Resilience and vulnerability to cumulative stress in police: the influence of coping mechanisms and self-concept

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Glossary and Abbreviations

American Psychiatric Association (APA): The main professional organization of psychiatrists in the US. It is the publisher of the Diagnostic and Statistical Manuals of Mental Disorders.

Borderline Personality Disorder (BPD): A psychiatric diagnosis marked by "*frantic efforts to avoid abandonment, unstable sense of self, unstable and intense interpersonal relationships, and impulsiveness"* (Cloitre et al., 2014). Generally thought to be associated with childhood sexual abuse.

The Clinician Administered PTSD Scale for DSM-5 (CAPS-5): Considered to be the most comprehensive measure for the identification of posttraumatic stress disorder (PTSD).

Central executive network (CEN): A large-scale brain structure associated with higher cognitive functioning.

Cognitive function: That part of functioning that involves conscious mental activities such as thinking, understanding, learning, and remembering.

Cognitive Behavioural Therapy (CBT): A therapy method based on improving mental health and developing adaptive coping strategies by challenging and changing cognitive distortions contained in thoughts, beliefs and attitudes.

Cognitive Processing Therapy (CPT): A manualized therapy used to treat individuals who have been affected by exposure to a traumatic incident. It is based on cognitive therapy that enables more beneficial appraisal of memories of the incident and counteracts avoidance of traumatic triggers that can block adaptive processing.

Crisis Assessment Teams (CAT) (also Crisis Assessment and Treatment Teams, CATT). Mental health professionals including psychiatric nurses, social workers, and psychologists who work together as a mobile team to provide crisis care in the community.

Critical incident: Any event that is overwhelming, unanticipated, and threatening, and may lead to a psychological injury.

Critical Incident Stress Debriefing (CISD): A debriefing procedure that used to be performed in a group context with those who had been involved in an event that was potentially a source of distress: in a more comprehensive later version referred to as Critical Incident Stress Management (CISM) (Mitchell, 1983, Mitchell & Everly, 1993). It is largely now discontinued since its potential benefits have been found to be unsupported by research.

Compass of Shame Avoidance (COSA): A model developed with the purpose of depicting diagrammatically an individual's shame avoidant styles in terms of their deviance around a central point of shame (Webb, 2003. 2010 adapted from Nathanson, 1992).

Complex Posttraumatic Stress Disorder (CPTSD): A diagnosis incorporated for the first time in ICD-11 to describe psychological injuries from a traumatic event that include those of PTSD, and in addition requiring evidence of *"disturbances in affect regulation, negative self-concept and difficulties in relationships"* (Brewin et al., 2020).

Department of Veterans Affairs (DVA): The department in the Government of Australia which provides income support, compensation and health programs for veterans and members of the Defence Force.

Disorders of Extreme Stress Not Otherwise Specified (DESNOS): A diagnosis included in the appendix of DSM-IV but removed from DSM-5. It was used to refer to a psychological injury, generally occurring in early life, that manifest as disproportionate emotional reactions. self-destructive behaviour, dissociative tendencies and disturbances in relationship.

Default Mode Network (DMN): A large-scale brain network that engages during resting wakefulness.

Diagnostic and Statistical Manual of the American Psychiatric Association (DSM). One of two diagnostic systems used world-wide. The diagnostic system of DSM-I was first published in 1952, DSM-II in 1968, DSM-III in 1980, DSM-IV in 1994, DSM-IV-R in 2000, and DSM-5 in 2013. In Australia DSM is used for the diagnosis of psychiatric disorders associated with research. The alternative diagnostic system, the ICD, is primarily used in epidemiology and health management. (O'Donnell et al., 2015).

Eye Movement Desensitization and Reprocessing (EMDR): A process whereby a reduction in the emotional content of trauma memories is stimulated non-verbally through bilateral stimulation, typically achieved through horizontal saccadic eye movements.

Functional Magnetic Resonance Imaging (fMRI): An imaging process that detects changes in blood flow and oxygenation that occur as a function of neural activity, enabling identification of the specific parts of the brain that are involved at the time.

Hermeneutics: The theory and methodology of interpretation. It was initially to in the interpretation of the Bible but has now been extended to include a more general field of application including written, verbal and non-verbal communications.

Hypothalamic-Pituitary-Adrenal axis (HPA axis): The central stress response system that acts as a complete set of influences and feedback reactions. It connects the hypothalamus, the pituitary gland and the adrenal glands.

Idiographic (also ideographic): An approach to knowledge that focuses on the study of the individual.

International Classification of Disease (ICD): The International Classification of Diseases, Classification of Mental and Behavioural Disorders, published by the World Health Organisation. ICD is the more commonly used diagnostic system by psychiatrists and psychologists worldwide to diagnose mental and behavioural disorders (Reed et al., 2011).

Interpretative Phenomenological Analysis (IPA): An approach to qualitative research based on phenomenology and hermeneutics that examines the meaning-making of the individual. It may be extended to groups who manifest common features.

Moral injury (MI): A psychological injury described as resulting from *"A betrayal of what's right, by someone who holds legitimate authority in a high stakes situation"* (Shay, 1994, 2014) and from *"The perpetration, failure to prevent or witnessing of events that transgress deeply held moral beliefs and expectations"* (Litz et al., 2009).

National Institute of Mental Health (NIMH): The lead federal agency in the US for research on mental disorders.

Phenomenology: The study of consciousness as it is experienced from the perspective of the individual.

Operational debrief: A structured procedure performed after an event that reviews the actions taken and focuses on and evaluates the processes used with the purpose of optimizing their future effectiveness.

PTSD Checklist for DSM-5 (PCL-5 with Life Events and Criterion A): The most detailed of the three versions of PCL-5, the diagnostic instruments linked to DSM-5 (American Psychiatric Association, 2013). It provides an entire life checklist of traumatic life events and asks the participant to identify their worst event and give some information about it. It also provides a checklist of trauma-related symptoms and asks how much the participant has "been bothered" by these symptoms in the last month.

Prolonged Exposure (PE): A form of therapy with both cognitive and behavioural aspects that is used to treat PTSD. It repeatedly uses either imaginal or in-vivo exposure to reminders of the trauma with the purpose of unpairing them from feelings of anxiety and stress.

Positron Emission Tomography (PET): A functional imaging technique that uses radioactive substances to measure physiological changes by attaching a radioisotope to a substance that is injected into the body and then identified in a scan.

Potentially Traumatic Event (PTE): The witnessing or experiencing of an event that involves actual or threatened death, serious injury or sexual violence. It may result significant distress and can lead to mental health issues such as PTSD, depression, anxiety or substance disorders in some people.

Posttraumatic stress disorder (PTSD): A set of reactions that develops in some people after exposure to a traumatic event that threatened their life or safety. It has the core symptoms of nightmares or flashbacks, avoidance of any reminders of the event and ongoing heightened arousal. It is also commonly associated with persistent negative thoughts and mood.

Royal Australian and New Zealand College of Psychiatrists (RANZCP): The principal organisation representing psychiatry in Australia and New Zealand. The college has responsibility for training, examining, and awarding of the qualification of Fellowship of the College to medical practitioners.

Randomized Control (or Controlled) Trial (RCT): A research design that randomly allocates participants to two or more groups, subjects the groups to different conditions and compares their responses. To be a properly controlled trial, it needs to include a control group that has no intervention. It has the purpose of reducing sources of bias.

Research Domain Criteria (RDoC): A research framework developed by the National Institute of Mental Health (NIMH) in the US for the investigation and integration of many sources of information. It uses a biological, rather than a symptom-based, approach to diagnosis.

Retired Peer Support Officer program: A program developed by the Retired Police Association in Victoria to offer support to retired police officers by other retired police officers. It focuses on, but is not confined to, mental health issues.

Situationally Accessible Memory (SAM): Memories that have been obtained from more extensive, lower level processing of an event of a traumatic nature and are triggered involuntarily by situational reminders of the event (Brewin, 2016a; Brewin et al., 1996, 2000). Triggers may include sounds and smells as well as visual reminders of the traumatic event, manifest as intrusions or flashbacks, and may contain distressing emotions associated with the event such as anger, fear, and shame (Friedman et al., 2011). Because they are involuntary, SAM memories are thought to be fragmented, out of sequence and disorganized and therefore resistant to modification by subsequent information.

Salience network (SN): A large-scale brain network that identifies the most relevant or salient internal or external stimuli and guides the individual response to the input.

Single-Photon Emission Computed Tomography (SPECT): Similar to a PET scan but slower to administer and has poorer image quality.

Test of Self-Conscious Affect (TOSCA): An instrument used to identify shame which uses scenario-based questions to assess trait or dispositional shame (Tangney et al., 1989). Its validity has come into question in recent times.

Trauma-related psychological injury; A generic term for any significant psychological reaction to an event experienced as traumatic. It may include PTSD, moral injury, depression, and anxiety,

United Nations (UN): The largest, most powerful intergovernmental organization in the world, which has the mission of maintaining international peace and security, developing friendly relations among nations, and working to achieve international cooperation.

Veterans' Administration (VA): The department in the US government responsible for integrating life-long health services to military veterans at VA medical clinics and outpatient clinics throughout the country.

Verbally Accessible Memory (VAM): The form of memory which is integrated with autobiographical memory, can be deliberately retrieved when required, and may acquire associations generated by subsequent cognitive appraisal (Brewin, 2016a; Brewin et al., 1996, 2000). Contrast with SAM memory.

Vietnam Veterans' Counselling Services (VVCS): A nation-wide counselling service that provided support for war and service related mental health conditions to Vietnam veterans and their families. Initially formed in the early 1980's as an initiative of the Vietnam Veterans' Association of Australia (VVAA) it initially declared itself independent from the Department of Veterans' Affairs (DVA). It was later renamed the Veterans and Veterans Families Counselling Service, then became Open Arms, which is administered by the DVA.

World Health Organisation (WHO): An agency of the United Nations which is responsible for international public health. Founded in 1948 and based in Geneva, Switzerland.

Abstract

Police are known to be vulnerable to PTSD and other trauma-related psychological injuries from cumulative exposure to occupationally related critical incidents and stressors. There is little known, however, about the specific nature and influence of these stressors and their potential interaction, or any protective coping mechanisms that might be associated with resilience to their effects.

The aim of this qualitative research study was to examine both vulnerability and resilience to cumulative occupational stress in a group of long-serving retired police officers, recruited on the basis that they believed they had *"experienced events during their policing career that had been life-changing".* It demonstrated how a broader trans-disciplinary concept of shame enabled better identification of the important role shame and shame avoidant mechanisms might play in the development, maintenance, and exacerbation of symptoms associated with Posttraumatic Stress Disorder (PTSD), and in the psychological distress that is the outcome of moral injury (MI), defined as a betrayal of the self or others. It also suggested that deliberate emotional detachment employed as a coping mechanism might be associated with resilience to potentially traumatic events.

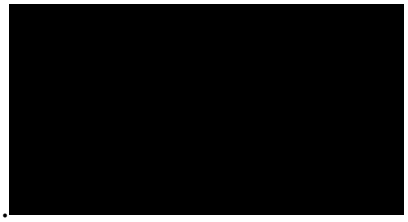
The research used Interpretative Phenomenological Analysis and largely unstructured narrative interviews, enabling identification of the sequential effects of events and their impacts. The fourteen participants fell into three distinct groups: five participants described coping with potentially traumatic events using deliberate emotional detachment and experiencing no symptoms of trauma-related psychological injury. These participants expressed no regrets, self-doubts or shame associated with their careers in policing and considered themselves to have been confident and competent police officers. Four further participants described experiencing trauma-related symptoms but said they had managed to achieve an active and satisfactory life in retirement without feeling self-stigma or shame

associated with their symptoms, regrets associated with their past actions, or any loss of self-esteem at having sustained a psychological injury. The remaining five participants described a negative self-concept, a progressive deterioration in their mental state and ongoing severe trauma-related symptoms. They attributed these changes in themselves to events during their policing career that had led to them feeling disrespected, unvalued, or rejected by others. Most acknowledged regrets at having used either anger and violence or alcohol overuse as shame avoidant mechanisms, and described experiencing depression, anxiety, multiple restrictions to their lifestyle and a poor quality of life in retirement.

The study indicates that experiences of shame from multiple sources may contribute to a progressive deterioration in mental state following trauma-related injury, leading to the development of co-morbidities and increased suicide risk. Conversely, absence of self-stigma and self-recrimination in the presence of trauma-related symptoms may assist in maintaining a more stable mental state. The findings indicate further that a coping mechanism based on deliberate emotional detachment may be associated with resilience. If substantiated by further larger scale empirical research, these findings have implications for preventative psychological support and education for police, and for changes in diagnostic, treatment, and compensation processes for those with trauma-related psychological injuries.

I declare that:

This thesis presents work carried out by myself and does not incorporate without acknowledgement any material previously submitted for a degree or diploma in any university: to the best of my knowledge, it does not contain any materials previously published or written by another person except where due reference is made in the test, and all substantive contributions by others to the work presented, including jointly authored publications, is clearly acknowledged.



Tess Faye Taylor

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Chapter 1: Introduction

Compared to other occupational groups, policing is recognized worldwide as presenting a high risk of psychological injury (Wagner et al., 2020). Throughout their careers police are exposed to a wide range of occupational stressors, but despite comprehensive evidence for their risk of occupational psychological injury, there is little research into the processes whereby their exposure might lead to injury (Varker et al., 2018). There is also considered to be a major gap in our knowledge of protective factors which might be associated with resilience to traumatic injury in police (Janssens et al., 2021).

The aim of this research was to address these gaps in our knowledge. It examined, at the level of the individual, how long-serving police might have perceived and responded to their exposure to potentially stressful events. These potentially stressful events are known to include operational critical incidents that might involve actual or threatened death or serious injury to themselves or others, or emotionally taxing situations such as delivering death messages or attending incidents involving the deaths of children (Weiss et al., 2010). Police are also routinely exposed to a range of operational and organizational stressors that might include shift work, administrative demands, workplace conflicts and lack of organizational support (Dollard et al., 2019).

All emergency responders work in high stress environments, but in some ways police are unique. In most incidents that might involve threat to life or property, transport accidents, rescue, and management of explosive devices, Victorian police are mandated to be the control agency (see *Emergency Management Manual Victoria*, 2013). Similar requirements for police exist in other Australian jurisdictions. The safety of all those present at incidents is the responsibility of attending police. They are also required to put the care of others before their own safety. Although other emergency response personnel may also face high stress and threat to personal safety, this is not their remit.

Policing in Australia has been reported to have become even more stressful and dangerous because of an increase in violent behaviour associated with illicit drug use (*Office of Police Integrity* report, 2012). A survey of 3,500 police officers (Iddles, 2015, p. 8) reported that officers described having had to "*shift their thinking from considering the risk of being assaulted as something that might happen on a bad day",* to "*something that is likely to happen any day unless prevented"* as a result of what was described as an *"ice epidemic".*

The difficulties experienced by people with mental illness in the community has placed a further workload on police (Gooding, 2017). Since the de-institutionalization of psychiatric hospitals that occurred in Australia late last century, management of people with severe mental illness has fallen increasingly on police (Clifford, 2013; Gooding, 2016). In a survey of the non-fatal use of force by Australian police (Kesic et al., 2013) people who had both a history of mental disorder and a criminal justice history were significantly over-represented. The problems involving police and the mentally ill exist worldwide and some attempts have been made to ameliorate them with policy changes, additional training and more effective liaising with health services (Morgan, 2021; Morgan & Paterson, 2017).

At the time of writing, police are facing further stress as frontline workers in the COVID-19 pandemic. They have been required to manage defiance to restrictions on the part of many members of the public, with the risk of infection added to that of other injury (McCarthy et al., 2021; Stogner et al., 2020).

Current State of Knowledge

A review of recent research into the mental health and well-being of Australian emergency responders (Varker et al., 2018) found significant gaps in current mental health research regarding both the prevalence of psychological injury in Australian emergency service workers, and the cumulative effects and potential interaction of operational exposures and other work-related stressful events to which they are routinely exposed. Emergency

workers were also found to frequently experience reactions to these events that were different from those of the general population. Anger and guilt were found to be often reported, rather than fear or horror, which had earlier been considered typical reactions to events experienced as traumatic (Friedman et al., 2011). The review concluded that further research is needed to guide organisations' policies and procedures, particularly in the areas of stigma, suicide/self-harm and alcohol and substance use disorders (Varker et al., 2018).

A similar lack of evidence for the prevalence of posttraumatic stress disorder (PTSD), co-morbid diagnoses, and risk factors for first responders worldwide was reported by Klimley et al. (2018). In a review of the literature, these authors reported that psychological injury is more likely to develop in emergency responders following the cumulative effect of repeated exposures to potentially traumatic incidents, rather than to a single event. Cumulative stress leading to PTSD was also found to occur significantly more frequently in emergency workers and members of the military than in the general public and most often as an exacerbation of sub-threshold PTSD symptoms (Utzon-Frank et al., 2014). In a study of police officers, the sources of cumulative stress were thought to be ill-defined but were found to be potentially influenced by coping strategies (Violanti, et al., 2018).

In an Australia-wide survey of emergency service workers, police were found to have the highest rate of mental health conditions amongst emergency workers, and 11% to have symptoms consistent with a diagnosis of PTSD, which increased sharply related to length of service (Kyron et al., 2019). The survey reported that the stigma associated with showing emotion that is part of police culture was found to be an issue and respondents described frequently reporting feeling shame that they were unable to "pull themselves together" and embarrassed about seeing a professional. Many with high levels of psychological distress who did not access services were found to either be unaware that they needed professional help or said that seeking support would make them seem weak, or negatively affect their

career prospects. Compensation processes were described as having a further negative impact on recovery (Kyron et al., 2019).

A comprehensive review commissioned by Victoria Police into the mental health of police in that state spoke directly to those affected (Cotton et al., 2016). The review found that serving and retired police officers had complex needs that they believed were poorly addressed by management. The review reported that depression, anxiety disorders and substance abuse were as frequent, if not more frequent, than PTSD (Cotton et al., 2016), and that police veterans who had left Victoria Police ten or more years earlier were still dealing with mental health issues relating to their police service. These issues included depression, substance abuse, conflict with family and relationships and social isolation. The review found lack of clarity around suicide risk in both serving and retired police and recommended a prevalence study. It reported that there is no official record of suicide in discharged police; partly a function of the way in which suicides are recorded by the State Coroner, partly because there is no police follow-up of discharged members (Cotton et al., 2016).

An Australian Parliamentary Senate review (Senate Review, 2019) into psychological injury and suicide in emergency workers also found a lack of data collection and absence of clarity. This review identified compensation processes to be a source of further trauma and dysfunction (*Education and Employment References Committee*, 2019).

Research studies focusing on Australian police found organizational issues adversely affected mental state (Hall et al., 2010; Tuckey et al., 2012) and cardiovascular health (Tuckey et al., 2010) but did not examine the specific effects of potentially stressful operational issues. A qualitative study of 19 Australian former police with a diagnosis of PTSD found the effects of exposures to stressors to be most often cumulative in nature and occur both from lack of organizational support and from exposure to operational traumatic events (Tuckey et al., 2012).

While police are known to be at risk of psychological injury from the effects of cumulative occupational exposure, there is little known about the individual risk factors that might contribute to this injury, either in Australian police (Varker et al., 2018), or in police worldwide (Wagner et al., 2020). As noted earlier, there is also little known about protective factors which might enable their resilience to injury (Janssens et al., 2021; van der Muelen et al., 2018). While it is reasonable to assume that all long-serving police are exposed over the time of their service to similar risk events, the individual consequences are markedly diverse. Individual risk factors that might lead to psychological injury and, conversely, its prevention or mitigation arguably represent a gap in knowledge that is significant for best practice in the management, treatment, and prevention of traumatic injury in police.

These individual reactions are examined in this research study, which explored how long-serving police perceived and responded to their cumulative exposure to potentially stressful events, using the qualitative approach of Interpretative Phenomenological Analysis (Smith et al., 2009). The study identified the subjective experiences, reactions and effects of cumulative exposure to occupational stressors in a participant group of fourteen retired long-serving male police officers from the states of Victoria and South Australia. The study also examined coping methods these officers might have used to deal with these stressors, their emotional responses to them and any subsequent changes in their mental state. If changes in mental state were reported, the narrative approach that was employed enabled sequential investigation, as described later in this chapter, of the ways in which each individual appraised and coped with these changes and their sequelae, and whether this might have contributed further to the psychological injury they had sustained.

The recruitment process invited participation from former police officers, male or female, who believed they had changed as a result of their police service. Not all the participants described themselves as experiencing post-trauma symptoms, despite all having

had similar multiple exposures to potentially traumatic events. The study specifically sought to examine both any vulnerabilities that might be associated with the development of psychological injury, any protective factors associated with resilience, and any coping mechanisms that were employed and their effects.

Background of Researcher

As a clinician and therapist, I worked with people with post-trauma psychological injuries from soon after the time PTSD was first described in DSM-III, the third edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* (American Psychiatric Association, 1980). Through my work in this field, I formed the view that our knowledge is limited about the enormously complex ways in which individuals respond to events they experience as traumatic, and that what we do know is often circumscribed by our area of expertise. For this reason, I undertook in this thesis a thorough review of relevant information across the key disciplines involved in research in the fields of trauma and emotion. These included theoretical and empirical academic literature from the disciplines of clinical and social psychology, psychiatry, psychoanalysis, sociology, neurobiology, philosophy, and ethology. This material is researched in detail in Chapter 2, which examines the conflicts that currently divide the field, and their historical origins.

My experience in working with people affected by exposure to traumatic events included two years at the Vietnam Veterans' Counselling Service in Melbourne, in crisis assessment teams on the road in rural NSW and Victoria, and in private practice as a counsellor/therapist. Over time, I have witnessed changes in the ways in which PTSD can manifest – from the florid flashbacks of Vietnam veterans – one veteran once called me, greatly disturbed, to say he had *"shot up the fridge"* - to the mental torment of what will be explored in this thesis as the various forms of moral injury.

I chose to investigate trauma in police based on the high level of risk of psychological injury they are known to face. I also had a pre-existing familiarity with policing. A close member of my family is a long-serving police officer. In addition to this, in a professional role as a crisis assessment clinician, I had close contact with police through the experience of working alongside police officers for some years at many incidents including suicides, sieges, attempted self-harm with a weapon, or jumping from a high structure – in one instance both, when a highly distressed man climbed outside the safety fence on a tower and repeatedly slashed himself with a knife.

As a clinician, I used a non-directive approach to trauma therapy based on identifying the processes whereby psychological injuries occur and are perpetuated. The way in which I conducted interviews with participants in the present research study was based on similar principles. They employed a minimal structure to allow the individual participants to freely tell their story; how they believed their exposure to cumulative potentially traumatic events had affected them.

Shame and Trauma

My interest in the potential role shame might play in trauma-related disorders began, some years ago now, with a conversation I had with a friend who had just completed a transdisciplinary PhD thesis on the nature and influences of shame (see Webb, 2003). My friend spoke of how shame avoidant mechanisms or schemas might manifest as aggression, depression, isolation and addiction. I was immediately struck with the resemblance between these *"shame avoidant"* mechanisms and the major symptoms and co-morbidities of PTSD. While I had worked as a clinician and therapist with people with this disorder for many years, I felt as if there was still much that I did not know about it. At that point I made the decision that I would like to find out more about this potential connection. The results of that decision have culminated in this thesis, which includes the examination of the potential role of shame

in post-trauma psychological injuries, and how it might be associated with defence mechanisms or coping mechanisms that might be utilized to avoid or manage its effects. Defence mechanisms are defined as largely unconscious (Lansky, 1994), whereas coping mechanisms, defined as changing behavioural and cognitive efforts to manage internal and external subjective stressors (Lazarus & Folkman, 1984) are thought to be conscious and purposeful. and may be either adaptive or maladaptive (Nathanson, 1987, 1992), In this thesis I have used the term *"shame avoidant mechanisms"* to refer to both unconscious and conscious forms that are maladaptive.

In an earlier theoretical publication, I proposed that shame and shame avoidant mechanisms bore a strong resemblance to the symptoms and comorbidities of PTSD (Taylor, 2015). I questioned whether shame and shame avoidant mechanisms might therefore constitute a previously unrecognized element in the exacerbation of the symptoms of post-trauma psychological injury and in the development of comorbidities. Whether this might be the case arguably presents a significant gap in the literature which is explored in this research study. For the purposes of this research, I define shame as it is broadly conceptualized in the transdisciplinary literature. This conceptualization is briefly described below, and Chapter 2 expands on this definition.

Shame: A Transdisciplinary Perspective

Because shame and guilt may often be fused and labelled as "guilt", shame has been described as the *"sleeper*" in psychopathology by Lewis (1987), since it can so often be unrecognized, disguised, or obscured. It has been defined variously as an emotional response that requires evaluation at a cortical level (Tangney & Fischer, 1995), as a basic affect associated with visceral and defence responses (Tomkins, 1962, 1963), and as an evolved basic affect incorporating elements of both (Corrigan & Elkin-Cleary, 2018; Gilbert, 2004). Shame has been described as an internal response to a perceived lapse from the ego-ideal by

Lewis (1976), as originating in threats to the social bond by Scheff (2000) and as constituting a family of emotions which includes, embarrassment, humiliation guilt, shyness and mortification (Elison, 2005; Izard, 1971, 1977; Nathanson, 1992; Scheff, 1988; Tomkins, 1963). Shame is proposed to result in insecurity; it attacks self-esteem, but it is thought to be often barely visible in everyday life, because to reveal shame in Western societies is often considered to be shaming in itself (Kaufman, 1989; Neckel, 2020; Scheff, 2004). Shame experienced as a threat to the social self has been found to be associated with immunological changes, expressed as increases in proinflammatory cytokines and cortisol (Dickerson, 2012; Dickerson et al., 2004; Dodson & Beck, 2017), and it has long been associated with social exclusion and stigma (Goffman, 1959; Neckel, 1996, 2020).

Recent research associated with the construct of moral injury, which at this time has been largely confined to members of the military (Griffin et al., 2019), has added a further dimension to the potential sources of shame. Moral injury occurs as the consequence of a reaction to trauma that does not involve exposure to actual or threatened death or serious injury, but is related to perpetration, or witnessing, trauma to others (Griffin et al., 2019) or to perceived injustice to the self. Available evidence suggests that outcomes associated with exposure to morally injurious events are distinct from those of PTSD and include guilt, shame, anger, social alienation, and increased suicide risk (Bryan et al., 2017).

To date there has been little research that investigates the applicability of the construct of moral injury to police, who arguably experience many similar trauma-related experiences to those of military personnel. These might include both witnessing events involving death or injury to others or perceiving themselves as being unfairly treated by those in authority. This presents a further significant gap in the literature which was addressed in this research.

The Study

All the participants in the study described experiencing a similar police sub-culture, and

all had also been exposed to multiple potentially traumatic events as a result of their length of service; however, they responded to these exposures in very different ways. As outlined earlier, the study investigated these differences by drilling down to *"how"* participants were affected; to the meanings that each former police officer attributed to events they experienced, the coping methods they might have used, and any subsequent effect on their mental state. Interviews took the form of a narrative rather than a question and response structure. Narrative enquiry is described as a way of *"shaping or ordering of experience and connecting and seeing the consequences of actions and events over time – making sense of meaning without necessarily ordering it chronologically"* (Chase, 2018 p. 547). A narrative enquiry enables an understanding of events as they are described and understood by the participant. It is therefore more suitable than a semi-structured interview to examine the dynamics of a process such as the effects of cumulative exposure to potentially traumatic events. The analysis of the individual transcripts used the methods of Interpretative Phenomenological Analysis (Smith et al., 2009). IPA is a phenomenological approach, concerned with exploring experience as it is described, and the meaning that is attributed to it by the participant. Following the initial analysis, individual case studies for each participant were constructed. These case studies are included as Appendix A. Further analyses examined common themes across participants. These analyses form Chapters 4, 5, 6 and 7 of this thesis.

This study investigated the ways in which cumulative occupationally related exposure to potentially traumatic events can impact on long-serving police at the level of the individual. Importantly, the study also had a specific interest in whether shame, recently included for the first time in the diagnostic criteria for posttraumatic stress disorder (PTSD) in DSM-5, *The Diagnostic and Statistical Manual of the American Psychiatric Association. 5th ed.*, (American Psychiaric Association, 2013) might play a role in this process. Current knowledge associated with the development of psychological injury after exposure to potentially traumatic events is

typically quantitative and focused on the effects of exposure. However, this approach fails to capture the dynamic processes involved – the ways in which these factors might interact. This research sought to examine those dynamic processes by using a research approach that gathers information from the perceptions of those who have been affected. In using this approach, I hope it will serve to contribute to praxis associated with how we can best diagnose, treat and mitigate – if not prevent - post-trauma psychological injuries.

The Research Questions

- How do former police officers make meaning of their exposure to potentially traumatic events that occurred during their police service?
- If they developed trauma-related symptoms, how were they impacted by these?
- How were self-concept and interpersonal relationships subsequently affected?
- Is shame associated with the meanings police officers place on their experience?
- What identifiable shame management mechanisms appear to manifest as patterns of behaviour, thinking or feeling?
- Is the presence of shame and shame management mechanisms associated with the severity of symptoms and the development of co-morbidities?

Overview of the Thesis

Chapter 2 provides a comprehensive review of the literature associated with the psychological response to trauma. It begins with an overview of the current ways in which it is understood and diagnosed, then examines the course of how it has been conceptualized since the end of the 19th century and how this has been impacted by social and political influences.This is followed by a critical analysis of the the current diagnostic systems of PTSD, its core symptoms, and the major theories associated with the disorder.These include a discussion of the neurobiology of the cumulative effects of stress, hyperarousal and dissociation, and the place of memory in PTSD. Current treatment methods for PTSD and

their effectiveness are evaluated. Alternative approaches to diagnosis are examined which include a neurobiological focus for diagnosis and a dynamic approach based on the interaction between symptoms.The literature associated with the place of shame in PTSD and suicide is examined and the significance of shame to the construct of moral injury is described. Finally, the transdisciplinary literature associated with shame is reviewed and I suggest that the application of this broader field of theory and knowledge might contribute to our understanding of how shame might play an influential, currently poorly recognized role in post-trauma disorders.

Chapter 3 describes the philosophical perspective and the methodology of the empirical research that informs the phenomenological/realist approach I have taken. The use of a narrative enquiry and the reasons for this are discussed, together with the specific application of the methodology of IPA. The research structure, recruitment procedures, participant criteria for selection, data collection and analysis, ethics requirements, potential researcher bias and research limitations are described. As noted earlier, in the initial stage of data analysis, individual case histories were compiled for each participant as the first phase (see Appendix A). Following this, themes associated with police culture were identified and analysed. Finally, how the themes were associated with the individual coping methods used by the participants was examined, together with their mental state at the time of interview, and these were used as the basis for dividing the fourteen participants into three groups.

Chapter 4 addresses the study findings in relation to police culture as it is described by all the participants. It identifies themes relevant to the police sub-culture (and in some cases also to the wider Australian culture), the participants' accounts of how police culture impacted on them during their service and after their retirement from policing, and the relevant literature associated with these themes.

Chapters 5, 6 and 7 examine, against the background of the prevailing police culture

described in the previous chapter, how the participants described: the cumulative stressful events that impacted on them during their policing career, their subjective responses to these events, how the police culture influenced these responses, and any symptoms they developed in the aftermath. Chapter 5 details the responses of the participants in Group 1, who described themselves as unaffected by their exposure to potentially traumatic events. Chapter 6 discusses the participants in Group 2, who described experiencing ongoing trauma-related symptoms but no subsequent deterioration in their mental state. Chapter 7 discusses the participants in Group 3, who described themselves as having been severely affected by trauma-related symptoms and as experiencing a subsequent progressive deterioration in their mental state.

Chapter 8 discusses the results of the research, their implications, and how they provide new contributions to existing knowledge. It explores how some of the results find support in the extant research and identifies areas where further research is needed. Gaps in the existing knowledge are identified and related to the emergent themes in the data. Concerns associated with suicide and suicide-homicide are discussed.

Chapter 9 looks at *"where to next?":* the areas for potential research that are suggested in the findings from this study and how certain findings point to an urgent need for a review of the current identification, management and prevention or mitigation of trauma in police. The need for recognition of the potential presence of moral injury in police is emphasized, and for a deeper understanding of the potential presence of shame in all post-trauma psychological injury. Finally, the implications of these findings for the diagnosis, treatment, management and prevention or mitigation of trauma-related psychological injury in police are discussed.

Chapter 2: Literature Review

> *The study of psychological trauma has a curious history. The subject provokes such intense controversy that it periodically becomes anathema. An understanding of psychological trauma begins with rediscovering history.*
>
> *Judith Herman, 1992 p. 2.*

Introduction

This review of the literature focuses on psychological injury occurring as a result of an exposure to a traumatic event, or in a cumulative manner from exposure to a series of traumatic events. Posttraumatic Stress Disorder (PTSD) is considered to be the most frequent form of this injury (Bryant, 2019). Since PTSD was first described in DSM-III (American Psychiatric Association, 1980) there has been considerable research into different processes thought to be involved in the disorder, leading to the development of a number of theories as to its psychology, biology and appropriate treatment approaches (Brewin & Holmes, 2003; Armour, Fried, Deserno et al., 2017). These theories include dual representation theory (Brewin et al.,1996), which proposes two types of memory, one accessible at will and integrated into general memory, the other accessible only through environmental cues. This second type of memory is thought to underly the phenomena of flashbacks and fragmented or inconsistent recall. A further theory, the cognitive theory of Ehlers and Clark (2000), proposes that PTSD becomes persistent as a result of individuals processing the trauma in a way that leads to a sense of current and serious threat A third prominent theory, emotional processing theory (Foa & Kozak, 1986; Foa et al., 2019), is based on an extension of the principle of fear conditioning. It conceptualizes trauma-related fear as a conditioned response to a highly significant experience which becomes represented in memory with its surrounding associations, which results in the formation of environmental cues that become in themselves fear-inducing.These may be progressively inactivated by exposure to the fear

memory through imaginal or in-vivo exposure together with competing information which modifies its effects over time. A further, more recent theory, network analysis, focuses on the role played by the interaction of trauma-related symptoms (Armour, Fried, Olff et al., 2017). These and other theories associated with the response to exposure to trauma are more comprehensively addressed through this chapter.

PTSD is considered to be a chronic, debilitating condition manifesting as "*recurrent distressing dreams or flashbacks; internal or external avoidance and hypervigilance or exaggerated startle"* (Walton et al., 2017, p. 254). There is some divergence between the two major classification systems for the disorder: DSM-5, *The Diagnostic and Statistical Manual of the American Psychiatric Association, 5th Edition* (American Psychiatric Association, 2013) and ICD-11, the *International Classification of Diseases, Classification of Mental and Behavioural Disorders, 11th Revision"* published by the World Health Organisation (World Health Organization, 2019). Both list the core symptoms of PTSD, but DSM-5 has added an additional symptom cluster of *"negative alterations to cognitions and mood"* (American Psychiatric Association, 2013, p. 552). Exposure to traumatic events is known to also lead to other psychological disorders including depression, anxiety and substance use, either in the absence of PTSD or as comorbidities, all of which can have a profound effect on well-being and health (Price & van Stolk-Cooke, 2015; Rosellini et al., 2021).

As described in Chapter 1, there has been recent increasing interest in a further type of psychological injury, that of moral injury, occurring as an outcome from either perpetration-based or betrayal-based potentially morally injurious events (PMIE's) (Jordan et al., 2017). The primary emotional states associated with perpetration-based events are described as shame, guilt, spiritual or existential conflict and loss of trust (Griffin et al., 2019; Jinkerson, 2016). Betrayal based events, which occur when personal moral expectations are violated by

trusted others, have been found to be associated primarily with anger (Jordan et al., 2017; Litz et al., 2018).

The precipitants and outcomes seen in moral injury are similar to those in the diagnostic category of Complex Posttraumatic Stress Disorder (CPTSD), described for the first time in ICD-11 (World Health Organization, 2019). The diagnosis of CPTSD in ICD-11, in addition to the core symptoms of PTSD as described above, requires evidence of *"disturbances in affect regulation, negative self-concept and difficulties in relationships"* (Brewin et al., 2020). A recent review of associated research has demonstrated a clear distinction between the ICD-11 symptoms of PTSD and CPTSD and found CPTSD to be related to greater functional impairment (Brewin et al., 2017).

How this wide range of trauma-related psychological injuries might best be conceptualized, managed, and treated is currently a matter of debate (Brewin, 2016; Bryant, 2019). This review of the literature in this chapter begins with an investigation of whether we might better understand this divergence of opinion through re-examining the history of trauma-related psychological injury, as eminent traumatologist Judith Herman (1992a) suggests. In this review of the literature I examine, firstly, how post-trauma psychological injury has been understood since the latter half of the nineteenth century and illustrate how past political and social influences might have contributed to the current lack of consensus around its diagnosis. I then outline what we presently know and identify what we still fail to fully understand about this heterogeneous psychological injury and its potential precipitants. Finally, I review the transdisciplinary literature associated with shame and guilt and conclude with the proposition that shame, as it has been more broadly conceptualized in this literature, might have a previously unrecognized influence on the course of trauma-related psychological injury and serve to provide a conceptual link between its different manifestations.

Trauma-Related Psychological Injury: A History

The ways in which trauma-related psychological injury has been understood and treated in Western civilization in the last 150 or so years have not followed a straight-forward path. This review of the relevant literature will illustrate how new and controversial ideas have at times failed to progress because they have not conformed to the political or cultural *zeitgeist* of the time. Others have failed to be incorporated because of the prevailing hegemony and have continued to languish on the sidelines, or in time, have withered away. Some old beliefs and stereotypes have persisted in the way in which trauma-related psychological injury is often regarded today. Stigma remains, perhaps tacitly still associated with an earlier presumption of underlying weakness or a predisposing disorder. In charting the course of trauma-related psychological injury since the mid-19th century, its turning points, how these came about, and what might have been lost along the way will be examined.

From the latter part of the 19th century to the present time, the symptoms thought to be associated with trauma-related psychological injury have been identified in a variety of different ways. Early descriptions of trauma by doctors treating soldiers in the American Civil War described a group of symptoms that included anxiety, nightmares, difficulty concentrating, guilt, and depressed mood (Dean, 1997). These became known as *"irritable heart"* or *"soldier's heart"* since unexplained heart palpitations were a central symptom. (Jones & Wessely, 2007). After the Franco-Prussian War, the neurologist Charcot (1889) described exhaustion, chest pain, dizziness and fainting, headache and back pain, tremor, disorientation and difficulty sleeping in combatants and noted that these symptoms persisted some years after the end of the war.

Civilian cases tended to occur in the aftermath of a single exposure, for example, quite frequently as a result of an accident in the early days of the railways (DiMauro et al.,

2014). Symptoms of railway accidents were described as including irritability, disturbed sleep and distressing dreams, anxiety, a tendency to be easily alarmed, memory and concentration problems, and a variety of somatic symptoms (Erichsen, 1866; Kinzie & Goetz, 1996). Neurological damage to the spine from the impact was thought to be responsible for these symptoms, and they were initially known as *"railway spine"* (Page, 1891).

Hysterical disorders

In the latter part of the 19th century there was extensive interest in the treatment of "*hysterical disorders*," as they were then known, in women. First investigated by French neurologist Charcot at the Salpêtrière Hospital in Paris, these disorders included anaesthesias, paralyses, blindness, and somnambulism (Charcot, 1889). They were identified as being functional in nature; that is, as having no organic basis, since they could be induced and terminated through hypnosis (Herman, 1992). They were later described by Janet (1907) and Freud (Breuer & Freud, 1893-1895), who both studied under Charcot, as symptoms arising from an altered state of consciousness caused by psychological trauma. Janet called this altered state of consciousness *"dissociation"* and considered it to be the result of a lack of integration between two or more aspects of consciousness, leading to an inability to integrate traumatic experience in memory (van der Hart & Rydberg, 2019). Freud considered hysterical disorders to be a result of exposure to sexual trauma early in life. After a short period, this cause of the disorders was recanted by Freud and replaced with the idea that they were a product of his patients' fantasies, perhaps because the idea that child sexual abuse was endemic among the bourgeoisie in Paris and Vienna was unacceptable at the time (Cuddihy, 1974; Herman, 1992). It was considered by Cuddihy, (1974) to be even more dangerous ground for Freud as a Jew practising in a Gentile society. By the advent of World War I (WWI), the works of Charcot and Janet had lost their novelty, and the scale of violence of all types inflicted on children of both sexes, and their mental health consequences in adulthood,

would fail to receive significant recognition until the latter part of the 20th century (Herman, 1992).

World War I (WWI)

Members of the military in WWI, where high rates of psychiatric casualties occurred, showed symptoms similar to those of hysterical disorders that included tremor, paralysis, and inability to walk or speak (Micale & Lerner, 2001). These were diagnosed as *"shellshock"* and were also initially thought to be neurological in origin and caused by exploding ordnance (Jones & Wessely, 2007; Mott, 1916). Towards the end of WWI, the symptoms experienced by veterans came to be recognized as functional, and some sufferers were treated by physician Arthur Hurst using persuasion, suggestion, re-education, and occupational therapy (Jones, 2012). Until recently these methods had been considered highly controversial; however, a re-evaluation of Hurst's filmed records by these authors has indicated the treatments were largely effective. Short-term outcomes appeared to be generally good but long term outcomes were not known because of lack of evidence (Jones & Stone, 2020).

Once its psychological origins had been recognized, the opposing ideas around the contemporary nature-nurture controversy were reflected in the contested origins of shell-shock (Shephard, 2004). On the one hand, the environmentalists argued that *"The war... has shown that a psychoneurosis can be produced in almost anyone if the environment be made difficult enough for him"* (Smith & Pear, 2017). On the other hand, the existence of a predisposition – an underlying or pre-war weakness such as a family history of insanity, epilepsy, paralysis, neurasthenia or parental alcoholism – were thought to underly most cases of shell-shock (Shephard, 2004). Those who held this point of view of trauma-related psychological injury continued to regard it as a moral weakness - an inability to show courage and stoicism in the face of fear (Mosse, 2000). It was sometimes treated with methods resembling torture, based on shaming and punishment, that included, for example,

the application of electric shocks to patients with mutism that continued until they spoke (Herman, 1992; Yealland, 1918).

Despite the recognition of their psychological origins, any soldier with symptoms who refused to obey orders was at risk of punishment for cowardice – in some cases this extended to execution (Corrigan, 2003). During the four years of WWI there were approximately 240,000 Courts Martial. 3080 of these resulted in the death sentence. In 346 cases this was carried out in the UK; however, no Australian soldiers were executed (Corns & Hughes-Wilson, 2001).

Because the term shell-shock had implications for the entitlement to a war-related pension for those affected, its use was discouraged in the military, based on a concern that it would encourage malingering and result in ballooning costs (Shephard, 2004). The term *"war neurosis"* emerged, with the implied pejorative assumption that the disorder was based on a hereditary pre-disposition (Jones & Wessely, 2007).

World War II (WWII)

Just prior to the beginning of WWII, in an attempt to avert compensation claims, the British Government announced that "*war neurosis*" in serving soldiers was to be regarded as "*exhaustion";* they were to be retained in the forces, and war-related psychological injuries would not be eligible for a pension (Shephard, 2004). This decision was reversed following public pressure two years later, but the idea that affected soldiers should be retained in the forces remained. Many similar symptoms earlier described in women as dissociative in origin were seen in soldiers exposed to military combat. They were described as *"conversion*" disorders because they were considered to convert psychological conflicts into physical symptoms (Hallet et al., 2016). While many of the symptoms described during this period, for example flashbacks, nightmares, hypervigilance and depression (Kardiner, 1941), are similar to those seen today, conversion disorders such as mutism, sensory loss or paralysis are no

longer considered to be part of the diagnosis of posttraumatic stress disorder (PTSD) (American Psychiatric Association, 2013; DiMauro et al., 2014). A putative explanation for this is discussed later in this chapter. Dissociation in other forms remains associated with exposure to trauma, however, and is now identified in DSM-5 (American Psychiatric Association, 2013) as a subtype of the diagnosis of PTSD. Conversion symptoms are described in DSM-5 within the classification of Somatic Symptom Disorder (American Psychiatric Association, 2013).

It was noted again, as had been earlier recognized by Charcot (1889), that the war-related symptoms persisted well beyond the end of combat (Southborough, 1920). This was a foundation for the later diagnostic category of PTSD (DiMauro et al., 2014). Despite this early recognition of the persistence of symptoms, the diagnostic assumption continued that, if they did not remit, this was indicative of a fundamental personal weakness or underlying disorder. This assumption remained until the publication of DSM-III (American Psychiatric Association, 1980) and the initial diagnosis of PTSD (Jones & Wessely, 2007).

Treatments included reassurance and hypnotic suggestion and were designed to act quickly so they could be administered as close as possible to the front line. Opinions differ as to the acceptability of this approach. Raftery (2000) condemned it as a cynical strategy to keep troops accessible. Other research cited the benefits of early intervention in preventing the disorders from progressing (Kardiner, 1941). There was also considered to be an advantage in not separating trauma sufferers from the support gained from their identification with a group, shown to frequently evoke feelings of shame from social exclusion, rejection and loss of status that can otherwise occur (Woodward et al., 2015). These principles of treatment as close to the front line as possible, with an expectation of early recovery and return to active duty, were widely used during WWII by both the UK and US military and

continued to be practised until recently by Western armed forces in Afghanistan and Iraq (Jones, 2010).

When the US entered WWII, attempts were made to identify and screen out those who might be predisposed to develop a trauma-related injury. This was thought to be unsuccessful, mainly due to lack of appropriately trained people to do the assessments, but also because no clear picture emerged of the purported underlying predispositions (Jones & Stone, 2020).

DSM and ICD: The Beginnings of the Current Approach to Diagnosis

War related psychiatric conditions continued to be regarded as neuroses during the Korean War. In 1952, DSM-I, the first edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* (American Psychiatric Association, 1952), was published containing the diagnosis of *"Gross Stress Reaction"*. This was described as a transient disorder with a good prognosis. In 1968 DSM-II the second edition of the manual was published (American Psychiatric Association, 1968), and Gross Stress Reaction was replaced with *"Transient Situational Disturbances".* If symptoms continued the diagnosis would become "*Anxiety Neurosis"*, classified as a personality disorder and implying that there had been an underlying pre-existing weakness or predisposition (Decker, 2013; DiMauro et al., 2014).

PTSD: first appearance in DSM-III

The first appearance of the diagnosis of posttraumatic stress disorder (PTSD) was in DSM-III, the third edition of the manual (American Psychiatric Association, 1980). It appeared some years later in ICD-10, the *"International Classification of Disease, Classification of Mental and Behavioural Disorders, 10th Revision"* (World Health Organization, 1992), and marked the beginning of the current approach to diagnosis of trauma-related injury. PTSD was then, for the first time, considered a universal response to

exposure to a terrifying and unexpected event; it also represented a "legitimization" of trauma-related psychological injury (Jones & Wessely, 2007).

The DSM-III diagnosis came about largely as a result of pressure to include a trauma-based diagnosis for Vietnam veterans, who had returned home from a conflict that was controversial and unpopular, adding to their war-related difficulties (Boscarino & Figley, 2012; McNally, 2016a). Thus, PTSD began as a politically driven diagnosis supported by anti-war activists and including prominent mental health professionals such as Shatan (1973) and Lifton (1973) and by Shay, (1994, 2002) who likened the struggles of the Vietnam veterans with those of Achilles in Homer's Iliad, and who first used the term "moral injury" to describe their psychological injury. The difficulties experienced by veterans were initially known as Post-Vietnam Syndrome. The themes repeatedly expressed by these veterans included: *"guilt feelings and self-punishment; the feeling of being scapegoated; rage and violence against often indiscriminate targets; combat brutalization and its attendant 'psychic numbing'; alienation from one's own feelings and from other people and doubt about continued ability to love and trust others"* (Shatan, 1973, p. 645-6).

These themes resemble both those now associated with the construct of moral injury (Griffin et al., 2019) and also those of Complex Posttraumatic Stress Disorder (CPTSD) as it is described in ICD-11 (Brewin et al., 2020). Recent studies of veterans found moral injury to be associated with: anger and aggressive behaviour (Worthen & Ahern, 2014), depression (McCormack & Ell, 2017; Purcell et al., 2016), substance addictions (Currier et al., 2017), and feeling condemned by and separate from civilians (Purcell et al., 2016). These behaviours and disorders also correspond with the shame avoidant mechanisms of anger, depression, addiction, and isolation, as they were described in Chapter 1.

The Vietnam veterans experiencing these difficulties were seen at the time as *"both victims and perpetrators of atrocity"* by the mental health professionals in the US who

supported them and participated in their group self-help or "rap" sessions (Shatan, 1973, p. 640). Because they carried an implicit criticism of war, these descriptions were controversial at the time amongst fellow psychiatrists and with the US Veterans' Administration (VA).

Mainstream psychiatry in the US was at that time in the process of revising the DSM away from an aetiology based on psychoanalytic theory, towards a descriptive system-based approach first proposed by Kraepelin in the 19th century, based purely on the principles of observation of the signs, symptoms and course of a disorder (Heckers & Kendler, 2020). Diagnostic categories were being constructed that were confined to being atheoretical in their aetiology and empirical (Decker, 2013; Kinghorn, 2020a, 2020b). At the same time, increasing pressure was placed on the American Psychiatric Association by veterans' supporters to recognize war-related psychological injuries. The struggle to achieve this became intensely political (Scott, 1990). It was based on the requirement that behaviour that had previously been regarded as abnormal needed to become a "normal" response to the situations faced by former soldiers (Kinghorn, 2020a, 2020b). The mental state and behaviour of the affected veterans were considered both an outcome of their experiences in Vietnam and a response to the effects of the opposition to the war that the combatants returned to in their home countries, that resulted in their shaming and alienation (Shatan, 1973). It was reported that in many cases their war-related symptoms did not surface until many months after their return, as they became increasingly aware that they felt disconnected from society in their homeland (Shatan, 1973).

A compromise position was reached between the DSM-III task force, headed by Robert Spitzer, and Shatan, Lifton, and the other supporters of the Vietnam veterans' cause. A member of the task force, Nancy Andreason, was tasked with writing the diagnostic criteria (Andreason, 2010, 2011; Kinghorn, 2020). Andreason had a background in treating trauma associated with burn victims. A group of symptoms was put together that included those she

had observed in this group and the more general symptoms then known to be associated with life-changing exposure to trauma (Kinghorn, 2020). These included the symptoms suffered by victims of rape, assault, torture and natural disasters. These then formed the basis of the overarching diagnosis of PTSD in DSM-III and met the requirements of being symptom focused and atheoretical in their origin (Andreason, 2010, 2011).

Because the context of the traumatic exposure did not form part of the diagnosis, the prominent feelings of guilt, shame and alienation described by Shatan (1973) as being experienced by the Vietnam veterans no longer formed part of their diagnosis. It would be thirty years before these feelings, arguably an inevitable component of psychological injury associated with war and the exposure to violence and death, reappeared in moral injury, and even more recently in the ICD-11 diagnosis of Complex Posttraumatic Stress disorder (CPTSD) (World Health Organization, 2019).

Initially, the diagnosis of PTSD in DSM-III was conceptualized as primarily a fear-based disorder (Brewin, 2016; Bryant, 2019; Foa & Kozak, 1986; Friedman et al., 2011). As mentioned earlier, the criteria for diagnosis of PTSD did not include some of the symptoms associated with earlier trauma-related psychological injury, for example, extreme conversion disorders, because they had ceased to be a major presenting symptom. There is speculation but little evidence in the literature as to why the symptomatology associated with trauma-related psychological injury appears to have undergone change over time (McNally, 2016a; Yehuda & McFarlane, 1995). The inclusion of the influence of context, excluded from the diagnosis since the publication of DSM-III, can make the nature of such changes in symptoms more comprehensible. What the WWI and WWII soldiers and the women who had experienced sexual abuse as children had in common was powerlessness. They could not escape from their situation. As a means of coping with it they lost the ability to fight by developing a functional paralysis, or to see, as in functional blindness. Functional

anaesthesias meant they no longer had to feel pain, Dissociative reactions of all types enabled them to separate their emotional response from the inescapable reality of their experience, as initially proposed by Janet (2007).

With the advent of the diagnosis of PTSD in DSM-III, trauma-related injury was for the first time regarded as potentially a chronic reaction to a traumatic experience or experiences, unconnected to any predisposing vulnerabilities (Jones & Wessely 2007). It was recognized as occurring as a response to exposure to severe trauma such as military service in a war zone, or to trauma over long periods from other sources, such as domestic violence (Brett, 2007; Herman, 1992a). At that time, it was regarded as a "normal reaction to an abnormal event", but subsequent empirical findings invalidated this definition, causing conflict between two opposing factions (McNally, 2016a): those who wished to support the foundational concept, normalize the status of sufferers and reject subsequent evidence that might jeopardize this, and those who maintained it was a disorder perhaps related to underlying constitutional predisposition or vulnerability. The idea that it represented a form of constitutional deficiency (Mosse, 2000) had resurfaced. There was also the growing complication of a plethora of individual and environmental risk factors other than the identified traumatic event (Brewin et al., 2000; Yehuda & McFarlane, 1995).

While it is now recognized that exposure to a life-changing traumatic event does not necessarily result in permanent psychological injury there is, nevertheless, evidence to suggest that some features of a traumatic event are more likely than others to result in PTSD (Larsen & Pacella, 2016; Wilker et al., 2015). Torture has been found to be the strongest precipitant (Steel et al., 2009), and events perpetrated by others more likely than natural disasters to leave a permanent impact (Brewin et al., 2000; Forbes et al., 2014; Kessler et al., 2017). It has also been found that the effects of traumatic exposure can be "dose-dependent"

and that cumulative exposure to potentially traumatic events can progressively influence the severity of the disorder (Geronazzo-Alman et al, 2017; Kolassa et al., 2010).

As described earlier, there are at present two major diagnostic systems that describe PTSD (Bryant, 2019); DSM-5 and ICD-11. Debate surrounding the diagnosis has intensified with the publication of ICD-11, which takes a narrow approach to defining the symptoms as opposed to the broader, more inclusive approach of DSM-5 (Brewin, 2020). ICD is the more commonly used diagnostic system by psychiatrists and psychologists worldwide to diagnose mental and behavioural disorders (Reed et al., 2011). Until the present time its use in Australia, however, as defined by the Royal Australian and New Zealand College of Psychiatrists (RANZCP) Diagnostic Manual (2016), has been largely confined to epidemiology and health management. As a result of this, hospital systems tend to use ICD criteria, while research uses DSM (O'Donnell et al., 2015).

DSM-5

The five-year process that led to the development of the PTSD criteria in DSM-5, the fifth edition of the *American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2013), has been described by the chair of the American Psychiatric Association sub-work group as having been based on a very conservative approach with a high threshold for change (Friedman, 2013a). One significant change was that PTSD was no longer considered an anxiety disorder but placed in a category of "trauma and stressor related disorders". Any other modification, deletion, or addition from DSM-IV-TR (American Psychiatric Association, 2000), the previous fourth edition of DSM, was required to have "*solid empirical support"* (Friedman, 2013a, p. 548). To capture the range of symptoms that emerge following exposure to traumatic stress, DSM-5 has expanded the criteria for the symptom groups from three to four. In addition to *"exposure to actual or*

threatened death, serious injury or sexual violence" (Criterion A), the following requirements for meeting the diagnosis are as follows:

1. *At least one of the following re-experiencing symptoms: Intrusive distressing memories, recurrent distressing dreams, dissociative reactions (e.g., flashbacks), intense or prolonged psychological distress at exposure to reminders of the trauma, marked physiological reactions to internal or external cues symbolizing or resembling an aspect of the traumatic event (Criterion B).*
2. *Active avoidance of internal (e.g., thoughts, memories) and/or external (e.g., situations, conversations) reminders of the trauma (Criterion C).*
3. *At least two "alterations in cognitions and mood" symptoms are needed, including inability to remember an important aspect of the traumatic event, persistent and exaggerated negative thoughts about oneself or the world, persistent distorted cognitions about the cause or consequences of the event, pervasive negative emotions, markedly diminished interest, feeling detached or estranged from others, persistent inability to experience positive emotions (Criterion D).*
4. *At least two of the following arousal symptoms: irritable behaviour and angry outbursts, reckless or self-destructive behaviour, hypervigilance, exaggerated startle response, problems with concentration, sleep disturbance (Criterion E).*

There is a requirement that people manifest these symptoms for more than one month after trauma exposure, in order to minimize pathologization of normal stress reactions (Bryant, 2019).

On the basis of epidemiological data (Stein et al., 2013) and neurobiological findings (Lanius et al., 2012) a sub-type of Dissociative PTSD was included in DSM-5. Despite extensive lobbying that began before the publication of DSM-IV (Brewin et al., 2017; van der Kolk, 2013), once again the inclusion of a diagnosis of Complex PTSD was rejected on the

basis that there was still considered to be insufficient high quality empirical evidence to support the inclusion of the construct (Friedman, 2013a).

Criticisms of DSM-5

The suitability of DSM-5 as a useful tool on which to base diagnosis and treatment has come under criticism for a number of reasons (Brewin, 2016; Bryant, 2019). It does not incorporate sub-clinical or subthreshold PTSD (McLaughlin et al., 2015), which is said to occur when an individual is experiencing some of the symptoms related to trauma but does not meet the criteria in all four of the diagnostic groups. Sub-clinical PTSD is thought to be potentially a chronic condition, with an unknown prevalence rate and extent to which it causes impairment because of variations in research methodology in the way it is defined and assessed – if it is assessed at all (Brancu et al., 2015). This is despite it being known to be associated with substantial disability, both social and occupational, and to increased suicide risk (Friedman et al, 2011; McFarlane, 2009, 2010b). DSM-5 has received further criticism because, if symptoms develop progressively over time with cumulative exposure to stressors, leading to them meeting the criteria for the four symptom groups but with no specific identified traumatic event, the affected individual will fail to meet Criterion A (Bryant et al. 2017) and would not meet the overall diagnostic criteria for diagnosis.

A further problem for the diagnosis is related to the known fluctuations of symptoms over time, which means that they might meet the DSM-5 criteria for diagnosis at one time and not at another, as a response to the amount of life stress the individual is experiencing at the time (Bryant et al., 2013; McFarlane, 2010a). Rates of enduring remission without treatment were found to vary widely (Morina et al., 2014) and lingering effects were found to potentially have a long-term impact on subsequent functioning (Bryant et al., 2016). A recent review of epidemiological studies of PTSD conducted world-wide found 70.4% of respondents reported experiencing lifetime effects (Kessler et al., 2017).

A *"clinical staging"* approach to diagnosis based on charting and incorporating the progressive nature of the individual's experience - which would include the context in which it occurred - has been suggested as a possible alternative to the existing static approach to diagnosis (McFarlane et al., 2017). This would ensure a timely approach to treatment, considered important by Shalev (2000), who postulates that there is a critical period of brain plasticity following exposure to trauma that occurs before it progresses to irreversible neuronal changes. A clinical staging approach to diagnosis is also described as marking a return to the consideration of the importance of context while preserving a phenomenological approach to diagnosis (Drozdzowicz, 2020; McFarlane et al., 2017; McGorry et al., 2014; McGorry & van Os, 2013).

Interestingly, the importance of exploring and understanding the detail of the individual's experience, and the belief that this had been lost over successive iterations of DSM, was stated by the original author of the criteria for the diagnosis in DSM-III (Andreasen, 2007). Andreasen described the original aim of DSM-III was to *"create a comprehensive system for diagnosing and evaluating psychiatric patients that would be more reliable, more valid, and more consistent with international approaches"* (Andreason, 2007, p. 108) and that it had been intended to have a *"gate-keeping"* function. She argued that, since that time, the unintended consequence had been that there had been a reification of the criteria and a decline in the careful investigation of the individual person's problems and their social context (Andreason, 2007, Kinghorn, 2020a). A similar view was stated earlier by Wilson (1993) who described the advent of DSM-III as marking the end of the *"clinically based biopsychosocial"* model of mental disorders and its replacement with a *"research-based medical model"* (p. 400).

ICD-11

ICD-11, the eleventh edition of the *World Health Organization International Statistical Classification of Diseases and Related Health Problem,* (World Health Organization, 2019) was published in its final form in 2019, though evidence as to its content had been available for some years prior to this. It was in agreement with DSM-5 in that it no longer considered PTSD an anxiety disorder; both diagnostic systems have placed it in a category associated with stress. In the case of ICD-11, this was described as *"disorders specifically related to stress".* However, as noted earlier, the ICD-11 working group proposed an alternative, more parsimonious approach to the criteria for diagnosis, aimed primarily at effectively discriminating PTSD from other related conditions and being adaptable to use in minimally resourced, non-English speaking countries (Brewin, 2013). PTSD as described in ICD-11 has a less specific definition for the precipitating traumatic event or events, requiring only that it be *"an extremely threatening or horrific event or series of events"* (Brewin et al., 2017). The required symptoms are described as:

> *...re-experiencing of the traumatic event in the present in the form of vivid intrusive memories, flashbacks or nightmares; avoidance of thoughts or memories of the event or activities, situations or people reminiscent of the event and persistent perceptions of heightened current threat* (Reed et al., 2019, p. 8).

Functional impairment was added to keep the threshold for diagnosis sufficiently high (Brewin, 2013). As noted earlier, ICD-11 also includes a separate diagnostic category of Complex Posttraumatic Stress Disorder (CPTSD). Risk factors for CPTSD include exposure to prolonged or repeated traumas from which escape is difficult or impossible, described as potentially occurring during, but as not confined to, childhood (World Health Organization, 2019). A diagnosis of complex posttraumatic stress disorder for the DSM was first proposed by Herman (1992). A diagnosis derived from it, *"Disorders of Extreme Stress Not Otherwise*

Specified" (DESNOS) was included in the Appendix to DSM-IV-TR (American Psychiatric Association, 2000) but does not appear in DSM-5 (American Psychiatric Association, 2013). DESNOS did not require PTSD symptoms to be part of the symptom set. The ICD-11 criteria for the CPTSD diagnosis do, however, include those of PTSD, with three additional symptom clusters that reflect "*disturbances in self-organization.* These are defined as *"affective dysregulation, negative self-concept, and disturbances in relationships"* (Brewin, 2020).

Despite its potential shared relationship with childhood trauma, accumulating empirical literature has shown that CPTSD is distinct and separate from that of borderline personality disorder (BPD). BPD symptoms not found to be present in CPTSD included: *frantic efforts to avoid abandonment, unstable sense of self, unstable and intense interpersonal relationships, and impulsiveness*, and BPD does not require a trauma history (though it is frequently associated with one) (Cloitre et al., 2014). BPD is essentially thought to be characterized by an unstable sense of self that alternates between positive and negative perceptions of the self and of others (Felding et al., 2021). In contrast, CPTSD manifests as a stable negative self-concept, defined as feelings of worthlessness or being a failure, feelings of intense shame and high self-blaming and an avoidance of relationships (Brewin, 2020; Brewin et al., 2017; Felding et al., 2021).

The considerable lack of overlap between the PTSD diagnoses of DSM-5 and ICD-11 is expected to create problems for researchers, clinicians, and for those who have received the diagnosis. It is considered likely to affect estimates of the prevalence of the disorder in epidemiological studies and case identification in clinical practice (Barbano et al., 2019). It is also thought likely to adversely affect the legal status of those who have been diagnosed, rendering claims for compensation more open to dispute (Kerig et al., 2020).

In a longitudinal study of nearly 4,000 survivors of a traumatic event, significantly fewer individuals were found to receive a diagnosis of PTSD using ICD-11 than were

identified using DSM-5, and ICD-11 criteria were also found to identify only the more severe cases when compared to those meeting the criteria in the earlier ICD-10 (Barbaro et al., 2019). The discordance between the diagnoses has been criticized as being incompatible with the advancement of the field (Vermetten et al., 2016). Conversely, the broad versus narrow definitions of PTSD have been seen by other authors in the field as an opportunity to investigate their respective clinical and heuristic values (Brewin, 2013: Maercker et al., 2013).

Two recent studies have investigated the presence of CPTSD in emergency service workers. A study that used ICD-11 to investigate PTSD and CPTSD in UK police officers (Brewin et al., 2020) found the prevalence CPTSD was 12.6%, and PTSD 8%. A study of former or present UK firefighters by Langtry et al. (2021) found 18.23% met the criteria for diagnosis of CPTSD and 5.62% for PTSD. These results suggest that CPTSD might be potentially considerably more common than PTSD in emergency service workers as well as both disorders being much more prevalent in this group than previously recognized. Their prevalence in a nationally representative population sample was found to be 3.4% for PTSD and 3.5% for CPTSD (Cloitre et al., 2019).

Compared to PTSD, CPTSD has been found to be more frequently associated with cumulative exposure to traumatic incidents of a non-violent nature, and with being subject to humiliation (Brewin et al., 2020). This suggests that the ICD-11 CPTSD criteria capture aspects of moral injury as it will be more fully described later in this chapter and that the core "negative self-concept" is often associated with shame. The similarities between CPTSD and moral injury are supported in recent research that found outcomes related to moral injury in a group of veterans aligned with symptoms of CPTSD in ICD-11 (Currier et al., 2021). This research concluded that those who had complex emotional responses that met the CPTSD criteria also endorsed high levels of distress consistent with those of moral injury.

As stated earlier, DSM-5 does not have a Complex PTSD diagnosis. Its authors consider that it captures the outcomes related to moral injury in Criterion D; *"negative alterations in cognition or mood"*, in the category of *"persistent negative emotional state (e.g., fear, horror, anger, guilt or shame)"* (Friedman, 2013b). This is much less specific than the description of symptoms described in ICD-11. Criterion D has seven categories of symptoms, two of which must be endorsed to meet the criterion. Since the category of *"persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame)"* does not necessarily have to be endorsed to meet Criterion D for a diagnosis of PTSD, the symptoms might exist without being recorded.

The criteria for diagnosis of CPTSD show promise of being capable of incorporating many of the outcomes related to moral injury when they are associated with PTSD and might provide a more appropriate basis for determining treatment. However, moral injury outcomes without the presence of PTSD symptoms would not meet the criteria for diagnosis of CPTSD, so arguably there remains a substantial gap in the ability of the current diagnostic systems to identify this important manifestation of trauma-related injury.

Posttraumatic Stress Disorder (PTSD): Symptoms and Current Theories

As described earlier, despite the differences described earlier between DSM-5 and ICD-11 in their definitions of PTSD, there is a shared recognition of three sets of core symptoms. (As noted earlier, DSM-5 adds an additional fourth set of symptoms described as "negative alterations in cognitions or mood"). The three sets of core symptoms described in both ICD-11 and DSM-5 include: *"intrusive re-experiencing of the traumatic event or trauma-related dreams"; "active avoidance of reminders or memories of the event"; and "alterations in arousal and reactivity"* (Walton et al., 2017, p. 254). These core symptoms and the predominant theories that explain their development and maintenance are described below.

Intrusions

Intrusions manifest as involuntary intrusive distressing memories or recurrent dreams that appear spontaneously rather than resulting from a deliberate search or effort (Berntsen & Rubin 2014). They are thought to generally last for some minutes and are usually accompanied by physical sensations of a highly distressing nature and could incorporate a variety of emotions that might include guilt or shame, anger, fear, or sadness (Reynolds & Brewin, 1999). Intrusions can be experienced as "flashbacks", thought to be confined to individuals with PTSD and experienced as a vivid "reliving" of the event (Brewin, 2015; Kvavilashvili, 2014), or as unbidden distressing memories in other forms, which are thought to occur across a range of other psychopathologies (Bryant et al., 2011b; (Brewin, 2015). In PTSD, intrusions may also manifest as trauma-related dreams (Bryant et al., 2011b).

Avoidance

Because exposure to reminders of the traumatic event is emotionally painful and distressing, this frequently results in deliberate avoidance of feelings, thoughts and memories of the event, and physical avoidance of places, people or activities that might serve as reminders of the trauma. This can frequently result in the life of those experiencing trauma symptoms becoming increasingly restricted. In addition to this, avoidance of trauma reminders then maintains the symptoms of PTSD and the trauma related distress (Foa & Kozak, 1986). This is the theoretical underpinning of the treatment method of prolonged exposure (PE), which is aimed at reducing or eliminating avoidance and enabling habituation to the traumatic memories (Foa et al., 2019). This treatment and its limitations are further described in the Treatments for PTSD section of this chapter.

The neurobiology of PTSD

Altered physiological reactivity is the third of the core symptoms of PTSD and can be identified in studies that measure functional brain imaging, including functional magnetic

resonance imaging (fMRI), positron emission tomography (PET) and single-photon emission computed tomography (SPECT) (Francati et al., 2007; Ko et al., 2013). Over-reactivity manifesting as re-experiencing/hyperarousal is viewed as a form of emotional dysregulation (Lanius et al., 2010) and associated with, amongst other symptoms, irritability and angry outbursts, "flashbacks", poor sleep with trauma-related nightmares and enhanced startle reaction. This occurs as a result of an under-modulation of regulatory inhibitory control by areas of the medial pre-frontal cortex over the limbic area of the brain, which is thought to register threat and is known to mediate anger, guilt or shame as well as fear-induced arousal and distress (Lanius et al., 2010; Nicholson et al., 2017; Nicholson et al., 2018; Fitzgerald et al., 2018; Yehuda et al., 2015).

A second way in which physiological reactivity can change in PTSD is as blunted affect, regarded as being the converse of hyperarousal and shown by brain imaging techniques to be associated with an enhanced suppression of the limbic area by the prefrontal area. It is described as dissociative in nature (Lanius et al., 2010; Nicholson et al., 2017). This conceptualization of dissociation forms the basis for the dissociative sub-type of PTSD in DSM-5 (Friedman et al., 2011).

While this brief outline of the brain's response to trauma refers to activities involving discrete structures in the brain, these structures do not function independently, but are part of three large-scale brain networks. These include firstly, the default mode network (DMN), which engages during resting wakefulness (Alves et al., 2019) and is thought to be related in PTSD to negative self-referential thoughts and alterations in autobiographical memory (Frewen et al., 2020). The second large-scale brain structure is the central executive network (CEN), associated with higher cognitive functioning and thought to be related to impaired cognitive function across multiple domains and to contribute to emotion under-modulation in PTSD (Nicholson et al., 2020). The third large scale brain network is the salience network

(SN) which monitors and responds to environmental input (Seeley, 2019) and is thought to be associated with increased and decreased arousal in PTSD (Lanius et al., 2015), All these brain networks are known to be impaired in PTSD and underly other symptoms linked to the disorder, such as cognitive impairment and persistent negative mood (Fragkaki et al., 2016; Lanius et al., 2015; Nicholson et al., 2020). They are also thought to be potentially linked to treatment resistance (Charquero-Ballester et al., 2020).

When the limbic area registers threat as described above, neural mechanisms activate a hormonal response in the hypothalamic-pituitary-adrenal (HPA) axis. Glucocorticoids are released which in turn act on multiple organ systems to prepare the organism for flight or fight (Herman et al., 2016). The stress response also activates other stress-responsive systems, including the autonomic nervous system, resulting in an increase in heart rate and blood pressure. Under normal conditions, feedback mechanisms limit this response to the duration of the threat (Herman et al., 2016; Zuj & Norrholm, 2019).

Continuing dysregulation of the HPA axis is generally accepted to be central to the development and maintenance of PTSD and ongoing exposure to stressors is considered to potentially operate as a cumulative process wherein normal feedback inhibition diminishes (Friedman et al., 2011). This failure of inhibition has been related to reduced cortisol response in PTSD (Lanius et al., 2010). It is proposed that this lower cortisol level prevents the capacity to achieve homeostasis after trauma, thereby leading to PTSD (Bryant, 2021) and low cortisol levels have been considered a potential marker for PTSD (Yehuda et al., 2015). However, some inconsistencies remain in the extant research, thought to be possibly related to time differences in data collection or other variables in the findings associated with cortisol levels in PTSD (Fragkaki et al., 2016) and for this reason it is considered that low cortisol levels cannot yet serve as a biomarker for the disorder (Speer et al., 2019).

While its authors acknowledge that research in this area is in its early stages, a review of neuro-imaging literature by Lanius et al. (2017) has shown evidence that threat-related stimuli can be registered subconsciously as well as consciously. This is proposed to occur as a rapid response to threat, mediated by a functionally connected sub-cortical brain network. It is considered an evolutionary defensive response and to contribute to hyperarousal symptoms in PTSD (Lanius et al., 2017). It means that appraisal at a cognitive level of the significance of a stressor takes place fractionally after the lower brain structures register the threat - or potentially might not take place at all. This in turn might inhibit any adaptive change in cognition or behaviour that might serve to mitigate the threat such as finding ways to reduce stress or seeking assistance to resolve it (McFarlane, 2014). An example of this might be a police officer noticing they had become increasingly irritable, or that their alcohol intake had increased, but failing to associate these changes with occupationally related stressors operating cumulatively, and progressively increasing their level of stress.

Dissociation

DSM-5 cites "dissociative symptoms" as confined to the dissociative subtype of PTSD, describing them as manifesting as the *"persistent or recurrent symptoms of either depersonalization or derealization"* (American Psychiatric Association, 2013, p. 272), This definition has been based in large part on the results of fMRI imaging showing excessive pre-frontal cortical activity combined with reduced activity in the amygdala, a reversal of the usual pattern seen in PTSD (Friedman, 2013a).

There is an ongoing debate as to the nature of the relationship between PTSD and dissociation which challenges the DSM-5 definition (Ross, 2018). There is a group of authors who argue that dissociation is characteristic of *all* PTSD (Dorahy & van der Hart, 2015). These authors propose that the narrow definition of the dissociative sub-type of PTSD as it described in DSM-5 creates a false dichotomy between the dissociative subtype and the range

of dissociative symptoms described within the main definition of PTSD (American Psychiatric Association, 2013, p. 274), which include flashbacks and amnesia. They maintain that dissociation is relevant to the diagnosis of PTSD more broadly than solely to the dissociative subtype, and that it is characteristic of all PTSD. They conceptualize the construct of dissociation as it was first identified by Janet in the late 19th Century (van der Hart & Horst, 1989; van der Kolk & van der Hart, 1989) and as occurring when the individual lacks the capacity to integrate their traumatic experience. This results in a division of personality into two or more sub-systems. These sub-systems may then manifest as dissociative symptoms which can be categorized as negative (functional losses such as amnesia and paralysis) or positive (intrusions such as flashbacks or voices) and psychoform (symptoms such as amnesia, hearing voices) or somatoform (symptoms such as anaesthesia or tics). (Nijenhuis & van der Hart, 2011, p. 418).

Apart from the role it plays in the dissociative sub-type of PTSD in DSM-5, dissociation is a term also used to describe a specific type of reaction that may occur at the time of exposure to a traumatic event. Referred to as peri-traumatic dissociation, this form of dissociation can be broadly described as an involuntary short-term alteration of awareness resulting in a state devoid of any affective or emotional response to the event (Bryant, 2007). While it might enable adaptive behaviour at the time of the event, it is thought to lead to fragmentation of the resultant memory, resulting in an impairment in memory retrieval for the event which serves to prevent its subsequent integration into the autobiographical memory (Lanius et al., 2010). In an extensive review by Ozer et al. (2003), the experience of peri-traumatic dissociation was found to be the most important factor leading to a subsequent diagnosis of PTSD. Bryant (2009) argues however, that because responses similar to dissociative states are known to frequently occur in the acute phase of a traumatic experience

and because dissociative responses are multi-dimensional phenomena, not all dissociative states can be assumed to lead to subsequent pathology.

Memory disorders

Intrusive memories experienced as a reliving of the traumatic event have resulted in PTSD being described as a disorder of memory by some authors (Brewin & Holmes, 2003; van der Kolk, 2007) but there is lack of agreement as to the processes whereby memory is affected (Rubin et al., 2016). One prominent theory, known as the Dual Representation Theory, describes trauma-related memory as potentially taking the form of two parallel systems (Brewin, 2016a; Brewin et al., 1996, 2000). It may be differentially encoded into normal "verbally accessible memory" (VAM) which is integrated with autobiographical memory, can be deliberately retrieved when required, and may acquire associations generated by subsequent cognitive appraisal. The second system, "situationally accessible memory" (SAM), contains memories that have been obtained from more extensive, lower level processing of an event of a traumatic nature and are triggered involuntarily by situational reminders of the event. Triggers may include sounds and smells as well as visual reminders of the traumatic event and may contain distressing emotions associated with the event such as anger, fear, and shame (Friedman et al., 2011). Because they are involuntary, SAM memories are thought to be fragmented, out of sequence and disorganized and therefore resistant to modification by subsequent information (Brewin, 2016b; Brewin et al., 2010). Exposure to trauma cues, particularly sensory cues, are thought to elicit SAM memories in the form of "flashbacks", which lead to the brain responding as if the trauma is occurring in the present (Brewin, 2016a).

A group of cognitive psychologists, Rubin et al. (2016) strongly disputes the concept of dual memory theory, maintaining a lack of empirical support, and propose a different, single system model of trauma memory. These authors cite research supporting their thesis

that all memory operates using the same mechanism (Berntsen & Rubin, 2014). They propose that disorganized memory for autobiographical events might occur because of a comorbid disorder such as borderline personality disorder or depression and might be attributable to impaired executive processes (Berntsen & Rubin, 2014).

Cumulative exposure

Epidemiological evidence from a World Mental Health Survey (Karam et al., 2014) supports the proposition that the effects of exposures to multiple traumatic events and other stressors frequently operate in a cumulative manner. This is thought to lead to increasing dysfunction that requires more specific and targeted treatment interventions (Karam et al., 2014). The mechanism that leads to a progressive onset of PTSD symptoms and their exacerbation over time has been described as a process of "*sensitization"* that causes increasing dysregulation of an individual's neurobiology (McFarlane, 2010b). Cumulative stress has been found to also lead to psychological disorders other than PTSD. These include depression, anxiety, substance use, and somatic disorders which may exist as co-morbidities, (Bryant, 2021) and or in various combinations without a diagnosis of PTSD (Chopko et al., 2013; Faulkner et al., 2020; McFarlane, 2010a).

Early life stress has been reported as providing a pathway for an increased risk of later development of PTSD through cumulative exposure, in effect re-activating the "prior vulnerability" argument that has long dogged trauma-related psychological injury (McLaughlin et al., 2017; Ramo-Fernandez et al., 2019; van Bodegom et al., 2017). Permanent sensitization of the hypothalamic-pituitary-adrenal (HPA) axis from exposure to stressors in early life, combined with the impact of re-traumatization is thought to sustain, amplify and perpetuate the existing symptomatology. Disturbance of the attachment relationship between the child and the major care-giver is thought to be of potential significance in providing a basis for later traumatization (Crittenden & Heller, 2017; Pratchett

& Yehuda, 2011). Early life stress is known to also be associated with mood disorders such as depression and anxiety in adulthood (Flory & Yehuda, 2015; Juruena et al., 2018).

Repeated cumulative exposures to stressors are also thought to be associated with somatic disorders, though this association is not included in the criteria for diagnosis. These might include chronic musculoskeletal pain, gastrointestinal disorders, hypertension, and cardiovascular disease, amongst other physical ailments (Benros, 2015; Flory & Yehuda, 2018; McFarlane, 2007; McFarlane, 2010a, 2010b; McFarlane et al., 2017; McFarlane & Bryant, 2017; McLeay et al., 2017; O'Donovan, et al., 2015; Pacella et al., 2013). McFarlane (2017) argues that confused thinking, based on Descartes' concept of body-mind dualism, has impeded the recognition of the extensive psychophysiological and somatic comorbidities of PTSD, and that it should be considered a systemic disorder.

Treatments for PTSD

The most frequently recommended first-line treatments for PTSD in international guidelines are the trauma-focused cognitive behavioural therapies. A number of different approaches come under the rubric of trauma-focused cognitive behavioural therapy, including prolonged exposure (PE), cognitive therapy, cognitive processing therapy (CPT), and imagery rescripting (Bryant et al., 2019). A trauma focused approach is based on verbal or written processing of the emotional and cognitive aspects of the traumatic event and because of this it is experienced as emotionally demanding (Steenkamp et al., 2020). A further first-line treatment, eye movement desensitization and reprocessing (EMDR) involves a process whereby a reduction in the emotional content of trauma memories is stimulated non-verbally through bilateral stimulation, typically achieved through horizontal saccadic eye movements (Shapiro, 2007). However, it similarly exposes the individual to emotionally demanding extended recall of the traumatic event. Although these treatments differ in their approach,

they all essentially comprise the processing of the traumatic memory and the integration of new corrective information (Bryant et al., 2019).

These treatments are considered “evidence-based” by major organizations worldwide (Cusack et al., 2016). This has been a matter of dispute for several reasons. Their customary reliance on random control trials (RCT’s) as their evidence base has been considered to be insufficiently inclusive and it is thought that this might result in potentially important evidence not qualifying for inclusion, hence being under-valued or ignored (Henriques, 2018). Both individual clinical evidence and accurate external evidence are considered relevant to determine treatment recommendations, while recognizing that studies other than RCT’s may be biased and should be interpreted with caution (Bisson et al., 2019). A further difficulty with RCT’s is that they frequently exclude participants with co-morbid substance use disorders or suicidal ideation with intent, suggesting their results might not generalize to those who typically seek clinical services (Ronconi et al., 2014).

The guidelines for “evidence-based” trials are also considered to be potentially inconsistent. A recent Australian review of treatments for PTSD concluded there is a need for more precise and uniform conceptual definitions of the methods and research structure used to assess the efficacy of treatments before they can be considered evidence-based (Varker et al., 2020). A systematic review by Barawi et al. (2020) reported an urgent need for consistent and standardized reporting of factors associated with treatment outcomes for evidence-based, treatment research, since ineffective psychological interventions result in too many individuals being left with enduring symptoms.

There is a reported high failure rate in trauma-focused treatment approaches, suggesting much more needs to be known about how to deliver effective treatment for psychological injury. A comparison of PE and CPT (Maguen et al., 2021) found similar and modest symptom improvement for both and concluded that there is a critical need for

research to develop better therapies for PTSD. The overall lack of effectiveness of current approaches to treatment has been recognized as being the result of both poor response and high dropout rates. CPT was found to fail to elicit an adequate response in up to 50% of people with PTSD (Resick et al., 2017). The drop-out rate for PE/CPT for members of the military has been found to exceed 36% (Kehle-Forbes et al., 2016), and to be particularly high for trauma focused therapies (Lewis et al., 2020). Both PE and CPT therapies are coming under increasing criticism as first-line treatments for veterans in the US (Steenkamp et al., 2020).

It has also been noted that clinicians tend to be reticent to adopt trauma focused therapies because of the level of distress associated with them, the inflexibility of manualized approaches, the presence of co-morbid conditions, and their high dropout rate (Finch et al., 2020; Lewis et al., 2020; van Minnen et al., 2015). Alternative therapeutic approaches have been limited in number and largely inconclusive in their reported outcomes and will not be reported in detail here.

The development of treatment protocols to address the known heterogeneity of symptoms, which in many cases is thought to indicate that a trauma-focused approach may not be the most effective treatment, is recommended by some authors (Cloitre 2015; Cloitre et al., 2016). The validity of an approach to treatment that focuses on the centrality of the trauma response has been called into question because it might not fully address moral injury, guilt or shame which may be attached to the trauma (Yehuda & Hoge, 2016). There is some disagreement in the literature as to whether exposure-based treatments are the most effective treatment for PTSD at all (Dimaggio, 2019; Yehuda & Hoge, 2016). Since the publication of ICD-11, Lehrner and Yehuda, (2020) have proposed that there is a need for the development of treatment guidelines for both DSM and ICD diagnoses that meet the diverse needs of all patients with PTSD. These authors consider it *"maddeningly oblivious to the clinical reality"*

that the existing treatments recommended for PTSD are insufficient for the more complex presentations of CPTSD, since they do not address shame or create a window for reflection on trauma material (p 154). Existing treatments are also thought to be inadequate because of their lack of emphasis on the building of trust and the creation of a safe therapeutic relationship to encourage the disclosure of trauma (Brewin, 2020). This is thought to often occur because trauma focused treatment approaches are generally manualized according to a protocol (Lehrner & Yehuda, 2020).

There is controversy as to whether PE treatments are suitable for the treatment of moral injury. Maguen and Burkman (2013) and Steenkamp et al. (2013) argue moral injury requires a different approach. Rauch et al. (2013) dispute this, maintaining that shame and guilt related to moral injury can be treated effectively with PE because it focuses on whatever symptoms are maintaining the injury. Treatments that have been considered more appropriate for moral injury include adaptive disclosure (Gray et al., 2021), compassion-based therapy (Au et al., 2017) and mindfulness based therapy (Banks et al., 2015; Boyd et al., 2018).

There is considered to be an urgent need for more specific optimal treatments for psychological injury in emergency service personnel to address their complicated clinical profiles and frequent incidence of co-morbidities (Bryant et al., 2018). Recent research with Australian emergency service personnel employed brief exposure to cognitive behavioural therapy (CBT) and found that a shorter exposure time to trauma memories to be equally effective in treating PTSD symptoms but less distressing and time consuming (Bryant et al., 2018). Because it was found to not be associated with any improvement in depression this is however a significant drawback, since depression is so frequently associated with PTSD (Flory & Yehuda, 2015). Successful treatment of complex presentations including disorders such as depression, and perhaps other disorders associated with chronicity, are suggested to

require more time and perhaps a different approach than that of brief exposure cognitive behavioural therapy (Bryant et al., 2018).

In summary, to date there are differences of opinion as to the most effective treatment approach for PTSD, and in its most frequently used forms it carries both high failure and non-compliance rates. The recent attention to moral injury and its effects, and the recent research associated with the diagnostic category of CPTSD in ICD-11 and its frequency in emergency service personnel, serves to complicate this picture further. Arguably, the differences of opinion associated with the effectiveness of the different approaches indicate that much might focus on the way the individual therapist approaches the individual concerned and the degree to which an effective therapeutic alliance is established, as suggested by Sijercic et al. (2021). This suggests that individual clinical evidence, as recommended by Bisson et al. (2019), and potentially based on qualitative research, might contribute to our understanding of effective treatment for trauma-related injury.

Alternative approaches to diagnosis

Several approaches to the diagnosis of post-trauma psychological injury have been proposed that are based on alternative criteria to those of DSM-5 and ICD-11. These are discussed and evaluated below.

Research Domain Criteria (RDoC)

Prior to the publication of DSM-5, the influential National Institute of Mental Health (NIMH) in the US proposed a new way of classifying mental disorders, the Research Domain Criteria (RDoC), which is based on neurobiological measures and behavioural dimensions, and considers the effect of development and environmental influences (Insel, 2014; Insel et al., 2010). This system of classification is still under review, with emphasis on the funding of research into the effects of cumulative stress (Gordon, 2017). The RDoC approach contends that mental disorders are in fact brain circuit disorders, and ultimately will be identifiable as

such (Insel et al, 2010). The linkage of the concept with symptom-based research has been suggested by Schmidt (2015) as a means of grouping patients according to predominant complaints and symptoms, rather than in a diagnostic category. While there is some evidence for its assumption that brain circuit disorders underly mental disorders, arguably to date there is insufficient substantiated research to advance this system of diagnosis, though it is considered by some authors to hold long-term promise as an alternative to the DSM-ICD system (Lilienfield & Treadway, 2016).

Network Analysis

The fundamental nature of PTSD is thought by some traumatologists to be poorly understood, since symptoms crystalize into the formal syndrome over a varying period of time, and the processes whereby the syndrome develops are unclear (Bryant et al., 2017). It has also been argued that there is still much that is unknown about aetiological and symptomatological differences in individuals, and whether specific symptoms might interact with each other to play important roles in perpetuating the disorder (Armour, Fried, Deserno et al., 2017). A diagnostic system that enables identification of these diagnostic concerns by focusing on symptoms and their interactions has recently been published. Known as Network Analysis (Boorsboom. 2008; Borsboom & Cramer, 2013), it has received attention worldwide. This system considers symptoms themselves to constitute the disorder, rather than being reflective of any underlying disorder, and to vary correspondingly according to the trauma, the culture and the characteristics of those affected, amongst other variables (Armour, Fried, Deserno et al., 2017).

The Network Analysis approach addresses psychiatric disorders by focusing on the interaction of symptoms. Each symptom is presented as a node on a graph, and the relationship between nodes is shown as a series of links. The structure then can be described formally using statistical analysis or referenced simply as a graphic representation. Using this

graphic process, the centrality and hence the influence of each node or symptom can be established. Based initially on a theoretical concept, and subsequently incorporating a range of statistical procedures, Network Analysis has been proposed as an alternative to current "cross sectional" models by its authors Boorsboom (2008) and Borsboom and Cramer (2013). Its authors argue that the symptoms of mental disorders can be better understood as distributed networks of mutually interacting, reciprocally reinforcing cognitions, emotions, and behaviours. In understanding this data, research associated with post-trauma disorders can then identify the system dynamics that are important and provide information about the factors that determine the onset and maintenance of PTSD (Fried et al., 2018). These factors are thought to be likely to be different for each individual, and because the method is well suited to the treatment of individuals (Fisher et al., 2017; Reeves & Fisher, 2020), Network Analysis is considered to offers the opportunity for structured personalization of assessment and intervention (Fisher, 2015; Fisher & Boswell, 2016; Piccirillo & Rodebaugh, 2019). This is thought to have the potential to improve the efficacy of treatment interventions (Armour, Fried, Deserno et al., 2017; Armour, Fried & Olff, 2017).

A number of studies using Network Analysis to investigate trauma-related psychological injury have been published to date. A study by of the relationships between posttraumatic stress, guilt or shame and depression (Frewen et al., 2013) found that an increased number of causal feedback loops was associated with an exacerbation of symptoms, and that guilt or shame, central to self-schema, was predictive of depressive symptoms. In a study of earthquake survivors in China, strong interconnections were found between nightmares, intrusive memories and flashbacks, between avoidance of thoughts and avoidance of places and activities associated with the trauma, and between exaggerated startle reaction and hypervigilance (McNally et al., 2015). A study by Bryant et al. (2017) found strong connections between intrusions, flashbacks and avoidance of thoughts, and

between hypervigilance, physiological reactivity to reminders of the trauma and exaggerated startle response. Studies by Armour, Fried, Deserno et al. (2017) and Mitchell et al. (2017) reported similar linkages between symptoms and clinical outcomes.

As reflected in the above research, a recent systematic review of the network approach (Birkeland et al., 2020) found substantial heterogeneity in the centrality of the nodes or symptoms in different studies. They considered this might have been due to either differences in samples or methodological difference, or to both. These authors emphasized that to date, no standard statistical tool for examining network analyses has yet been established, making any comparison of different studies questionable.

Despite questions as to its replicability, Network Analysis continues to grow in popularity and has gained considerable world recognition (Fried et al., 2018). It has been described as an approach that can *"transform psychopathology"* (McNally, 2016b, p.95) *"a revolution in the field of clinical psychology and psychiatry"* (Fried & Cramer, 2017, p. 999), and as a *"change in thinking from a static to a dynamic view of psychopathology"* (Wichers et al., 2017, p. 8). As a theoretical approach, it is considered relevant to treatment and management as well as to diagnosis, since the identification of stable pathological networks provides not only a focus for therapeutic intervention as suggested earlier (Armour, Fried, Deserno et al., 2017; Armour, Fried & Olff, 2017), but can also be an indicator of the severity of the person's disorder (Fried & Cramer, 2017). These authors suggest PTSD is a *"hybrid model"* when considered within a network analysis framework. The onset – exposure to trauma – has a common cause, and its maintenance is fuelled by the interaction of symptoms that vary according to the individual.

The use of Network Analysis to inform existing diagnostic systems of PTSD by identifying the symptoms that most strongly influence other symptoms, and to provide a set of the most representative criteria for diagnosis, is suggested by Mitchell et al. (2017). These

authors suggest that this might be a way of reducing the *"unwieldy and overlapping"* symptom constellation of DSM-5 and conversely, ensuring that the small number of symptoms in the ICD-11 diagnosis are those most strongly associated with the diagnosis (Mitchell et al., 2017, p. 1).

Moral Injury

It was noted earlier that there has been recent increasing interest in the concept of moral injury. There is presently no consensus definition of the construct of moral injury, but Functional Magnetic Resonance Imaging (fMRI) has provided early neurobiological evidence to support the negative self-referential emotions of shame and guilt as its primary emotional states (Barnes et al., 2019).

Moral injury has been described as resulting from *"A betrayal of what's right, by someone who holds legitimate authority in a high stakes situation"* (Shay, 1994, 2014) and from *"The perpetration, failure to prevent or witnessing of events that transgress deeply held moral beliefs and expectations"* (Litz et al., 2009). The term was first used by psychoanalyst Jonathan Shay in his work with troubled Vietnam Veterans in the 1990's (Shay, 1991, 1994, 1995), and referred to a *"character wound*" resulting from one's betrayal by an individual in a position of legitimate power (Shay, 2014, p. 182). Basing his theory on the importance of the relationship of a leader to his people first described by Homer, Shay emphasized the need to take a comprehensive history to identify the presence of moral injury and its causes, and said it resulted in a *"deterioration of ideals, ambitions and attachments, the destruction of trust and the creation of an expectancy of harm, exploitation, and humiliation from others"* (Shay, 2014, p.186-188).

The second, empirically based, definition of moral injury was proposed by psychologist Litz and his colleagues (Litz et al., 2009). In this definition, moral injury is thought to occur as a consequence of the perpetration or witnessing of events that violated

one's core beliefs or values and results in anger, guilt or shame, loss of meaning, appraisals of blame and self-blame, avoidance behaviours and social disconnection (Currier et al., 2015). More generally, Farnsworth et al. (2017) conceptualize these outcomes as reflecting a *"social, psychological and spiritual suffering stemming from costly or unworkable attempts to manage, control, or cope with the experience of moral pain"* (p. 392).

Because it *"impairs the capacity for trust and elevates despair, suicidality and interpersonal violence"*, Shay (2014. P. 182) considers that moral injury in either form is a separate entity that is not captured by the DSM diagnosis of PTSD. He proposes that both types of moral injury involve betrayal; in his definition, the violator is the powerholder, in the Litz et al. (2009) definition the violator is the self, but that both "*deteriorate character"* (Shay, 2014 p. 142). Shay considers his version of moral injury to be of additional importance because it can to some degree be controlled, unlike that of Litz and his colleagues, which is essentially based on events that occur by chance (Shay, 2012).

While moral injury is generally thought to be different from PTSD, because both can present together this is thought to present a challenge in differentiating between the conditions (Stein et al., 2012). Bryan et al., (2017) suggested two profiles: exaggerated startle reflex, flashbacks, nightmares, insomnia and memory loss associated with PTSD, and guilt or shame, anger, anhedonia, and social alienation associated with moral injury. Litz and Kerig (2019) suggest that moral injury could yet be appropriately subsumed under the rubric of PTSD if changes were made to the criteria for the diagnosis.

Moral injury has been found to be associated with increased risk of suicide (Bryan et al., 2013; Bryan et al., 2017), and in its betrayal form to be associated with anger (Bryan et al., 2017). Studies by Jordan et al. (2017) and Litz et al. (2018) found an association of betrayal based incidents with an anger response and perpetration based events with a shame and guilt response. In a qualitative survey of veterans Schorr et al. (2018) found the betrayal

type of moral injury was mentioned more often than all the other categories combined. "*For these veterans, the fact that they were not only disrespected, but actually despised by the very people they risked their lives for, represented the ultimate betrayal and conflicted with their sense of right and wrong."* (Schorr et al., 2018, p. 2214). A connection between moral injury and hazardous alcohol use was found by Battles et al. (2018, 2019) and between moral injury and substance misuse by Frankfurt and Frazier (2016), Jinkerson (2016) and Teeters et al. (2017).

In their recent review of the extant empirical literature associated with moral injury, Griffin et al. (2019) described limitations to current knowledge including variable definitions of morally injurious events, the lack of a consensus definition of the concept and the almost complete absence of its application in anything other than a military-related context. They identified only two studies Komarovskaya et al. (2011) and Papazoglou and Chopko (2017) which investigated moral injury in police. They also emphasized that the current lack of an accepted definition for moral injury was identified as presenting a problem when it requires clinical intervention, because of the absence of diagnostic criteria affecting its eligibility for compensation.

Whether moral injury should be considered a psychiatric disorder is not yet established, since it does not fit into current models for classifying psychiatric disorders (Griffin et al., 2019). Farnsworth et al. (2017) believe it should not be pathologized by being considered a psychiatric disorder. Farnsworth (2019) suggests moral injury could be differentiated from PTSD by their associated cognitions, proposing that moral injury is prescriptive in that it describes *"what ought to be"*, while PTSD is descriptive in describing *"what is".* In both cases it is proposed by his author that the psychological trauma results from the adoption of exaggerated appraisals of the traumatic event. Nash (2019) emphatically disagrees with the idea that the psychological trauma results from exaggerated appraisals,

saying this excludes the effect of exposure to psychologically injurious events on phylogenetically old brain functions operating below the level of the cerebral cortex. Nash (2019) proposes that certain stressors can be of such magnitude that they cannot be managed and will result in physical tissue damage from "allostatic load", as described by McEwen (2013), or as irreversible injury to intrapsychic structures, such as one's concept of the self or the world. Recent advances in knowledge of neurobiological changes in PTSD (Lanius, Frewen, et al., 2015) and with changes in the sense of self (Lanius, Terpou, et al., 2020) provide some support for this view.

A similar position is taken by Shay (2014), who argues that betrayal by a trusted leader is coded by the body as a physical attack and causes it to prepare itself to counter-attack. Jinkerson (2016) reviewed phenomenological descriptions, aetiology and effects of moral injury and suggested a *"moral injury syndrome"* that identified the primary core symptoms and emotional states as *"shame, guilt, spiritual/existential conflict and loss of trust"*, and secondary symptoms of *"depression, anxiety, anger, re-experiencing, self-harm and social problems"* (Jinkerson, 2016, p. 1). These secondary symptoms bear a strong resemblance to the shame avoidant mechanisms of aggression, depression, isolation, and addiction that were described in Chapter 1, and will be further discussed later in this chapter.

The identification of shame as a central component of moral injury has focussed considerable attention on this previously neglected element in post-trauma psychological injury. Significantly, much of the moral injury literature refers to "shame/guilt", thus sidestepping the need to make a distinction between the two emotions. While shame (or shame/guilt) is frequently recognized as an outcome of moral injury, to date there has been little evidence as to how it might contribute to the other emotions, behaviours and co-morbidities identified in post-trauma disorders. However, Griffin et al. (2019) have recommended further investigation of the place shame and/or guilt might have in moral

injury because of how these emotions have been historically conceptualized as contributing to an array of avoidant and aggressive problems.

In summary, the history of the course of diagnosis of trauma-related psychological injury illustrates the twists and turns in the many ways in which it has been conceptualized, identified and treated in Western civilization in the last 150 or so years, and how this might have influenced how it is understood today. It illustrates how some knowledge has not progressed or has failed to be incorporated because it did not accord with the thinking of the time, as earlier suggested by Herman, (1992a), and how old beliefs have at times persisted. The present differences between the two major diagnostic systems and the peripheral status of moral injury presents a current problem for traumatologists worldwide, and arguably an even greater problem for those who have been diagnosed as having a trauma-related psychological injury. Diagnosis is important because it is related to the recognition that an injury has been sustained, to eligibility for compensation and to the provision of treatment (Hoge et al., 2016). It can also be important in management. If psychological injury is recognized early, changes in location and occupationally related duties might serve to prevent its progression (McFarlane et al., 2017). The way in which diagnosis of trauma-related psychological injury is conceptualized is, critically, also related to stigma. This includes both the self-perception of the person who suffers the injury, and how they might be regarded in their community (Soomro & Yanos, 2019).

Shame in PTSD

As discussed earlier, PTSD as it is diagnosed in DSM-5 is now accepted as being potentially associated with a variety of clinical presentations that were not initially part of the diagnostic criteria in earlier versions of DSM. In addition to fear and anxiety, these may include anger, substance abuse, guilt or shame, dissociative symptoms, or a combination of

any or all of these (Resick & Miller, 2009). DSM-5, the most recent publication of the DSM (American Psychiatric Association, 2013), states:

> *The clinical presentation of PTSD varies. In some individuals, fear based re-experiencing, emotional and behavioural symptoms may predominate. In others, anhedonic or dysphoric mood states and negative cognitions may be the most distressing. In some other individuals, arousal and reactive-externalizing symptoms are prominent, while in others, dissociative symptoms predominate. Finally, some individuals exhibit combinations of these symptom patterns (American Psychiatric Association,* 2013, P. 274).

While its presence in PTSD has been acknowledged for the first time in DSM-5 as *"a persistent negative emotional state e.g., fear, horror, anger, guilt, or shame"* (American Psychiatric Association, 2013, p. 272), guilt and shame have long been associated with PTSD in the existing literature in both primary and secondary forms as having a place in post-trauma psychological injury (Budden, 2009). It is likely, however, that the majority of these publications do not reflect the true prevalence and significance of shame in PTSD or in other trauma-related disorders. This is because the variety of theories associated with the nature of shame, how it is identified, and the absence of a consensus as to its definition, have inevitably compromised the validity of research associated with the place of shame in post-trauma psychological injury (Oktedalen, Hagtvet et al., 2014; Saraiya & Lopez-Castro, 2016; Tilghman-Osborne et al., 2010).

Primary or peri-traumatic shame

A meta-analysis of empirical research examining the effects of primary or peri-traumatic emotions occurring at the time of trauma found that the intensity of the emotions experienced in the peri-traumatic period, which included fear, helplessness, horror, guilt and shame, was among the strongest correlates of PTSD and predicted a higher level of post-

trauma symptoms (Ozer et al., 2003). Intrusions following a traumatic experience are thought to be memories of these peri-traumatic "hotspots" or moments of peak emotional distress and found to often contain cognitions and emotions related to psychological threat to the self that included abandonment, or shame related to self-blame (Brewin et al., 2010; Holmes et al., 2005). A study of outpatients receiving treatment for PTSD showed that re-experiencing of these emotions that had been felt at the time of the trauma were among the most distressing symptoms experienced by this group. (Holmes et al., 2005; Grey & Holmes, 2008).

Secondary trauma-related shame

Secondary emotions are based on appraisals following the trauma. It is well recognized in cognitive models of PTSD that negative appraisals made in the aftermath of exposure to trauma have a significant influence on subsequent psychological adjustment, and they are thought to be primary factors in the development and maintenance of PTSD and its comorbidities (Barton et al., 2013; Beck et al., 2015). These may include beliefs about the self, others, or about the world (Brown et al., 2019; Held et al., 2017; O'Donnell et al., 2007), and may include self-blame, guilt, and shame (Tran & Beck, 2019). Evidence from the longitudinal studies in a recent meta-analysis provides support for these cognitive models and the persistence of the associated mental states, showing that effects remained one year after the trauma (Gomez de La Cuesta et al., 2019).

Ehlers and Clark's (2000) early cognitive model of PTSD has been influential (Gomez de La Cuesta et al., 2019). This model proposes, firstly, that symptoms persist if individuals process the trauma in a way that results in a sense of ongoing threat. Secondly, that this threat might be the product of emotions other than fear and include shame and guilt, identified as being related to damaged self-concept (Ehlers & Clark, 2000). This might result from judgements of their actions *("I should have dealt with that situation differently"),* or their subsequent mental state *("I'm not the person I used to be").* Based on this theory, Lee et

al. (2001) and Harman and Lee (2010) proposed a clinical model of shame and guilt-based PTSD, suggesting that the effects of shame and guilt operate as a current threat in that they attack the person's psychological integrity, result in feelings of inferiority, social unattractiveness, and powerlessness, and contribute to later psychopathology and effect help-seeking (Andrews, 1995, 1998; Gilbert, 1997).

Feelings of unworthiness, failure to act in some way during combat, and shame they experienced because of their fear was found by Glover et al. (1990), to be present in a group of Vietnam veterans with PTSD. Investigating this further in Vietnam veterans, Wong and Cook (1992) considered shame and its related feelings of alienation and inferiority might also result from a break in social connection, initially described as a *"breaking of the interpersonal bridge"* by Kaufman (1989) and as resulting in:

> *...the depersonalization of others, failures to act in accordance with internalized concepts of duty and action, the ripping apart and transgressing of internalized values, the continual breaking of the bridge of comradeship via death and perhaps betrayal, the betrayal of the American people and the government felt by some veterans, and the breaking down of trust and its resulting feelings of paranoia and isolation - all examples of the breaking of connection.* (Wong & Cook, 1992, p. 557).

Viewing shame in PTSD within the framework of affect theory, Stone (1992), asserts that shame could be the outcome of the self's perceived inadequacy in coping with an altered self and/or world view after trauma, and by the lack of control over reactions associated with hypervigilance. Following Stone's concept of PTSD as a disturbance of affect systems, Budden (2009) relates this inability to cope with the effects of post-trauma symptoms to its impact on the social self and suggests that *"Posttraumatic shame functions in a number of ways: it activates defensive reflexes to social threats; it transforms acute subjugation and violations of norms into helplessness, loss of moral integrity, painful self-consciousness; and*

it severs continuity with cultural meaning, identity, and social roles." (Budden, 2009, p. 1036).

Cognitive and somatic disturbances in the sense of self were found to be associated with PTSD by Lanius et al. (2020), and related to changes in large-scale neural networks, as described earlier in this chapter. These changes in sense of self were expressed in thoughts that reflected persistent negative core beliefs which often contained elements of shame. These included *"I do not know myself anymore," "I have permanently changed for the worse"* and *"I will never be able to experience normal emotions again"* (p. 2)

Wilson et al. (2006) define trauma-related shame as arising from both acute and secondary appraisals of the damage to the social self. These include perceptions of the self as having diminished self-worth or moral integrity, and with feelings of powerlessness, inadequacy, and failure. They consider these feelings to result in depression; a variety of destructive defensive behaviours, including substance disorders; and an increased potential for suicide as a result of self-condemnation. In a study that investigated the association of shame and guilt in a survey of veterans with PTSD seeking care at an outpatient facility, Cunningham et al. (2018) found that shame, rather than guilt, fully accounted for suicidal ideation in the group. On the basis of this finding, they suggested that shame might provide a key link between PTSD and suicidal ideation in the veteran population. Similar significance for the centrality of shame in suicide ideation was found by Bryan, Ray-Sannerud et al. (2013), who found that shame interacting with hopelessness significantly increased suicidal ideation in a group of active-duty military personnel seeking treatment for PTSD.

In an early contribution from neurobiological research, monitoring of cortisol levels over 48 hours in a group of Vietnam Veterans found low levels of cortisol which they related to disengagement coping strategies and shame-laden depression (Mason et al., 2001). The authors concluded that the relatively inconspicuous clinical feature of shame from both

primary and secondary traumatization was worthy of greater attention in understanding the pathogenesis and pathology of PTSD. I had the opportunity to ask co-author Professor Rachel Yehuda, when she was a keynote speaker at a conference in Melbourne in 2016, why research associating this aspect of shame with PTSD had not progressed beyond this study. She replied: *"I suppose there wasn't much interest in shame back then".* This lack of interest may in part explain why much of the significant discussion and research in the early part of this century on the place of shame in PTSD appears to have lacked prominence, or progressed further, when arguably it reflected many of the issues that later re-surfaced as moral injury (Kinghorn, 2020).

Shame: A Transdisciplinary View

> *"What an awfully complex subject [shame] is. I suppose that no two persons would ever quite agree, and I expect hardly anyone will agree with me. But as yet I nail my colours to the mast."*
>
> Darwin (1998/1871, p. 54).

Herman (1992a) proposed that the diagnosis of post-trauma disorders provokes such intense controversy that ultimately lack of consensus causes fragmentation of potentially valuable knowledge that then does not build on what has gone before. Arguably, shame has suffered a similar fate. When it has been discussed in Western literature, the presence and effects of shame have long been controversial. The disputes surrounding shame in individualistic, Western societies date from at least the 19th century when they were described by Charles Darwin (1965/1872). Darwin had made the proposal, contentious at the time, that the display of emotions, including shame, in man was similar to that of non-verbal creatures, and that it remained consistent throughout life. Also in the 19th century, Nietzsche believed shame regulated social relations in a fundamental and beneficial way but could also

be harmful and dangerous if directed towards the self or used to shame others (von Fossen, 2019).

Initially influenced by Nietzsche (Lansky, 1994), Freud's early writings in psychoanalysis conceptualized shame as an "incompatible idea" that would cause distress, self-reproach, and psychic pain. He asserted that defence mechanisms were therefore employed to avoid anticipated shame from becoming conscious. He also, paradoxically, considered shame itself to be employed in a defensive way, used as a type of modest behaviour that prevents the self as being seen as *"shameless".* Much of Freud's early work took place in Paris, and his concept of shame as a defensive operation becomes comprehensible when it is understood that there are two words in French for shame: *"honte",* referring to the emotion itself, and *"pudeur"* referring to a behaviour similar to modesty or restraint. English lacks that subtlety, so in this language one can experience shame (undesirable) but also be "shameless" – which is generally thought to be equally undesirable. After 1905 when Freud turned to the investigation of unconscious fantasy, shame was replaced with drive, which had its origins in sexuality, as the object of defence. Lansky (1994) argues however that in the later writings of Freud, shame was still present but was called by different names; for example, *"signal anxiety"* referred to a threat to one's social standing, *"castration"* to social humiliation, and *"separation anxiety"* to the threat of rejection or alienation.

Shame emerged in later psychoanalytic theory as relating to the ego-ideal (Lansky, 1994). Piers and Singer (1971) regard shame as a tension between the ego and the ego-ideal and guilt a product of the super-ego. Lansky (2005) believes that shame is associated with vulnerability and fear of rejection and is not acknowledged because of the fear that this would generate more shame. He proposes guilt however as being generally regarded as *"action and*

power-oriented", and therefore that it may be used as a defence against shame and act to obscure it (Lansky 2005, p. 53).

Pivotal empirical research by psychologist and psychoanalyst Helen Block Lewis identified the presence of unacknowledged shame, which she described as the *"sleeper"* in psychopathology because its presence was so often disguised or obscured (Lewis, 1987). She conducted a systematic study of one hundred and fifty recorded therapy sessions (Lewis, 1971) using the Gottschalk, Winget and Gleser (1969) scale. On the basis of this study, she reported finding words occurring in the context of shame to be far more frequent than those associated with any other emotional state, but unlike those other states, they were not commented upon by therapist or client. She found stimulus situations that evoked a shame response included disappointment, defeat, rejection or fear of rejection, betrayal, judgemental comparison, loss of face, exposure, rebuff, inattentiveness, unrequited love, failure, disrespect, and ridicule. She proposed two methods whereby shame goes unacknowledged; overt, "undifferentiated" shame when the person is clearly distressed, but does not identify the emotion as shame, and "bypassed shame", which occurs when little or no emotion is felt in response to the shame event. Lewis (1976) also described *"feeling traps",* which she described as self-amplifying states that occur when the person feels ashamed of being ashamed, enraged at being ashamed, then ashamed at being enraged. She described the physical and affective or feeling reaction to shame as follows:

> *The body gestures and attitudes include head bowed, eyes closed, body curved in on itself, making the person as small as possible. At the same time that it seeks to disappear, the self may be dealing with an excess of autonomic stimulation, blushing, or sweating or diffuse rage, experienced as a "flood" of sensations. Shame is thus regarded by adults as a primitive reaction, in which body functions have gone out of control. One is often ashamed of being ashamed. (Lewis, 1976. p.427-428).*

Lewis (1976) defined the difference between shame and guilt as "*shame being evoked by a lapse from the ego ideal, and the punishment is loss of love in one's own or the other's eyes. Guilt occurs when there is a transgression, and the punishment is fear of danger"* Lewis, 1976, p. 179). She also noted however, that: *"When shame and guilt are both evoked in the context of a moral transgression, the two states tend to fuse with each other, and to be labelled guilt"* (Lewis, 1976, p. 187).

This definition by Lewis (1976) of shame as about a lapse from the ego-ideal and guilt about a transgression was important because it was adopted by later theorists who used it to create measures they claimed would differentiate between guilt and shame. These measures were then widely used by the next generation of researchers (Blum, 2008). Foremost amongst these was the Test of Self Conscious Affect (TOSCA) (Tangney et al., 1989), which uses scenario based questions to assess trait or dispositional shame, and the State Shame and Guilt Scale (SSGS) (Marschall et al., 1994), which uses brief phenomenological descriptions of shame and guilt to define the propensity for shame-proneness over a variety of situations. Shame was envisaged by these and other contemporary theorists as a destructive emotion with little or no adaptive value and guilt as the adaptive and mature emotion (Tangney & Dearing, 2002; Tracy et al., 2007; Marschall et al, 1994). These authors moderated their position and briefly mentioned in later works that guilt might become maladaptive when fused with shame (Tangney et al., 2007) and that shame might have some constructive potential (Tangney et al., 2014). Conversely, it could be argued that the presence of guilt *without* shame is undesirable and suggests a certain lack of conscience.

The idea expressed by Lewis (1971) that shame may fuse with guilt and be labelled "guilt" did not however, form part of the popularly used measures, meaning that any response defined as guilt became "not-shame" and failed to be recognized. In much of the existing relevant research, the measures used are based on this assumption that shame and guilt are

separate constructs (Oktedalen, Hoffart et al., 2014; Oktedalen, Hagtvet et al., 2014) This implies that if guilt is identified it is assumed that shame is not present.

Other authors who also based their work on that of Lewis took a different view of shame. Sociologists Scheff and Retzinger described shame as ubiquitous but unrecognized in individualistic Western society, and as operating as the "*master emotion of everyday life"*- a signal that some aspect of a relationship is needing attention and that rejection is a possible outcome (Scheff & Retzinger, 2000). In an analysis of therapy sessions, Retzinger (1995) identified multiple verbal and non-verbal cues that indicated the presence of shame. These included feeling ridiculous, foolish, silly, idiotic, stupid, dumb, humiliated, disrespected, helpless, weak, inept, dependent, small, inferior, unworthy, worthless, trivial, shy, vulnerable, uncomfortable, or embarrassed. Non-verbal cues include hiding behaviour, such as covering all or parts of the face, gaze aversion, with eyes downcast or averted, hanging head, hunching shoulders, squirming, fidgeting, blushing, biting or licking the lips, biting the tongue, or false smiling. She believed that shame can most easily be detected in the defences used against it, in which she included "denial or any form of hiding behaviour: repression, negation of the other, anger and violence" (Retzinger, 1995, p. 1106). She believed that shared laughter following an acknowledgement of shame was the most effective means of making reparation (Retzinger, 1987).

Judith Herman, daughter of Helen Block Lewis and influential author in the field of trauma (Herman, 1992a, 1992b, 2011, 2012), also understood shame to be one of the primary regulators of social relations and considers it a *"fast-track physiologic response"* that can overwhelm higher cortical functions (Herman, 2012, p. 160). She proposed that mild experiences of shame are part of everyday life, and that socially acceptable behaviour is learnt through the ordinary experiences of shame.

The view that shame can serve an adaptive function was expressed by ethologists Keltner and Harker, (1998) who compared the appeasement behaviour of social animals to the observed human response seen in shame and suggested it served a similar social function. Psychoanalyst and ethologist Bowlby (1982), and psychologist and therapist Kaufman (1989), also believed shame had an adaptive function with its origins based on the child's early need to maintain an attachment relationship with the carer. A show of shame (averted gaze and hanging head) could be seen as a preverbal way of indicating a desire for reparation. Psychologist and developmentalist Schore (2003) proposed that the young child learned that a shame response elicited a repair in the attachment bond that had been threatened by the carer's disapproval and considers it to have the function of dampening excited emotional states. Clinical psychologist Paul Gilbert (Gilbert, 1989, 1992, 1998a, 1998b, 2000; Gilbert et al., 2007) and psychologists and anthropologists Sznycer et al. (2016) relate shame to social status and believe that shame serves to modify behaviour. They describe it as: an adaptive defence that evolved in situations of dominance and subordination, that it stems from feelings of being devalued by others, and that it has cross-cultural application.

A further group, known as the affect theorists, described the phenomenology of shame. Tomkins (1962) identified nine distinct and separate primary affects, which included shame, in terms of their facial presentation, and the experience of their bodily components, including visceral sensations. The organization of components of each of the affects Tomkins referred to as the innate "script" and described the affect as acting as an "amplifier" for the script. Izard (1971, 1977) who studied facial expression as reflection of emotion, also asserted that the components of emotion are an organized system but are capable of being regulated. Their universality of the affects and the manner of their expression was identified in cross cultural studies by Ekman and Friesen (1971), echoing the earlier observations of

Darwin, and supported in the findings of a more recent major study into potential cultural variations in shame (Sznycer et al., 2018).

A central tenet of affect theory is the idea that an affective reaction is not necessarily conscious and may be all the more influential because of this. As psychoanalyst Basch (1976) describes it, feelings occur following an awareness of affects, and emotions are the result of feelings combining with person's cognitive awareness of them and their place in autobiographical memory. As mentioned earlier, recent advances in neurobiology (Lanius et al., 2017) have provided us with a putative model for the theoretical proposal of Basch (1976) and the affect theorists, as it relates to a perceived threat being registered subconsciously before it gains conscious recognition.

Gilbert (2004) suggests shame is best regarded as a product of the limbic system from birth onwards which is mediated by cognitive factors during development and influenced in an ongoing process by socialization and level of maturation. It would arguably then have the potential to evoke a variety of responses, unique to the individual's history and personality, and be likely to incorporate elements of guilt, fear and anger, amongst other emotions.

While the phenomenology of shame might be manifest in a similar way across cultures, it is regarded very differently. In contrast to collectivist societies, modern Western societies are built based on individualism. Persons learn to regard themselves as if they function as independent entities, rather than as having reciprocal obligations to the group; this results in alienation and the hiding of shame since it does not serve any positive function, and results in further shaming should it become apparent to others (Scheff, 2004). In unwesternised parts of Asia, Africa, and South and Central America, and in collectivist cultures generally, a display of shame is usually considered positive, and thought to perform an adaptive function in regulating social behaviour (Sheikh, 2014).

Kaufman (1989) also describes shame as hidden in Western cultures; he argues that because there is "*shame about shame"* it often remains taboo, and unspoken, as if it did not exist. He considered shame to play a central role in low self-esteem, to produce self-doubt and disrupt security and confidence, and to underly much psychopathology including depression, addiction and eating disorders. He believed the self to be shaped by three interactive processes; affect, imagery and language, and shame to be central to identity formation by "binding" to previous events and subsequently re-experienced when these events recur, in the manner of classical conditioning (Pavlov, 1927). He argues that shame might exist not just at an individual level but could also affect ethnic or minority groups within a dominant culture, or even an entire nation (Kaufman, 1989).

Gilbert (2001) proposes that shame may be internal or external in origin or may be a mixture of both (see also Cook, 1988). Internal shame relates to the subjective sense of self – how the self makes a judgement of the self as measuring up to the ego-ideal. External shaming relates to the way one believes one is perceived in the eyes of others; our internal perception of the other's perception. This is an important distinction because it implies that we might believe that allowing others to know that one is experiencing internal shame might put one at risk of experiencing external shaming unless it is our perception of the other that they can be trusted to understand and not condemn or judge. This is explained in Cooley's (1902), theory of the "looking glass self" which suggests we may often operate socially in a way that is based on our need to avoid the disapproval of others. In order to achieve this, we imagine how we appear to others in a social situation, we imagine what we believe they might think of us if they knew the truth about how we feel, and we conceal this if we believe their reaction will be negative.

Dickerson, Gruenwalde et al. (2004), Dickerson, Kemeny et al. (2004), and Dickerson, Gable et al. (2009) found that threats to the social self, of which shame was a key

component, were related to an increase in inflammatory markers and cortisol and may also affect the inhibitory mechanisms connected with these. While these authors consider this response to be potentially adaptive in short-term situations, they propose that prolonged or repeated exposure to shaming could result in adverse physical health outcomes through multiple pathways. They suggest that the shame family of emotions is vastly understudied in psychobiological research. Dolezal and Lyons (2017) suggest shame might be the "elephant in the room" in health care and that it could influence health outcomes through acute shame avoidance, chronic shame health related behaviours, threat to stigma and social status, and biological mechanisms.

Janoff-Bulman (1992) proposes that we develop an internal conceptual system, a set of assumptions, developed over time and generally positive, that provides us with expectations about ourselves and about the nature of the world. If subsequent experiences shatter an individual's expectations and cause them to believe that they, or the world, are not as they had thought, the effects can be profound. If the individual does not live up to his or her valued self-image, they may experience shame and a crisis of identity. If they perceive the world as malevolent rather than benevolent, powerlessness and depression may ensue. Janoff-Bulman suggests that a person may then also become stigmatized and alienated, and therefore shamed, because others avoid them, fearing their own expectations might be violated by contact with them.

Shame Avoidant and Coping Mechanisms

There has been recognition in the literature that shame avoidant behaviours might operate as a defence mechanism against the distress associated with feelings of shame, at both unconscious and conscious levels. Nathanson (1987, 1992), following Tomkins' (1962) idea of script theory, proposed four scripts or coping mechanisms whereby individuals defend against the painful experience of shame, each containing a combination of different

cognitions, emotions, motivations and behaviours. The schematic representation of these he described as the *"Compass of Shame"* (Nathanson, 1992). Using the language of participants in a qualitative study (Webb, 2003, 2010) reframed the avoidance and withdrawal poles of Nathanson's model as "hide from self" and "hide from other". The four poles could be then seen to correspond with "attack other" or aggression; "attack self" potentially leading to depression, self-harm or suicide; "hide from other" leading to self-isolation and alienation; and "hide from self" potentially leading to any of a range of addictions, (see Fig 1). Webb (2010) also added the "masking" emotions of fear, anger, disgust and distress as the affects most likely to be manifest by the individual at the time.



Fig 1 Compass of shame avoidant behaviours and masking emotions (Webb, 2010)

Because these shame avoidant mechanisms are considered to correspond with both shame defences and shame coping, they are thought to potentially incorporate various levels of awareness and do not imply that the underlying shame is necessarily unconscious. All the potential shame defences or coping mechanisms described above have been identified as being frequently associated with PTSD. Anger and aggression are frequently described

concomitants of PTSD (Forbes et al., 2014). The connection with depression is conceptualized as self-condemnation potentially leading to depression, self-harm, or suicide *("I am a bad person"),* and also as the symptom of the loss of self-worth *("I am worthless"),* both carrying an association with shame (Elison, Lennon et al., 2006; Elison Poulos et al., 2006). Isolation – avoidance of social contact - is frequently described in PTSD (McIlveen et al., 2019) and thought to be often related to shame associated with unwanted changes in the self that are associated with the symptoms of the disorder (Wilson et al., 2006; Budden, 2009). Addictions related to drugs and alcohol are also frequently associated with PTSD (Battles et al., 2018). There is evidence that these shame avoidant mechanisms may also potentially be associated with moral injury, but to date there is insufficient empirical evidence to support this proposition (Griffin et al., 2019).

Empirical evidence for the Compass of Shame patterns of shame avoidance was provided using a measure, the Compass of Shame Scale (COSS) developed by Elison, Lennon et al., (2006) and Elison, Poulos et al., (2006), which demonstrated diagrammatically an individual's shame avoidant styles in terms of their deviance around the central point of shame. Shame avoidant styles were described as an individual's preferred, but not necessarily only method of coping with or defending against shame (Elison, Poulos et al., 2006). An adaption of the COSS for military purposes, the M-COSS, was developed by Campbell (2016).

As mentioned earlier, cross cultural research suggests the application of this type of construct should be confined to Western, individualistic societies; in collectivist cultures where shame is valued it is thought to evoke different reactions (see Kirschner, 2017; Lewandowska-Tomaszczyk & Wilson, 2017; Liddell & Jobson, 2016; Sheikh, 2014).

Shame and post-trauma disorders

Lansky (2003) identifies an altered ego state in PTSD that is fragile and at risk of fragmentation, arising from the traumatic event or events. This state in turn gives rise to an awareness of not being able to meet one's standards of self-worth, competence and social connectedness. Failing to meet these standards gives rise to shame and shame defences that ward off awareness of shame, leading to an exacerbation of symptoms. These may include anger, impulsive self-destructive behaviours, withdrawal, and the development of co-morbidities such as depression and anxiety (Lansky, 2003). These underlying shame dynamics might often be difficult to detect, since they might present not as an overt affect or emotion, but rather as the defensive operation that has been mounted to avoid awareness or display of shame (Lansky, 2003; Retzinger, 1995). Since defence mechanisms are generally considered to operate at an unconscious level this also means there might be little or no awareness of the underlying shame (Lansky, 1994). Shame operating at this unconscious level was described as being *"bypassed"* by Lewis (1971).

In a recent meta-analysis of the place of shame in PTSD, shame is described as frequently present in many individuals with PTSD, and it is proposed that its presence warrants a better understanding of the central role it might play in the disorder (Lopez-Castro et al., 2019). Some studies in the review indicate that the distress triggered by shame might trigger pathological avoidance or coping mechanisms expressed through engagement in maladaptive behaviours. However, the meta-analysis included only research articles with a measure of self-reported shame and is therefore based on two assumptions: firstly, that the individual will recognize that they are experiencing shame, and the secondly, that he or she will acknowledge its presence. Both these assumptions are thought to be questionable (Eterović, 2020; Lanius et al., 2017). Because the review describes shame as *"a self-conscious emotion that requires frontal-cortex cognitive processing"* (Lopez-Castro et al.,

2019, p. 484), this implies that the participant recognizes its presence. It therefore fails to include presence of undifferentiated or bypassed shame as described by Lewis (1971) and Lansky (2003), that exists in a largely unconscious form, has therefore not received cortical recognition and processing, and may be associated with the subsequent development of maladaptive shame defensive mechanisms. Finally, because it excluded all studies where shame was not measured as a separate construct from guilt, those where shame might merge with guilt were also not included. Most of the measures used in the current empirical literature are unfortunately predicated on this premise that shame is different from guilt; if guilt is present, it is assumed shame is not (Bannister et al., 2019; Pugh et al., 2015). I propose that this assumption is not only questionable; it is likely to result in much of the shame failing to be identified. This differentiation of shame from guilt – the identification of guilt as "not shame" - has undoubtedly served to prevent the identification of shame in much of the existing research.

There has been some recent research that has begun to recognize the important conceptual difference between shame and guilt and that shame may merge with guilt and be unidentified, as first proposed by Lewis (1971). A systematic review of studies which sought to identify the role of guilt in PTSD, Pugh et al. (2015), concluded *"...the direction of association between guilt and PTSD is unclear and possibly confounded by overlapping constructs such as shame."* (p.138). Tilghman-Osborne et al. (2010), in a review of definitions and measures of guilt, proposed that lack of conceptual clarity created measurement issues that should be considered a great concern to researchers. These authors concluded that guilt is a complex construct with both affective and cognitive components at its core. Bannister et al. (2019) found shame and guilt to be both related to severity of PTSD, but that shame added additional variance not accounted for by guilt. These authors concluded

that their results indicated guilt is possibly always fused with shame, as originally proposed by Lewis (1976).

In summary, there remains little apparent understanding in the literature that shame might fail to be acknowledged in self-report measures because of *"shame about shame",* as suggested by Eterović, (2020). There is no acknowledgement that it might exist as an affect that has not received recognition at a cortical level, or that the vulnerability associated with post-trauma psychological injury might magnify the extent to which shame might damage self-esteem (Lansky, 2000). These are all arguably ways in which shame might be implicated in contributing in a cumulative way to post-trauma psychological injury. As described by Retzinger (1987), shame is involved in a number of common cognitive evaluations of the self, such as feeling foolish, disrespected, inept, shy, uncomfortable, or embarrassed. As part of ordinary everyday experience, shame can remain largely innocuous, or cause transitory distress. However, in a person rendered vulnerable by the symptoms of a trauma-related psychological injury, it is possible that the effects of shame might operate in an erosive manner, resulting in a fragile and progressively deteriorating mental state, as described by Lansky (2000).

The complexity of shame and shame defences as it has been described here in the transdisciplinary literature highlights how the effects of shame might frequently be undetected in much of the recent empirical research in post-trauma psychological injury. It suggests that a more comprehensive recognition of the effects of shame and shame avoidance might result in a more successful approach to the mitigation of these effects and contribute to how we might best diagnose, manage, and treat trauma-related injury.

The Gaps in Knowledge

This review of the literature associated with post-trauma disorders has identified

multiple gaps in the knowledge as to how we might better identify, manage and treat these disorders and prevent or mitigate their development.

Current systems of diagnosis are fragmented and fail to incorporate important manifestations of trauma-related injury. Because we cannot systematically and accurately diagnose these injuries, we cannot put in place early management and treatment options that might prevent their progression. Current recommended treatment options have a high failure rate and are considered by many clinicians to be inappropriate for the symptoms they purport to treat. Finally, because the importance of the element of shame and associated shame avoidance in the symptoms or disorders associated with trauma is often unrecognized, it becomes difficult to make the changes necessary to address their often destructive influence.

Summary

This chapter has examined the diverse ways in which trauma-related psychological injury is currently conceptualized and diagnosed, and how these have been potentially influenced by social and political forces since the late nineteenth century. The present state of our knowledge of the symptoms of post-trauma disorders and their neurobiological basis was described. The current dominant diagnostic systems of DSM-5 and ICD-11 were discussed and alternative proposals for diagnosis were outlined, together with the evolving concept of moral injury. The suitability of the present options for treatment were examined. Finally, it was proposed that the element of shame as it has been broadly described in the transdisciplinary literature might be shown to have a previously unrecognized influence on the course of trauma-related psychological injury and serve to provide a unifying link between its different manifestations.

This chapter has outlined the gaps in knowledge and the inadequacies in our present systems of diagnosis, management and treatment, and the prevention or mitigation of trauma-related injury. The next chapter outlines how this research begins to address these problems

by examining the processes in the individual whereby post-trauma psychological injury occurs and develops, or conversely, the factors that might be associated with the development of resilience.

Chapter 3: Methodology

As indicated earlier, amongst emergency workers, including ambulance officers and firefighters, police have been identified as being particularly at risk of trauma-related psychological injury as a result of their occupation (Wagner et al., 2020). Throughout the course of their policing service police are exposed to ongoing, regularly occurring, potentially traumatic incidents and to other occupationally related potential sources of stress, including shift work and a variety of operational and organizational difficulties (Hall et al., 2010; Tuckey et al., 2012).

In their service careers which, generally begin in uniform “on the road”, police officers are regularly called to incidents such as severe motor vehicle accidents, domestic and other types of violence, and sudden deaths (Faulkner et al., 2020). Coping with this level of repeated exposure to death and disaster would be almost unimaginable for most ordinary members of the community, but it is what we expect of our police. The cumulative effects of these exposures is thought to have cost many police officers their psychological health and wellbeing (Papazoglou, 2013).

It has been recognized that members of the military and emergency workers are particularly susceptible to psychological injury from cumulative exposure to potentially traumatic events (Levi-Gigi et al, 2014), and that the effects of cumulative exposure differ from those of a single traumatic incident (McFarlane, 2010a). As indicated in the previous chapter, there remains some controversy about cumulative trauma, including the nature of the events that might progressively further impact on the individual and their potential interaction (McNally, 2012). There are also questions as to whether the existing systems employed to diagnose and subsequently inform management and treatment of psychological injury can adequately encompass and represent its heterogeneity (Lehrner & Yehuda, 2020).

In this research study, I explore those questions through analysis of the narratives of the participants, fourteen long-serving retired police officers from South Australia and Victoria. While both serving and retired police were initially considered for the study to maximize the information to be gained in the interviews, for pragmatic reasons the only participants included were those who had been discharged from police service. An application was made to the Police Department in South Australia for ethics approval, a requirement for the approval of the ethics application from the Human Research Ethics Committee (HREC) of the University of South Australia. This application to the Police Department was rejected. The only reason given was that the Department conducted its own research. While it would have been informative to have data from both active-duty serving police and from those on leave as a result of psychological injury, who had not yet been discharged, the ethics requirements precluded this possibility.

The analysis examines sequentially the events the participants described experiencing during their policing career and afterwards, how they reacted to these events, and what followed for them after this. In doing this, it reframes the information to reflect its sequential nature and its complexities, and to incorporate the influence of the previously poorly recognized element of shame and its potential influence.

Research Aim

The aim of this research was to examine how long-serving police might perceive and respond to their cumulative exposure to potentially stressful events.

Research Questions

- How do former police officers make meaning of their exposure to potentially traumatic events that occurred during their police service?
- If they developed trauma-related symptoms, how were they impacted by these?
- How were self-concept and interpersonal relationships subsequently affected?

- Is shame associated with the meanings police officers place on their experience?
- What identifiable shame management mechanisms appear to manifest as patterns of behaviour, thinking or feeling?
- Is the presence of shame and shame management mechanisms associated with the severity of symptoms and the development of co-morbidities?

Social Context of the Research

This research seeks to provide information that might guide improved treatment and management for police who have suffered psychological injury in their service to the community. In a comprehensive review of the mental health of Victorian police that spoke directly to those affected (Cotton et al., 2016), serving and retired Australian police officers were reported as having needs that they believed were poorly recognized and ill-supported. My research aimed to investigate and describe the needs of police who had sustained psychological injury, the areas where further support is needed and how we might prevent or ameliorate psychological injury for this group in the future.

Deficiencies in the areas of appropriate support and compensation are considered to be in part associated with State Governments' legislation to limit their liability to emergency service personnel (McFarlane & Bryant, 2017). It has been argued that many of those Australian police who were injured ensuring the safety of the public were, and continue to be, rendered unsafe themselves by the lack of appropriate care. McFarlane et al. (2009) consider that the support services available to police after discharge are inadequate and should be specifically aligned to the optimal treatment of the effects of exposure to trauma that are unique to this group.

Research Methodology

The use of a phenomenological approach

The focus of this research, as discussed in Chapter 1, was to examine how a group of long-serving retired police officers make meaning of their cumulative exposure to potentially stressful events, the nature of the events that might contribute to psychological injury in this group, and any role that shame and shame avoidant mechanisms might play in this process.

Since the research aimed to investigate: the meaning individuals attributed to events in their lived experience in its social and cultural context, how the effects of these events might interact in complex ways, and whether this meaning contained elements of shame, phenomenology was selected the most appropriate methodological framework to use in the research design. (Starks and Trinidad, 2007). Originating in the thinking of Husserl in the early 20th century (Husserl, 1970), phenomenology studies how objects appear in consciousness. By consciousness Husserl meant not only awareness, but also preconscious and unconscious processes (Giorgi, 2012). However, a limitation of mainstream phenomenology (Ashworth, 2008) is its emphasis on description, at the expense of analysis or interpretation. It fails to investigate how the individual makes meaning of his or her experience - although this is a point of contention between different writers in the field; (see Giorgi, 2017).

Interpretative Phenomenological Analysis (Smith et al., 2009) was chosen as the most appropriate methodological approach because it incorporates interpretation in its design. Based on phenomenology, hermeneutics and idiography (Smith, 2011), Interpretative Phenomenological Analysis has two primary aims: to look in detail at how someone makes sense of life experience, and to then give detailed interpretation of their account to understand the experience. Because it investigates how the participant experiences events,

how they make meaning of this experience, and then enables the researcher to attempt to make sense of the participant making sense of their world, Interpretative Phenomenological Analysis in effect creates a double hermeneutic (Smith et al., 2009). The researcher's "making sense" of the transcript – the interpretation – is defined by Smith (in conversation with Willig [Willig, 2012]) as not tied to any theoretical approach but he acknowledges that it could be adapted to do this.

First used primarily in health psychology, Interpretative Phenomenological Analysis' field of use has recently expanded (Smith, 2017). Generally based on the semi- constructed intensive interview, it begins with a specific individual analysis of each individual in the form of a case study. The methodology then allows for a relatively small number of interviews within a selected homogeneous population to be examined for themes common to some or all the participants – or, conversely, "outlier" data that does not seem to be shared. In doing this it provides the potential to identify common factors across the total body of data, and in some circumstances generalize what this might mean for the group and perhaps also for the larger population from which it had been drawn (Smith et al, 2009).

While it is based on phenomenology, Interpretative Phenomenological Analysis is described by its authors as having a broadly realist ontology, in that it is structured to produce an interpretative analysis which is tied closely to the account coming from the participant (Smith, 2017). It contrasts with other qualitative approaches that often conform to the postmodernist position which maintains that "objective reality" does not exist; that all reality is a construction and that multiple constructions exist, as conceptualized by Derrida (see Dooley & Kavanagh, 2014) and others.

In applying Interpretative Phenomenological Analysis to my study, I have blended both a realist and an interpretative approach. My approach is realist in that it presupposes an objective reality i.e., the ontological independence of the participants' memory of their

experiences and the way in which they attribute meaning to them. However, the approach is also interpretative in the sense that it acknowledges that I as researcher make further meaning of the participants' narratives. This interpretation is necessarily subjective in nature and is guided by my selection of the themes that are contained in the research questions and by my theoretical orientation. This blend of a realist and interpretative approach to analysis of the data is consistent with Interpretative Phenomenological Analysis (Reid et al., 2005).

While it was unavoidable that I, as researcher, brought clinical knowledge and a theoretical orientation to the interviews I conducted, I remained aware that I needed to exercise reflexivity to maintain an inductive approach. This type of approach is described by Willig (2012) as a *"balance between reflexivity and subjectivity"* and refers to the relationship between the perspectives described by the participant and the researcher's standpoint or perspective (p.156). Willig (2012) differentiates between a " suspicious" and an "empathic" approach, and anything on the continuum in between. "Suspicious" interpretation tends to be theory driven and aims to bring out the latent meaning contained within the data and assumes the participant may not be aware of this meaning. "Empathic" interpretation, on the other hand, aims to understand the meaning that the data has for the individual. It makes connections between different features and notices relationships between them. As it is defined by Willig (2012), empathic interpretation does more than just describe what the participant says. It seeks to help the participant to understand their experience more fully – the meaning *they* place on it. Coming from the way in which I conducted my therapeutic practice, my orientation fell squarely into the empathic category. My approach required that I reflect back to the participants the meaning I thought they had placed on their experience, if this was unclear to me, and correct my understanding if it did not accord with theirs.

Smith et al. (2009), the group of authors who developed Interpretative Phenomenological Analysis, make a point of emphasizing that while "making meaning" may

be construed as a cognitive activity, Interpretative Phenomenological Analysis is concerned with all levels of experience, not just those that pertain to reflection, but also pre-reflective activity – "what we are aware of without being aware of it". They describe four distinct layers of reflection:

- *Pre-reflective reflexivity* – the minimal level of awareness.
- *The reflective "glancing at" a pre-reflective experience* – how a physical sensation might remind us briefly of a past experience.
- *Attentive reflection on the pre-reflective* – how we might focus on what has accidentally come to mind, find it significant, and how it might then promote further reflection.
- *Deliberate controlled reflection* – for example deliberately recalling a past event and examining it further (Smith et al, 2009, p.188).

When applied to the perception of affect, feelings and emotions as these were described in Chapter 2, these levels of reflection described above by Smith et al. (2009) parallel quite closely the descriptions by Tomkins (1962), Basch (1976) and others, of the different levels at which an input might be registered. *Pre-reflective reflexivity* corresponds with an affect which is registered by the body but does not necessarily become conscious (Tomkins, 1962). At this level the meaning that might be made of the input is that it might constitute a threat. This is the level at which a stressor can be registered at an unconscious level and potentially contribute to cumulative stress, as described by Lanius et al. (2017). *The reflective "glancing at" a pre-reflective experience* occurs when the perception reaches the cerebral cortex and attention diverts to the input. As a function of its relationship with past experience, the meaning made of it is that it is assessed as either requiring or not requiring further attention (Brewin et al., 2010). *Attentive reflection on the pre-reflective* might be seen to corresponds with the effect of awareness of the affect acting as an "amplifier" as described

by Tomkins (1962) – resulting in meaning being made of the input that identifies it as significant and requiring focused attention. Finally, the *Deliberate controlled reflection* corresponds with cognitive appraisals which reflect on the event and make meaning of it in relation to the individual's experience and history. These appraisals, if negative in nature, can lead to a deterioration in mental state (Brown et al., 2019; Held et al., 2017; O'Donnell et al., 2007).

The use of Narrative Inquiry

Since the study was designed to address how participants were sequentially affected by their exposures to PTE's and the meaning they attached to these exposures, the interviews were conducted as largely unstructured narrative inquiries, allowing the narrator to describe the sequence of events as they had been remembered (Chase, 2018). Events, their associated consequences and the dynamic processes involved are identified in a manner that would not be possible in a semi-structured interview (Wang & Geale, 2015). Because verbal input and direction from myself, the researcher, was limited, the narrative approach could also be expected to allow the narrator the maximum opportunity to develop their story, and to reflect on its content.

In-depth audio-recorded interviews were conducted with each participant with minimal direction from myself as the researcher. This approach was used to minimize my effect on the participants' constructions of events. The interviews lasted 1-3 hours; in the case of two participants who experienced severe symptoms, two interviews at weekly intervals were planned in advance to reduce the stress associated with the process. The purpose of the interviews was to investigate at the level of the individual how these former police described themselves as affected by their policing experience: how they made meaning of this experience; if they experienced subsequent psychological difficulties, when and how they began; how they dealt with these, and having acknowledged them, how they reacted to the

systems that dealt in turn with them (see Appendix D). It also investigated the choices they made after discharge and any post-retirement changes in their values and self-image.

Data analysis

There is ongoing controversy in qualitative research as to the desirability of using a single or multiple coders. In this research I have chosen, as researcher and interviewer, to not use a second person in the analysis of the data, since IPA as a method of qualitative analysis of data assumes a single analyst. IPA describes the process of analysis as follows:

> *Although the primary concern of IPA is the lived experience of the participant and the meaning which the participant makes of that lived experience, the end result is always an account of how the analyst thinks the participant is thinking* (Smith et al., 2009, p.80).

As analysis is described in IPA, it takes a different approach to that of "coding" as it is performed in other types of qualitative research and it would be difficult to know how it might translate to a second analysist, or what might be gained from doing this. The process of analysis was ordered to follow the general protocol described by Smith et al. (2009, p. 189).

1. All the recorded data were transcribed by the researcher without the use of computer software and with attention to punctuation related to prosody. Any significant non-verbal communications that had been previously noted at the time of interview or shortly afterwards were added.
2. The information for each individual was assembled, and any descriptive core statements were noted that related to things such as processes, events and relationships that were matters of concern for the participant. Comments were added to these where appropriate. These included descriptive comments describing the content, comments focussed on any specific use of language, and initial conceptual thoughts (Smith et al., 2009).

3. The data sets were then coded into segments, defined as "the most basic segment, or element, or the raw data or information that can be assessed in a meaningful way regarding the phenomenon" (Boyatzis, 1998, p.63). These were subsequently collated in terms of their potential themes. This was done using copy and paste procedures, and some segments of data were allocated to more than one theme. At this point pseudonyms were given to the participants and any identifying references were removed or changed.
4. Groups of segments were then organized into emergent themes. At this point the process of interpretation began. As described by Willig (2012), this involved the process of extracting, and clarifying or elaborating, meanings contained within the data. In this process I was guided by my axiological position of wishing to give voice to my participants and contribute to clarifying their expressed needs.
5. Based on the recurrent themes, shared observations on police culture were first described and discussed, forming a background for the individual and shared themes (Chapter 4).
6. The themes for each participant were then organized into a sequential sequence, following the temporal direction indicated in their narrative, and individual case studies were constructed for each participant (see Appendix A) and illustrated with extracts from the transcripts, and their potential significance discussed.
7. Any general recurrent themes and what these might mean for the participants, as a group of former police who had experienced service-related cumulative trauma, were noted and discussed, and participants were divided into three groups on the basis of their shared themes (Chapters 5, 6 and 7).

Changes Based on Additional Emergent Themes

Initially this research study was conceptualized as one that would be based on

individual case studies. The course of the study changed, however, when analysis of the case studies indicated that significant themes could be identified that enabled the division of the participants into three distinct groups based on shared emergent themes, and the analysis of the differences between the groups became central to the research. This is consistent with the approach described by Smith et al. (2009), who say that common themes might in some circumstances generalize to what this might mean for a group. The idea that further groupings might be identified within a larger group is not generally part of Interpretative Phenomenological Analysis but was considered justifiable in this research study. The number of 14 participants - 14 is on the upper end of the number recommended by Smith et al. (2009) - contributed towards this being possible. The case studies located in Appendix A provide a valuable context for the ways in which each individual made meaning of their experience. They are not, however, required reading for an understanding of the findings of the research.

Initially, case studies were constructed for each participant (see Appendix A). Then common themes associated with police culture were identified across the narratives of all the participants. These themes are discussed in Chapter 4. Other key themes were then identified, based on participants' responses to their cumulative exposure to potentially traumatic events, and on their mental state at the time of interview. On the basis of these themes, the 14 participants were then divided into three groups There were five participants in the first group (Group1), four participants in the second group (Group 2), and five participants in the third group (Group 3). These three groups are discussed in Chapters 5, 6 and 7. Two overarching themes emerged, illustrated within each group in different ways: vulnerability, or conversely, resilience to the effects of potentially traumatic events.

8. Participant Group

The research participants were former police officers who had been discharged due to injury or who had retired from policing.

The choice of police as a participant group

As described in Chapter 1, the choice to research police as a study group was based in part on my personal connection with policing, since I have a family member who is a long-serving police officer. This has enabled me to see policing "from the inside" – the person behind the uniform, and the ways in which this person can undergo change in order to cope with the pressures they can experience, both in policing and in their family and social lives. In addition to my family connection, as mentioned earlier, I liaised with and frequently worked alongside police during my employment in Community Mental Health, where I worked for a number of years as a Crisis Assessment Team member. I had further experience in working with police as a Country Fire Authority (CFA) member and peer support person, primarily through attendance at motor vehicle accidents and other incidents where police and fire brigade members were present together.

Selection criteria

Discharged police officers, male or female, who were:

- members of the police force for a period of at least five years. This minimum period of police service was selected in order for them to have had the opportunity to experience a variety of potentially traumatic events (PTE's) during their service.
- more than 25 years of age at the time of the study. This was to ensure a reasonable level of maturity in the participants. As would be expected, drawing from a population of retired police, most participants were considerably older than this.

The 14 participants were all male and were aged between 55 and 77. All had spent a considerable time as police officers, ranging from 18 to 42 years. They had retired from police service between two and 19 years earlier. At the time of their leaving police service most had attained the rank of Senior Constable, and several had reached a higher rank. Six had received a formal diagnosis of PTSD.

At the time the participants served, few police were female, although police recruiting practices later changed. It was unfortunate that no females were recruited, since the effect of cumulative exposure on women is insufficiently understood (Park et al., 2015). There is also evidence to indicate that the incidence of PTSD, the effects of post-trauma variables, and recovery following treatment have gender-related differential effects, though the nature of these is as yet unclear (Blain et al., 2010; Bowler et al., 2010).

Most participants spent at least some of their period of service in rural or remote areas and had often been required to operate there without the support of other police officers. In addition to this, a number of participants grew up in rural areas.

The participant group included only police who had received a formal discharge from police service. This measure was necessary because recruitment of non-discharged member would have required separate police ethics approval. As stated earlier, SA Police rejected the application for approval.

Exclusion criteria

Any participant who, in my experience as a clinician, showed evidence of vulnerability on interview which might place them at risk was excluded. This included any person who displayed disordered or delusional thinking indicative of underlying psychosis, mood instability possibly indicative of impulsive or hypomanic tendencies, and depression with suicidal ideation. There were no exclusions on the criterion of vulnerability. It was notable that all the most affected participants said at the conclusion of their interviews that

they welcomed the opportunity to talk about their experiences and hoped that doing so would help others similarly affected, despite having found the process difficult. A sheet detailing available support services was given to all participants following the interview (Appendix G).

Recruitment

Fourteen participants were recruited from the states of Victoria and South Australia using the following methods:

- Two former police officers who had a diagnosis of severe PTSD were referred by a treating psychiatrist known to me.
- Verbal and written invitations to participate were sent to retired police who had contact with the Retired Peer Support Officer Program (RPSO) in Victoria. There was no comparable service in South Australia.
- "Snowball" recruitment was encouraged, with interested participants asked to speak to other potential participants and give them my contact details.
- An advertisement was placed on a closed website based in South Australia serving retired police, which I located through my professional networks.

It was not specified that participants had a diagnosis of posttraumatic stress disorder, only that they felt they had experienced events during their police service that they considered life-changing. This approach was taken for two reasons. Firstly, a number of studies have shown that trauma effects do not need to meet the diagnostic criteria for PTSD to significantly impair functioning and quality of life (Brancu et al, 2016; Bryant et al, 2016). Secondly, I did not wish to assume that all changes that follow police service are necessarily negative.

Prior to my meetings with the participants, a copy of The PTSD Checklist for DSM-5 (PCL-5) with Life Events and Criterion A (Weathers et al., 2013) (see Appendix B) was sent

to them, and they were asked to fill it out and keep it to give to me at the interview. At the same time, they were sent the Human Research Ethics Committee (HREC) consent form (Appendix C) containing my details, those of my supervisor, and a Participant Information Sheet giving comprehensive details of the research (see Appendix D).

The PCL-5 with Life Events and Criterion A is the most detailed of the three versions of PCL-5, the diagnostic instruments linked to DSM-5 (American Psychiatric Association, 2013). It provides an entire life checklist of traumatic life events and asks the participant to identify their worst event and give some information about it. It also provides a checklist of trauma-related symptoms and asks how much the participant has "been bothered" by these symptoms in the last month. Prior presentation of this instrument had a twofold purpose: it gave the participants an opportunity to review what questions might be asked when meeting with me, and it gave me an indication of the trauma exposures they considered most significant for them during their lives – not necessarily confined to those related to their policing careers. While the instrument is considered a comprehensive and accurate diagnostic screening device (Weathers et al., 2013), because it asks about symptoms experienced only in the last month it did not give any indication as to how the individual might have experienced symptoms in their less recent past. Because of this, it is arguable as to whether this currently employed screening device for the identification of PTSD is optimal to ascertain mental state, given the known nature of cumulative stress, and the variability of the symptoms (Bryant et al, 2016; McFarlane et al., 2017). The Clinician Administered PTSD Scale for DSM-5 (CAPS-5) (Weathers et al., 2015) is more comprehensive but is time consuming to administer and was for this reason considered unsuitable for use in this research.

Despite six of the participants saying they had been given a diagnosis of posttraumatic stress disorder, only two of the six met the criteria on the PCL-5. The majority of those who did not, despite having been given the diagnosis, indicated that the severity of their symptoms

tended to fluctuate over time, depending on their life circumstances and associated stress, as had been anticipated and mentioned above. For three participants PCL-5 scores were unavailable. While all were sent copies of the screening instrument prior to the interview, some of the participants had not brought them to the interview. While they said they would send them on to me, unfortunately this did not happen in these three cases.

Ethics Requirements

As mentioned earlier, the Human Research Ethics Committee (HREC) Ethics Protocol for the research required that all participants be discharged, rather than serving, police. While it would have been informative to also speak with some currently serving police, this would have required separate ethics approvals from the Police Departments in both South Australia and Victoria. Because this was refused by SA Police, the decision was made to confine the participant group to retired police. Interviewing discharged police had the disadvantage that most of them had not been affected by contemporary police culture and practice. It also had the potential advantage that those who participated could not place their employment at risk and might have been more willing to talk openly about their former employers.

To preserve the anonymity of potential participants until they volunteered to take part in the research, they were contacted by a third agency or individual and given my university email address and university phone number until they formally consented to take part in the research. Following their initial expression of interest, I contacted potential participants by phone or email, depending on the contact details they provided. They were given a short description of what would be involved in their participation, and the general aims of the research. If they wished to take part (and all did after that initial contact), a meeting time and place to conduct the interview was made.

An effort was made to find venues that were in a public area (for safety reasons) but private and quiet enough to be suitable to conduct the planned interviews. This proved difficult and unfortunately was not always possible.

At the conclusion of each interview participants were given a Contacts for Information and Independent Complaints Procedure form (Appendix E), a sheet detailing counselling and emergency help available in their state (Appendix F), and also told they could make contact with me if they had concerns.

The Interviews

The overall structure of the interviews was flexible and open-ended, allowing the participants to have an important influence over what was said, in line with the recommendations of Smith et al., (2009). A list of questions (Appendix G) was developed. This was referred to towards the conclusion of the interviews to confirm that all topics of relevance to the research had been covered. This was primarily factual information: e.g., age at enlistment, years served, and when the participants first started experiencing changes in themselves. Some additional questions were added over the course of the interviews to check out emerging potential themes that I had noticed across participants. In addition to asking participants to expand areas relevant to the research, I also made a point of returning the participant to a subject area – e.g., saying "you mentioned earlier" to explore a particular aspect of interest, rather than interrupting their narrative. When interviews continued beyond an hour, all participants were offered the opportunity to cease the interview at regular intervals. All chose to continue, typically saying they had not yet told the full story – and that it was important to them that they did.

The interviews were held at a variety of locations, from a crowded coffee shop (unfortunately resulting in a poor quality recording, and probably a less in-depth interview), a church building, participants' offices, and participants' homes. In all cases the venues were

the best that could be managed, given the individual circumstances and the geographical locations of the participants. Michael, (2004) emphasises the importance of material factors in influencing the interview. In a public place, participants might be less willing to touch on emotional areas, for example, and someone in their office space might take on a persona consonant with those surroundings. Following the limitations encountered in the initial interview performed in a public place, I ensured that future venues were more appropriate. In home situations in many cases there were family members coming and going, and one participant with a diagnosis of severe PTSD wished to have his wife (and his dogs) present for support. In cases where others were present, other than in the coffee shop example, I did not get the impression that the presence of support people or family had a negative influence on the depth or course of the interview. In any case, I did not think it appropriate to attempt to control the environment further.

I used very limited disclosure of my own background, in keeping with the caution recommended by Smith et al., (2009). It was confined to letting the participant know, where appropriate, that I had a family member (who does not share my surname) who is a police officer, that I was a former Country Fire Authority (CFA) member and peer, and that I had a rural farming background. This last disclosure proved to be particularly productive. It encouraged several participants to refer to aspects of farming life that several said they would not have spoken about to a city person, and how they felt these experiences had made them more resilient as police officers.

Managing Potential Researcher Bias

As a clinical psychologist with more than 25 years' experience as a therapist, I am experienced in conducting interviews. In clinical practice, the first interview is intended to function as information gathering prior to commencing therapy with a client, and to begin to establish a relationship of confidence with the client. It was important for me to distinguish

this type of interview from a research interview that would not have any therapeutic content or planned follow-up but would attempt to leave the research participant in a reasonably settled state of mind and would provide the depth of information needed for the research. The need to maintain a clear distinction between the clinical interview and the research interview was addressed by Fog (1984, 1992) (described in Brinkmann & Kvale, 2005), herself both therapist and researcher. She emphasized the need to maintain a reflexive attitude, since she believed much of the clinician's approach as a therapist can become automatic over time. Briggs (2007) emphasized that the interview is a social construction that contains roles, relations and positions that are often taken for granted. I endeavoured throughout to remain aware of this, and to approach my participants as a researcher, not as a clinician.

From the first interview, I was surprised at the willingness of many (but not all) of the participants to share intimate details of their lives to me. The phrase *"I've never told anyone else about this…"* was used by more than one participant. Atkinson and Silverman (1997) suggested that this phenomenon applies in a general sense when interviews are conducted. They described it as an "interview culture" or "interview society'' and believed it can make a significant contribution to qualitative research. Arguably, it also suggests that an atmosphere of adequate trust has been established.

In the case of several of the participants who had severe symptoms of PTSD, I spoke with them after the conclusion of the interview with the intention of reinforcing their self-confidence and self-belief. I found it interesting that the most severely affected individuals, who felt they had been treated unjustly, appeared to be those with the most strongly held value systems and sense of fairness. This suggests that they were suffering moral injury as described by Shay, (2014) and arguably also suggests that perhaps those who had the most strongly held values might be most at risk of this type of moral injury. I thought it was

important to reflect back to them that it seemed to me that they had, in fact stayed true to what they believed in, and that I thought this could justifiably be a source of pride. I was aware when I did this that this approach is not acceptable to many researchers. In a sense however I felt a duty of care as a function of my training as a therapist to reassure those participants who had dug deeply into their emotional lives to give me the information that they hoped would help others and had experienced distress in doing this. I was also careful to do it only at the conclusion of the interview so that it did not influence the content. Brinkmann & Kvale (2018) describe the qualitative interview as *"saturated with … concealed forms of power"* (p. 589). If one acknowledges one's power in the role of researcher, I argue that to use it to benefit the participant, if appropriately trained to do so, and doing so does not distort the data obtained in the interview, accords with the requirement of beneficence in research. In doing this I was not attempting to make conscious what might have been denied (described by Brinkmann & Kvale (2005) as an inappropriate intervention in qualitative interviewing) but rather summarizing what the participant had said and "reframing" it in a more positive sense, as described by Bandler & Grinder (1982).

Limitations to the Data

It should be said that this research did not examine the situation from the point of view of the official agencies providing treatment and compensation to retired police with psychological difficulties, so it remains an examination of one side of what is possibly a complex and vexed area.

As discussed earlier, the limitation that the participant group did not contain any female former police officers was unfortunate but unsurprising given police recruiting practices at the time.

While it was advantageous in some ways that the participants in this study were long-serving police officers, as discussed earlier in this chapter, most had ended their service some years before they were interviewed. This meant that some of the events they described might no longer occur because of changes in policing and police culture that might have taken place in the intervening time. While some of the circumstances and aspects of police culture might not apply to current policing, they nevertheless still apply to the cohort of police who were the contemporaries of the participants and as such are highly relevant to the current mental health of this group. It was noted in Chapter 1 that a recent survey of Victoria Police (Cotton et al., 2016) found that veterans who had left the police force ten or more years earlier were still experiencing mental health difficulties related to their police service.

A further limitation was an inability to access current police policy and procedures in a number of areas, other than those publicly available on the internet. While some recommendations for change have been made in this thesis, it is possible that similar initiatives to these have already been instituted.

Finally, because the participants who took part in the study were recruited employing convenience sampling methods, this might have resulted in the presence of unidentified vulnerabilities which might possibly have contributed to the differences between the reactions of the participants in the three groups. However, the focus of the research was to identify the stressors inherent in policing at the time the participants served, and the cumulative effect of these in each individual over the course of their policing career. Its retrospective nature did of course not allow for any assessment of the participants prior to the commencement of their police service.

With respect to the use of any measures of shame-proneness, the lack of conceptual clarity of the current measures of shame in the current empirical literature has been discussed in Chapter 2. Because of their inherent weaknesses, the application of any of these measures

at the time of the data collection would have been unlikely to have added any relevant information as to the vulnerability of the participants to the broad definition of shame as it is conceptualized in this research.

Summary

This chapter has outlined my reasons for choosing to research cumulative trauma, and for choosing retired police as a participant group. My experience as a clinician and therapist is central in contributing to my commitment to attempt to provide information to guide better treatment and management for police who have been exposed to cumulative trauma in their service careers. I have described how my professional experience also guided my choice of participants, the methodology and how the studies were conducted.

The next chapter discusses police culture as it was described by the 14 participants in the study: the changes it underwent over time, and how it influenced the values and the behaviour of those affected by it.

Chapter 4: Police Culture

This chapter draws on the interviews with all the participants across the three groups to bring together their shared experience of police culture, describe the ways they believe it underwent change over time, and illustrate how they perceived and were influenced by it over their period of service. Major themes identified include an increase in vigilance and a heightened awareness of surroundings as a result of policing, the importance of black humour to deal with stress, and the use of alcohol as a means of debriefing and the effects of this on families. Many referred to a culture change in policing towards professionalization and how this had negatively impacted on solidarity - on police supporting other police. Despite this, most thought a bond between former police officers remained into retirement. Police violence and its aetiology were mentioned by several participants. Most of the participants referred to the stigma associated with revealing emotions and how this discouraged the seeking of assistance for the effects of trauma.

In this and the following chapters, I have provided lengthy and detailed quotes from the case studies of the participants to illustrate the central themes that I identified in the data. The quotes are structured so that they group together the experiences of the participants in relation to the specific aspects of the culture and the meanings they have placed on these experiences. At times sentences have been regrouped. Where words not pertinent to the account have been deleted ...[.]… is shown. Where words have been inserted [replacement words] …. is shown. Many quotes have been left intact. Their often lengthy nature allows context and other relevant information to be inferred from how the themes were presented. I considered it important to provide sufficient data to allow the reader the opportunity to do this.

Participants

The 14 participants in this research served as police officers between the years of 1959 and 2016. (One participant retired two weeks before the interview but had been off work on stress leave for two years). The longest period of service was 43 years, and the shortest period was that of two participants who both served 18 years. Over the time they served, many of the participants described experiencing significant culture changes in policing, and their responses to these changes are reflected in many of their narratives. Almost all the participants said they believed that their policing experience had been life-changing, for better or worse; that it had shaped their personality and permanently influenced their identity and self-image.

As mentioned earlier, in the recruitment process, the research was described as *"exploring how people adapt and adjust to potentially traumatic experiences".* Participation was invited from retired police who thought they had changed as a result of their police service. This question produced descriptions of both negative and positive changes.

For the purposes of the data analysis, pseudonyms were given to the participants and other details have been changed where these might enable recognition of their identity. The 14 participants are referred to as: Jack, Pat, Frank, Gerald, Stuart, Cliff, Murray, Don, Bruce, Ivan, Victor, Denis, Phil and Peter. A brief overview of each participant is given in Table 1.

Group 1	**Age**	**Years of service**	**Mental state**
Jack	Age 76	Served 1959-2000 41 years	No trauma-related symptoms
Pat	Age 60	Served 1966-2009 42 ½ years	No trauma-related symptoms
Frank	Age 57	Served 1976-1998 22 years	No trauma-related symptoms
Gerald	Age 56	Served 1976-1998 22 years	No trauma-related symptoms
Stuart	Age 56	Served 1978-1996 18 years	No trauma -related symptoms
Group 2	**Age**	**Years of service**	**Mental state**
Cliff	Age 56	Served 1977-2000 23 years	History of mental health difficulties beginning after discharge, but probably contributed to by police service. Continues to lead an active life.
Bruce	Age 68	Served 1965-1996 31 years	Retired early with service-related mental health difficulties but continues to lead an active life.
Murray	Age 67	Served 1967-2002 35 years	Discharged as medically unfit because of service-related physical injuries. Has been given a diagnosis of PTSD but lives an active and satisfying life.
Don	Age 69	Served 1969-1997 28 years	Retired with a diagnosis of PTSD. Severely affected

			by symptoms but active and fully occupied with voluntary occupations in retirement
Group 3	**Age**	**Years of service**	**Mental state**
Victor	Age 56	Served 1978-2016 38 years	Severely affected by service-related trauma symptoms but active in voluntary work in retirement.
Denis	Age 70	Served 1968-2004 36 years	Has a service-related diagnosis of PTSD. Severely affected by symptoms with an associated restricted lifestyle.
Phil	Age 65	Served 1970-2006 36 years	Has a service-related diagnosis of PTSD. Severely affected by symptoms with an associated restricted lifestyle
Peter	Age 60	Served 1984-2002 18 years	Severely affected by service-related and non-service-related symptoms. Leads a restricted lifestyle.
Ivan	Age 62	Served 1972-2014 42 years	Has a service-related diagnosis of PTSD. Severely affected by symptoms with an associated restricted lifestyle

Table 1. Table of Participants: Pseudonym, age at time of interview, years of service and mental state

Table 2 summarizes the themes associated with the culture of policing and its effects that were identified from the interviews of all participants.

Theme 1. How the policing experience shapes character and lifetime attitudes *"We became suspicious bastards..."*
Theme 2. The importance of black humour *"We laughed at things we probably shouldn't have laughed at..."*
Theme 3. The centrality of alcohol in debriefing *"Debriefing was simply a piss-up... "* *"It's the effect on your family that you don't realize..."*
Theme 4. Culture change over time and its effect on cohesiveness and mutual support *"The loss of the thin blue line"*
Theme 5. The enduring bond between former police officers *"I'd lie if I said I didn't miss that blue line, the camaraderie..."* *"it's another life, it's another language, you know..."*
Theme 6. The loss of respect for police and the escalation in drug-related violence *"We used to get respect..."*
Theme 7. Culture change and police violence *"A bunch of fives"*
Theme 8. Police culture and revealing vulnerability *"There's a culture about manning-up, not showing your feelings..."* *"... people who have difficulties for some reason..."*

Table 2. Themes Associated with Police Culture Across All Groups

Analysis of the Data: Themes

Theme 1. How the policing experience shapes character and lifetime attitudes

"We became suspicious bastards..."

Foremost amongst the changes was that almost all the participants, both those affected and those not affected by trauma-related symptoms, believed their policing experience had

shaped their characters. They described having become more observant, vigilant, and suspicious as a result of their training; they were more risk-aware and dealt with the world more directly. Most saw this as a way of maintaining as much safety and effectiveness as possible during their police service, and as a continuing lifetime habit.

I can always remember this comment and the bloke who said it. We were standing in parade at the Academy. [and he said] "Gentlemen you'll be classified as suspicious bastards and you'll remain so for the rest of your life". (Gerald).

Policing itself is so inground into everything that you do, you know, even subconsciously, you walk down the road – and even today, you know, I'll look at something and I'll think that looks really odd and suspicious. I see people, I look at the way people drive, I think this is what's going on there, and – see – all those – it's constant, in what you do. You look at people more intensely, you look at things, and nuances about them, what they're wearing, or you know, what about their shoes. I suppose if you say does it make you risk aware of things then that's a positive. On the flip side does it mean that you never have that advantage in life of just being able to relax your way through it? (Stuart)

You know I was very very – super aware, overly aware of my surroundings, still am, I suppose, but I like to think that's just a habit of work, more so normally I'd be sitting where you are so that I could see who was coming in and out too – not that I'm – you know people say what are you looking at? I say I'm not looking at anything, what's wrong with you, but I'll bet if you asked me, I could tell you who walked by. (Murray)

I'm– verbally aggressive – in that I'm very direct in what I say to people, very controlled in what I say. I'm a person who needs a black or white answer. I think my character of today is directly a result of policing. (Frank)

I think that strong work ethic [that I have] just comes back to the bloody land of policing. You've just got work to do, you've got a job to do, and you just go out and do it. (Frank)

It's an inculcation. You know you spend twenty years of your life in a disciplined environment where you're para-military. You wear a gun every day, and you take on a mantle of service and a responsibility. (Gerald)

Not all the participants agreed that the change was entirely appropriate or beneficial.

I know in the group that I'm around, a lot of the older guys, they look at people, they still get this offender orientated look into people, you know. (Stuart)

Because some coppers become a little bit paranoid about everything, you see that. And they forget that ninety five percent of the people you deal with are nice people. (Pat)

Theme 2. The importance of black humour

"We laughed at things we probably shouldn't have laughed at..."

A number of participants spoke of the use of black humour as a coping mechanism during their policing careers. They indicated that they saw it as a protective device – a way of achieving detachment from the emotional effects of exposure to situations that might otherwise have become overwhelmingly stressful.

Every now and then you saw some absolutely hilarious things. Probably things that you shouldn't laugh at – but it was a way of – dealing with some pretty shocking things. I used to go to those homicides in a number of different roles, but it didn't matter, you'd walk through, the black humour would come in there or whatever and you were totally dissociated with it. (Don)

Delivering death messages is gut wrenching – especially if you're delivering a death message to a parent – I've done a few of them here, and the trouble with being in a small town is you know them. Worst job in the force, death messages, because no matter which

way you go about it, it's a no win situation. You can't do a damn thing. And that's why humour – black humour – it's called black humour sometimes, is within the police force. (Peter)

Theme 3. The centrality of alcohol in debriefing

"Debriefing was simply a piss-up... "

The majority of the participants spoke of regular and excessive alcohol consumption as a problem in policing, if not for themselves, for others. The belief that alcohol use – or overuse – had been a common way of dealing with potentially traumatic incidents and with stress in general during their time in policing, was acknowledged by most of the participants. While they said they were aware of the dangers associated with it, many suggested there had been no alternative available to them.

You didn't debrief at work. Debriefing was simply a piss-up, and the difference between a night when there'd been a tragedy and a night when there wasn't, was that the night when there was a tragedy you had reason. It's all go – and drink the grog. (Bruce)

They used to leave the police club open till the last person left. And it was the best debriefing you could do. You'd go there - you wouldn't write yourself off drunk – and in fact if you'd had a few too many you'd get the afternoon shift, or the night shift crew and they'd drive you home. And it was a way of coping. What's the alternative? (Don)

In uniform we'd have night shift barbecues at the end of a week of night shift, and – ah – you'd celebrate your wins, and you'd drown your losses, more or less. (Cliff)

Go down to the pub and fill up. No one's taking me home, I've still got to drive home - you always drove home because you were probably too drunk to walk. Back then – who's going to pull you over if you're a copper and you're pissed? No-one's going to

touch you. Now it's a completely different thing of course, because it's unacceptable. (Murray)

Both the past and present potentially fatal effects of overuse of alcohol were recognized.

When my job was to investigate road fatalities, you walk along and you go I know him, and he's sitting there dead in the car. Or you're picking them up off the side of the road, or - I don't know him but I recognize the bloody uniform, and they're shit faced drunk. And they're dead. (Murray)

Drinking is a big problem. If I keep on going the way I'm going alcohol will kill me, no doubt about that. I've got to cut back, I was self-medicating, so to speak. (Peter)

I mean look, you know what I think is the biggest problem with the police force now? There won't be drug testing and alcohol testing on a random basis. I think that's poor. They're carrying guns! Why would you think you would give a police officer a frigging gun, and mace, and taser guns, and not test them? I mean for goodness sake. I mean that's bullshit. (Gerald)

I buy a slab every night on the way home from work. Generally speaking, I have to buy another one the next night. And then I come to work, get a gun and ammo, and my spray, and police car and all that. I've always wished that someone would stop me [participant quoting an officer he had counselled]. (Murray)

"It's the effect on your family that you don't realize..."

Several of the participants acknowledged that the drinking culture often had a destructive effect on families and expressed regret that their drinking had caused relationship damage in the past. Despite this, however, it was also seen as a necessary survival mechanism in the absence of any other ways of debriefing after critical incidents, and in generally dealing with stress.

Because you'd knock off after duty and you'd go to the pub. We no longer do that although traditionally police are really heavy drinkers. I think most of us my age and around survived because we went to the pub and got pissed. And I'm an advocate of self-medication with alcohol. The problem is that we didn't care about getting home – because back in the early 80's because there wasn't drink driving, because we were the police, we did what we wanted to, right? We would go to the pub after work. Every single night. Every single shift. And then we would go home. That's probably why we're all divorced– multiple times. (Victor)

[Drinking] would take its toll on a lot of the wives, they wouldn't put up with it for too long, lot of my mates on second marriages, a lot of them on third marriages, you know, because of self-medication. It's the effect on your family too that you don't realize. (Cliff)

Theme 4. Culture change over time its effect on cohesiveness and mutual support

"The loss of the thin blue line"

Four of the participants spoke of significant culture change associated with a push towards professionalization and increased accountability in the police force. This appeared to be a trend in Western societies generally (Green & Gates, 2014). In a study of Scottish and Dutch police the culture change was described by Terpstra et al. (2019) as improving effectiveness and efficiency, but also as disruptive to the personal relationships between police and their senior officers, and as undermining existing police culture. This view was supported by many of the participants, who saw the culture changes, while having some positive outcomes, as being largely divisive and disempowering in their effects. Several remarked that the concept of the *"thin blue line"* – police defending police – had been lost and replaced with a *"culture of fear"* where police might turn against each other as a result of competitiveness associated with opportunities for promotion.

> *[Professionalization] was an experiment to make us a corporate entity and call us a service, not a force, and they wanted us to do all these things in line with corporate goals and corporate governance, and all of that. These days – they're being run by KPI's which is all well and good, um you know makes the government feel fantastic and happy about these things, but I think they have a much more difficult job to do today, by comparison.* (Victor)

Some benefits of the effort to improve safety and performance were also noted by some participants.

> *As time went on [state police force] gave more training to things like occ health and safety*. (Pat)

> *About 18 years ago [state police force] brought in incident management and operational safety training. We are now one of the most operationally safe police forces in the world.* (Victor)

While some welcomed the increased emphasis that was given to developing policy and procedures, some also experienced the changes as reflecting a lack of trust by management that had the effect of diminishing the loyalty police had traditionally given to each other. They suggested that this occurred through the emphasis on increased accountability which they said had the effect of pitting officers against each other. Two participants spoke of an increased level of observation by management. While acknowledging it had its basis in countering corruption, they said it also led to increased stress for members.

> *We'd lost our carefree way of policing, um – everything had to be accounted for, there was a surveillance on the police – in the police station, there was surveillance cameras in the cells, so you felt as though – I used to wonder, who were they after, the police or the crooks, you know?* (Jack)

The thin blue line concept, you know, it didn't matter – you backed up the other police officers, even if they did something stupid - that was what you did. Because if you didn't there was no-one else. I don't think [now] they have their mate's back in that same sense. (Stuart)

The two sides of the traditional police culture – good and bad – were described by one participant.

The traditional culture that – if you'd been with me in the 1980's, you could not break us. They've torn away the "we circle the wagons", the thin blue line, they've taken what was always perceived as the bad bit because it leads to corruption, and the thin blue line hiding bad practices and all of that. In actual fact it did, but also, we supported each other. We looked after each other. Now coppers are constantly afraid when they're going to get in the shit, when something bad's going to happen, when internal investigations branch are going to come around, when they're going to get audited. They live in a constant state of stress unrelated to them dealing with the crooks. A culture is like – shared beliefs – we [used to] believe in honesty, we believed in integrity, we believed in looking after our mates, we believed in protecting our mates, we believed in preventing our mates from making bad decisions. We'd stop people from doing things in the past, they don't now – they let them and [then] they dob them in. (Victor)

Two participants suggested that the changes in culture were manifest largely in the behaviour of younger officers. One said – *"the young ones today are so snipey, snappy and vindictive"* (Frank). The other believed that corporate focussed culture change caused a perception of disempowerment at all levels, resulting in negative practices that were passed down through the hierarchy and end up being perpetrated on the public.

I can't believe those people, the things they do, the way they speak to people. It's so unnecessary. It's because they're totally disempowered. So, they wield the power the way

it's been wielded to them. And the sergeants wield the power the way the inspectors have wielded it to them. To the point that our young police officers now are so aggressive on the road. They're pinching people left right and centre for fucking piss-weak traffic offences. (Victor)

Chapter 2 described four potential shame avoidant mechanisms: "attack other" expressed as aggression, "attack self" manifesting as depression, "hide from other" manifesting as self-isolation, and "hide from self" manifesting as addiction (Elison et al., 2006; Webb, 2010). Arguably the disempowerment that Victor believed was being experienced by younger officers might be demonstrated in an "attack other" response of increased aggression towards the public.

Theme 5. The enduring bond between former police officers

"I'd lie if I said I didn't miss that blue line, the camaraderie..."

While some believed police officers could be highly critical of their fellow officers, and that perhaps this reflected the more recent current push towards professionalization, many of the participants in the study spoke of still feeling strong bonds with fellow officers that had lasted beyond the time of police service.

But I see in a lot of police officers, or ex-police officers, including myself, this – connection. And you never quite lose it. I've been out as long as I was in, you know, and it's amazing how incredibly it influenced my whole life. (Stuart)

– I'd lie if I said I didn't miss that blue line, you know, the camaraderie. (Gerald)

You know cops are really loyal to each other. Not so much to the management but to each other. (Cliff)

"it's another life, it's another language, you know..."

Part of the feeling of connection between former police officers described by several

seemed to be the perception that others did not understand how police were changed by what they were exposed to.

> *Because [when] you're in mixed company and you start telling war stories and people just look at you – because of what you're seeing you tend to have a very black sense of humour, and you know [because the] stuff that we would laugh at – that would be politically incorrect to laugh at – ah – you know – you tend to surround yourself - you're mainly with cop mates. You don't tend to have a lot of people that aren't police.* (Cliff)

> *You go to a function where there's another police officer – and you just break up from the rest of the mob and just talk. And they don't understand, the other people – well that's what we think anyway. They don't understand what we're talking about, they don't understand what it's all about, you know, because it's another life, it's another language, you know.* (Jack)

Theme 6. The loss of respect for police and the escalation in drug-related violence

"We used to get respect..."

Several participants thought respect toward police from the general public had diminished over their years of service, negatively affecting their status in the community.

> *We [used to get] respect in [capital city], even walking the beat. But there don't seem to be any boundaries these days, it was a totally different environment to work in, you know, because you got that respect.* (Jack)

A participant who had served more recently also spoke of increased violence towards police associated with substance abuse.

> *It's [the lack of respect] has probably got worse in the last ten years as substance abuse has really escalated. I reckon when I first started you might get one in ten who'd be really aggressive – probably eight out of ten, by the time I finished.* (Pat)

A marked increase in violence towards police and its association with substance abuse, particularly *"ice"* (crystal methamphetamine), has been recently substantiated in the Victorian Police Association's submission in July 2019 to The Royal Commission into Victoria's Mental Health System (Cotton et al., 2016).

Theme 7. Culture change and police violence

"A bunch of fives"

Some of the longer-serving participants spoke of the culture change associated with the amount of police violence considered acceptable.

> *[In the] 80's – if someone was aggressive to you they got a bunch of five knuckles across their face. And that was instantaneous. If it wasn't your knuckles, it was your offsider's knuckles that got there before you. It never went over the top - um – it was controlled but – a couple of punches was acceptable. But you wouldn't be going 5 or 6, you know. And it was done as a method to subdue the offender, right? Whereas in today's world, don't even think about it. So that aggressive side of policing has gone.* (Frank)

> *They resolved problems by – crook put his head up, making a bit too much noise, he'd find he'd get a bunch of fives – but that culture eventually got stamped out.* (Pat)

> *I had no issues with being violent with people – didn't worry me because that was just one of those things you did.* (Ivan)

It could be hypothesized that a tacit acceptance between police and potential offenders as to the level of opposition that would be tolerated by police had undergone change. This is not to suggest that police violence no longer exists, but that it might now be more associated with the tolerance level of individual police officers rather than any sort of shared understanding of "acceptable" behaviour on the part of the offender.

One participant suggested that some police violence was a product of the risks they took – and the high level of adrenaline that resulted from the dangers of the job.

If anyone says they didn't get a buzz about high speed chases, they were full of shit, you know. You go at a hundred miles an hour in side streets and it's just flashing past you – voom -voom -voom. Anyone could come out. Anyone could back out of their drive. They're not going to know you're coming. When they arrested people, I saw blokes flog the shit out of [them] – it's the adrenaline. (Gerald)

Another participant suggested that many disciplinary issues, including violence, might be a result of unrecognized stress-related injury.

People often when they get in trouble, with the internal investigations branch, go off on stress. Often. But the reason they got into trouble [might have been] because of stress, or PTSD. or their inability to control their anger, make good decisions. So [state police force] deals with the facts of that. They punched somebody, they made a really bad decision, right, and that's dealt with, and full policy, process procedure is followed. And they're often sacked, or they get into an awful lot of trouble, or they get transferred – a whole bunch of things. And as a result of that, that causes stress, anxiety, angst, as well – but was it the chicken or the egg? Did they get stressed because they made this decision, or they got into trouble, or they punched this person, or they stole this whatever -- or did that happen because they were stressed? (Victor)

Theme 8. Police culture and revealing vulnerability

"There's a culture about manning-up, not showing your feelings..."

An aspect of police culture that has not appeared to have undergone significant change over the period the participants served is the stigma associated with revealing emotions associated with vulnerability (Velazquez & Hernandez, 2019). The way in which it is referred to by several of the participants suggests that for them, this aspect of police culture equates with the cultural stereotype of masculinity. This is described by Kennedy and Birch (2018), as characterized by dominant, emotionless and often aggressive behaviours and they

argue that this hegemonic notion of masculinity does not reflect the diversity of attitudes held by police officers. Because it is shared by police themselves, this shared belief is thought to militate against any display of vulnerability by the individual police officer and results in a build-up of stress and affects mental health (Kennedy & Birch, 2018).

This proposal that police feel the necessity to portray a "tough" image is supported in a national survey of the mental health of police in Australia conducted in 2019 for Beyond Blue, which found that affected respondents felt very high rates of self stigma and shame about their mental health condition, and more than half avoided telling others about it (Kyron et al., 2019). Similarly, a current police culture *"based on stoicism, the endurance of pain or hardship without a display of feelings and without complaint, separating yourself from feelings and emotions to get the job done"* was described by the Australian representative at a recent international conference on police mental health (Kamkar et al., 2019, P.3). Most of the participants in this study spoke in various ways about how they perceived this culture and how it shaped their behaviour and influenced their mental state and physical health.

> *I joined an organization where you didn't show any sign of weakness or fear – you never took a step backwards - and an occupation where you relied a hell of a lot on trust. You know people had to trust you. The environment was – you never discussed it [a potentially traumatic event]. You know you sit around and yak about things like that, you're either a bullshit artist, or can't you handle it? Is there something wrong with you?* (Murray)

> *At times you know I used to vomit on the way to work, you know, knowing that I had to start at seven o'clock and go to half past three knowing that I'm going to have a conflict somewhere, whether out in the street or with the boss and – um – [that I had] to keep my brave face going, till half past three, and then I'd go home and I was just about – I'd collapse at home.* (Phil)

Two participants suggested that initial recruitment of police officers had changed to render them more vulnerable to the effects of potentially traumatic exposures.

> *Why is it they changed the psychological profiles of the police some years ago to make it a softer person. and now as a result a lot of people are not surviving because they say that – I didn't know I'd see dead babies and dead bodies – I did but – you know... Because you were inappropriately selected in the first place. Why was it that half my course were from the country? Now hardly any country people join the police.* (Victor)

> *And – er – I suppose the people that they may have recruited and psychologically profiled [back then], you know, were the ones who'd come from a certain background, or you knew were people that they profiled that they thought could be tough enough to withstand the rigours, you know, of day to day policing.* (Cliff)

Two participants questioned whether even the provision of debriefings would be sufficient to counter the culture of concealment and the fear of career damage associated with acknowledging vulnerability.

> *If something happened really bad, we'd have our own sort of debrief and talk about it at a team level. The lads might relate to it badly but wouldn't say I'm not feeling the best, you know, to anyone, they'd just keep it within themselves. I wouldn't– have spoken to anyone about it.* (Denis)

> *You don't want to go and – and – um – admit that there's a hassle. Because particularly in a country town - there's too much image.* (Bruce)

> *I look back and it's about the amount of stuff we see – um – I'm not even sure whether debriefings would help, because even, as a youngster, debriefings would have been good to make me understand lots of things - um, but there's stigmas, there's a culture, about manning up, there's a culture about not showing your feelings. I went to work with a charade going on, because you can't show that something's affected you.*

There's a stigma in the police that if someone found out you were going to see a psychiatrist or something, or a psychologist, even if you stayed in the job and they found out, your career's doomed. You're not going to get selected for another job, you're not going to get selected for anything, you'd get pushed into a corner. They'd say [it's for] other reasons, but you'd be over. (Phil)

A recent study of active duty police officers suggests a similar stigma exists in the US. Soomro and Yanos (2018) found that the police officers studied showed not only higher rates of current PTSD than the general population, but also higher rates of negative stereotypes about people with mental illness, and that those experiencing PTSD endorsed the most stigma about mental illness. Bell and Eski (2015) and Hoge (2010) suggest that, because their training and sub-culture emphasize stoicism, police affected by trauma-related symptoms fear becoming alienated, and further shamed, if their mental state became public. One participant said that to speak out even about work-related stress, would have been demeaning and career damaging.

The minute I had ever gone to any of my superiors and said my work-load is crippling me I can't do it, they would immediately have said – just not fit for promotion - can't handle the pressure, can't handle the workload, can't handle the stress, totally unreliable. (Murray)

Another participant believed the police force had withheld information to protect its own interests and had failed to appropriately care for him.

I was never looked after, never cared for, and you know I look back and it was appalling. And the police don't tell you anything - when you think about it they don't want you to know about it because then everyone starts becoming sick with it – um – after a big job that was bad – um – there was never debriefings. (Phil)

"... people who have difficulties for some reason..."

The need to keep any emotions associated with vulnerability concealed because of fear of stigma was endorsed by most of the participants who described having symptoms associated with exposure to traumatic events. In contrast to this, consistent with the findings of Soomro and Yanos (2018) referred to above, the participants who described themselves as not experiencing ongoing trauma-related symptoms did not appear to attach any particular stigma to the symptoms if they were experienced by fellow officers. Gerald, who had experienced some symptoms that had been mild and transitory, suggested that not talking about stress-related symptoms was simply *"typically male behaviour".* In saying this, he seemed to be suggesting that his concealment of his symptoms was not only a product of police culture, but also of the way police culture aligned with the gender differences in the larger community (Andrew et al., 2013; Silvestri, 2018). He said he had felt reassured when he found out others were experiencing similar stress-related symptoms to his own during a difficult operation – after it had been exposed by their wives; *"we'd talk peripherally around things – typical men."* This participant also mentioned that he *"wouldn't have shown emotion on the job."*

Generally, the participants in Group 1, the group who said they experienced no ongoing symptoms, were tolerant and non-judgemental when speaking of the effects of trauma on others. They spoke of *"being supportive"* of fellow officers with trauma-related symptoms, of symptoms being *"something that happens to people who have difficulties for some reason"* and *"how you handle it [exposure to potentially traumatic events] being different for each person".* One participant (Frank) who had not developed symptoms himself, was critical of management for actively discouraging those affected from seeking assistance, saying it had been made clear that they would be considered a *"liability"* for needing *"someone to fill the gap"* when they took time off to *"have a chat"* with a

counsellor. This participant suggested that this had made it difficult for counselling services to *"get their feet on the ground"* when they were first established.

Discussion

Most of the participants across all three groups agreed that policing had greatly influenced their lives and had changed them in enduring ways. They had become more vigilant and aware of any risk-potential associated with people or events in their surroundings. There are few references in the literature to this increased vigilance in police. A study of serving police by Kubiak et al. (2017) investigated the effects of dispositional vigilance and cognitive avoidance and their potential relationship to stress. They concluded that in the case of serving police it served a protective effect but if no actual threat was present vigilance served to increase stress unnecessarily. Given that the participants in this study who described increased vigilance all said that it persisted into retirement it appears that "unlearning" it may not be an option. While it is possible it might contribute to ongoing stress in retired police, none of the participants specifically suggested this. The increased vigilance described by the participants across all three of the groups is not considered to be comparable to hypervigilance as it is defined in PTSD. Rather, it is considered to reflect the high level of situational awareness and alertness that is necessary to stay safe as a police officer, as suggested by Gilmartin (2002). Faulkner et al. (2020) consider it important that the adaptive healthy situational awareness described by many police officers should not be pathologized by considering it to be synonymous with the heightened physiological reactivity seen in PTSD.

Most of those participants who acknowledged that they had changed in this way did not seem to think of it as either an advantage or a disadvantage, although two participants suggested it might make for a more cynical or less relaxed approach to life. Positive change

resulting from their policing experience mentioned by some participants was that they believed they had become more disciplined and developed a stronger work ethic.

Many of the participants spoke of using black humour as a coping mechanism during their policing careers - though none gave any indication that this had persisted into their current lives. While they acknowledged that some of the events they had treated as humorous would not have been regarded this way by general members of the public, they were unapologetic. It is likely that black humour marked one of the ways in which these former police felt different; why they tended to seek each other out at social gatherings. They could then talk about the past without censoring what they said – and tell their "war stories" - as one participant described the content of their conversations.

A study of the use of black humour by emergency personnel, including police, found it could help to defuse emotions, increase camaraderie, and forge solidarity in their daily work of dealing with death (Scott, 2007). Scott (2007) argues that, rather than being considered an "inappropriate" response, black humour should be thought to be a cathartic stress-reducing mechanism, and might be perceived as an appropriate, if not essential, part of coping for emergency personnel.

A further study that examined coping strategies in a group of police officers tasked with body-handling after a major disaster, paired with a matching control group, found little post-traumatic distress or psychiatric morbidity in the group that had performed the task (Alexander & Wells, 1991). The authors attributed this lack of post-trauma impact to the coping strategies of the officers, which included black humour, high morale and good team relationships. Young (1995) suggests that black humour is fostered during the training of police recruits, and that the ability of the recruit to deal with a *"sticky sudden death"* is considered an indication of whether the recruit will become a *"good copper".*

The importance of the place of alcohol in policing and its use to deal with stress and exposure to potentially traumatic events was expressed by all the participants, and several described policing as "a drinking culture". In the years that most of the participants served, and in the absence of any other support, over-use of alcohol was arguably a survival mechanism that carried a high price in terms of both health and relationships. This is supported in research findings that cite reliance by police on alcohol to deal with trauma (Devilly & Varker, 2013; Ménard & Arter, 2013) and a study by Arble & Arnetz, (2017) which found that amongst first responders, police have the greatest problem with substance use.

The de facto use of alcohol as a debriefing mechanism was described by some as *"the best"* - or at least the only - solution available to them at the time. Some referred to the later introduction of formal debriefing, but this did not seem to be generally endorsed as having been a solution to the effects of exposure to events of a potentially traumatic nature because of the inhibiting effects of the culture-based stigma associated with revealing vulnerability. Rather, the failure of police departments to provide supportive care in a timely way seemed to be the identified as the main problem because it was considered indicative of lack of concern by management for those experiencing difficulties.

Several participants made a point of emphasizing that the police culture around drinking had undergone some change; that there was less tolerance of excessive drinking in the police force generally, and that police could no longer expect indemnity from driving under the influence of alcohol. A report presented by the Independent Broad-based Anti-Corruption Commission (IBAC) in Victoria in December 2016 showed that there had been a slight increase in dismissals of officers detected exceeding the breath-alcohol limit in the period 2000-2015, but most of the officers detected retained their employment. VicPol's response to the recommendations of the report was that any disciplinary measures should be

able to consider the "often complex nature of policing and the cumulative effects of trauma" (IBAC, 2016). This recent comment by VicPol suggests that, while there had been some tightening of regulations around alcohol, the use of alcohol by police to deal with work-related stress remains a recognized and tolerated option within the organization.

The professionalization of police services was noted by some participants, and it was considered to have had both advantages and drawbacks. While several participants said it had resulted in better training, the general feeling associated with professionalization was that most of the changes associated with it had been negative. A number of participants believed the "thin blue line" – police backing police – had been lost and in more recent times the general culture had become less supportive. One participant made the observation that he believed problems associated with misuse of power started at the top and were passed down through the ranks, culminating in a deterioration in the quality of encounters between police and the public.

A number of the participants made observations associated with violence. Several described an earlier culture of violence by police towards offenders that had now been curbed; whereas a certain measured amount of physical violence had once been condoned this was no longer the case. At the same time violence from the public towards police had increased, much of it associated with more widespread use of drugs such as "ice". Several of the participants who had served earlier said they believed there was no longer respect for the police from the general public. It was also suggested by Victor that some instances of "bad behaviour" in police, which might include violence or poor decision-making, might occur as a result of unrecognized trauma-related symptoms and that perpetrators were unfairly punished, adding to the difficulties they were already experiencing. This is discussed further in Chapter 8.

Meta-analytic reviews by Olatunji et al. (2010) and Orth & Wieland (2006) showed that an increase in anger and aggressive behaviour has long been associated with the diagnosis of PTSD, most frequently in military samples, and associated with a variety of situations. It has been particularly noted in those who have been trained to react to threat with defensiveness, such as members of the military (Hoge, 2010). This type of response would arguably extend to police, whose training emphasizes a similar approach. As described by Murray "*you – tactically withdrew - but you never took a step back"*. If combined with the hyperarousal features of post-trauma symptoms, as described by McHugh et al. (2012), lack of ability to control anger reactions and related "bad behaviour" in police might in many cases reflect both the influence of training and unrecognized symptoms of trauma.

There is evidence that the continuing stigma and potential career damage associated with the acknowledgement of stress-related symptoms is a major factor influencing the course of trauma-related psychological injury. The majority of the participants referred to the enduring stigma associated with showing vulnerable emotions within police culture and awareness of stigma seemed to be more acute in those who experienced symptoms themselves, particularly if they perceived themselves as "weak" and felt ashamed because they had developed these symptoms. Those participants with trauma-related symptoms said they believed that showing emotion in policing continues to be seen as a sign of weakness, a source of shame; it would result in loss of the trust others had in you, and career damage. This belief seemed to be less evident in those who did not experience trauma-related symptoms themselves. The general impression was that there had been little change in this aspect of police culture, and this is supported in recent surveys of mental health in police discussed in Chapter 1.

Participants in Groups 2 and 3 who experienced more severe ongoing symptoms saw themselves at risk of being ostracized and their careers permanently impacted if they publicly

acknowledged they were experiencing difficulties. Evidence from the surveys of police mental health discussed in Chapter 1 suggests their expectations of ostracization and career damage may well have been realistic in many cases. Some, but not all, saw themselves as weak for experiencing symptoms with a negative change in self-image and self-confidence resulting from this. It was notable that, if they attached this meaning to their experience and they felt ashamed of having developed trauma-related symptoms, this served as a further source of shame-associated stress for them. This "internal shame", as it has been defined by Gilbert, (2001) and discussed in Chapter 2, was confined to the participants in Group 3 and is discussed further in Chapter 7. The nature of this subsequent appraisal, described in IPA (Smith et al., 2009. p. 188) as "deliberate controlled reflection" is arguably critical in its influence on whether a deterioration in mental state occurs following a trauma-related injury.

Against this background of the influence of the police sub-culture, the next three chapters examine how the individual police officers in each of the three groups described navigating their way through the challenges they encountered in their police service, and any coping mechanisms they had developed. As described in Chapter 3, individual case studies were constructed for each participant (see Appendix A) and following this the participants were divided into three groups based on their descriptions of the symptoms they described experiencing at the time of interview. As in the present chapter, I have chosen to present the data in the form of direct extended quotes from the case studies of the participants where possible. Recurrent themes within each group are identified and discussed with reference to any potential shame elements, and how in turn these elements might be associated with the mental state of the individuals in each group.

As previously described, all participants were given pseudonyms and any other identifying details were removed or changed.

Chapter 5: Group 1 (Jack. Pat, Frank, Gerald, and Stuart). These participants described themselves as experiencing no current trauma-related symptoms, despite having had exposure to multiple potentially traumatic events during their policing career.

Chapter 6: Group 2 (Cliff, Murray, Don and Bruce). These participants acknowledged ongoing symptoms associated with their exposure. They described the intensity of their symptoms as varying as a result of periods of stress, but as not worsening over the time since their discharge. from policing. While they described experiencing ongoing trauma-related symptoms, they said these had not been associated with subsequent deterioration in their mental state or significant limitations to their lifestyle.

Chapter 7: Group 3 (Ivan, Victor, Denis, Phil and Peter). These participants described experiencing unrelenting severe trauma-related symptoms and a subsequent progressive deterioration in their mental state and their quality of life.

The next chapter examines the coping mechanisms and personal characteristics of the five participants in the study who described experiencing no lasting psychological effects from their lengthy careers in policing and their multiple exposures to potentially traumatic events.

Chapter 5: Group 1 Maintaining detachment and achieving resilience

This chapter examines the narratives of the five participants in Group 1: Jack. Pat, Frank, Gerald, and Stuart, who described themselves as experiencing no lasting trauma-related symptoms, despite having had exposure to multiple potentially stressful or traumatic incidents during their policing career. These participants described themselves as having deliberately found ways during their policing career to emotionally detach themselves during exposure to events that were potentially traumatizing. They described having deliberately focused on the job in hand at the time to assist in achieving this detachment and as having avoided dwelling on potentially traumatizing events afterwards. They tended to portray themselves as confident, as having good self-esteem, and as willing to fight for their entitlements. However, most of them also described recognizing when they had reached a point in their career when it was time to leave policing and either retire or find other employment.

Analysis of the Data: Themes

While the experiences of the participants in this group were different, there were some identifiable common themes. The majority of the participants in Group 1 suggested that they considered themselves to have been confident and competent in their work as police officers and gave no indication of any feelings of shame or regrets associated with their police service. Despite this, they acknowledged that it had been important to them that they kept any vulnerabilities concealed, in conformity with the prevailing police culture. Most acknowledged the effect of the drinking culture in policing and its use to manage stress, if not for themselves, for others. Several suggested that lack of competence could prove a source of stress for some police officers, and also that any conflict with the department could prove a further source of stress.

The effects of events involving children

"*Deaths of kids were a little bit different...*"

While the participants in this group did not identify any event in their policing career that they described as having left them with permanent trauma-related symptoms, they were not immune to transitory distress. Four of the five identified incidents involving children that they described as being difficult to cope with at the time.

> *I've got to honestly say I don't like SIDS deaths, and I had a number of those in a short period of time, and I'll always remember taking this baby away from its mother's arms, you know which you had to do, and my [child's name] was just born. And coming home the next day – sitting – I absolutely sat in his room at the end of an afternoon shift– and just sat there, you know. And um – nothing I really shared with anybody – but yeah, you had to go through that.* (Stuart)

Stuart's account indicates that he did not try to evade the impact of the SIDS death and the difficulty of taking the child away from its mother. In his words, he had to go through it, and he chose to do this without sharing the experience with anyone else. Implied in *"going through it"* is the idea that it is a process with an end – that it is possible to come out the other side. This suggests two things about the coping methods Stuart described using. He appeared to not seek any support from others in dealing with a difficult experience, and he seemed capable of accepting the inevitable, and the necessity to move on.

Gerald described an incident early in his policing career involving the death of a child that he had handled decisively.

> *When I was only a young bloke - I would have been God – twenty one - a bloke ran over his three year old boy. And I had to pick the boy up - the ambulance had got there but they couldn't touch him once they realized he was dead. We put him in the ambulance and took him to the hospital and I had to strip him down, toe tag him, I had to identify him, all*

that sort of stuff, and then I had to take him to the autopsy, and I had to stay at the autopsy because I had to define – you know he could have been an assault victim. Then I went to the pub, on a Friday night, and the father was there. And he was there crying all night. And I said come here, come outside, and I said look, there's no easy way of telling you this, it was an accident, I can't tell you to get on with your life but I said you need to suck it up I said I don't need you sitting in the pub where I am crying your eyes out every night because you've had a loss. I said because you being there is not going to help anyone in this community, It's too small. I said you're feeling sorry for yourself, go and get some counselling. go and get some counselling or I'll order it. (Gerald)

Central to Gerald's account of the way in which he – at a very young age – dealt with the grief of a father who had killed his own child is again the idea of accepting an event and moving on. Gerald indicated that he was also was aware of the potential disturbing effect of the father's grief – and no doubt his immense guilt – on the small country town community. In *"ordering"* counselling for the father he was perhaps saying two things – that what you are doing will negatively affect the community – and that the community can't help you.

Frank spoke of an incident when he provided support for a doctor who had failed to save the life of a child.

A two year old girl drowned at [outback town]. In the backyard swimming pool. And bloody dad was home babysitting and mum was at work. And dad was absolutely – he lost it. So, we just treated that one a little bit different, you know, because of the emotional side of things it was a hard thing to do. So, this lady [doctor] came in -she must have been 20 or 30 years older than me, and when it came to trying to save this kid in the medical facility, she had just like an open phone line to [capital city] do this - do this – do this – do this. At the end of it when it was over and done the kid was dead, they couldn't find – the child was dead in the beginning anyway, couldn't be revived – I actually sat down with her

and made her a cup of coffee. This is like three o'clock in the morning. And I think that the best thing I could do for her, mmm. She felt very lost. (Frank)

Frank's account of the way in which he handled this event appeared to show that while he himself chose – and evidently managed to - maintain detachment from his own emotional involvement, he remained acutely aware of the distress of the doctor who was unable to revive the child. When he said he *"actually"* sat down with her and made her a cup of coffee he was most likely indicating that this was a departure from his usual behaviour, but that he thought it was justified and appropriate in the circumstances.

Jack described the behaviour that had concerned him.of a coroner that he suggested had failed to show respect for deceased babies.

The old coroner sergeant used to keep his whisky and his lunch in the fridges with the bodies. He was a ghoul; he really was a ghoul. But I could understand why he was like that because he was doing it all the time. I've seen him throw a body, like a baby's body, across the room from the fridges on to the table, sling it across the room by the arm, and I thought – well there's no need for that, you know. (Jack)

Jack's account of the behaviour of the coroner showed his discomfort with the lack of respect shown for the bodies during the autopsy procedure – in particular, those of babies. It also showed his understanding however that someone doing this work all the time might become inured to it and less sensitive in their approach. This could be seen as similar in nature to his account in the previous chapter of the important role that black humour plays in policing.

While the participants in this group spoke of coping with exposure to incidents involving the deaths of children in various ways, they were in agreement in suggesting that they had not been able to maintain the same level of detachment that they described being able to achieve with adult victims. While the incidents involving children had an impact at

the time however, there was no evidence in the participants' accounts that any of them sustained any lasting psychological injury from these events.

Although almost all the participants in Group 1 spontaneously said that incidents involving the deaths of children had been distressing for them at the time they occurred, even though this was not a specific interview question, there is surprisingly little in the literature about this aspect of policing. Exposure to the deaths of children was found to play an important role in the onset and continuation of PTSD in a study on trauma in emergency workers by McFarlane et al., (2009). These authors suggested that a register documenting a worker's exposure to incidents that have the potential for distress might address the potential cumulative effect of these on the individual. I have no knowledge of this suggestion being adopted anywhere in Australia.

The use of deliberate emotional detachment

"*I didn't think of it as another human being….*"

All five participants who reported that they had been relatively unaffected by trauma shared a coping strategy they described in various ways as being a deliberate emotional detachment from potentially traumatic events involving distress or revulsion, typically associated with violent death or physical injury. They achieved this in various ways, which included not dwelling on horrific events afterwards. Most described ways they were able to *"dehumanize"* bodies.

> *Just [gesturing to the back of his head] put it in the back – kept it at a distance, yeah. I think I'm good at compartmentalizing, just putting [it] in little bottles. And you just leave the lid on.* (Gerald)

> *I would say it's the ability to – um – see things and be around things that aren't pleasant, and really not take them overly to heart, in that sense. You do – police officers do, there's no doubt about it. But there's something with the coping mechanisms around*

that to say – [if] I've just seen something really horrendous, you know – how do I cope (Stuart)

Both these participants seemed to be indicating that they had consciously looked for coping mechanisms to manage their emotional reactions to difficult circumstances. Gerald "*put them away"* and did not revisit them, effectively isolating them in his memory and thereby minimizing any potential reminders. Stuart seemed to be indicating that he did not have a preferred coping mechanism, but actively attempted to find an appropriate one when he thought it might be needed. He also suggested that avoiding *"taking it to heart"* – perhaps meaning dwelling on the injustice or the tragedy of an event – was something that he and other police officers had to do in order to survive. Two of the five talked about growing up on farms and how they believed this might have inured them to death and unpleasant experiences.

I grew up on a farm – we were killing things left right and centre. (Pat)

We had to do all sorts of things with animals on the farm. Slaughtering sheep and that sort of thing – that didn't worry me at all. Sheep with footrot – terrible. And maggots and all in there – and you've got to cut it all off, cows birthing, having trouble with calves, pulling them out and that sort of thing, you know, we did all that and it didn't worry me, you know. And I've been to some pretty horrific road accidents where there were horrible injuries and things like that – and I'm not that fussed – it didn't sort of bother me. With a body, if you approach it correctly, you don't treat it as a body, it's just another lump of meat, another carcass. I didn't think of it as another human being. That's how I did it. (Jack).

I used to– sort of disassociate myself from the fact that it's a human. The life's gone out of it, that's it. (Pat)

These two participants spoke of their exposure to farming having allowed them to habituate to death itself and to revulsion associated with unpleasant sights and smells. Jack and Pat are saying a little more however in describing how they manage to dissociate themselves from the death of a human being. When life has gone, a person becomes a *"lump of meat."* While this might sound harsh, it nevertheless does not affect the deceased person, but does allow the police officer to deal with a very difficult situation. In Jack's case at least, he had already demonstrated that he had respect for the remains of a human being when he spoke of his distaste for the coroner's treatment of dead babies.

Some participants thought that being exposed to activities associated with post-mortems served to accustom them to coping with death.

> *Police of my era, we used to get exposed to a lot of things that they don't get exposed to now. If you're in the country, you're the coroner as well, so all the road accident victims, you had to get them, strip them off, bag them up, put them in bags, put them in police aircraft, fly them down to [capital city], all those sorts of things. They don't do those things anymore.* (Pat)

> *'Cos part of the training was going down to the city mortuary, and a lot of the cadets, they dropped out then. They resigned that day, they couldn't stand it, seeing a post-mortem. The local doctor used to do the post-mortems on the bodies - didn't really worry me, no. In fact, I helped him. I'd always pick the head and saw the top of the head off.* (Jack)

Habituation, this time to the structured procedure of a post-mortem, seems to be a central theme here, with the recognition that early exposure meant that those who had been unable to cope left policing as cadets, rather than perhaps finding at a later point that there were aspects of the job that might prove difficult for them.

While all the participants described in various ways how they managed to distance themselves from any emotional reaction to events involving death or revulsion, none spoke of using any specific coping mechanisms for dealing with events associated with a threat of death or injury to themselves, although all described experiencing exposure to incidents with this potential. In most cases they indicated in various ways that such events had simply not worried them, either at the time or later. Possible reasons for this are discussed further in Chapter 8.

"...you just get a grip and go and do..."

The participants in this group indicated that, while there might have been some support available from fellow officers, being thought of as *"unable to cope"* was avoided. The need to develop appropriate coping mechanisms to *"get on with the job",* to *"not let your mates down"* was considered important.

Toughen up. Have a beer - you suck it up – you don't let your mates down. The words you'd hear people say –you have to get the job done. (Stuart)

It's just a case of you've just got to pre-plan, have some strategy, I've got to do this, I need to do this, let's just go do it. (Frank)

I developed a – what I call a task or an attitude of just being in robot mode. Go there. View. Examine. See. Do. This is the job; it's got to be done. I can't handball it to somebody else. You've got to do it, so you just get a grip and go and do. Go and see – go see. You walk out and you think it's OK, now I've finished that. (Frank)

Getting on with the job, finding the plan as to the best way of doing it and just *"doing it"* is the general theme of these accounts. It's your job, you have to do it, and you'd be letting your mates down if you failed to do so is also implicit. So too the idea that, if necessary, you might have to toughen up, and alcohol might help with this. Keeping busy and not dwelling on the event afterwards was part of *"getting on with it."*

You've got to deal with it. You've got to get on with it. Keep busy. If you dwell on it of course it's going to eat you up. (Gerald)

If you sort of dwelled on it too much, I think it would get to you. (Jack)

Keeping emotions concealed

"I don't want to be seen to not be able to cope..."

The necessity of keeping emotions concealed was an aspect of police culture referred to by the majority of the participants in Group 1.

People would recognize that people had had bad experiences, and they'd be supportive, but it was very much "I don't want to be seen to not be able to cope with this by other people". (Stuart)

You're a liability if [you] have to go down the pathway of any form of counselling. To take yourself out of the position at work where you're supposed to be, organize for someone to fill the gap while you went across and bloody – had a chat and so on - seen as a sign of weakness, very much so. Very, very much so. (Frank)

[On hearing that a friend had a terminal illness]. When I hung up from him, I started crying - I would never have shown that sort of emotion when I was in the job. (Gerald)

These participants did not seem to have been concerned solely with keeping their emotions under control because of how they might appear to others. In some instances, they spoke of needing to develop these coping mechanisms when they were working on their own. They indicated that they were aware that their psychological welfare needed to be actively managed in connection with their exposure to potentially traumatic events. The existence of stigma associated with counselling as described by Frank, suggests that it is likely that this was not unanimously viewed as an acceptable option for managing their welfare.

The drinking culture and black humour – ways to deal with stress

As discussed in Chapter 4, for many police officers, debriefing with alcohol formed part of the coping process and this was described by several participants in this group as a significant aspect of police culture. In the absence of any other way to manage their exposure to stressful events, their use of alcohol – sometimes to excess - was acknowledged by the participants in this group.

Alcohol was a big issue. Because it was a desensitizer, you know. (Gerald)

Basically, the police department forms you into a person, and for a lot of them, it's very much a drinking culture. The use of alcohol to deal with stress came out of this drinking culture. There was definitely an era, and I was in on the end of [it]. (Stuart)

You know we didn't think in terms of posttraumatic stress disorder, but there was people that I worked with who were functional alcoholics - sometimes dysfunctional alcoholics. (Stuart)

As far as dealing with any – incident on the road or anything you thought was a bit ugly and bloody – it was simple. You know you get a six pack of beer and go and visit one of your mates and have a chat That was it. It was all done in house, right. Um – anybody who was there – we just went and had a beer afterwards. We may not have stopped at six though – as long as people understand that – and, we wouldn't have done it – we rarely ever socialized in town. We'd get in a couple of four wheel drives and piss off and go for a drink – for a day or two. (Frank)

Most of the participants in this group acknowledged that the use of alcohol had been an important part of helping them to deal with stress after difficult experiences, and a way of managing to get their job done. They considered this use of alcohol to be an influential part of police culture. What they also recognized was the potential for alcohol over-use itself to

become a problem, and that it might perhaps also serve to conceal a persisting underlying psychological injury.

One participant thought that black humour and cynicism helped relieve the stress, a view shared with many of the participants in the other groups. Another said he disliked cynicism but recognized it as a survival mechanism in the ongoing relentlessness of some aspects of policing.

> *And that's part of the secret to relieving stress. Being cynical, black humour, um – making a joke of very bad things, you know – cos a lot of police officers have got black humour and they're cynical about things.* (Jack)

> *Most coppers are cynical. And that was one of the things I hated about being a policeman was the cynicism, and the – that putting things down, was that – throw away – but that was a mechanism. That was a mechanism for people to survive, and to do the things they did, day in day out, but it was one of the things I hated the most. I thought we were better than being cynics.* (Gerald)

While they did not experience an enduring trauma-related psychological injury, most of the participants in this group did not deny that they had found policing stressful, and that some had used alcohol to cope with this stress. None, however, described developing an addiction to alcohol.

Social support, competence and *"don't rock the boat..."*

Participation in social networks were seen by several participants as being a protective mechanism, and isolation from social networks the source of potential misunderstanding and division between the police officer and the community. One participant suggested that police officers who came from the city might find it difficult to assimilate in a country environment.

> *But I've always involved myself in the communities wherever we've been, that helps, if you sort of isolate yourself you won't get on, yeah.* (Jack)

I think the other thing too is the social networks and – if you're a person who doesn't mix easily with other people – like some police get a siege mentality – we used to get a few of them in the country, they'd come from the city, and they found it very difficult to mix in with the community. (Pat)

Because some coppers become a little bit paranoid about everything, you see that. And they forget that ninety five percent of the people you deal with are nice people. (Pat)

The general impression created by many of the participants was that police officers who came from a country background began with an advantage in terms of their ability to tolerate challenging experiences, and to generally become part of rural life. This is potentially significant, since most of the participants spoke of receiving often lengthy postings to rural and remote areas, sometimes working alone in one-man stations.

For a police officer to be competent, feel confident, cope adequately and act professionally was thought to be important by some participants.

The system's very bureaucratic, you have to be very efficient with typewriters, and putting stuff down on paper so a lot of them didn't like that. If that part's not going so well, well you're going to be – you're under the pump. So, it just compounds itself. It's very eroding. It makes a lot of difference if you're a confident person. If you're professional about it you don't seem to get as many problems. Those around them soon latch on to that, body language is there. You put somebody who's confident [makes a motion of the crowd parting] – it's like Moses - the waters sort of – those sorts of people, people like to work with. (Pat)

So, I guess training, education, and then on the job experience, [if] all those things come together, you're going to be pretty right. (Pat)

I'm introvert – so – but – I trained myself to be extrovert. (Gerald)

One participant suggested he had learnt his coping skills as a child in a boys' home, where he was forced to scrub bathrooms every morning before school.

> *I soon worked out the routine of the place and hierarchical system among the boys. It was hard work, something that I had never experienced before but looking back on it, it taught us some responsibility which must have been of some benefit later in life. So, I put my police experiences as being helped by my childhood experiences. I've seen a lot of bad things, don't get me wrong, but it hasn't had any lasting effect on me,* (Jack)

Avoiding conflict with the Police Department was thought to be significant by two participants.

> *So, like – gee - throughout the career, ah, you'd be diligent, you'd be observant, be careful, but above all whatever you do, don't bring discredit on the department. Full stop. That is the golden rule. Right? Um – and if you do things [right], we will look after you. That is never said to you, but it's the ethos of what you get. Very much so. Very much so. You're going to rock the boat, don't climb on board.* (Frank)

> *If you are in conflict with the department – and I wasn't in conflict with the department - you could be treated really miserably.* (Stuart)

Several related themes appear to emerge from this section associated with social support, competence and the desirability of *"not rocking the boat".* A country background seemed to be thought to convey some advantages associated with assimilation into the community. In the previous chapter the advantage of a country background was also suggested by Victor who said he believed that the recruitment process had changed resulting in a *"softer"* profile and that there had been an associated significant reduction in recruits from a rural background, who he believed had been better suited to policing. Another theme was that of lack of professional competence and the eroding effect of this on confidence. In summary, it was implied by several of the participants that that a successful career in policing

could involve both ability and attitude: the ability to make a realistic assessment of the behaviour that is required of a police officer, the acceptance of this, and the competence to develop the required skills.

While worker's compensation issues presented significant problems for the other two groups, none of the participants in Group 1 described having made any claims. All said they had not sustained any psychological injury, and none referred to any physical injury that could have formed the basis for a claim.

Discussion

The participants in Group 1 demonstrated an ability to maintain an intentional emotional detachment from events involving death and horrific injury to others. They described developing coping mechanisms that enabled them to maintain control over their emotional responses to potentially traumatic events, with the possible exception of those involving children. "Coping mechanisms" in this context refers to *"efforts to prevent or diminish threat, harm, and loss, or to reduce associated distress"* (Carver & Connor-Smith, 2010, p. 685). Those who mentioned incidents involving the deaths of children described a period of distress from which they recovered over time.

These participants described a number of different coping mechanisms that they had developed as police officers. These included *"getting on with the job"* not *"letting their mates down"* and focusing on the processes involved in a job while performing it and then deliberately not thinking about it afterwards. Not *"taking it to heart"* - which perhaps meant not dwelling on the injustice or the tragedy of the event – was also described as a coping mechanism for some of this group. Some spoke of *"dehumanizing"* deceased victims. What these coping mechanisms had in common was that all functioned in a preventative or adaptive sense – as a means of avoiding becoming traumatized in the first place. This was a contrast to the coping mechanisms described by Groups 2 and 3, which are described in the

next two chapters. In these two groups the coping mechanisms utilized were directed at dealing with the consequences of being traumatized and were frequently maladaptive in that, in themselves, they increased the negative consequences of the traumatic reaction.

In maintaining control over their emotions, the participants In Group 1 avoided the potential shame and career damage that might have resulted had they failed to conform with the prevailing police culture of emotional concealment. Perhaps even more significantly, however, their coping mechanisms seemed to enable them to avoid any permanent psychological injury associated with their exposure to occupationally related stress in all its forms. Their narratives suggested they achieved this in part by laying emphasis on *"getting the job done"* and said they consciously kept this as their focus during potentially traumatic incidents. Research in the US has explored the effectiveness of various coping styles employed by law enforcement officers and found some similarities to the techniques described by participants in this group (Arble et al., 2018). It found that police officers who used *"active coping styles",* defined as the ability to identify specific sources of stress and develop a plan of action to address the issue, were able to reduce stress by confronting the source of tension and working towards a resolution. In contrast, they defined avoidance style coping as characterized by the desire to escape, withdraw, or deny the existence of a stressor (Arble et al., 2018). Research examining the effect of coping styles on trauma symptoms supported this in a study of police officers by Violanti et al. (2018), which found that lower active or higher passive coping was generally found to exacerbate the effect of work related stress on PTSD symptoms. This study found that the effects of administrative and organization pressure, physical and psychological threats and lack of support were sources of work related stress in addition to the exposure to potentially traumatic events.

Coping mechanisms similar to those used by the participants in Group 1 were identified in a qualitative study of ambulance personnel, who described preparing themselves

in advance for a potentially traumatic incident and focusing their attention on the technical aspects of their job while they performed it. (Avraham et al., 2014). Those who used these techniques appeared to be subsequently less affected by their exposure to trauma.

A further feature shared by the participants in Group 1 was that they did not express regret, guilt or shame for anything they had done during their policing careers. Rather than this indicating that they were incapable of feeling these emotions, they appeared to have made every effort to do their job as well as they could, and if something had not turned out as they had intended, it is likely they would have accepted this and resolved to do it differently next time. Confidence in their ability to do this seemed to be either expressed or implied by all the members of this group. As suggested by participant Pat, a police officer's lack of competence and confidence might correspondingly have an *"eroding"* effect by increasing stress associated with other aspects of the job and this could increase their vulnerability to trauma from other sources. The potential influence of confidence and competence is further discussed in Chapter 8.

The next chapter discusses the experiences and themes described by the four participants on Group 2. This group is rather more heterogeneous than Group 1. What the participants have in common however, is that all developed trauma-related injuries, and while their lives were affected in various ways by their symptoms, they nevertheless described having managed to lead satisfying and productive lives following their discharge from policing.

Chapter 6: Group 2: Injured but moving on

This chapter examines the narratives of the four participants in Group 2: Cliff, Bruce, Murray, and Don, who described experiencing multiple exposures to events they had experienced as stressful or traumatic, and subsequent development of lasting trauma-related symptoms. These participants acknowledged that they had developed symptoms resulting from their repeated exposures to traumatic incidents and to occupationally related stressors. Their narratives did not, however, indicate that they experienced any shame, self-blame or damage to their self-concept. This suggests that they did not see their development of symptoms as meaning there was any weakness or failure on their part. All described themselves as successful and actively involved in subsequent careers or activities. Some of those in this group also indicated that they had recognized and acted on a realization that it was time to retire from policing.

While their actual traumatic experiences were dissimilar, a common theme in this group was that they described themselves as retaining a positive self-concept despite the psychological injuries they sustained. All went on to productive and satisfying lifestyles following their police service and none indicated that they experienced any further decline in their mental state. Further shared themes among the four members of this group included their experience of reactions that might be described as those of moral injury in the case of three members, and the cumulative development of symptoms of PTSD, anxiety and depression following repeated exposures to traumatic incidents. All in the group spoke of deriving satisfaction from helping others in various ways, and none expressed any shame or regret associated with their own actions during their policing careers.

This chapter describes the nature of the traumatic events experienced by the participants, the cumulative effect on them of the exposures, how they made meaning of their experiences, the varying coping mechanisms they adopted to deal with them, and the

symptoms they subsequently developed. For most of these participants the development of symptoms culminated in a decision to leave policing to limit their future exposure to stress. However further stress was described by some these participants associated with their passage through the worker's compensation process. How this process impacted on their symptoms and any coping mechanisms they used to manage this are described. As in the previous chapter, in presenting the data I have chosen to do it in the form of direct extended quotes from the case studies of the participants where possible.

The Significance of the Traumatic Events and the Development of Symptoms

The effects of early trauma - Cliff

Cliff described an early experience at the dentist that had been intended to toughen him up but which he had experienced as highly traumatizing and resulted in him having to be "*dragged back kicking and screaming"* to the next visit.

> *My dad to toughen me up when I was – about 11 – took me to the dentist and said – ah – we'll toughen him up – my dad was ex-navy – no injections, so I got held down and they did two – and they were big deep fillings back in those days, with a slow drill, and – basically put his hand on my chest and said you'll sit there and you'll go through this, and he basically had to drag me kicking and screaming to go back the second time, because it was like bloody torture.* (Cliff)

Cliff described a further traumatic incident early in his policing career with a similar theme of being forced into a stressful situation.

> *I suppose it's a genetic thing, you get niggly things that get through to you, and, you know, from a very early age – I don't think I'd been graduated that long – ah – you know bloke had hung himself and I'm up with my shoulder under the dead body cutting the rope down, and the old senior connie's there, you know, I've done millions of these, it's your turn. In you go. And you know the body's groaning and there's fluids coming out*

everywhere, and back in those days no rubber gloves, no overalls, no protection, no handwash. And you smelt like a dead body for the rest of the day. (Cliff)

Later in his policing career, Cliff was again told he had to toughen up. He described having been ordered to sit through the post-mortem of a fellow officer who had suicided, and who also had been a friend – despite having requested that he be excused on that basis.

So, the superintendent says [to me] OK when the body goes to the morgue, you've got to sit through the post-mortem, toughen up princess, off you go and do it. I'm the superintendent and you're not. Do as you're told. So, here's me having to sit through the post-mortem of a guy I knew really well. (Cliff)

Cliff described this as the worst traumatic incident he had experienced during his police service. He said he went on a *"week-long alcohol binge"* following the incident, and said he still felt very upset and had a strong physical reaction when reminded of it.

It is notable that the three experiences Cliff recalled as traumatic had a common theme; he believed he had been affected by being subjected to an injustice by being forced to endure traumatic experiences, against his will, by persons in a position of power. This reaction corresponds with moral injury, defined as *"a betrayal of 'what's right' by a person in legitimate authority in a high stakes situation"* (Shay, 2014, p.142),

Cliff described experiencing his most severe psychological injury subsequent to leaving policing that he said had been result of bullying in his next job.

I was scaring hell out of my wife, sitting home crying all day. So it was a pretty terrible thing to go through, and I looked like grisly Adam, I grew a long beard and just sat there. She'd go to work and come home, and I hadn't moved, I'd just be sitting there like a bit of a wreck. (Cliff)

Sent to a psychiatrist by his GP, Cliff was diagnosed as having severe depression and anxiety and was treated with antidepressant medication and beta-blockers for his anxiety. He

took a lengthy period of sick leave and then left his employment. At the time he was interviewed Cliff said he was working in a job well below his qualifications but that it suited him because it was not stressful. There were indications that he had not recovered fully from his depressive episode and anxiety.

> *I try and avoid stressful situations, because the stress will put me – I'll have a panic attack so the panic attacks when I was sick would manifest in me with – vomiting. I can't wear a tie anymore – anything near my throat I feel as if I'm being strangled, and I'll throw up.* (Cliff)

While Cliff described his most severe symptoms of psychological injury as having occurred after he had left policing, there is a strong similarity between all the traumatic events he described; he described feeling powerless, believed he was being treated unjustly, and felt unable to defend himself. It could be argued that each experience of powerlessness Cliff experienced rendered him more vulnerable. When he was subjected to workplace-related bullying, Cliff related how this led to a major depressive episode and an ongoing anxiety state and somatic symptoms. His symptoms of vomiting and being unable to cope with pressure on his throat might be seen as a somatic expression of *"I can no longer take this/put up with this [swallow this]"* as described in Chapter 2, where somatic symptoms are described as a physical manifestation of a dissociated emotion. While Cliff's account indicates his somatic symptoms are linked to his exposure to traumatic events, somatic symptoms are no longer included in the criteria for a diagnosis of PTSD.

Deaths that might have been prevented and cumulative stress – Bruce

Bruce described an accident he had when he was 19 and a police cadet, which he said had been life-changing for him. He believed that this experience precipitated a crisis of faith for him, and that it had made him a more empathic person.

When I was 19, I hit a woman. Um - and she was an 84 year old returned missionary crossing the road and um – it was a dark, rainy night, and she got confused and started to run. And – um – I pulled over to the left, which was silly – if I'd sort of thought you silly old bitch and driven faster, at her, I would have missed her. You don't, you try and avoid it, so I kept her in my sights, you know it was just slightly to the right of centre, where I hit her –and broke both her legs, put her back out and gave her concussion. We went into the police station, and we reported it – but at that [time in my life] I had to make the choice as to whether my Christian faith meant anything to me or whether it was a load of crap. I found that as I went through a searching stage, I just found that no, I need that faith, you know, the Christian friends around me, I need that support, and um – you know it was the makings of me as a person. Um – it gave me more empathy, you know I could feel for people after that… you could just say look, everybody has their hassles, you'll get over it, you'll feel better. As you do, then you'll be a strength for somebody else. (Bruce)

While Bruce's early traumatic experience might be seen to have led to an experience of posttraumatic growth, described as a life change after traumatic experience manifesting as greater personal strength, among other positive characteristics (Kleim et al., 2007; Tedeschi & Calhoun, 1996), this seemed not to apply to the later traumatic incidents he described.

Bruce spoke of his anger later in his policing career at three deaths that he believed could have been prevented, and in a separate incident, his distress at the tragic death of a child. The event he described as the most traumatic for him was a triple murder perpetrated by a man who was apparently psychotic, but who had failed to be detained under the Mental Health Act because he was not thought to be meeting the criteria of being a danger to himself or others.

An accident that could have been avoided the day before if the police had been able to lock up a bloke, but they couldn't because very recently before that they'd changed the Mental Health Act – you know, you get that angry. (Bruce)

He also described the death of a child known to him, and the effect of this.

There was a kid that went to kindy with my eldest son. When they were seven, this kid and a friend were playing cowboys. They found a gun in a shed, one of those ones that's covered in dust, and one of them is running up the outside of the shed going bang bang bang, pulls the trigger, and shot his mate, inside the shed, through a corrugated iron wall, shot him straight through the heart, killed him. And I had to go from sort of being the copper at that killing scene, back home, and get in the shit for not dancing on the roof for my birthday party that the kids had lined up. (Bruce)

Both these events might be described as accidents that could – and should - have been prevented. The way in which Bruce made meaning of them suggested he felt both overwhelming anger and sadness as a response to being a witness to deaths that he believed should not have happened. The way in which he responded suggests that he had experienced a moral injury, as defined by Litz et al. (2009) as *"failing to prevent, bearing witness to, acts that transgress deeply held moral beliefs and expectations"* (Litz et al., 2009, P. 700), and discussed in Chapter 2.

Bruce described finding during his policing career that he was being increasingly affected by emotional triggers and feeling the necessity to conceal this in the presence of others.

I first noticed the problem that I hated sirens, which was bloody handy working in a police car, [laughs] um – ah – and you had to be under that control because you had all the stress, and then you'd have a cry on the way home – um I'd been doing crime scene work for fifteen years at that stage. Well, with two of you doing the job, you had a 50-50

chance of striking it – of - um – you know, fatal accidents, murders, um – um -ah – major fires, and um – all of the grief-type situations. (Bruce)

Bruce described the car accident he had at nineteen as having *"given me more empathy."* His reactions to later events suggest this enhanced empathy with the suffering of others might have made him more vulnerable to the *"grief-type situations",* as he described them, that he encountered as a police officer. Significantly, it was these *"grief-type situations"* that Bruce said had affected him. He did not speak of feeling revulsion as a result of his exposures to the sights, sounds and smells of death and violent injury that the other participants described as having often been a difficult part of policing.

As time went on Bruce described how he had developed further emotional triggers. He described how he might first become aware he had tensed up – and then become aware of the reason for this.

[If] a helicopter went over, and I started to tense up –just before the helicopter is physically - and then oh yeah here comes a helicopter. Now I've never ridden in a helicopter, but it's always a symbol of something wrong. if the helicopter comes in, someone's going to die. If it's the plane, there's a fifty-fifty chance they're going to live, there's some chance of survival, if a plane comes in. But no, the helicopter is just totally different because whoever went out on a helicopter they come back in a box. (Bruce)

For Bruce, hearing a helicopter signified for him that *"someone's going to die".* Bruce's triggers seemed to function to set up an emotional state of fear in anticipation of a future disaster. He described three levels of the way in which he made meaning of his experience of hearing a helicopter. First, he might become aware of the physiological response of having *"tensed up",* then, secondly, he becomes aware that this is because he can hear a helicopter. Finally, his emotional reaction is one of fear because of the impending death that this signifies for him.

These three levels of awareness are described in IPA (Smith et al., 2009) and discussed in Chapter 3. They comprise:

- *Pre-reflective reflexivity* – the minimal level of awareness.
- *The reflective "glancing at" a pre-reflective experience* – how a physical sensation might remind us briefly of a past experience.
- *Attentive reflection on the pre-reflective* – how we might focus on what has accidentally come to mind, find it significant, and how it might then promote further reflection. (Smith et al, 2009, p.188).

As also discussed in Chapter 3, these levels of awareness describe how a stressor can first register at an unconscious level, e.g., *"I'm tensing up"* and be interpreted as a threat (Lanius et al, 2017). As a function of its relationship with of past experience meaning is then made of it *"Oh yeah - here comes a helicopter"* and it is registered that it requires further attention (Brewin et al., 2010). Finally, the full significance of the awareness sets up an ongoing emotional state of fear or dread – *"someone's going to die".*

Bruce also described suffering anniversary phenomena that evoked a similar state of fear or dread which he attributed to horrific events having impacted on him at certain times of the year.

> *I just hate Christmas – um – because I've got a birthday eight days before it, and then you've got Christmas the eight days after, but there's always a tragedy, either on my birthday, or on Christmas day that's going to stuff up either my birthday or Christmas. The only third alternative that you'll get is that both can be stuffed up in that year.* (Bruce)

Repeated exposure to these fear triggers appears to have culminated in the symptoms Bruce described experiencing at the time he was interviewed, which were consistent with those of PTSD. He did not however describe however, having experienced fear as a result of exposure to incidents that posed a risk of death or injury to himself. His fear was rather a response to

triggers that functioned as reminders of traumatic events that might involve potential death or injury to others. He found these reminders highly distressing and made efforts to avoid them when he could. His initial responses to these events were thus more typical of moral injury, reflected in Bruce's belief that the events were traumatic for him because they "*shouldn't have happened".*

Cumulative stress, concealment and increasing symptoms – Murray

Murray described having been exposed to a succession of life-threatening incidents during his policing career. These included being bashed unconscious in a pub brawl and left with permanent physical injuries. He said he noticed that over an interval of time that he was experiencing an increasing emotional response to events that he said would not have troubled him earlier.

> *Sitting there watching TV and I see a policeman get shot or hurt, I'll start crying – not flooding down but – oh – and I'm not sitting there going oh that's horrible, that's horrible, but I just feel myself being emotional.* (Murray)

He said he concealed this because of the prevailing police culture of not showing emotion.

> *I didn't want to be seen as being weak - the environment was – you never went and discussed it anymore. You know you sit around and yak about things like that, you're either a bullshit artist, or can't you handle it – is there something wrong with you?* (Murray)

Murray also described noticing he had become increasingly vigilant and defensive.

> *I had a bloke walk up behind me – they used to give us big polycarbonate batons and I just stopped it about there on his face and I said if you fuckin' walk up on me again I'll kill you.* (Murray)

The increasing increased vigilance and emotional lability described by Murray are consistent with "*marked alterations in arousal and reactivity",* or hyperarousal, and *"marked*

physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s)". These two symptoms are associated with a diagnosis of PTSD as it is defined in DSM-5 (American Psychiatric Association, 2013, p.271). The way in which Murray described these symptoms increasing over time is consistent with the way cumulative trauma occurs as a response from multiple exposures to traumatic events, as described in Chapter 2 (Bryant et al., 2013; Geronazzo- Alman et al, 2017; McFarlane, 2010b). His defensive reaction to someone approaching him from behind illustrates the way in which threat is first registered in lower brain centres and a response is instigated fractionally before the signal reaches the cerebral cortex for interpretation, as also described in Chapter 2 (Lanius et al., 2017). It was fortunate that the signal reached Murray's cortex and the meaning of the event was interpreted as non-threatening before his baton reached the other officer's face.

Multiple traumas and dissociation – Don

Don described multiple traumatic events over a long policing career. At the beginning of this career, he served overseas as a peacekeeper, where he identified his powerlessness to intervene as a source of trauma.

> *I was there when [neighbouring country] invaded, and then, you know, there was mass graves, and genocide, and you know, just horrible. And we were standing back watching some of the most horrific things you could think of, and we couldn't do anything.* (Don)

Don's symptoms were as a result of his experience as a peacekeeper and correspond, like those of Bruce, with the aspect of moral injury described as "*witnessing of events that transgress deeply held moral beliefs and expectations"* (Litz et al., 2009). In an Australian study, peacekeepers were found to have a significantly higher 12 month prevalence of PTSD, major depressive episodes, generalized anxiety disorders, alcohol misuse, alcohol dependence and suicidal ideation compared to a matched civilian sample (Forbes et al., 2016). The mental

health risks of peacekeeping are thought by these authors to be poorly recognized and to be associated with their role as non-combatants who might witness atrocities against civilians but be unable to intervene.

After his return to Australia, and still at an early point in his policing career, Don was involved in a life-threatening incident in the bombing of a major police headquarters in the 1980's.

> *I was actually on the road 12 metres from the car, when it went up. Directly opposite. And I was blown back that 12 metres into the bluestone wall and about a metre off the ground. I wasn't shaking. I wasn't even shaking. I just went into work mode. I was two hours at the scene with half my clothes missing and burns and scalds and broken bones and whatever and it took another policeman to say, "hey Don - what are you doing here?". One of the assistant commissioners threw me in the back of an ambulance, they were taking glass out of my eyes, and patched me up – cracked my arm, and bit of blood and burns and whatever. Went back, got my car, drove home, had a couple of beers, yes, she's great, no worries. Couldn't hear for a week, went to work the next day and walked through the scene with the investigators. And I went home crook in the afternoon because my head – just felt like it was a watermelon, going to burst. And almost exactly a month later I had a panic attack. An absolute doozie. And I'd never had one before.* (Don)

In the bombing incident, Don experienced a very significant threat to his life. His description of his behaviour, his lack of emotional response and awareness of his injuries at the time of the incident, coupled with a major delayed reaction and ongoing symptoms from that time suggests that he experienced a peri-traumatic dissociative response. As he described it, he *"went into work mode".* This enabled him to deal with the situation devoid of any emotional state connected with it, as described in Chapter 2 (Bryant, 2007). A month later he described experiencing the first of many panic attacks and he described developing an

ongoing severe anxiety disorder. The meaning he attributed to the way he responded - "y*ou just dissociate yourself, do what you have to do and get on with it, if you've got a job to do."*- was that his dissociative reaction enabled him to cope with this situation at the time it was happening. However, he described later experiencing severe delayed physical and psychological effects, which corresponded with the symptoms of both PTSD (hypervigilance, intrusive memories, negative emotions and thoughts, and avoidance) and anxiety disorder with associated panic attacks. While it might be adaptive at the time, peri-traumatic dissociation was found to be the most important factor leading to a later diagnosis of PTSD (Ozer et al., 2003). Don said he had also experienced loss of memory associated with his exposure to other traumatic events. This is also consistent with a peri-traumatic dissociative response leading to the subsequent impairment of memory recall for the event (Brewin et al., 2010; Lanius, Vermetten et al., 2010).

> *All I remember is that we went to this accident. and he [police officer also on scene] described it all to me {later]. And I know there was lots of dead bodies. and it was horrible, horrible. Babies, and kids, and matching heads to bodies and whatever. But I've completely suppressed some of that stuff.* (Don)

Don described experiencing other traumatic events when he had been unable to dissociate himself from his emotions. These included in his experiences as a peacekeeper "*but, like when you're in the federal police, working overseas as a peace-keeper, you didn't have a job to do..."* On those occasions, he was prevented from directing his attention on to *"doing a job".* Because of his status as a peace-keeper he was rendered powerless to intervene in any way when atrocities were being committed in front of him. He also spoke of an incident involving the deaths of two children in a fire that had greatly affected him. In this instance he said that having children the same age had made it impossible for him to dissociate from his subsequent emotional response.

We go in there, here's this five year old boy lying on top of his two year old sister, to protect her. Now how do you go home from that and just go to sleep when you've got kids that age? And a burnt body, that is the one that just gets me, every time. I couldn't dissociate myself from that one, I just broke down completely – not then, I had [a job] to do – [but later]. (Don)

Don's description of his traumatic experiences suggests that while he understood that he had an ability – and a tendency - to dissociate at the time of an event and concentrate on doing a job, this ability did not function when there was no job he could do. When exposed to the death of the two young children in a fire he was also prevented him from dissociating after his job at the scene was completed because of a connection he made with his own children. He also indicated that he was aware of the connection between the later occurrence of panic attacks and ongoing anxiety and his prior dissociative state in the bombing episode. While reacting in this way had enabled him to respond without any associated emotional reaction, as he described it this was not voluntary decision, but it did appear to relate to having a job to focus on. It was ultimately also not protective since he later developed severe and lasting symptoms which he associated with the event. The concept of dissociation and how it differs from the deliberate detachment described by the participants in Group 1 is discussed further in Chapter 8.

Variable reactions to different types of traumatic experiences - Cliff

Cliff described having reacted in a variety of ways to different potentially traumatic events.

You know [sometimes] you look at it professionally, you walk in professionally, I've got a job to do, and especially with paedophiles and things like that, you feel like reaching across the table and throttling someone, but that's not going to help your cause, you want to get them in jail, you know, get the best result you can for the victims. Other jobs it's like

you have a force field up and it just bounces off and you didn't even feel it, you're professional, you went through the job, do the job by the numbers, and did what you had to do and then you moved on and you didn't even think about it, but every now and then there'd be something that would stick with you and niggle and niggle. (Cliff)

Having a job to do was also important for Cliff. He described the different reactions of being able to contain his emotions by keeping the best interests of the victims in mind, at other times feeling quite unaffected as if he had a *"force field"* around him, then at other times again finding that *"niggly things*" *"got through"* to him and *"niggled and niggled". H*e did not indicate that he attached any meaning to the reason that some things affected him this way, but perhaps relevant might have been the common elements of powerless and injustice, described earlier in the three incidents he considered his most traumatic experiences.

Coping Mechanisms

Ways of coping from early life experience - Bruce and Murray

Both Bruce and Murray described earlier life experiences that they believed had been critical in shaping their later attitudes. Murray attributed his attitude to life to his mother.

I remember her saying to me once, listen, it's a test of character, how you handle adversity. She said "have your sook, have your cry, get over it and move on. Don't dwell, don't wallow in your own self-pity". (Murray)

Bruce attributed the maintenance of his self-worth to always feeling valued.

I didn't lose my self-esteem, when I got diagnosed with depression, Um – ah – I think that was partly the Christian background where you know you were taught you're valued, you know, I'd been brought up in a good family, um – and - um, and you didn't have the abuse and things like that, so everything was positive, that – about me personally. (Bruce)

Both also used humour as a way of achieving resilience in dealing with setbacks. After losing his uninsured house in a fire, Bruce described how he had achieved an acceptance of the event.

> *When God shuts the door, he opens a window, but I just wish he'd left some bloody walls to hang the windows on! I've got a list of words I've always used to the kids in foster care. Pick yourself up, dust yourself down, your eyes are stuck in the front of your head so you can look forward. If God had wanted you to look back. there'd have been at least one eye in the back of your head. So just keep going forward.* (Bruce)

In his dealings with worker's compensation associated with the physical injuries he had sustained, Murray presented himself as prepared to fight for what he believed he was entitled to and used humour as a coping mechanism. When told he needed to go back to his doctor each time the Velcro straps that attached his CPAP mask needed replacing, his response was that his GP *"wasn't a doctor of "velcroology" – maybe I should go to Bunnings [a major chain of hardware stores] for an opinion".*

Caring for others as a coping mechanism

Both Bruce and Murray described experiencing increasing emotional disturbance over time as a response to cumulative traumatic experiences. However, nothing they said indicated that this negatively affected their self-concept or identity. Both said they gained satisfaction from caring for others, and perhaps this might have counterbalanced any potential damage to their self-regard. The effect of *"compassion satisfaction"* – the gaining of personal benefit from helping others - in helping to modify some of the stresses involved in policing has been suggested by Anderson and Papazoglou (2015) and Chopko (2011).

Avoidance as a coping mechanism for managing trauma symptoms - Bruce

Bruce's contribution to the care of others was to foster troubled teenage boys, which he continued to do up to the time he was interviewed. However, he thought that the stress

associated with this also eventually contributed to his *"burnout"* as he described it, and his early retirement.

> *But I think the burnout itself was caused by a combination of my lifestyle, because I had up to six teenage boys at home. And when you look at three seventeen year olds, two fifteen year olds and a thirteen year old, well I [used to say] I went to work to get away from it- but – um there was things that would overlap, where your time was sort of drained.* (Bruce)

In his time in the police force Bruce believed he had also been empathic and supportive to members of the community and had been appreciated for this. "*Like when you go back to a town to work and someone says, I owe my life to you, [you were] the only person who was prepared to listen to me when I needed somebody."*

Of the four participants in Group 2, Bruce seemed to have the most precarious life in retirement. He said that he continued to experience both traumatic triggers and that he practised avoidance as a coping mechanism, two of the four symptoms of PTSD. "*I'm really just – just – I've got to handling it – um where you get your stresses – I've got to know what to avoid – what not to – and um – and get on and live a life."*

Avoidance used in this sense is one of the criteria for diagnosis of PTSD (American Psychiatric Association, 2013). The mechanism whereby initial symptoms associated with moral injury might later potentiate those of PTSD was illustrated earlier in Bruce's description of how he reacts to the sound of a helicopter. Bruce's initial reaction was one of distress resulting from his exposure to *"the grief-type situations",* that *"shouldn't have happened".* Later, he developed a fear response to triggers that indicated similar situations might be about to happen, and avoidance of exposure to any situations that might act as a trigger.

Bruce retired from the police force at the age of 47. He said his GP had sent him to a psychiatrist who diagnosed him as depressed and recommended he leave policing. He said he had never received the diagnosis of PTSD and was adamant that he did not wish to receive it because of the stigma – and perhaps pity - he believed would have been associated with it. He described having suffered a stroke at age 44 and said he experienced the apparently well-intentioned offers of help he received after his stroke as demeaning and humiliating- *"like being kicked when you're down".* At that time, he said he fought against opinions that his policing career was over and returned to active duty within six months.

The way that Bruce regarded the attempts of others to assist him, coupled with his own dedication to helping others, suggests the maintenance of his self-concept might have been in part associated with the role being a *"helper"* and that he felt shame and humiliation if he found himself in a position where he might need support from others. This could conceivably create a difficulty for him if at any time in his life he found himself in the position of having to be dependent on others.

Ensuring the safety of others as a coping mechanism - Murray

When he had worked at investigating road fatalities Murray said he had been distressed by the many police deaths he saw related to alcohol consumption. *"It was just fatality after fatality after fatality."*. He later served as a police educator in ethical behaviour, and instigated treatment for police alcohol over-use, particularly for those who would still be over the blood alcohol level when they went on duty after drinking heavily the night before. He described ensuring their safety and that of the public by insisting that they would not have access to a firearm or get into a police car. While his activities served a valuable function, he later recognized them too as a way of avoiding his own difficulties. "*I thought I'm over all this, I'm in charge of all this, my role is to look after you, and I had to do that on a number of occasions, you know."*

Murray said he had earlier received a formal diagnosis of PTSD. However, he did not describe having ever developed the symptoms of intrusive memories and avoidance that are the other criteria for meeting the diagnosis, nor did he suggest that his self-concept had been adversely affected when he developed symptoms. He did not speak of feeling ashamed of either his trauma-related symptoms or any aspect of his policing career; on the contrary, he spoke with pride of his achievements as a senior officer. If he acknowledged shame at all it was in relation to his difficulties with worker's compensation, described later in this chapter.

Both Bruce and Murray described experiencing increasing emotional disturbance over time as a response to cumulative traumatic experiences. However, nothing they said indicated that this negatively affected their self-concept or identity. Both said they gained satisfaction from caring for others, and perhaps this might have counterbalanced any potential damage to their self-regard. The effect of *"compassion satisfaction"* – the gaining of personal benefit from helping others - in helping to modify some of the stresses involved in policing has been suggested by Anderson and Papazoglou (2015) and Chopko (2011).

***"Putting on the mask"* - and caring for others as coping mechanisms – Don**

Don described the effects of his dissociation at the time of the bombing as resulting in him experiencing increasingly severe anxiety which he apparently successfully masked during his subsequent lengthy and successful police career.

> *Often [I'd be] travelling to and from work blowing into a brown paper bag because I was hyperventilating and having panic attacks. Get to the job, cool, calm, collected and "in charge". Giving presentations, I'd have a pulse rate of over 200. I could mask my symptoms, and no one knew.* (Don)

Don said his symptoms worsened over time and included those considered typical of PTSD: nightmares, events that triggered past traumatic memories, and patterns of avoidance (American Psychiatric Association, 2013). He said he began having panic attacks at night,

waking up in a cold sweat after what he described as *"flashbacks"* – probably vivid dreams involving actual events. He also described panic attacks triggered during the day by a variety of events, particularly to smells which reminded him of dead or burnt bodies. He said he avoided watching anything on television that might have triggered him, and said *"I couldn't put my computer on because I was afraid I'd be confronted by something I couldn't handle".* He said he had used alcohol *"as a crutch"* and his intake had increased. At the time he was interviewed he said he still used alcohol to assist with his anxiety, but that he had his intake under control. "Y*ou know I'm not an alcoholic, but I would drink two-thirds of a bottle of wine a day. If I don't, I've probably got to take a Xanax. Because I'll go to bed, and I'll go – eeeah."*

When asked what he thought was the main factor that influenced trauma-related symptoms, Don said he believed it was lack of support. "*My ex-wife – we were good friends – would never, ever, be interested in what happened to me during the day. I had to go home and be a totally different person. Put the mask on."*

Don said he had recently been involved in a group treatment program for PTSD that he said had been helpful. At the time of interview however he said he was still experiencing difficulties with anger control, panic attacks preceded by a period of disorientation, palpitations and stomach pains, and nightmares. He was on a comprehensive medication treatment regime. Don's symptoms suggest he suffered PTSD, anxiety disorder with panic attacks, and moral injury.

Despite this, Don described putting much of his time and energy into caring for others. At the time he was interviewed he was putting in extensive work as a case manager to support and manage former police with trauma-related difficulties. However, his description of his experience indicated he continues to be severely affected by trauma symptoms himself – unsurprisingly, given his history of multiple extreme exposures, described in Chapter 2 as

being associated with an increased severity of symptoms (Bryant, 2019; Kolassa et al., 2010).

Being Aware it was Time to Leave Policing – Cliff, Murray, and Bruce

Cliff and Murray both described having *"an epiphany"* and realizing it was time to leave policing. Cliff said he decided to leave because he believed there was corruption in human resourcing and suggested that this resulted in curtailment of his opportunities for promotion. In addition to this he was unhappy with the limitations on his family life presented by shift work.

> *A number of issues happened to me during the course of my time in the police that – you know – the light bulb went off and I had a bit of an epiphany and thought I'm wasting my time here, this is not a great place to work, the management aren't very nice people and the corruption in HR was really what forced me out. And I was in my early forties and I thought this is a waste of time plus the shift work and young kids – my kids never saw me.* (Cliff)

Murray described recognizing a *"turning point"* in his life.

> *I'm one of these move-on guys. I say now and it was very very hard for me, going through that, it was very traumatic. And it was one of those – what do they call them – epiphanies - when you wake up at two o'clock one morning and you go – no. Enough of the bullshit. I'm moving forward. I'm turning here.* (Murray)

Bruce decided, after experiencing a brief episode of peace, that he had had enough of the stress associated with policing.

> *I'd arranged to do a charity walk from [place name] up to [place name]. I got to the top of a hill, after two days of walking, and cried. Just looked over and there was so much of nothing, it was so peaceful, by the time I got back to [place name], on the walk, um – I was telling myself, I've got to go into work tomorrow. Then I thought I don't need this shit.* (Bruce)

Compensation Conflicts – Cliff, Murray, Bruce, and Don

Cliff had not made a worker's compensation claim himself, but he was highly critical of the way he believed the compensation process had affected other police officers. He said that he attributed the suicide of a fellow officer in part to his distress that he was being watched by private investigators engaged by the worker's compensation organization.

Following a heart attack and bypass surgery, Murray made a claim for this, citing occupational stress, but this claim was rejected, despite the existence of contemporary research indicating that occupational stress can affect cardiovascular health in Australian police (McFarlane 2010b; Tuckey et al., 2010). His time in policing ended when he was found medically unfit for work based on his physical injuries. He said that after this he was *"I was basically left on my own".* He said he had been told by the police union to go on to worker's compensation and use all his sick leave, but he did not wish to accept this option - *"I wanted to sever ties".* At the time he was interviewed he continued to experience conflict with worker's compensation associated with the provision of appropriate treatment for the facial injuries he sustained when bashed in a pub brawl. He described his dealings with worker's compensation after his retirement as:

> *A battle over small things, but an accumulation of 12 years of frustration but it increases your stress level [said with emphasis] something shocking. You're not quite – I would never say that I felt that I was begging, but you've certainly got to fight hard for what you're entitled to.* (Murray)

Retired from policing with a diagnosis of depression, Bruce said he did not attempt to claim worker's compensation because *"you start with a fight".* As mentioned earlier, he was adamant that he had not wished to receive a diagnosis of PTSD because of the stigma he thought would be associated with it; perhaps another reason why he did not claim worker's compensation.

Don said he believed support and acceptance from the worker's compensation organization was important, and that lack of it increased the shame the person might already be experiencing.

> *Any person who is diagnosed with stress, PTSD or depression should instantly be accepted. They can't go to work. They're ashamed because they can't go to work - all you're doing, and I've seen it so many times, is making their condition worse.* (Don)

Don described the interview he went through as part of his compensation claim as "*just a Spanish Inquisition. And this is what people are subjected to. And you walk out of one of those things and you're feeling ten times worse than when you walked in".*

Entering a New Phase of Life

All the participants described ways in which they shaped a new identity after leaving policing. Cliff described staying in touch with other former police, being active in facilitating contact between them and organizing events where they could connect with each other. He described how he experienced solidarity with other ex-police, and his pride in having been able to make a difference in people's lives.

> *You tend to stay in touch. It's a loyalty thing you know. You know cops are really loyal to each other. Not so much to the management but to each other. You know some of the things you see and do, the jobs that you go to are life-threatening – you know you could lose your life and you trust the guy standing next to you and you form very strong bonds. People will bring up stories about stuff that you did in the seventies and eighties, and you'll go – one, you were able to protect the public, two, you did a good job, you made a difference in people's lives, and that was a real positive part of it.* (Cliff)

Murray also continued to have contact with other former police through voluntary work. He was selective about those with whom he spent time socially, however. He emphatically resisted invitations to join groups of ex-police, saying that he would rather

move on – in keeping with the advice he had received in earlier years from his mother. He said however that it was his experience that *"moving on"* might take some time.

> *But even though when you ultimately relax, or feel yourself starting to relax, it's still ticking – you know, you stop reading things about – involving the police because you're creating new interests for yourself, you're making that separation. But it takes a minimum of six months, after thirty five years. And I think that until you make that separation you can never move on. [I'd rather do this than] go and sit around with a lot of blokes who talk about things that happened twelve to twenty to thirty years ago. And I think that until you make that separation you can never move on, you get very stagnant, you get very bitter, um – you know I think these are people – these are people who are dwelling on things they can have no influence on whatsoever.* (Murray)

While he acknowledged he had regrets associated with the injuries he had received, Murray was adamant that he would not dwell on the past.

> *I didn't ask for this, you know, I didn't have control. I wish I hadn't have gone into that pub [where he was bashed, resulting in his permanent injury] – but I did, and it was part of my job. People don't see that, and nor do I go around telling them because I sort of think – it's over. And you know, like I said before, I'm one of these move-on guys.* (Murray)

Barry described leading a busy life. At the time I spoke with him his own children had left home, but he was continuing to foster troubled boys and worked part time in disability support. He had also spent some time managing hostels for people with disabilities. He believed his successes with difficult clients had been a result of his police service.

> *It was just the police experience that got me these things - and see I'm not politically correct – I don't know whether you've picked that up in the conversation, but I believe it's*

the police training of seeing what the problem is and dealing with the problem that we had back in those days. (Barry)

Barry acknowledged that he believed he had PTSD – despite his resistance to being given a formal diagnosis - and described knowing that he was loved by his extended family countered its effect on him. "*I'm not the worst PTSD you're going to come across. For the girls to come in the door, love you grandpa, you know, and straight up, you always know that you're loved."*

Don said he left policing on the advice of a psychiatrist who he said had been shocked at the amount of medication he had needed in order to function. Don was happy with his decision to leave, and using his extensive contacts moved straight into supporting other police with trauma-related injuries. At the time I spoke to him he said he was involved with this on a full-time basis. He said that while for others leaving policing might be difficult, for him there were benefits in being fully occupied.

You've gone from sergeant to mister. Your standing in the community goes zoomp [indicating a downwards motion] in your own mind. You know from the day I left the police force it's never worried me. I couldn't care less. Because I'm busy. (Don)

While all said when interviewed that they continued to experience symptoms of trauma-related injury, the participants in this group did not describe any progressive worsening of their mental state subsequent to their retirement and all described active involvement either in the workforce or in voluntary activities, or in both. Despite their acknowledgement that their symptoms presented difficulties for them at times in various ways, all said that they had found ways of adjusting to cope with them or avoiding exposure to situations that might trigger them. All considered that they retained the capacity to lead a satisfactory and rewarding life, albeit with some limitations, and said they had actively maintained their social connectedness.

Discussion

The four participants in Group 2 described having experienced cumulative stress from repeated exposures to a variety of traumatic incidents. Their reactions to these exposures differed; Cliff said he experienced generalized anxiety as a sequel to a major depression that occurred after he left policing, but was arguably a sequel to the cumulative effect of occupational stressors experienced during his policing career. Bruce described being initially exposed to stressors – "things that shouldn't have happened" and "all the grief type situations" that led to effects resembling those of moral injury. The way in which he made meaning of his initial experiences then appeared to lead to him developing symptoms of PTSD. Murray described developing symptoms of PTSD resulting from repeated exposures to life-threatening events. He did not describe any effects which might be associated with exposure to any morally injurious events. Finally, Don's narrative indicated that he developed symptoms consistent with PTSD. He also described ongoing anxiety state with panic attacks, following the cumulative effects of multiple exposures to events that were life-threatening. In addition to these symptoms, he described effects consistent with moral injury, associated with his experiences of witnessing atrocities perpetrated on civilians when he worked as a peacekeeper.

Not all the participants in this group described their trauma-related injuries as solely associated with exposure to life-threatening events. Three of them, Cliff, Bruce and Don, described effects considered more typical with those of moral injury. In Cliff's case, as a result of injustices perpetrated on him by persons in authority. In Bruce's case, from feeling "burnt-out" as a consequence of witnessing the events he said "shouldn't have happened" that he had experienced while policing. In Don's case, he was haunted by the injustices perpetrated on civilians caught in a war zone. As described earlier in Chapter 2, moral injury, to date largely associated with members of the military but beginning to receive recognition

in other groups exposed to potentially traumatic events, has two definitions. The first as a response to *"a betrayal of 'what's right' by a person in legitimate authority in a high stakes situation"* (Shay, 2014, p.142); the second, a response to *"failing to prevent, bearing witness to, acts that transgress deeply held moral beliefs and expectations"* (Litz et al., 2009, P. 700). Because of its status as an emerging construct, the outcome from moral injury varies according to different authors, but there is evidence that shame, guilt, spiritual/existential conflict, and loss of trust are associated with exposure to perpetration-based events (Jinkerson, 2016), and anger with events involving betrayal (Frankfurt et al., 2017; Jordan et al., 2017). This is consistent with many of the effects described by the Group 2 participants.

In summary, two of the participants in Group 2 described experiencing trauma-related symptoms associated with both PTSD and distress associated with the effects of moral injury, one described experiencing symptoms of PTSD, and one described symptoms indicative of anxiety and depression, and distress associated with the effects of moral injury. Despite this however, they did not indicate that their mental health had deteriorated further after leaving policing, and all expressed satisfaction with the life they were living in retirement. In their various ways, all these participants described similar themes in their attitude to life. All indicated that they had been able to recognize when it was time for them to leaving policing, and they had left without regrets. All of them also said they had found significant occupations associated with helping others in their retirement, and while they did not directly acknowledge this, it could be inferred that they gained considerable satisfaction and pride from these activities. This was the defining element in the difference between this group and Group 3 whose experience is detailed in the next chapter. The participants in Group 2 said they had been able to maintain their confidence in themselves and their sense of self-worth despite having developed symptoms, and all indicated that they had been able to achieve a satisfactory quality of life in retirement.

The coping mechanisms employed by the participants in Group 2 were directed at dealing with the consequences of having developed trauma related symptoms. In this way they were different from the coping mechanisms of the participants in Group 1, whose coping mechanisms were directed at the prevention of any initial trauma related effects. However, with two notable exceptions, the use of avoidance by Bruce, and Don's "putting on the mask" and battling on despite the presence of severe symptoms, the coping mechanism used by the participants in this group were adaptive. Not "wallowing in self-pity", the maintenance of self-esteem despite having developed symptoms, the use of humour and gaining satisfaction from helping others were described by the participants in this group as helpful in assisting them to feel better about themselves and to generally maintain a more positive mental state.

It was notable too that, when they looked back on their police service, the participants in Group 2, like those in Group 1, did not speak of experiencing any ongoing shame or regret associated with their own behaviour and actions during their police service, despite their distress associated with exposure to events that had impacted negatively on themselves or on others. With respect to their trauma symptoms, their narratives suggested they conformed to the culture of the time in not revealing their symptoms and risking exposure to the culture-based stigma they might have been subjected to as a consequence. Despite having concealed their symptoms however, they did not describe feeling any internal shame associated with them – in simple terms, they appeared to not be ashamed of having developed symptoms. Internal shame is considered by Kaufman (1989) to play a central role in low self-esteem, to produce self-doubt and disrupt security and confidence, and to underly much psychopathology. While the participants in this group were realistically aware that they were likely to be viewed negatively by others if they acknowledged experiencing trauma-related symptoms, this did not appear to apply to how they viewed themselves.

The narratives of the participants in Group 2 also suggested that their self-concept and sense of identity had remained intact. Janoff-Bulman (1992) suggests that if the individual does not live up to his or her valued self-concept, they may experience shame and a crisis of identity. The participants in Group 2 gave the impression that they continued to have confidence in themselves and their abilities and arguably this had contributed to them being able to achieve a satisfactory quality of life despite their symptoms. This suggests that the absence of internal shame might have significance by conferring a certain amount of resilience to a further deterioration in mental state in the presence of symptoms of psychological injury. How this enhancement might be approached through psycho-education is discussed further in Chapter 8.

The next chapter examines and discusses the experiences, responses and shared themes of the group of participants most affected by their policing exposure, and how they made meaning of their experiences and the subsequent effect of this on their mental state and psychological well-being.

Chapter 7: Group 3: Injured and Worsening

This chapter examines the narratives of the five participants in Group 3: Victor, Denis, Phil, Peter, and Ivan, who described experiencing ongoing severe trauma symptoms and a progressive deterioration in their mental state, following multiple exposures to events they had experienced as stressful or traumatic. At the time they were interviewed all these participants said they had received a diagnosis of PTSD with comorbid major depression, and the symptoms they described appeared largely consistent with these diagnoses. They said they believed that they had undergone permanent change from the person they had been prior to developing symptoms of psychological injury. They experienced regrets and shame associated with this change and with how it had influenced their behaviour and limited their activities. All indicated that they saw the effects of their psychological injuries and their associated symptoms and distress, both psychological and physical, as central in their lives, and instrumental in necessitating their retirement or had resulted in their forcible discharge. All described themselves as unable to work, although some participated in limited voluntary activities.

A shared theme in this group was that all attributed the progressive deterioration in their mental state to a negative self-concept and shame associated with the changes they perceived in themselves and in their behaviour that were associated with their post-trauma psychological injury. A further theme was that all believed they had been treated unjustly by their respective police departments and senior officers and felt ongoing humiliation and anger associated with this. All the participants also described ways in which they believed their symptoms were exacerbated by the effects of the prevailing police culture, which discouraged the showing of any emotional reaction to a traumatic event.

Three of the five participants described experiences and symptoms that were consistent with cumulative trauma from exposure to potentially life-threatening critical

incidents involving violence, death and injury. One participant, Peter, suffered a psychological injury from the effects of having killed an offender in the line of duty, and from subsequent related events. One participant, Victor, did not describe any trauma-related symptoms associated with policing duties, but rather a trauma-related psychological injury as a consequence of challenging the actions of senior officers.

The Initial Traumatic Event or Events and the Reaction

***"I was devastated – I just fell over"* – Victor**

Victor said that for much of his policing career he had been confident of his abilities and had enjoyed his work and the opportunities it gave him to be innovative. When he discovered that a program to improve justice in selection of police officers for promotion that he had instigated had later been maladministered, he reported this. He was then accused by the Internal Investigations Branch of criminal activity and, significantly, of *"bringing discredit to the police".* This resulted in him feeling an acute sense of injustice and complete disempowerment. He described having what he believed were his rights as a whistle-blower ignored and his actions redefined as aberrant and unethical. Describing himself as having felt shamed and defeated, he said he had subsequently felt unable to face returning to work and had isolated himself for some months.

> *They were fabricating results. And I - put them in. And it was the biggest turnaround I've ever seen in my fucking life. They immediately attacked me. And there were interviews that went for a couple of hours when I said you people are incompetent. I'm a whistle-blower, I've actually invoked my protection under the Whistle-blowers Act, you're fucking breaking the law by doing these things. You can't do these things! And they just fucking did it anyway. And then – they charged me with – all of these breaches of regulations – over what I did. All category A, all sackable offences. And it was malicious charging. It was the biggest most horrible turnaround that ever happened in my career.*

> *And I was devastated. And I just fell over. I couldn't go to work. I just woke up one morning and I said I couldn't face it again. And then I was off work for five months I [went] off on stress, where I sat home, I didn't do anything, I was a hermit, I was embarrassed, ashamed, felt silly.* (Victor)

While Victor describes having had little respect for senior officers prior to this event, his account indicated that he had believed that justice was still inherent within the system. He describes then being devastated by the injustices perpetrated on him by senior officers when he believed he was within his rights to defend the system he had instigated, which had been in itself an attempt to make the promotion system more equitable. He spoke of attempting to defend himself from the charges brought against him acting on the belief that he was operating as a whistle-blower – in the interests of truth and justice. Instead, he said the tables were turned on him and he was both rendered powerless and subjected to massive external shaming and humiliation by being told it was he who had brought discredit to the police. Victor acknowledged experiencing embarrassment and shame as a consequence of this, and his psychological health suffered. His response was consistent with that of moral injury as a betrayal of *"what's right, by a person in authority, in a high-stakes situation* (Shay, 2014, p. 182).

In contrast, the other four participants in Group 3 described experiencing shame as a secondary response subsequent to their initial development of symptoms associated with exposure to operational critical incidents.

***"You start to unravel, a little bit at a time..."* – Denis**

Denis reported beginning to experience difficulties when he was posted midway in his policing career to a remote rural area. He spoke of having to endure constant community violence that he could not escape because he was on his own. He also struggled with primitive and squalid working and living conditions – which he attributed to cost-cutting

measures and *"no one caring".* In his own words, he began to *"unravel";* he became increasingly angry, and, with this, he became concerned he might become violent if someone "*stepped over the mark".*

> *You were there by yourself, you know, it was just constantly – if you're there – they say on days off you're not on call – but shit's happening all the time. That lawlessness, that complete violence – hard to put it into words – when you see someone coming at you with a bloody axe or whatever and they're completely, they're just zoned out and you know you've got to deal with it, and you know you can't run, and you've just got to deal with that problem there and then. There's a tin shed in each community, but they're just absolutely filthy, defies bloody imagination, you know, the dirt inside of them – who's going to work in that environment. The guy who was previously in charge cut the funding to say oh this is how much I've saved you, but no one ever went out there to have a look. I just felt really tight in the guts, feel really anxious, feel all sorts of things happening within me - shit I just need to escape, get away. You start to unravel, a little bit at a time, but you don't see it, it slowly creeps up on you. I was just worried what I might do to someone – [being] angry - dealing with someone you might—some idiot you know, you might step over the mark or something.* (Denis)

Denis describes his reaction as beginning with somatic symptoms, a feeling that he needed to get away, and increasing anger. He said he was unaware of the meaning of these symptoms initially because of their gradual onset. As he said, he unravelled – a bit at a time. It is notable that he did not mention experiencing what must have been the paramount emotion for him, that of fear, in his account of a situation where he could have sustained a serious or even fatal injury at any time. While it is possible that he was unwilling to admit to fear in the interview situation, his account suggests, rather, that he was simply unaware of it – that it was not part of his image of himself as a police officer and an adult male, and he would

have felt shame had he acknowledged it even to himself. He may have also felt disregarded and humiliated because of the neglect and lack of concern for his welfare that he believed were associated with his living conditions. His unacknowledged fear and humiliation were then expressed as somatic symptoms and increasing defensive anger.

"I was a loose cannon out on the streets..." – **Phil**

Phil described a similar gradual onset of symptoms. He said that midway through his policing career he recognized he was beginning to have difficulties and requested a transfer that was summarily denied. He described his response to this as one of increasing anger and fear of becoming violent, culminating in suicidality.

I was having troubles on the road. I was seeing too many bodies, and violence, and I wanted to go to an office area to get off the road for a while. And I had a transfer as well, like a piece of paper saying I wanted to go from patrols to an office area. And I wanted him [the senior officer] to sign it. And you know... that response I got back from him was there's no one transferring so I suggest you just get over this. Go back to work. Well, I was a loose cannon let back out on the streets. I was starting to lose the plot with lots of things, and my anger was building. He confused the hell out of me because I didn't know what was going on in my head. It didn't come good the next year – I was too frightened then to go to anyone else, and I got no treatment for anything, I was on no medication for anything. I didn't know what was going on with me – I was becoming more violent. and you know I didn't know who to go to and you know I couldn't go to a private psychologist or anything, or doctor, because I didn't know what I had – um – I thought I could be embarrassed or humiliated by walking in to a professional and – um – and also them telling me we've got nothing - you know – I had nothing to hang on to. And I was doing things – um – I was doing things – um – where I hoped someone would kill me – you know – I didn't want to be around anymore - um – I was badly confused. (Phil)

Like Denis, Phil recognized that his environment was causing damage to his mental state. Phil did not suggest that he felt in physical danger; his account suggests rather that he felt increasing stress and was aware that it was associated with his exposure to traumatic incidents. While Phil recognized that he needed to change his environment, his application to do this was rejected by senior management. This added a further layer of stress. He felt trapped within a system that was unsympathetic, and perhaps indifferent, to his needs, and he became increasingly angry. Because of the way his request for transfer had been summarily rejected, he then felt reluctant to seek assistance elsewhere, believing he would suffer further embarrassment and humiliation. Phil's narrative illustrates how initial symptoms, if subjected to an unsympathetic response when help is sought, can evoke both feelings of shame, and an unwillingness to seek help in the future. In Phil's case, his increasing anger – both against others and against himself - suggested that he then employed this as a shame avoidant response. Not knowing what was wrong with him, unwilling to seek help because he believed it might result in further humiliation, Phil said he reached a point where he was feeling suicidal, and was taking risks that he hoped would result in someone else killing him.

***Killing in the line of duty* – Peter**

Peter said his difficulties began following a life-threatening situation when he shot and killed a man who had been aiming a shotgun at him. He said he had experienced mixed emotions following the event, including anger, sadness for the victim and doubts about whether he could have acted differently.

And - ah – I just happened to look at that instant, when he was coming back out of his car, with that shotgun, and – ah – really makes you think who was looking after me on that day – and um – he's then gone to the front left hand wheel of his car, and I've done the same with mine, I've gone around the other side to get some protection from the engine block, and as I've got there he's bringing the shotgun up, so I let go two shots, one of them

hit him in the head, he's gone down – I didn't know that at the time – he's gone down behind my hands, just dropped, and it wasn't till back-up arrived - um – that – some fifteen minutes later, I guess, and one of the blokes walked up the road with his gun, walked right up to him and said – shouted out to me – looks like he's dead. So, I walked across with my gun still in my hand and – ah – yeah, he had blood trickling down his nose, and you could see there was a wound on the side of this head. But – the feeling that you get is one of – difficult to explain, but it's probably the most irreversible thing you can do is to kill another human being. And then you have very mixed emotions – I was angry, I was sad for the bloke, I was – what if I did this, what if I did that – and that lasted for about eighteen months. (Peter)

Peter describes the tumultuous effect on him of the guilt, doubts and sadness he experienced as a result of taking a life in the line of duty, something that has been well documented in the literature associated with moral injury (Griffin et al., 2019; Purcell et al., 2016) and amongst police (Komarovskaya et al., 2011).

***"...backed into a corner"* – Ivan**

Ivan also described his involvement in a shootout early in his career. He said he and a fellow officer had tried to apprehend a criminal who had then attempted to escape in their police car. Both officers had hung on to the side of the vehicle and were dragged about 50 metres before apprehending the offender. This incident brought him an awareness of the dangers of policing, earned him a reputation he felt he had to live up to, and marked the beginning of his trauma symptoms.

I became aware of the dangers and everything I'd [signed up] to. And I had two weeks off and back to work and off you go really. All it became was, here's a guy that managed to have a big shoot-out, get crushed by a car, and yeah, he's rough and tough and that sort of thing and that was the way the people looked at it, I was one of the tough guys for doing

it. One of the boys, you know, and all that sort of stuff. And that's where you get that reputation, so you couldn't really back down, you know -you're backed into a corner. I didn't realize what was really happening with me psychologically, or physically, really, with the outcome of that shooting, that night. So not knowing what was going on inside me – I just suffered ah - nightmares, night sweats, ah – disrupted sleep, um – alcohol, all that sort of stuff, I was smoking.... (Ivan)

Ivan was in a position where he believed he had to live up to his reputation as being *"one of the tough guys"*. The culture had in a sense trapped him into this, and for a while he conformed, against the background of his heightened awareness of the risks involved in policing.

I had no issues with being violent, pulling up cars or dealing with people or whatever, I certainly wasn't afraid to use violence – to ah – you know – threaten to shoot people, and that sort of stuff and – um – you always had that reminder, that it was there. (Ivan)

Subsequently aware of the dangers of the job he'd signed up to following his initial exposure to a life-threatening incident, Ivan had coped with this by acting out his reputation as a *"tough guy"* and pushing reminders of his fears out of sight. Like Denis who may not have recognized that he felt fear, Ivan's fear was expressed in other ways; it came back as nightmares to haunt him and his alcohol intake and his smoking increased.

How the Participants Made Meaning of Their Experience

***"...too damaged to recover"* – Victor**

Victor maintained that all police were to some extent affected by stress. He said he believed access to appropriate treatment was important – but that some officers were simply too badly affected to ever recover.

I say every cop is suffering from a degree of stress and PTSD – every single one. And that's evident because some of my mates who are not [diagnosed] – have symptoms of it,

> *you know. I think psychiatrists are very important because sometimes people need a tranquillizer dart in their ass before they cause dramas. They wreck their lives, they commit crimes, they need to have that edge sliced off as soon as possible. But – I think you can't get better with medication. I think psychotherapy, or whatever you call it, going to a psychologist, is the way. And you have to have trained psychologists who know what will work for people. And you have to trust them – bear in mind most cops don't trust anyone. And also, you have to have psychologists who are not addicted to a certain type of therapy. But I can't see [some people] getting better. Um – they're too damaged, they're too hurt, they're too afraid, they're too introverted, they've lost their skill, their confidence, their ability to think. They're really, really damaged.* (Victor)

There is a lot of pertinent information in this statement of Victor's. He suggests that stress-related symptoms are much more common that recognized. That sometimes drastic measures are necessary to prevent the individual from making further trouble for themselves and that ultimately therapy is needed – but it has to be with the right therapist using the right therapy. Finally, he suggests – from his experience in running a group for police officers with PTSD – that some individuals are too badly damaged to fully recover. They have lost their confidence in themselves because they feel as if they have lost their ability to think and their skills. Because they have lost confidence in themselves and their abilities, Victor said he believed these severely affected individuals had withdrawn from contact with others, and this in turn lessens the possibility of their rehabilitation. While Victor does not say so, an individual in this position would be very likely to be a high suicide risk.

***"...everything can just crumble around you"* – Denis**

Denis said he believed police culture and fear of rejection and stigma had prevented him from getting help with his difficulties. He said it should be possible for someone to seek help and remain positive about themselves, rather than feeling marginalized and stigmatized.

You're a young connie, and you get out on the road and it's great, but once you get into a life threatening situation, something happens to you, everything can just…crumble like that around you and – they talk about support, but later on down the track when that person's starting to take some sick days and things – well there's a reason, you know, there's something behind it, you know, and they need to feel comfortable with themselves to come and say jeez I don't feel bloody good about whatever, you know, or I need to get off the bloody road. It's not supported, no, no it's not and they just feel if they go to speak to someone then they'll be marginalized, and they won't feel good about themselves, feel like they're doing something wrong um and…they should be able to feel positive about doing something like that and feel good about – you've got to feel good within yourself, you know what I mean, not have that stigma of oh yeah, he's got a mental problem there, depression, whatever, you know, he's a malingerer. (Denis)

Denis said he would not have acknowledged his own feelings of vulnerability because of the stigma associated with it within the culture and he suggested this might apply to any young officer.

If something happened really bad the lads might relate to it badly but wouldn't say I'm not feeling the best, you know, to anyone, they'd just keep it within themselves. I wouldn't have – spoken to anyone about it – don't know, how I felt then, if someone had wanted to question me about it – I wouldn't have spoken about it. It's not something you'd say, to knock on the boss's office and say you weren't feeling the best, this is happening in my life. He'd say get out of my bloody office, get out and do your job. God strewth – you were too scared to walk in the bloody door. (Denis)

Denis describes the flow-on effects of a stigmatizing police culture that discourages the acknowledgement of psychological injury and marginalizes those who admit to it, and the likelihood of an unsympathetic response from a senior officer if assistance is requested. He

suggests that the ultimate damage to the individual would be so much less severe if they were encouraged to seek assistance early - before they were forced into it by the decline in their mental state and capacity to do their job. When he spoke of his own experience of being exposed daily to the risk of severe or fatal injury, Denis indicated that he had not known what was wrong with him when he developed somatic symptoms and increasing anger. However, he does suggest in the quote above that there might be a certain amount of awareness in the case of others, but that the affected officer would be strongly discouraged from seeking support by the associated stigma and perhaps accusations of malingering.

Subsequent Traumas and their Effects: Attempts at Coping Mechanisms

"...s*at there for five days. No work. No contact*" – Victor

Victor, who had described his response to his initial trauma as being one of humiliation and shame, described a second incident when he refused to work as ordered resulting in his duties being withdrawn and marking the end of his police service. "*Sat there for five days. No work. No phone calls. No contact. And I came home - and I went round to my GP, and she said you're not going to go to work".* This situation resulted in Victor feeling further powerlessness and alienation. He had challenged those in authority because he believed this action was justified, and he had been defeated. He described a subsequent lengthy period of sick leave during which he said he isolated himself, followed by his ultimate discharge from policing

"*You go to work and put on a charade...*" – Phil

Phil spoke of having to maintain a façade of coping after being denied a transfer, while progressively losing confidence in his abilities to do his job, becoming increasingly violent and experiencing suicidal thoughts. He described his stress level as also resulting in multiple physical symptoms. He reflected on how he had progressively lost confidence in his abilities.

You go to work and put a charade on for eight hours. And by the weekend or on my days off – for years – I was laid up in bed on my days off and – with headaches and migraines and – I never enjoyed those days off for years. I look back and I remember – you know – having patches of losing confidence in stuff I was doing, in policing. it was probably more fear of me starting to lose – confidence - in myself – fear of not getting jobs right anymore. Because everything I did in the past, I got it right. You know I went through the police doing studies for first class constable, for senior constable first class and sergeant and senior sergeant – and a lot of my subjects I topped the state – um – because my practicality and knowledge and studies and I knew how the law, and policies all worked, so I found all of that easy. Then, as new laws were coming in, or new computer systems were coming in, I was eager to learn, but it just wasn't sitting here anymore – I might have picked up 80% of it – years to come I was picking up 60% until at the end I was walking out, going "what was that about?" And then I was getting criticised a bit more by the hierarchy and I – I don't take well to that. (Phil)

Phil describes here the somatic consequences of ongoing stress in his headaches and migraines, a recognized part of trauma response but not included in the diagnostic criteria for PTSD (Pacella et al., 2013). He also refers to a decline in his cognitive abilities, also mentioned by Victor in his descriptions of affected officers. As a result of Phil's cognitive decline, he was predictably receiving more criticism from senior officers, further contributing to his loss of confidence and feelings of humiliation. He described experiencing progressively increasing anger that he acknowledged was for him a shame coping mechanism resulting from his belittlement by senior officers. He said his police career had ended when he *"snapped"* and assaulted a senior officer who deliberately taunted and humiliated him.

I had half custody of my children, and there was a boss there who made light of it, made fun of it – tried to make me out to be like a housewife, unmanly and – um – um –

very degrading. And that went on for eighteen months to two years. And it came to a head with my last boss – ah - where he was being very sarcastic, very degrading and I already had no confidence at this stage because I was hanging on, hanging on hanging on to where I snapped. I sat him back in his chair and I pulled my fist back – um - I was shaking and I was looking him in the eyes - and I didn't hit him. I walked out and went home and that was my last day, so I left in a lot of anger. (Phil)

The humiliation that Phil felt as a result of being bullied by a senior officer he described as the final event that caused him to "snap" and marked a regrettable end to his policing career.

***"Stuff it, I'll deal with it myself"* – Peter**

Peter said that he had received a valour medal for the incident in which he shot a man dead, but that subsequently he had incurred disapproval from both senior officers and colleagues when he insisted on giving evidence at the inquest because he thought it was the right thing to do. "*I was told not to, and I said why not, I've got nothing to hide. Well – it didn't sit well with me - and being a copper in a small country town – um – it's not going to look good."*

In wishing to give evidence to the inquest on the shooting he was involved in, Peter said he believed that not doing this might cause suspicion and negatively affect the way he was regarded in his country town. Later, he said that he had felt alienated when he was excluded from a group dinner. Either way, he faced potential censure and exclusion for his choice of action.

Police Association put on a dinner for all of the police members involved in what became known as the [state] police shooting enquiry. I didn't get an invite. Not till the following week, I got one on my own. And when I got to the Police Association rooms where the dining facilities were, I looked around the room and said where's the other blokes? And ah – they said we've given you a special one because you got the Valour

Medal – and I thought then how stupid do you think I am? And – ah – the reason was that the others didn't want anything to do with me. And that sort of spread – that was difficult to deal with as well, not being – being felt to be – not part of the group – and I became – on top of everything else I became irritable, cantankerous, and that spread to my workmates here and it got to the point where many of them didn't want to work with me either, you know because depression was really getting to me. (Peter)

Because he did not receive the support he needed from his fellow officers, Peter said that he developed an increasing resentment towards them which resulted in his further alienation because he was perceived as difficult to work with.

There was no peer support, nothing like that. And I think from the shooting onwards, I had difficulty getting on with my colleagues – not all of them, but probably most of them. Shortly after the shooting you'd be working two up, and your offsider would say listen mate if you want to talk about it, get if off your chest, by all means do so. And without exception, whenever I brought it up, they'd immediately change the subject. So, I stopped talking about it and just – and just – built it up. This resentment started to build up, and that came out in the way I spoke to them, and the way I treated them – they preferred not to work with me, which now I completely understand. Whereas if I had a partner, you could go to the pub that night, um – and toss it backwards and forwards, between you. You can't talk about it with your wife, because she's got no idea. I went on sick leave for quite a while, on worker's compensation, which was approved, and they sent me to a psychiatrist. But he was absolutely no value whatsoever. That's when I thought oh stuff it, I'll deal with it myself. I was self-medicating [with alcohol], so to speak. (Peter)

Alienated by the rejection he experienced from senior and fellow officers and unable to find appropriate professional assistance, Peter eventually decided there was no help to be had – he would have to manage on his own. Isolation and alcohol addiction functioned as

shame avoidant mechanisms for him. His earlier experience of killing in the line of duty may have also contributed to his subsequent feelings of isolation from others, as suggested by Komarovskaya et al. (2011). His mental state continued to decline to the point where he made plans to suicide. He described buying a length of hose to gas himself in his car, but said he then found out the attempt would have failed because of the emission controls on the vehicle. At this point he said he had seen the absurdity of the situation and had laughed at himself. *"But I was in a really dark place. A really, really really dark place."*

***"Branded a dog"* – Ivan**

Ivan, whose traumatic experience of being dragged by a stolen police vehicle and subsequently lauded as a *"tough guy*", said he also found no understanding or support at the time. This is perhaps not surprising since the incident pre-dated the first appearance of the diagnosis of PTSD in DSM-III in 1980. The symptoms he experienced – nightmares, night sweats and increased alcohol consumption were not generally recognized as being related to trauma prior to this (Yehuda & McFarlane, 1995).

> *...1978, the only real things were – there was no counselling – it was just to have a beer. And that was basically it. And I had two weeks off and back to work and off you go really. There was nothing else said about it, in regard to mental health and the way you felt."* (Ivan)

Ivan's experience is a reminder of how comparatively recently trauma-related psychological injury has been recognized, and that there still might be many other former police in a similar situation, struggling with trauma-related symptoms many years after discharge, as was identified in the Victoria Police Mental Health Review (Cotton et al., 2016). Ivan reported secondary trauma from a series of subsequent events. Offered a bribe by a fellow officer, he reported the incident to the Internal Investigations Branch and was subsequently alienated and threatened with violence by other police for being a *"dog".*

It absolutely cruelled my career with the CI, all the squads, because all those other guys were detectives. And I never went – from that night I didn't socialize with police, I never went anywhere with police, functions or anything else like that and I had to draw up a plan of the house for the SOG [Special Operations Group], and all that sort of stuff, so they actually knew what was around. (Ivan)

Ivan's account suggests that the ostracization he experienced resulted in increasing loss of self-esteem and feelings of hopelessness. At one stage he said he had taken out his shotgun, intending to kill himself; he said he had not followed through on this because "*Probably just people cleaning up the mess, you know annoying the hell out of people who would have been affected by it and everything else like that you know".* Further alienation and damage to his self-esteem occurred when he was not notified of a police shooting at his own station – *"just left me right out of the loop. Totally inconsiderate sort of behaviour, so you can imagine my self-esteem and self-worth and everything absolutely just plunging right down, so destructive, that sort of being left out".*

Refused an upgrade to which he believed he was entitled, Ivan's mental state deteriorated further.

From that point I was just on a downward spiral. And then when we kept on meeting, and I was having my rating, I remember sitting in meetings with him [a senior officer], and crying, begging to be told how I'd gone wrong, and how I could improve myself, and he would sit there in silence, waiting for me to stop crying, and then just continue on to say well look, suck it up sort of thing. (Ivan)

When he saw the senior officer several years later at a function, Ivan said he had become very angry and threatened to attack him. *"[I said] there's XX XX– I want to go and punch him. I want to go and punch him in the face."*

Ivan's narrative illustrates the cumulative effect of psychological injury which began with a traumatic incident which resulted in him acquiring a reputation as a *"tough guy"* that he then felt he had to live up to. This resulted in him suffering undiagnosed PTSD and probably co-morbid depression, expressed primarily as nightmares and increased stress level associated with overuse of alcohol. It also illustrates how he responded to the humiliation he experienced subsequently with anger and aggression as shame coping mechanisms.

"***I've turned into something I shouldn't have turned into"* – Denis**

When he developed symptoms following his time in his remote posting, Denis described how he felt unable to go back to work, despite telling himself he should not abandon his career. In conflict, and feeling bewildered and disempowered as a result, Denis said he developed an identity crisis, and with this, feelings of worthlessness and embarrassment, and because of this he isolated himself.

> *I said why are you doing this? You should be able to do this, you know that horrible regret, just walking out the door, leaving my career behind when I should have just bit the bullet and just go on with it, but I couldn't… I'd look in the mirror sometimes and sort of think it's not me, you know what I mean, it's not me, I've just turned into something I shouldn't have turned into I'm just not – why is this happening to me you know I'm just – wasn't coping, getting very emotional about things you know. I just felt worthless, embarrassed - that's why I kept away from everyone. And I thought maybe I should you know just forget about all that that was happening to me and just go back to work and be done with it. But I couldn't, I was really shaking, you know - I can't do that. I want to do that, and I can't do it.* (Denis)

The Effects of Making a Compensation Claim

"...the washing machine [compensation system]" – Denis

Denis described finding the process of making a worker's compensation claim as having been humiliating because he said he had been put in a position of trying to convince those assessing him that there was something wrong with him. The meaning he attributed to the compensation process was that it was casting doubt on his integrity and he reported reacting to this with anger. He said he was given pills rather than the information he wanted about what was wrong with him.

> *I can understand I need to go off and see someone and get treatment, [I'm] suffering from posttraumatic stress disorder well – how can I get better – but then they say oh no, we don't believe that so we're going to send you off to someone who says that you haven't got it. You think I'm a liar – that I'm a criminal, that I'm trying to commit a fraud on you– [I] nearly actually grabbed someone and threatened them. [I was} sitting there and getting really really angry because, you know, they've come here with a certain agenda again – saying that you are lying – and – we're right, you know. I'm a police officer [and] you're just screwing me over; you're not giving me any positives in life to help me where I'm going. You feel embarrassed about the whole thing, having to talk about it and at the start not knowing what was really going on with it myself. Thinking what am I doing, what is going on, I shouldn't be like this, I should be back at work, should be getting back into it. You feel like shit, you feel like a criminal. Taking money under false pretences and they're saying there's nothing wrong with you - it was just bloody awful, it really was attacking my integrity as a police officer, as a person, - you're at your most vulnerable then, and you're not thinking straight. You go and see these psychiatrists and whatever and talk to them. I don't have to prove anything. I know who I am, I know what I am. When they put me through the wringer – the washing machine [compensation system] – you've got to go and see all these people and sort of carry on – it's bloody awful - that was a terrible time really.* (Denis)

Denis described responding to these challenges to his integrity with embarassment because he initially did not know what was wrong with him, and when he felt his integrity was attacked, with the shame avoidant mechanism of anger, illustrated by his description of "*feeling like grabbing someone and threatening them"*.

***"...it could be bang bang bang and then themselves"*- Phil**

After he went off work on compensation, Phil was allocated a case manager who told him he would get him back to work with the assistance of whatever medication might be necessary, apparently without assessing whether Phil felt capable of this.

> *The first [compensation case manager] I got – said don't worry Phil, we'll get you pumped up on meds and we'll get you back to work soon. I was actually starting to think if I went back to work, I would have shot and killed people – um – I was that bad. I would have grabbed a gun, I would have gone berserk, I would have killed myself. I was not ready to be told what to do - I was anti-police, anti-authority. It was heightened when I was going through my sickness and the department was bullying me as well. And I really mean sinking the boots into me – they were bringing this on the family – ah – through me and that's where the uselessness and all that comes into it. I didn't want to be here. I was like a walking ghost really. And we lost a lot of people, we had a few suicides during this period. I've lost nine friends in the last two years from suicide – um – it's through the lack of help, you know, and there's going to be a lot more because they're too scared to go claim worker's compensation, so they sit waiting, hoping, that whatever they've got, like me in 1994 – hoping what they've got will just pass, because they're confused. If they had a problem in the workplace, it could be bang bang bang bang and then themselves, you know.* (Phil)

Phil suggests that he believes police suicides are the result of a sense of hopelessness; of individuals with trauma-related symptoms seeing no way out of the situation they found

themselves in and feeling they had nowhere to turn for help. He indicated that he believed that officers suffering trauma-related symptoms were often confused and angry and did not understand what was wrong with them. He said he had been bullied by the worker's compensation organization and that the effects of this had also been damaging to his family. He described himself as feeling useless as a result of this and as having suicidal thoughts. His suggestion that a police officer in a similar state of mind, with access to firearms, could kill others and then suicide, is a significant cause for concern. This is discussed further in Chapter 8.

The mental state that Phil described suggests the humiliation he had received as a result of bullying translated into the shame-coping mechanisms of anger and aggression. To be forced to go back to work against his will would undoubted have been viewed as further disempowerment and humiliation and would have been very likely to inflame his anger further and increase the likelihood of his suicide risk and perhaps also of potential violence to others.

***"No support for my claim"* – Ivan**

Ivan believed the police department abandoned him when he attempted to make a worker's compensation claim.

> *...and then they said even though the court case for compensation is coming up shortly it has nothing to do with [state} Police, it's between you and your insurer. [The insurer] fought it all the way because they said we don't have any of the paperwork on the shooting. And there was no support from [the police department] to say hang on we support the claim.* (Ivan)

Despite having received a medal for bravery for his part in the incident early in his career when he was dragged by a moving vehicle and injured, Ivan was later unable to access the documentation for this event from official sources. Without this evidence the insurer refused

to allow his claim. He and he experienced this as another injustice, and it contributed to a further decline in his mental state.

Life After Discharge

***"...it comes back to haunt you"* – Victor**

Victor described how feeling humiliated, treated unjustly, and disempowered caused him to use anger as a defence, and alcohol to deal with his level of distress. He said that the accusations levelled at him had shaken his belief in himself. In retirement he said that he questioned many of his actions as a police officer, experienced regret rather than pride when he reflected on his policing career, and with this he experienced further shame and guilt.

And guess what, today I'm having a good day. Bad days, bad days, and most people don't see me on my bad days. My wife sees me on my bad days. She sees when I drink myself into a stupor in the shed, or hide in there for 3 days, or yell at my children or ostracize my friends. And it's like I'm on a fucking runaway train. Cos anger is the best fuel to not feel bad about yourself. It makes you feel as if you have some control. That's how I do it [that's how] I've dealt with it all of my life. One of the things that has happened with me as well is that I have not necessarily been openly angry. I haven't yelled, I haven't screamed, but I've plotted revenge, and it's soiled my heart. And it's darkened my soul. See I don't believe anger is a primary emotion. I think it's secondary because it hides your true emotion. Why are you angry? Are you angry probably because you're hurt, you're disappointed, you're upset, you feel betrayed, those reasons. And as a result, your defence mechanism is to get angry. I think about my life a lot, and I spent 38 years in the police not living my values. My parents were generous, they were honest, whereas during the police I was harsh, I was less than compassionate, I turned against my values because the job had to be done. And that's what they got us to do, right. So, don't treat people like that. Because it comes back to fucking haunt you. I have a lot of regrets

about a lot of things – like I should have been less insubordinate because then I would have got promoted to a higher place and I could have done more good. (Victor)

In this reflection on these past feelings and behaviour, Victor perceptively explains the process leading to his mental state at the time he was interviewed. He felt hurt, disappointed, and betrayed, and shame and humiliation as result of this. He used anger and alcohol as shame coping mechanisms to feel better about himself and then felt further shame about behaving in this way. He felt further shame again when he reflected on his police service, believing he had betrayed his values and in doing this he had betrayed his integrity, which had initially been devastated when he was accused of *"bringing discredit to the police"* after he reported the maladministration of a program he had initiated.

Victor describes being proactive in running a support group for former police with PTSD, and through this believed that his personal experience helped him to help others.

And that's one of the problems that I tell people in relation to stress and PTSD and anxiety and depression and all that. Is that until it happens to you can't get it. That's why I formed the XXX group. Cos guys and girls walk into that room, and they know instantly that they're in a room with people who get it. (Victor)

In saying this, Victor seems to be suggesting that it is impossible for anyone to fully understand the experience of suffering a severe psychological injury unless they have experienced it themselves – and perhaps that people who experience this level of psychological injury believe they can only be helped by those who understand them.

***"...like I didn't exist anymore"* – Denis**

At the time he was interviewed, Denis said that he remained severely affected. He had, however, been able to name the fear he had experienced during his remote rural posting, gained some acceptance of it as being a normal reaction and said he no longer felt ashamed of

reacting in that way. He described continuing to have periods of depression and said that he tried to avoid exposure to anything that triggered his emotions.

> *You know my life as a police officer was finished when I walked out of that door, and that was it and they said goodbye, like I didn't exist anymore. [I thought] you're just screwing me over; you're not giving me any positives in life to help me where I'm going. 36 years and in the end, I just wiped policing from my life. It's a line drawn and I'm never going over it again. Shows on TV that show violence and that sort of thing - I don't watch those that deal with violence and family violence and that sort of crap – I don't need to see things like that, or if I see a violent situation that will do it. Yeah, you know if I hear a fight or when something's happened, I'm looking around, trying to work out if I'm safe. Some sort of disturbance happening - I feel nauseous and upset. I don't like going into police stations. I lost the ability to enjoy almost everything – I still do it, stay at home, not want to go out in the yard. I didn't want to see other people because they'd say oh why aren't you back at work, you know what I mean. I'd see people I know at the shopping centre, and I'd walk the other way. Now I force myself to see them and I go no I've got nothing to be afraid of anymore. I'm not embarrassed. I was afraid, I've just got to go up an confront my fears about that sort of thing and say yeah, alright, things happened to me and I've got over it, with what I did with working up in the [remote area], feeling the way I did, that fear, I suppose that was just a normal reaction to that situation as I see it now yeah - not ashamed of that anymore.* (Denis)

Denis describes one significant victory in this statement. He says he now understands that his fear was normal given his situation at the time and no longer feels ashamed of having felt it. However, he suggests that he still feels that he was abandoned by the police force and that he could then only *"wipe it"* from his life. He says he continues to experience depressive symptoms and has been unable to regain the ability to fully enjoy his life.

"*... these dead people visit me at night*" – Phil

Phil described still experiencing regret and shame when he reflected on some of the things that he had done during his policing career. He acknowledged that at times he had administered swift justice to offenders in a manner that had not been in line with police policy, and while he now saw it as a product of his angry mood state at the time, in retrospect he felt shame about it. *"I was recklessly indifferent as to whether it was lawful or not. I just wanted the job done. And I feel ashamed, absolutely ashamed of it."* He said the way he had been treated when he was experiencing symptoms – the criticism and what he believed to be lack of caring on the part of police – now came back to haunt him in retirement. He said he actively avoided any reminders but had not fallen into the trap of using alcohol to deal with his memories.

> *You know that talk of – you know – if you go sick tonight we know where you live and we'll go and drag you to work – well that sort of went in that ear and out that ear but as I got older in years, all those things started to revisit me, the criticism and – the horror of seeing things that now can't be unseen – um – you know the mutilations of bodies from accidents or shotgun wounds to the head – so I feel horror and – um – and anxiety creeps in. I get scared of the thing. 'Cause these dead people visit me at night – their faces – I can see their faces at the time and I can see it during the day at times…I can talk to you now, I've got a hundred images going on out here, of incidents I've been to – it's like a fast forward DVD – it's flashback after flashback after prang after death, after domestic violence, after fights and high speed chases and crashes and …it's just so many, just so many, and it creates confusion for me and – it goes day and night. I don't watch the news, I haven't watched the news in over ten years, I haven't read the paper for fifteen years. I never went down the path [of alcohol]. I was strong in that way and not in others.* (Phil)

On a positive note, Phil also describes gaining satisfaction from being involved in activities that assisted others. "*I've got my dogs; I rescue dogs and – and we travel a lot – to {overseas developing country] –because now I do work in the villages and they're just beautiful people – we take over all our clothing and schoolwork – books and they just love it. I love them."*

Phil describes still living with feelings of shame associated with his actions at the time when he was experiencing severe symptoms and had been prevented from transferring to a less stressful environment. He spoke of regret and shame that he had acted in anger at the time and that his actions had hurt others. His description of how he sees constant images of traumatic events from the past indicates that he experiences intrusions – unbidden distressing memories – despite avoiding watching the news on television and not reading newspapers. Both his intrusions and his avoidance of any situations that might function as reminders of past trauma are amongst the diagnostic criteria of PTSD. Together with the shame he describes experiencing associated with his acts in the past, Phil's symptoms suggest that it is likely that he suffers both PTSD and moral injury. There are indications that he feels some pride at not using alcohol to attempt to cope with his symptoms. His activities of rescuing dogs and visiting and assisting people in [overseas developing country] give the impression of perhaps being countervailing sources both of satisfaction and pride.

"*Tired of life"* – Peter

Peter described being unable to leave behind the feelings of powerlessness he had experienced when confronting death and suffering while policing, and how this has left him *"tired of life".* His said his alcohol intake increased in an attempt to deal with his mental state.

Delivering death messages is gut wrenching –. You can't do a damn thing. Things like that sort of build-up and build-up and build-up – I don't think you ever get rid of them I

don't know - it gives you a feeling of being – and this is going to sound suicidal – but tired of life, you know - I don't want to be here. I've had my share – and I think that's pretty much it, you know, because all these things that get thrown at you, you sort of just shrug them off and go on to the next one, but you don't get rid of it, it's still there, until you go on the next one and the next one, and eventually the load – it's like the last straw on the camel's back, you've got to get away from it, you know, get away from it and – try and get some perspective I suppose – on the job. There's so many people that you come across, you know, with that sort of mind set. That have been in the police force and – um – well probably like me, every fatal you go to, every dead body you go to, you don't leave it totally behind. Part of it stays with you, as you go on. Drinking is a big problem. If I keep on going the way I'm going alcohol will kill me, no doubt about that. I've got to cut back. (Peter)

The feelings described by Peter have been described as "compassion fatigue" by Anderson and Papazoglou (2015), Figley (1995) and Violanti and Gehrke, (2003). They ascribe it to the *"cost of caring"* that frontline professionals experienced in their work with victims of crime, accidents, and other traumatic events, and suggest it is pervasive in policing. Peter describes how his exposures operated in a cumulative manner for him "*every fatal you go to, every dead body you go to, you don't leave it totally behind"*. An alternative description of the way in which he responded to his exposure to death and suffering might be that he had sustained a moral injury, as defined by Lizt et al. (2009). It was my impression that Peter was also suffering clinical depression and had done so for some time prior to when I spoke to him. Given Peter's previous suicide plan, his current alcohol use, and his lack of support, his mental state at the time he was interviewed was concerning to me. We spent some time speaking about his plans for the future at the conclusion of the interview, and how he might seek help if his mood deteriorated further, or he began making any future plan to

suicide. He was given telephone numbers he could call if he needed help, as were all the participants.

***"Lots and lots of triggers"* – Ivan**

At the time he was interviewed, Ivan described diminished quality of life and a constricted lifestyle. He felt unable to do the things he had planned to do after retirement.

> *Lots and lots of triggers. I mean I can't watch the news, read the paper, you know all these bits and pieces. Can't go near a police station – skirt around them. I don't have a big verbal communication with friends because I don't string a lot of things together, there's confusion, there's memory loss – concentration, and I don't drink alcohol, I don't smoke, I just sit there. I was so outgoing, and now, I could go down to a – I usually avoid them – neighbourhood barbecues or get-togethers and if I do go to them, I'm just quiet because I can't interact.*
>
> *I've always wanted to help. I could have toured the state, on the bike, with purpose, talking to people, even talking to new recruits, things like that. I had already offered my services to the Association and been accepted of being a roving guy to go to police stations around the state to talk about PTSD and anxiety and things like that, to be an advisor on a welfare basis, but because it affected me so dramatically, I just couldn't do it.* (Ivan)

Ivan's avoidance of the many situations that might act as triggers for an acute emotional response served to severely limit his life and – unfortunately – prevent him from speaking to new recruits about psychological injury. He also showed evidence of the cognitive impairment known to be associated with PTSD (also described by Phil and in other officers who had PTSD by Victor). At the time he was interviewed, Ivan described severe symptoms associated with PTSD. He did not speak of being ashamed of his mental state at the time he was interviewed. There are indications however, that his earlier feelings of

humiliation associated with the last period of time he spent in police service, the circumstances of his forced retirement, and his subsequent difficulties in claiming compensation had contributed to a severe decline in his mental state at the time, from which he had not recovered at the time he was interviewed.

Despite his loss of faith in [state] police, in the end, Ivan believed he had fulfilled his oath, and he kept some pride associated with his policing career.

> *I didn't do dishonest things. And that was – I was true to myself, I was true to the organization, and I think that was my downfall. I didn't necessarily bend. I swore an oath, in 1973, and without fear or favour, I would look after the community. And I looked after the community and people.* (Ivan).

Discussion

All five of the participants in Group 3 could be described as suffering moral injury within the current definitions of the construct (Litz et al., 2009; Shay, 2014). Victor described feeling embarrassed and ashamed when he was accused of *"bringing discredit to the police*" after he had attempted to expose what he believed to have been unethical behaviour by other police. Victor's belief that he had been treated unjustly by those in a position of power corresponds with moral injury as described by Shay (2014). While anger has been described as a more typical emotion associated with this betrayal by those in a position of power (Jordan et al., 2017; Litz et al., 2018), Victor's response seemed to be primarily that of shame. For Victor this experience of betrayal was his initial source of trauma. When he later reflected on some of the ways he had acted as a police officer he experienced further shame associated with a belief that he had perpetrated injustices on others. This second form of morally injurious events, the perpetration or witnessing of injustice to others, is described by Litz et al. (2009). For the other four participants in this group, the effects of their moral injury was secondary to their development of symptoms of PTSD and reflected both their belief that

they had been treated unjustly by the Police Department and by senior officers, and by their witnessing of injustices or simply *"events that shouldn't have happened"* to others, described as a source of moral injury by Litz et al. (2009).

Three of the five participants in Group 3 had symptoms of intrusions, avoidance, negative alterations of cognitions or mood and altered arousal indicative of PTSD as it is currently defined in DSM-5. One participant (Peter) was experiencing depression subsequent to killing in the line of duty and the events that followed this. On the basis of his narrative, one participant, (Victor) appeared to be suffering moral injury without any obvious symptoms of PTSD. Those three participants who described symptoms consistent with PTSD said they avoided places or people likely to function as triggers for further emotional distress, resulting in their increasing social isolation. All described a diminished quality of life and a limited lifestyle. Their narratives provide accounts of how they attributed meanings to their development of symptoms, and to other events that followed their initial psychological injury, and how these attributions of meaning in turn negatively impacted on their mental state.

For the participants in Group 3, the coping mechanisms they employed served only to negatively affect their mental state. They used avoidance and isolation to deal with their symptoms of PTSD. They dealt with feelings of shame, lowered self-concept and changed self-image primarily with anger, perhaps reflecting their police training to respond to threat with aggression. However, they also became depressed, over-used alcohol and self-isolated, all of which have been described as maladaptive shame avoidant mechanisms.

The participants in Group 3 described reactions to the events that occurred after the development of their trauma-related symptoms as having elements of humiliation, shame and powerlessness. Their readiness to acknowledge, unprompted, their feelings of shame and the associated shame coping mechanisms they had employed was unanticipated and did not follow the theoretical prediction that shame is often bypassed or unacknowledged (Lewis,

1971). As indicated earlier, one participant (Victor) described his initial trauma as shaming as well, suggesting that his psychological injury was wholly shame induced. This means that, according to the existing diagnostic criteria in DSM-5 he would not meet the criteria for a diagnosis of PTSD (American Psychiatric Association, 2013, p. 271, despite appearing to have sustained a significant psychological injury. This would be likely to also be the case for Peter who suffered depression as a sequel to killing in the line of duty.

An increase in anger and aggression was described by all the participants in Group 3, typically expressed as concern that they might become violent. In the case of some of the participants this had occurred. Anger has been described earlier as a shame avoidant reaction to the experience of humiliation (Elison et al., 2014). The participants in this group also described the use of the other potentially shame avoidant mechanisms of isolation (avoiding others), addiction (alcohol dependence) and self-criticism associated with either current or past depression (Elison, Lennon et al., 2006). Victor clearly identified his own processes, saying that he was aware that he used anger as a *"defence mechanism"* to feel better about himself when he felt *"hurt, disappointed or betrayed".* He also acknowledged using alcohol to excess.

Distinguishing this group of participants from Groups 1 and 2 is the progressive decline that they described in their mental state. There are several potential reasons for this decline. All the participants in Group 3 described a negative self-concept that they attributed to having felt disrespected, unvalued, alienated or rejected by others in the latter part of their policing career or in the process of claiming compensation. Most saw themselves as having changed and they did not like what they had changed into, and experienced diminished self-respect and depression. The process whereby exposure to trauma can affect identity through damage to self-concept were described by Ehlers and Clark, (2000), and discussed in Chapter 2. These authors propose that threat to the self-concept creates a sense of current threat in that

it challenges the individual's view of themselves as able to cope. It may also shatter their assumptions of invulnerability (Janoff-Bulman, 1992), also as discussed in Chapter 2. Fear associated with exposure to actual or threatened death or serious injury as described in DSM-5 (American Psychiatric Association, 2013), was described by only one participant (Denis).

Individuals with PTSD who had higher levels of shame have also been found to be more likely to engage in self-critical thinking and were also more vulnerable to criticism from others (Harman and Lee, 2010). Many of the participants in Group 3 described feeling further shame because of the impact their shame avoidant behaviours had on others around them, and several described experiencing criticism from others because of their reduced performance associated with impaired cognitive functions. These included deterioration in their memory functions, together with a reduced ability to concentrate. This type of cognitive decline, described in Chapter 2, is thought to result from changes in large-scale brain networks and is recognized as being associated with PTSD.

In the following chapter these findings from Chapters 4 to 7 are discussed in the context of the current literature, and their implications for best practice in the diagnosis, management, treatment, and prevention or mitigation of post-trauma psychological injury are examined.

Chapter 8: Discussion

This chapter elaborates the findings in Chapters 4 to 7 in greater depth and situates them in the current theoretical and research literature. Chapter 4 examined police culture, how it was perceived by the participants and the ways in which they reported its changes over time. Chapters 5, 6 and 7 described the sequence of the participants' exposure to potentially traumatic events and to other occupationally related stressors during their police service. These chapters examined the meanings the participants attributed to these events and stressors, any coping mechanisms they might have used to deal with them, and how they were ultimately affected. The present chapter examines the differences between the participants in the three groups, the roles of emotional detachment and of shame in these differences and the ways in which the findings might relate to the current state of knowledge.

As described in Chapter 3, the narratives of the fourteen participants in the study were analysed following the steps for data analysis in Interpretative Phenomenological Analysis as outlined by Smith et al. (2009), and individual case studies (contained in Appendix A) were constructed for each participant. The participants were then divided into three groups, based both on their descriptions of how they had responded to the repeated operational exposures and other work-related stressful events to which they had been routinely exposed, and on their mental state at the time they were interviewed.

While all the participants described similar exposure to police culture and to occupationally related stressors, they described markedly different responses and coping mechanisms. The five participants in Group 1 were clearly identifiable as a relatively homogeneous group in that they said they experienced no trauma-related symptoms and described no regrets or feelings of shame associated with their police service. The four participants in Group 2, while acknowledging that they had developed trauma-related symptoms, described a relatively stable mental state in their retirement, without any lasting

regrets or shame associated with their policing careers. The five participants in Group 3 described their mental state as having progressively deteriorated during their police service and into their retirement. They described their current lives as being dominated by traumatic memories, regrets and shame, their quality of life in retirement as poor and their lifestyle limited. The main characteristics identified in each group, initially summarized in Chapters 5, 6 and 7 were as follows:

Group 1: Maintaining detachment and achieving resilience (Jack. Pat, Frank, Gerald, and Stuart).

The five participants in this group described themselves as having deliberately found coping mechanisms that enabled them to emotionally detach from the effects of exposure to events during their policing career that were potentially traumatizing. They described having deliberately focused on the job in hand at the time to assist in achieving this detachment and as having avoided dwelling on potentially traumatizing events afterwards. They tended to portray themselves as confident, as having good self-esteem, and as willing to fight for their entitlements. However, most of them also described recognizing when they had reached a point in their career when it was time to leave policing and either retire or find other employment.

Group 2: Affected but moving on (Cliff, Bruce, Murray, and Don).

The four participants in this group acknowledged that they had developed symptoms as a result of their repeated exposures to traumatic incidents and to occupationally related stressors. While they acknowledged they had been affected, their narratives did not suggest that they experienced any shame, self-blame or damage to their self-concept. This suggests that they did not see their development of symptoms as meaning there was any weakness or failure on their part. All described various coping mechanisms that included active involvement in subsequent careers or activities that involved assisting others, and ways of

coping with their symptoms that enabled them to do this. Some of those in this group also indicated that they had recognized and acted on a realization that it was time to retire from policing.

Group 3: Affected and unable to move on (Victor, Denis, Phil, Peter, and Ivan).

The five participants in this group believed that they had undergone permanent change from the person they had been prior to developing symptoms of psychological injury. They experienced shame and regrets associated with this change and with how it had influenced their behaviour and limited their activities. All indicated that they saw the effects of their psychological injury as central in their lives, and that its associated symptoms, both psychological and physical, had been instrumental in necessitating their retirement or had resulted in their forcible discharge. All described themselves as unable to work, although some participated in limited voluntary activities. The coping mechanisms they described using included avoidance of people, places and activities that might trigger distress for them. They acknowledged experiencing shame and lowered self-concept and attempting to cope with these emotions with the use of shame avoidant mechanisms that included anger, the use of alcohol, and social isolation. Several suffered past or current depression.

Shame in Post-Trauma Psychological Injury

The association between shame and symptoms

The narratives of the five participants in Group 3 indicated an association between their persistent feelings of internal shame, their low self-esteem and the perpetuation and exacerbation of their symptoms. All the participants in Group 3 acknowledged their feelings of shame without prompting. Most of them also made a connection between their experiences of being shamed or humiliated and how they believed this might have led to shame avoidant mechanisms, both in themselves and in fellow officers. It has been suggested that shame is likely to remain hidden if an individual believes they will be judged and further shamed if it

is revealed (Eterović, 2020). The willingness of most (but not all) of the participants across all the groups to disclose many personal details in the context of the interview situation most likely suggests that in most cases an atmosphere of trust had been created – perhaps in part as a function of my former profession of therapist. Several of the participants suggested there were some experiences they preferred to not revisit, and these topics were not pursued further.

Shame avoidant mechanisms.

I proposed in an earlier publication that shame and shame avoidant mechanisms might often be unrecognized elements in trauma-related psychological injury (Taylor, 2015). Shame avoidant mechanisms or schemas, as initially proposed by Nathanson (1992), and modified by Webb (2010), are described in Chapter 2. They are described as potentially manifesting as *"aggression", "depression", "isolation", and "addiction"*, either alone or in combination with each other. Their function is to defend against or ameliorate feelings of shame, humiliation, alienation, and powerlessness. They might manifest either as shame defences operating at a largely unconscious level (Lansky, 1994), or as deliberate shame avoidant mechanisms (Nathanson, 1987, 1992). Shame as a persisting negative emotion occurring after exposure to trauma has been included for the first time in the most recent edition of DSM-5 (American Psychiatric Association, 2013), where changes in the diagnostic criteria for posttraumatic stress disorder (PTSD) for the first time recognize shame and guilt, alongside fear and anger, as significant emotional states associated with the disorder. Despite their strong resemblance to many of the signature symptoms and co-morbidities of the disorder, however, shame avoidant mechanisms have not received recognition as potentially linked to these symptoms and co-morbidities. Some authors have suggested less specifically that posttraumatic shame is linked to vulnerability and defensive behaviour (Lansky, 2003),

to anger (Griffin et al., 2019; Hoge, 2010), to dysregulated affective states (Wilson et al., 2006), and that it contributes to later psychopathology (Andrews, 1995; Gilbert, 1997).

The shame avoidant mechanisms of aggression, depression, isolation, and addiction are evident in the narratives of the participants in Group 3. These participants made a clear association between these responses and feeling humiliated, devalued, disempowered or isolated by the actions of others, feeling ashamed of themselves and their own actions, or of both. There was unsurprisingly a predominance of descriptions of the shame avoidant mechanism of anger in the narratives of many of the participants in Groups 2 and 3, whose training as police emphasized responding to threat with defence rather than withdrawal (Hoge, 2010). It is arguable also that in the case of some participants their shame avoidant responses of anger or violent behaviour might have been augmented by the neurobiological changes known to take place in PTSD. This occurs as a result of change in the hypothalamic pituitary adrenal (HPA) axis (Lanius et al., 2012), causing the individual to become more reactive, seen in a clinical sense as symptoms of hypervigilance, increased startle reaction, and increased physiological arousal and distress to environmental stimuli (Lehrner &Yehuda, 2014). This was demonstrated by Murray in Group 2 whose hypervigilance had caused him to come very close to hitting with his baton a fellow police officer who unexpectedly walked up behind him.

In Chapter 4, Victor in Group 3 described how officers' conflicts with management associated with bad decisions or increased violence are normally dealt with harshly according to defined policies and processes, often resulting in suspension or discharge. He said he believed that these conflicts often reflect unrecognized underlying stress on the part of the offending officer. This perception is supported in a review of the literature by McFarlane, Williamson et al. (2009) on the impact of the occupational environment on emergency service workers, which suggested that conflicts with supervisors may be an unrecognized

manifestation of the individual having developed PTSD. Arguably these breaches of discipline are expressions of shame avoidant mechanisms.

Shame, hopelessness, and suicide risk

Several of the participants in Groups 2 and 3 made a connection between shame and suicide. Cliff in Group 2, speaking of fellow officers affected by trauma, suggested that lack of support and continued criticism from senior officers, coupled with a sense of failing in a professional sense, might be associated with the known high rate of police suicide. Phil in Group 3 described feeling confused and angry when an attempt was made by his worker's compensation case manager to dose him up on medication and return him to work. He made the disturbing prediction that a police officer in the future could have a similar problem and that this might culminate not only in suicide but also in homicide because of their level of anger and feelings of disempowerment and hopelessness.

Suicide is already well recognized as a potential outcome in post-trauma disorders (Bryan et al., 2013; Cunningham et al., 2018) and Australian police are known to be at increased risk (Ferguson, 2016; Murray, 2018; Roberts, 2019; Skeffington, 2016). This known high suicide risk in police and the potential risk for homicide-suicide arguably serve as an imperative for further research into the presence and potential influence of shame and hopelessness in post-trauma psychological injury in police, and how it might best be addressed in this high risk group. A similar situation exists in the US, where a systematic review of first responders examining suicidal thoughts, behaviours, and/or fatalities (Stanley et al., 2016) indicated that police officers in the US are less likely to die by an accident or homicide than they are to die by suicide. A review of the literature associated with risk and protective factors for police suicide (Chae & Boyle, 2013) found that the interaction of multiple factors had a cumulative effect in increasing the risk for suicidal ideation, and the

primary contributing aspects of police work identified were critical incident trauma, organizational stress, shift work, relationship problems and alcohol use and abuse.

PTSD symptoms, stress and shame have been found to be associated with hopelessness and suicide risk in a number of studies. Hopelessness was linked to increasing stress from administrative practices and lack of support in police officers with PTSD symptoms (Violanti et al., 2016). Hopelessness was found by Boffa et al. (2018), to be a risk factor for suicide and a target for preventative treatment in a study of a group of civilians experiencing post-traumatic stress symptoms. In research with a population of veterans undertaken by Jakupcak et al. (2011), hopelessness was found to be elevated in those with subthreshold and threshold PTSD symptoms, as opposed to those experiencing minimal symptoms. The interaction of shame and hopelessness in the exacerbation of suicide risk was investigated in a cohort of active duty military personnel by Bryan et al. (2013), who found that shame significantly interacted with hopelessness in augmenting suicide risk.

Because police officers have ready access to firearms, and this is already known to provide an increased risk of suicide (Kaplan et al., 2009; Miller & Hemenway, 1999), the potential risk of suicide combined with homicide should be a significant cause for concern. The link between violence and emotions connected to shame has been made by both Scheff (1994, 2011, 2014, 2019), who relates it to the increase in worldwide terrorism, and by Gilligan (1997, 2001), who argues that all violence has shame and humiliation as its core.

Shame in the compensation process

None of the participants in Group 1 had made a worker's compensation claim. The participants in Groups 2 and 3 who had made claims said the experience had been a further source of stress and shame, causing them to feel disempowered and humiliated as a result of feeling that they had to prove they had a psychological injury and believing because of this that their integrity was being questioned. Coming at a time when they already felt vulnerable,

all those who had made a compensation claim said they believed it had adversely affected their mental state. The "gold-standard" *Expert guidelines: Diagnosis and treatment of Post-Traumatic Stress Disorder in emergency service workers,* (Harvey et al., 2015), identified that *"the systems involved in medical assessments and compensation for emergency service workers with PTSD symptoms may, at times, contribute to dysfunction and impairment. The potential iatrogenic effects of such systems are not well understood"* (p. 53). The authors reported that the lack of knowledge associated with the reasons for the damaging effects of medical assessments on emergency workers represented a significant gap in the relevant literature, and that further research was necessary. As described above, the participants in the present research study were in no doubt as to how the process had been damaging for them. By calling their truthfulness into question and showing an apparent disregard for their vulnerability, it had humiliated and shamed them at a time when they were probably highly unlikely to be in a position to adequately mount a defence.

Pride and shame

The current trauma literature contains few references to pride. Bryan et al. (2013) found that pride buffered the effect of shame and could possibly function as a protective mechanism. A number of the participants in all of the groups spoke about feeling genuine pride in their police service; that they had taken an oath to protect the community and they believed they had done so to the best of their ability. In contrast to this, several participants in Group 3, as described earlier, felt shame because they believed they had not conformed with the values and integrity they had sworn to uphold.

Changes to police culture over time, related to dominant values, were mentioned by several by several participants from across all three groups. They said they believed police no longer supported other police as they had in the past and were more likely to report other officers for potentially punishable offences. Vincent in Group 3 also suggested that police

were no longer *"pulled into line"* – or shamed - by fellow officers for behaving badly – for example for disrespecting female police officers. He suggested, rather, that they let them commit punishable offences – and then reported them. These examples might arguably reflect a change in police culture over time from incorporating the elements of a *"shame culture"* to those of a *"guilt culture".* In a shame culture, avoidance of being shamed is thought to moderate antisocial behaviour. In a guilt culture behaviour is considered to be moderated by fear of punishment (Benedict, 1967; Hacker, 2017).

The potential for satisfaction and pride gained from an involvement in activities assisting others was referred to by a number of the participants in all three of the groups. Several spoke of providing support for ex- police suffering PTSD or of undergoing training to provide that support. One operated an online group for ex-police, another fostered troubled teenagers. Several participants in Group 3 spoke of their regret at being unable to participate in similar activities because of their mental state.

The importance of the attribution of meaning to symptoms

In Chapter 2, a distinction was made between internal shame – how the self makes a judgement of the self, based on the ego-ideal – and external shaming, how the person believes they are perceived in the eyes of others. Gilbert (2001) maintains that this distinction is important because it implies that allowing others to know that one is experiencing internal shame might put one at risk of external shame as well.

All the participants in Groups 2 and 3 described developing trauma-related symptoms and all were exposed to the effects of police culture. However, the groups differed in the meaning they placed on these experiences. The participants in Group 2 did not allow these experiences to define their sense of who they were as individuals. They all indicated that they had been able to maintain confidence in themselves and their sense of self-worth and did not see themselves as *"weak"* or feel ashamed of having developed trauma-related symptoms.

Because their self-concept remained intact, they did not experience subsequent internal shame as it is described above. While these participants might have been potentially subjected to external shaming had they publicly acknowledged their symptoms, they did not experience internal shame because they did not see themselves diminished because they had developed the symptoms. This is an important distinction, since it implies that it is the meaning that the individual places on their shaming experience that affects whether they will suffer the destructive consequences of internal shame.

All the participants in Group 3 described experiencing internal shame as it is defined by Gilbert (1998a). They accepted the stigma associated with the trauma-related symptoms they had developed; stigma that was and remains inherent in police culture (Kyron et al., 2019; Lawrence et al., 2018). Because they placed this meaning on their symptoms, they felt ashamed of having developed them and their self-concept suffered. They saw themselves as failing to live up to their ego-ideal – *"becoming someone they did not wish to become".* In an individual rendered vulnerable by the symptoms of a post-trauma psychological injury this internal shame is thought to potentially operate in an erosive manner, resulting in a fragile and deteriorating mental state, as described by Lansky (2003).

The participants in Group 3 also felt devalued and humiliated as a result of their treatment by senior police and by the effects of claiming worker's compensation. In addition to these sources of internal shame, several of the participants in this group also described feeling ashamed because they recognized that they had become unable to perform many aspects of their job as easily or efficiently as they had done in the past. The deterioration in cognitive abilities described by these participants has been recognized as being associated with changes in brain networks associated with the development of PTSD (Clausen et al., 2017; Samuelson et al., 2017) as discussed in Chapters 2 and 7.

The acknowledgement of internal shame manifesting as negative self-concept was a differentiating factor between the participants in Group 3 and those in Group 2. Arguably, it was the presence of this internal shame that eroded the self-confidence and self-esteem of the participants in Group 3 and resulted in the progressive decline in their mental state, which was not experienced by the participants in Group 2.

The identification of this internal shame in all its forms in police and former police could be critical to their mental health since it appears to have the potential to give rise to damaging shame avoidant mechanisms leading to aggression, alcohol or substance abuse, depression, isolation, and to potentially increase suicide risk. This shame avoidant behaviour might also then be subject to punishment, as described earlier by participant Victor in Group 3. How training and psychoeducation might contribute to prevention of internal shame and enhance resilience is discussed later in this chapter.

Moral Injury

Chapter 2 described moral injury, a reaction to trauma that does not involve fear, but is related to the perpetration, or the witnessing, of trauma to others (Griffin et al., 2019; Litz et al., 2009), or as a betrayal of "*what's right*" by a person in legitimate authority in a high-stakes situation (Shay, 2014, p.182). It is thought to result in guilt or shame, anger, and social alienation (Litz & Kerig, 2019). Much of the distress described by the participants in this study might arguably be defined as a product of moral injury.

Several of the participants in groups 2 and 3 described their perpetration of acts on offenders and members of the public that later caused them shame. They described these acts as a reflection of their levels of underlying stress at the time. Cliff in Group 2 described his investigations of the perpetration of sexual abuse on children as a source of distress and anger for him that he needed to suppress in order to ensure justice for the victims. This area of investigation has been identified empirically as a significant source of trauma in police (see

Burns et al., 2008; Krause, 2009), who found that exposure to child pornography and violence increased the likelihood of police officers working in the area experiencing psychological distress. The effects of these experiences are consistent with those of moral injury as described by Litz et al. (2009). Many of the participants in both Groups 2 and 3 also described having experienced criticism, lack of support, and humiliation by senior officers, and further humiliation and attacks on their integrity during their claims for compensation. The ways in which they responded to these events, attributed meaning to them and the emotional state they experienced as an outcome are consistent with moral injury as described by Shay, (2014).

As noted earlier, while it has been widely investigated in the military, the presence of moral injury in police, either in its perpetration or witnessing, or in its betrayal forms, has received little investigation (Griffin et al. 2019; Papazoglou & Chopko 2017). Because of its potential impact on mental health, identification of the presence of moral injury in police needs to be addressed as a matter of urgency. The development of measurement instruments appropriate to police is a priority. Currently available measures are unlikely to be applicable because the concept of moral injury has been primarily associated with military service. The participants in this study spoke of being exposed to child deaths from sudden infant death syndrome (SIDS), child abuse, and deaths from suicide or homicide. They delivered death messages to families. They described prolonged contact with victims and physical evidence at the scene of a violent crime, at autopsies, or with crime scene photographs. They experienced bullying or humiliation from senior officers or perceived injustice associated with the compensation process. These experiences left them at risk of both direct and vicarious trauma resulting in moral injury (Faulkner et al., 2020). Because police have exposure to stress that occurs over longer periods of time than generally occurs in military service, this has been thought to place them at increased risk of PTSD from the effects of

cumulative trauma (McFarlane 2009). This is arguably also likely to be the case for the effects of moral injury.

The need for investigation of the presence and significance of moral injury in police has implications both for management and for treatment of affected individuals. There is no clear consensus as to its prevalence in police in the existing empirical literature, either in Australia, the US and Canada or in the UK. In members of the military, moral injury has been found to be associated with the frequency of depression, alcohol use disorders, and increased risk for suicide in PTSD (Griffin et al. 2019). In the US and Canada, there is concern about a phenomenon referred to as *"operational stress injury"* in police. This a broad term used to describe job-related persistent psychological difficulties and their effects including PTSD, depression, alcohol use disorders and increased for suicide (Faulkner et al., 2020). As mentioned earlier, a recent independent review into the mental health of Victorian police (Victoria Police Mental Health Review, 2016) reported that depression, anxiety and substance abuse disorder are as common as PTSD in this group, that shame and stigma associated with mental health are entrenched, and there is lack of clarity around suicide risk. Whether, and how, moral injury might be implicated in the development of these disorders is presently unknown.

The Stigma Associated with Showing Emotions

As described in Chapter 4, there is a sub-culture in policing that regards the display of any emotional vulnerability as potentially shaming and stigmatizing. Most of the participants, across all the groups, spoke of having been aware of the cultural imperative that they conceal their emotions, and without exception all indicated that they had attempted to conform with this. A number made the point, however, that effective policing required the suppression of emotion at times; examples they gave included interacting effectively with members of the public who are themselves in a high state of emotional distress or dealing with potentially

life-threatening situations that required clear thinking and prompt action. The belief that they needed to keep their emotions concealed appeared to not be confined to any of the groups. What seems significant, though, is how they achieved this detachment from their emotions, and the marked differences in this that were evident across the groups. The next section examines the *"how"* in detail, its relationship to current knowledge and the ways in which it might have impacted on their post-trauma mental state.

Deliberate Detachment as a Coping Mechanism

The participants in Group 1 showed a resilience to the effects of exposure to potentially traumatic events that seemed to be associated with an ability to maintain deliberate emotional detachment at the time of the incident, and to consciously avoid subsequent negative trauma-related appraisals. Refraining from subsequent negative appraisal is a recognized aspect of resilience to trauma-related injury (Barton et al., 2013; Beck et al., 2015), However there appears to be no reference in the existing literature to the use of a voluntary type of emotional detachment as a protective device, such as that described by the five participants in Group 1. Brown (2006) describes a range of detachment experiences, from mild non-pathological to extremely disabling symptoms, but with an assumption that all are involuntary in nature. In contrast to this, the participants in this study described a variety of deliberate approaches to achieving this detachment. Further research to investigate the prevalence of the use of deliberate detachment, how it could be achieved, and whether it might lend itself to resilience training might prove productive.

That this type of deliberate detachment might enable processing of events as they occur has been suggested by Scheff (1979). Based on his comparisons of different therapeutic styles, Scheff (1979) proposes that the ability to maintain what he calls "aesthetic distance" allows the immediate processing and assimilation of each traumatic event as it occurs and allows it to be recalled at will. He contrasts this with both over and under distancing, which

he believes causes the experience to be “mis-stored”, leading to repression. The distressing events are then either seemingly forgotten, or conversely re-experienced involuntarily (Scheff, 1979), resembling the effects of intrusions in PTSD. The consequences of repression and mis-storage are then thought to lead to negative changes in perception, feeling, thought and behaviour.

Scheff (1979) relates the inability to achieve adaptive aesthetic distance to early socialization. He postulates that the more punitively any display or discharge of emotions is treated in the child, the more likely it is that the individual will be unable to maintain the desirable aesthetic distance from stressful events in adulthood (Scheff, 1979. 211-213). This interpretation of the potential effects of stressful events according to the extent to which the individual is able to maintain optimal psychological distance has parallels with voluntary detachment as it has been identified and described in my study. Over or under distancing could be seen to correspond to dissociation, thought to be associated with both impaired recall and the development of post-trauma symptoms. Scheff (1979) suggests the prohibition of emotional expression during the process of socialization is associated with an inability to learn how to achieve “aesthetic distance” from trauma. If this were the case, individual differences might be expected to be associated with potentially identifiable differences in family background and early life experience, perhaps a potential topic for future research.

There has been interest but no consensus on the protective factors that might be associated with resilience (Agaibi & Wilson, 2005; Hoge et al., 2007). Resilience to the effects of exposure to potentially traumatic events in police has been described both as an innate quality or characteristic that protects an individual from developing PTSD following traumatic events such as disasters, as well as a factor that might be influenced through training or experience resulting in improved psychological outcomes (Bonanno, 2012; Connor & Davidson, 2003; Tedeschi & Kilmer, 2005). Competence, self-confidence,

supportive leadership, and persistence and effort when facing challenging circumstances were found to increase resilience and improve performance in the operational capacity of police by Paton et al., (2008) and Quinn and Spreitzer (1997).

There is little consensus in the literature as to whether any specific form of training might improve resilience in police. Training police in resilience through imaginal exposure to potentially traumatic events has been shown to have some benefits (Arble et al., 2017). No benefit was found for police in mental strength training, defined as skills for managing stress before, during and after a PTE (van der Meulen et al., (2019), although the teaching of controlled respiration to manage stress was found to have some beneficial effects by Andersen et al. (2015). Using response training to develop coping skills by practising adaptive responses to exposure, and frequent rehearsal of learned skills improved performance during simulations of a potentially traumatic nature was found to result in improved mental and physical health over a period of two years of police work, in a study by Arnetz et al. (2013).

The results of the study described in this thesis seem to suggest that resilience in police might be related both to personality style and to competence and that it might arguably show some benefit from interventions based on training to develop competence. There is little evidence to suggest that teaching stress management techniques alone is effective. In many of the studies cited above skill enhancement is combined with stress management techniques; meaning that treatment effects from each cannot be differentiated.

The participants in Group 1 in this study described adopting a deliberate focus on the job at hand and various idiosyncratic ways of countering their emotional responses. None described focusing on their emotional response. This suggests that resilience training that encourages a focus on stress-related symptoms and their management at the time of exposure might prove to be counter-productive. Further research might investigate whether training in

learned responses to specific incidents, as it is described above in the Arnetz et al. (2013) study, might have the effect of providing in a certain amount of emotional detachment through directing focus on to the cognitive and behavioural rather than the emotional aspects of response. The preliminary findings of the present study suggest a potential direction for further research in this area.

Arguably, group post-trauma debriefing might also allow an early "aesthetic distance" from an event, as described by Scheff (1979), to be achieved if it is addressed in a group context. This might allow individuals to revisit and explore their traumatic experience in a supportive environment shared with those who had a similar experience, and to begin to integrate it.

The data from the participants in Group 2 suggest another potential factor in the development of resilience. As described earlier, while these participants had developed trauma-related symptoms, the meaning they place on this appeared to be that while it was unfortunate that this had happened, this had occurred through no fault of their own. They did not suffer any subsequent loss of self-concept as a result, nor did they experience internal shame as it is defined by Gilbert, (2001). This contrasts with the reaction of the participants in Group 3, who felt ashamed as a result of having developed trauma-related symptoms and who experienced lowered self-esteem, loss of self-confidence and depression. This suggests that, as a normal part of police training, intensive psychoeducation that focuses on normalization of trauma-related symptoms, and the recognition of indications that they might require treatment, could be beneficial. This information might conceivably function as a preventative measure at an individual level by serving to counter the prevailing influence of the culture-related stigma and its associated shame. I have no knowledge of any training with this specific focus being provided at present.

Detachment vs. Dissociation

In this research study, I have referred to detachment as it was employed by the participants in Group 1 as *"deliberate detachment"* and suggest that it appears, from the narratives of the participants, to be a fully voluntary pre-planned behaviour that is employed with a self-protective purpose. As the participants in this group described it, it is a voluntarily adopted process rather than a *"dissociation"* (although several of them referred to the process using the term dissociation). As described earlier in Chapters 1 and 2, in the trauma field the mental state of dissociation has a specific meaning. A broad definition of peri-traumatic dissociation, that is, dissociation occurring at the time of the trauma, is that it is an *involuntary* alteration of awareness at the time of the traumatic experience (Bryant, 2007). The term *"detachment"* is generally considered in the literature to also be a type of involuntary dissociation associated with a damping down of emotions, in a category with depersonalization, derealization and numbing (Baekkelund et al., 2018).

An interesting gender difference was noted in studies by Tekin et al. (2016) and Aho et al. (2017), who reported males as being more likely than females to respond with dissociation in the peri-traumatic period, perhaps reflecting the effect of early socialization that discourages displays of emotion in male children.

It is generally accepted that both dissociation in the peri-traumatic period and dissociative tendencies appear to be risk factors for later development of post-trauma symptoms (Bernstein & Putnam, 1986; Bremner, Southwick et al., 1992; Bremner & Brett, 1997; Ozer et al., 2003). Dissociation has long been thought to have its origins in trauma (Carlson et al., 2009; Janet, 1907; Liotti, 2009; Schore, 2009; Vermetten et al., 2007). That dissociation predisposes to the development of PTSD by interfering with normal encoding and subsequent retrieval of traumatic memory is also a generally accepted explanation for how this occurs (Brewin et al., 1996; Lanius et al, 2010; van der Kolk & van der Hart, 1989).

Dissociative tendencies are thought to be common in the general population (Kihlstrom et al., 1994) and to reflect a dimension of normal personality. In my searches of the research literature, I have found no evidence of any studies that investigate whether those who have a tendency to react to trauma with dissociation can learn to respond differently. Given the known association of post-trauma psychological injury with dissociation, this might provide a valuable area for future examination.

In their descriptions of their coping techniques, Group 1 participants also appeared to demonstrate that their capacity to achieve voluntary emotional detachment was associated with an absence of trauma-related symptoms. For the participants in Group 2 and 3, those who described experiencing involuntary emotional peri-traumatic dissociation reported the subsequent development of trauma-related symptoms. Don, in Group 2, described reacting to the bombing of a police headquarters by "*just going into work mode"* and being unaware of significant injuries he had sustained in the blast. He was later diagnosed with PTSD and experienced other associated difficulties. Ivan, in Group 3, began having vivid trauma-related nightmares associated with a shoot-out and being dragged by a vehicle without being aware that these related to this experience – in part probably a function of his subsequent reputation as *"rough and tough"* and his belief that he needed to live up to this. His PTSD failed to be diagnosed until the termination of his policing career 34 years later. While a review by Bryant (2007) challenged the previously popular notion that there is a linear relationship between dissociation and PTSD, the dissociation experienced by these participants and the later appearance of their symptoms is consistent with findings showing that peri-traumatic dissociation can frequently (but does not always) precede the later development of PTSD (Bryant, 2007).

A dissociative response to a potentially traumatic event might be described within IPA (Smith et al., 2009) as lying within the first category of making meaning, described as

"pre-reflective reflexivity – a minimal level of awareness" as described in Chapter 3. This might correspond, in turn, to an affect which is registered by the body but does not reach consciousness (Tomkins, 1962; Lanius et al., 2017), This affect which has been registered by the body can then later be expressed in trauma-related dreams, somatic symptoms, or in other symptoms of PTSD.

An association between dissociation and later development of symptoms was noted in a longitudinal study of active-duty police officers by Galatzer-Levy et al. (2011) who identified three trajectories of symptom response following exposure to a life-threatening event: resilient; distressed-improving, which they described as sub-syndromal but potentially highly reactive to stress; and distressed-worsening, associated with PTSD symptoms progressively increased over time. They found dissociation absent in the resilient group and argued that it distinguished this group from the symptomatic groups of individuals, and that the existence of peri-traumatic dissociation differentiated the distressed-worsening group from the others. Aspects of this response pattern bears a strong resemblance to the different responses to potentially traumatic events of the participants in the three groups in this study. This similarity may indicate that those able to maintain full awareness of their surroundings through deliberate detachment might process the meaning of events as they occur, and therefore achieve maximum resilience though leaving them in more control of their emotional reactions and how they later attribute meaning to them.

Alcohol and Debriefing

Most of the participants across all the groups spoke of the ubiquity of the use of alcohol by police and suggested that the use of alcohol had been the best way they had found to deal with stress and traumatic incidents in the absence of any alternative, like formal debriefing, being available at the time. The deleterious consequences of the drinking culture after a potentially traumatic event were obvious even to those who took part in it, were

described in detail by many of the participants in Chapter 4, and have been identified in research (Devilly & Varker, 2013; Menard & Arter, 2013). Reasons for any potential benefits arising of its association with debriefing have not, to my knowledge, been explored. Recurrent themes among the participants across all the groups were that (a) drinking after a critical incident was a police-only exercise; that is, police only drank with other police; (b) this drinking frequently occurred with fellow officers who had been present at the same critical incident, and as such could be reasonably relied upon to be non-judgemental; (c) the disinhibiting effect of alcohol meant that some aspects of an event that could potentially be threatening were more likely to be aired, and finally, (d) it occurred immediately after a critical incident, at the time of highest stress. This suggests that ideally the most effective support after a potentially critical incident would occur as soon as possible after the incident and include only those present at the incident. There would be no judgement or stigma associated with individual actions and responses to the incident.

While responses differ within and between organizations, initial support to police following a critical incident is now generally provided at an individual level through a peer support system, with referral on to a psychologist or other service if requested or considered desirable (Cotton et al, 2016). Those providing the service will not have been involved in the incident and are unlikely to be police. Trust in those offering these services might prove difficult for some officers– as summarized succinctly by Victor, in Group 3; "*bear in mind most coppers don't trust anyone*". Lastly, and importantly, for logistical reasons, any counselling or support that is provided often does not occur in the critical period immediately after an incident when emotions are running high, and the individual makes meaning of their experience (Cotton et al., 2016).

There has been a significant change in debriefing policy associated with emergency services and other workplaces where a traumatic incident had occurred. Until about the end

of the last century group debriefing was routinely performed for personnel in the emergency services and also in many other work-related situations (Devilly & Cotton, 2003). The process originated in in the US in the 1980's and was adopted in Australia around the same time (Tuckey & Scott, 2014). It operated primarily on what became known as the "Mitchell Model" (Mitchell, 1983) which fell into disrepute early this century following the publication of research citing a lack of reliable data for its effectiveness (Tuckey, 2007). The Mitchell model for Critical Incident Stress Debriefing (CISD) and its later version, Critical Incident Stress Management (CISM) were criticized by Australian researchers Devilly and Cotton (2003; Devilly et al., 2006), amongst others, as unreliable because of lack of research evidence for their efficacy, and indistinct because they were loosely defined. The ensuing controversy generated a considerable amount of debate, with an ultimately ineffective defence for the Mitchell model mounted by another Australian author (Robinson, 1995, 2007, 2008). The difficulties and ethical considerations associated with performing acceptable randomized research in the area were described by Tuckey (2007), and possible solutions discussed. Later research by Tuckey and Scott (2014) provided some directions for future research and some support for CISD but acknowledged that the efficacy of the procedure remained unresolved. The initial research findings, however, resulted in the abrupt discontinuation of group debriefing (Robinson, 2007; Tuckey, 2007). There has been no widely endorsed replacement, and group debriefing following a critical incident, confined to those present at the incident, now seems to be no longer routinely performed within the police departments of VICPOL and SAPOL, or with other emergency responders.

There is empirical evidence to support some aspects of the now-discredited model of debriefing. A qualitative study of police officers' experience of "supportive" versus "unsupportive" interventions by Evans et al. (2013) suggests that for it to be most effective in ameliorating distress, the type of social support is critical; that it needs to engender trust, and

the belief that one will be understood, not judged and therefore not subject to external shaming. Participants in the present study suggested that non-judgemental support following a critical incident might be most frequently found among fellow officers, in particular those who have shared the same experience, or dealt with similar incidents – those who *"get it",* and *"speak the same language"* in the words of Group 3 participant Victor. Debriefing in a group context might also be beneficial in counteracting self-stigma by normalizing trauma-related responses. Group 1 participant Gerald said he had received reassurance from finding out that other members of his group were suffering similar symptoms to his in the context of a high-stress investigation.

Two participants suggested models for group debriefing. Victor in Group 3 suggested that senior officers should be trained in basic supportive debriefing to be performed immediately after a potentially traumatic incident with those officers involved. This suggestion has been given support in a longitudinal study by Birkeland et al. (2017), who found that high levels of both leader support and general social support were independently associated with a more rapid decline in distress following a traumatic event. Pat in Group 1 spoke of it being a common practice in the 1980's that senior officers ran a debrief immediately after a critical incident. If concerns were identified these were addressed with an emphasis on ways that training might be improved, rather than on any criticism of individuals concerned. I could find no evidence in the literature or other available resources for any current formal structure for debriefing to be led by a senior officer – and it is likely that there would be some senior officers unwilling or unsuitable to perform this task. However, starting from the basic principles of understanding through shared experience, and the importance of trust and timeliness, I suggest it is worthy of consideration for further research as a first response to exposure to critical incidents. The present system of support for police after trauma is arguably inadequate, and the stigma within police culture associated with

concealing emotions is likely to operate as a disincentive for an affected officer to request further help.

A general need for current policing to move from a *"blame culture"* to one of *"learning from failure"* and a call to *"develop, plan, and engage a program for staff focusing on trust, commitment, overt actions, and communication to normalize the language of mental health within the workplace"* was expressed by the Australian representative in a recent international meeting of a Panel on Police Mental Health and Wellbeing (Kamkar et al., 2019, p. 2). This high ranking, well known police officer also revealed his own diagnosis of PTSD, and said he did this to attempt to counteract the stigma associated with the diagnosis.

A further feature that distinguished the participants in Group 1 from those in Groups 2 and 3 was their apparent ability to remain unaffected by their exposure to incidents that were life-threatening. It is less clear from the available data how this group maintained resilience in the face of these incidents, which all but one acknowledged having experienced. None of the group offered any direct evidence as to how they might have achieved this, but it seems likely that it lay in their ability to employ the same mechanism of deliberate detachment from environmental stimuli that they described in coping with potentially traumatic incidents involving deaths and horrific injuries to others. Refraining from subsequent negative appraisal was also described as important by the participants in Group 1. As noted earlier, the importance of negative appraisals following trauma has been shown to have a significant effect on subsequent psychological adjustment and thought to be a primary factor in the development and maintenance of PTSD and its co-morbidities (Barton et al., 2013; Beck et al., 2015). Several of the group described how they avoided dwelling on unpleasant experiences afterwards, with the awareness that this would have an undesired effect. As expressed by one participant in Group 1 "*If you dwell on it of course it's going to eat you up".*

Post-Trauma Appraisals

The participants in Group 3, who described themselves as being frequently preoccupied with memories of past events and of actions they had later regretted, also experienced depression and a progressive decline in their mental state after retirement. The meanings they attributed to their past experience and actions were largely negative. Their appraisals correspond in IPA (Smith et al., 2009) with *"Deliberate controlled reflection"* – described as deliberately recalling an event and examining it further; in the case of the participants in Group 3, in self-critical terms. The content and frequency of post-trauma cognitions, including negative cognitions about the self, negative cognitions about the world, and self-blame were found to predict the persistence of symptoms over time by O'Donnell et al. (2007). As discussed earlier, the importance of the effect of post-trauma appraisal was initially suggested in the cognitive model of posttraumatic stress disorder proposed by Ehlers and Clark (2000), who posited that persistent PTSD occurs only if individuals process the traumatic event and/or its sequelae ways that produce a sense of serious current threat, and that this might be associated with shame or threat to personal integrity. Higher levels of shame and depression were found to be significantly associated with higher levels of negative thoughts about the self by Beck et al. (2015) and self-blame, guilt and shame were found to be different from peri-traumatic fear, and independently predictive of PTSD symptoms by Tran and Beck (2019). There are potentially two implications flowing from the importance of negative appraisals: the first, that their identification in treatment is critical; the second, that early post-trauma intervention, as suggested by McFarlane et al. (2017), might serve to arrest the process before it becomes strongly established and thus prevent further harm.

Event Centrality

The perceived life-centrality of the trauma (referring to the extent an individual construes a traumatic experience as a central part of their identity and experience their trauma

symptoms as the dominant influence in their lives) was also found to be significant in increasing trauma reactions (Berntsen & Rubin, 2006, 2007; Boals & Schuettler, 2011). The salience of event centrality was initially remarked upon in a study by McNally et al. (1995), whose authors noticed that Vietnam veterans who came to their research facility in vestiges of their military regalia displayed much higher rates of PTSD than those who did not dress this way. Subsequent research has indicated that event centrality may be a better predictor of the severity of subsequent PTSD than reported rates of trauma exposure (Bernard et al., 2015).

The majority of the participants in Groups 1 and 2, who did not describe any deterioration in their mental state after leaving policing, were similar in that they did not describe the potentially traumatic events they had experienced as occupying a central position in their current lives. They indicated in various ways that, while policing had been important to them, they had moved on.

Conversely, the participants in Group 3, who said they experienced a progressive deterioration in their mental state, indicated that their memories were dominated both by events during their policing career that were associated with regret and shame, and by the traumas they had experienced that were still vivid and alive for them. Again, early post-trauma assessment and therapy, or perhaps structured rehabilitation activities might serve to counter the dominance of the centrality of damaging post-trauma memories by directing attention outwards and increasing social contact.

The effect of event centrality as it is described in the literature does not appear to have been found to be consistently negative, however, as it has also been described as leading to posttraumatic growth (Kleim et al., 2007). Posttraumatic growth is described as positive life change after traumatic experience, such as greater appreciation of life, and improved self-confidence and personal strength (Tedeschi & Calhoun, 1996). Reference to posttraumatic

growth associated with events experienced during their policing career was notably absent in the narratives of the participants in this study, although some of them looked back and said they believed they had performed their duties well. A number of participants across all of the groups referred to early life experiences that they considered had "made them stronger" in their later lives. None, however, spoke of having experienced any positive change as a result of their exposure to trauma while police officers.

Implications for Rehabilitation and Treatment

As discussed in Chapter 2, the most frequently recommended first-line treatment for PTSD in international guidelines is trauma-focused cognitive behavioural therapy, which includes prolonged exposure, eye movement desensitization and reprocessing (EMDR), cognitive therapy, cognitive processing therapy, and imagery rescripting. However, trauma-focused therapies are known to have a high failure rate (Bryant et al., 2020) from both poor response and high drop-out rates and there is controversy as to whether these therapeutic approaches are suitable to treat the effects of moral injury. The advantages of group treatment, referred to earlier as potentially providing group support and normalization of symptoms, might conceivably extend to treatment of PTSD and moral injury and some evidence for their efficacy is described in Chapter 2 (Brucia, 2018, Bryan et al., 2018). Don, in Group 2, who experienced severe symptoms of PTSD and also the effects of moral injury, underwent a structured group treatment process and said he had found it extremely helpful.

Rehabilitation through community based activities might offer an alternative route to an improvement in mental state for those severely affected. Service to others has been found to be a way to meaningfully transform difficult personal experiences in programs for US veterans (Yehuda et al., 2016). The participants in Group 3 described experiencing shame based on having been disrespected, unvalued, and alienated or rejected by others. Their self-esteem was damaged, and they felt further shame because of behaviour related to their

symptoms and the way it had affected others. Some felt sadness simply at the amount of human grief and trauma they had witnessed and had been unable to remedy. Restoration of self-respect, self-belief and *"justified or genuine"* pride as it is described by Scheff (2000) might perhaps occur through their participation in activities providing assistance to others. Most of the participants in Group 2, and several in Group 3, described existing involvement in these types of activities. Two participants in Group 3 described their wish to pursue them but were unable to do this because of the severity of their symptoms.

Many of the participants in this study said they became police officers to protect the community. Given the necessary assistance, perhaps some of those with severe psychological injury could again become involved in a variety of community-based roles, using the substantial experience gained in their policing careers to assist others. Through this they would also gain the opportunity to increase their social contact and re-integrate into the community.

Summary

This chapter has discussed the major themes in the participant data identified in chapters 4, 5, 6 and 7 in the context of the current state of knowledge. These include the major differences between the groups in how the participants described their coping mechanisms for dealing with potentially traumatic events, the influence of police culture, the stigma associated with psychological injury and the presence of internal shame and how it might be associated with a deterioration in mental state. The use of shame avoidant mechanisms was discussed with reference to how they might be linked to the exacerbation of symptoms, the development of co-morbidities and suicide risk. The place of moral injury in trauma-related psychological injury in police was considered. The use of deliberate detachment, active coping styles and avoidance of negative appraisals were examined in the context of resilience. The historical place of alcohol in the debriefing process and how it

might inform our current approach was also debated. Finally, how rehabilitation of trauma-related psychological injury might be achieved was evaluated.

In the next chapter, the implications of the findings of the research study will be described and evaluated in terms of how they might apply to best practice through changes in policy and practice in the diagnosis, management and treatment of post-trauma symptoms, and in any measures that might prevent or mitigate their initial development.

Chapter 9: Conclusion

Cumulative exposure to traumatic stressors in police and other emergency workers has been recognized as a path to psychological injury, including PTSD, depression, anxiety disorder, substance abuse and suicide risk (Chopko et al., 2013; Faulkner et al., 2020; McFarlane, 2010a). The qualitative research described in this thesis has used a phenomenological approach through a narrative enquiry to examine the sequential nature of the events that might lead to injury and the processes whereby this might occur. It has explored whether and how moral injury might occur in police and more broadly, whether shame, as it is broadly described in the transdisciplinary literature, might be a previously poorly recognized element in cumulative stress.

This study has examined the effects of exposure to potentially traumatic events in a group of fourteen long-serving retired male police officers from the states of South Australia and Victoria. Participation was invited from former police who *"experienced events during their policing career that had been life-changing".* The study focused on two aspects of the participants' police service: their experience of police culture, and against this background, the impact on them of their exposure to cumulative operational critical incidents and other occupationally related stressors. This has included any coping mechanisms they used to deal with these events, their emotional responses to them, any sequential processes of change to their mental state that occurred, and the meanings they attributed to both the events and to any subsequent changes in their mental state.

For some of the participants in the study, elements of shame were found to contribute to cumulative stress through their experiences of humiliation, disrespect, and alienation. Regrets associated with appraisal of past events were found to erode confidence and self-esteem and act as a further source of shame. For these participants, this shame, and the use of shame avoidant mechanisms to defend against it were found to be important elements in the

exacerbation of their psychological injuries and appeared to be associated with a progressive decline in their mental state and a subsequent poor quality of life.

Those participants in the study who experienced trauma-related psychological injury but did not show a subsequent deterioration in mental state were found to exhibit positive self-esteem and an absence of shame associated with their symptoms or past actions and experiences. They all expressed satisfaction with their post-retirement quality of life.

Not all the participants in the study described experiencing a psychological injury. An unexpected outcome of the research was evidence from these participants that coping mechanisms that entailed deliberate emotional detachment and a task-related approach appeared to lead to their resilience to trauma-related psychological injury.

Overview: The Study Methods

Face to face audio-recorded interviews were conducted with 14 participants, whose length of police service ranged from 18 to 43 years, and who served between the years of 1959 and 2016. The interviews were conducted as largely unstructured narrative enquiries, lasting 1 to 3 hours, and the data analysis performed using Interpretative Phenomenological Analysis (Smith et al., 2009), an inductive approach that explores the meaning of experience as it is described and understood by the participant.

Transcripts were constructed by the researcher from audio-recordings of the participants' narratives. Information relevant to the research topic was then contextualized and ordered according to the sequence of events as described in each narrative, and individual case studies were constructed for each participant (see Appendix A for individual case studies). The participants were given pseudonyms and background details were changed or removed where necessary to prevent identification. The case studies reflected the chronological sequence participants placed on the reactions they experienced to occupational stressors and the reasons they gave for their reactions based on the meaning they attributed to

them. Notable and consistent differences emerged in the ways that the participants described having reacted to the potentially traumatic events they had experienced during their police service. Based on these differences, the fourteen participants fell into three groups. Group 1 consisted of five participants who described themselves as unaffected by their exposure to cumulative PTE's. Group 2 consisted of four participants who said they experienced trauma-related symptoms following their cumulative exposure, but who described their subsequent mental state as stable and their quality of life as satisfactory. Group 3 consisted of five participants who described experiencing severe trauma-related symptoms, a progressive deterioration in their mental state, and significant limitations to their quality of life in retirement.

Characteristics of the Groups

The five Group 1 participants, who described themselves as unaffected by trauma-related symptoms, said they had deliberately found ways to emotionally detach themselves when exposed to events that were potentially traumatizing. These included focusing on the job in hand and not dwelling on the events afterwards. The participants in this group tended to see themselves as having been confident and competent police officers, but most said they had also been aware, for various reasons, when it was time for them to leave policing. All had successfully moved on to other employment or activities after their retirement.

The four Group 2 participants said they accepted that they experienced ongoing trauma-related symptoms related to their police service but indicated that they could manage these in various ways. They said that their self-concept had not suffered damage as a result of having sustained a psychological injury. All were able to actively pursue subsequent careers and activities. None of the participants in this group expressed regrets associated with any aspect of their police service, despite memories that they described as disturbing at times. This group however was not as homogeneous as Group 1. Some of the participants described

periods of difficulty when their memories of the past and the emotions associated with them were activated and their mental state became temporarily less stable, but unlike the participants in Group 3, they reported that they subsequently fully recovered.

The five Group 3 participants, who experienced a progressive decline in their mental state after developing symptoms, indicated that they believed they had been irrevocably psychologically damaged by their police service and by events in its aftermath, most of these associated with their attempts to claim compensation for their psychological injuries. They described their well-being and lifestyle as being severely limited by their symptoms, which they experienced as occupying a central position in their lives, preventing them from participating in many activities they wished to pursue, and limiting their ability to socialize. They described feeling ongoing distress because they believed they had been disrespected, unvalued, alienated or rejected by others. Their self-concept had deteriorated because they viewed themselves as damaged and inadequate – *"not the person they used to be"* -- before the development of their symptoms. Most said they had experienced increased anger in a variety of situations and expressed shame and regret for the ways their anger had negatively influenced their behaviour, and for the effect of this on those around them. Most of the participants in this group also described experiencing ongoing depression or anxiety, or both, and avoided social contact where possible.

Major Research Findings

In an earlier publication (Taylor, 2015) and in Chapter 2, I proposed that the presence of shame frequently fails to be recognized in post-trauma disorders, and that shame avoidant mechanisms may be employed as defences to ignore, reduce, or displace the distress associated with it. I further proposed that these shame avoidant mechanisms, when employed by an individual experiencing the effects of post-trauma psychological injury, might contribute to an exacerbation of symptoms of PTSD or to the development of comorbidities.

These proposals appeared to have been borne out in different ways in the narratives of the majority of the participants in the study.

In Group 1, both shame and any strategies that might be identified as maladaptive shame management or shame avoidant were notably absent in the narratives of all the participants. The Group 2 participants acknowledged concealing their symptoms to avoid potential shaming by others, but they did not indicate that they felt ashamed of themselves or that they accepted the culturally based stigma as being applicable to them. This was not the case for the Group 3 participants, who described experiencing both external shaming and associated internal shame or self-stigma. All the participants in Group 3 also described using, or having used, shame avoidant mechanisms that included aggression, overuse of alcohol and isolation.

While the conclusions that can be drawn from a study of this size are obviously limited by the design of the research and the participant numbers, this study shows distinct and consistent differences between the groups of participants, and these differences are related primarily to two prominent findings. The first of these is that the attainment of a type of deliberate emotional detachment at the time of exposure to a potentially traumatic event appears to be associated with an absence of psychological injury. The second finding is an apparent association between a deteriorating mental state and the presence of internal shame, and the use of shame avoidant mechanisms, which appeared to further contribute to a deterioration in mental state, to harmful behaviours, and to self-doubt and regret.

If they were to be substantiated by further research, the findings from this study have the potential to make two significant contributions to knowledge. The first, and unexpected, contribution is the finding that a process or state of voluntary emotional detachment in the peri-traumatic interval might contribute towards resilience to potentially traumatic events. This type of detachment, described by the all the participants in Group 1 and co-occurring

with their apparent resilience to potentially traumatic events, has not been previously identified in the existing literature.

The second significant contribution to knowledge offered by this study is preliminary evidence to suggest that internal shame and shame avoidant mechanisms might be an important element in an erosive process that leads to a progressive deterioration in mental state in PTSD, and to the development or exacerbation of co-morbidities. A prominent feature of the narratives of the participants in Group 3 is the way in which they demonstrated how the traumatic effects of experiences of humiliation, rejection and exclusion could be cumulative, result from exposure to a variety of different events and lead to a deterioration in mental state. The narratives of the Group 3 participants also identified their use of shame avoidant mechanisms which included anger and aggression, alcohol abuse, and self-isolation. Most of the participants in this group also described a history of depression which might putatively be linked to negative self-concept. This association between shame and shame avoidant mechanisms and a potential exacerbation of the symptoms of PTSD and development of co-morbidities has also not, to my knowledge, been identified in existing empirical research.

A further significant contribution to knowledge from the study was that the majority of the participants in Groups 2 and 3 described psychological injuries consistent with those of moral injury; in some cases, in addition to PTSD, in others existing in isolation. As described earlier, moral injury is thought to result from exposure to events that involve either perpetrating or witnessing actions that violate one's core beliefs (Litz et al., 2009), or betrayal by a leader or trusted authority (Shay, 2014). It has been researched extensively in members of the military since the early years of this century but to date has received little application to police (Griffin et al., 2019). It is thought to be associated with guilt, shame, emotional distress, self-deprecation and spiritual or existential crisis, and has been found to be an

important underlying element in suicidal ideation and completed suicide (Bryan, Bryan et al., 2017; Bryan, Ray-Sannerud et al., 2013). Two participants did not describe the neurobiological symptoms consistent with the current diagnosis of PTSD but had nevertheless sustained a significant psychological injury consistent with moral injury, which they attributed to betrayal by senior officers or others in a position of power and to regrets associated with their past actions.

I propose that the major findings of this study, if they are supported by further empirical research, have multiple potential implications for the diagnosis management, treatment, and mitigation, if not prevention, of post-trauma psychological injury in police.

Implications of the Findings

Identification of moral injury in police

Because of the potential impact of moral injury on mental health, I argue that the construction of measures to identify moral injury in police, who conceivably face many similar cumulative potentially traumatic events as those experienced by military personnel (McFarlane et al., 2009), is a research area needing early attention. Currently, available measures associated with military exposure are unlikely to be applicable. Shame associated with changed self-concept was a prominent feature in the narratives of the participants in Group 3. For this reason, it would be very important to construct any future measures of moral injury in police to include shame from this as well as from other sources. These measures would need to be comprehensive, and record both the context of the event exposure, and the post-exposure moral injury outcomes.

Implications for diagnosis

While DSM-5 (American Psychiatric Association, 2013) acknowledges the frequent presence of shame in PTSD, the cross-sectional, phenomenological nature of this diagnostic system precludes the identification of any interaction between symptoms that might signal the

potential for a further deterioration in mental state. The recently published diagnosis of Complex Posttraumatic Stress Disorder in ICD-11 (World Health Organization, 2019) might specifically identify the presence of the effects of moral injury when they are associated with PTSD. but cannot address their interaction.

The diagnostic approach of Network Analysis (Boorsboom. 2008; Borsboom & Cramer, 2013), which conceptualizes mental disorders as mutually interacting, reciprocally reinforcing emotions, cognitions, and behaviours, was suggested in Chapter 2 as a means of identifying the dynamics involved in the exacerbation of symptoms or the formation of co-morbidities. Network Analysis has the potential to identify the ways, and the extent, to which shame might affect the course of a psychological injury. Because it has the potential to identify idiographic network structures in individuals, its concepts might conceivably be used at the level of the individual and incorporated in a pre-treatment assessment, important for the selection of an appropriate therapeutic approach and for further management.

Implications for police management

The importance of the recognition of shame for police management would apply to both the disciplinary and the compensation processes. In the disciplinary processes, the identification of psychological injury and associated shame avoidant mechanisms as potentially underlying so-called “bad behaviour” or co-morbidities, as suggested by a participant in Group 3 might provide a more equitable and humane method of dealing with affected individuals.

It has been well recognized for some time that making a compensation claim frequently leads to a further deterioration in the mental state of those with a psychological injury. The findings from this study strongly suggest that shame and humiliation are critical factors in the compensation process. Participants described believing their integrity had been called into question– one said this had brought him close to physically attacking the

examiner. Another described being pushed to the brink of suicide, and possibly even homicide-suicide, by the prospect of being *"dosed up"* on medication and forced back to work. These types of reactions to the compensation process are indications that the system – or series of systems nationwide – urgently need to change. While the ways in which the compensation processes are managed differ from state to state in Australia, all state government policies associated with compensation to emergency workers are limited by legislature designed to limit their insurance liabilities (McFarlane & Bryant, 2017). There is evidence from the Australia-wide surveys of emergency workers described in Chapter 1 that all the insurance companies involved in workers' compensation appear to operate on an adversarial basis in relation to claimants. This structure gives them the potential to disempower, humiliate and further damage injured police, and might also act as a disincentive to injured police who might have a valid claim for support. As a participant in Group 2 said, he *"hadn't bothered"* to make a claim, because *"it always starts with a fight"*.

Implications for treatment and rehabilitation

The most widely used treatment methods for PTSD and for moral injury were described in Chapter 2, and their applicability discussed in Chapter 8. Here I add some observations and comments based on my experience as a clinician and therapist and on the concerns expressed by the participants in this study.

Beyond the therapy method employed there are arguably many influential, less obvious variables that might affect the course of treatment. This research indicates that the presence of underlying, unidentified shame might be foremost among these. Shame might not be acknowledged or even recognized and may be translated into shame avoidant behaviour such as aggression, depression, alcohol or drug abuse, and isolation. While shame might be present, for the therapist to suggest its presence would be likely to be unhelpful in that this would be likely to be experienced as further, external, shaming. It might however be

identified in three dimensions: intrapersonal shame through examination of any changes in self-concept, interpersonal shame both through any changes or difficulties in close personal relationships, or at an occupational or social level, through issues of isolation or exclusion.

Variables that might further influence the course of treatment include: the therapist's openness to the sharing of shame related information; the possibility that the therapist's own discomfort with the topic might inhibit its discussion, as suggested by Herman (2011). The amount of structure imposed in the therapy session; whether it allows for this sharing of shame-related information, considered important by Lehrner and Yehuda (2020). The importance of an atmosphere of trust being established between the therapist and the client that allows the client to acknowledge shame without fear of further shaming, considered necessary by Brewin (2020). The possibility that the client might hesitate to discuss disturbing aspects of their experience – perhaps the ones they struggle most with themselves – to avoid the therapist's reaction of horror or revulsion as suggested by Herman (2011). Other variables that might affect outcome were cited as important in the narratives of the participants. These included the therapist's familiarity with policing – do they *"speak the same language?"* When it comes to how it feels to have a trauma-related psychological injury, does the therapist "*get it*?".

A further issue potentially impacting on police mental health that emerged from this research was the concern expressed by many of the participants about the absence of adequate debriefing for police who had been exposed to potentially traumatic incidents. As suggested previously, this might alternatively be provided in low-key, end of shift debriefs conducted by senior officers, who could receive basic training in the process. This would provide support immediately following the incident, within the context of the group involved in the incident, and from a group leader, three elements known to be relevant in minimizing adverse consequences from potentially traumatic events. The current support systems

available to police do not meet any of these criteria and this raises the question as to whether alternatives should be explored.

It was suggested in Chapter 8 that pride might serve as a buffer for shame. Those participants who described satisfaction from being involved in activities that helped others in various ways in their retirement indicated that this had contributed to their self-concept. Finding ways to support an involvement in voluntary work or other community service occupations for retired police with a psychological injury might assist in their rehabilitation by helping to restore their pride in themselves and their social re-integration. All of the participants Group 2 and one participant in Group 3 described their existing involvement in various assistance programs or activities as beneficial. Two participants in Group 3 expressed a desire to be involved in providing support and information to others as part of a retired police support program but were unable to do so because of the limitations posed by their mental state.

Questions for Future Research

Can training improve resilience in police?

Chapter 8 discussed current research associated with the use of training to develop resilience. No clear picture emerged but while there were indications that pre-existing personality and exposure to early life trauma were factors, competence, confidence, decisiveness, and a pre-planned approach to critical incidents also played a part. It is possible that these qualities might be enhanced through targeted training. Routine post-incident operational debriefs aimed at improving performance rather than allocating blame might also assist in avoiding subsequent negative appraisals and self-doubt. This was suggested by a participant in Group 1, and by a senior officer at an international policing conference. Both accounts were described in Chapter 8.

It was also suggested in Chapter 8 that intensive psycho-education that focuses on normalization of trauma-related symptoms and the nature of traumatic injury might assist in the prevention of self-stigma or internal shame and contribute towards resilience by countering the prevailing cultural stigma associated with psychological injury. This was based on the narratives of the participants in Group 2, who were well aware of the cultural stigma, concealed their symptoms to avoid external shaming by others, but did not feel internal shame – they were not "ashamed" of having developed symptoms, and their self-concept remained intact.

The participants in Group 1, who all described an absence of any ongoing symptoms, indicated that they believed they had been competent police officers and confident of their ability to assess and adapt to novel situations. This corresponds with an *"active coping style*" as described Arble et al. (2018), and Violanti et al. (2018) and found to be associated with resilience to trauma-related injury. This coping style was described by these researchers as incorporating an ability to both confront and make a realistic assessment of the source of stress and the capacity to develop a plan of action to deal with it. While these coping mechanisms appear to be largely related to personality style, some might also be feasibly incorporated into police training to enhance resilience.

Dissociation as a risk factor for police – can it be changed?

As discussed earlier, dissociation might be broadly conceptualized as an involuntary protective or coping style that is thought to develop in early life associated with a perception of powerlessness in the face of traumatic experience, (Dorahy & van der Hart, 2015). This contrasts with voluntary detachment, as it has been described by the participants in this study, appearing to reflect a coping style based on confidence and competence in the face of challenge, and with a realistic acceptance of associated risk factors. While dissociative tendencies are thought to represent a relatively stable dimension of normal personality

(Bernstein & Putnam, 1986) they seem to place police who have these tendencies at a disadvantage, given their frequent exposure to potentially traumatic incidents and the recognition that dissociation in the peri-traumatic period is an increased risk factor for the later development of psychological injury (McCanlies et al., 2017).

Whether those who have a tendency to react to trauma with dissociation can learn to respond differently might also provide an area for future examination, since it is well accepted that both dissociation in the peri-traumatic period and dissociative tendencies appear to provide risk factors for later development of post-trauma symptoms. Whether any specific training might moderate reaction in the peri-traumatic period to prevent dissociation has not to my knowledge been addressed in the extant literature

Scheff's (1979) proposal that an absence of the ability to maintain an adaptive *"aesthetic distance"* from potentially traumatic incidents could be associated with a prohibition on display of emotion in childhood raises the further question of whether this might be more common in males, perhaps reflecting early socialization discouraging displays of emotion in male children. This could indicate that female police officers deal with potentially traumatic events differently and in a way less damaging to their mental state. This possibility was suggested by Cliff in Group 2 and might provide an area for further research.

Concluding Comments

This research has examined the effect of cumulative stress in a group of fourteen long-serving retired police officers. It provides preliminary evidence for the factors that might be associated with resilience to psychological injury resulting from exposure to the cumulative potentially traumatic events frequently encountered in policing. It also provides preliminary evidence for the importance of the effects of shame and shame avoidant mechanisms in contributing towards the exacerbation of the symptoms of PTSD and other psychological injuries, and the development of co-morbidities. The importance of the recognition of the

potential presence of moral injury, and the early development of measures to identify it, and other sources of shame, in police has also been discussed. Finally, the potential contribution to psychological injury resulting from existing policies associated with claims for compensation, and the need for adequate preventative support following exposure to critical incidents is outlined.

Every day, in order to protect the community, police officers face potential exposure to events that could result in them sustaining a psychological injury. The primary purpose of this research has been to attempt to contribute to the prevention or mitigation of these psychological injuries in police, and to provide evidence to identify ways to achieve a positive change in the level of care to which they are entitled. I hope it might also increase understanding of the difficulties involved in policing, and their potential impact on mental health, as they have been so vividly described by the participants in this study.

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Ferguson Sarah (Host); Quentin McDermott (Reporter) ; Graham Ashton (Contributor) ; Rob Bailey (Contributor) ; Brendon Bullock (Contributor) ; John Cox (Contributor) ; Glenn Keyte (Contributor) ; Sandy McFarlane (Contributor) ; Tony McHugh (Contributor) ; Tony Crowley (Contributor) Four Corners (ABC1); *Insult to Injury: the scandalous treatment of police suffering from post-traumatic stress after exposure to violence and trauma.* Time: 20:30; Broadcast Date: Monday, 1st August 2016; Duration: 43 min., 55 sec. Available online

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Appendix A: Case Studies

Group 1: Jack, Pat, Frank Gerald & Stuart

Group 2: Cliff, Bruce, Murray & Don

Group 3: Victor, Denis, Phil, Peter & Ivan

Pseudonyms have been used for all participants and details have been changed where necessary to avoid identification. Because the case studies nevertheless contain extensive information about the participants, they will be redacted from the thesis in its publicly available form.

Group 1

Jack

Jack said he had joined the Police Academy shortly after his 16th birthday, after failing to be accepted into the Air Force as a trainee mechanic. He said he had been looking for stability after some years of a difficult home life. He served 41 years and retired in 2000 with the rank of senior sergeant.

> *Yeah, I suppose we had a fairly tough childhood. And going down to the police barracks in 1959, the training there was pretty tough, we were treated pretty badly, but it didn't worry me, I thought it was a home away from home, I loved it, you know. But a lot of the blokes that had come straight from school, into the police force, they had trouble handling it, a lot of them couldn't. They got out you know. [it was] no picnic – the physical and mental demands on the recruits were very stringent - you were just treated like dirt, you'd be yelled at, screamed at.*

Jack described fellow recruits as also a hazard – a favourite activity was for a group of them to blacken the testicles of a recruit with boot polish if he was known to be meeting his girlfriend that night. Jack had however already developed a repertoire of survival skills and coped in situations that resulted in more than half of his fellow recruits withdrawing before they completed their training. This ability stayed with him in his later career as a police officer. "So, I put my police experiences as being helped by my childhood experiences. I've seen a lot of bad things, don't get me wrong, but it hasn't had any lasting effect on me, you know."

Jack said his parents had lived close to a large extended family, and his early life appeared to be relatively stable and happy until his mother's sudden death from a stroke when he was nine. He described her death as "the worst trauma" in his life. Jack and his younger brother did not attend her funeral and were not told she had died for "two or three

weeks". He said from that time onwards he resented his father for "not giving us the opportunity to say goodbye to Mum". Shortly after his mother's death Jack and his brother were put into a Salvation Army boys' home for five years. "They were pretty brutal in there, they used to thrash you, and cane you, and all sorts of things." He made a point of saying he was not sexually abused, but physical abuse was rife, the children walked around barefoot because they were not given any shoes, they had one bath a week, and food was "nothing to write home about". Jack said his time in the home resulted in him learning how to stand up for himself. "I soon worked out the routine of the place *and hierarchical system among the boys."* Duties were allocated to all the boys and Jack remembered scrubbing the bathrooms before school every morning. He said: *"It was hard work, something that I had never experienced before but looking back on it, it taught us some responsibility which much have been of some benefit later in life."* And it taught him survival skills.

Jack's father married his housekeeper, and the boys were sent home because it was assumed they now had someone to care for them. His father's new wife - "the stepmother from hell" - did not welcome them. "To us kids she seemed very strict and unreasonable, and at first everyone was too scared or too polite to argue with her." Family and friends "gradually stopped coming around". Jack described his father as:

...a pretty weak man, and when he remarried, he wouldn't stick up for the kids – he always followed what the stepmother wanted to do, you know. She threw a hot cup of tea over me one night, and I looked at my father and said what are you going to do about it? He shrugged his shoulders. So, I picked up the teapot and emptied it over her. Pretty drastic stuff. Shortly after hat I got out. I'd had enough.

When he left the Police Academy Jack said he spent most of the first half of his policing career in remote outback areas – at one stage being the sole police officer

responsible for 35,000 square miles. Because he was on the sole main route from one capital city to another, he said this alone added a dimension to his responsibilities.

A lot of criminals used that road, the number of people that were wanted, that I stopped, was phenomenal. You go out on the road, and you check cars and that, it's amazing what you turn up, you know.

On one occasion he said he single-handedly arrested two men in a stolen car. On another he described arresting a murderer with the assistance of his wife.

I didn't know that they were wanted for an armed holdup in Sydney and attempted murder of the – guy behind the teller's cage They were bad buggers, you know, but you didn't sort of think about that. But I didn't know who they were, I didn't know what they'd done, and (later) that really had an impact on me because I thought well – they've shot a bloke! I did think about that afterwards. And I thought what could have happened, you know. Another time was, I was going out to XXXXX aboriginal reserve, and I knew there was an aboriginal in the area who was wanted by the XXXXX police in Western Australia for murdering two white fellows and chucking their bodies down a mine shaft. And there was a group of aborigines on the side of the road, and I pulled up – I usually pulled up and had a yarn to all of them if I saw them like that, and this one bloke walked away, and he went about fifty metres away from me, away from the car. And I asked the other blokes – I said who's he? Is that {the wanted man]? Arrr – he's a bad man – and I knew straight away who he was. And he started throwing these great big rocks at me, when I told him to come over and see me. And he was getting quite aggro, and Jocelyn and kids were in the front of the car. And I had my old .303 rifle in there, and I yelled out to Jocelyn – bring me my rifle – so she grabs that and brings it around to me – I was at the back of the car. I put one up the spout and I said put those rocks down, and he wouldn't, chucked another great one at me, and so I put a bullet between his feet, and he was standing on an outcrop of

limestone, and that shattered the rock, and that cut all his feet and his legs. So, while he was down there trying to hold his legs I went over and grabbed him and put him in the back of the Land Rover and locked him up – but he was a bad bugger. And I knew, I knew that now that I had this bloke, he was the one that had murdered two blokes in XXXXX, so they took him back over there and – I don't know what he got, but – you don't know who you're dealing with, you know, you don't know.

Jack said that witnessing post-mortems were an early part of the job:

...cos part of the training was going down to the city mortuary, and a lot of the cadets, they dropped out then. They resigned that day, they couldn't stand it, seeing a post-mortem. When we were at XXXXX the local doctor used to do the post-mortems on the bodies and there were only two of us on the staff of five that would put their hand up and go and help him, and I was one of them. Didn't really worry me, no. In fact I helped him. He'd draw on the body with an indelible pencil and he'd say do you want the head or the body. And I said what do you mean help you, I'm here to take notes, not to help you. He said oh no you've got to help me. And I'd always pick the head and saw the top of the head off.

Jack's way of coping with potentially traumatic events involving death was with emotional detachment, and he said that he believed that this was the *"correct"* way to deal with it.

With a body, if you approach it correctly you don't treat it as a body, it just another lump of meat, another carcass, and that's how I did it. If you sort of dwelled on it too much, I think I would get to you, yeah. I didn't think of it as another human being lying on the slab. It was something that had to be done. And I found it interesting, because this particular doctor, he explained everything that he did. Like working on a farm before I went into the police force – that helped. Slaughtering sheep and that sort of thing. Yep – we had to– er – do all sorts of

*things with animals on the farm – that didn't worry me at all – even - well you'd know [*I had mentioned to Jack that I had been a farmer myself] – *sheep with footrot – terrible. And maggots and all in there – and you've got to cut it all off, cows birthing, having trouble with calves, pulling them out and that sort of thing, you know, we did all that and it didn't worry me.*

Black humour was another coping mechanism that Jack said he and others used.

> *And that's part of the secret to relieving stress. Being cynical, black humour, um – making a joke of very bad things, you know – cos a lot of police officers have got black humour and they're cynical about things. I remember once out from XXXXX we went out to a place called XXXXX to a fatal accident and I didn't have my Land Rover going so I had to take my own car, which was a Falcon car, had the body there, and didn't know how I was going to get it back – so I opened the boot, curled him up, wrapped him in a blanket, took him back, and when I got back the boot lock had fallen off the car and he was locked in the boot By the time I got the boot open he was all stiff and curled up – and I had to straighten him out.*

Jack showed that he was nevertheless capable of dealing sensitively with situations where this was required. He believed they needed to be "handled pretty delicately" by a police officer in order to minimize stress.

> *Another thing that sometimes could get stressful was going to a house in the middle of the night to tell the wife that her husband had just been killed in a road accident. You had to handle that pretty delicately, you know. No-one taught me how to do it, but as a junior officer I could follow what my partner did in the early part, here in XXXXX. And the secret is, don't beat around the bush. Because they know if a policeman knocks on the door at two o'clock in the morning, they know it's bad. And try and get a neighbour or someone to come in with you, yeah. But it's pretty traumatic when you see the reaction, sometimes*

hysterical. You can't blame them; you know do so you try to leave them with someone - so if you don't handle it properly it can get stressful. You've got to feel your way, you know.

Jack clearly had some limits too as to what he regarded as acceptable behaviour.

The old coroner sergeant used to keep his whisky and his lunch in the fridges with the bodies. He was a ghoul; he really was a ghoul. But I could understand why he was like that because he was doing it all the time. I've seen him throw a body, like a baby's body, across the room from the fridges on to the table, sling it across the room by the arm, and I thought – well there's no need for that, you know. But that's what he did. That's how he – I suppose that's how he handled it, I don't know – but to me it was pretty uncalled for, but that was how he did it, all the time, you know. All the old guys talk about him. They've never forgotten [him] you know.

Jack retired early and continued with a second career in local government that he had begun some years earlier. He said he saw big changes happening in the police force in the late 80's, early 90's.

I was pleased to retire. I should have retired three years earlier than I did. I could see just how much the job had changed from the time I joined to what it was then, and it was - er – and I didn't like it. We'd lost our carefree way of policing, um – everything had to be accounted for, there was a surveillance on the police – in the police station, there was surveillance cameras in the cells, so you felt as though – I used to wonder, who were they after, the police or the crooks, you know? And a lot of the blokes thought that - everything you did had to be documented, you know, it was just overwhelming at the end. When I first joined in '59 – went out on the beat in '63 – I enjoyed it. It was fun. But it wasn't fun towards the end – I don't know what the young fellows think these days, but I couldn't do it. Not these days. I think it might have been a bit of reaction or opposition to changes that

were going on in the organisation too, because you don't like – the older people don't like change, and I didn't like it. Had to accept it, but with reluctance, you know.

Jack also believed there was diminishing respect for police over that period of time.

We [used to get] respect in XXXXX, even walking the beat. The kids that were around at the time then, you'd ask then to do something, and they wouldn't hesitate, they'd do it, you know. They knew where the boundaries were. But there don't seem to be any boundaries these days. They don't care, you know. Yeah. So no, it was a totally different environment to work in, you know, because you got that respect. And of course, out in the country it was totally different again, because on the social scale in the country the policeman was up with the doctor and the headmaster. But I've always involved myself in the communities wherever we've been, that helps, if you sort of isolate yourself you won't get on, yeah.

Jack said he still liked to get together with other police officers after he retired – because they understand the life and speak the same language.

You know you can talk freely with them you know. When you get outside socially, and you may not be at a police function, but you go to another function where there's another police officer – and you get to know – that you two just break up from the rest of the mob and just talk, you know, don't go near them, you know. And they don't understand, the other people – well that's what we think anyway. They don't understand what we're talking about, they don't understand what it's all about, you know, because it's another life, it's another language, you know.

Summary

Jack appeared to have demonstrated resilience in completing 41 years of police service and exposure to a number of potentially traumatic events without experiencing any ongoing mental health difficulties. The data obtained from the transcript of my interview with

him, and from a lesser extent from a book he published online, suggest some factors that could be relevant to this. Jack's ability to emotionally detach himself from potentially difficult experiences – and to avoid dwelling on them afterwards - seemed to be his primary coping mechanism. He also strongly expressed a view that there was a *"correct"* way to deal with the bodies of dead people that entailed regarding them as *"just another lump of meat or carcass"*. While witnessing post-mortems, because he had his attention directed towards the procedural aspects of the process by intellectualizing it, this would have been likely to have functioned as a protective mechanism by enabling him to put another barrier between the experience and his emotions. Jack also believed there was a right way of dealing with death messages to avoid stress – to avoid *"beating around the bush".*

Jack considered his childhood experience of living in a boys' home had taught him survival skills. He suggested too that his experiences working on a farm and many of the jobs he had had to do such as slaughtering animals and treating sheep with flystrike had also inured him to death, and sights and smells likely to evoke disgust and revulsion. Another coping mechanism Jack described using was black humour – *"making a joke of bad things"* as he put it; something he said he shared with a lot of police officers. Despite this, when the occasion called for it he demonstrated that he could deal sensitively with others, for example *"feeling your way",* and initially following the lead of a senior officer when delivering death messages. He also had limits when it came to acceptable behaviour. The coroner's throwing of the bodies of children across the room was an example of behaviour that exceeded those limits. Although he did not say so, this might indicate that he found it more difficult to detach himself from experiences involving children.

In instances he described of life-threatening confrontations with criminals Jack did not indicate that he had felt in fear of his life at the time. He said he had *"thought about it*

afterwards", but it had not continued to trouble him, in that he had not engaged in *"what if"* thinking or dwelled on it in any negative way.

Pat

Pat said he enrolled in the police force in 1966 at the age of 17 and served 42 ½ years, retiring in October 2009. For the last three years he said he worked on secondment to the Federal Police, working at international airports and also did a Social Science degree part time while he was serving in the police force. He worked for 25-26 years in the country, the rest of the time in the city, and retired as a senior sergeant. Pat left policing with no identified symptoms of exposure to trauma. He did however describe a number of significant memories. These included a time when his superior officer let all the prisoners out of the cells.

My boss at the time there was an alcoholic, heavy pisspot. And one night when I was on afternoon shift, we had some prisoners in the cells, um – he came back about two o'clock in the morning drunk as a skunk, went in there – they were making a hell of a racket, so went into the cells to give one of them a hiding and they all escaped! So, we went to welfare, made them aware of what the situation was, then we went and seen him, and once he'd found out we'd been to welfare he was stuffed – he had to do something about it.

One of the ramifications of this event was that it caused divisions in the team.

And the other thing it did was it actually split the station as well, so you had some who were like – who were sitting on the fence, didn't know which way to jump, others who were whatever the boss said was fine, and there were others like me who were concerned by the way things were happening – because it was quite unprofessional, a lot of things that was going on, and really needed to be fixed up. It eventually did get fixed up – but it was quite stressful there for a while – to come to work. It probably had more of an effect on my wife, than myself, yeah.

Ensuring that events were conducted in a professional way typified Pat's approach to policing. This did not always make him popular.

I had to swim against the tide a bit. It probably – it just needed someone like myself on this occasion, to show that little bit of leadership – yep, we've got to do something about this. [In one station] a lot of the people had stayed there for a long long time. They'd been there since the seventies, some of them. Extremely set in their own ways. And yeah so we had a few arcs and sparks when I got there, because I changed the paradigm. Yeah – but – you know, that's how it was. No - they were very comfortable, didn't really want to change.

Pat believed officers who found policing difficult often did so because they lacked confidence in their own abilities.

OK, they'd sort of – move through the academy, done OK I guess, but struggle with the processes and scrutiny, and all that sort of stuff that comes with trying to be part of the criminal justice system. The system's very bureaucratic, you have to be very efficient with typewriters, and putting stuff down on paper so a lot of them didn't like that.

He believed that pressure could be cumulative, and that lack of ability to deal with everyday duties involving technology might be erosive and undermine a police officers' abilities to deal with potentially traumatic events experienced in the job. He also said he believed underlying mental health issues might contribute to traumatic stress.

Well, it all goes hand in hand doesn't it. If that part's [managing technology] not going so well, well you're going to be – you're under the pump. So, you're getting put into positions where you should be doing something about something, that's happening, they'll avoid it, duck it and dodge it, or fail to report it properly, so it just compounds itself. Oh yeah it's very eroding, yeah. Some people I think come into policing and they probably don't pick up the fact that they've got underlying mental issues. A lad that I had, him and his partner went to a job – ah – the offender pulled out a great big knife and he was going to knife them, so he shot this person five – about five times or something. Several days later this person dies, um – the police department was not terribly wonderful in managing

those sort of things – um – officers often felt a bit isolated, especially if they were the person who did the business – um – guns were taken off you, and you know you're rushed off and they start interviewing you and all sorts of things. But it was interesting, his grandfather had a - underlying – had a mental health issue that he spent most of his adult life in his bedroom, basically, and that's what happened to XXXX after a while, too, he succumbed to the same sort of – depression it would have been - and he never come back to work after that, yeah. It's a bit sad because he's ruined his life, really, it destroyed his life - you'll see people do things like – or they'll get on the booze, drink very heavily, you know engage in risky behaviour – some of those things are on that check sheet that you – they're all the sort of things you might see, yeah.

In describing a shooting incident in a remote area in which he was personally involved, Pat did however indicate that he was aware that people handled potentially traumatic events in different ways, and that support after trauma was important. Speaking of that operation he said:

I'm driving the car, with three Starries [STAR Force members] inside of it, they were all, you know, full kit, I was in nothing, We started to track this guy through farmland – you know crops about this high, we're driving over fences, and every time we got within 70 or 80 metres of him he'd start shooting at us – so – two of the guys I had with me that day – ah – were pretty hardy types. They were - um – fairly forward, nothing used to worry them too much, but one of these guys, one of the rounds that got fired went right through his hair, and into the side of the old grey ghost, and put a dent in the old paddy wagon. The guy that got pretty close to being shot, he was one of these – he always presented as robust, nothing worries me – and it rattled his cage big time. Couldn't sleep at night, all sorts of things came up. And it took him a while to get over it, but I guess he was in a better environment up there because we were supportive and helped him through it. And I

think it was probably the first time in his life that he – wasn't as bullet-proof as he liked to think he was (laughs) – you know, he was that sort of an individual.

Pat said that going to court after this incident was more stressful for him than the incident itself – and that what he found even more stressful was giving driving tests – "*they're super scary, especially with elderly people - their driving was atrocious, some of them, because a lot of them would only come in once a year to renew the licence, most of them never drove"!* Pat said he had seen marked changes in police culture and practice during his service, and he saw these changes as positive. "*When I first started, no-one had a phone - coppers had to get out and go to a phone box to ring up – the technology itself made a big difference in that time."* He also said it had earlier been a *"patriarchal culture".*

Blokes ruled the roost – some of the older school coppers – It's my way or the highway – and they resolved problems by – crook put his head up, making a bit too much noise, he'd find he'd get a bunch of fives – but that culture eventually got stamped out. I think as time went on they gave more training to things like occ health and safety. That probably come in about the mid-eighties though, when people got trained how to manage - not only to be able to use their firearms and other equipment, but they were also tested on how you respond as a first responder to something – what processes you put into place, yeah. So that's professionalism. And it's interesting, as the 90's came about the police force was trying to employ more women, and that caused a bit of trouble when it first started. I never found any issues there, I thought that females were just as good as working with guys.

Pat said he had also experienced resistance when he negotiated to upgrade the authority of indigenous community constables.

In the early 90's we were one of the first stations in the state that employed some indigenous people as community constables. Employed three. After they had been working with us for twelve months, I took steps to get the minutes of the appointment changed so

they could exercise the full powers of a police officer. They had limited powers of authority; they could only exercise their powers if they were with another officer. But we found from experience that we were sending them off to do things and they were confronted with stuff, and they couldn't exercise their powers. So, I got it changed – well – a couple of people in my station didn't like it at all.

Pat professed himself to be sceptical about recent media publicity about PTSD in police.

It's always hard to tell with those TV shows because they only show you what they want you to watch – and sometimes that can be quite skewed. I've seen officers that have gotten into those states of mind, yeah. I sometimes wonder though whether it's just a convenient hook to jump off the ship - a bit hard to tell.

Pat believed that doing the job right, keeping an optimistic attitude and a degree of acceptance to be the important factors in maintaining a healthy mental state.

If you're professional about it, you don't seem to get as many problems. It makes a lot of difference too if you're a confident person – and I've seen it plenty of times, you put someone into a crowd that's a bit skittish, those around them soon latch on to that, body language is there. You put somebody who's confident (makes a motion of the crowd parting) – it's like Moses - the waters sort of – and it gets back to – those sorts of people, people like to work with. Because the job just rolls along - it gets done, you have fun, you can have a lot of fun, actually, some of the things you get up to. But I'm an upside person, even when things are pretty dark, I can usually see – yeah – it's happened for a reason, or whatever, yeah, don't get too worried about it.

Pat also suggested that early exposure to death and trauma perhaps served as an inoculation to future difficult experiences.

I grew up on a farm – we were killing things left right and centre – but I think the other thing is – police of my era, we used to get exposed to a lot of things that they don't get

exposed to now. If you're in the country, you're the coroner as well, so all the road accident victims, you had to get them, strip them off, bag them up, put them in bags, put them in police aircraft, fly them down to Adelaide, all those sorts of things. They don't do those things anymore. The only ones that really used to get to you a bit are the ones that are stinky – you know dead for weeks, and you've got to go and do something about them – you smell a bit for a day or two.

Pat said that he didn't dwell negatively on the experiences he'd had involving deaths and used dehumanization of a body as a coping mechanism.

I was often fascinated by it, to be honest with you. You know you'd see something – a good example was at XXXXX this guy he was unloading slabs – that they build buildings out of – you know those great big – and the strap let go and it fell on him – his head was about the size of this frigging table – and when we got up to the hospital and we opened up the back door of the ambulance the amount of blood that come out of there was remarkable, I've never seen anything like it in my life, you know – so – yeah. I used to dis – sort of disassociate myself from the fact that it's a human. The life's gone out of it, that's it. So, you get to see that a fair bit, in forty years, plane crashes, drownings, car accidents, god knows what else.

Pat also believed that social networks served as a protective mechanism, and police from the city could find themselves isolated because they stayed apart from the community.

I think the other thing too is the social networks and – if you're a person who doesn't mix easily with other people – like some police get a siege mentality – we used to get a few of them in the country, they'd come from the city and they found it very difficult to mix in with the community.

Pat also believed in the importance of not allowing policing to affect his view of the world.

Because some coppers become a little bit paranoid about everything, you see that. And they forget that ninety five percent of the people you deal with are nice people, yeah. I always suspect though that a lot of people who end up with those issues probably have an underlying mental health issue – depression, schizophrenia, bipolar stuff, those sorts of things. Yep. So, I guess training, education, and then on the job experience, [if] all those things come together, you're going to be pretty right.

When asked if he harboured any regrets for anything he had done in his policing career, Pat responded by speaking of the value of operational debriefs – essentially the process whereby those involved discussed an event, and what might have been done better.

From the eighties onwards practice became that you run a debrief pretty well straight away, and everyone – at those debriefs - they were pretty frank, OK, so if someone stuffed up - you might look at it – how can we help you fix that up? What's the training issue that comes from that? Can we make – can we help you make sure that it doesn't happen here again? Yeah – were you overwhelmed by it, you know, all those sorts of things – yeah – and some people are. And the supervisor would write a paper about it – um was helpful actually, because I had to do it in the AFP. Not long after we started two lots of bikies got together in the XXXXX Airport and ended up having a brawl, and yeah, the boys had no radios, they had no comms, they had no protective gear, and all this sort of stuff – it was very handy for me I got to argue very strongly that they got a national radio network out of it, a whole heap of good things come from it, so – ah – I ran a debrief, documented it, gave everyone an opportunity to have a say.

Pat's response to being asked if he harboured any regrets associated with his policing career was striking; it implied there was no place for regrets and there should be no blame associated with having done the wrong thing. Rather it was defined as an organizational issue, and steps to remedy it identified.

The philosophy has become with the police department, that if you're the first person there, it's up to you to do something about it, so we encourage the young ones to yeah, take charge, get into it, you know, bad luck if you make mistakes, you thought that was the right thing to do at the time, no-one's going to criticize you.

While it seemed evident that this was the way Pat had operated as a senior police officer, it is arguable as to whether it reflected the general attitude within the police force at the time. His dislike of criticism extended to those outside the Police Force. He said had no time for criticism of police from others who did not understand the difficulties and dangers of policing. He remarked on the recent escalation of violent encounters for police.

Very easy for armchair experts to sit there later on – they weren't there dancing around, trying to get a hold on something, yeah. It's pretty challenging sometimes. It's probably got worse in the last ten years as substance abuse has really escalated. I reckon when I first started you might get one in ten who'd be really aggressive – probably eight out of ten, by the time I finished.

Summary

Pat described serving over 42 years in State and Federal police and retiring with no identified symptoms of exposure to trauma. He suggested the reason that he had experienced no apparent difficulties could be attributed to two factors – always following police regulations and having the ability and competence to do this. He maintained that having confidence, an optimistic attitude and a degree of acceptance were also important to him. He appeared to have experienced no conflict between his personal belief system and the regulations he followed, and he had confidence that he had been able to adequately – or more than adequately – cope with all that the job had thrown at him. Despite this he did not appear to have avoided interpersonal conflict, showing leadership when he thought it was needed and aware that this made him unpopular at times.

Pat considered that lack of ability, and consequently feeling under constant pressure, was eroding to officers' mental health. He suggested that failure to cope with potentially critical events could also be due to unidentified underlying mental illness or could be a convenient way of exiting the police force. He also recognized however that previously "pretty hardy types" of police officers could be affected by life-threatening incidents, and that support from those around them was instrumental in recovery.

Pat suggested that the exposure to death from growing up on a farm may also have served to inoculate him from trauma later and added that as a country officer he had been exposed to more potentially traumatic events than officers are now. Rather than dwelling on those experiences, he said he had often been fascinated by the forms that death could take, and able to dissociate himself from the fact that it involved a human being. Once life was gone "that was it".

Pat recognized that policing has the potential to embitter an officer's view of the world, believing himself that most members of the public were "nice people". When asked if he had any regrets for anything he had done, or failed to do, during his policing career, Pat did not refer to himself. Rather, he emphasized the importance of operational debriefs following an incident, and how these should be used to identify not "who had stuffed up", but where procedure or training could be improved so that the failure did not occur again. He said he had always encouraged younger police to make decisions if there is no superior officer present, and if this later turned out to be a mistake they should not be criticized. It could be hypothesized that he also applied this maxim to himself. In feeling confident that he had always done the right thing during his policing career; that there was no room for self-criticism and no conflict between his personal values and his actions.

Frank

Frank said he entered the police force at the age of 17 and served 22 years, leaving in 1998 to manage his parents' farm. He gave no particular reason why he had chosen policing – saying it had been one of several jobs he had applied for when leaving school. He said he had grown up on the farm and had had a closer relationship with his father than his eight siblings. "*Good relationship with dad. Number 4 – and there's four after me - went lots of places with dad where my other brothers didn't go."*

Frank said he thought that the only change he had undergone as a result of his policing career was that he had become more *"verbally aggressive".* He attributed this to 13 years spent in remote areas and wanting to bypass the paperwork involved in taking minor matters further.

> *I'm – verbally aggressive – in that I'm very direct in what I say to people, very controlled in what I say, I'm a person who needs a black or white answer I suppose people either loved me or hated me. They either understood – [or they didn't]. I think my character of today - is directly a result of policing. I think that's where part of the attitude of me came as far as the directness in speech to people – at (name of outback town) – didn't have time to sit down and put your fingers on a keyboard and go to paper wars for bloody anything – it's bloody better off just verbally resolving it – the job's done.*

Frank said physical aggression had also been part of police culture earlier in his career – but was not anymore, and that the change in police culture had been "huge" during the time he served. He said that "street-smart coppers", twenty years on had become "academic coppers, lecturing on telly."

> *'80's – if someone was aggressive to you, they got a bunch of five knuckles across their face. And that was instantaneous. If it wasn't your knuckles, it was your offsider's knuckles that got there before you. Right? It was a physical world. Of policing. It never went over*

the top - um – it was controlled but – a couple of punches was acceptable. But you wouldn't be going 5 or 6, you know. One or two, that was it. And it was done as a method to subdue the offender, right? It wasn't as if you just hit them for the sake of hitting them – and it was tolerated. Right? Within the department. Whereas in today's world, don't even think about it. So that aggressive side of policing has gone.

When asked what he knew about posttraumatic stress disorder, Frank's answer was noncommittal and suggested he was disinterested in the topic. While he acknowledged that there were some experiences in his policing career he would prefer to not revisit, he described in detail his coping mechanism of *"going into robot mode" for* dealing with the unpleasant events that he regarded as an unavoidable part of policing. This approach involved an acceptance that he had to do the job, and a plan for how it was to be done.

I mean I haven't read much about it at all – I just don't really care about it, you know. Only that it's something that bloody happens to people who have difficulties for some reason. Right? Can you pick why? No. Do I think I have PTSD? The answer is no idea. Um – there are some things which in my life I prefer not to talk about, but I think as far as the rest of policing I don't think – it just didn't worry me. And as we spoke on earlier, when it comes to handling the dead and so forth, it just became a fact of life, go do, deal – be done with it. OK, fatal accident dash coroner's investigations – so you're dealing with dead people. I don't like seeing dead people. But it's part of your role as a copper that you've got to. And so I developed a – what I call a task or an attitude of just being in robot mode. Go there. View. Examine. See. Do. This is the job; it's got to be done. I can't handball it to somebody else. You've got to do it, so you just get and grip and go and do. Go and see – go see. You walk out and you think it's OK, now I've finished that. It's no different from extracting people who are dead from a wrecked motor car. I mean you think OK how can I get you out? And I'm not talking about here in XXXXX, I'm talking about

way up in the north –where resources are very minimal and so you say I'll grab you by the shirt and collar and haul you out, that way. It's not a case of being multi-skilled but it's just a case of you've just got to pre-plan, have some strategy, I've got to do this, I need to do this, let's just go do it.

Frank mentioned a drowning involving a 2 year old child however as having been difficult, and he had sympathy for the female doctor who was unable to revive the child.

...two-year old girl drowned at (outback town). In the backyard swimming pool. And bloody dad was home babysitting and mum was at work. And dad was absolutely – he lost it. So we just treated that one a little bit different, you know, because of the emotional side of things it was a hard thing to do. So this lady [doctor] came in -she must have been 20 or 30 years older than me, and when it came to trying to save this kid in the medical facility she had just like an open phone line to XXXXX to do this - do this – do this – do this. At the end of it when it was over and done the kid was dead, they couldn't find – the child was dead in the beginning anyway, couldn't be revived – I actually sat down with her and made her a cup of coffee. This is like 3 o'clock in the morning. And I think that the best thing I could do for her, mmm. She felt very lost.

Frank said he had been involved in a siege situation, for which he had received a bravery medal, but gave little detail, other than to express his dissatisfaction at being forced to do a double shift in the situation and believing this had been done deliberately to test him. While he did not appear to suffer any adverse consequences for what happened there, he accepted that his fellow officer had done so, and that people are affected differently.

When that siege happened, I was on night shift. And at ten to seven in the morning we had a phone call. This vehicle you've been looking for from interstate is getting fuelled at this roadhouse. And it just went on from there. Have 8 hours down and then come straight back to work. Anyway, slap in the face for the police department for making me go back

out to the scene that night and I don't blame the copper for having said it, or asked us to go back out there, yeah? I put it down as being the archaic way of police deal with their own. Let's test him to see how good he is. As in, what's happened today, is it going to be a problem for him. and – whether it left any damage – lasting scars on me? God knows. I was on the better side of the car. Dunno. My superintendent was there too. I didn't put a compensation claim in, um – he did – it just wasn't in me to worry about shit like that, the persistent battle to justify bloody – a claim – for compensation. XXXXX's wheels did fall off, right, he became a little bit unstable as far as – having the ability to go back into the front line. And I said look I don't mind I'll run him down to XXXXX and he and I ran down here and he went and saw the police shrink, and I'd rung the welfare section, had a chat with XXXX XXXX, mmm – yeah – just make sure everything was hunky dory as far as I was concerned. And off I went. Well, I think we can go through different bloody things – different bloody incidents in our life, and the outcome – how you handle it – can be different for each person. How somebody reacts to something, what happens to one person may not affect the other as much. To me it becomes an individual thing, how somebody reacts to something.

Frank said he had been uncomfortable with the attention he received after the siege.

It almost became a case of – I wish [it] had never happened, that siege, because like 18 months later you're flown to XXXXX, you're given a presentation parade, you're treated like royalty, and every commissioned officer wants to come and give you a slap on the back and shake your hand. And then the expectation was that wherever you go you'll wear this little blue tag – on your shirt. Well, every bugger wanted to know what it was for. It became more of an embarrassment [than anything].

Despite his expressed embarrassment at the attention, he had received at the time, there were indications that Frank was proud of his medal for bravery. He arrived at the interview with all

his medals, and said he was to receive a further one at an award ceremony in a few days. “I’ll hang them on my chest with pride – on Thursday – and it'll probably be the last time I wear them. Because I don't wear a uniform anymore.”

Frank said during the period he served, counselling after a potentially critical incident was not an option. Any debriefing occurred with fellow officers was alcohol aided – and might last some time.

As far as dealing with any – incident on the road or anything you thought was a bit ugly and bloody – it was simple. You know you get a six pack of beer and go and visit one of your mates and have a chat That was it. It was all done in house, right. That's what we did in [rural town]. That's where the blue ribbon came from. Um – anybody who was there – we just went and had a beer afterwards. We may not have stopped at six though – as long as people understand that – and, we wouldn't have done it – we rarely ever socialized in town. We'd get in a couple of four wheel drives and piss off and go for a drink – for a day or two.

Frank said he believed that attempts by police welfare to provide counselling were defeated by the prevailing attitude held by senior officers at the time, and that it was unfortunate that this had happened.

Way back in the early 80's we had the police welfare branch, right. when they were sort of starting out and trying to get themselves into a niche of being accepted by management within the police force. Um – a slap in the face to the department for their attitude that– you're a liability if [you] have to go down the pathway of any form of counselling. To take yourself out of the position at work where you're supposed to be, organize for someone to fill the gap while you went across and bloody – had a chat and so on - seen as a sign of weakness, very much so. Very very much so. And that's where it became very hard for

those people from the police welfare section, to get their feet [on the] ground – you know what I mean?

Overall, however, Frank believed the police force had looked after him, and that the process had been a reciprocal one. He indicated that he had been well aware of how he needed to behave in order to stay out of trouble. He said however that he thought the culture had changed since in the intervening years since he had left.

So, like – gee - throughout the career, ah, you'd be diligent, you'd be observant, be careful, but above all whatever you do, don't bring discredit on the department. Full stop. That is the golden rule. Right? Um – and if you do things [right], we will look after you. That is never said to you, but it's the ethos of what you get. Very much so. Very much so. You're going to rock the boat, don't climb on board. [But] I wouldn't be with the police today. I spoke to a mate one day – he was very high up in rank - and he said you're so lucky, he said, the young ones today are so snipey, snappy and vindictive–and he said I don't know how I'll last. Looking forward to retirement.

When Frank left policing in 1998 and took over the family's farm from his parents, he was forced to take an off-farm job because the farm was not making enough money. He said he had little time left for reflection.

So, I went and got a job as a private investigator. And just – expanded that role – so 15 – 20 hours a week in the beginning, to now well – any time between forty and sixty. I think that strong work ethic [that I have] just comes back to the bloody land of policing. You've just got work to do, you've got a job to do, and you just go out and do it. And then unfortunately you just keep finding that there's another job, then another job. In my lifetime I don't have time to think about things afterwards. I just move on to the next thing and keep going. I'm a person who works 70 hours a week. I actually don't have much to do

with the coppers these days. I've got two that are friends and that I associate with but that's it. Life's moved on.

Summary

At the time he was interviewed life Frank appeared to have avoided acquiring any symptoms associated with exposure to trauma, while acknowledging there were some things in his life he preferred to not talk about. He gave no evidence to suggest that his tendency to verbal aggression – or perhaps directness of speech – was anything other than his personal style, or that he had failed to control his aggressive behaviour.

Frank's main coping behaviour for dealing with potentially traumatic incidents, which in his case appeared to be feelings of disturbance and revulsion associated with death and injury – things that were "a bit ugly and bloody", was to "get a grip" and "go into robot mode". While he acknowledged that he had not liked this part of his job, he accepted that it was part of policing, and he dealt with it as best he could. He spoke of the importance of having a strategy or plan, and it was evident that emotional control and detachment from what he was doing was part of this. The only time he spoke of when he had been unable to maintain this detachment was the drowning of a 2 year old girl, when he made a cup of coffee at 3 am for the distressed doctor who had been unable to revive the child.

Debriefing was talking – and drinking – with fellow officers - "for a day or two". Frank made a point of saying these were police only gatherings, and that they occurred out of town. While he respected the attempts of police welfare to introduce counselling, he did not appear to have used it himself other than to be checked out following the siege incident for which he had later received a bravery medal. He did not appear to have suffered any ill effects from his exposure to the incident, but he gave me the impression that he wished to downplay any effect it might have had. He offered to drive his traumatized fellow officer to XXXXX and arranged for his treatment, and there was no indication that he felt critical of

him and in fact excused him by saying that he himself had been on the right side of the car and therefore exposed to less danger. While he professed having no interest in posttraumatic stress disorder, Frank displayed an understanding and tolerance of those who had been affected, saying he believed everyone reacted differently.

Frank was looking forward to wearing his police medals "with pride" for the last time at an upcoming award ceremony. He spoke of no regrets associated with him police service – but made a point of saying throughout his policing career he had always been careful to not do anything to bring discredit on the Department – to "rock the boat" - and he believed he had been looked after in return.

At the time he was interviewed Frank appeared to remain unaffected by his exposure to potentially traumatic incidents during his policing career. However, he has allowed himself little time for reflection. If this were to change, it is possible that the things in his life he prefers not to talk about might cause him some difficulties.

Gerald

Gerald said he entered the Police Academy in 1976, graduated in 1978, worked briefly as a governor's orderly because he was too young for active policing, then served 20 years, twelve of these as a detective before leaving the police force in 1998. He left after doing a degree part time in his last five years of service, as part of a plan to change careers. He had initially considered the army as an alternative career. He thought that discipline, which he'd first experienced at boarding school, had been the attraction – but he said he had also wanted to have some fun.

> *You know I didn't join the job to be an – ah – automaton. I joined to get - I wanted a little bit of fun out of it, I wanted some adventure out of it. I had an uncle that was a – detective sergeant in charge of Darwin CIB, I couldn't get into the Northern Territory police because I wasn't old enough, and they only had six month training spots, and dad was a contract miner, carpenter in Tennant Creek, in the territory, and I really, you know – I thought about the army, going into the army, I think it was just that discipline, you know. I went to boarding school where we – you know – we were very disciplined, and your lockers – your foot lockers where your clothes were, your clothes were all folded in a certain way. I've probably got OCD. I could go and live in the bush on my own and it wouldn't worry me. But I've trained myself to – and I'm introvert – so – but – I trained myself to be extrovert.*

Gerald described experiencing some symptoms of hypervigilance and irritability at times and recurrences of disturbing memories that were a legacy of his policing career. He said however that these did not create a significant problem for him but said he also had difficulty remembering stressful experiences. He said explicitly that he had dealt with difficult events he had encountered during his service by putting away his memories of them, and not dwelling on them afterwards – because he believed they would "eat you up" if he did.

He described an event early in his policing career that he described as a "defining point". He said however he would not have considered it a traumatic incident and described how he had dealt with it decisively.

Look I remember some of the defining points, you know, when I was only a young bloke - I would have been god – twenty one – twenty two or twenty three – when I was in XXXXX – a bloke ran over his two – three year old boy. And I had to pick the boy up you know, and the ambulance had got there but they couldn't touch him once they realized he was dead. We put him in the ambulance and took him to the hospital and I had to strip him down and toe tag him, I had to identify him, all that sort of stuff, and then I had to take him to the autopsy, and I had to stay at the autopsy because I had to define – you know - he could have been an assault victim.

Then I had to go to the pub, on a Friday night, and the father was there. And he was there crying all night. And I said come here, come outside, and I said look, there's no easy way of telling you this, it was an accident, I can't tell you to get on with your life but I said you need to suck it up I said I don't need you sitting in the pub where I am crying your eyes out every night because you've had a loss. I said because you being there is not going to help anyone in this community. It's too small. I said you're feeling sorry for yourself, go and get some counselling. Go and get some counselling or I'll order it.

When asked how he dealt with stress from potentially traumatic incidents Gerald described how he maintained detachment.

I don't have flashbacks and that sort of stuff. You've got to deal with it. You've got to get on with it. Keep busy. If you dwell on it of course it's going to eat you up I just (gesturing to the back of his head) put it in the back – kept it at a distance, yeah. I think I'm good at compartmentalizing, just putting [it] in little bottles. And you just leave the lid on. But that's the way I've dealt with it, I think, you know, it's hard to tell.

Gerald said his reaction had been quite different, however, when a close friend had called him a few days earlier to say he had a terminal illness.

When I hung up from him, I started crying, it's stress, you know, but it's more shock because I just didn't want to hear it. You know because he's a good mate, it's a really important thing, I would never have shown that sort of emotion when I was in the job.

Gerald said that working as an investigator in the Anti-Corruption Branch had been the most stressful part of his career. This had involved an investigation in the 1990's, called Operation XXXXX, of systemic theft by police in the 1970's and 1980's.

I'd been pretty straight, - um - comparatively speaking, and I got seconded to this Operation XXXXX. Police had keys, master keys, to bloody businesses, and they were breaking in a stealing stuff, you know, for themselves, you know it might have been minor in the sense that each individual object being only a few dollars each, but it was theft. A bloke was driving down XXXXX Road in the police car and he had so many bloody plants in there it looked like a mobile bush. Well, doesn't detract from the fact that it was theft. It was theft.

In this instance he experienced the stress symptoms of teeth grinding and nightmares. He said it was a relief to find out that other officers he was working with on the operation were experiencing similar stress.

I was having dreams of having shootouts with cops and – you know – was cracking teeth - I split teeth in half, from grinding my teeth at night– and I wasn't the only one. All these guys I worked with; they were all having similar issues. It was only when they got the wives together – or partners, because some of them were husbands – which they did because of [the stress associated with it] we lost 16 cops in six weeks, because you realized you weren't strange, that things [weren't just] happening to you. They took us up to the training base, and they separated us, and they started talking about all the issues –

that it came out. Because the women said what was happening. We wouldn't – you talk peripherally and around things you know– typical men – and girls – and the wives said well this is what's happening and I wasn't the only one so after that I thought well it's as good a panacea as anything,

Eventually it was disempowerment from being unable to make a difference, disillusionment with the police department's failure to prosecute the offenders, and the possibility of threat to his family, that caused him to leave police work.

I was with my wife, and we were walking through the Central Market, I'll always remember it – a detective, he's still in the job – he got out and they let him back in – I can't believe it, you know, he's walked up behind me – you'd better be careful mate, he said, we're going to get you. They should have got rid of them [the offenders] [but] the management said oh – well we can't have that bad publicity about the police service. [So] they wouldn't make decisions to deal with it. You just had to suck it up and move on. You couldn't make a difference. You couldn't get the crooks, in my case a lot of it was the guys that were coppers. I wish I could have got them [but] you weren't going to beat the system. It wasn't long after that that I decided to look around for another job. We had young kids and I said to my wife I've got to get out.

Gerald said that he had regarded policing as a service and a responsibility; it had caused him to become suspicious, but not cynical, and that he had remained this way.

It's an inculcation. You know you spend twenty years of your life in a disciplined environment where you're para-military. You wear a gun every day, and you take on a mantle of service and a responsibility. I can always remember this comment, and I know who the bloke was who said it. We were standing in parade – I joined with a bunch of hairy-legs – young blokes, grade 12 – and he said gentlemen you'll be classified as suspicious bastards and you'll remain so for the rest of your life. As a police officer you –

you – you - do become that suspicious bastard, I was a gut person; you just had a feel. I watched body language. If people didn't look at you, I'd go and pull them over.' Cos they're too obvious. What do normal people do when they see a police car (mimes swivelling head) – they do this! If you look straight ahead and don't look at me, or if you see someone fighting in the street, what're you going to do. You're going to gawk. When you just ignore it and drive straight on – yeah, something's wrong with you, you don't want to be noticed, you know which is the opposite – I can remember pulling a bloke out of his car one night, it was dark, four in the morning, near XXXX XXXX hotel, just – didn't seem right. It was a gut feeling. [I] pulled him over and he had a .45 down the back of his pants and one up the spout. You know, they're the sort of things – because I know it scared me, you know, [but] to me that's not a traumatic incident, but you think…

When trauma happens around you, you know, you reflect on it and you go – well there but for the grace of God go I – but most coppers are cynical. And that was one of the things I hated about being a policeman was the cynicism, and the – that putting things down, was that – throw away – but that was a mechanism. That was a mechanism for people to survive, and to do the things they did, day in day out, but it was one of the things I hated the most. I thought we were better than being cynics.

Gerald suggested that some police officers got caught up in the "adrenaline rush" that resulted from the dangers of the job, and that this could translate into violence against offenders.

If anyone says they didn't get a buzz about high speed chases, they were full of shit, you know. Adrenaline – you go at a hundred miles an hour - it's bullshit what they say – oh they pulled out after doing 130 kilometres an hour. They've gone up over the hundred k, 160 k's whatever – you go that in side streets and it's just flashing past you – voom -voom -voom. Anyone could come out. Anyone could back out of their drive. They're not going to

know you're coming. Chasing a motor bike that went up the wrong side of XXXX Road in peak hour, my offsider was about to go, and I said stop stop stop stop. I'm going home at the end of the day. Stop. And he got all up and antsy and I said we know who he is. Let's go to his house. We sat outside the front of his house, he rocked up on his motorbike. When he got there, we arrested him.

One thing I would never hit prisoners. When they arrested people, I saw blokes flog the shit out of them – it's the adrenaline - and I used to say why are you doing that, you'll kill them, just don't touch them, you've got them, put them in the cells. And you know I'd get one, I'd arrest someone and you'd [say] just back off, it's my prisoner, you don't put a hand on them.

Gerald said he believed alcohol had been, and remained, a problem for police.

Alcohol was a big issue. Because it was a desensitizer, you know. I mean look, you know what I think is the biggest problem with the police force now? There [isn't any] drug testing and alcohol testing on a random basis. I think that's poor. They're carrying guns! Why would you think you would give a police officer a frigging gun, and mace, and taser guns, and not test them? I mean for goodness sake. I mean that's bullshit.

When Gerald was asked for his thoughts about PTSD, he told the story of a friend.

Look I think there's – look there's people – If you've got any sort of mental instability, or some sort of depression, or depressive episodes in your family or you're prone to it– that can exacerbate it. I've got a mate that I've grown up with, he was a senor detective in XXXXX, went to boarding school with him. He joined the job almost the same year as I did. And he's been awarded two George medals for bravery and – shot a bloke dead in front of him, he'd killed his mate. I know he's suffered from PTSD. But in some ways, he's probably the perfect candidate for it because I think he had such high ideals – he was always a high achiever. Could have been anything he wanted. I think that his would be

that he couldn't save his mate. I reckon it showed up ten, maybe fifteen years after he got out of the job – he'd had time to dwell on it. It's not a weakness – I still think it's about sometimes – I think there's a propensity there for depressive episodes or whatever, and it may just get to you. With some trigger like – I think his triggers were probably some of his mates dying and think they might have – look this is just me surmising – some of his mates from his time in the job –and the stress has only shown up since – he's been out of the job as long as I have, nearly twenty years.

At the time of his interview Gerald said he was operating his own business, a consultation service, which he said was successful and expanding. He acknowledged that there were some things he missed about policing, and he could empathise with those serving now.

I don't think I'd want to be a policeman now – but I do miss it occasionally – I'd lie if I said I didn't miss that blue line, you know, the camaraderie. And I empathise, with what the guys and girls are going through when trauma happens, or you – sometimes you get emotional about it. But I think that's just a natural thing. You spend twenty years of your life standing on the front line. You know what's involved.

Summary

When the stress of the work he was doing was expressed in somatic symptoms and intrusions – his teeth grinding and nightmares while investigating fellow police Gerald felt reassured to find out that the other officers he had been working with were experiencing similar stress but he had been unwilling to reveal it prior to this. When describing how he had expressed his emotions recently, on hearing of the illness of a friend, he said "*I would never have shown that sort of emotion when I was in the job"*, indicating that he had conformed with the police culture at the time of not showing emotion.

Gerald gave the impression that he approached life in a measured and rational manner. He said he had trained himself to be an extrovert. He avoided risks while serving as a police officer, for example unnecessary high speed chases, and accepted those aspects of policing that he was unable to change. He recognized when he himself needed to make changes by planning ahead to leave policing, when he became disillusioned with the Police Department's failure to carry through and prosecute identified police offenders, and he believed this might constitute a threat to the safety of his family.

Gerald indicated that he thought policing involved an obligation to take on *"a mantle of service and responsibility".* He would not allow unnecessary violence to offenders. He would not adopt the cynical attitude he said he saw in many fellow police, but understood it was a protective mechanism. He gave the impression that he was capable of empathy with others – *"there but for the grace of God go I"*- but was intent on maintaining sufficient detachment to avoid becoming overly emotionally involved, something that he said changed when he left policing. He showed both empathy and insight in his story of his friend suffering severe PTSD.

Gerald acknowledged that policing had left its effects on him. He said he had remained a "*suspicious bastard"* and kept his memory of what it felt like *"to be on the front line".*

Stuart

Stuart said he had always wanted to be a police officer, and that this was perhaps because he had an "*overactive sense of justice".* He joined the police force as a cadet in 1978 and left in 1996. He said he left because of his disillusionment with the promotion process, saying it had left him "*stagnating*" after he had fulfilled the requirements for promotion to senior sergeant, but failed to be promoted from constable, and had a bad experience going through the adversarial appeals process. Following this he decided to do a degree in economics while working part time. He said he was the first male in a part time policing pilot scheme that was primarily oriented towards female police officers. After completing his degree, he said he served for a period in the Federal Police, and then left when he was refused further leave to continue this. His period of service was varied with some time spent in regional areas, some in CIB, but said *"[I] started on the beat, ended on the beat".*

Given his length of service, Stuart surprisingly described having been exposed to only "*3 or 4*" stressful incidents during his policing career and said he had not felt his life had been threatened at any time. He indicated the major effect of his time spent in policing was his increased tendency to be continually observant of his surroundings.

> *Policing itself is so inground into everything that you do, you know, even subconsciously, you walk down the road – and even today, you know, I'll look at something and I'll think that looks really odd and suspicious. I see people, I look at the way people drive, I think this is what's going on there, and – see – all those – it's constant, in what you do. So, you look at people, you go to a shopping centre, you – I don't like the term character assassinate, but you do tend to sum up people around you. And you look – and there is no doubt in my mind – and certainly in my case I suppose – you look at people more intensely, you look at things, and nuances about them, what they're wearing. Or you know, what about their shoes, you look at things – more intensely Because every time a*

police officer goes on the road, they're not going around looking for the warm and fuzzies. So, you tend to look at what there is about that circumstance, does that cause me any concern, so you look at that. I think it can have a real negative impact, and um – I know in the group that I'm around; I think I sense that in what I see in people, they literally, a lot of the older guys come, and they look at people, they still get this offender orientated look into people, you know. I suppose if you say does it make you risk aware of things then that's a positive. On the flip side does it mean that you never necessarily I suppose have that advantage in life of just being able to relax your way through it?

Stuart said he thought there was a lack of understanding in the general public about policing and what it involved which led to unwarranted criticism and lowered the standing of police in the community.

You'd see five police officers jump on a person, and somebody might make a comment about – that looks terrible. And I go you know what - do you actually understand what alternative there is to actually restraining someone and how you actually do that, and you have no concept of this you know. In the community - I mean social media and things like that - I think the nature of policing and the exposure has in many cases lowered the standing of police in the community.

Stuart said he thought policing required a certain toughness.

I would say it's the ability to – um – see things and be around things that aren't pleasant, and really not take them overly to heart, in that sense. You do – police officers do, there's no doubt about it. But there's something with the coping mechanisms around that to say – [if] I've just seen something really horrendous, you know – how do I cope? I've got to honestly say I don't like SIDS deaths, and I had a number of those in a short period of time, and I'll always remember taking this baby away from its mother's arms, you know which you had to do, and my XXXXX was just born. And coming home the next

day – sitting – I absolutely sat in his room at the end of an afternoon shift– and just sat there, you know. And um – nothing I really shared with anybody – but yeah, you had to go through that.

While he thought a certain amount of support was given by other officers to those who had experienced trauma, Stuart believed the need to be seen as being able to cope, and the prevailing culture, led to alcohol being used to manage stress. He suggested that the "drinking culture" in policing was part of an era that was now past, and that he had entered the police force at the end of it.

It was later on that we started to have police psychologists– in the early days it was just toughen up. Have a beer - you suck it up – you don't let your mates down. The words you'd hear people say –you have to get the job done. And people would recognize that people had had bad experiences, and they'd be supportive, but It was very much I don't want to be seen to not be able to cope with this by other people. Drinking is probably the worst part of that, I'm not saying it was necessarily trauma, but it was dealing with stress, the use of alcohol to deal with stress – um – including I would have said some police officers who I would think did things that they wouldn't have been proud of and it came out of this drinking culture and – there was definitely an era, and I was on the end of a particular type of era. Basically, the police department forms you into a person, and for a lot of them, it's very much a drinking culture. You know we didn't think in terms of posttraumatic stress disorder, but there was people that I worked with who were functional alcoholics, sometimes dysfunctional alcoholics.

Stuart believed there had been significant culture change within the police department in recent years, and that it had not made life easier for police.

The thin blue line concept, you know, it didn't matter – you backed up the other police officers, even if they did something stupid - that was what you did. Because if you didn't

there was no-one else. I don't think [now] they have their mate's back in that same sense. I know guys and they go nuh, that's gone.

We [also] had a lot more freedom. We had discretionary powers, which they just don't have – these days – they're being run by KPI's which is all well and good, um you know makes the government feel fantastic and happy about these things, but I think they have a much more difficult job to do today, by comparison.

Stuart said he thought that the police department is currently failing in its duty towards maintaining the health and well-being of serving officers, and insufficiently proactive in treating those with an alcohol problem.

So many police officers are physically unhealthy, ah the police department does nothing, in real terms to provide them with an effective means of physically staying healthy, which is obviously a clear correlation between a healthy fit person and their ability to cope with stress, and – um – and I think that's a big issue in it. [And] why is it when you've got a police officer who has a problem with alcohol, you don't recognize that, and recognize that this is a medical condition, and manage them?

Stuart suggested that some people had been damaged by the way they had been treated by the police department, but that they retain a connection with each other as ex-police, and that he himself remained greatly influenced by his police service.

If you are in conflict with the department – and I wasn't in conflict with the department - you could be treated really miserably. There are guys out there who've come out with a lot of grief, who've been really hurt, you know, along the way. The retired police group– it's interesting, there's a couple of guys when I was in there who were never my friends, but they're really – they've changed. One of the guys has a tremendous issue with the police, he's psychologically been really hurt by a lot of things.

Stuart said he had never quite lost the connection he felt to other police officers or former police officers, and he believed that his experience as a police officer continued to influence his life.

> *...I see in a lot of police officers, or ex-police officers, including myself, this – connection. And you never quite lose it. So – and when you see things, and um – it makes you think about things. I mean I drive places sometimes – but I remember that. I remember that happening here. You know and you go why did that come into my head, you know, and it's been so long for me, I've been out as long as I was in, you know, and it's amazing how incredibly that influenced my whole life, you know, in terms of doing things. So – who knows.*

Summary

Stuart's narrative suggested he had served 18 years in policing (including his time spent in the Academy) without being affected by trauma. It is possible that his limited exposure to potentially traumatic events was relevant to this. He acknowledged that a certain amount of *"toughness"* was required in police officers, an ability to *"not take things to heart"*. He seemed to regard this as a personality trait, rather than a characteristic he had needed to develop. He said the culture at the time dictated that it was necessary to *"toughen up, have a beer, suck it up, don't let your mates down"* – to get the job done and not share your feelings with anybody lest you were thought of as being unable to cope.

Stuart acknowledged that his police service had changed him in that he had become more observant of his surroundings and more suspicious of members of the public, automatically *"summing them up"* as he observed them. He saw this as a double-edged sword – that it probably contributed to his safely in everyday life, but also meant he could not "relax" his way through life as others could. He remarked that despite the length of time since

he left the police department, he continued to be amazed by the influence it was still having over his life.

While he did not indicate that he had experienced a problem with alcohol, Stuart said the police department "forms you into a person", and that for many that meant they became part of the drinking culture as a means of dealing with the everyday stress of policing. He said it occurred as part of an era, and that he had come in at the end of it. He spoke of other significant changes that had occurred while and after he was policing. He said officers no longer backed up the officers they worked with – the "thin blue line" concept had disappeared. Officers made fewer independent decisions and were now "being run by KPI's". Stuart said he believed that the police department was failing in its duty to maintain the health of its officers, both physically and mentally. He also believed that support from fellow officers had dwindled but nothing had taken its place. He believed that, as a consequence, many former officers had been embittered and damaged in conflicts with the department. What had not changed however, he said, was the connection between former officers; "*you never quite lose it".*

Group 2

Cliff

Cliff entered the Police Academy in 1977 as an 18 year old and left policing in 2001. He said he had decided on policing as a career after being befriended by a police officer staying at his parents' guest house and being very impressed when he attended a police graduation ceremony with him. He said he served 24 years in total, eight years in uniform and the rest in plain clothes and undercover and had intended it to be a life-long job when he enlisted, but lack of opportunity for promotion that he attributed to nepotism had led to his resignation.

> *But a number of issues happened to me during the course of my time in the police that – you know – the light bulb went off and I had a bit of an epiphany and thought I'm wasting my time here, this is not a great place to work for, the management aren't very nice people and the corruption in HR was really what forced me out, because it was not what you knew it was who you knew to get promoted. I did a degree at XXXX XXXX and jumped through all their hoops, and they'd dangle the carrot, but they'd never let you have a bite. And I was in my early forties, and I thought this is a waste of time plus the shift work and young kids – my kids never saw me, I did undercover work, I was in the drug squad and then I was a surveillance supervisor doing undercover coded surveillance and – er – you're just never home and they expect more and more and more.*

Cliff said he had experienced a period of mental illness as a result of being bullied in his job with the State Government that he had begun after he left policing.

> *I was scaring hell out of my wife, sitting home crying all day, so it was a pretty terrible thing to go through, and I looked like grisly Adam, I grew a long beard and just sat there - she'd go to work and come home and I hadn't moved, I'd just be sitting there like a bit of a wreck. And I'd seen some really tough cops go through depression and then you sit there*

and go wow, and it's a real feeling of helplessness and ah – you know no-one to turn to – luckily, I recognized it early and got some good help and got out of it.

Sent to a psychiatrist by his GP, Cliff was diagnosed as having major depression and associated anxiety and treated with medication. He took a lengthy period of sick leave and left his employment with a package in 2011. At the time I interviewed him he was working in a job he said was below his qualification level but suited him at the time. There were indications that he had not recovered fully from his depressive episode in 2011.

Cliff described as his worst trauma while policing as the effects of being forced to attend the post-mortem of a fellow officer known to him who had shot himself. He described still having a strong physical reaction when reminded of the event and avoidance of thoughts related to it. He said he also avoided any stressful situations that might evoke a panic attack.

I try and avoid stressful situations, because the stress will put me – I'll have a panic attack so the panic attacks when I was sick would manifest in me with – vomiting. I can't wear a tie anymore – anything near my throat I feel as if I'm being strangled, and I'll throw up.

Cliff said he had not received a diagnosis of PTSD, but he described a number of exposures to potentially traumatic events during his life. Significant in his history was the suicide of his father when he was 21 and had just graduated from the Academy. Cliff had not had a good relationship with his father. He described an early traumatic event he had experienced.

My dad when I was – about 11 – took me to the dentist and said – ah – we'll toughen him up – my dad was ex-navy – no injections, so I got held down and they did two – and they were big deep fillings back in those days, with a slow drill, and – basically put his hand on my chest and said you'll sit there and you'll go through this, and he basically had

to drag me kicking and screaming to go back the second time, because it was like bloody torture.

Despite Eye Movement Desensitization and Reprocessing (EMDR) focussed psychotherapy – that he said had no effect – Cliff said he still experienced extreme stress when he visited the dentist. He developed a tentative relationship with his father as an adult, but this ended with his father's suicide.

My parents were publicans, and they split, and my dad took us and moved back to XXXXX to the family, and in the end for us kids Mum came back, and – ah – um -um – that only lasted a couple of years and in the end she kicked him out. And – um – he killed himself. Took an overdose of Nembutals – ah - just after I graduated. Dad was really tough – never gave me a hug, never ever said he loved me – ah – all came from mum. But I had a moment, stood up to him in the end, just before he killed himself. We'd just started getting back on to – I could visit him and have a beer with him and ah – ah then he killed himself, so – you know – very hard to forgive someone when they do that.

Cliff said he had considered suicide himself when he was depressed, but that his experience earlier with his father's suicide had acted as a deterrent.

I think – you know they say it's the coward's way out, but having been there myself and sitting there with a safe full of guns going, you know, I feel worthless, I'm not any use to anyone, I could just go and load one of those guns up now and shoot myself – but my dad had killed himself, so I thought, you know, I looked at the effect it had had on me and my sister – not that she was close with him – we're both very close to our mum, and I couldn't do that to my kids, you know.

Concern and distress about the suicides of fellow police officers was a dominant topic in Cliff's narrative. He identified undiagnosed depression, self-blame after an unsupported court appearance, unreasonable work demands, and undeserved criticism from

superior officers as precipitants in four suicides, as well as the stress of possibly being followed by private investigators.

A number of my mates have killed themselves, over the course of my career when I was inside and outside the police department, so – hangings, gassings, a lot of them ate their guns, you know, shot themselves. I had a mate a couple of years ago went out the back of XXXXX police station – detective – we knew he was a bit different, but we never knew he had the black dog on his shoulder, and just walked out the back door, stuck the gun in his head and killed himself. And he had everything to live for.

And one nice young lad, did his detective training, went into the CIB – and when you've got a big matter and you're in court there's a lot of pressure on you – and normally you might have a mentor or an older detective to look after you, but quite often you just get dumped on your own. So, this lad's in court, and he had one of the state's top QC's bashing the hell out of him in the witness box, and he thought jeez I'm going to lose this, and he basically blamed himself for the way things were going. And he just come in to work one day, got his gun, went down to the beach, threw a coat over his head so he didn't mess up the police car, stuck the gun under his chin and shot himself. His wife was a cop, he was a coach of the kids' basketball team, and you know everything was going perfect, but that was pressure of the job. The hierarchy don't have an understanding of the pressures that they place on the staff.

I think the sad part is I don't think the commissioner – or the series of commissioners – and the hierarchy -- have really learned from past experience. There was a superintendent shot himself about 12 years ago, and highly respected, hard worker, ah – couldn't say no, so they just kept loading him up with more projects – until he broke, so basically working 7 days a week and not having any breaks. And a bloke I know found him just before he was about to kill himself and had a chat with him and he said he was just going for a walk

through the forest, and this guy said – just didn't feel right, and only drove for about 5 minutes and thought – I'm a bit worried about him and he turned around and come back and then found his body. A number of my colleagues said to me he thought he was being watched that he was under surveillance by the private investigators. And it had that effect on him that he did kill himself.

When you're criticized when you don't do the right thing from on high - the guys put it on themselves, and the girls [too], that there's – one girl that I worked with in surveillance, ah – she got quite sick and tried to kill herself and they found her, pumped her stomach, basically watched her like hawks for about 12 months and she just waited for the right time and then went and did it again, did it properly.

When asked what *"putting it on themselves"* meant, Cliff suggested that criticism from both superior or fellow officers, combined with a feeling of having failed in their professional performance, can result in destructive self-criticism and subsequent loss of self-worth.

I think it's their pride and professionalism – so you know back in the old days they – people'd call us pigs, and that was our acronym for pride, integrity and guts. So you know - very proud in the work that you did as a professional, and you know when you stuff up it sort of hurts a bit and people tend to – I think take that weight on themselves and tend to be over-critical rather than letting it go. A lot of the guys would ruminate on things, and you couldn't let things go and you'd just keep bringing it up and bringing it up, and that self – critique I think is a big thing that the cops – you know you tend to be over self-critical, especially – and cops can be quite cruel, so, you know, it's a very tough atmosphere – and you know there's the veneer now of equity and diversity, but you know between the guys, the guys can be really viciously cruel.

Cliff suggested that women police officers are more able to tolerate criticism than men and perhaps this was because male police officers might sometimes have more of their

self-worth invested in their professional performance than their female counterparts. He described male self-worth as being susceptible to a slow process of attrition, before suddenly reaching crisis point.

You know I think women are a lot stronger than blokes, with what they can put up with, and what they can tolerate. I think they're able to put a bit of a shield up and let a lot of that stuff bounce off them – they don't tend to internalize it so much and let it soak through, where guys take it a little bit more personally and there's a little bit more over a longer period of time – that osmosis when, you know, when the little niggly pieces will get through to you. And then all of a sudden, you'll snap.

Cliff speculated about reason why *"things might get through"* and concluded that the recruitment process in the past might have identified those who were *"tough enough"* to withstand the difficulties encountered in policing – and that perhaps this could be genetic, or that those people might come from a particular background.

I suppose it's a genetic thing, you get niggly things that get through to you, and, you know, from a very early age – I don't think I'd been graduated that long – ah – you know bloke had hung himself and I'm up with my shoulder under the dead body cutting the rope down, and the old senior connie's there, you know, I've done millions of these, it's your turn. In you go. And you know the body's groaning and there's fluids coming out everywhere, and back in those days no rubber gloves, no overalls, no protection, no handwash. And you smelt like a dead body for the rest of the day. And – er – I suppose the people that they may have recruited and psychologically profiled [back then], were the ones who'd come from a certain background, or were people that they profiled that they thought could be tough enough to withstand the rigours, you know, of day to day policing.

Noting that police suicide is not publicized now as it had been in the past, Cliff reiterated his belief that the need to do a good job might be at the heart of suicidality, and a

person seeing themselves, and being seen by others as failing in this, acts as a precipitant to suicide.

There was a superintendent shot himself down at XXXXX, killed himself, in the 70's and I remember hearing some of the older detectives talk about it and sort of mumbling why nothing was done, you know. But it was on the front page of the paper and all the rest of it - cop kills himself. Now, the police department just hush it all up and don't say anything, it's not for publication, but it's interesting to see, and having a look back, and thinking about the number of my friends who have killed themselves, or been sick, ah – you know to put a finger on why they got sick or why they committed suicide I think, very difficult. And I think it gets back again to that professionalism and wanting to be professional and then seeing themselves as not doing a good job and then seeing themselves as not being viewed upon as doing a good enough job by their peers, and that pressure, that perceived pressure, was something that pushed them over.

Cliff spoke of the unpredictability of his reactions to different types of potentially traumatic events – that he always found the deaths of children to be distressing, at times he had an emotional reaction he had to suppress to get the job done, but sometimes it was as if he had a *"force field"* and everything bounced off – and sometimes something got under his skin and he was unable to let it go.

Look, I don't know how many murder scenes I've been to and seen brains dripping off of roofs, and people with heads missing, going to car accidents and pulling people out of cars, you know people who suicide in a car, drive into a tree, you've got to pull them out, some of those injuries are quite horrific but you do get attuned to them and used to them. I've seen motorcycle injuries with dismembered torsos, bodies pulled apart, and I saw one the other day and I just looked, and I thought well, that's a bit sad, and it doesn't tend to –

that just bounces off me. But you know little kids, kids' deaths were always really hard to do – seeing little kids...

You know you look at it professionally, you walk in professionally, I've got a job to do, and especially with paedophiles and things like that, you feel like reaching across the table and throttling someone, but that's not going to help your cause, you want to get them in jail, you know, get the best result you can for the victims, and, you know, get a good result in court, a conviction, and take them off the street.

There was a police officer [I knew] who was interviewed for breaking into a shop and stealing from a shop. They grilled him very hard, and they said right, ah – we've having a break, you've got a weekend to think about this. Come back and tell us what you think on Monday, and – um – um – Monday morning came in, and he went into work, told his partner to wait in the car, went in and drew a gun from the equipment room and then went into the toilets and committed suicide. So, the gun just behind his ear. And I never knew he was a crook. And – I don't know whether you've seen a post-mortem or know what goes on in a post-mortem, but they're pretty brutal. And I said to the superintendent look I know this bloke really well, and, you know, I'm not real comfortable in doing this. And – so, the superintendent says [to me] OK when the body goes to the morgue, you've got to sit through the post-mortem, toughen up princess, off you go and do it. I'm the superintendent and you're not. Do as you're told. So, here's me having to sit through the post-mortem of a guy I knew really well.

Cliff said that being forced to be present at the autopsy had affected him greatly, and he had gone on a week-long alcohol binge in an attempt to deal with it. He said he believed that, in the absence of any form of formal debriefing, for many police self-medicating with alcohol played a big part in dealing with trauma, and that this in turn was destructive to family relationships.

And I didn't realize but it really got under my skin, [having to be present at the autopsy] and I was basically drunk for a week, by wife was really cranky with me – and you know it's the only real falling out we've ever had– the whole time we've been married. And she said I come close to leaving you because you were just a drunken mess. I didn't realize it, but I was self-medicating because of what I'd seen and - you know you tended to over-medicate with alcohol – alcohol's the big crutch. In the police in the old days, it was really not recognized what you've seen and there was really no debriefing available to me in the day, anyone professionally coming to me and saying – you've seen some pretty horrible things – do you want to talk about it. There's no real avenues to – in uniform we'd have night shift barbecues at the end of a week of night shift, and we'd all get on the turps, have a barbecue, and sort of de-stress and you'd talk about jobs and things like that. In the CIB it was the same, but the frequency was a lot– you'd get smashed as a rat – ah – when you'd been through some stressful incidents, and – ah – you'd celebrate your wins and you'd drown your losses, more or less. And that would take its toll on a lot of the wives, they wouldn't put up with it for too long, lot of my mates on second marriages, a lot of them on third marriages, you know, because of self-medication. It's the effect on your family too that you don't realize.

Cliff said he was grateful that he had never had to shoot anyone during his policing career – though he said he had come close to doing this.

I've come close to killing someone – lawfully, when I was in uniform at a job, domestic violence incident, and the male offender come running out of the unit with a rifle. And I'm backing away, and I knew if I shot him, I might kill him, because I'm a pistol shooter, I'm going to put one right in his heart. My partner's screaming at me not to kill him – so I'm going – all my training's saying shoot him in the centre mass, protect yourself, because – and I knew the gun was only a .22, but a .22 rifle aimed at my head would kill me – or hit

me in the heart, I'm dead, and ah – just got to that point where I'm about to finish squeezing the trigger and he ran, turned tail and ran. And I did get criticized for not defending myself, but you know I'm glad I never had to take a human life because the guys that I know that have shot people, you live with that for the rest of your life, you never ever get rid of that, and – er – um – I think that probably would come back to haunt you.

Cliff said that when he had been a police officer, most of his friends and social contacts were also police. After he left policing, he kept many contacts with police-related clubs and activities.

Well in a social setting – and my wife had a go at me about this the other night – and I'm very lucky, I've been married 32 years this year, and you know – how she stuck with me I'm buggered if I know –you'd go to a Christmas show, and all the guys would end up in the corner and the girls'd be in the other corner, because the guys were just talking work. Very difficult to divorce yourself from the work. So – you know – I suppose it was our way of debriefing, if no-one gave us a formal debriefing. Because [when] you're in mixed company and you start telling war stories and people just look at you – because of what you're seeing you tend to have a very black sense of humour, and you know [because the] stuff that we would laugh at – that would be politically incorrect to laugh at – ah – you know – you tend to surround yourself - you're mainly with cop mates. You don't tend to have a lot of people that aren't police.

Cliff said he now appreciated having a diverse group of friends, as this had not been the case while he was serving. He said he did however also enjoy reunions with the people he had worked with.

You tend to stay in touch. It's a loyalty thing you know. You know cops are really loyal to each other. Not so much to the management but to each other. You know some of the things you see and do, the jobs that you go to are life-threatening – you know you could

lose your life and you trust the guy standing next to you and you form very strong bonds. People will bring up stories about stuff that you did in the seventies and eighties and you'll go – one, you were able to protect the public, two, you did a good job, you made a difference in people's lives, and that was a real positive part of it.

Summary

While Cliff's mental health crisis occurred after he had left the police force, he described, clearly and perceptively, the difficulties he had experienced as a police officer, and those experienced by his fellow officers, and how he observed they had dealt with them.

Despite saying he had been unable to forgive his father for suiciding, Cliff expressed an understanding of the reasons why fellow police officers had done so. He also spoke of his concern for the frequency of the suicides, the pressures he believed acted as precipitants, and the lack of understanding of this by senior management. He said he believed that the police hierarchy had long failed to understand the pressures the job puts on police officers, and that they continued to do this. He also Identified criticism from superior officers as deleterious, particularly if the officer is already blaming himself or herself for having failed in their professional performance. Fellow officers too, he said, could also be vicious in their criticism of each other. Cliff had also experienced his own suicidal thoughts and said his memory of the effects of his father's suicide on himself and his sister functioned as a powerful deterrent to him acting on these, despite having the means.

At the time of his interview Cliff acknowledged significant vulnerabilities to certain stressors and memories that related to his time in policing, and perhaps also to his childhood. It is likely that he suffered cumulative trauma over this time and possible that the later bullying experience functioned as a tipping point, rather than the cause of his period of mental illness and its failure to fully resolve (see McLaughlin et al., (2015), Ramo-Fernandez et al, (2019), and Van Bodegom, Homberg, & Henckens, (2017) for a discussion of the

cumulative effects of trauma). This is suggested by the physical responses he described still experiencing to reminders of his traumatic experiences while a police officer and his avoidance of thoughts associated with them.

Cliff described different ways that he himself reacted to potentially traumatic events. Sometimes it was if he had a "force field" around him and was able to deal with horrific scenes of death and mutilation without any apparent reaction. At other times, particularly if children were involved, he became emotionally disturbed. He said certain types of criminal activity, such as paedophilia, caused him to become angry, but he had been able to contain this and remain professional in order to get the best result for the victims. Every now and then, he said, something would get under his skin and *"niggle and niggle".* This was exemplified in his reaction to having to witness a post-mortem on a fellow officer he had known who had shot himself. Following this Cliff went on a week-long alcohol bender that almost brought his marriage to an end. He became distressed when he spoke of the effect of this on his family, and said he said he had not recognized how much the event had affected him at the time. His narrative suggested that the element that had been significant for him had been the injustice of being arbitrarily ordered to be present at the post-mortem of a fellow officer who had been a friend, when he had asked to be excused on this basis.

Cliff acknowledged using alcohol as a substitute for the absence of any debriefing or psychological support during his policing career – a behaviour he said was endemic in police culture at the time, and responsible for many failed marriages. He suggested the meetings for drinks together at the end of the shift had a positive side as well – those group meetings at pubs or barbecues had provided support for all, understanding for those who were experiencing difficulties, and were largely free from judgement. Cliff said he had also been part of the culture that police tended to not socialize with non-police at social gatherings, and

that the reason for this had been that police often felt unable to talk freely about the work they did because of the negative reactions they often received.

Cliff said he stayed in touch with his former police colleagues out of feelings of loyalty to the group and described himself as having been highly active in organizing reunions and keeping others connected within the group. He said the trust they had experienced with each other had resulted in a very strong bond, and he looked back on his policing career as a positive experience where he did a good job and made a difference in people's lives.

Cliff's narrative suggests he is suffering chronic anxiety and a history of major depression as a sequel to cumulative stress associated with his experiences in early life, his time spent policing and with subsequent employment related stressors. It is perhaps also relevant that he had not chosen to expose himself to these events but had been forced to do so by those in a position to exert power over him, repeating his early experience of being forced by his father to undergo painful dental treatment without an anaesthetic.

Bruce

Bruce said he had entered police force in December 1965 at the age of 17 as a three-year cadet, because *"I saw a copper walking the street and thought it looked like an interesting job".* On the advice of a psychiatrist, he retired in 1996 with a diagnosis of depression. Bruce said had not received a diagnosis of PTSD at any time in his life. He said he believed that being given the diagnosis would have stigmatized him.

> *I've never been diagnosed with it, probably be bigger the embarrassment that you don't want to go and – and – um – admit that there's a hassle. Because particularly in a country town there's too much image. But it's when you get home that you end up with all the hassles, you know, the moods, and – when you can be yourself.*

About midway through his policing career. Bruce said he started noticing his vulnerability to emotional triggers and general decline in his mental state.

> *Ah – a couple of years before I admitted it to myself. I'd admitted to myself that – when I first noticed the problem that I hated sirens, which was bloody handy working in a police car, [laughs] um – ah – and you had to be under that control because you had all the stress, and then you'd have a cry on the way home – um I'd been doing crime scene work for fifteen years at that stage. Well, with two of you doing the job, you had a 50-50 chance of striking it – of - um – you know, fatal accidents, murders, um – um -ah – major fires, and um – all of the grief type situations.*

Bruce described crime scene work as particularly difficult.

> *If you and I went out to a job – or if you went out to a job, and – um – you saw – you went in and found a gruesome sort of a scene, you could turn around and go - oh hell, you know, he's obviously dead, but call in the Crime Scene – but you didn't have to go back and look at it over often, you could rely on the pictures and sort of get yourself into the system. Whereas from the Crime Scene Squad you'd have to focus on the worst bits to*

photograph them and then have the court arguing over whether you should or should not be showing those photos to the jury because they're too gruesome. um – but um – ah – but once I got out of the Crime Scene work, I went back on patrols, you can say well was it good or was it bad – it's debatable.

The event Bruce described as the most disturbing during his policing career was a triple murder perpetrated by a man who was apparently psychotic, but who failed to be detained under the Mental Health Act because he was not thought to be meeting the criteria of being a danger to himself or others. Bruce believed this was:

...an accident that could have been avoided the day before if the police had been able to lock up a bloke, but they couldn't because very recently before that they'd changed the Mental Health Act – you know, you get that angry.

Another traumatic event he described involved both the accidental death of a child he knew, and his inability to speak about it afterwards because of obligation to his own children.

There was a kid that went to kindy with XXXX, my eldest son, but when they were 7, it was on the 17th of December, and um – the – um –two kids, him and a friend, playing around, playing cowboys, they found a gun in a shed, one of those that's covered in dust, hasn't been used for years, and one of them is running up the outside of the shed going bang bang bang, pulls the trigger, and shot his mate, inside the shed, through a corrugated iron wall, shot him straight through the heart, killed him. And that was the kid that lived at the house. The visiting kid that had it. And of course, I knew the parents from the kindy days a few years before, but then you're sitting in the lounge room, with mum sitting that side of the Christmas tree, the Christmas tree in the corner, me on this side of the Christmas tree, and um – ah - then – what are we going to do with these presents. And I had to go from sort of being the copper at that killing scene, back home, and get in the shit for not dancing on the roof for my birthday party that the kids had lined up. You know

and that sort of thing, it did get you, you know, because – um – you couldn't necessarily just unload, because you didn't want to be having a conversation and get walked in on by the kids – so....

Bruce described being involved in a serious accident at the age of 19, when he was a police cadet. He said he was reminded of this at a later accident he attended as a police officer that profoundly affected him: –

A young fellow -um - hit a pedestrian, and -um – and killed him, and I had to do the breathalizer test on him, but you know he was going through shock and um – it just reminded me of the woman that I'd hit when I was 19. Um - and she was an 84 year old returned missionary crossing the road and um – it was a dark, rainy night, and she got confused and started to run. And – um – I pulled over to the left, which was silly – if I'd sort of thought you silly old bitch and driven faster, at her, I would have missed her. You don't, you try and avoid it, so I kept her in my sights, you know it was just slightly to the right of centre, where I hit her –and broke both her legs, put her back out and gave her concussion – well, I look back several time, you know I didn't suffer shock [at the time], we went into the police station, they took us in there and we reported it...

Later Bruce's shock set in and following this a seminal moment - a total examination of his life to that point, and whether he could continue to sustain his Christian beliefs.

There was a group of four of us going down fishing to and the shock hit in. Started crying, and before then – boys don't cry – I was one of four boys – boys don't cry. You know I started crying, started shaking, and there was no way I was going any further, and my mates said the night's mucked up for you, why go home and muck it up for your parents, we might as well go fishing as planned, and then go home and you've got all day to get over it tomorrow. So that's what we ended up doing and we didn't get any fish anyway. [laughs without humour] so the night was completely stuffed but um – you know

it was from that that I – I could look back and say well that made me, I've been brought up in a Christian home, and you know everything had just fallen into place -um – but at that stage I had to make the choice as to whether my Christian faith meant anything to me or whether it was a load of crap.

Ultimately, Bruce decided he needed his faith, and thought he had become a better person and more able to help others as the result of the accident.

I found that as I went through a searching stage, I just found that no, I need that faith, you know, the Christian friends around me, I need that support, and um – you know it was the makings of me as a person. Um – it gave me more empathy, you know I could feel for people after that… you could just say look, everybody has their hassles, you'll get over it, you'll feel better. As you do, then you'll be a strength for somebody else.

Following the child shooting Bruce attempted to put separation between himself and his work, but he found he was not able to do this successfully.

It was sort of around that time that I made sure that I shut the door of the police station when I left. Because symbolically you were leaving – um – the police force at work. But it was only temporary, you know, because then you'd have to go back and do the paperwork and relive so much of it, yeah. But you sort of bottle it up until the end of a shift and then go home, have a cry on the way home. But then not long after that there was a fatal accident down at XXXXX, and the mum and dad and three kids – um - three pre-school kids – um – heading from XXXXX after celebrating Christmas, heading to XXXXX to celebrate Christmas. So, you know everything happens at Christmas – um – you know, even as a Christian, I just hate Christmas – um – because I've got a birthday the week before, or eight days before it, and then you've got Christmas the eight days after, but there's always a tragedy, either on my birthday, or on Christmas day that's going to stuff

up either my birthday or Christmas. The only third alternative that you'll get is that both can be stuffed up in that year.

As he progressed through his policing career Bruce said he found he was being increasingly affected by emotional triggers; certain times of the year, like Christmas, or events that occurred in the rural areas where he worked. The ways in which he attributed meaning to these events set up for him in turn an anticipation of further disaster, which served to further impact on his mental state.

And [if] a helicopter went over, and I started to tense up –just before the helicopter is physically - and then oh yeah here comes a helicopter. Now I've never ridden in a helicopter, but it's always a symbol of something wrong. if the helicopter comes in, someone's going to die. If it's the plane, there's a fifty-fifty chance they're going to live, there's some chance of survival, if a plane comes in. But no the helicopter is just totally different because whoever went out on a helicopter they come back in a box.

After two years in patrols, he decided he'd had enough. He described it as being "burnt out".

It actually started to really affect me, and then I'd arranged to do a charity walk from XXXXX up to XXXXXi. I got to the top of a hill, after two days of walking, and cried. Just looked over and there was so much of nothing, it was so peaceful, you could see trucks on the highway below and you couldn't hear a sound. And you know they were moving but you couldn't hear anything they were so far away, there was so much of nothing. Yeah by the time I got back on the walk, um – I was telling myself, I've got to go into work tomorrow. Then I thought I don't need this shit. But I think the burn out itself was caused by a combination of my lifestyle, because I had up to six teenage boys at home. And when you look at three seventeen year olds, two fifteen year olds and a thirteen year old, well I [used to say] I went to work to get away from it- but – um there was things that would overlap, where your time was sort of drained.

There were other triggers too, and Bruce said he found these worsened after he retired. He became increasingly aware of the things he needed to avoid in order to evade stresses as much as possible.

> *I'm really just – just – I've got to handling it – um where you get your stresses – I've got to know what to avoid – what not to – and um – and get on and live a life. You sit down to relax and – um - in front of the telly – you put the news on, and you know it's full of the shit that you've just left at work. You know so – while I was a copper it didn't work badly so much, um – but um – ah – you know since I've left, and got into more – caring – fields, it affects you a lot more.*

When asked why he thinks it now affects him more, Bruce's response suggested he experienced difficulties because he was unable to share his distress.

> *You didn't debrief at work. Debriefing was simply a piss-up, and the difference between a night when there'd been a tragedy and a night when there wasn't, was that the night when there was a tragedy you had a reason. It's all go – and drink the grog. I could at least say I've got to get home to the boys - in the later part of my career I had my three boys living at home, the wife had left, I had the three boys and then I'd gone into doing foster care just for something different - you'd have to come home and be someone that you're not, and then in the private time - and of course I didn't have a wife to – sort of – share the burden with.*

Bruce retired from the police force in 1996 at the age of 47. He said he made no attempt claim compensation because *"you start with a fight".* His GP sent him to a psychiatrist who diagnosed him as depressed and recommended he leave the police force. He received a lump sum payout and bought a bush block with two houses on it, with the intention of living in one himself and putting his foster kids in the other. He lived there for 12 months. Just prior to Christmas, after playing Father Christmas all day at the local

shopping mall, he was distracted by having to drive one of the boys somewhere urgently, left oil on the stove and burnt his house down. He had earlier refused to renew his insurance because the premiums doubled. Bruce's reaction to this event, when asked what he was going to do next by a friend, is perhaps a reflection of his attitude to life.

I said when God shuts the door he opens a window, but I just wish he'd left some bloody walls to hang the windows on! I said I've got a list of words I've always used to the kids in foster care. Pick yourself up, dust yourself down, your eyes are stuck in the front of your head so you can look forward. If God wanted you to look back there'd have been at least one eye in the back of your head. So just keep going forward.

At the time I spoke to him Bruce said his own children had left home, but that he was continuing to foster troubled boys. He also still worked part time in disability support with clients that he had been seeing long term. He said he had also had a stint in managing hostels for people with a range of disabilities. He believed his successes with difficult clients had been a result of his police service.

It was just the police experience that got me, that got me these things, and see I'm not politically correct – I don't know whether you've picked that up in the conversation, but I believe it's the police training of seeing what the problem is and dealing with the problems that we had back in those days.

When asked about whether his experiences had affected his self-esteem Bruce answered in the negative, but acknowledged that he believed he had PTSD, despite not having formally received the diagnosis.

I didn't lose my self-esteem, when I got diagnosed with depression, Um – ah – I think that was partly the Christian background where you know you were taught you're valued, you know, I'd been brought up in a good family, um – and - um, and you didn't have the abuse and things like that, so everything was positive, that – about me personally. For me

it's psychological, that's why I say I'm not the worst PTSD you're going to come across. For the girls to come in the door, love you grandpa, you know, and straight up, you always know that you're loved. And when you go back to a town to work and someone says, "I owe my life to you, the only person who was prepared to listen to me when I needed somebody."

Summary

While still a police cadet Bruce faced a life crisis and his religious beliefs unravelled when he hit an elderly pedestrian who was ironically a returned missionary. It was unclear how much he blamed himself for the accident, but he certainly expressed the wish that he had handled the situation differently. Ultimately, he returned to his faith, feeling that he needed the support of his Christian friends. He said that the effect of the accident was to make him more empathic – to feel for people.

After serving 15 years in Crime Scene work Bruce's memories of the earlier accident in which he had been involved were triggered by a similar one he attended, followed shortly after by the accidental death of a child in a family known to him. He said he started experiencing symptoms around this time, but it was about two years before he acknowledged their significance. Sounds and events he associated with traumatic events – and believed predicted them - acted as progressively more powerful triggers to undermine his emotional state. At that time, he was also lacking in support as he was fostering a series of difficult boys and his wife had left, leaving him very much on his own with the responsibilities of parenting. While off work for a period before his retirement he said he had received some support from two friends he'd met in the church, but little from within the police force.

Bruce's GP sent him to a psychiatrist who diagnosed him with depression and on his advice, Bruce left the Police Force. He avoided making a compensation claim because he anticipated and wished to avoid further conflict. He had never received the diagnosis of

PTSD and was adamant that he did not want it because of the stigma – and perhaps pity - he believed would have been associated with it. He said he had suffered a stroke at age 44 and had experienced the apparently well-intentioned offers of help he received after his stroke as demeaning - *"like being kicked when you're down".* At that time, he had fought against opinions that his policing career was over and returned to active duty within six months.

After he retired Bruce found his symptoms worsened. He tried to keep them concealed from those around him and used avoidance as a coping mechanism. Despite his difficulties he continued with a busy, community-oriented life, much of it performed at a voluntary level. He maintained that through all his difficulties his belief in himself had remained intact, and that appreciation he received from the people he helped, and love from his grandchildren, were what maintained it. He said he had also begun his life with the advantage of having a family who gave him security and made him feel valued.

Throughout all the obstacles he experienced in his life Bruce remained doggedly optimistic and kept a wry sense of humour. His history suggests his intact self-esteem is a product of his image of himself as a person who helps those in need and refuses to give up when faced with adversity, but does not always welcome help from others, often experiencing it as demeaning and disempowering.

During his Crime Scene work however Bruce was exposed to many people he couldn't help – *"all the grief type situations".* Although he did not specifically say so, it is very likely that this would have been very difficult for someone who valued helping others as Bruce did. Since, as he said, his accident at age 19 had made him more empathic, this empathy with others would have been likely to have made him more vulnerable. His reaction might be best described as moral injury, as defined by Litz et al. (2009) as "perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations" (p. 700). Moral injury has been associated with a broad range of

symptoms, including guilt, shame and spiritual crises (Litz, 2009). Certainly, Bruce experienced a spiritual crisis after he hit a pedestrian while a police cadet, and the ultimate effect of this incident marked the beginning of his vulnerability.

While the topic of moral injury has been written about extensively in relation to the military, its application to police officers – who face many of the same challenges – has not been addressed in the current literature (Papazoglou, 2013). A related phenomenon, moral distress (described by Morley (2018) as ongoing "unfixable suffering" has been described in caregiving professionals as leading to helplessness, powerlessness and shame (Elpern, 2005) and as a form of "compassion fatigue" by Papazoglou and Chopko (2017), and found in death-related situations, killings, handling human remains, and injured people who could not be helped (Frankfurt & Frazier, 2016). These were all experiences Bruce had in the course of his policing career. Notably he did not describe experiencing revulsion in these situations. His distress seemed to come rather from his empathy with the suffering of others.

Murray

Murray entered the police academy immediately on leaving school and served 35 years before being discharged in 2002 as medically unfit with the rank of Inspector. He was at that time diagnosed with PTSD and experienced ongoing breathing difficulties from a facial injury caused by being bashed and kicked unconscious in an on-duty incident when he was trying to break up a pub brawl. He had also suffered a heart attack and subsequently undergone a triple bypass just prior to his retirement. He said he had attempted to claim compensation for this citing occupational stress, but this claim was rejected and after his retirement he was *"basically left on his own".* Advised by the Police Association to go on to compensation and use all his sick leave, Murray didn't accept this option - *"I wanted to sever ties".* He went off work on a superannuation pension and responded to a friend who suggested that he had been fortunate using a humorous – but direct – analogy.

> *A very close friend of mine said, I'm really envious that you can stay at home and you get a pension. He said I'd love to be able to do that and stay at home. I said, look, I can help arrange that, I said, lay on the floor and I'll kick you unconscious.*

Murray spoke about his 35 years in policing and the incidents of violence and danger he'd been exposed to without any obvious distress. It was notable that he showed most emotion when he spoke about the way he had been treated after he left the police force. He described his dealings associated with compensation after his retirement as *"a battle over small things, but an accumulation of 12 years of frustration".* He said he showed his intolerance of this with the use of *"witty sarcasm"* in his correspondence with them. He was unhappy with the response he had from them around the funding the CPAP machine he had to use as a result of his facial injury. *"They're not in the business of conceding that these things are a problem, to me they're in the business of finding reason why you should be going back to work".* When told he needed to go back to his doctor each time the Velcro straps that

attached his mask needed replacing, his response was that his GP wasn't a doctor of velcroology – maybe he should go to Bunnings (a chain of hardware stores) for an opinion. Murray said that he continued to claim his entitlements, but that the conflict exacerbated his stress levels.

> *Look, you could turn around and say Oh for god's sake for the sake of ninety dollars, for the sake of a hundred for this, they can stick it. But no, I was injured, I was very badly injured, and I'm – I'm just not going to do what other people do when they said no we've had enough of this, I'm not walking away. Which is probably getting away from the PTSD aspect of it, but it increases your stress level (said with emphasis) something shocking. You're not quite – I would never say that I felt that I was begging, but you've certainly got to fight hard for what you're entitled to.*

In his early life Murray and his sister experienced violence from their father *"not so much physical violence but he was an expert intimidator".* Murray said his father took a lot of pride in training Murray's sister to enhance her sporting abilities on the track that ran up a hill near where they lived:

> *...my sister being my sister, some days she didn't want to run all that hard, but when someone's shooting at you, just pinging shots behind you, she had that incentive, yeah. But also, he'd hold a gun to my mother's head, and he'd say I'm going to shoot the two kids, but I'm only going to cripple you, and then I'll kill meself he said, so you'll have to live with it. Gospel truth. So when she finally left him I was 16, and I was sitting in my friend's house, basically across the road, sitting there watching TV and he walked in and I said oh g'day dad, and he walked over – and he was a big man – and he stood there with his fist right in my face, and he said "you fuckin talk to me again and I'll punch your teeth down your fuckin' throat". Silence. That was him – and that frightened the livin' jesus out of me.*

There were threats rather than actual violence, but Murray indicated that he recognized early in his life that he needed to stay out of trouble with his father. "S*eeing what he did, seeing how he conducted himself, seeing how he – seeing how he confronted other people in the street, looking back, he'd established his reputation with me long before he stood in front of me like this* (holding up fist). Later, Murray was able to reverse the power balance of his early relationship with his father by humiliating him. They met at a motor vehicle accident when Murray was a sergeant and his father a fireman attending the incident.

> *...and he walked up to me and he stood here (holds hand in front of face), and he said "what's your fuckin' number." And I said I beg your pardon, and he said I asked you a fuckin' question what's your number – and I said XXXXX. And he said what was that again. And I said one – that's that line that goes straight up and down – it's vertical, the seven is another one but it's got a little bit coming out of the side, and an o's a circle, I can help you write the four and then another round thing. And I said the days of you intimidating me are long gone. I said best you take a step backwards. And he did. He turned around and walked off.*

Murray indicated that his mother was probably instrumental in shaping his early attitude to adversity.

> *My sister and I call my mother slash and burn. And she can be a hard bitch, you know – arrr - cut cut cut – but – ah – I remember her saying to me once, "listen, it's a test of character, how you handle adversity". She said "have your sook, have your cry, get over it and move on. Don't dwell, don't wallow in your own self-pity".*

Her tough love also appeared to be the deciding factor in his joining the police.

> *I was looking for a job to be an accountant. I was sitting around home and my mother said to me "don't you think you're going to be sitting around here, go down to the Essendon*

bloody police station and you can see if you can get into the bloody police force, so that you're doing a damn job".

He later learned his mother had lubricated his acceptance by sending a dozen bottles of beer down to the station.

When I asked Murray if he thought his early exposure to violence from his father might have left him more vulnerable to trauma later his answer reflected the influence of police culture at the time – you might *"tactically withdraw"* – but you never took a step backwards.

Maybe it could have been there, but remember I then joined an organization where you didn't show any sign of weakness or fear – you never took a step backwards, even if you were - now they're different, they're more appeasing, but when I worked with them not on, not on. You never took a step back. Even if you were outnumbered you –you- you – tactically withdrew, but you never took a step back. So when you ask that question, probably not, because I was in an environment that – um – I was in an environment that didn't allow you to be like that. I was in an environment and an occupation where – ah – ah – you relied a hell of a lot on trust. You know people had to trust you. He doesn't drink, you know, he doesn't smoke, what's fuckin' wrong with him? I can't trust him. He isn't out playing up on his wife, or he isn't...- It was the boy's club. You know particularly when I joined in '72 because there were no policewomen, there were only police ladies.

Early in his policing career incident Murray witnessed his partner get shot three times in front of him. Two other police who were with him shot the man who'd done the shooting. Murray left the scene to take a child off the street who was in the field of fire, but later was the arresting officer who apprehended the injured criminal. He remarked that his superior officer at the time had asked two others to take him to the pub after this incident *"...take young Murray and a couple of the others and get down to the dooder and have a couple of*

beers. XXXXX, you're - don't forget you're back on the van at seven o'clock in the morning – go on bugger off. That was it". Asked how he felt about that, Murray said "*I didn't want to be seen as being weak. It frightened me but I think maybe I was too young to really know what it was all about then. I was only 18 ½ - 19 when that happened".* He added: *"and you know the officer never said to you don't go drinking too much because I don't want you to drive. No one's taking me home, I've still got to drive home - you always drove home because you were probably too drunk to walk."*

On another occasion he and his partner were ambushed by two men who had just committed an armed robbery and pointed loaded rifles in his face. He managed to take the rifles off them without injury but was affected later about thoughts of what might have happened; however, the prevailing culture meant he again had to keep that to himself.

> *That – that just made you think, but you never – once again the environment was – you never went and discussed it anymore. You know you sit around and yak about things like that, you're either a bullshit artist, or can't you handle it – is there something wrong with you?*

In a further incident Murray was held on the ground and his gun snatched from him. He said following this he noticed that he became increasingly vigilant.

> *I had a bloke walk up behind me – they used to give us big polycarbonate batons and I just stopped it about there on his face and I said if you fuckin' walk up on me again I'll kill you. You know I was very very – super aware, overly aware of my surroundings, still am, I suppose, but I like to think that's just a habit of work. More so normally I'd be sitting where you are so that I could see who was coming in and out too – not that I'm – you know people say what are you looking at? I say I'm not looking at anything, what's wrong with you, but I'll bet if you asked me, I could tell you who walked by.*

Murray also noticed he was becoming more emotional – *"sitting there watching TV and I see a policeman get shot or hurt, I'll start crying – not flooding down but – oh – and I'm not sitting there going oh that's horrible, that's horrible, but I just feel myself being emotional".* He said he became increasingly focussed on caring for those working under him, ensuring they received support after critical incidents, but remained relatively unaware of his own state of mind. He remembered thinking "*I thought I'm over all this, I'm in charge of all this, my role is to look after you, and I had to do that on a number of occasions, you know".*
Murray said he had gone to counselling once:

> *...because there was more money in it. And I remember I sat there, and she said what happened – you wouldn't fuckin' read about it - she said, "you ignorant bastard, just look at you sitting there with your bloody arms folded, the big solid blue wall put up".*

In a general sense Murray gave the impression of being very positive about his time as a police officer and how he coped with the experiences it threw up for him.

> *I've got to be honest, apart from a couple of things jesus it was funny, it was an eye-opener, it was predominantly boring, but every now and then you saw some absolutely hilarious things. Probably things that you shouldn't laugh at – but it was a way of – it was a way of dealing with some pretty shocking things, but in the main, I thoroughly enjoyed it.*

Murray said his only regret was that his career had suffered because of the bashing he'd experienced and the resultant the physical injury he'd been left with. He said he thought the PTSD was "*already there*" – a result of the earlier life-threatening incidents he'd experienced, but that he had not known this until he saw psychologists after his retirement.

During his policing career Murray became increasingly aware of the damaging effects of police culture and looked for a way to make change. This came in the form of a new role as an educator in ethical behaviour for police officers. Murray described it as a tough job but believed he did it well.

You walk into a room of – you're invited – and they pick their chairs up and sit with their backs to you. And I'd say "come on boys we're not at school anymore. Turn around or I won't allow you out for lunch." And they brought a guy in who was doing his doctorate I remember, and he said, "the reason why you've been so unbelievably successful is because you have credibility, because everyone knows you've been in more shit than half of them have anyway".

For the four years he was a Senior Sergeant, when attending police functions Murray said he insisted that no-one drove afterwards. When he had worked investigating road fatalities, he said he saw a lot of police, and heavy alcohol consumption by police was rife in those days.

And you go I know him, and he's sitting there dead in the car. Or you're picking them up off the side of the road, or you're just – I don't know him, but I recognize the bloody uniform, and they're shit faced drunk. And they're dead. So – you dealt with that too, and it was just fatality after fatality after fatality.

He said now it was very different. With the change in community attitudes had come a change in police attitudes to drink driving, and the blood alcohol level of all police involved in accidents was recorded. Murray said that previous Chief Commissioner had said that anyone driving a police car with any level of alcohol would be sacked. Murray said he had welcomed the change in culture, and actively intervened to set up treatment for police known to drink heavily – in particular those who would still be over the blood alcohol level when they went on duty after drinking heavily the night before. He ensured they would not have access to a firearm or get into a police car.

Police culture also did not allow people to complain about their workload. Murray said he experienced stress as a result of work demands but felt unable to change this because

of potential damage to his career. During one period of time he said he was working ten hours a day and having to manage two jobs in separate locations.

So – very very long days, weekends, and as the police medical officer said to me [at the time of his discharge], no-one ever says to you how did you manage to get all that work done? Because the minute I had ever gone to any of my superiors and said my work-load is crippling me I can't do it, they would immediately have said – just not fit for promotion - can't handle the pressure, can't handle the workload, can't handle the stress, totally unreliable..."

After his retirement Murray said he initially found making the separation from police work difficult.

But even though when you ultimately relax, or feel yourself starting to relax, it's still ticking – you know, you stop reading things about – involving the police because you're creating new interests for yourself, you're making that separation. But it takes a minimum of six months, after thirty five years.

He emphatically resisted invitations to join groups of ex-police, saying he'd rather move on:

...not go and sit around with a lot of blokes who talk about things that happened twelve to twenty to thirty years ago. And I think that until you make that separation you can never move on, you get very stagnant, you get very bitter, um – you know I think these are people who are dwelling on things they can have no influence on whatsoever.

A further obstacle Murray said he had to negotiate was the sudden and unexpected end of his marriage shortly after his retirement. When asked if his injury had any influence on this, he answered emphatically in the affirmative but said his change in attitude had also been a factor.

I'll guarantee you it did, because she told me it did. There was other reasons, but she said I'm not fuckin' laying with you every bloody night with that damn thing [the CPAP

machine] going – I didn't plan it, you know. That was a bit of a cold knife that, but it played a role. It wasn't the straw that broke the camel's back, but it was definitely one of them. And, as she said, look at you, the man I met when you were in the police force. And this is how she did it [snaps fingers] you were in control, you took command, you were decisive, people looked up to you, you had a fantastic reputation – look at you now. And I've gone – not realizing the seriousness of it – hey, not bad eh, kicking back, retired, relaxing. She said, "it's gone past you".

Murray indicated he had experienced regrets, but again recognized the inevitability of the situation and made the decision to move on.

I didn't ask for this, you know, I didn't have control. I wish I hadn't have gone into that pub [where he was bashed, resulting in his permanent injury] – but I did, and it was part of my job. There's those sorts of things, people don't see that, and nor do I go around telling them because I sort of think – it's over. And you know, like I said before, I'm one of these move-on guys. I say now and it was very very hard for me, going through that, it was very traumatic. And it was one of those – what do they call them – epiphanies - when you wake up at two o'clock one morning and you go – no. Enough of the bullshit. I'm moving forward. I'm turning here. And I look now and I think – I wouldn't have done a tenth of the things I've done since, travel wise, everything.

After Murray left, the police force implemented an award – the Police Star - for members seriously injured on duty. Murray applied for it, and after a two year struggle, and support from the Police Association, it was awarded to him. The presentation was at a graduation ceremony at the Police Academy. Murray attended with his mother and son. Even at that point however, he said he felt he had to fight for recognition of his injuries.

But what added a little bit of insult to injury, a very proud day for me, that guy who's chair of the honours and awards committee, he says to me after – he congratulated me,

and he said well at least Murray you can say after all these years you've forgotten about it can't you. And I thought – you don't know anything. And I said actually I can't. I have to wear a mask every night for the rest of my life – and he went – he did he went – oh fuck I never knew that.

Summary

Murray was exposed to a number of potentially traumatic incidents, and also to work related stress, as part of his role as high ranking police officer. He experienced trauma-related symptoms throughout much of his policing career. He did not, however experience any deterioration in his mental state from events other than his trauma exposure, indicating that the coping mechanisms he employed had worked for him. It is possible, however, that the cumulative stress he experienced contributed towards the heart attack he suffered towards the end of his policing career, though he failed to receive any official recognition of this (see Tuckey et al., 2010 for a study investigating cardiac outcomes and stress in police). Prior to receiving a formal diagnosis of PTSD, which did not happen until after his retirement and following his heart attack, he had noticed changes in himself. He became more vigilant and defensive. He became more emotional in response to certain triggers; becoming tearful when exposed to information about police shootings, for example. He was not able to say when the process had begun, and he attributed his increased vigilance to a *"habit of work*". His coping mechanisms at that time included black humour – *"sometimes I laughed at things I shouldn't have laughed at"*, and denial and displacement; believing that he was coping adequately himself, probably in part due to lack of information about the significance of his symptoms, but also in being active in putting in measures to protect fellow police officers from the effects of trauma and misuse of alcohol. There was no indication that he had used avoidance of certain situations as a defensive measure, nor did he employ excessive drinking to deal with stress.

Murray had high standards and took pride in meeting them. He indicated that from early in his career he had recognized clearly the detrimental effects of aspects of police culture, both on himself and on others, and when his rank enabled him to make changes he did so. He took on whatever work his superior officers required of him – partly as he said, that to say he couldn't cope would have meant the end of any further promotions, but partly also I suspect because he enjoyed the challenge, and perhaps also because he felt he needed to live up to the trust invested in him by others. He acknowledged that he had been ambitious and had enjoyed the role of a high-ranking police officer. He took responsibility for his own decisions, did what he could to care for others, and expected the same high standards from them.

Murray's mother's views were probably instrumental in shaping his attitude to adversity. That how you handle it is a test of character. *"Have your cry, but then get over it and move on. Don't dwell on it, don't wallow in self-pity."* His narrative indicated that he never succumbed to bitterness or self-recrimination but maintained his ground and quietly fought back with his *"witty sarcasm"* and focused on the positive eventual outcomes of initially challenging events. Despite his diagnosis of PTSD and his physical injuries, at the time he was interviewed Murray looked back on his policing career with satisfaction and without regrets and had built a rewarding life for himself post retirement. He had a part time paid job and worked in a voluntary capacity for an agency supporting former police with trauma-related difficulties.

Throughout the challenges that life threw his way, I believe Murray never lost his self-respect. He maintained a realistic view of his entitlements, and if necessary, fought for the respect he believed he deserved from others. He was able to turn the tables on a father who had frightened and humiliated him as a teenager. He took pride in doing his job well and looking after the needs of others. He fought for the police medal he was entitled to and did

not hesitate to correct the impression that he "*must have forgotten about it long ago".* In his battle with Compensation and suggestion that they get an opinion from Bunnings he fought back with ridicule, similarly he jokingly offered to kick his friend unconscious to enable him to be eligible for retirement because of injury.

In conclusion, Murray's narrative suggests he could cope with posttraumatic stress symptoms in a positive way by dealing with potentially shame-inducing situations with appropriate assertiveness in whatever way was available to him, by taking responsibility for himself rather than attributing his difficulties to circumstances outside his control, and by recognizing when it was time to accept the inevitable and move on.

Don

Don gave little information about his early life except to say *"I was my own person from the time I was very young. I was very independent."* He said he joined the police force at the age of 22 in 1969 after a short period serving in the military and retired in 1997 with the rank of chief inspector on the advice of his treating psychiatrist. In his response to the request for participants for the study he described himself as having done extensive work around the support and management of colleagues who had trauma-related difficulties and said that while he had been diagnosed with posttraumatic stress disorder (PTSD) himself, he had put considerable effort into getting his symptoms under control.

The circumstances of Don's departure from the police force were unclear in his narrative but at the time he retired he was experiencing severe symptoms associated with his trauma-related psychological injuries and required ongoing psychotropic medication. Some years after his retirement he said he participated in a three month group-based treatment course for PTSD that he described has having been extremely helpful in assisting him to understand his symptoms and in giving him the opportunity to interact with others who had undergone similar traumas. While he believed he had benefitted greatly from the treatment program, Don said he still had difficulties with anger-control, panic attacks preceded by a period of disorientation, "*I feel like I'm in someone else's body*", palpitations and stomach pains, and emotional distress at reminders of past incidents he had witnessed. He said that while he placed restrictions on his alcohol use, he might drink up to two-thirds of a bottle of wine a day. He said he was taking antidepressant medication and using Xanax, a powerful benzodiazepine, when necessary to cope with his panic attacks. He said he had recently stopped smoking after 55 years of being a heavy smoker, and this had resulted in him having more difficulty managing his anger. He said he used exercise – going to the gym and playing golf – to feel better; "*gets the endorphins going, you feel good about yourself*".

Early in his policing career in 1974 and 1975, Don served for two years as a UN peacekeeper in Cyprus. Part of the stress associated with this mission he described as a feeling of helplessness resulting from being unable to do what he had been trained to do – protect others. As an unarmed peace-keeper, he had been prevented from doing this.

I was there when Turkey invaded, and then, you know, there was mass graves, and genocide, and you know, just horrible. It's well documented what the Australian police went through, because we lost two guys, and there was only 22 of us. And I think all those that are alive are on gold cards. [We were] unarmed. Observers. And we were standing back watching some of the most horrific things you could think of, and we couldn't do anything. Do you reckon that's not stressful? So we took a lot of notes, and we got a lot of people hung later, for war crimes. Military or police, doesn't matter, you know yourself, there's fight, freeze and flight. We only understand one. We have no connection – whatsoever – with freeze and flight. You just dissociate yourself, do what you have to do and get on with it. If you've got a job to do – but, like when you're in the federal police, in Cyprus, you didn't have a job to do...

Don said his anxiety symptoms had begun a month after he was involved in the bombing of the Russell Street Police Headquarters in 1986.

So, I still don't understand freeze or flight. With the Russell Street bombing it's amazing – you know I was actually on the road 12 metres from the car, when it went up. Directly opposite. And I was blown back that 12 metres into the bluestone wall and about a metre off the ground. And it went off at 1 o'clock and I've got a note in my notebook that 1.01, bomb blast at Russell Street. I wasn't shaking. I wasn't even shaking. I just went into work mode. I was two hours at the scene with half my clothes missing and burns and scalds and broken bones and whatever and it took another policeman to say hey Don what are you doing here – just – you could actually hear me on the radio, because there was

more explosions happening and because I'd been in Cyprus I knew it was an incendiary device, and the other explosions I knew were the tyres from the car. I was the closest person to it – how I wasn't killed was just - they're still pulling bits of glass out of me occasionally, and – I went home. Oh - she'll be right. One of the assistant commissioners threw me in the back of an ambulance, they were taking glass out of my eyes, and patched me up – cracked my arm, and bit of blood and burns and whatever. Went back, got my car, drove home, had a couple of beers, yes she's great, no worries. Couldn't hear for a week, went to work the next day and walked through the scene with the investigators. And I went home crook in the afternoon because my head – just felt like it was a watermelon, going to burst. And almost exactly a month later I had a panic attack. An absolute doozie. And I'd never had one before.

Don said by 2000 he was experiencing a range of post-trauma symptoms, including *"flashback"* type nightmares, events that triggered traumatic memories, (in particular, smells reminding him of burnt bodies), and patterns of avoidance. Despite these symptoms and increasing levels of anxiety, he described continuing with an outwardly successful police career.

I was very upwardly mobile, achieving a senior rank and receiving some serious accolades on the way through, but often travelling to and from work blowing into a brown paper bag because I was hyperventilating and having panic attacks. Get to the job, cool, calm, collected and "in charge". Giving presentations, I'd have a pulse rate of over 200. I could mask my symptoms, and no one knew.

Don described losing much of the memory of some horrific incidents he had attended.

We {he and a police colleague} had the first fatal accident on the XXXXX Freeway and it was two cars both on the same side of the freeway, one had come on the ramp on the wrong side. And both doing a hundred kilometres an hour and both in the same lane –

didn't even touch the brakes. There was bodies everywhere. All I remember is that we went to this accident. And I know there was lots of dead bodies. And he said – and he described it all to me [later] and it was horrible, horrible. Babies, and kids, and matching heads to bodies and whatever. But I've completely suppressed some of that stuff.

Don described his ability to dissociate from many experiences – often with the use of black humour - but not those involving children.

I think it was 128 bodies I've seen. Homicide or suicides or whatever. 128. I used to go to those homicides in a number of different roles, but it didn't matter, you'd walk through, the black humour would come in there or whatever, you'd walk through, and you were totally dissociated with it. The only ones that got me was burnt bodies. Mother, father, 5 year old boy and a 2 year old girl – house on fire. Mum and dad get out, the house is an inferno, dad tries to get back in, got 2 metres inside the door and asphyxiated – wasn't burnt to death, he was dead before he could get burnt. Anyway, firies got there, put the fire out, OK boys we've got to go in and see because we know there's people in there. We go in there, here's this 5 year old boy lying on top of his 2 year old sister, to protect her. Now how do you go home from that and just go to sleep when you've got kids that age? And a burnt body, that is the one that just gets me, every time. I couldn't dissociate myself from that one, I just broke down completely – not then, I had [a job] to do – [but later].

Don spoke also of the added stress of not knowing what might be coming next, and the lack of support he experienced at home. He said he considered lack of support to be a critical factor in the progression of his trauma-related symptoms.

Now one of the things as well is the aggregation –sometimes you just sit round – if you're in a divvy van or whatever, and you've got nothing to do for an hour, and that's the worst time. That is the worst time, because you don't know what's coming next. And then you might go to ten jobs in a row, fatal accident, picking a head up, matching it to bodies

like I had to do, in paper bags. And then you go home and be normal. Forget it. It's impossible. I couldn't go home to my ex-wife – we were married for 41 years – and that is part of the problem my ex-wife – we were good friends – would never, ever, be interested in what happened to me during the day. She never once said how was your day. So I had to go home, put the mask on and be a totally different person. That is just – unhelpful.

They used to leave the police club open till the last person left. And it was the best debriefing you could do. You'd go there - you wouldn't write yourself off drunk – and in fact if you'd had a few too many you'd get the afternoon shift or the night shift crew and they'd drive you home. And it was a way of coping. What's the alternative?

As a former peacekeeper, since his retirement Don said he had been receiving a Department of Veterans' Affairs (DVA pension) and had a gold card, enabling him to have free medical treatment. However, he believed that the assessment processes entailed in his compensation claim had contributed to a decline in his mental state.

I remember sitting in front of a panel one time with my PTSD, and there was a doctor, a psychologist, and a psychiatrist. And they started questioning – oh - what date did this happen? And we're talking about 1974 – can you remember the dates? And I said is this a memory test? It was just a Spanish Inquisition. And this is what people are subjected to. And you walk out of one of those things and you're feeling ten times worse than when you walked in.

Don said he had not had difficulty leaving the police force – but suggested that many did.

You've gone from sergeant to mister. Your standing in the community goes zoomp [downwards gesture]. In your own mind. You know from the day I left the police force it's never worried me. I couldn't care less. Because I'm busy.

In 2011 Don was awarded the Police Star in recognition of his work as a peacekeeper in Cyprus, and for the injuries he sustained in the bombing of Russell Street Police

Headquarters. At the time he was interviewed he said he was fully occupied working as a peer support person with veterans through DVA and involved in the setup of a company dealing with anonymous reports from whistleblowers. He described his current relationship as giving him all the support he needed. *"The best doctor in the house is the person you love. Or who loves you."*

Summary

Don had significant exposure to trauma early in his policing career in his peacekeeping mission in Cyprus, when he described being compelled to stand by and watch acts of displacement of civilians, brutality and genocide and be unable to intervene. He said he tried to dissociate himself but was unable to do so because he "*didn't have a job to do".* The experience was rendered even more difficult by his training – as he said, of the freeze, flight and fight responses he only understood fight – and this he was unable to do. There were also dangers associated with the deployment, as he was essentially unarmed in a war zone. There were indications during various parts of the interview that he had formed close and supportive relationships within the small group of Australian police deployed, and this probably served as some protection.

Don reported his symptoms of anxiety and panic attacks as beginning a month after his second major trauma exposure in the bombing of the Russell Street Police headquarters. This time, he did have a job to do, and went, as he said, *"straight into work mode". A*lthough he had sustained significant injuries in the blast, he directed other police on the radio and gave out information based on his experience in Cyprus. He was given some basic first aid, went home, and walked through an investigation of the scene the next day, before succumbing to the physical effects of the incident. The psychological effects were delayed but significant when they eventuated.

Don concealed his anxiety and panic attacks and progressed through the ranks in his police career. The traumatic exposures continued. He said he had attended *"about 128 violent deaths",* and for two years he said he was in charge of the audio visual recording of all major incidents, insisting, as the senior officer, on always being present although he said this was not necessary. He said he had been particularly affected by the death of two young children in a fire, when his own children were a similar age, and he had not been able to dissociate from his emotional reaction to this. In another incident he attended, involving multiple deaths in a motor vehicle accident, he said he retained almost no memory of the incident.

Don said the stress of not knowing what would come next had also affected him. Further stress came from his inability to talk about his work experiences at home, so there was little support available for him there. His *"debriefing"* came from drinking with other police, and he said he used alcohol *"as a crutch"* and his intake increased.

Don's primary coping mechanisms appeared to be those of peri-traumatic dissociation and denial, and the use of alcohol to escape his symptoms he suffered at a later point. In keeping with his statement that he *"only understood fight",* he did not retreat from exposure to difficult and testing situations, but rather seemed to throw himself into them in a way that could perhaps be seen as counter-phobic, or in psychoanalytic terminology, as constituting a *"reaction formation"*. This is best described as a psychological defence mechanism in which the person uses conscious behaviours that are the opposite to their underlying impulses. This behaviour is adopted because they consider their anxiety or fear to be socially unacceptable or inconsistent with their self-image or ego-ideal.

Don described a steady increase in his symptoms during his time in policing, most of which he said he still experienced at the time he was interviewed, although he believed he had learned to better manage them. Despite his symptoms he indicated that he felt satisfied with his quality of life. In his retirement he described being fully occupied in his role as peer

support person in DVA and said he gained great satisfaction from this. He also described being happy and settled in a supportive relationship.

Group 3

Victor

Victor served 38 years in the Police Force and retired in 2016 with the rank of detective senior sergeant. He said that his career as a police officer ended after he was accused by Internal Investigations *("the toe-cutters")* of criminality, of bringing discredit to the police and of being subsequently relieved of all duties for refusing to relocate to the Academy. He said had been on stress leave for two years since he left work at that time and had been discharged on a full pension about two weeks before we spoke.

Victor's narrative suggested him to be an individual with strongly held ethical beliefs, who had believed in the job he had done as a police officer and had been shattered at the sense of injustice he had experienced in the way in which his integrity had been challenged. Post discharge, his faith in the policing system shaken, he then began to question how he had acted his role as a police officer and reflect on how it had conflicted with his fundamental personal values, further affecting his mental state. He made a point of telling me I was seeing him on a good day.

> *And guess what, today I'm having a good day. Bad days, bad days, and most people don't see me on my bad days. My wife sees me on my bad days. She sees when I drink myself into a stupor in the shed, or hide in there for 3 days, or yell at my children or ostracize my friends Ah – it's normally to do with -- ah – some sort of a confrontation in relation to anything. And it can be minor. That's my biggest trigger. Any sort of a confrontation. And then I go on a number of steps. And it's like I'm on a fucking runaway train. I know what's happening, I try to stop it, and normally what I have to do – and my wife and I agree – I isolate myself. Because I like the Hippocratic Oath – and I always tell everybody, do no harm. It's better to sit there and do nothing than do harm. 'Cos the people that we harm the most are our families. We yell at them, we get divorced, and you*

know if you're really bad you go out, you punch someone, you get drunk, you start a fight, you do that. 'Cos anger is the best fuel to not feel bad about yourself. It makes you feel as if you have some control. That's how I do it [and that's how] I've dealt with it all of my life. One of the things that has happened with me as well is that I have not necessarily been openly angry. I haven't yelled, I haven't screamed, but I've plotted revenge, and it's soiled my heart. And it's darkened my soul.

Victor said he believed that the anger he experienced was a defence mechanism against feelings of powerlessness and damaged self-esteem and he acknowledged experiencing shame at the ways in which his anger had impacted on others in the past. He said he had avoided reflecting on these things at the time and in his retirement, they had come back to haunt him.

See I don't believe anger is a primary emotion. I think it's secondary because it hides your true emotion. I look at myself. Because I've had – obviously I'm a cop – so I've always had problems with anger, right. And I've thought about it a lot. I tell my daughters [to think] -- why are you angry? Are you angry probably because you're hurt, you're disappointed, you're upset, you feel betrayed. Those reasons. And as a result, your defence mechanism is to get angry.

I think about my life a lot, and I spent 38 years in the police not living my values. My parents were generous, they were honest, whereas during the police I was harsh, I was less than compassionate, I turned against my values because the job had to be done. And that's what they got us to do, right. Because what you do – the crooks called you a fucking prick or a cunt or something so you have punched them, you may have put the handcuffs on too tight, you may have treated them poorly, you may have abused their wife, you may have – you know – searched their house less than carefully. Right? And you may have done things in their house like accidentally smashed the picture of their wife and family

because you know that will annoy them more than anything else. Right, and you go away, and you think you've got some vengeance and some sort of justice, but later on, that will come back and haunt you. And what you will do is you will not think about it. You will put up a wall. Do not think about those things. But they'll get you later. So, don't treat people like that. Because it comes back to fucking haunt you. What you do, and what lots of cops do, and why they change who they are is they don't ever think about it and they continue to justify their actions. For ever. I know. Because it's me.

I have a lot of regrets about a lot of things – like I should have been less insubordinate because then I would have got promoted to a higher place and I could have done more good. That's what I think. I could have changed some of the culture in policing, but all I did was affect a small number of individuals who worked with me. I should have suffered the fools a little bit more lightly because I – if people didn't fit in my team or the way I – I culled them from the team instantaneously. And ruthlessly. Perhaps I should have spent more time with the children and I [should have used] those methodologies at home.

Victor said he believed his policing career had been largely successful despite charges that had been levelled against him earlier in his career and the way in which he had been deliberately alienated, resulting in his final departure from policing. He acknowledged he had challenged authority but had never deserved the accusations of unethical behaviour.

I've been off on stress you know for the last two years, but I won't define my thirty-eight and a half year career – or as I tell people I was in the police for 14,004 days, right? I will not define that by six hundred days. Yet we all get defined by our last act. Well, I have been a bit of a scallywag. I've been in more shit than the early settlers. Never once over stealing anything, never once over corruption, or anything like that, you know. And one of the speeches we had at my retirement barbecue the other day, people said Victor is of the highest integrity, uncompromising integrity. And I sort of thought back and I

thought - oh I never thought I was that good. But I was insubordinate and disobedient in the police because I thought I was working for idiots.

I was a Drug Squad, Organized Crime, Italian Organized Crime, Undercover, I didn't wear a lot of suits in my career. I wore a lot of jeans and had ponytails and all of that. And then, I used to always assist on the detective training courses in relation to the drug things. And I wrote big scenarios, and I really enjoyed it. And I used to give a lot of lectures because I really enjoyed it. And [then] the senior sergeants' position came up as the head of detective training, so I applied for it, because I thought that would be funny, and I won!

Victor said he had been innovative in his approach to detective training, and he had put together a program together with a police psychologist that rated trainee detectives on employability skills, attracting attention from a variety of quarters, and eventually received positive recognition.

My god. I was interviewed by anti-corruption branch, by the ombudsman, by the university investigators – everyone was interviewing me. And in the end, it came back to saying we never ever have seen such a marking methodology that gets rid of prejudice - because there was lot of prejudice, a lot of nepotism, and cronyism, in detective training. You know, if we liked you, you passed, well not when I was there.

Victor had two major setbacks during his policing career. The first occurred when he left detective training to work on a project and was tipped off that his carefully crafted assessments were being ignored.

They're just writing their marks down so that they don't have to run the assessments. When I wasn't there. They were corrupt, they were lying, they were fabricating results. And I - put them in. and it was the biggest turnaround I've ever seen in my fucking life. They immediately attacked me. They said how did you know this? And I said well I went in

and checked the computer records, because I still had access to them, they then got me in and interviewed me and it got to the point where they ordered me on several occasions to tell them who my whistleblower was. And I refused. they raided my office three or four times, took my computers, everything And so they put all these directional orders in that I wasn't to go here, I wasn't allowed to talk to these people. And it just overwhelmed me. . . And there were interviews that went for a couple of hours when I said you people are incompetent. I'm a whistleblower, I've actually invoked my protection under the Whistleblowers Act, you're fucking breaking the law by doing these things. You can't do these things! And they just fucking did it anyway. And they actually were interviewing me criminally for unlawfully accessing the records. And then – they charged me with – all of these breaches of regulations – over what I did. All category A, all sackable offences. And it was malicious charging. Like the biggest one they charged me with was brought discredit on the police – that's like – you know – and I went to the magistrate's thing, and they went to the Tribunal, and the magistrate said – are you serious? In the end they charged me with one breach of regulations, which was – when they came down and seized my computers and all that sort of stuff, I had a usb plugged in the side which was my private usb. Not allowed to do that. They charged me with that. And I pleaded guilty, because that was true, I said this is fucked (laughs). It was the biggest most horrible turnaround that ever happened in my career. And I was devastated. And I fell over. I couldn't go to work. I just woke up one morning and I said I couldn't face it again. And then I was off work for five months I [went] off on stress, where I sat home, I didn't do anything, I was a hermit, I was embarrassed, ashamed, felt silly.

I went off on stress and then I came back. I went back to work. And I then worked for a couple of great bosses who are – were my friends, protected me. And the funny part is when I came back, they put me as the outlaw motorcycle gang coordinator. And I had a

wonderful job down there and I did it and I worked – it was great. And it was a great job for a year. It was great and I loved it. And it was about to become a permanent position, which – probably, if it had become a permanent position in the police, I probably – may very well still be working. Then that position was just sent up to Intel, the whole thing died, after that they transferred me back to the position which had previously caused me stress with exactly the same people I was working with – and then they were going to send me down to the Academy.

Victor had returned to work, but his second – and final -- setback occurred when he was told he would be transferred back to his original detective training position and that it would be taught out of the Academy, a move he said would destroy its effectiveness. He appealed against this twice, and eventually he was given a workstation on his own in a very small office. His superintendent told him he didn't know what work to give him:

...because technically you're supposed to be down at the Academy – but you are not speaking to these people – is that right? I said I can't. They won't speak to me, I won't speak to them. Sat there for five days. No work. No phone calls. No contact. And I came home - and I went round to my GP, and she said you're not going to go to work. And then I – um – you know -went and got a – had a really bad bad bad– probably nine months, and you know, I isolated myself, I - you know – I didn't do anything, I didn't go out.

Victor believed he had seen major and influential changes in police culture during the period he had been serving – that there had earlier been mutual understanding and support between police officers that was no longer there. He said that while the changes had been intended to eliminate corruption –they had also resulted in culture change that meant police no longer supported each other.

Oh yeah, it's a whole new culture. The traditional culture that – if you'd been with me in the 1980's, you could not break us. They've torn away the "we circle the wagons", the

thin blue line, they've taken what was always perceived as the bad bit because it leads to corruption, and the thin blue line hiding bad practices and all of that. In actual fact it did, but also, we supported each other. We looked after each other. And there was a saying that went right back to the 70's, even through to the 80's and even up to the 90's, which strangely enough is not part of the culture now. You do a job, and something would happen, you'd be sitting round, and someone would say this is terrible, and someone else would say ah – the job's fucked. And that was the acceptance. The job's fucked. And we knew it was fucked – so – and that was a saying. It's not now in the police force. They don't say it anymore. I don't know why.

But also, some of the reason we exist are disappearing. We're supposed to serve the community. The police are no longer a service organization. Why do we have the police? Because a long time ago we had armies. A long time ago we took all the swords off the civilians, and we said we'll look after you. Now we're using the swords against them. And we're not protecting them. And we're not looking after them, you know.

One of the things is we've got a job to do – we have a duty – which is another thing – we're sworn, you know. They want to make us a profession, like nurses, and doctors, and - we're not. Because we're unique. We swear our duty. We serve the people. We're not employed. When I resign I'm no longer a police officer. I can't take my coppology degree and go and get a job in the Philippines. [They] tried to make the police like a big corporation, and called it a service, not a force, and wanted us to do all these things in line with corporate goals and corporate governance, and all of that. [But] we're a para-military organization, we have to be – and people say why – because we carry guns! (laughs) How about that for a big giveaway!

Victor suggested that the selection process for new recruits had changed too as a result of the professionalization push, and that this had affected the type of person who volunteered and had also created a culture of fear.

Why is it they changed the psychological profiles of the police some years ago to make it a softer person. and now as a result a lot of people are not surviving because they say that – I didn't know I'd see dead babies and dead bodies – I did but – you know... Because you were inappropriately selected in the first place. Why was it that half my course were from the country? Now hardly any country people join the police.

It's moving in a bad direction. Because what they've done is that they're ticking all the corporate boxes to pass audits. Anyone can do that. But they're not changing the culture, as a matter of fact they're creating [a culture of fear]. Coppers are constantly afraid when they're going to get in the shit, when something bad's going to happen, when the toe-cutters are going to come around, when they're going to get audited. They live in a constant state of stress unrelated to them dealing with the crooks. And that's not a culture. That makes them all robots. A culture is like – shared beliefs – we [used to] believe in honesty, we believed in integrity, we believed in looking after our mates, we believed in protecting our mates, we believed in preventing our mates from making bad decisions. We'd stop people from doing things in the past, they don't now – they let them, and they dob them in. Because that's a really good thing to put on your job application for a promotion. Right? Because in the end all they care about is power. And I – and that permeates through all of the police. To the point that our young police officers now are so aggressive on the road. They're pinching people left right and centre for fucking piss-weak traffic offences. I'm absolutely, still gobsmacked that there is so much inappropriate behaviour in the police, both [that] and sexually, in respect to women– it's a terrible thing, I'm in the police for 38 and a half years, and I can probably remember one occasion

where someone may have spoken to a woman inappropriately, and he got ripped into gear by the rest of the guys. I can't believe those people, the things they do, the way they speak to people. It's so unnecessary. It's because they're totally disempowered. So, they wield the power the way it's been wielded to them. And the sergeants wield the power the way the inspectors have wielded it to them.

Victor said he believed that the function of alcohol in the process of recovering from a critical incident and stigma in relation to mental health issues were casualties of culture change. While he acknowledged the adverse effect this had had on families, he also emphasized the benefits of alcohol in increasing cohesiveness among police and the mutual support that came out of this.

Because you'd knock off after duty and you'd go to the pub. We no longer do that although traditionally police are really heavy drinkers. I think most of us my age and around survived because we went to the pub and got pissed. And I'm an advocate of self-medication with alcohol. The problem is that we didn't care about getting home – because back in the early 80's because there wasn't drink driving, because we were the police, we did what we wanted to, right? We would go to the pub after work. Every single night. Every single shift. And we would go home. That's why we're probably all divorced, and – multiple times.

It's not because we died inside by hardening up. Because you were still there with your mates at work, you were still supported, things still went pretty well. You went back to work after a critical incident and things were bad, everyone was feeling the same way, you all hardened up together and you all did it together. If someone fell over it was – oh so and so's cracked a wobbly, is what we used to say. And when they eventually came back to work, you'd say are you alright mate – yeah, I'm alright – OK no problems. But now you do this (mimes hiding). You can't look – it's you can't look at your mates for stressing out.

There's a massive stigma attached to it. Right – ah – immediately trust issues come in – whether you can still trust that person anymore, right, nobody talks to them about it, right, and they are inadvertently ostracized by ignoring that it occurred.

Victor said he believed that mental health issues were often disguised as bad behaviour and punished.

People often when they get in trouble, with the internal investigations branch, go off on stress. Often. But the reason they got into trouble [might have been] because of stress, or PTSD. or their inability to control their anger, make good decisions. So SAPOL deals with the facts of that. They punched somebody, they made a really bad decision, right, and that's dealt with, and full policy, process procedure is followed. And they're often sacked, or they get into an awful lot of trouble, or they get transferred – a whole bunch of things. And as a result of that, that causes stress, anxiety, angst, as well – but was it the chicken or the egg? Did they get stressed because they made this decision, or they got into trouble, or they punched this person, or they stole this whatever -- or did that happen because they were stressed?

Victor emphasized the deleterious mental health effects of policing and advocated strongly that instruction aimed at the prevention of mental health injury should occur alongside incident management and operational safety training.

I say every cop is suffering from a degree of stress and PTSD – every single one. And that's evident because some of my mates who are not [diagnosed] – have symptoms of it, you know. But I can't see [some people] getting better. Um – they're too damaged, they're too hurt, they're too afraid, they're too introverted, they've lost their skill, their confidence, their ability to think. They're really, really damaged. I think psychiatrists are very important because sometimes people need a tranquillizer dart in their ass before they cause dramas. They wreck their lives, they commit crimes, they need to have that edge

sliced off as soon as possible But – I think you can't get better with medication. I think psychotherapy, or whatever you call it, going to a psychologist, is the way. And you have to have trained psychologists who know what will work for people. And you have to trust them – bear in mind most cops don't trust anyone. And also, you have to have psychologists who are not addicted to a certain type of therapy.

Victor suggested that senior officers could play a part in giving support following a critical incident.

They [the police force] have forgotten that their greatest asset is their people. Even though they say it all the time. And the one thing that can only change for the better is to prevent these people from being injured in the first place. And it's just a simple, simple process that your supervisors grab everyone before they go home (after a critical incident) and says to them look today was a fucking hard day, bad things happened. We saw bad things. You might think about it when you go home. You might worry about it – he says – if anyone needs me to chat a little bit more afterwards no problem. But it doesn't matter, tomorrow morning we're all on duty at 10 o'clock, we're all going to have a coffee, we're going to have a bit more of a chat, how everyone's feeling because guess what I'm feeling pretty fucking shit about this myself – it's bad. But the whole idea is it's going to affect us all differently. You know if it's affecting you really badly, we'll regroup tomorrow at 10 o'clock and we'll see where we can go from that.

Victor had plans for a very different future in his retirement.

My wife and I are moving to the country. We've got a beautiful block overlooking the river. And I like it that I'm by the river. Because I have a saying – if you sit on the riverbank long enough the bodies of your enemies come floating by. Which is what I'm hoping. And while you're there you might as well fish.

Summary

While he did not say he had received any diagnosis other than stress, Victor described experiencing lengthy periods of psychological distress associated with his police service and indicated that currently his mood was labile – he still experienced *"bad, bad days"* when he might isolate himself and "d*rink himself into a stupor in the shed".* He described not being in control of his anger at those times - *"like being on a runaway train*", and that anger had always been his way of dealing with feeling bad about himself. He described it as a "*defence mechanism*" because it "*hides feelings like being disappointed, upset or betrayed*".

Victor's history suggested that for much of his policing career he had been confident of his abilities and had enjoyed his work and the opportunities it gave him to be innovative. When he was accused by the Internal Investigations Branch of criminal activity and significantly of *"bringing discredit to the police",* he experienced an acute sense of injustice because his personal integrity had always been central to his self-identity. At the same time, he experienced complete disempowerment. What he believed were his rights as a whistleblower were ignored and his actions redefined as aberrant. Shamed and defeated, Victor went through a period of withdrawal and isolation. He said he hadn't always been openly angry, but rather that he had plotted revenge – and that this had "*darkened [his] soul".*

Victor's final blow was the result of a second disempowerment – the removal of his duties as a response to his refusal to work out of the Academy. While it is not possible to know in retrospect how he felt at the time, there are indications that he was shamed by external forces, but not ashamed, as external and internal shame are defined by Gilbert (2001). In other words, he felt criticized, excluded and ostracized, but remained confident that his actions had been morally correct.

Victor's time in policing happened against a background of significant culture change described by many of the participants in this study. This change was associated with

professionalization and increased accountability in many police forces in Western societies (Green & Gates, 2014). Victor described this as a loss of the old culture of police supporting police, and the creation of a culture of fear of being *"dobbed in"* by a fellow officer or investigated by the *"toe-cutters",* resulting in a constant state of stress unrelated to any of the external dangers of policing. Arguably, Victor was able to combat his feelings of exclusion with the justification that he didn't wish to be part of the present police culture. He was rejecting it, rather than believing that it had rejected him.

When Victor ceased work, he had time to reflect on his life and he began to feel regret and shame because he began to believe he had spent much of his time as a police officer not living his values and had concealed this from himself at the time. He believed he had been harsh and less than compassionate in the way he had treated criminals who had been verbally abusive of him. He believed that his actions had been in contrast to those of his parents, whom he described as generous and honest, and said that these actions had now come back to haunt him. He also expressed regret that he might have gained more promotion had he been less insubordinate, and therefore been able to do more to change police culture. He believed he should have been *"less ruthless"* in removing from his team those people who did not fit, and more patient in the parenting of his daughters. It is likely that Victor's ongoing rumination about the way he had behaved in the past and the shame – in this case internal shame - associated with this was driving his current anger- since in his own words, he had always used anger to not feel bad about himself.

Victor suggested that changes in police recruiting practices had resulted in inappropriate selection of people who were less able to deal with difficult areas of policing. He remarked particularly on the greatly diminished number of recruits drawn from the country. He also believed that ongoing stress led to bad behaviour through inability to control anger in many police officers who were then punished for their behaviour, further increasing

their stress level and perhaps leading to PTSD. He said that he believed every police officer was suffering stress to some degree. He said he believed that the old culture of going to the pub together after a critical incident had served as a valuable support and an opportunity to debrief, and that the current culture provided fewer opportunities to prevent psychological injury from potentially traumatic incidents. He believed psychiatric treatment and medication were sometimes necessary to prevent further problems from out of control behaviour, but that effective treatment required a flexible approach by psychologists who inspired trust and were not *"addicted"* to a particular therapeutic style.

Victor's psychological trauma seemed to be wholly related to his response to the treatment he received from the police department and the powerlessness, humiliation, and sense of injustice he experienced as a consequence. He then used alcohol as a means of dealing with the external shaming he had experienced. As he reflected on his past actions as a police officer and judged them to have been morally wrong and not in accordance with his fundamental values, his feelings of shame then appeared to generalize into internal shame as well. His psychological injury meets the criteria of moral injury as described by Shay (2014) of *"...betrayal by those in a position of power"*.

Denis

Denis left school at 15 and served an apprenticeship as a pastrycook before joining the police force at 22 and serving 36 years with a final rank of senior sergeant. He left because of worsening psychological injuries that began during a posting to a remote area. When he was unable to continue working, he felt confused and did not understand his inability to perform as he had earlier in his life. He also felt angry and with it concern that he might become physically violent if provoked.

Left in April 2004, just walked out the door and never came back. I'd had a gutful. I wanted to do my forty years, that was my goal, but I could not, in all honesty, do any more, I did not want to go into another bloody police station. I said why are you doing this? You should be able to do this, you know that horrible regret, just walking out the door, leaving my career behind when I should have just bit the bullet and just go on with it, but I couldn't… I was just – you know – just felt really ill, very very ill, and I just could not… do it, you know what I mean. I was just worried what I might do to someone – I don't know - angry, certain morons and that, you just don't want to deal with them anymore, dealing with someone you might—some idiot you know, you might step over the mark or something.

Denis said his difficulties began after he was exposed to ongoing violence and lack of policing support in a remote location, after his posting there in 2002 at the age of 48. He indicated that he thought it would be difficult to identify a single incident as being the most stressful – that rather it was both the ever present dangers and constant pressure he was subjected to that wore him down.

We were just policing non-stop, you were there by yourself, you know, it was just constantly – if you're there – they say on days off you're not on call – [but] shit's happening all the time. That lawlessness, that complete violence – hard to put it into

words – when you see someone coming at you with a bloody axe or whatever and they're completely, they're just zoned out and you know you've got to deal with it, and you know you can't run, and you've just got to deal with that problem there and then.

His said working conditions had been primitive and that this had added to his stress.

There's a tin shed in each community, but they're just absolutely filthy, defies bloody imagination, you know, the dirt inside of them – who's going to work in that environment. You've got one phone in there, and one desk and a bloody rotten old chair, and that was it, because the guy who was previously in charge cut the funding to say oh this is how much I've saved you, but no one ever went out to have a look. And then they sent me out there to do training [of community constables] – and I'm going – and how can I bloody do my job, you know, where can I stay, you know, I'm swagging in these – you know – with mice running over the top of you in the middle of the night, and this sort of caper, and dealing with all the other bloody problems.

Denis said his first symptoms were physical – stress related chest pain and irritable bowel – then anxiety and an awareness that he was becoming vulnerable to emotional triggers.

I just felt really tight in the guts, feel really anxious, feel all sorts of things happening within me - shit I just need to escape, get away. You start to unravel a little bit at a time, but you don't see it, it slowly creeps up on you. When you're younger you're bulletproof, it's not a problem, you just get into it and do it, you know, you just get punched about and smacked about, bruised, broken noses and all that sort of thing. When I was younger, I was always the first one in the door, before your men, you know, that was the way things were done. Then when you get made up to sergeant you've got to lead by example, you've got to do things and I've just got to do this and yeah but – after a while, things start to unravel a bit you know, things happen, more things happen, triggers, I don't know.

Denis said police culture at the time was not conducive to acknowledging work-related stress. He and others did not feel confident to acknowledge any difficulties they were experiencing because they anticipated humiliation, being marginalized or being considered to be malingering.

> *If something happened [that was] really bad we'd have our own sort of debrief and talk about it at a team level, but the lads might relate to it badly but wouldn't say I'm not feeling the best, you know, to anyone, they'd just keep it within themselves. I wouldn't– [have] spoken to anyone about it – don't know, how I felt then, if someone had wanted to question me about it. It's not something you'd say, to knock on the boss's office and say you weren't feeling the best, this is happening in my life. He'd say get out of my bloody office, get out and do your job. God strewth – you were too scared to walk in the bloody door.*

Denis also spoke of how he felt about the importance of support being available at an early stage, and the significance of being able to request it without being shamed.

> *You're a young connie, and you get out on the road and it's great, but once you get into a life threatening situation, something happens to you, everything can just…crumble like that around you and – they talk about support, but later on down the track when that person's starting to take some sick days and things – well there's a reason, you know, there's something behind it, you know, and they need to feel comfortable with themselves to come and say jeez I don't feel bloody good about whatever, or I need to get off the bloody road. It's not supported, no, no it's not and they just feel if they go to speak to someone then they'll be marginalized, and they won't feel good about themselves, feel like they're doing something wrong um and…they should be able to feel positive about doing something like that and feel good about – you've got to feel good within yourself, not have*

that stigma - of oh yeah, he's got a mental problem there, depression, whatever, you know, he's a malingerer.

When Denis went off work on Compensation he developed depression, and with it came feelings of embarrassment, worthlessness, and a questioning of his very identity. He did not understand what was happening to him; why he could not *"operate normally*".

[I] first started having symptoms of depression at about 54-55 when I'd come back to XXXXX – never had it before in my life. Didn't want to do anything – just sitting around watching TV, trying to do things, trying to keep yourself motivated. I'd look in the mirror sometimes and sort of think it's not me, you know what I mean, it's not me, I'm just turned into something I shouldn't have turned into I'm just not – why is this happening to me you know I'm just – wasn't coping, getting very emotional about things you know - should be doing- you know - operating normally, just– out in the shed for hours and not doing anything. I just felt worthless, embarrassed - that's why I kept away from everyone. And I thought maybe I should just forget about all that that was happening to me and just go back to work and be done with it. But I couldn't, I just felt – you know, something pulling me back. I just wanted to go to work, and I can't. I was really shaking, you know - I can't do that. I want to do that, and I can't do it.

Denis said he found the process of making a Compensation claim humiliating; he was given pills rather than the information he wanted about what was wrong with him.

When they put me through the wringer – the washing machine Compensation –you've got to go and see all these people – it's bloody awful, that was a terrible time really. I felt like a criminal. Taking money under false pretences and they're saying there's nothing wrong with you - or there is something wrong. You feel embarrassed about the whole thing, having to talk about it and at the start not knowing what was really going on with it myself thinking what am I doing, what is going on, I shouldn't be like this, I should be

back at work, should be getting back into it. I never went down that road in my life before you know. You go and see these psychiatrists and whatever and talk to them. I [shouldn't have] to prove anything. I know who I am, I know what I am, what I've done in life and whatever. I don't know what is happening to me. One psychiatrist he gave me tablets and said you'll be right, and I said no, I don't want to take tablets, I want to know what's happening with me. I felt like I was falling apart, and I didn't know why.

Further humiliation came with the process of assessment, when he felt he was at his most vulnerable. He said he was given the diagnosis of posttraumatic stress disorder – then told he had to have a second assessment to prove he was not malingering. He experienced this as a direct attack on his integrity. He became angry to the point of feeling he was close to violence.

[I said] I can understand I need to go off and see someone and get treatment, you know what I mean, and he says yeah, you're suffering from posttraumatic stress disorder well – how can I get better – but then they say oh no, we don't believe that so we're going to send you off to someone who says that you haven't got it – you're saying to me, you're attacking my integrity as a police officer, as a person, you know, my integrity is always high, whereas some people I know, they can't even spell the word, so you're saying to me that you think I'm a liar – that I'm a criminal, that I'm trying to commit a fraud on you. And the compensation and this sort of stuff – the game – and you're at your most vulnerable then , and you're not thinking straight, and I...nearly got up and walked out... nearly got up and - nearly actually grabbed someone and threatened them – you know I need to get out, this is wrong, you know, sitting there and getting really really angry because, you know, they've come here with a certain agenda – saying that you are lying...

Denis also said he found he had to struggle for recognition from the police force that something had happened to him in his role as a police officer – an acknowledgement that his occupational psychological injury was what was preventing him from returning to work.

They attack your credibility, and yeah there are fraud cases, dealt with them on the job, for god's sake, but I'm not going to throw 36 years of service out of the bloody window, you know I'm – I'm who I am, and, things happened to me, and you struggle to deal with them, and then you've got to prove who you are again, so you've got some credibility, you've done it. In the end, they want to get you off the books, and they give you a reduced cut out fee and whatever, they could've offered me two dollars I'd have taken it – I'm not after your fucking money, I'm here [for you to] say something's happened to me – I want you to say yes it did happen to me – not – like I'd broke an arm, or whatever, not like I'm some I'm some crook or whatever, you know what I mean. And the fact that I can't go back to it – well, I can't go back to it.

Denis said he left policing feeling disillusioned and betrayed by the service he had given 36 years of his life to. He believed he and others with psychological injury were being treated as criminals, that once he had left the police force it was as if he did not exist anymore, and there was no recognition or appreciation of his service and the price he had paid for it.

People who are out there who are suffering, are not trying to rort the system, they're not criminals, they're not doing it for their own benefit. It's happened and you don't know what's happening, and you don't know how to deal with, and you've got to try to deal with it with and [the police department] says – you're a crook. And the people from [the department] I thought should come and speak to me, none of the commissioned officers, you know, no one of senior rank, you know what I mean, they don't want to know you anymore. You know my life [in policing] was finished when I walked out of that door, and

that was it and they said goodbye like I didn't exist anymore. And you're in that system, that washing machine system of bullshit yeah, it's so concrete, I'm a police officer. You're just screwing me over; you're not giving me any positives in life to help me where I'm going. [becoming tearful]) - 36 years and in the end, I just wiped policing from my life. It's a line drawn and I'm never going over it again.

At the time he was interviewed Denis described remaining severely affected, though he said he had gained some acceptance of the fear he'd experienced as being a normal reaction, and no longer felt ashamed of it. He continued to have periods of depression and tried to avoid exposure to anything that triggered his emotions. After a failed first marriage Denis had remarried, and said his wife was his greatest support. He also said he spoke frequently with a fellow former police officer also suffering severe trauma symptoms and found this helpful.

Shows on TV that show violence and that sort of thing - I don't watch those that deal with violence and family violence and that sort of crap – I don't need to see things like that Or if I see a violent situation that will do it. Yeah, you know if I hear a fight or when something's happened, I'm looking around, trying to work out if I'm safe, some sort of disturbance happening - I feel nauseous and upset. I don't like going into police stations.

I lost the ability to enjoy almost everything – I still do it, stay at home, not want to go out in the yard. XXXXX's good...I don't want to go anywhere, don't want to go down to the shop, she'll go to the shop, I'll stay home, I'll just go I don't want to go. I didn't want to see other people because they'd say oh why aren't you back at work, you know what I mean. I'd see people I know at the shopping centre, and I'd walk the other way. Now I force myself to see them and I go no I've got nothing to be afraid of anymore. I'm not embarrassed. I was afraid. I've just got to confront my fears about that sort of thing and say yeah, alright, things happened to me, and I've got over it, with what I did with working

up in XXXXX, feeling the way I did, that fear, I suppose that was just a normal reaction to that situation as I see it now yeah - not ashamed of that anymore. It's been really, really really really good to be able to talk to XXXX about these sorts of things, you know, that sort of – happened to me – yeah – so... Whereas before I wouldn't have spoken about it at all, full stop. I haven't spoken to - many people – still see it as something we shouldn't talk about. XXXX, you know, back in the eighties, we worked together, went through a lot together, you know, yeah, I can talk to him on all sorts of levels. I think we should talk about it, you know, so many people fall off the bloody rails, you know, what are they doing about it – need to do something about it – it's the biggest worry, if you haven't got someone to support you. No-one knows who's out there because it's a totally unknown situation - no–one wants to know about those horrible people who are out there in the darkness, you know.

Summary

Denis's narrative illustrates how a downward spiral can operate from cumulative traumatic incidents to posttraumatic stress symptoms, feelings of shame, identity confusion and co-morbid depression. He first experienced somatic symptoms, then anxiety. As he accurately put it, he started to unravel, a bit at a time, and the changes slowly crept up on him, for some time outside his awareness. He started experiencing triggers in his environment and responded with increasing anger to provocations. When he did become aware of the changes within himself this precipitated an identity crisis. He was no longer the fearless person he had been. He did not understand why he could not make himself return to work – to *"operate normally",* despite wanting to do this.

When he observed the ways in which he had changed Denis felt ashamed and his self-worth deteriorated sharply. He subsequently developed depression from which he appeared to have never completely recovered. Unable to continue working as a police officer, he then

experienced further shame and humiliation as a result of the compensation process that followed. Seeking information, he was confronted with suspicion, accusations of malingering and pills. He experienced the process of assessment as similar to being treated as a criminal and an attack on his integrity as a police officer.

Finally, Denis believed he did not receive the recognition he believed he deserved for his service, and what it had cost him in terms of his mental health. He felt thrown out, discarded, and this was a further source of shame. Aware that there were other police officers who had suffered a similar experience, he believed no-one wanted to know about them – those "*horrible people out there in the darkness".*

Denis initially developed symptoms of PTSD as a result of exposure to an accumulation of fear-inducing incidents and multiple other stressors. He then felt ashamed of his inability to function as he had in the past – not being the person he used to be and not liking who he had become. This led to him developing depression. This might not have occurred had he received the psychoeducation about the symptoms of cumulative trauma and appropriate support that he advocated for young police officers. Finally, the compensation process caused further trauma for him by questioning his integrity, and the police department added to this by not showing recognition that his injury had been caused by his police service. At the time he was interviewed he was suffering both the symptoms of chronic posttraumatic stress disorder, depression, and a sense of having been betrayed by those in a position of power, consistent with moral injury as described by Shay, (2014). He was experiencing both internal and external shame, as described by Gilbert (2001). His quality of life remained greatly affected by his symptoms and the avoidance he employed to avoid exposure to emotional triggers.

Phil

Phil entered the Police Academy at the age of 16, underwent 3 years' training and served 36 years. He went on sick leave and on to compensation in 2006. After what he described as a long and difficult battle with compensation, he was paid out in 2014 with a diagnosis of PTSD and depression. At the time he was interviewed he described his symptoms as continuous and unremitting.

> *I can talk to you now, I've got a hundred images going on out here, of incidents I've been to – it's like a fast forward DVD – it's flashback after flashback after prang after death, after domestic violence, after fights and high speed chases and crashes and ...it's just so many, just so many, and it creates confusion for me and – it goes day and night.*

Phil said that his need to care for the community had led him into policing.

> *To do good for people – you know - it's all about the safe community. Personally, I always feel proud of what I did – because I was always a policeman that – um – I never hid anything from anyone. I always looked at people – at family members as if it was my family being told about things, so any fatality or suicide or anything I went to – um – I always kept people informed. And we used to work very, very, hard for victims – to get a result for them. That era of cops is gone now, I think. I got proudness out of it, but the knowledge that I was out helping victims. My reports were always good, so I always had a bit of proudness there too.*

Phil said that in his early years of policing he was not aware of how quickly his exposure to cumulative trauma was affecting him and he suggested that this was because the police culture at the time meant that no-one spoke of the effects of their exposure to traumatic incidents.

Probably while I was young keen and bullet proof it was all fun and games to me in those days – I was in my early twenties then – but you look back and this stuff, without being spoken about to anyone because of our culture, was obviously building up so quickly.

He dated his symptoms as having begun many years earlier when he was refused a request for a change in duties because he was having difficulties, without being clearly aware that he was experiencing the effects of cumulative trauma. He said that at about the same time his first marriage ended and attributed this to his increasing anger.

Back in 1994 or 1996 – I forget dates now – it was that era... I actually went to a boss when I was working at XXXXX because I was having troubles... I didn't know what it was – but I was having troubles on the road. I was seeing too many bodies, and violence, and I wanted to go to an office area to get off the road for a while. And I had a transfer as well, like a piece of paper saying I wanted to go from patrols to an office area. And I wanted him to sign it. And you know... that response I got back from him was Phil, there's no one transferring so I suggest you just get over this. Go back to work. There's no one going anywhere out of this station – so – it's not going to happen. [Things] got worse and worse then - 'cos my marriage –split– might have been around '96 actually probably not long after I got told. A lot of it was my fault because I was starting to lose the plot with lots of things, and my anger was building - I was a loose cannon let back out on the streets. He confused the hell out of me because I didn't know what was going on in my head, I only really worked out what was going on after '94 over the last couple of years. So *– that was 94-96 – before that I was open to everything, you know – jovial, fun, made light of lots of stuff you know, I was a prankster, I was a jokester - always worked with good people, just came across some authority within that that gave me hard times.*

As Phil's mental state worsened, he said he started having suicidal thoughts, did not understand what was wrong with him and did not seek help because he thought this might

result in him being humiliated, embarrassed or told nothing could be done for him. He suggested that little information was given to police about the effects of trauma because it was thought "*everyone would start getting sick with it".*

I didn't come good the next year – I was too frightened then to go to anyone else, and I got no treatment for anything, I was on no medication for anything. I didn't know what was going on with me – I was becoming more violent. And I was doing things – um – I was doing things – um – where I hoped someone would kill me – you know – I didn't want to be around anymore. Um – I thought I'd run my course um – um – I was badly confused. Um – and you know I didn't know who to go to and you know I couldn't go to a private psychologist or anything, or doctor, because I didn't know what I had – um – I thought I could be embarrassed or humiliated by walking in to a professional and – um – and also them telling me we've got nothing - you know – I had nothing to hang on to. And the police don't tell you anything - when you think about it they don't want you to know about it because then everyone starts becoming sick with it – um – after a big job that was bad – um – there was never debriefings.

Phil suggested that, even if debriefings had been performed, the police culture at the time would have limited their effectiveness.

I look back and it's about the amount of stuff we see – um – I'm not even sure whether debriefings would help, because even, as youngster, debriefings would have been good to make me understand lots of things - um, but there's stigmas, there's a culture, about manning up, there's a culture about not showing your feelings, there's a culture about – um – like I said I went to work with a charade going on, because you can't show that something's affected you. There's a stigma in the police that if someone found out you were going to see a psychiatrist or something, or a psychologist, even if you stayed in the job and they found out, your career's doomed. You're not going to get selected for another

job, you're not going to get selected for anything, you'd get pushed into a corner. They'd say through other means, other reasons, but you'd be over.

Phil said he believed that the behaviour of senior police at the time demonstrated a lack of care for officers and a failure to understand the effects of the stressors to which they were exposed.

I was never looked after, never cared for, and you know I look back and it was appalling. On my own I caught a serial killer. Um – and at that stage he was Australia's most wanted. We had a shootout with each other I shot at him and he – ended up fainting because apparently one of my bullets must have grazed him and he's heard it and it sort of made him pass out – um – which was good. I didn't have to kill someone or shoot them. I'd been up for... sixteen hours and I had to do lots of things before going home- had to give interviews on TV and I had to type up some staff and talk to people and – and – on my way out this big boss, he comes to me and he said – Phil, don't think you can just go sick tonight because of this. If you go sick I'll be round there to drag you out of bed. So you be at work tonight. Um – that's the best of thanks – closest to thanks I got for what I did that day – that night. And he took my – proud moment - away that night. No one else has achieved that and you know – um – and created more anger, you know – he just – you know this is how you get treated in the police.

Confused and increasingly angry, Phil continued to work normal duties over a more than ten year period and *"put on a charade*" because of the cultural prohibition against showing feelings. He began having physical reactions from his level of stress.

So, I went right through then to 2005-2006 – out in public, doing things. That was hard and confusing to me for a long time and was it just me going through that sort of behaviour, trying to keep it quiet and not showing others that – what the police would think – a weak moment. Because our culture breeds – um – you can't show feelings and

this sort of stuff so you – and that's the other hard part – you go to work and put a charade on for eight hours. At times you know I used to vomit on the way to work, knowing that I had to start at seven o'clock and go to half past three. Knowing that I'm going to have a conflict somewhere, whether out in the street or with the boss and – um – [having] to keep my brave face going, till half past three, and then I'd go home and I was just about – I'd collapse at home. And by week end - or my days off – for years – I was laid up in bed– with headaches and migraines and – I never enjoyed those days off for years.

Phil acknowledged that at times he had administered swift justice to offenders in a manner that had not been in line with police policy, and while he now saw it as a product of his angry mood state at the time, he felt shame about it, and about the way his mood affected his family.

I was recklessly indifferent as to whether it was lawful or not. I just wanted the job done. And I feel ashamed, absolutely ashamed of it. I got paid to do a good job – and you know 90% of my police work was a bloody good job, I got high accreditations and – um - and rewarded with commendations, more than anyone else in the department. I reckon I came close to permanently wrecking my relationship with my children, very close. the kids saying – if [my wife] picked them up from school – um – they'd ask, you know, what's Dad like tonight – um – what's his mood like. But – I was good at home, there was never domestic violence, never violence – um – I was too aware of all that stuff you know - it was just my shortness and lack of empathy and care and – um – participation – and all that stuff. Snappiness and oh – all that stuff. It just wasn't going well and my kids – you know…

Phil said he also found that his cognitive abilities and memory deteriorated, and with that came a progressive loss of confidence in himself and his ability to do his job adequately.

I look back and I remember – you know – having patches of losing confidence in stuff I was doing, in policing. it was probably more fear of me starting to lose – confidence - in myself – fear of not getting jobs right anymore. Because everything I did in the past, I got it right. You know I went through the police doing studies for first class constable, for senior constable first class and sergeant and senior sergeant – and a lot of my subjects I topped the state – um – because my practicality and knowledge and studies and I knew how the law, and policies all worked, so I found all of that easy. Then, as new laws were coming in, in years to come or new computer systems were coming in, I was eager to learn, but it just wasn't sitting here anymore – I might have picked up 80% of it – years to come I was picking up 60% until at the end I was walking out going "what was that about?" And then I was getting criticised a bit more by the hierarchy and I – I don't take well to that. Approximately 2003-4-5 - somewhere around there it started really being a problem for me – where I was shirking issues and not wanting to be involved. I was going out in the street not wanting to get involved any more in stuff out there either- and the public was suffering because I didn't want to be a part of it anymore.

Phil said that there had been many occasions when he said he had felt *"very humiliated"* by senior officers.

I had half custody of my children, and our policy within SAPOL we have childcare type leave. there was a boss there who made light of it, made fun of it – would call me "CC" – remember that advert that came out – it was a stupid advert you know "CC" that chip packet thing - and he called me that – um – um – tried to make me out to be like a housewife, unmanly and – um – um – very degrading. And that went on for eighteen months to two years.

There came a point where he could no longer contain the anger he felt as a result of being bullied and feeling humiliated, and this event marked the end of his policing career.

I had my boss, my chief inspector, by the scruff of the neck on my last day at work – at a meeting, of all things. I'd been bullied within the job by other bosses. And it came to a head with my last boss – ah - where he was being very sarcastic, very degrading and I already had no confidence in the job at this stage because I was hanging on, hanging on hanging on to where I snapped. I sat him back in his chair and I pulled my fist back – um - I was shaking and I was looking him in the eyes - and I didn't hit him. I walked out and went home and that was my last day, so I left in a lot of anger.

Off work on Compensation, Phil was presented with a new set of difficulties, and an eventual small victory against the injury management person who had bullied him.

The first person [compensation agent] I got – this is the first time I went off work, the first month – he's come to see my doctor with me – said don't worry Phil, we'll get you pumped up on meds and we'll get you back to work soon. I was actually starting to think if I went back to work, I would have shot and killed people – um – I was that bad. I would have grabbed a gun, I would have gone berserk, I would have killed myself. I was not ready to be told what to do - I was anti-police, anti-authority. I was ready to walk away for no money at all because of what she [the person in charge in injury management] was doing to me. She was sending people round from rehabilitation centres. They were trying to get me back to work at any cost– like I said I was the highest decorated cop in the police and for public servants – for a person to bully me and create a target, and she would go home and sleep safe at night because of people like me in the past – was just offensive to me, really offensive. They wouldn't pay me. They wouldn't pay my travel. They were withholding my money, my claims, my medicines, it was all coming out of my pocket, it was all illegal, I was backwards and forwards to my lawyers. I was at the ombudsman all the time, the ombudsman was kept putting out reports, a couple of things I brought up they got caught out with, that they weren't being transparent, and I kept complaining - and

then she got caught out with a group of people I know in similar situations like me – um – so she got caught out and sacked.

Phil's said his battles with compensation continued until he was offered a payout he thought was adequate.

Police funded treatment for the whole time until last year They wanted to get rid of me. Tried to get rid of me a long time ago but offered me an absolute rubbish of a [payout]...to get me off the system but I refused – and I was becoming a real pain for them [and] it was costing a fortune – travel, medications, my own doctor, so they upped it, got rid of me, and I was happy with what the amount was.

In retirement Phil said he continued to struggle with his memories.

You know that talk of – you know – if you go sick tonight we know where you live and we'll go and drag you to work – well that sort of went in that ear and out that ear but as I got older in years, all those things started to revisit me, the criticism and – the horror of seeing things that now can't be unseen – um – you know the mutilations of bodies from accidents or shotgun wounds to the head – so I feel horror and – um – and anxiety creeps in. I get scared of the thing. 'Cos these dead people visit me at night – their faces – I can see their faces at the time, and I can see it during the day at times…Something hits me and it takes me a couple of weeks to start fathoming where that's all come from. It's things like something new, from some obscurity thing that I did so many years ago, that I've utterly forgotten, can still pop into my head from an incident.

Phil acknowledged that he had experienced his own experiences in the past with thoughts of suicide and said he was now concerned about the welfare of former fellow officers and hoped that speaking about his experience might help others. He said he had lost many friends through suicide because they had not received help. He suggested that one day a police officer in this state of mind might even be driven to shoot others before shooting

himself and said he was speaking out in an effort to help other police who might be experiencing similar feeling to those he experienced at the time.

It was heightened when I was going through my sickness and the department was bullying me as well. And I really mean sinking the boots into me – they were bringing this on the family – ah – through me and that's where the uselessness and all that comes into it. I didn't want to be here. I was like a walking ghost really. And we lost a lot of people, we had a few suicides during this period.

I've lost nine friends in the last two years from suicide – um – it's through the lack of help, you know, and there's going to be a lot more because they're too scared to go to Compensation, so they sit waiting, hoping, that whatever they've got, like me in 1994 – hoping what they've got will just pass, because they're confused. If they had a problem in the workplace, it could be bang bang bang bang and then themselves, you know. If I had've gone back to work they would say to you – that's alright, we're going to put him in an area where there's no guns and firearms and that's fine – I can go to any toilet in any police station – if the cubicle's shut, reach over and grab a police belt – it's just too easy. I've still got friends in the job and who knows if they're sick or hiding it – I don't want them to go through what I went through. I want to be able to look back and feel I've made a difference, whether it's with you, to make things clearer, or better or more recognized.

Phil said he was now leading a quiet life and avoiding reminders of the past.

I don't watch the news, I haven't watched the news in over ten years, I haven't read the paper for fifteen years. I never went down the path [of alcohol]. I was strong in that way and not in others. I didn't want to be fogged out. I wanted to be on high alert – I felt I needed to be on high alert. I'm very nature oriented, and my life is surfing. And if I'm not surfing – on the day's there's not waves, I sit somewhere on the coast with my cameras and take all these photos. I've got my dogs, I rescue dogs and – and we travel a lot – to

XXXXX –because now I do work in the villages and they're just beautiful people, and they have no agendas, and I just love walking into places with no agendas, they're just thrilled to see me – we take over all our - all the clothing and schoolwork – books and they just love it. I love them.

Summary

Phil's history illustrates the process whereby symptoms can worsen over time if not recognized and treated, and how this in turn can influence behaviour. In Phil's case he said his anger caused him to be *"a loose cannon let back out on the streets".* He believed that anger also cost him his marriage and adversely affected his relationship with his children.

Had Phil's request for a change of duties been granted when he started having difficulties in 1994, the outcome for him might have been very different. The refusal of the request had two outcomes; the first that he continued to be exposed to events that continued to traumatize him further, the second that he felt disrespected and not looked after and cared for, and this resulted in him becoming increasingly angry. He acknowledged having always had some difficulty with authority but said prior to this he had not been a person who angered easily. Phil also felt discouraged from seeking further help from a professional because of fear he would be further *"embarrassed and humiliated",* and by the police culture at the time of *"manning up and not showing feelings".*

Further loss of control, humiliation and shame followed: lack of recognition from a senior officer that he said *"took my proud moment away"* when he captured a serial killer single handed, later earning him a bravery decoration. Violence towards offenders that caused him to feel "*absolutely ashamed"* of his behaviour, loss of confidence in himself when he became aware his cognitive abilities had declined and he experienced increased criticism from senior officers because of this. Finally, a series of humiliating incidents of bullying

behaviour from senior officers that culminated in an act of threatened violence that ended his police career.

Phil's exposure to compensation began a new round of humiliations for him when professionals questioned and minimized his symptoms. Attempts to get him back to work despite his mental state created a new and dangerous possibility – that he was afraid he would suicide using a firearm, and that he would possibly take others with him.

After what he described as a long drawn out battle Phil retired. He said he continued to do his best to avoid anything that reminded him of the events of the past, but he described memories constantly continuing to revisit him. His symptoms at the time he was interviewed were consistent with those of severe chronic posttraumatic stress disorder, according to the diagnostic criteria specified in DSM-5. He also had a history of depression which was being effectively managed with antidepressant medication. He described experiencing both internal and external shame, as described by Gilbert (2001) associated with regret associated with his past acts, and with his treatment by the police department and by compensation. His resentment towards senior police and the police department and towards compensation are also consistent with moral injury as described by Shay (2014). His shame at acts he had perpetrated himself are consistent with moral injury as described by Litz et al., (2009).

Peter

Peter said he joined the police force in 1984 after spending some time in the Military Police. He said he left policing in 2002 after his marriage ended because he wished to access his superannuation to purchase a house for himself and leave the country town where he and his wife had lived. He had indicated when we spoke by phone prior to the interview that he was going through a difficult period that had begun about a year earlier when he was accused of family violence by his former wife. The couple had had a complicated relationship for some years after their separation and Peter considered the charge to be set up by his wife and others in order to incriminate him. He was subsequently arrested and jailed overnight for breaching an intervention order by local police officers, with whom he had worked in the past. As well as losing his house as a result of this event he lost his driving licence, his job and his relationship with his son. Following this he bought a length of hose to gas himself in his car, but said he found out the attempt would have failed because of the emission controls on the vehicle. At this point he said he had seen the absurdity of the situation and had laughed at himself. *"But I was in a really dark place. A really, really really dark place."*

Peter said he thought his mental state had improved since that time, but he was aware he needed to address his alcohol consumption. *"Drinking is a big problem. If I keep on going the way I'm going alcohol will kill me, no doubt about that. I've got to cut back, I was self-medicating, so to speak."* He said he had been given a diagnosis of PTSD and an associated diagnosis of alcohol over-use by his GP. At the time he was interviewed he was taking antidepressant medication and was also prescribed diazepam to assist in management of his alcohol consumption that he said had been a problem since he was a young man.

Peter said he had left home at a young age, and shortly after this had what he called the "scariest" experience of his life. He said the worst aspect of it was that he had had no control over the situation.

When I was 15, I left home because the old man left when I was 14, and the old lady couldn't afford to keep us, so I got a job on cattle stations. And the first one I worked on was Macumba, which was out of Oodnadatta. And at 15 I got lost in the Simpson Desert on horseback, driving nine horses in front of me. And, that day, I thought I was going to die. And so what I did was rather than push the horses in the direction I wanted them to go, I thought they don't want to die any more than I do, so I look back on it now, I'm very proud of the decision I made as a fifteen year old, I'll just follow the horses – in other words if anyone was going to die we were all going to die, but the horses had a far greater chance of finding water than I did. And – about four hours later we found water – the horses found water. And that was probably – at that time of my life, that I was most frightened, simply because I had not control whatsoever, over my life, and as you would be well aware when humans are put in that situation when they don't have any control, it's very frightening - especially for a fifteen year old. But that was probably at that time – or even up to date, the scariest event, simply because of the that factor – I had no control.

A major event in Peter's policing career occurred in 1988 when, patrolling alone, he stopped a vehicle with false number plates, fought the driver to get two firearms away from him, then shot and killed him after he had taken a shotgun from his car and aimed it at Peter. Peter said he had experienced a powerful, lasting emotional response to having killed another human being, and had questioned whether he might have acted differently for at least eighteen months following the incident, for which he was awarded the Valour medal.

And - ah – I just happened to look at that instant, when he was coming back out of his car, with that shotgun, and – ah – really makes you think who was looking after me on that day – and um – he's then gone to the front left hand wheel of his car, and I've done the same with mine, I've gone around the other side to get some protection from the engine block, and as I've got there he's bringing the shotgun up, so I let go two shots, one of them

hit him in the head, he's gone down – I didn't know that at the time – he's gone down behind my hands, just dropped, and it wasn't till back-up arrived - um – that – some fifteen minutes later, I guess, and one of the blokes walked up the road with his gun, walked right up to him and said – shouted out to me – looks like he's dead. So I walked across with my gun still in my hand and – ah – yeah he had blood trickling down his nose, and you could see there was a wound on the side of this head. But – the feeling that you get is one of – difficult to explain, but it's probably the most irreversible thing you can do is to kill another human being. And then you have very mixed emotions – I was angry, I was sad for the bloke, I was – what if I did this, what if I did that – and that lasted for about eighteen months.

Following the shooting Peter said he was offered some written information – American in origin – by a police psychologist on how to deal with stress. He said he was offered support should he need it at a later time but when he contacted the person several years later to request this, he was told they were too busy to see him. The inquest for the shooting incident was grouped with other police shootings and did not take place until six years after the event, a further source of stress for Peter. Then, because he had given evidence at the inquest when asked not to by the Police Association lawyers, he found himself ostracized, his mental health deteriorated, and his marriage ended.

But then what added to my problems was throughout that entire inquest I was the only one that gave evidence. I was told not to, and I said why not, I've got nothing to hide. And they said oh not we just want to keep an even theme throughout the - um – all of these inquests. Well – it didn't sit well with me, being a copper in a small country town – um – it's not going to look good. So consequently, I wasn't very popular with other police members after that. And to highlight it, after the inquests were finished, and the findings were all handed down, the Police Association put on a dinner for all the police members

involved in what became known as the Victoria Police shooting enquiry. I didn't get an invite. Not till the following week, I got one on my own. And when I got to the Police Association rooms where the dining facilities were, I looked around the room and said where's the other blokes? And ah – they said we've given you a special one because you got the Valour Medal – and I thought then how stupid do you think I am? And – ah – the reason was that the others didn't want anything to do with me. And that sort of spread – that was difficult to deal with as well, not being – being felt to be – not part of the group – and I became – on top of everything else I became irritable, cantankerous, and that spread to my workmates here and it got to the point where many of them didn't want to work with me either, you know because depression was really getting to me. So much so that 2001 my wife and I broke up for the first time, and she left a note saying – um – I'm going to mum's to live, I can't put up with your mood swings any more.

After an initial short period of adulation following the shooting, Peter said his fellow officers had offered support to him but had failed to follow through on it. This caused him to feel increasing resentment that was reflected in his behaviour towards them, resulting in his further alienation. His attempts to get professional support failed and he became disillusioned, believing he would have to deal with his difficulties on his own.

On the day you're sort of made to feel like a celebrity, I guess, I kept getting radio messages to go and see this officer and that officer, and assistant commissioners and deputy commissioners – because they thought it was a big deal. Then – nothing. There was no peer support, nothing like that. And I think from the shooting onwards, I had difficulty getting on with my colleagues – not all of them, but probably most of them. Built up a certain amount of resentment– shortly after the shooting you'd be working two up, and your offsider would say - listen mate if you want to talk about it, get if off your chest, by all means do so. And without exception, whenever I brought it up, they'd immediately change

the subject. So, I stopped talking about it and just – and just – built it up. The resentment started to build up, and that came out in the way I spoke to them, and the way I treated them – they preferred not to work with me, which now I completely understand. Whereas if I had a partner, you could go to the pub that night, um – and toss it backwards and forwards, between you. You can't talk about it with your wife, because she's got no idea. I went on sick leave for quite a while, on Compensation, which was approved, and they sent me to a psychiatrist. But he was absolutely no value whatsoever. That's when I though oh stuff it, I'll deal with it myself.

Peter said he thought that the frequent inability to make a difference results in an increasing load on many police officers – the cumulative effect of being witness to so much grief and so many deaths that they never leave behind. He said the effect on him was that he had become *"tired of life"* – he felt as if he had experienced more than his share of tragedy.

Delivering death messages is gut wrenching – especially if you're delivering a death message to a parent – I've done a few of them here, and the trouble with being in a small town is you know them. Worst job in the force, death messages, because no matter which way you go about it, it's a no win situation. You can't do a damn thing. And that's why humour – black humour – it's called black humour sometimes, is within the police force.

Peter described cumulative stress as the *"pancake effect".*

...you know, one thing happens, and it's not so much on its own, then another thing happens, and if you don't deal with each one it builds up and builds up and builds up – I don't think you ever get rid of them I don't know - it gives you a feeling of being – and this is going to sound suicidal – but tired of life, you know I don't want to be here. I've had my share – and I think that's pretty much it, you know, because all these things that get thrown at you, you sort of just shrug them off and go on to the next one, but you don't get rid of it, it's still there, until you go on the next one and the next one, and eventually the

load – it's like the last straw on the camel's back, you've got to get away from it, you know, get away from it and – try and get some perspective I suppose – on the job. There's so many people that you come across, you know, with that sort of mind set. That have been in the police force and – um – well probably like me, every fatal you go to, every dead body you go to, you don't leave it totally behind. Part of it stays with you, as you go on.

At the time he was interviewed Peter said he accepted that his relationship with his former wife was over. He had earlier completed training as a peer support person within the Retired Police Association, but he was not currently active. He said, "*it felt great – like being back in the force",* but that he was currently not working at it *"because of my own issues".* He said he had been:

...pretty keen to do it, because it's something I believe in – I believed in – ever since my shooting, peer support. Especially if you can connect with somebody that has been through something very very similar to yourself. That's better than any psychologist – far far better, in my view anyway.

Summary

Peter's narrative indicates that his troubled relationship with his wife had been the source of many of his difficulties, causing him ongoing uncertainty, failing to provide support when he needed it and was unable to find elsewhere other than in his "self-medication" with alcohol. When he described his experience of being lost in the Simpson Desert at the age of 15 Peter said lack of control had been the worst factor. In the course of his policing career, he said he believed the cumulative effect of the years of exposure to death and the suffering of others – which again he had been unable to control or ameliorate – had caused his mental state to deteriorate to the point where he described himself as *"tired of life".*

The shooting incident had also been very significant in Peter's policing career. He suffered many conflicting emotions for a long period of time afterwards, including self-

doubts as to whether he might have dealt with the incident differently. He was unable to find anyone he could talk to about his feelings, and he became increasingly irritable and resentful, further increasing his alienation from his fellow officers. When he insisted on being the only officer to give evidence at the inquest on police shootings, he believed he was deliberately excluded from subsequent participation in a dinner event hosted by the Police Association. He found it difficult not being part of the group, and this experience was followed shortly afterwards by his wife leaving him because she could no longer cope with his moods.

Peter said he believed that police officers who had experienced potentially traumatic events needed to be able to connect with people who had had similar experiences, and who would be able to understand the emotions involved. He had hoped to help provide this by becoming a peer support person and had undergone training to do this. He said he was looking forward to becoming active in this capacity once he felt more in control of his own difficulties.

While I did not assess Peter to be a suicide risk at the time I met with him, because of his earlier plan to suicide and his mood state, we discussed his level of risk at the conclusion of the interview, and how he might deal with any future suicidal ideation. He was given the appropriate emergency numbers to call if his mood deteriorated.

At the time he was interviewed Peter appeared to be recovering from a depressive episode with associated suicidality. He did not appear to be experiencing symptoms consistent with a diagnosis of posttraumatic stress disorder. He acknowledged a long history of over-use of alcohol. During his policing career Peter's difficulties began with the incident where he was required to shoot an offender in order to protect his own life. Following this he experienced a predictable period of psychological instability for which he had been unable to enlist support. Peter also described a build-up over his policing career of feelings of sadness and helplessness as a result of his repeated exposure to the deaths and suffering of others.

This is consistent with moral injury as described by Litz et al., (2009, p. 700) as *"bearing witness to, or being unable to prevent trauma to others".*

Ivan

Ivan Joined the police force in 1973 and served 42 years before he was retired in 2014 because of ill-health, with the rank of senior sergeant. He said he had no particular reason for joining:

> *I didn't know what to do when I left school. The young fellow across the road joined the police force and said oh this is a good job. And I thought – that sounds pretty good to me, so I put my application in.*

He was seen in his home together with his wife. She was herself a long-serving former police officer, and Ivan described her as his only support. Ivan described revisiting his experiences as highly stressful and I think it would have been very unlikely that he would have agreed to, or indeed been able to go through with the interview had she not been present. Towards the end of the interview Ivan took a Diazepam tablet to settle himself down, and we ceased the interview and had a coffee and a general chat until he was ready to proceed, which he said he wished to do, saying *"I've always said that I'd like my experiences to be out there so people can learn from them."*

Ivan was given a diagnosis of PTSD in 2012 after having experienced symptoms of the disorder for approximately 34 years. He described three major incidents in his policing career as significant: being involved in a shooting incident early in his career, bullying and exclusion as a result of having reported a crime committed by police officers, and lack of support and fair treatment by management in the latter part of his career. The initial incident occurred in 1978 when Ivan, together with a fellow officer, tried to apprehend a criminal. A number of shots were exchanged, and the criminal drove off in the police van with both officers hanging on to the sides of the vehicle and being dragged for 50 metres. The wounded criminal crashed the car and Ivan and his fellow officer apprehended him. This event had a

profound effect on Ivan. It made him more aware of the dangers of policing, but with his increased awareness of his vulnerability came a reputation of being *"tough guy".*

> *[I became aware of] the dangers and everything I'd [signed up] to. And I looked to every day after that as – as being a bonus, really, and, because that was in 1978, the only real things were – there was no counselling – it was just to have a beer. And that was basically it. And I had two weeks off and back to work and off you go really. There was nothing else said about it, in regard to mental health and the way you felt. All it became was, here's a guy that managed to have a big shoot-out, get crushed by a car, and yeah, he's rough and tough and that sort of thing and that was – the way the people looked at it, but ahh – I was one of the tough guys [inaudible] for doing it and that sort of thing.*

Following the incident Ivan began experiencing symptoms of avoidance, nightmares, night sweats and increased alcohol consumption, without recognizing that these were a sequel to the shooting incident. (In 1978 it would be two years PTSD was recognized in the publication of DSM-III, but Ivan's symptoms at that time would have been likely to have met the criteria for diagnosis of the disorder).

> *So not knowing what was going on inside me, it was by sheer coincidence I was reading a book about police – and it was right where the police characters in that were being shot at in an onion field, and I couldn't read that, that – I just had to put it down. And um – I just suffered ah - nightmares, night sweats, ah – disrupted sleep, um – alcohol, all that sort of stuff, I was smoking [too much]. But it was – I didn't realize what was really happening with me psychologically, or physically, really, with the outcome of that shooting, that night.*

At the same time Ivan was living up to the *"tough guy – one of the boys"* reputation he had acquired.

Pulling up cars or dealing with people or whatever, I certainly wasn't afraid to use violence – to ah – you know – threaten to shoot people, and that sort of stuff, and – um – you always had that reminder, that it was there. In Russell Street (Police Headquarters) in the 70's, nearly the 80's, detectives were the – kick the door in type people and all that sort of stuff. There was no – SOG (Special Operations Group) may have been a fledging, you wanted to kick a door in you got a detective, because [they] were taught the entry procedures and all that sort of stuff. So, we just – did all those sorts of things. And I had invites from the Homicide Squad, the Armed Robbery Squad, the Consorting Squad, all those tough areas, because – at that point – I was seen as a tough guy. One of the boys, you know, and all that sort of stuff. Through my actions. But you were just knocking doors in – it was just exciting. And that's where you get that reputation, so you couldn't really back down, you know -you're backed into a corner. [And] as a sergeant in the Community Policing Squad, we seemed to work the brawlers, either at the football, music concerts, demonstrations, New Year's Eve and all that sort of stuff, and if you worked the brawler you were expected to – you know – handle people, and you know we'd be locking up people and that sort of stuff and I had no issues with being violent with people – didn't worry me because that was just one of those things you did.

Ivan said he was suffering nightmares every night that were variations of his actual experience in the shooting incident and waking in a panic drenched in sweat.

[They were] all the same, repetitive dreams, the tremors, the – all those things, and I didn't actually put two and two together that my dreams and everything, my night-time suffering, was down to the shooting. Because part of the shooting – ah – was – we were shooting at each other and I had him lined up at one stage across the bonnet of the car, and the gun went click, I'd run out of ammunition. And he fortunately, also had run out of ammunition. And that was one of the themes in the dreams where – um – I would be

looking for more ammunition, but the ammunition would be the wrong size, like – um – too big, too small, the wrong gun, or whatever, you know. So it was all these variations on that sort of stuff, um – and driving fast cars, and, but a lot of it was crawling in dark areas and dark parts of town, or rough parts of town… Dreaming of being overwhelmed by waves and water - driving down to what could have been the end of the XXXXX River when all of a sudden there's all this – you see these waves starting to come in, and they're getting bigger and bigger, and you're just totally overwhelmed. And the same as if I was on a holiday in the dream, going to a beach or lake or something and saying oh this is really fantastic here and rent a cabin and that sort of thing, and then it was as if I was standing on a cliff top and you'd be watching these good surfing waves come in, and people swimming and all that, and all of a sudden just a great big burst of wave coming over you, and that was every night. And I would be absolutely just soaking in the bed.

Ivan stopped wearing the Valour Award he had been given following the shooting incident because it served as a reminder he wished to avoid.

I had been awarded the Valour Award, from that shooting incident. When I went back into uniform as a sergeant, people'd ask what it was for, because it was very uncommon. So you'd make something up, that was ridiculous, or humorous, or whatever, and not tell anyone. And in the end I just didn't wear it. Because it was just a constant reminder of everything.

Ivan's life took a further twist when he was offered a bribe by a fellow sergeant, while drinking in the Police Club, to provide a brief of evidence to assist in the trial of a criminal acquaintance of the sergeant. He immediately reported the incident to a police officer friend whose wife worked in the Internal Investigations Branch, and he was contacted for a statement the next day and asked to get further evidence. His identity as an internal source – a

"dog" as it was known - soon became public knowledge and resulted in him receiving threats from fellow officers.

I was approached by a sergeant I knew from Prosecutions, who – was a little bit bent, and things like that, unbeknownst to me. And he was jiggling with – or friends with – or associating with – um – people who – crooks who were in the brothel game, standover men, drugs and that sort of stuff. And something had happened where they'd been charged, and they were looking for a brief of evidence from a member at Greensborough. So this fellow approached me and he said look, if you want to make some quick easy money, ten thousand dollars, get a copy of the brief for me and I'll give it to whoever, and – ah - and we're all sweet. And I was pretty drunk at the time and I thought no, this is not right. So I rang a friend just to report it – record it – and his wife worked at Internal Investigations. The next day anyway Internal Investigations contacted me and I gave them a statement. So what Internal Investigations asked me to do [then] was go and have conversations with different people while I was wired up so they could record it. And you've got this recorder and you're thinking – Jeez – am I going to get discovered here. And it's all taped to your body of course – we're talking late 80's technology. After there's further investigations [and] the sergeants and other people are – interviewed, they're charged, then of course it comes out, and two and two are put together that I'm the internal source.

Then one night I'm drinking at the club [Police Club] there was a group of people and they're all looking at me. And one of them came over, and he said you'd better just put the beer down, and you'd better go, because those blokes over there are going to punch the shit out of you. They're going to beat the crap out of you for being a dog, you're blabbing on people and things like that. And I said well they can go and get stuffed, I'm not going anywhere. And he said I came over because I'm your friend, I have to do this for them because if it wasn't for me, they'd come over and beat the crap out of you right here and

now. And I said nuh - thank you very much - and ordered another pot, had the pot, and um – these guys were carrying on, and – um – I was talking to the barman and all of a sudden, my brain just – it was like a flash of lightning, just went snap. And – um – I was just incoherent and everything else like that and it was virtually a brainsnap, a breakdown – just started to cry a little bit and everything like that.

It [reporting the attempted bribe] absolutely cruelled my career with the CI, all the squads, because all those other guys were detectives. And I never went – from that night I didn't socialize with police, I never went anywhere with police, functions or anything else like that and I had to draw up a plan of the house for the SOG, and all that sort of stuff, so they actually knew what was around.

Ivan's wife said he had slept with two truncheons beside the bed, and that she and other officers were told to check him nightly for fear he would take his life. I asked him if he'd had a firearm, and Ivan acknowledged he'd owned a shotgun, and he had considered suiciding with it at the time, something his wife said he had never told her before. "*I'd actually considered it, and I actually had got the shotgun out to – ah - to do it. Had it there, you know, [the shell] in the barrel."* I asked him what had stopped him.

Probably just people cleaning up the mess, you know annoying the hell out of people who would have been affected by it and everything else like that you know. And so from then on I was really fragile – from that breakdown. Then as – because – of my integrity and my ethics and my high standard of work – ah – I probably didn't create too many friends either. By being too pedantic and all that sort of stuff. So I was taken out of operational duties and all that sort of stuff – um – and I just didn't know who to trust.

Ivan was then promoted into the Traffic Branch shortly after it had undergone major change. He said he had instigated innovations that had a significant effect on reducing the road toll in the area he covered. However, the changes he introduced created further

opposition for him against a background of mistrust, and he said he did not receive support from management for trying to make improvements.

Too many hassles down at traffic with people complaining about - how rigid you are, and how – um – you're trying to extract too much out of them, being let down by management, which then went back to the threats and distrust of the internal source things. All my authority, and that, was just wiped. The lack of support by command and the lack of understanding of really trying to manage and bring integrity into the police force just wasn't – it wasn't happening. A kick to the guts and all that sort of stuff.

Ivan battled on however and said for a brief period he had a lot of fun. He described a raid he organized on a disturbance at a country hotel. *"I took about ten cars up, and the sound of v8's at that time of the night through the hills of XXXXX was absolutely fantastic."*

Ivan's nightmares continued unabated. He woke his wife and son frequently "*Just about every night - are you OK, you know, you're talking, yelling, screaming, that sort of stuff*".

Changes around increased accountability in policing resulted in a partial reprieve for Ivan, but this was short-lived, and depended on the attitude of individual managers.

As newer senior sergeants were coming in, they start to respect my administrative abilities. I started to fit in a lot more – um – because of that accountability and integrity and the reports and things like that. Depending on who you actually had in your divisional or district circle as managers – it all depended on how you got on.

A sequence of events then occurred that caused Ivan to feel excluded, unappreciated and redundant. A police shooting occurred at his station, and he was not notified, and then later his work performance was criticized when he applied for an upgrade.

This is the way I was treated by a new inspector. She considered me a dinosaur, old fashioned, she wanted to get rid of me, and she wanted to clean all the old dinosaurs out. I was the Association delegate for the area, I was the senior sergeant at the police station at

that time, and I'd gone home, it was about 5.30 or something, we're not talking about middle of the night stuff, and – um – I knew nothing about the shooting having happened till the next morning. And I thought – you have just left me right out of the loop. Total inconsiderate sort of behaviour, so you can imagine my self-esteem and self-worth and everything absolutely just plunging right down, so destructive, that sort of being left out.

Then when he applied for an upgrade, he said this was *"when I really went downhill".* He said he was told by a senior officer:

We've considered it, the committee, and everyone thinks that you're not good enough, you don't actually understand where the police force is going, you don't understand policy, you don't do this and you don't do that. So no. And I said – and I've just choked up again, and I knew from that 1988 flash or whenever it was, the brain was just about to break. And I said well there's nothing in my assessment, over many years, no one's pulled me aside and said I can't do anything, where's your evidence? What have you got? Who's said what, you know? How can I improve myself if I don't know what I've done incorrectly? And that was it– he said I'm not going to talk about it now. [I left] virtually in tears, and from that point I was just on a downward spiral. And then when we kept on meeting, and I was having my rating, I remember sitting in meetings with him, and crying, begging to be told how I'd gone wrong, and how I could improve myself, and he would sit there in silence, waiting for me to stop crying, and then just continue on to say well look, suck it up sort of thing. That was in February – 2010. I broke down in 2011, went and saw the GP in 2011 and that was it. I went off on leave, I was off for five months, I was an absolute dribbling mess. Um – and – um – I was in bed all the time just sleeping. It was then I was diagnosed with depression, anxiety and all that sort of stuff.

When Ivan saw the senior officer who had dismissed his upgrade application several years later at a function, he became very angry and threatened to attack him. His wife described

what had happened and said it had been typical of Ivan's anger outbursts at the time, when his investigations of poor police performance were being dropped by management because of internal alliances.

> *Ivan said – there's XXXXX– I want to go and punch him. I want to go and punch him in the face. And he was deadly serious. And I go with him to a lot of things because I'm the guard. And I went no you're not. And he said yes I am I'm going to go down there and punch him in the face. Because he was so angry at all that had happened to him. And I went to him you're not doing it, and I'm not letting you go. I do remember at this stage Ivan was coming home very angry all the time. He was so disillusioned with everything. And this is when everything started to come adrift, to unravelling. He kicked cars. He actually kicked the doors in.*

Ivan acknowledged his anger, but said he no longer had it all the time, and his level of vigilance had subsided to some extent.

> *Oh yes, I used to be very angry – very very angry. I'd abuse everybody, wouldn't I. People coming out of the service station the wrong way - I no longer really have that anger – [though] it can surface at times. And at the start of the conversation, I think I mentioned I could have taken someone's life, well I no longer really think about that. I probably could, but I'm not really thinking about it. Just to go back quite a few years, you've got the railway line here. And at night- time the workers, you know, they put detonators on the track and I'd hear the detonators go off, I'd be awake, I'd be sweating, I'd be working out a plan – do I hear footsteps, was there a robbery, was it shots fired at the service station, and sometimes I'd get up and have a look, if a car went up the street or whatever, you know – that's how hyper I was.*

Following his period of leave Ivan returned to work briefly, but his mood state failed to improve. His GP sent him to a psychiatrist who specialized in treating trauma-related

injuries and who took a full history. For the first time, and to his surprise, Ivan received a PTSD.

> *Because they were concentrating on that 2010 – 2011 issue with the superintendent, where I'd had my breakdown, they were trying to solve the issue that was current. When I went through the shooting, and the sleepless nights, the sweating and all that sort of thing, he said – you've got PTSD! Until I was diagnosed, I didn't really know what was happening with me, and that's the thing, you know. You just think it's part of the normal – memory pattern – but it's not.*

Ivan was commenced on antidepressant and antipsychotic medication, and said he had his first good night's sleep for as long as he could remember. He returned to work with the support of a senior officer. That person was replaced, and he was urged to retire, which he refused to do. His police service was summarily terminated in 2014. He put in a Compensation claim which was initially rejected and experienced the way these events occurred as further traumatic rejection.

> *I have no respect for Victoria Police anymore – as an organization. I've been let down so much, and the last straw really was two registered mail letters. The first one – unless you've got a valid reason you're being terminated, you haven't got a valid medical reason. No notification, no contact from his superintendent, no personal contribution other than can you please bring your kit back in and make sure you bring it all. And then they said and even though the court case for Compensation is coming up shortly it has nothing to do with Victoria Police, it's between you and your insurer. [the insurer] fought it all the way because they said we don't have any of the paperwork on the shooting. And there was no support from [the police department] to say hang on we support the claim.*

A court battle with the insurer ensued. The insurer eventually accepted the claim, but Ivan found the process extremely stressful. His wife described how it had affected him.

He literally had a breakdown in this little conference room. He was in tears, he was crying, he actually fell asleep upright in a chair. I said you may as well go into court and have a mental breakdown in the witness box, a physical mental breakdown in front of the magistrate, because it's the only way we're going to get any settlement. And for whatever reason, [the insurer] did a 360 – turned around and said – OK we'll give you the claim. He's pretty much still recovering from that breakdown in 2014 - that then set him back probably a full six months.

At the time he was interviewed Ivan's life was constricted and diminished. He described his concentration and memory as impaired. He said he avoided social situations and felt unable to do the things he had planned to do after retirement.

Lots and lots of triggers. I mean I can't watch the news, read the paper, you know all these bits and pieces. Can't go near a police station – skirt around them. I don't have a big verbal communication with friends because I don't string a lot of things together, there's confusion, there's memory loss – concentration, and I don't drink alcohol, I don't smoke, I just sit there. I was so outgoing, and now, I could go down to a – I usually avoid them – neighbourhood barbecues or get-togethers and if I do go to them, I'm just quiet because I can't interact.

I've always wanted to help. I could have toured the state, on the bike, with purpose, talking to people, even talking to new recruits, things like that. I had already offered my services to the Association and been accepted of being a roving guy to go to police stations around the state to talk about PTSD and anxiety and things like that, to be an advisor on a welfare basis, but because it affected me so dramatically I just couldn't do it.

Despite his loss of faith in the police force, in the end, Ivan believed he had fulfilled his oath.

I didn't do dishonest things. I was true to myself, I was true to the organization, and I think that was my downfall. I didn't necessarily bend. I swore an oath, in 1973, that

without fear or favour, I would look after the community. And I looked after the community and people.

Summary

Ivan's traumatic exposure in 1978 had a paradoxical effect. He felt more aware of the dangers of policing, causing him to feel vulnerable. Police management at the time offered him no support, and there was no recognition of trauma-related psychological injury at that time. At the same time, he acquired a *'tough guy"* reputation he felt he had to live up to in his policing behaviour. He experienced nightly fearful dreams but felt he was required to project a fearless image during the day. His alcohol consumption increased, and he began to avoid reminders of the incident that triggered the emotions associated with it. He described himself as being *"not afraid"* to use violence as a defence. This is similar to the response of participant Don (Group 2) that was described as a reaction formation – a psychological defence mechanism in which a person uses conscious behaviours that are the opposite to their underlying impulses. The behaviours are adopted because the person considers their anxiety or fear to be socially unacceptable or inconsistent with their self-image or ego-ideal.

When he reported an attempted bribe by a fellow officer to the Internal Investigations Branch, apparently without hesitation though he must have known the potential significant consequences, Ivan was exposed to the stressful and risky collection of more data in undercover conditions. Then, because his actions became public knowledge, he was ostracized by the bulk of the people with whom he had working contact. This, together with overt threats of physical harm, severely affected his mental health. He spent five months off work with a diagnosis of depression and anxiety. He came very close to suicide at this time.

When Ivan returned to work, he faced mistrust as a result of his earlier bribe report, and entrenched opposition to many of the innovations he tried to make. To someone who prided himself on making a contribution by assessing and maximizing performance, this was

a blow to his self-esteem. Following this, he believed he was excluded from participation in decision making that he believed would have been appropriate for his rank and position because he was regarded as a *"dinosaur".*

Finally, when he applied for an upgrade and was responded to in an obdurate and humiliating manner, Ivan's mental health again deteriorated sharply, and he went off work again. He became progressively angrier and potentially violent, to a point where his wife felt she needed to go out with him *"as a guard"* to prevent him from physically attacking those who frustrated him. This increase in anger and violent impulses was described by a number of the participants as being a defence mechanism associated with managing feeling of humiliation.

Because his mental health failed to improve, his treating GP sent him to a psychiatrist who specialized in treating trauma affected individuals, and for the first time he received the diagnosis of PTSD. Despite having experienced symptoms for close to 34 years, it appears that those treating him had failed to take a full history of his responses to sequential traumatic experiences and had not recognized the effects of cumulative trauma that had built on the initial shoot-out incident he was involved in, in 1978.

Ivan's final blows came from his unexpected dismissal from police service when he refused to retire, which he experienced as lack of recognition and respect for his achievements, which included his Valour award. The subsequent battle with his insurers, in which he failed to receive support from the police department, acted as a final blow, leaving his mental state such that he was unable to follow through with plans for voluntary service to police. At the time he was interviewed he had few pursuits to occupy him and avoided social contact any exposure to situations that triggered his emotional state. He remained heavily medicated at the time he was interviewed.

Ivan suffered PTSD which remained undiagnosed through his full policing career from his initial exposure to a life-threatening situation. He then felt impelled to ignore his fears and live up to his *"tough-guy"* reputation and used alcohol to excess to assist in this. He suffered further threats from other police when he became an informer. He then suffered humiliation and damage to his self-esteem in a series of events involving exclusion, alienation, and criticism, becoming suicidal at one point as a result of this and also progressively angrier and at times violent. Finally, Ivan experienced further humiliation through being summarily dismissed from the police force and initially being refused compensation while being unsupported by the police department in his claim. Cognitive deficits and avoidance of trauma triggers severely limited his quality of life at the time he was interviewed. He said he no longer used alcohol to excess.

Appendix B

PCL-5 with Life Events and Criterion A

https://www.ptsd.va.gov/professional/assessment/documents/PCL5_LEC_criterionA.PDF

Appendix C

Human Research Ethics Committee (HREC) consent form

This project has been approved by the University of South Australia's Human Research Ethics Committee. If you have any ethical concerns about the project or questions about your rights as a participant please contact

the Executive Officer of this Committee, Tel: +61 8 8302 3118; Email: humanethics@unisa.edu.au

SECTION 1: CONTACT AND PROJECT DETAILS	
Researcher's Full Name:	Terry Faye Taylor
Contact Details:	(08) 8302 4594 terry.taylor@mymail.unisa.edu.au
Supervisor's Full Name:	Professor Anthony Winefield
Contact Details:	(08) 8302 4052 anthony.winefield@unisa.edu.au
Protocol Number:	0000034833
Project Title:	**Life after trauma: changes for better or worse?**

SECTION 2: CERTIFICATION

Participant Certification

In signing this form, I confirm that:

- I have read the Participant Information Sheet, and the nature and the purpose of the research project has been explained to me. I understand and agree to take part.
- I understand that I may not directly benefit from taking part in the project.

- I understand that I can withdraw from the study at any stage and that this will not affect my status now or in the future.
- I confirm that I am over 18 years of age.
- I understand that I will be audio-recorded during the study
- I understand that the audio recordings) will be transcribed, de-identified, stored in a secure location and destroyed according to University policy after a period of 5 years

Participant Signature *Printed Name* *Date*

Researcher's Certification		
I have explained the study to subject and consider that he/she understands what is involved.		

Researcher's Signature *Printed Name* *Date*

Appendix D: Participant Information Sheets and Recruitment Information Sheets

Participant Information Sheet (Given to all who expressed interest in taking part)

About this project

This research project is exploring how people adapt and adjust to potentially traumatic experiences, and any events that follow which create further difficulties. By exploring how people have been supported, or how they think they might have been better supported by the various organizations, groups and individuals who have impacted on their lives, we hope to gather evidence for changes that will benefit people who may have similar experiences in the future.

The research is being conducted by Tess (Terry) Taylor, a Clinical Psychologist who has been working with people who have been exposed to potentially traumatic experiences since she began her professional career working in the Vietnam Veterans Counselling Service in the 1980s. The research will form the basis for a PhD dissertation at the University of South Australia. The project does not involve any financial gain for the researchers and is not being conducted in association with any other agency or organization outside the university.

The research aims to identify how people respond to events that may be difficult or traumatic in the most direct way possible – by hearing their stories first-hand and giving people the opportunity to say what they think, how they feel about what happened to them, and how they have changed as a result.

If you agree to participate you will be asked to sign a consent form before the beginning of the interview. Participation in this research is entirely voluntary and participants can choose to withdraw at any time. All information provided by participants will be kept confidential. The results may be published as papers in academic journals or presented at professional conferences, but participants will not be identified or identifiable in these presentations.

What is involved

Participation will involve the completion of a short questionnaire to find out more about your exposure to events you have encountered during your policing career and how you have reacted to them. You will then meet with the researcher on one or possibly two occasions. The first meeting will be an interview where you will be asked some specific questions, but also asked to describe, in your own words, what your experience has meant to you. You may later be invited to a second interview to follow up on areas that have been found to be significant to the research project because they have been frequently mentioned by other participants.

The interview/s will take place at a time and in a location convenient to you. Each meeting will last about an hour and will be audio-recorded so there is an accurate record of everything said. These recordings will remain confidential. They will be transcribed by the researcher and any details that could identify you, (such as name, places or other specific information) will be removed before other people involved in the University research see the transcripts. Other than subject to legal requirements to disclose, all information provided will be treated as strictly confidential. It will be securely stored at the University of South Australia for a period of 5 years after the project has finished, and then destroyed in keeping with university policy.

Any questions or concerns?

If you would like more information about the research, or you have any questions or concerns, contact Tess on: (08) 8302 4594 (This number may be diverted to her mobile or a message bank service) or email her at: terry.taylor@mymail.unisa.edu.au.

This project has been approved by the University of South Australia's Human Research Ethics Committee. If you have any ethical concerns about the project or questions about your rights as a participant, please contact the Executive Officer of the Committee, Tel: +61 8 8302 3118: Email: Vicki.Allen@unisa.edu.au

Alternative Information Sheet used for recruitment

Have you changed as a result of your police service?

Police face many difficult, challenging, and dangerous incidents as part of their job. More needs to be known about what best to do (or not do) to support those who are experiencing difficulties as a result.

A research project conducted by Clinical Psychologist Tess (Terry) Taylor, at the University of South Australia, is gathering information about how former police might have changed as a result of their police service, and how subsequent events, including organizational problems and conflicts, might contribute to any difficulties they might experience.

If you have experienced difficulties, and you are willing to participate, please call Tess on: (08) 8302 4594. The call may be forwarded to a mobile where you can leave a message with your name, phone number and best time for her to call you. You can e-mail *terry.taylor@mymail.unisa.edu.au* for more information.

Participation in this research will involve completion of a short screening questionnaire followed by a one-hour interview, with the possibility of a follow-up interview later. All information given will be confidential and used for the purposes of the research only.

This University research project has no association with any other agency or organization. It has been approved by the University of South Australia's Human Research Ethics Committee.

If you have any ethical concerns about the project or questions about your rights as a participant please contact the Executive Officer of this Committee, Tel: +61 8 8302 3118; Email: humanethics@unisa.edu.au

Information Sheet used for Facebook group recruitment

Request to discharged police for a study investigating the effects of exposure to trauma.

My name is Tess (Terry) Taylor and I'm a Clinical Psychologist who worked for some years in private practice in rural Victoria. Prior to this I worked in Community Mental Health in Crisis Assessment Teams, and with the Vietnam Veterans Counselling Service. After many years of treating trauma, I've now moved into research at the University of South Australia to study questions that have arisen out of my experience. The purpose of my research is to provide information that might assist SAPOL, and police departments in other states, to address more effectively the prevention of mental health difficulties and suicide in serving and discharged officers.

Because I've spoken to so many individuals in my clinical practice who've had traumatic experiences and seen the many ways in which these experiences can affect people, I wanted to start my research here – looking at the individual experience – and going on from there to find out what is really important to those who've experienced trauma. This includes how they might best be served by organizations, and by others who have contact with them.

I'm looking for participants, male or female, who have experienced one or more police service related traumatic events that they believe have been life-changing for them. They may have a diagnosis of posttraumatic stress disorder, or experienced changes connected to the traumatic events that significantly impact on their life, but have not received a formal diagnosis.

Participation will involve completion of a questionnaire to find out more about each person's exposure to potentially traumatic events, and a 45 to 75 minutes semi-structured interview, which will allow each person to talk in detail about their thoughts and experiences. They may be requested to attend a further interview to follow up on areas that have been found to be significant to the research project because they have been frequently mentioned by other participants. All participants will be free to terminate the session or their involvement in the entire process at any time.

All information from screening and interviews will be de-identified and the researcher will be the only person who has access to identifiable data. All data will be stored according to University ethical requirements.

Meetings will be conducted in a mutually convenient location that will allow confidentiality and privacy for participants. Any travel costs for the participants will be reimbursed if required.

If you would like to participate, please may contact me by phone on (08) 8302 4594 (this call will be forwarded on to my mobile), or by email at terry.taylor@mymail.unisa.edu.au

This University research project has no association with any other agency or organization. It has been approved by the University of South Australia's Human Research Ethics Committee.

If you have any ethical concerns about the project or questions about your rights as a participant please contact the Executive Officer of this Committee, Tel: +61 8 8302 3118; Email: humanethics@unisa.edu.au

Form used for "Snowball" recruitment

Are you a former police officer?

A research project conducted by Clinical Psychologist Tess (Terry) Taylor, at the University of South Australia, is gathering information, in their own words, from former police who believe they have experienced changes that have significantly impacted on their lives as a result of their service.

Participation will involve attendance at one interview, and possibly a second interview at a later point, each taking about an hour. The first one will include a screening procedure and following this an opportunity to talk about how you feel about what happened to you, and how you feel as a result. All information given will be confidential and used for the purposes of research only. This research project has no association with any other agency or organization.

If you would like to participate, please call Tess on: (08) 8302 4594 (Your call may forwarded on to a mobile). If she does not answer please call back later or leave a message with your number, first name and the best time to call you.

You may also contact Tess by email on terry.taylor@mymail.unisa.edu.au and request that she call you back or send additional information to you.

This University research project has no association with any other agency or organization. It has been approved by the University of South Australia's Human Research Ethics Committee.

If you have any ethical concerns about the project or questions about your rights as a participant please contact the Executive Officer of this Committee, Tel: +61 8 8302 3118; Email: humanethics@unisa.edu.au

Appendix E

Independent Complaints Procedure form

The University of South Australia

CONTACTS FOR INFORMATION ON PROJECT AND INDEPENDENT COMPLAINTS PROCEDURE

The following study has been reviewed and approved by the University of South Australia's Human Research Ethics Committee:

Project Title:	Life after trauma: changes for better or worse?
Application Number:	0000034833

The Human Research Ethics Committee monitors all the research projects which it has approved. The committee considers it important that people participating in approved projects have an independent and confidential reporting mechanism which they can use if they have any worries or complaints about that research.

This research project will be conducted according to the NHMRC National Statement on Ethical Conduct in Human Research:

(see http://www.nhmrc.gov.au/publications/synopses/e72syn.htm)

1. If you have questions or problems associated with the practical aspects of your participation in the project, or wish to raise a concern or complaint about the project, then you should consult the student researcher:

Name:	Ms Terry Taylor
Phone:	(08) 83024594 terry.taylor@mymail.unisa.edu.au

2. If you wish to discuss with an independent person matters related to:

   - making a complaint, or
   - raising concerns on the conduct of the project, or
   - the University policy on research involving human participants, or
   - your rights as a participant,

   contact the Human Research Ethics Committee's Executive Officer on phone (08) 8302 3118 or by email to Vicki.Allen@unisa.edu.au

Appendix F

Counselling and emergency help

SUICIDE PROTOCOL to be followed if necessary

If someone admits to thinking about committing suicide:

Find out:

If yes ask next question:

Do they have a plan as to how and when they are going to commit suicide?

If no, give number for helpline, offer to call for them.

If yes, ask next questions:

Are they prepared to commit suicide (do they have the necessary equipment e.g. firearm, pills etc. to follow through plan)?

If yes, get as much information as possible about what they are intending to do, give them phone number for helpline, inform them that you will have to notify someone who can help them and phone The SA Mental Health Triage

Service.

REGARDLESS OF ANSWERS TO OTHER QUESTIONS ASK:

Do they have somebody they feel comfortable going to for support (family,

If no, give phone number for helpline, offer to call for them. If yes, advise that they talk to this person about what is going on.

SA MENTAL HEALTH TRIAGE SERVICE: 13 1465

ALFRED PSYCHIATRY: (03) 9076 2000

*Inform Supervisors

Given as hard copy to applicants at conclusion of interview

Agencies Offering Crisis Support and Counselling (Police)

Lifeline 24 hour crisis support -**13 11 14**

Hold On To Life @ the Australian Suicide Prevention Foundation (24/7) - 1800 HOLDON (**1800 465 366)**

Suicide Callback - **1300 659 467** (available 24/7)

Appendix G

Interview Questions for Participants

Open-ended questions

How is your general health? Please let me know if you're feeling overly stressed during the interview, we can take a break or terminate the interview at any time.

1. What led you into choosing policing as a career?

- Was there anything in your early life that influenced this decision?
- Any person?
- If you had the choice over again – would you make the same choice?
- If not – what's the reason – or reasons - for this?
- What advice would you give to a young person who was considering policing as a career?
- What qualities do you believe are important for a police officer?

2. When did you first start experiencing changes in yourself – how you felt?
3. What were they?
4. What was their influence on how you functioned?
5. What was going on generally in your life at that time? (i.e. personal life)
6. In the beginning did you understand why these changes were happening?
7. How would you describe yourself before these changes started happening in your life?
8. After you started developing symptoms, what happened next? When/how did you receive your diagnosis?
9. What did you know about PTSD? Have your thoughts and feelings about it changed since then?
10. Was PTSD the reason you left the service? If so, how did your leaving come about?
11. What changes have occurred in your life since then?

12. What has helped you to manage? Who has been most helpful to you during the course of your illness? How have they been helpful?
13. What is a typical day for you now (good days – bad days)?
14. What effect has it had on the people close to you?

Ending questions

15. What strengths have you discovered in yourself as a result of developing PTSD? What do you value most about yourself as a person now? What do you think others most value about you?
16. Do you think your values have changed since you developed PTSD?
17. What advice would you give to someone who is developing symptoms of PTSD?
18. Is there anything that's come up as a result of this interview that you might not have thought of before?
19. Is there anything you would like to ask me?

Appendix H

Ethics Approval

The Ethics Protocol was created at the University to Adelaide and carried forward by the University of South Australia when I commenced my candidature there. The Project Number was H-2014-173: RM No. 0000019357 and it was approved by the University of Adelaide on 13 November 2014. At that time, I was using the name Terry Zeeher but changed this to Terry Taylor before I enrolled at the University of South Australia, then legally changed my first name to Tess.

When I transferred to the University of South Australia the protocol number became: Ethics Protocol 0000034833 – *'How does the individual attach meaning to their exposure to trauma and related changes in their life and well-being? How might this relate to subsequent persistent negative mood states and co-morbidity?'* The process has been a little complicated and I attach a recent email that in part explains it.

Dear Tess,

Re: Ethics Application 0000034833 *"How does the individual attach meaning to their exposure to trauma and related changes in their life and well-being? How might this relate to subsequent persistent negative mood states and co-morbidity?"* (E1 Approved 17/12/2015 to 30/11/2017)

Thank you for your email.

If you have finished data collection then an extension of your ethics is not required, as it is only needed when conducting the in-person research. We do however require a completion report to formally close the ethics file. Adelaide University being the lead HREC for this project would also require that.

I have attached our template for you to complete and return. You will need to contact the Adelaide Ethics department directly to see what paperwork they require to close the ethics at that end.

Many Thanks,

Tori

Tori Brown | Acting Human Ethics Officer | Research Ethics and Integrity

University of South Australia | Mawson Lakes Campus | Mawson Lakes SA 5095

GPO Box 2471 | Adelaide | South Australia 5001

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