of my generation and generation X have

used words, like "I have to pay a mortgage" to explain why they persist in jobs that they hated? So, on the one side of the coin I see the rate of burnout occurring perhaps earlier, but, to be frank, many who get to stage 1 as indicated above will just quit, especially if they are asset poor and cashed up.

This will not just make them mobile, but as one cop said to me they haven't joined "the job" these days, but just a job. He was differentiating between policing as a job, as compared to a vocation. The loyalty of the past may be just that, in the past, and so while my concerns about the mental health of our officers continues to be foremost, perhaps in the longer term; the question may not be just one of mental health, but a serious issue for the NSW Police of retention.

In the next section of this chapter I intend to examine the options of what needs to be done when the decision is made to leave policing, again I am using the NSW Police as my example.

On Leaving

In NSW the options vary significantly, simply based on whether you joined before 1988 or after 1988. It is an amazing act of discrimination that two officers who share exactly the same responsibilities can be covered by quite different entitlements, with profound differences in compensation and pension, but more of this later in the chapter.

For now, if you are a police officer and you are making a decision as to whether to stay or go. If you determine it is time for you to go, then these are some of the matters you should take on board when determining how you might exit the NSW Police.

The first cop that ever came to see me related a story that will always stay with me, and over the years his concerns have been verified by science. He said that he had a brain tumour and, as a result of increasing stress, it had become even more problematic. Measurement of his tumour was monitored and as you might guess, it worsened based on his levels of distress. The Police force rejected his claim. Next I saw a police officer from forensics that, I noted, had an area of responsibility of almost the entire north-eastern seaboard of NSW. After his third heart attack he

refused to return to work, and even though the heart attacks correlated with high levels of stress, his claim was disputed. He left and survived, as did my first client. More recently, or at least 10 years ago, a police officer with gastrointestinal disorder came to see me with stress. Over the next 5 years he continued to work as a fully operational police officer and, not surprisingly, his work stress increased, while his ability to cope plummeted. As a result, he developed irritable bowel, and eventually colon cancer. His surgeon, one of Australia's most respected gastroenterologists, suggested that there was a correlation, and indeed that his stress contributed to the physical pathology. In short, the more he got stressed the sicker he became. Obviously, today the connection seems obvious, but at the time of writing of this book, now some three years later, his employer, the NSW Police, while refusing previously to accept the connection, overturned their decision to reject it, and accepted his claim as duty related. Why, you might ask did they at first reject it? It was of course a matter of "loss adjustment". Simply put, by accepting his claim, they saw not just a substantial payout but, had it gone to court it would have "opened the flood gates" as they see it, of so many more claims, i.e. those that are foremost psychological in nature but have a physical correlate and, of course, vice versa.

Earlier, I suggested that you need to think carefully as to what psychological stage you are at, i.e. brownout, burnout, psychiatric breakdown or suicide. Likewise, you need to ask, "How is my job affecting my health!" I could give you a long-winded explanation of how your thymus may no longer produce the necessary ingredients for good health, or how your adrenal gland is producing cortisol (17hydroxycorticosetroiid), which is an immune suppressive, but I won't. This is common sense biology and available to everyone through the popular media and, of course, these days you can "Google" it.

In the next, and final, chapter I will discuss how you might develop better resilience, both at a psychological, physical, emotional and spiritual level and then continue to soldier on. Or you can examine the realistic options of leaving the job you love and develop a new resilience and future, in either case resilience is the key.

I emphasise "the job that you love" because I have rarely seen a police officer who thought otherwise. You need to differentiate the job itself from the administration. In fact, I will go one step

further and suggest the latter is just as likely a cause of occupational burnout than, say, the actual work that police officers do.

In NSW, as I indicated earlier, there are some substantial differences in respect to entitlements for those enlisted before and after 1988. This book, while it isn't just written for NSW Police, but rather a broader readership, necessarily because of my experience base, takes on at times a more parochial nature. However, I expect that, while there are differences or anomalies to be found in other agencies, the way in which difficulties arise and bureaucracies respond to their people have some commonalities wherever they exist! Thus while the examples are specific, the impact of such frustrations is more generalizable across agencies. In chapter 6 I briefly mentioned how cops in the city in which I live often face the "eighty wheeler". This is a reference to the train that they may have to take when transferring to Sydney (165kms), which supposedly has eighty wheels. Likewise, in California they have "freeway transfer"; both have in the past been used as a form of "punishment", legitimised as being an administrative imperative to keep some pressure on compliance. I raise this as one of the deterrents for making any claim, it is not just the fear of the process, or the adverse outcome, but the fear of even reprisal and ridicule. This is certainly changing, but it's so deeply engrained in the culture there is a strong reluctance to "rock the boat", or appear to be weak.

Making a claim

It is anathema to police to leave their "post"; it is regarded as "letting the side down", or even more simply put, malingering. Thus it is understandable that police have, more generally, some difficulty in putting "their hand up", as they refer to it, to get help. The first step is however to attend upon a general practitioner who has some real understanding of what it is to be a cop. Moreover, a doctor who understands the limitations imposed in terms of what is, and is not, possible by rehabilitation. The general reaction to police stress is to pathologise it, and a range of diagnoses are offered, eg adjustment disorder, anxiety, post traumatic stress disorder, or depression. Having been examined by a general practitioner, officers could then submit an application for these injuries to be recognised as hurt on duty, (HOD). This may take months, or in some cases even longer. In that time, a rehabilitation officer from within or without the Police force will be appointed. Rehabilitation

officers are well meaning, but ultimately paid by the department and have a primary agenda, i.e. to get the injured officer back to work. Obviously, this can be a most desirable outcome, but what if the officer should not return?

Where it is the best form of action, this is normally achieved firstly by providing supportive counselling (perhaps using the EAP – see chapter 3) then, in most cases, a graduated return to work program which may include non operational duties. If this is not possible, then the officer will be reassessed. Ultimately, at least in NSW, if rehabilitation is not possible, the officer will be medically discharged. This is achieved, in the first place, by a referral for an independent assessment so as to confirm the work relatedness, or otherwise, of the officer's condition. Then, if agreed upon, a separate referral is made to yet another independent assessor for a recommendation of medical discharge. In the case of those officers enlisted prior to 1988, a submission to the Police Superannuation Committee (PSAC) or for post 1988 enlisted officers, a submission to HealthQuest. I have no doubt that there are similar systems throughout the states.

There is an important point to be made here, and that is, when an officer decides that they can no longer serve, that they can nonetheless still recover. For many officers, it's more about the probability of relapse. Julie Berg, a psychologist for HealthQuest, said it all when she recently commented in a report I read, "This officer is no longer fit for operational duties, due to the high risk of relapse, if he returned to police work". This emphasises three important issues, she implied the officer was recovered (in remission), that secondly he may suffer a relapse should he return, and that thirdly there is a duty of care to ensure this doesn't happen. This is so important; getting better should not, and does not, mean a return to police duties.

After policing, of course, there is the opportunity for rehabilitation into the "civilian" world. As I indicated earlier, making a claim is often fought with difficulty even from the outset. As I indicated in chapter 6 many years ago I referred to the "Karl Hettinger Syndrome", this was, if you recall, the resultant psychological distress that can be caused by this process. As you also saw in "Barry's Story", in Chapter 7 there are psychiatrists and other medical doctors prepared to write reports that are not only at odds with reality, but that cause these matters to be unnecessarily thrust into litigation. I need not add that it is the solicitors who ultimately gain from this adversarial system.

The rejection or questioning of a genuine claim is always offensive to the officer, and only reinforces the sense of abandonment that they feel. Yet there is worse.

I want to draw an analogy between police agency and sect religions. There is in any recruitment to a sect a period or grooming and indoctrination. This is reinforced by either an indication of how special the person or the group are. They, in fact, are a group set aside from the community and the importance of loyalty is emphasised. So then, the rituals and totems that belong to that particular sect are passed on and shared only within the sect. Likewise, once a fully fledged group member, any deviance is treated by a series of three strategies. First, by threat, then pleading and promises (similar to spousal abuse), then of course again the threats, gossip and innuendo. Ultimately there is banishment and isolation. This is the trade mark behaviour of a sect toward an errant member, but also, sadly, the way police act towards an officer who wants out. They are treated as a being disloyal, often repudiated as a "shonk", threatened, and then, ultimately, ostracised (There is no ex like an ex cop). In reading this, you may regard my analogy as hyperbolic, or simply put, over the top. Yet what needs to be explained is, if the organisation does not see itself complicit in this, how is it that this is exactly how cops describe what happens when they have decided that they have had enough?

Their leaving is classed as abandonment, and this, in fact, is the ultimate betrayal; remember the teaching on recruitment was that "if you look after us, we will look after you", much of which I spelt out in Chapter 1. I suppose that a police manager or administrator could take some umbrage at this, in fact I have had many question me whenever I have spoken publicly. This analogy has been written to explain the gravity of the sense of despair literally hundreds of cops have felt, so if it's not true, then what is the explanation for their despair?

None of this should deter the officer who feels it's time to move on. Like Bill in chapter 6, i.e. "Bills Story", the challenge is to develop a life outside policing, to develop resilience, and to see that transformation is possible, even if there has to be some suffering on the way.

As I said earlier, there are over 20 million people in Australia, of whom all but about 17000 are not in the Police in NSW, and many of us are enjoying our lives. Your happiness is not contingent on

being a member of any organisation but, ultimately being part of a family, your own family, and in addition having, as Victor Frankl says –"some meaning in your life".

Of course, there is also the possibility and hope that any officer who comes to see me will be able to soldier on and, in that case, he or she needs to develop a new sense and understanding of resilience – indeed the subject matter of the next and final chapter.

Chapter 10

On Becoming Resilient

"All officers in the field face dangers everyday and this is a tragic reminder of the very nature of police work". [Commissioner Ken Moroney: on the death of Snr Const Gordon Wilson – November 2006].

This is the longest chapter of the book, and so it should be. What we know about policing and the very nature of it, as discussed in this and other books like it, makes the development of a strong resilience an imperative. Important to developing resilience is the notion of self responsibility. In chapter 3 I emphasised the need to understand the dictum, "If it is to be – it is up to me" and to encourage police to reach out. This Chapter is written to emphasise the need to develop psychological, physical, and spiritual strength. The facts are that, probably, policing is going to become more challenging, as will simply living our day to day lives. Even if that were not the case, our resilience does, in fact, erode as we get older - we become less able to bounce back. Thus, building this essence, i.e. resilience, becomes critical; it's in fact the very stuff of survival. So I share these ideas because they come from what I have learned in 20 or more years as a psychotherapist.

1. Catching Up With the Past

It's interesting, when you leave university, how you feel you come out "full bottle", a term we used to use in the Army for being full of knowledge, theories and ideas. In this way, you perhaps believe, that you are ready and equipped to "fix" everybody's problems. Interestingly enough, many of the ideas that I was taught as a younger man at university are now not only obsolete, but were probably not correct in the first place. When I left university in the 1980's after teaching psychology, I entered a world where the buzzword was "stress". You, as consumers of matters psychological have been hearing it now for twenty to thirty years. It wasn't a new term then, nor did it ever quite mean just stress, as it is always used to connote distress, which in turn usually means "anxiety". Many people asked questions then (and still do today), "How is it that we can be less stressed?",

"How do we make our environment less stressful?" We all ask questions about whether we could manage our stress better. For instance, so many reading this book will have attended a stress management seminar or workshop; and in fact, have not only been to a stress management workshop, but you may have also bought books and even relaxation tapes in the past or at least CD's today.

One of my favourite questions I ask in seminars is "How many people have a relaxation tape or CD?" I recall in Wollongong, where I addressed 600 people, when I asked this question, more than two thirds put their hands up. Then I said, "Now how many people have listened to that tape in the last month?" and got just one or two hands out of all those people. Then I said "What about once every 6 months?" and again I got a few more hands. And then I asked "How many of you have honestly never ever completed the tape, not even once?" and literally scores of hands went up.

You see, I think the madness industry in the 70's, 80's, and even 90's, were very effective in selling the idea of stress. I think it was in the late 90's that my friend, Barry McNamara from Wollongong, wrote a paper, "What does it mean if I'm not stressed?" Barry has a very dry sense of humour.

I look back and ponder, and question just how effective we were; did people really benefit from those types of workshops, (mine were called "Stress Management 101, 201 and 301")? I wondered about the practical application of those workshops; sure you felt great while doing them, but what about afterwards, when you next encountered a stressful situation? I think the provision of these types of workshops was useful in keeping the issues in respect to stress on everyone's mind. It's my belief that persistently repeating the messages (the simpler the better) impact in terms of public knowledge, and in the long run can cause changes in behaviour. "Do the right thing", "Buckle up", and "Quit" are programs that give some strong evidence of this; some refer to this type of phenomenon as a paradigm shift. I also think these stress courses added to a different form of personal knowledge, the type referred to as "intuitive knowledge".

So I pacify myself somewhat with the idea that, while these courses may not have made significant changes to all the participants, and certainly not to entire organisations, they did help install some useful information, and stir in many what, I believe, is intuitive knowledge about what is good for us.

In this way the courses on stress management did also contribute in some way to broader community awareness of the deleterious impact that distress can have, both on individuals, and on communities.

2. Care of the Self

In between my stress management course and the resilience course that I present, came another series of courses that were entitled "Care of the Self". I borrowed this title from Thomas Moore's wonderful book, "Care of the Soul". I changed "soul" to "self" because I think some people are quite uncomfortable when we talk about the soul. The soul has religious connotations for some, but I think that can be inaccurate, at least in part, because ultimately it's not only in a religious context, but in a spiritual context, that we can, and should, talk about the soul. Some people who have studied some Greek know that psychology is derived from the Greek word "*psyche"*. The word "psyche" actually means "soul", so a psychologist's work is literally a study in soulfulness. In these courses I took and treated the word "self" and "soul" to be synonymous terms.

Secondly, I chose the theme, "Care of the Self", because it seemed to me that in reviewing the under-pinning philosophies of legislation like the Occupational Health and Safety, Anti-Discrimination, and Workers Compensation Acts, there was an almost myopic focus on the responsibility of the employer in the workplace. Indeed, as it remains today, employers are to provide a safe place, both psychologically and physically, as provided by the Occupational Health and Safety Act. Further, that an employer will take out insurance for their employees in relation to Workers Compensation. An employer will also be an "equal opportunity" employer. So I asked myself in the 90's whether this emphasis was somewhat one-sided? Where was the personal accountability and responsibility in all of this? My program, which is still available, "Care of the Self", is very much focused on helping individuals take control of their lives, be accountable for their own behaviour, and to take responsibility for the outcomes which are so often created by their own decisions.

You may even think of people at your workplace who have that "poor me" mentality, or "everyone's against me", "that no-one's doing what they should", "it's my entitlement". How many times have

you ever heard, “it’s my right”? Viktor Frankl makes an insightful statement in his book “Man’s Search for Meaning”, saying that on the East Coast of America they have the Statue of Liberty, but suggests that on the West Coast that they should build a statue of responsibility.

So we arrive at this chapter about resilience, after my own personal and professional journey, and to the next step of not just building resilience, but building resilient communities.

I want to first describe to you one of the key connections between being individually resilient and having resilient communities. I take communities as being as small as a family, then of course there are larger communities such as a school, a workplace, or even a larger community such as a town or city. Within any community there is a sense of wellbeing, a sense of what is termed “esprit de corps”, a sense of morale, and a sense of belonging. For instance, a fully functional family may be identified by its internal and external healthy relationships.

The previous Bishop of Newcastle, Roger Herft, was once giving a talk, and he told the following story. He said that an African was visiting Australia and went to one of our very large properties, you know the kind, thousands and thousands of square kilometres, and he noted, that, unlike his own property back home in Africa, that there were no fences. He asked, “If there were no fences, how did they keep the animals from straying?” The farmer said that there was no need, as they had dug very deep wells, and also, they had very large dams, so that there was no need for the animals to wander off. The African then enquired, ”What about other stray animals coming onto the property?” The property owner told him that the answer was that they built wells deep enough to supply the water for all the other animals to drink from too.

So I believe that in a healthy, functional family there are deep wells of living water: water such as knowledge, self-respect, wells that are full of water such as affection, wells that can also accommodate friends that come into the family, where there is a reciprocal relationship of unconditional love in abundance. However, we know that if a person in any family is unwell for a lengthy period of time, either in a physical or mental sense, it has the potential to affect the dynamic of the family, usually in a quite adverse way.

3. Co-dependence

Most understand the notion of "co-dependence". If, for instance, an alcoholic lives with a family, it is not necessarily so much that other members will drink but, because of the alcoholic behaviour, others will be affected, and indeed often go on to develop other forms of psychopathology.

Let me perhaps give you a more light-hearted example of this co-dependency with another community I worked with, a rugby league football team. The coach, who, in fact, had been a teacher, was an anxious type of person. He had a great fear of failure, and in so doing developed a fairly sizeable neurosis. His idea was that when the team failed he would train them even harder. Probably the best answer to their performance slump was to give them some time off and to get them re-charged. Coach Michael Hagan's team, in the year prior to the of writing this book had just had a four match-losing streak. After losing the previous Friday night's game, he sensibly gave them time off until the following Thursday. In the case of the neurotic coach it was his anxiety that hampered the team and contributed to their poor performance; if you like, their "dysfunctionality". However, I remember on the occasion of the last game of the year, they were playing a team at the top of the competition and they were coming at the bottom. The anxiety prone coach simply told them all, "It doesn't matter, just go out and have a good time". Needless to say, his team won, much to his surprise.

Another phenomenon in society is the prolific nature of mental disorders. Many names have been made up to describe these, but, in fact, cover any range of meanings of unhappiness. No one ever says simply that they are unhappy any more, nor suffer from just any type of depression, but "clinical depression". This seems to be at epidemic proportions and, if the combined Federal and Victorian Government project "Beyond Blue" is correct, now as many as 20%, or one in five people, suffer sufficient symptoms to warrant diagnosis using the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Just as a matter of interest, back in 1986 in a previous edition of the DSM, homosexuality was considered to be a disorder. It was removed after lobbying by homosexuals. While Post Traumatic Stress Disorder was voted into the DSM, as you might guess, by lobbying by the Vietnam Veteran

Association of America. The DSM, for all it's usefulness, is politicised and manipulated to suit varying agendas, and care needs to certainly be taken in using it, a loudly made criticism in Australia by the "Black Dog Project".

You may have caught some cynicism already, but I think we can over-medicalise what are so often existential problems. Yet, while I am sure that depression and anxiety are real conditions, I am equally sure that people are also misdiagnosed, and certainly too easily put on medication. However, for those who suffer the profound sadness of clinical depression, we should have significant compassion and we need to make available trained, adequate and professional care.

Like alcoholism and the model of co-dependence, it's understandable that if you live with someone who has a condition of depression, then you may develop symptoms and anxieties in respect to that condition, even depression itself. There are now many families affected by depression, and there are communities affected by people with depression. As indicated earlier in this book, the French have the term, *"le folie au deux"*. This literally translated means "the insanity of two", or "the silliness of two". The term is meant to describe what happens to a person who lives in a family with others who are mentally disordered. So, as indicated, you might expect to find, if one partner has depression, then the other partner could show symptoms. This is the third time I have raised this in this book, because it is particularly important when examining the adverse effects of ill health of a police officer upon their family.

Through 1999 to 2001, we tested this theory, with police officers and their partners. My son, Martin, was completing his thesis at the University of New England, Armidale. What he did was to take two groups of "civilians", these were firstly, miners engaging in 12-hour rostering, and secondly, Newcastle Port Corporation employees, whose organisation was going through major change, and formed what is called a "control group". We wanted to include in our control group, a comparison group that would account for variables such as 12-hour rostering and massive organisational change, both of which are features and stress factors for the NSW Police Force. We then took another group (the experimental group) of police officers, as well as their partners (none of whom were in treatment for any physical or psychological disorders). We had both the control and

experimental groups complete a number of questionnaires, one of which examined anxiety and depression. These were returned anonymously and separately. The results were quite stunning.

Partners in the control group had similar depression and anxiety symptoms as their spouse, but were within the normal expected range of anxiety and depression for the general population. In the case of the police, or the experimental group, their anxiety and depression scores also correlated with their partner's, but were as much as three times higher than their civilian counterparts or the general population. I will return to what is a matter of contagious behaviour later when examining resilience

I suppose by now you may have started to become a tad depressed yourself, but I have emphasised all of this to stress the importance of not just caring for yourself, but also the critical and core element in all of this, developing a sense of resilience. If people who are depressed, anxious, unhappy, cynical, or negative can adversely impact on their communities of reference, then it must be equally likely that motivated, optimistic and resilient people may positively impact upon, and in, their communities. That is, if you want to build resilient communities, you have to be resilient yourself. If you are depressed and anxious, you will create depressed and anxious communities.

I spoke earlier about morale and esprit de corps; the critical elements of morale are healthy and functional interactions. Thus, if the interaction is unhealthy, even by one party, but especially if they are the leaders, then the impact on morale will be self evident and contagious at that!

I said at the beginning of this chapter that this particular idea of building resilience was part of my ongoing professional development and, indeed, part of my life journey. This was reflected earlier in my career by the stress management type programs I presented in the 80's, and in the later part of the 90's when I presented workshops I called "Care of the Self". Now in the new millennium, I have developed workshops, seminars, and now this chapter on resilience. So it might be worthwhile, in developing this notion of resilience, to first draw from what I have learned in conducting these other programs.

Aside from my scepticism and some real concern about the sometimes shallow nature of stress management offered by the madness industry, there were nonetheless some principle components that are essentially self evident if one is to have a physically, emotionally, and mentally healthy life.

5. Relaxation Revisited

The first of the concepts that was promoted by these types of courses was the importance of relaxation. One of the things I managed to do in my courses was to suggest that relaxation was simply more than just good for you, and I went on to explain how intimately the endocrine system and our overall physiology interacts. In examining the physical issue, it's important to understand that the dichotomy between mind and body is now more accepted as an integrated notion. Thus it's plain to see that if you want to improve your participation and success in relaxation, there are some essential mental and physical ingredients. It is impossible for the body to be relaxed and stressed at the same time. You have two competing systems; the sympathetic nervous system, and the para-sympathetic nervous system. Simply put, the sympathetic system is the 'accelerator', and the para-sympathetic system is the 'brake'.

Simply by closing your eyes and slowing your breathing you will have a resultant effect on your adrenal glands, and an increased effect on glands such as the pineal gland, which is responsible for both the relaxation and the sleep responses.

Simply put, if you haven't got relaxation as part of your repertoire, then I think you'll find it hard to become resilient. It is the ability to relax and sleep well that is essential if we are to achieve focus in our day.

Short periods of sleep deprivation, such as when you have a cold or a particularly arduous period of duty, seem to have little effect on the human being in the short term. However, it is the chronic and persistent nature of this kind of deprivation that leads to illness and perhaps provides the reason why shift workers have higher mortality and morbidity rates than other people.

Hinted in those first courses was the connection between relaxation and our spirituality. I pointed out that, 20 to 30 years ago, 23% of Catholics, for instance, attended mass. Now it's down to 13%, and in my local parish it's as low as 8%. I am not suggesting to people that they return to their church, as that's a personal decision that they make. I am also not suggesting that you take up religion. What I am saying here is that the ritual and prayer that accompanied most religious activities has been abandoned by many, and leaves open the question "What then have they replaced it with?" David Tacey says that there is a new worldwide spiritual revolution happening, and that perhaps ties in well with what I am implying here. I'll bring this question of spirituality up again a little later.

6. Getting the Basics Right

So in stress management 101, the notion of relaxation, exercise, sleep and diet were the corner stones of managing stress better. Both relaxation and exercise share something in common. They both have the capability of reducing that hormone most frequently associated with distress, 17 hydroxicorticosteroid (cortisol), which is the biological marker for anxiety, and yes, simply put, exercise reduces anxiety. Out of interest, the latest data for Australians place the number in regular exercise at just 25%, and then we wonder why we are becoming more obese and sick as a nation! While both exercise and meditation reduce anxiety, and should be compelling motivation enough, a high level of cortisol have an inverse effect on our immune system, and leaves us vulnerable to disease. So again, meditation and exercise can reduce distress as well as disease; it doesn't get much simpler than that!

Yet, as the saying goes, "there's more!" International research shows that up to 16% of cardiovascular disease in men can be attributed to job stress. Yet this figure rises as high as 35% for men who have long-term exposure to low job control. It is said that other stressors such as shiftwork, bullying, working longer hours, (We currently work longer hours than any other countries in the OECD) may also significantly increase these estimates. Current wisdom suggests that job stress causes mental health injuries, and this is an increasing burden on society. So much so that the Victorian Government in 2006 commissioned through VicHealth a strategy to combat this ever increasing problem, ["Workplace stress in Victoria – Developing a Systems approach (2006)]

You know, it never ceases to amaze me that with all the talk of stress over the years, there are still some people who reject even the idea of it. But I suppose there are always those, who for whatever agenda, find stress syndromes difficult to accept. Peter Debnam, one time leader of the NSW Opposition, made some fairly spiteful comments in 2006 talking about people with stress claims and "rorting the system", and further, "if they didn't like the job then they should just leave". This shows an absolute lack of understanding and genuine compassion, which is made even worse by the fact that his own party leader was treated for depression, as was the Western Australian leader, and at the same time he said this, we were mourning the loss of Rugby League great Steve Rogers, earlier this year, i.e. 2006.

Even as recently as this year, the National Academy of Science published a study of pregnant women, and compared those with stress to those without. I mentioned this earlier in the book, and indicated that they reported that the chance of miscarrying in the first trimester was three times higher in the stressed group of women compared to the other. Not surprisingly the psychophysiological measure of stress was in fact serum cortisol.

Diet, too, becomes a critical feature in coping better. It was interesting when I asked people, in another course I conduct, to write up a diet for the week. They inevitably chose a diet that was weight reducing. In other words, they came up with something along the lines of the Pritikin, Atkins, or Weight Watchers diet plans, which is all well and good, but that is not what I really asked. Diet is simply what we eat, and should contain the five food groups. It is not about making you fat or thin, it's about making you healthy.

I may have done myself a disservice by only providing such a brief outline of what was actually stress management 101, etc, but what that course did do was allow me to design what I thought was a much more holistic course, which was the "Care of the Self series". Those courses from 1995 are still current today. It is from those courses I wrote two books, "Managing the Impact of Trauma", and "A Wish before Dying".

So what have I learned from the "Care of the Self" Program? I think there was any number of core elements, but there are four things that I want to share with you. These are; that conflict really is the issue, the matrix of stress, learned optimism and coping better.

7. Conflict is really the issue!

The first was an understanding of what causes anxiety and how we learn to become anxious. Ultimately I think conflict is the key in all of this. Bill Glasser, with whom you may well be familiar, wrote "Schools without Failure", "Control Theory", and many others. Bill was a cognitive behaviourist who believed that conflict sat at the seat of all anxiety. Simply put, no conflict, no anxiety. Conflict again in its most basic form is the difference between what you want and what you get. You must have had times like that. Think about how an employee may react if they are not paid. They are indignant, they are angry, and they are anxious. Perhaps it's because they feel a sense of loss of control, or, if nothing else, simply a sense of not being respected. They may also be frightened. Can you think of a time you were distressed that didn't involve conflict?

Sometimes conflict is within our self as well. Just earlier I spoke about happiness coming from meaning in our lives, and that meaning doesn't come from happiness. There is also another dimension that needs to be considered in this whole notion of happiness, and that is one of expectation. Alexis Tocqueville, a nineteenth century philosopher who was quoted by Alain de Botton in his book "Status Anxiety," suggests that: Happiness = Success/ Expectation. It is de Botton's concern that we in western society are constantly told from the earliest time of life that we can be anything we want, even prime minister. We can do whatever we want, as long as we want it bad enough.

This is statistically a preposterous proposition. While it is true that people can achieve amazing feats, most people live out their lives in a routine and mundane way. I want to suggest that when people have too-high expectations, and when their unrealistic expectations are not met, they remain unhappy, often for most of their lives. For instance, if you are a football coach and your only criteria for success is winning, then I suggest that even if you are the best coach ever produced in Australia, then more than 25% of your time you are going to be downright miserable.

I think it is this modification of our expectations against our unrealistic ambitions that needs to be better addressed, and is critical. This is not to take the initiative away from humans who have a capacity to do the extraordinary, but instead to have a life where one's expectations are constantly being met, because they are reasonable and will help lead to a lifetime, according to both Tocqueville and de Botton, of happiness. The evidence, of course, is that we are becoming increasingly more unhappy. For instance as our gross domestic product, (GDP) increases, and we become even richer, the rate of depression continues to rise. de Botton refers to the cause of this as being, "Status Anxiety", and he suggests that our underlying anxiety and depression stems from our failure to meet what are, in the final analysis, unrealistic expectations, and thus conflict ensues.

8. The Matrix of Stress

Many years ago I conducted a study that examined the question of why so many bus drivers suffered from stress, and subsequently why the workers compensation claims were on the increase. I won't go into why bus driving might be stressful, although that may be self-evident. But I found at that time that the actual duties of a bus driver were not the cause of the stress. What made this particular study interesting was that another psychologist, working for the government, (I was working for the union), came up with an identical appreciation of the problem. I am not sure whether she (Kerry Borthwick) ever went on to use this as part of her psychological intervention with clients, but the matrix of stress became a cornerstone of "Care of the Self" programs. It's a simple paradigm. For instance, if you think about the many times you have been stressed, there are in fact some common features. You feel a sense of being overwhelmed (excessive demand), you feel isolated (without support), you feel out of control (not in control), and fourthly, you are unsure where the circumstance will lead to, (uncertainty). These four give us the following diagram I call the "Matrix of Stress".

DEMAND	**SUPPORT**
CONTROL	**CERTAINTY**

In the "Care of the Self" classes, I asked people to consider on a scale of one to ten, with "ten" being really bad, and one being not at all, the last time they were stressed. Then account for each one of those in each of the four quadrants and see how high they score. The next part of the exercise is to think about now, or perhaps think about a time you were happy and content, and then re-score them. The difference is always significant. So part of this caring for the self is dealing with conflict by first appreciating conflict in terms of its magnitude, and your reaction to it. For instance, recently I had a client whose baby son was still born, and he told me that the anxiety was so overwhelming he was able to recalibrate what was, and what is, not important. I said to him, "so I suppose you won't be getting angry when you are stuck in a long queue in the supermarket". He said, "Those types of things are now in some appropriate proportion". You see, he has a new bench mark for what is stressful, or what conflict is.

One of the good things about the matrix of stress is that while it tells you why you are anxious, it also gives you the remedy. A template, if you like, for reducing your anxiety. All of us have more control then we think. Some things are certain in this life (aside from death and taxes); that there is support to be found for people in all sorts of places, to help reduce the demands on us and then by practising some assertive skills, you can reduce the expectation and often unrealistic demands made on you.

On the matter of support, it always grieves me to see the suicide of a young person, but you may also be familiar with the fact, so often found, that at their funeral the church is packed with maybe 600 people who cared. Most who suicide, I am sure, never fully realised how much they were loved and how much they were supported. You see, the "Care of the Self" programs I conducted not only acknowledged this, but asked each person who participated to reach out. It is a course that promoted and encouraged people to reach out and gain support from the various communities that they are members of and, incidentally in the same way, give back to them in return.

As I suggested earlier in "Getting Help", chapter 3, a good friend once commented, "it's not just a case of loving your neighbour as yourself, but also letting your neighbour love you!"

9. Learned Optimism

The second finding that came out of "Care of the Self" was better understanding of the importance of optimism. This is an essential ingredient in the building of resilience. This notion of optimism was written about in particular by Martin Seligman in his book "Learned Optimism", and was in fact the antithesis of what he wrote about in the 70's and 80's, i.e. his theory of "Learned Helplessness". The two are opposed. In a state of helplessness, there is no resilience, there is simply compliance and giving up, but in optimism there is a challenge, there is anticipation, there is a light at the end of the tunnel. Helplessness is coloured by cynicism, negativity, hatred, and self absorption. Optimism is coloured by, maybe, scepticism, but it is a healthy scepticism, and it focuses on what is possible. The Chinese have a sign for change. One part of that sign alone says "danger"; the other part says or means "hidden opportunities". So the optimist looks at change in terms of those hidden opportunities, while the pessimist and the person who has learned to be helpless, looks at the dangers. Later I will talk about how optimistic people have a reduced risk of coronary heart disease (CHD). Optimism in this way can undoubtedly be regarded as having a psychosomatic connection.

The third imperative in "Care of the Self" that becomes the corner stone of resilience is the importance of developing strong coping resources. In a book by Erica Frydenberg, "Beyond Coping", we find a bridge between the care of the self-coping, and the optimism of Seligman, which Frydenberg describes as "hope". Whether or not hope should be part of life's skills is rather self-evident. Simply put, people who hope, cope. People who don't cope become both helpless and hopeless.

10. Coping Better

Whatever the role of hope, there are five core elements to coping better. These are firstly self-esteem, secondly social networks and support, thirdly emotional wellbeing, fourthly spiritual wellbeing, and fifthly physical wellbeing. These five, according to research psychologists Hamner and Marting, who researched this more than two decades ago, are the critical elements, along with personality, that will dictate whether a person will cope well or not.

I would like to spend a little time on each of these because without coping mechanisms like relaxation and those other aspects in "stress management", it is very hard to see how a person could develop a sense of resilience. It was M Scott Peck in his book, "A road less travelled", who observed that once you understand, really understand that life is difficult, you can transcend it and thus, instead of trying to make your life easier, accept that the road is hard and sometimes painful. The connection I want to draw is that first you should try and not spend your coping resources simply trying to make your life stress free, but face the inescapable fact that life is indeed difficult. Having left this burden behind, you are then free to use your coping resources in a creative manner so as to cope better with this difficult life. In fact, I would suggest that there is, more often than not, a pervasive approach by most people in society to try and avoid accepting or confronting this challenge at all costs. Thus, the ubiquitous use of drugs, alcohol and other diversions such as pornography, are undoubtedly a desperate attempt to soften, or satisfy, invalid or non-authenticated, even imagined, needs.

I suppose the other important lesson that came out of the "Care of the Self" program was that, in order to take care of others you must first take care of yourself. You may have heard many times, in this regard, the analogy between self-care and the safety instructions given by airline cabin crews prior to take-off. They say something like, "If an oxygen mask falls from the locker above and you're sitting next to a child, make sure your own mask is fully adjusted before attending the needs of the child". This is such a critical and pivotal issue, especially in the way in which we develop adequate coping resources. In fact, I would suggest that the resilient person, ultimately, is the person who cares for themself first. Not in a self absorbed manner, but in a sufficiently self-focussed way so as to allow them to be energised, and then able to assist others. In fact, there is a paradox working here, is there not? If you put others first and wear yourself out, and then overburden yourself in the process so you can no longer cope, then it may be that you will in fact become dependent and needful of others? This circumstance is the very reverse of what you intended. You intended to be someone else's rock, but in fact by not taking care of yourself, you can become invalid, infirm, either physically, mentally or both. Then you simply add to the stress and strain of the person you intended to care for!

I would now like to briefly discuss each of the three elements that make up our coping resources. The first, self-esteem, is not the same as self-absorption. Self-absorption is where you put the welfare of yourself above all others. The wonderful writer and philosopher, C.S Lewis, suggests that authentic love is simple; it's when the welfare of the other person is more important than your own. There is a dichotomy between the negative notion of being self absorbed or self centred, and the positive way in which you take care of yourself in order to take care of others.

The second of these coping resources is "emotional needs". Most adults find this in an intimate, traditional marriage. I need not tell you that marriages, whether they be traditional marriages or so called "new age" marriages, have a terrible attrition rate, some would say one in two, but at the very best, one in three. Ultimately marriages fail because of a failure by each person to communicate and be mindful of the needs of the other. I would have spent more time in the last twenty years trying to assist women see the world from a man's perspective, and men to see the world from a woman's perspective, than anything else in relationship counselling. There are distinct differences between the two, and whether my feminist friends like it or not, John Gray's book, "Men are from Mars and Women are from Venus", in good humour, highlights some significant differences. It would be wonderful to spend some time here, because most reading this book will probably be in a relationship. Suffice to say, happy and loving relationships are inevitably tied to sound communication and understanding of our differences.

Apart from communication, I think "friendship" is, as John Gottman says, the single most reliable predictor of a healthy marriage. All of us have emotional needs. These are met by our families and loved ones, especially our partner, although with 50% of marriages failing (it doesn't get better the second time), one has to wonder about whether we are facing an era of serial, rather than lifetime monogamy. A well known social commentator Hugh McKay has said that perhaps we have to change our view about what marriage is. This is especially true if we follow the example of the United States, where, according to John Gottman, a relationship expert, 67% of marriages in America now fail.

So what is it that makes marriages successful? We know that in the early stages, as highlighted in a recent edition of the Chemistry Journal, that the kind of neuron peptides that go with falling in

love, and I expect them to be vasopressin in men and oxytocin in women, have a half life of two years. So what sustains a marriage past the initial love bug? As I said before in chapter 8, I think it is actually friendship, and I think that is far more important than any other aspect of why relationships will or won't work. In fact, it could account for why arranged marriages often are quite successful.

In my course "Reinventing Relationships", I stress the importance of reinventing that friendship to meet the time that you are in. You have a friendship when you are newly married without children. You have a different kind of friendship when children come along, especially when they are completely dependent on you. A relationship must change to accommodate change, say as you become older and your children are becoming more mature. "Empty nesters" – that buzz word, defines a critical time when a marriage might have to reinvent itself. Finally, marriage in older age is again a time for reinvention especially if one partner may become chronically ill.

In all of that I stress the importance of reinventing the friendship. The young relationship that you had in your twenties simply won't fit in the thirties. It certainly won't fit you being in your fifties. It needs to grow and mature with you. It needs to move from the early days, sparked from those peptides that give us the "oh wow" response, to something more mature and fully immersed in one another, being no longer two people, but one.

Friendship is maintained by just two simple things. The first is by showing affection, and the second is affirmation. I have fully explored these in Chapter 8, so I will leave the issue of emotional support and now address the importance of spirituality.

This is the third core element of coping better. It's frustrating when I address this issue and people respond, "I am not religious". I need to say that even atheists have spirituality, a sense of that inner self, or 'ego,' that Freud spoke about. Your personality, if you happen to be an atheist, is your soul, the very element that is unique to you. Carl Jung saw it as so important (even if he did use the word "religion") that he said, *"Among all the patients in the second half of life …there has not been one whose problem in the last resort was not that of finding a spiritual outlook on life. It is safe to say that every one of them fell ill because they had lost that which the living religions of every age*

have given to their followers, and none of them has been really healed who did not regain a spiritual outlook" (Carl Jung 1933). One of the times we may feel most spiritually connected is during times of sorrow or suffering.

One of the questions that we ask ourselves is "why do people suffer?" Some use a fairly naïve, reductionist approach like "how could God let this happen"? In fact, God doesn't let it happen at all. What we have is a world that is chaotic, and that sometimes things go wrong. People make mistakes, people are selfish, people are thoughtless, and people therefore can create a world that is even more vulnerable than is by way of its very nature. In short most, if not all, of our suffering is caused by our own actions and deeds. The Dalai Lama says, "The main cause of suffering is the egoistic desire for one's own comfort and happiness". Yet in saying "main", he doesn't mean all!

For instance, we were probably all filled with anguish a couple of years ago when a town in Bangladesh was swept away by flood, yet we know full well that it may have been avoidable if they had had the materials and the economic wealth to build protection against these kinds of disasters. Isn't this the type of social injustice that rock stars Bob Geldof and Bono are outraged about? More locally, we complain about the length and waiting times in hospital queues in Australia, yet we find money locally in my city to build a $40 million football stadium.

The simple answer to a lot of these questions is that there are always alternatives and choices. However, suffering has long been part of our lives. We find in the Book of Numbers, in the Bible, an entire Jewish people wondering why they had been in the wilderness for 38 years. Had their God abandoned them? What hope was there in all this suffering?

James Cowan picks this up in his book "A journey to the inner mountain", in talking about St John the Divine, a fourteenth century saint, where he speaks of prevenient grace. This is the grace that comes from the bad stuff that happens to us; for instance, a death in the family, the loss of a job, etc, but through it all something comes out of it that is beneficial, even transforming. John Cavanaugh, a friend, gave a paper some time ago entitled "Unexpected Gifts". The name of the paper shouldn't surprise you, but the fact that he worked in an oncology unit may have added a twist or perhaps even an irony in respect to the theme of that paper. What good does come from

cancer? However it is in these circumstances we see aspects of prevenient grace; families reconcile, families forgive, families get to say goodbye. In addition, courage is found; a dignity we can all admire and that sets a good example. There are always some of the unexpected gifts even in the worst times, and they are examples of prevenient grace.

For a moment I would like you to again consider Bill's story. As I indicated, I used a paper that I had previously, ("Stations of the Cross for Atheist") to analyze Bill's circumstances. I suggested then that I think the Stations of the Cross, found in any Catholic Church, are metaphoric for each of our lives. As I once said to a young man, when he was facing his third drink driving charge "Well you keep going back to the first station". You might remember that station as "the condemnation". The journey of these stations, as you may also know, takes us through to the death and burial on the fourteenth station. I also pointed out in that paper that throughout the stations there is always someone there for Christ, whether it is Veronica, or his mother, or someone just "carrying his cross". Thus it is true in our lives that when we look and feel in despair the most, there are in fact, people around us.

Christian churches focus on the importance of the resurrection of Jesus Christ. Some would go as far as to say that if there is no resurrection, then there is no Christian faith. I am not sure Bishop Shelby Spong agrees with that, but we will take it that it is one of the basic tenets of Christian faith. I want to go one step further, however, and point out that all the suffering was not just for resurrection, but for something even more important, and often missed, and that was his transformation. You will remember the story says that after visiting the grave, or tomb, Mary Magdalene doesn't recognize Jesus and thinks he is the gardener because he was transformed from what he was to what he had become. Later, Cleopas and his companion don't recognize Jesus on the road at all, and then only did recognize him when they went home and ate together. And thus, the purpose of suffering can be in fact transformation, and without transformation it seems to me that we go back to relearning the same lesson until we do. Moreover, as Bill was to find out that transformation was to so change him, so that even his friends didn't "recognize" him.

Sometimes this is through the illusion of death, and if you are a good Buddhist, you might understand that if you haven't learnt it at that point, then you will come back until you do learn it, until you reach Nirvana.

For the atheist and the skeptic, these stories may seem at first to be little more than religious mumbo jumbo, but I want to suggest that they are beautiful metaphors, and stories that we can apply to our own lives, that we can all take the journey through suffering. It is in the learning and transformation that we became more whole, or as the Dalai Lama might say, "you only lose when you lose the lesson".

11. Burnout Briefly Revisited.

I would like to re-introduce some of the subject matter from Chapter 7 on Burnout, and point out that ultimately burnout is caused when we no longer have the resilience to continue in our chosen profession. So just by way of summary what does happen when our resilience fails us?

I am not one for definitions, but I think the pedagogy of this is important. Pines and Aronson (1981) noted that burnout is "characterised by physical depletion, by feelings of helplessness and hopelessness, by emotional drain, and by the development of negative self-concept and negative attitudes towards work, life and other people...It is a sense of distress, discontent, and failure in the quest for ideals" (p 15). Freudenberger and Richelson (1980) described burnout as a "state of fatigue or frustration brought about by devotion to a cause, way of life, or relationship that failed to produce the expected reward", (p 13). Edelwich and Brodsky (1980) defined burnout as a "progressive loss of idealism, energy, purpose, and concern as a result of conditions of work" (p 14).

Burnout is, of course, subjectively experienced, but is as a state of physical, emotional, and mental exhaustion caused by long-term involvement in situations that are emotionally demanding. The emotional demands are most often caused by a combination of very high expectations and chronic situational stresses. Burnout is accompanied by an array of symptoms including physical depletion, feelings of helplessness and hopelessness, disillusionment, and the development of a negative

self-concept and negative attitudes towards work, people involved in the work, and life itself. In its extreme form, burnout represents a breaking point beyond which the ability to cope with our work environment is severely hampered. Indeed, burnout tends to mostly afflict people who enter their professions highly motivated and idealistic, expecting their work to give their lives a sense of meaning. It is a particular hazard in occupations in which professionals tend to experience their work as a kind of "calling" such as policing. When I wrote the chapter devoted to burnout, I had in mind the fact that police who struggle with their psychological wellbeing, do not present simply with PTSD, or depression. As I indicated, these can be co-morbid conditions in any case. So many police also have the symptoms of burnout. Now while this is not adequately understood, or even accepted as a psychiatric condition, it is important that therapists and clients alike understand that such a condition may impinge on treatment, and underlie, or be causal, of the pathology in the first place. To ignore burnout as a cause of psychological damage would be similar to considering PTSD without acknowledging trauma.

The protective shield, the psychological armour against burnout is resilience, and is the topic of the final section of this chapter and the book.

12. Resilience

I have spent more than two-thirds of this chapter to get to this point as I believe that having the right foundations are necessary before resilience can be properly developed. It is my thesis that being resilient ourself rubs off. You see, that was the idea I introduced at the beginning of this chapter, i.e. that notion of co-dependency. This works both ways, as I pointed out; if you live with someone who is distressed or anxious, alcoholic or depressed, then there may be ramifications for the entire family unit. Similarly, if you live or work with someone who is positive, vibrant, optimistic, then undoubtedly that can rub off too!

Let me describe this a little further. In the introduction to this chapter I talked about co-dependency, and I talked a little about how the anxiety of one person might lead to an anxiety in another. In the autumn term in 1998, a teacher at Tennessee High School noticed the smell of gas in a class room and soon felt dizzy and nauseous. Some of the students then reported feeling unwell also, and they

were all then transported via ambulance to a nearby hospital as concerned staff and students watched them go. Some of those left at school started to feel sick as well. By the end of that day, 100 people had showed up to emergency with symptoms that seemed to be associated with exposure to gas, but the illness could not be explained by medical tests.

Extensive environmental tests concluded that no toxic source could be the cause. These results were published in the New England Journal of Medicine. It was suggested that what occurred was real illness, although not caused by germs or fumes. It was not an infection, but it certainly was transmitted.

The contagious notion is not that unusual, and is often quoted in cases of hysterical illness, but I want to make the point, of course, especially in relation to resilience, that just as we are able to communicate disease, so too we are actually able to pass on positive attributes such as optimism, laughter, and so on.

Sibal Barsade at the University of Pennsylvania, [In Wang, S., (2006) Contagious Behaviour] says it is important that people understand that emotional contagion is not just a self contained phenomena that ends with the catching of the emotion. In a study on group behaviour, he finds that, not only do individual moods shift towards their leader, but the variation of emotion between group members decreases over time. Individuals end up feeling not just better or worse, but more similar to each other. It therefore makes a lot of sense that if I want to belong to a particular group that I will think, act, behave, and in this case feel, like the rest of my group members.

Our experiences over the years help us build scripts or routines that we tend to perform in particular situations. When a script is acted, it triggers off a set of behaviours with a high degree of automaticity. Imitating another's behaviour is only part of what makes emotion contagious. According to one theory, we infer our emotion from our expression behaviours. We smile, so therefore we must be happy. Alternatively, we may use the emotional behaviours of others as a means of comparison to gauge how we should be feeling and acting in a particular situation. Matching others may also be a way to show empathy, or just to let them know 'I like you'.

Researchers have brought couples into the laboratory and observed their behaviour. Those with like behaviour act more similarly, and if a couple is out of synchrony and don't like each other much, then they are resistant to imitating behaviour. Synchrony is necessary in social animals. It is fundamental not only to having a back and forth interaction, but we actually look for basic correspondence. Philological mimicking occurs with facial expression, and sometimes we ourselves don't even realise we are doing it, but it is important to our social interactions. To put it as simply as I can, "laugh and the whole world laughs with you".

Again, Sibal Barsade brought a group of participants into the lab to complete a managerial exercise. The group included a research confederate who was either positive or negative, and who exerted high or low energy, examining both participants by self reported mood and independent video code as ratings. Barsade found that individuals in groups with positive mood confederates became more positive over time, while those in the other condition became, as expected, more negative.

"We aren't emotional islands", says Barsade. "People are sort of walking mood conductors and we need to be aware of that". Again, resilient people create resilience in others and, in turn, resilient people create resilient communities. As I have used police as my target organisation, perhaps this is what binds the NSW Police - a contagious negative view, a sense of polarization, "them" versus "us"? As I suggested in Chapter 3, almost irrelevant of the efficacy of any welfare initiative, if it occurs in a negative, suspicious environment it will be less than effective, even fail. It is the negativity and sense of alienation that undermines resilience. Indeed, I have spent some considerable time emphasising this because I believe if you hand around with negative people, it only hampers your efforts to become resilience, either as an individual or at an organisational level.

So just what is resilience?

Defining resilience:

- The Oxford Dictionary says that "resilient" means 1). Resuming its original shape after compression; 2). Readily recovering from shock, illness, etc." I like to refer to it as simply "bouncebackability".

13. The Core Elements of Resilience

There are a number of qualities inherent in resilience that are not very well conveyed by the definition above, or in fact any definition. So you have to look deeper than simple definitional terms, and I've come up with a series of core elements that stand out. The first of these (and they aren't in any particular order), I would describe as "childlike curiosity". One of the many things that's made technology advance so quickly is its appeal to younger people. Some of you may still have the idea that if you want your VCR or DVD tuned, then ask a person under the age of 18. My New Year's resolutions for 2000 were, in fact, to understand my mobile phone, to be able to program my VCR, DVD, television combinations, and to understand my way around a computer better than I did in 1999. I might say I achieved that, some of the few resolutions I have ever managed to keep. I think the thing prodding me in the back of my mind was a phrase that I heard many years ago when the Internet first came out. I went to a workshop on the Internet, and the presenter said "Children learn quicker because they are prepared to push buttons". It stuck in my mind that as adults we are too often frightened of making a mistake, frightened of getting hurt, frightened of being embarrassed, all of which inhibits our ability to really enjoy and integrate new skills. Experiment with things, ask questions, and see the funny side of things. You know the distance between rage and laughter is just a decision made in the brain (at the hippocampus), a signal will either go to your left frontal lobe or your right frontal lobe for interpretation, and depending on to which side it goes, will mean you will laugh or become angry.

The second quality is akin to the first, "learn from experience". Resilient people understand that within suffering and times of sorrow, there is nonetheless a learning experience available. It was Victor Frankl who said, "Lord that I be worthy of my suffering", and in Frankl's case, he was talking about many people in Auschwitz, who despite the horrific circumstances were able to show their humaneness and dignity. As I have mentioned several times in this book, the role that suffering may have is the chance that prevenient grace may transform us.

So learning from experience is not just about the positive things in our lives, but also the negative. The resilient person bounces back from the negative and is willing to adapt what they have learnt

to the future. Some such as Karen Reivich "The Resilience Factor" says that how we deal with adversity is simply the most important predictor of resilience.

This brings us to the third element, which is to "adapt quickly". People who do not have resilience resist change. Do you see the connection between the first three, curiosity - learning - adaptation? Many people are fearful of change. They never see the opportunities; they only ever see the dangers. So adapting quickly allows for the removal of procrastination. Edward Young, the 18th Century English poet, once said that "procrastination is the thief of time". Now that's easy for me because I love change. I love fluidity. Other people prefer things to be the way they have always have. Abraham Maslow described this when he talked about the "hierarchy of needs", in respect to human motivation. The second rung of those needs being "security and order". This was the second of five, the fifth; realising self-actualisation. So the need for order and predictability and routine can keep us a long way from being fully fulfilled, or actualised.

Attached to this, resilient people have a talent for serendipity. Resilient people learn lessons in the "school of life". Serendipity is the antidote to feeling victimised. They can convert a situation that is emotionally toxic for others into something emotionally nutritious to them. They thrive in situations distressing to others, because they learn good lessons from bad experiences. They convert misfortune into good luck, and gain strength from adversity. A good indicator of exceptional resilience is a person talking about a rough time that said "I will never willingly go through anything like that again, but it was the best thing that ever happened to me". They ask "How can I turn this around?", "Why is it good that this happened?", "What's the gift?"

Fifthly, the resilient person has solid self-esteem and self-confidence. I mentioned self esteem earlier, its part of our coping resources. Self-esteem enables you to receive praise and compliments, and it also acts as a buffer against hurtful statements, while at the same time being receptive to constructive criticism. Self-esteem is about self talk, and positive statements about one's self. Imagine, if you will, I was to tell you how terrific I am; that I am a good speaker, I am a good writer, I am a great psychologist, and I am a fantastic father; what would be the cringe factor in this? Yet in our society we readily accept people who say "Gee, I'm stupid", "God I'm an idiot", and other such self effacing terms. In our world, there needs to be at least a middle ground where I

feel comfortable saying that I'm okay. Self-confidence allows you to take risks without waiting for approval or reassurance from others, to expect to handle new situations well because of past success, and this is again tied in, of course, with the third core element above of adapting quickly.

The sixth core element is having good friendships and loving relationships. Research has demonstrated that people in toxic working conditions are more stress resilient and are less likely to get sick when they have a loving family and good friendships. I have mentioned in therapy many times, and earlier in this book, that "you cannot fight a battle on two fronts". If you have a toxic work environment, then you need a loving home environment. Loners here are more vulnerable to distressing conditions at work. Talking to friends and family does help and diminishes the impact and difficulties, while increasing feelings of self worth and self-confidence.

The seventh core element is the ability to express feelings honestly. Resilient people express anger, like, dislike, appreciation, love and grief, and the entire range of human emotions openly and honestly. But resilient people are also able to suppress their feelings when they believe it would be best to do so. Think for instance of anger, is it always appropriate to express one's anger? Argument, is it always wise to argue? I've always used the theory that you only argue when you have a chance that the other person will accept your point of view.

The eighth feeling is very much tied into the "Care of the Self" Theory, and that is a sense of optimism; deep optimism, guided by internal values and standards. Resilient folk have a high tolerance for ambiguity and uncertainty. An optimistic person can work without a job description, and is a good role model by virtue of their professionalism. Ultimately, however, they have a synergistic effect that brings stability to crisis and chaos. They ask, "How can I interact with this community so things turn out well for us?" Probably today this is the single core element that Police need to develop, i.e. communities. A sense of optimism that things will work out well.

The Archives of Internal Medicine, in 2006, published a study that specifically examined 545 healthy men aged 64-84 years of age. Optimism was measured in 5 yearly intervals from 1985 - 2000. Over 15 years nearly 70% died, with half the deaths due to cardiovascular causes. What the

study found was that those men who scored highest on optimism had a 50% lower risk of cardiovascular death, even after considering other risk factors.

The ninth core element is the ability to empathise. That is, the ability to put yourself into another person's shoes. Too often we go into situations with a winning attitude, and a pervasive philosophy of that if I win, you must lose. It's a cliché to talk about win-win attitudes, but an empathetic person attempts always to see the situation from the other's point of view, and behaves accordingly.

The tenth and final core element relates to something that goes back to the beginning of this program, when I introduced you to a form of knowledge that you know, but a form of knowledge that is not always practised because of our bias towards the scientific method, I refer to intuition. The resilient person uses intuition and creative hunches. They accept subliminal perception and interaction as valid useful sources of information. "What's my body telling me?" "Did that daydream mean anything?" "Why don't I believe what I'm being told?" "What if I did this?" These are some of the questions the intuitive person asks. Goleman picked up this theme of intuition in his book "Emotional Intelligence". This, along with empathy and optimism, I consider to be the three elements that are the most essential in building resilience.

Yet to achieve this resilience the basics, as discussed in this chapter, also have to be not just understood, but inculcated into a repertoire of behaviour which is habitual and thus long lasting. To this end, I have appended a questionnaire at the conclusion of this book which provides not just an assessment of your resilience, but when the scores are examined, may give you a template to build better resilience skills. [Despite my efforts I have failed to identify the author of the questionnaire but I acknowledge it here].

14. Conclusion

So we come to the end of this chapter and book. I expect that the changes and adaptation that we will all be required to make in the next 50 years will be gigantic. In fact, the likelihood that we will make our lives easier and less stressful is not a view supported by our experience of the last century. The future will be filled with paradoxes in the same way as the last century, where we

were told that computers would make our lives easier, and mobile phones would improve communication. If you think that their introduction have only improved our society, then I could do with some help on that.

In reading this book you may have picked up some negativity. You may feel that there was some bite in my comments on where we are now, and where we are heading. However, if you see it only in this way, it is unintended, and I think gives only a negative spin that would be at the cost of missing my actual real sense of optimism and hope. I think it's as I said earlier, that in accepting that life is difficult we can transcend or rise above it. In so doing, we can save a good deal of our stress, and certainly stop wasting energy that could be used in more creative ways. In fact, I believe it is the continuing challenges in our lives that cause them to be so rich and interesting.

However, irrespective of all that is written in this and so many similar books, I believe that in order to be resilient each of us must ultimately have meaning in our lives. Viktor Frankl again suggests that happiness only comes from meaning; we do not achieve meaning through happiness.

Ultimately our quest here on this planet, as we hurtle through the universe, holding on for dear life, is to see that our lives do have meaning. Quite often this can be obscured, especially when we compare ourselves to others. Or worse still because we are not in the centre of the picture, we may think we have no real import at all. I often quote two names to my clients; Joachim and Anne. Here were two people who lived near Jerusalem more than 2000 years ago, who may have pondered the same question. Living under Roman rule and struggling day by day to get by, they may have thought that their lives had little meaning. Yet their lives were to change the course of history. They were the parents of Mary, who gave birth to Jesus, a Nazarene who was to have more impact on global affairs than any other person in history. You see, Joachim and Anne were in fact a part, or piece of that tapestry, not the main subject of it.

Likewise, resilient people see their lives as having meaning. People in vocations such as policing have been entrusted with the safety of our community and laws, and I can think of a no more sacred trust, and thus meaning, than that.

Resilient people build resilient communities. Yet, there is another suggestion that flavours this chapter, and that is that resilient people positively impact on their community: in short resilience can be contagious.

Too often we wait until things are broken before we fix them, in policing (and in other professions) this means breakdown. Then we tread the weary path of rehabilitation or medical discharge. This is the least desirable way to care for ourselves, and especially police. In more recent and enlightened times we have used interventions that are reactive, e.g. Employees Assistance Program (EAPs), or used interventions that are designed to be reactive, e.g. Critical Incident Stress Debriefing (CISD). These may prove to be efficacious both in financial and in human cost, but still not pre-emptive. The ultimate weapon against burnout, depression and even physical illness is resilience. In the earlier chapters of this book I wrote of the predictability of psychological injuries in the emergency service work. Given that undeniable risk, the best approach is to accept your humanness. That, further, you are not "bullet proof", and that every opportunity should be taken to build resilience and counter the inherent demands that you are chronically exposed to. In fact, the donkey, in Shrek, like the rest of us, should not have been so close to the edge in the first place!

Selected Bibliography

Bolman, L. G, Deal T.E., (2001) Leading with Soul, John Wiley, San Francisco
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Bonanno G.,Galea, Bucciarelli, Vlahov D., (2006) Psychological Resilience After Disaster: New York City in te Aftermath of the September 11th Terrorist attack.

Brahm A., (2004) Opening the Door of your Heart, Lothian Books, London

Brewin, C.R., McNally R.J., Taylor S., (2006) and Point-Counterpoint: Two views on treatment memories and posttraumatic stress disorder. Journal of Cognitive Psychotherapy Vol: 18 99-114.

Brock, P., (2006), You Must Come Away, Melbourne, Vic, Australia.

Clarke J., (2005) Monsters in the Workplace, Random: House Sydney, NSW, Australia.

Cowan J, (2002) Journey to the Inner Mountain, Hodder and Stoughton. London.

Dale.D., (2006) Who We are – a Miscellany of Australia. Allen & Unwin. Sydney, NSW, Australia.

De Botton, A., (2002) Status Anxiety, Pantheon Books, New York, USA.

Diagnostic and Statistical Manual of mental Disorders Ed IV (TR) (2000) American Psychiatric Association, Washington, USA.

Dodson, B., (2001) The Sharp End. MacMillan Sydney

Duncan, B.L., Miller S. D., (2000) The Heroic Client. Jossey-Bass John Wiley San Francisco.

Dyer, W. W., (1998), Wisdom of the ages, Harper Collins, New York, USA.

Everly, G. S., (1989), A clinical guide to the treatment of human stress response, Kluwer Academic Publication, New York, USA.

Everly, G. S., (1995), Psychotraumatology, Springer Verlag, New York, USA.

Farber, B. A., (1983), Stress and Burnout in the Human Service Professions, Pergamon Press: New York, USA.

Faust D, Ziskin J., (1988) The Expert Witness in Psychology and Psychiatry, Science, Vol 241, pages 31-35.

Figley, C. R., (1985), Trauma and its wake volume one the study and treatment of post-traumatic stress disorder. Brunner/Mazel Inc: New York, USA.

Figley, C., (In) Violanti, J. M., and Paton, D., (1999) Police Trauma Psychological Aftermath of Civilian Combat, C.C. Thomas, Illinois, USA.

Fothergill, N., (2002), You are not in the forces now, Vietnam Veterans Counselling Service, DVD Melbourne, Victoria , Australia.

Frankl V, E., (1959) Man's Search for Meaning, Washington Square Press New York, USA.

Frydenberg E (2002) Beyond Coping, meeting goals, visions and challenges, Oxford University Press Oxford, U.K.

Gilbert, D., (2006), Stumbling on Happiness, Calm Books, Sydney, NSW, Australia.

Gilbertson, M.W., Shenton M.E., Ciszewkski A., Kasai, K., Lasko, N.B., Orr S.P., Pitman, R.K.. (2002), Smaller Hippocampal, Volume

Glasser W., (1984) Control Theory, Harper and Row Publishers, New York, USA.

Gliddon J., (2006) Reasons to be Tearful, The Bulletin, Jan 31 pp: 31-34.

Goleman,D, (1995) Emotional Intelligence, Bloomsberry Publishing, London.

Gottman J.M., (1999) The Seven Principles for Making Marriage Work, John Wiley, New York, USA.

Gottman J.M., (2001) The Relationship Cure, Random House, New York, USA.

Gray J, (1992) Men are from Mars and Women are from Venus, Harper Collins, New York, USA.
Heath, R., (2006), F**k off it's our turn, Pluto, Melbourne, Vic, Australia.

Hendra T, (2004) Father Joe, Penguin Books, London

Horowitz, M. J., (1992), Stress Response Syndromes (EDII) Aronson Inc, New Jersey, London.

Hutchins, H., Kirk., (1997) Making us Crazy, The DSM Bible and the Creation of Mental Disorders, Free Press, New York, USA.

Ireland M., (2006), Stress can writing about it help, Police News, Jan; pages 15-17, Sydney, NSW, Australia.

Jaffe, D. T., Scott, C. D., (1984), Self Renewal, Simon and Schuster, New York, USA.

Kolk B, (2001) The Assessment and Treatment of Complex PTSD, [Yahunda R., Traumatic Stress]: American Psychiatric Press, New York, USA.

Kutchins, K. & Kirk, S. A., (1997). Making Us Crazy. Simon & Schuster, Inc, New York, USA.

Levitt, S. D., Dubner, S. J., (2005), Freakonomics: A rogue economist explores the hidden side of everything. Harper Collins Publishers Inc: New York, USA.

Lindahl M.W., (2004) A New Development in PTSD and the Law: The case of Fairfax County vs Mottram, Springer Sciences, pp 543-546

Livingston G., (2006) And Never Stop Dancing, Avalon Publishing, New York, USA.

Mann, R., [InMcCarthy, P., Sheehan, M., Wilkie, W.,] (1996), Bullying - from Backyard to Boardroom, Millennium Books, Alexandria.

McCarthy, P., Sheehan, M., Wilkie, W., (2006), Bullying from backyard to boardroom, Millennium Books, Sydney, NSW, Australia.

McFarlane A.C., Yehuda R., Clark C.R., (2002), Biological models of traumatic memories and post traumatic stress disorder, the role of neural networks, Psychiatric Clinics of North America, 25(2): 253-70, USA.

McGrath, A., (2004), The Twilight of Atheism, Eider, London.

McGregor, S., (2000), Creating Happiness Inventory, Calm Books, Sydney, NSW, Australia.

McKay, E., (2006), Crime Scene. Penguin Sydney.

Mitchell, J. T., & Everly, G. S., (1995), Critical incident stress debriefing, Chevron Publishing Corporation: Maryland, USA.

Moncrief J., Kirsch I., (2005), Antidepressants are no better than Placebo: British Medical Journal, Vol 331, pp 155-9.

Moore T., (1994) Care of the Soul, Harper Collins, New York, USA.

Moore, T., (1996), The Enchantment of Everyday Life, Hodder and Stoughton, Sydney, NSW, Australia.

Murray vs. NSW Police Commissioner Supreme Court of NSW Court of Appeal 2004. NSWCA 365, Giles Ipp and Tobias.

NSW Workers Compensation and Rehabilitation Act, (1996), Government Printer, Sydney, NSW, Australia.

Peck M.,S., (1993) A Road less Travelled, Plenium, New York, USA.

Peters R .F. (2001) A Wish before Dying, HEAS Publishing, Hamilton, NSW, Australia.

Peters R.F, (2000) Managing the Impact of Trauma, HEAS Publishing, Hamilton, NSW, Australia.

Peters R.F. Peters M., (2002) Le Folie au Deux, Biennial Police Association Conference, Wollongong, NSW, Australia.

Peters R.F., (1999), Managing the Impact of Trauma, HEAS Publications, Newcastle, NSW, Australia.

Peters R.F., (2005) The Payne of it all, Police News, April, Sydney, NSW, Australia.

Peters R.F., (2006), The Dignity of Work, The Proceedings of the Police Biennial Conference, Terrigal, NSW, Australia.

Phelps A.E., LeDoux J.E., (2005) Contributions of the Amygdala to Emotion Processing: From Animal Models to Human Behaviour Neuron, Vol 48(2) pp 175-187.

Pines, A, Aronson, E, (1988) Career Burnout, Collier MacMillan, New York, USA.

Reyna V.F., Farley F, (2006) Risk and Rationality in Adolescent Decision Making – Implications for theory and public policy. Psychological Science. Journal of the Association for Psychological Science.

Robles T.F., Glasser R., Kiecolt-Glasser J.K., (2005), Current Directions in Psychological Science, Volume 14 (2) pages 111-115.

Seligman M,E., (1994) Learned Optimism, Random House, Milsons Point.

Shatte A., Reivich., K, (2002) The Resilience Factor, Broadway Books, New York, USA.

Shephard B., (2000), War of Nerves, Harvard University Press, Massachusetts, USA.

Shapiro, F., (1995), Eye movement desensitization and reprocessing, Guilford Publications, New York, USA.

Simon, R.I., Ed (1995), Post Traumatic Stress Disorder in Litigation, American Psychiatric Press: Washington, USA.

Tacey, D., (2003) The Spirituality Revolution, Harper Collins, Sydney, NSW, Australia.

Volf, M, (1996) Exclusion and Embrace, Abingdon Press, Nashville, USA.

Wambaugh, J., (1974. The Onion Fields, Delecorte Press N.Y.

Wambaugh J., (1987) Choir Bays, Delecorte Press N.Y..

Wilkins G., (2006), The use of putative cerebellum exercises to control and relieve symptoms of posttraumatic stress, Personal Communication: April 2006

Williams M.B., Sommer J.F., (Ed) (2002) Simple and Complex Post Traumatic Stress Disorder- Strategies for treatment in Clinical Practice, Haworth Press: New York, USA.

Workplace Stress in Victoria – Developing a Systems Approach Victorian Health Promotion Foundation. May 2006. Victorian Health Department Publication www.vichealth.vic.gov.au/workplacestress

World Health Organization Geneva, (1993), The ICD-10 Classification of Mental and Behavioural Disorders, Who Library Cataloguing in Publishing Data, Switzerland.

Yehuda, R., (2002), Post Traumatic Stress Disorder, New England Journal of Medicine, Vol 346 p108-114.

Appendix I

Partners & PTSD

Roger F Peters PhD

This pamphlet came about because of a real concern that many police officers who see me and who have Post Traumatic Stress Disorder (PTSD) do not fully explain to their partners, firstly even the fact that they have been diagnosed. Or secondly, what the ramifications for having PTSD are for them, their relationship and their family. For many it is just too painful to talk about.

This pamphlet is aimed in some small way to address this, and is principally aimed to assist partners of police officers. The ratio of police based on gender is still three to one, and so this brochure will be addressed to women, but this information is also relevant and certainly should be read by husbands of police officers, and in fact other non police clients, especially those who live with those who have been traumatised by awful events including war.

PTSD is a relatively new psychiatric entity, although talked about for many years. It wasn't until the 1980's when PTSD [after some heavy lobbying by the Vietnam Veteran population in North America] did eventually find its way into a so called "bible" of the psychiatric nomenclature, the Diagnostic and Statistical Manual of Mental Disorders, (DSM).[1]

I do not intend to write a full clinical explanation or even an overview here, but hopefully this pamphlet will instead provide some practical comments and suggestions. If you wish to read more and you have access to the web, then through my webpage www.heas.com.au you will find a good deal of information about PTSD. In fact in these four pages I want to avoid complicated analysis, but instead address some of the core issues.

The Cause

PTSD comes about as a result of the impact that traumatic incidents can have on an individual. Most of us can expect to have relatively few, perhaps less than seven traumatic experiences in a lifetime. Police officers of course may have seven in one week. The recovery from trauma, at least among the general population, is anticipated to be somewhere between 93% and 97%[2].

[1] Diagnostic Statistical Manual of Mental Disorders now in its fourth Edition as at 2000.
[2] Jeff Mitchell a leading author in psychotraumatology in Mitchell and Bray, (1986).

In short, few people go on to develop PTSD. A traumatic event is defined as an incident that causes a threat to our safety or the integrity of others, either physically and or emotionally. A good example of emotional trauma could be domestic violence or bullying. Secondly, it must be unjust or undeserved, and thus the deaths of children provide the basis for horrid and traumatic experiences. Finally, it must expose our vulnerability. Police officers who have a family of their own are particularly affected by such experiences as the death of children.

However, as I indicated, most people recover from singular traumatic experiences and recent research shows that 94% of people who were actually in the Twin Towers on September 11 have made their way to recovery.[3] While this might be statistically the case for civilians, the reality is that police officers, especially, are a group set aside who not only experience several traumatic experiences, but hundreds of life threatening and traumatic incidents in their career as police officers. The anticipated number of emergency service workers who go on to develop some level of post trauma psychopathology in the Western world is 20%[4]

So what goes wrong?

The general preponderance of opinion is that the normal processing of trauma becomes 'stuck', and that PTSD is no more than the accumulation of prolonged emotions that a person can experience shortly after a traumatic event. [These are outlined in an appendix to this pamphlet, page 4] People may continue to experience these distressing and unfamiliar symptoms for months, even years, afterwards. A particular system of the brain, i.e., the limbic system, is considered to be particularly responsible for the triggering of these emotions.

When diagnosing PTSD the mental health professional looks for three essential features. Firstly, that the person is excessively anxious and hyper-vigilant. They have as a result difficulty with sleep and during the day are bothered by minor issues and may become quite irritable, or to use an Australianism, "cranky". Many families say that it's like walking around the house on "egg shells". This is because the person is not just anxious, but hypervigilant or "wired". Implicated in all of this is the activity of endocrine system, and I have described this more fully in several articles on my web page.

The second feature of PTSD is intrusivity of thought. These are thoughts we have when we don't want to have them, and they are quite involuntary. They may be triggered by rather obvious things such as a news report with a traumatic theme, or obscure stimuli, i.e., like something someone might inadvertently say. These then not only trigger intrusive thoughts, but later in sleep are likely to cause nightmares. Perhaps you can now see the circularity, if a person has nightmares and is not sleeping, this brings with it even more fatigue and anxiety, and of course, depression. Good sleep hygiene is essential to all of us, but especially those who struggle with their psychological wellbeing.

Flashbacks are relatively uncommon, but may happen more by way of the olfactory senses. That is, that sometimes a person may believe they can smell something again from a past traumatic episode. This occurs because a particular part of their brain has been activated by sensing a similar associated smell - barbeques can be dangerous places for those who suffer PTSD.

Finally, avoidance; if a person is avoidant, and for instance they are war veterans, then it's quite reasonable to ask what are they actually trying to avoid? They are no longer at war; they are no longer in the armed forces. The answer to that is that they are in fact trying to avoid conflict. Simply put, in their minds, where there are people there is a potential for conflict. Have you not noticed that your husband or partner is reluctant to go anywhere? He has become perhaps anti-social, preferring to stay at home, and to use John Gray's term, prefers to stay in "his cave".[5] By avoiding socializing and withdrawing, a sufferer of PTSD simply

[3] Bonnano G., et al (2006). Psychological Science, Vol 17, page 181.
[4] See Lindhal (2004) Mottram vs. Fairfax Country a case study.
[5] John Gray "Men are from Mars Women are from Venus".

reinforces in their mind that when they are not around people there isn't conflict, they feel less vulnerable. In so doing they seem, at least to themselves, to manage better. Obviously this is not what the person was like before they suffered PTSD and this needs to be addressed. This is one of the many challenges of PTSD, and so one of my therapeutic goals is to help clients beat these symptoms of isolation.
[You should help them fight isolation and withdrawal]

Can you catch PTSD?

This sounds like a funny question because if you were not exposed to a trauma yourself, how is it that you could be traumatised? My son Martin wrote a very fine dissertation when he was at University, and we subsequently wrote a paper "Le folie au deux"[6]. This emphasised that when you live with someone who is anxious, then it is possible to actually become anxious yourself. We understand this well in matters relating to alcohol, and thus we have the notion of co-dependence. The reason that ALONON was set up was to support those people who are family members of alcoholics, not that they were alcoholics themselves, just that they as a consequence experienced the adverse affect of their family member's alcoholism. So it is with PTSD, it is important that while you cannot catch PTSD, living with someone who has can in fact be as they say "hell". Marriages run the risk of failure at this point because it seems that in the shorter term we can in fact care for others and put up with quite a bit, but this is normally as long as there seems at least to be some 'light at the end of the tunnel'. The strength of a relationship will normally of course determine just how long a person's tether is. I am aware that many of you, by the time you are reading this, have reached "the end of your tether", but to mix metaphors, "there is light at the end of the tunnel".

What will happen in therapy?

What your partner will be introduced to in therapy with me are two things. First, they will be introduced to what I call a "pre-therapy schemata". Secondly, "cognitive behaviour therapy" called CBT. You will undoubtedly have access one way or another to the web. Even if you don't have one at home you can access my web page through facilities at your local library. There, among many other articles, you will find the four principles that I have found as absolutely essential in assisting police officers with PTSD, even before actual therapy begins.[7]

The "schemata" briefly explained

Controversial though it may be, I believe that any police officer diagnosed with PTSD needs to think seriously about leaving the police. Most police have PTSD of a "complex" type because it is not just one particular traumatic experience that has caused this circumstance, but instead, a large number. These tend to accumulate over time and almost predictably can lead many officers to 'breaking point'. Whereas some believe that police officers can return to work, I am quick to point out that while they inevitably get some remission from PTSD, their chances then of aggravation and going into relapse are as much as nine times higher than a police officer who has not suffered PTSD[8]. Thus, there may be some foreseeable risk, and I think that risk needs to be addressed.

There is some sound research that indicates that there are four principle reasons to explain and account for why some people get PTSD and others don't[9]. Firstly, the existence of some pre-morbid history of psychiatric illness; this is generally not true of police. Secondly, the severity of the trauma, although there is some question about that, it makes common sense to see that the more traumatic an experience then the more it is likely to have a more profound impact.

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[6] This literally means the "silliness of two", or "shared insanity: The Paper was presented at the 2002 Biennial Police Association Conference
[7] www.heas.com.au, type heasvault (at enter the vault) then password "fishstix"
[8] Ozer, E, Weiss, D, (2004) Who develops PTSD, Current Directions in Psychology Vol. 13 (4), p169
[9] Ibid p170

It is the third and fourth reason given that is the basis as to why I believe that police should seriously consider leaving when they suffer from PTSD. The third reason given is that there is a more likely re-occurrence of PTSD when there is exposure to repeated trauma. A police officer returning to work would be exposed to risk again and again.

The fourth reason, and a critically important point, is also that PTSD is likely to occur in organisations that do not support their people. There is little doubt in my mind that, while the NSW Police say the right thing, they do not always follow through. The experience of police in respect to critical incident stress debriefing would be a good example of this often found lack of care. So from my point of view as a therapist, if I want to put the odds of recovery in the officer's favour, my general recommendation is to leave. This however should only be done after the diagnosis has been **confirmed**.

Secondly, police officers who intend to leave must develop another community of reference. Police are programmed to think like police 24 hours a day. They also behave at times, as if they are in what some people suggest, is like a "cult", especially conditioned to believe that they will be looked after. Likewise, in turn they are programmed to never take a backward step, and to always support each other. Thus, leaving "the job" goes against all that they have been trained to do. Many feel like they are abandoning their comrades, while indeed the police left at work may act as if these officers have betrayed the "cause".

The mistake that some officers make is to try and find a replicate in this new community of reference, and so replace policing. This is impossible. This is a unique vocation, thus, the new community of reference cannot replace, but simply assist the officer move on.

The third in what I refer to as the "pre-therapy schemata" is the importance in compliance with medication. Officers should not take drugs if they do not need them. A local newspaper journalist, Jeff Corbett[10], referred to anti depressants recently as "happy pills". These drugs do not make people happy, but just remove the magnitude of the swing between depressed and normal moods. In fact, they slow down some people, they make them sluggish, and they may even gain weight as a result, as well as other unwanted side effects. You might understand why compliance is compromised when the side effects of medication can be quite nasty.

One adverse affect of both medication and or PTSD is that they may no longer seem to have an interest in intimacy. Libido is poor, and they may have erectile dysfunction. This is a time for both of you to recognize that there are a number of contributing factors. People generally do not reproduce as well in unsafe environments as they do in safe environments (I'm a baby boomer). Thus, men especially need to be mindful that social withdrawal, which is part of their condition and their lowered libido, which may be part of their depression often accompanies PTSD, and both impact on any relationship.
Partners on the other hand should not take this withdrawal to mean firstly that they are not still beautiful, or secondly, that they are not well thought of. Finally, such withdrawal is not an indication that there is another woman. This is something that you both need to thoroughly discuss and address together. You need to make time to have periods of intimacy that does not, as is sometimes misunderstood by men, just involve sex. Both partners need to develop a comprehensive understanding of PTSD, the manifestations, and address them as a couple.

The fourth part of the schemata; includes sound health principles and is critical to people who have PTSD. It has been indicated recently that exercise alone may account for half the variance in any recovery from depression.[11] We know that you can't be stressed and relaxed at the same time, so relaxation also becomes important. We certainly know that alcohol will nullify the positive effects of medication. Alcohol will also exacerbate depression as it is a depressant. Thus, it is important that together you create the opportunity to get the best

[10] Jeff Corbett writes a daily comment in the Newcastle Morning Herald, this comment in particular was in March this year
[11] Trividi, M. (2004) Exercise helps reduce symptoms of depression, American Jnl of Preventive Med.

results from these founding principals of health, including sound diet and good sleep hygiene. These could create a brochure alone, but your role as I see it, is as my "co-therapist", is to make sure that these basics of health and fitness are adhered to, as well as the three other foundation building blocks of what I have called my pre-schemata to therapy.

Again, those four points in summary are: a) to seek an exit from the NSW Police; b) to build a new community of reference; c) to take medication in a responsible and compliant manner; and finally, d) become obsessive about health and fitness.

Conclusion

When you were married you undoubtedly said "for better or for worse, for richer and in poorer, in sickness and in health". Mental health should not be separated from physical health. PTSD is a health issue because it impacts on every aspect of a person's functioning. It can change a person from being a gregarious, outgoing and a very much in control person, to someone who instead seems argumentative, difficult to live with, depressed and "not the man I married". The process of psychotherapy is not to return that man back to you, but to return someone who has learnt from their experience and grown, but also a person who has transformed their life as a result of their suffering.

One final issue that needs to be quite clearly identified is a variable in all of this which is beyond me, you and your partner's control. This is the speed with which the NSW Police will act. I indicated earlier that in a supportive organisation the rates of PTSD are lower[12]. Perhaps the lack of support in the Police is no better emphasised than in the time it takes for any kind of process of any type of claim in relation to HOD to be processed, which may take twelve months. Likewise any exit, even after an application for medical discharge is submitted, is estimated to take between eight and twelve months. This means that therapy cannot always have the continuity that both the client and I would wish for. Thus it may seem that for a good deal of time we tend to tread water. This is why it is important that you reinforce your partner's commitment to maintain those important core issues outlined in the pre-therapy schemata indicated above. Without keeping fit, keeping positive and developing new challenges during this period while waiting an exit from the NSW Police, the risk of relapse is high and the symptoms of PTSD can be aggravated rather than remitted.

I can assure you as you read this brief pamphlet your partner will recover and go on to lead a healthy and useful life. That is statistically the case, the evidence is overwhelming. In other words, we too often worry about something that this is unlikely to happen, a case if you like of faulty thinking. It is both sensible and reasonable to expect your partner will eventually recover. I extend to you an offer, that should you require any assistance or would like to talk to me at any time please do not hesitate to do so.

Newcastle 2006

Some additional information on traumatic or critical incidents
Critical incidents may produce a wide range of stress symptoms which can appear immediately at the scene, a few hours later or within a few days of the event. Stress symptoms can usually be classified into the following four categories:
PHYSICAL
Fatigue, nausea, muscle tremors, chest pain*, difficulty breathing*, elevated BP, rapid heart rate, thirst, headaches, vomiting, grinding teeth, weakness, dizziness, profuse sweating, chills, shock symptoms, fainting, etc.
COGNITIVE
Blaming someone, confusion, poor attention, poor decisions, heightened or lowered alertness, poor concentration, memory problems, hypervigilance, increased or decreased awareness of surroundings, poor problem solving and abstract thinking, loss of time/place/person orientation, disturbed thinking, nightmares, intrusive images, etc.
EMOTIONAL

[12] Peter Cotton – PPL Trauma Conference Melbourne March 2005

Anxiety, guilt, denial, severe panic (rare), emotional shock, fear, uncertainty, loss of control, depression, inappropriate responses, apprehension, feeling overwhelmed, intense anger, irritability, agitation, etc.

BEHAVIOURAL

Change in activity, change in speech patterns, withdrawal, emotional outbursts, change in communication style, suspiciousness, loss or increase in appetite, alcohol consumption, inability to rest, antisocial acts, non-specific bodily complaints, startle reflex intensified, pacing, erratic movements, change in sexual function.

Importantly these symptoms remit over time; they are a normal response to abnormal circumstances. If they do not ameliorate over time you should seek assistance.[13]

FOR FURTHER INFORMATION CONTACT

(02) 4925 3333

www.heas.com.au

[13] Managing the Impact of Trauma Peters,R., (1999)

Appendix II

A Question of RESILIENCE

	Almost never	Rarely	Sometimes	Quite often	Most of the time
1. I am very resilient, adapt quickly and good at bouncing back from difficulties	①	②	③	④	⑤
2. I am optimistic, I see difficulties as temporary. I expect to overcome them and have things turn out well.	①	②	③	④	⑤
3. In a crisis, I calm myself and focus on taking useful actions.	①	②	③	④	⑤
4. I am good at solving problems logically.	①	②	③	④	⑤
5. I can think up creative solutions to challenge and trust my intuition.	①	②	③	④	⑤
6. I am playful, find the humour and can laugh at my self.	①	②	③	④	⑤
7. I am curious, I ask questions, I want to know how things work, and I am prepared to experiment.	①	②	③	④	⑤
8. I constantly learn from experience and from the experiences of others.	①	②	③	④	⑤
9. I am very flexible and feel comfortable with complexity in my inner life, including contradictions, i.e. trusting and cautious, unselfish and selfish, etc	①	②	③	④	⑤
10. I Anticipate problems and I expect the unexpected.	①	②	③	④	⑤
11. I am able to tolerate ambiguity and uncertainty about situations.	①	②	③	④	⑤
12. I feel self-confident, enjoy healthy self-esteem, and have an attitude of professionalism about work.	①	②	③	④	⑤
13. I am a good listener. I show empathy, including the ability to “read” people well.	①	②	③	④	⑤
14. I can recover emotionally from losses and setbacks. I can express my feelings, let go of anger and ask for help.	①	②	③	④	⑤
15. I am a durable person and will keep on going during tough times.	①	②	③	④	⑤
16. I have been made stronger and a better person by difficult experiences.	①	②	③	④	⑤
17. I convert misfortune into good fortune and discover the unexpected benefit.	①	②	③	④	⑤

Now add up your score.
15-39 points: Talk to someone **40-49 points:** You’re struggling
50-59 points: Just adequate **60-69 points:** Better than most **70-85 points:** Very resilient!

THE BURNOUT SCALE

Review all of the parts of your life: work, social and family. How have they changed over the last six to twelve months? Give yourself 0-5 points on each item. On items where things have remained as good as ever or even improved, give yourself 0 points. On items where things have deteriorated badly, take 5 points. In between would be 1-4 points.

1. Do you tire more easily? Feel fatigued rather than energetic? ☐
2. Are people annoying you by telling you "You don't look so good lately"? ☐
3. Are you working harder and harder and accomplishing less and less? ☐
4. Are you increasingly cynical and disenchanted? ☐
5. Are you often invaded by a sadness you can't explain? ☐
6. Are you forgetting (appointments, deadlines, personal possessions)? ☐
7. Are you increasingly irritable? More short tempered? More disappointed in the people around you? ☐
8. Are you seeing close friends and family members less frequently? ☐
9. Are you too busy to do even routine things like make phone calls or read reports or send out your Christmas cards? ☐
10. Are you suffering from physical complains (aches, pains, headaches, a lingering cold)? ☐
11. Do you feel disoriented when the activity of the day comes to a halt? ☐
12. Is joy elusive? ☐
13. Are you unable to laugh at a joke about yourself? ☐
14. Does sex seem like more trouble than it's worth? ☐
15. Do you have very little to say to people? ☐

0-25 You're doing fine
26-35 There are things you should be watching
36-50 You're a candidate
51-65 You're burning out
65+ Take special note, distinct threats to your health and well-being

The Burnout Cycle

Burnout syndrome does not strike overnight; it develops gradually over time. Psychologist Herbert Freudenberger and his colleague Gail North have divided the process into 12 phases. The steps do not necessarily follow one another in order. Many victims skip certain stages; others find themselves in several at the same time. And the length of each phase varies from patient to patient.

1. A compulsion to prove oneself

The beginning is often excessive ambition: their desire to prove themselves at work turns into grim determination and compulsion. They must show their colleagues - and above all themselves - that they are doing an excellent job in every way.

2. Working harder

To meet their high personal expectations, they take on more work and buckle down. They become obsessed with handling everything themselves, which in turn demonstrates their notions of “indispensability”.

3. Neglecting their needs

Their schedules leave no time except for work, and they dismiss as unimportant other necessities such as sleeping, eating and seeing friends and family. They tell themselves that these sacrifices are proof of heroic performance.

4. Displacement of conflicts

They are aware that something is not right but cannot see the sources of their problems. To deal with the root cause of their distress might set off a crisis and is thus seen as threatening. Often the first physical symptoms emerge at this stage.

5. Revision of values

Their Isolation, conflict, avoidance and denial of basic physical needs change their perceptions. They revise their value systems, and once important things such as friends or hobbies are completely dismissed. Their only standard for evaluation of their self-worth is their jobs. They become increasingly emotionally blunted.

6. Denial of emerging problems

They develop intolerance, perceiving colleagues as stupid, lazy, demanding or undisciplined. Social contacts feel almost unbearable. Cynicism and aggression become more apparent. They view their increasing problems as caused by time pressure and the amount of work they have – not by the way they have changed.

7. Withdrawal

They reduce social contact to a minimum, become isolated and walled off. They feel increasingly that they are without hope or direction. They work obsessively "by the book" on the job. Many seek release through alcohol or drugs.

8. Obvious behavioural changes

Others in their immediate social circles can no longer overlook their behavioural changes. The once lively and engaged victims of overwork have become fearful, shy and apathetic. Inwardly, they feel increasingly worthless.

9. Depersonalization

They lose contact with themselves. They see neither themselves nor others as valuable and no longer perceive their own needs. Their perspective of time narrows to the present. Life becomes a series of mechanical functions.

10. Inner emptiness

Their inner emptiness expands relentlessly. To overcome this feeling, they desperately seek activity. Overreactions such as exaggerated sexuality, overeating, and drug or alcohol use emerge. Leisure time is dead time.

11. Depression

In this phase, burnout syndrome corresponds to depression. The overwhelmed people become indifferent, hopeless, exhausted and believe the future holds nothing for them. Any of the symptoms of depression may be manifest, from agitation to apathy. Life loses meaning.

12. Burnout syndrome

Almost all burnout victims now have suicidal thoughts to escape their situation. A few actually carry them out. Ultimately, they suffer total mental and physical collapse. Patients in this phase need immediate medical attention.

Source: Scientific American (Mind) Vol 17 No 3 2006