To combat stigma and discrimination, we must first make them visible!

Patrick Corrigan

Winston Churchill Fellow

Report by
Katie Tonacia

9/9/2012
Acknowledgements.

I am sincerely grateful for the opportunity granted to me by the Winston Churchill Memorial Trust. Being fortunate enough to meet with leading researchers in the field of Post-traumatic Stress Disorder (PTSD) and Mental Health Stigma internationally has been undeniably a life changing experience. I feel honoured to have been selected and would like to publicly thank the Board for not only selecting my project, but also for believing in the very critical work I am carrying out. I would also like to thank the ladies in the office who have been delightful in assisting me from the beginning to the end of my whole Churchill experience. A special thank you goes out to Meg for your support, understanding and kindness during the recent adversity I faced upon my return from overseas.

I am deeply indebted to those experts in the field who so kindly offered to meet with me in their own time to discuss the ways in which we can combat the stigma towards PTSD within the culture of our uniformed services. Having the ‘one on one’ time to chat openly and to ask specific targeted questions was an incredible opportunity. Establishing international partnerships and friendships was an additional bonus. (Those I met with and their speciality area are listed at the end of my report.)

I would like to acknowledge my referees, Ms. Carmel O’Sullivan and Ms. Elizabeth Ward, and thank them for their kind words and belief in my ability to complete this project. To Carmel specifically, you have provided an insuperable amount of knowledge to me regarding PTSD, as well as support and guidance for my family; you have also provided me with the courage and belief that I can make a difference to those who suffer the debilitating consequences of PTSD.

For all those past and present members of Picking Up The Peaces and the team at the Vietnam Veterans and Veterans Federation ACT Branch, I can’t thank you enough for your encouragement and support; Laurie Drake and Mrs. Toscan, you will forever hold a special place in my heart. I would also sincerely like to thank the ACT Government, Mental Illness Education ACT and the Emergency Service Agency ACT for assisting Picking Up The Peaces with our PTSD pilot education program: through the independent evaluation we were able to clearly identify how stigma prevents those from an emergency service culture utilising the in-house services provided. Stigma is an enormous barrier to help-seeking behaviour.

A heartfelt thank you goes to my parents, David and Pam Jenkins, for taking care of our children, animals and home while I was traveling. I could never have achieved what I have without your love and support. I truly love you both.

For everyone who has supported me in my endeavors, “thank you”. There are far too many people to thank individually for their support and encouragement, but you know who you are. We are making a difference. I aim to disseminate this knowledge using every opportunity I can, and I hope in time that “Stigma” will be eradicated so those experiencing early signs of trauma-related distress can step forward and seek the respectful treatment they so deserve.

I would also like to thank the Australian Federal Police (AFP) for granting me four weeks’ leave so that I could complete this very important study project. I hope in time this information can be utilised within many organisations, including the AFP, to assist those who at times suffer PTSD as a consequence of their work!

To my beautiful children Peter, James and Sarah; I love you dearly. You never complain I’m always working late or buried deep in a book learning what I can about PTSD. I know my commitment to raising awareness of PTSD has come at such a cost to you. Have comfort knowing that you too are helping reduce the stigma, and this in-turn will help many people!

To my gorgeous husband David, to acknowledge you have PTSD is incredibly courageous, however to do this openly and publically is without doubt far more heroic than wearing any uniform. You have now given those struggling with PTSD a reason to step forward. You make the world a better place. I am so proud of you and love you dearly. Xx
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Signed  
Dated 9/9/2012

The opinions offered in this report are those of the author based upon personal experience, education, working close to those who experience Post-traumatic Stress Disorder and through my Churchill Fellowship research project. It is not intended to reflect current or future policy decisions of the Australian Federal Police or reflect the opinions of any other individual or organisation.
“Mental illness is nothing to be ashamed of, but stigma and bias shame us all.”

Bill Clinton
Executive Summary

Katie Tonacia
Australian Federal Police Edmund Barton Building,
47 Kings Avenue
Barton ACT 2600

Project Description
To study and investigate methods for eradicating the stigma and misconceptions surrounding Post-traumatic Stress Disorder among our uniformed personnel.

Through funding provided by the Winston Churchill Memorial Trust I was privileged to travel to the UK, Canada and the USA between May 2 and June 22, 2012. This extraordinary opportunity permitted me to meet with world leading researchers in the field of Post-traumatic Stress Disorder (PTSD) and also those who specialise in the ‘ stigma’ of mental illness.

The intensity of stigma attached to PTSD can be dangerous and unacceptable; some have described it as more debilitating than the initial trauma. Through my travels I was given the opportunity to ask those in my chosen field specific targeted questions relating stigma and ways in which we can combat this very real problem that exists throughout frontline emergency service environments. Numerous conversations took place and my topic was discussed in detail. It was evident there was a common theme that emerged: mental health stigma needs to be addressed as a matter of urgency and at a national level. Strong mental health leadership, the introduction of a solid mental health strategy, and raising awareness and education throughout high-risk organisations will directly assist with breaking down the stigma and assist in preventing mental health injury.

The following report offers the highlights I experienced, coupled with key discussion topics and learnings from those I had the privilege of meeting with. There are recommendations that derived from compiling my research, and also general relevant information learned throughout my journey.

My Churchill Fellowship experience has been life-changing and exceptionally educational. I believe through my newfound knowledge and experience it can be life-changing for others, especially those who have suffered tremendous stigma due to a PTSD diagnosis. I hope in time PTSD stigma is
eradicated and those who find themselves experiencing difficulties can feel comfortable enough to step forward without the fear of prejudice, shame and guilt.

The overall objectives for my Churchill Fellowship research project

I chose to meet various leading experts, not only in the field of PTSD, but also those who comprehend the emergency service culture, experts in the field of stigma and mental illness, those with the lived experience of PTSD, and experts in grief and suicide. By combining the experience of each and every one I met with, I was able to draw on an immeasurable amount of knowledge.

The objectives of my Fellowship were to examine various methods of combating the stigma that exists in frontline emergency service cultures. This included examining the ‘macho’ culture, and why it plays a lead role in preventing people from stepping forward, understanding how language plays an important role when discussing mental illness, and the social identity that comes from donning a uniform.

Over many years I have made a number of observations in relation to the obstacles faced by those experiencing PTSD and associated illness, and why they are unlikely to want to step forward. It is a fear, and on most occasions a reality for those diagnosed with PTSD, that it will end their chosen career. Even when successfully rehabilitated, the stigma faced when returning to work will, on most occasions, cause further distress.

Our organisation, Picking Up The Peaces—a national initiative to raise awareness of PTSD within high-risk workplaces—has developed a PTSD Education and Literacy Program. The objectives of my Fellowship were to gain further knowledge to implement into our training program to directly assist with: breaking down the stigma of PTSD; changing the culture within emergency service organisations to view PTSD as a normal workplace injury, and enabling those experiencing difficulties to feel comfortable to seek assistance before PTSD becomes entrenched and more difficult to treat.

The experience and knowledge I have gained has now been integrated into the PTSD education program and is demonstrating a significant shift in culture towards those diagnosed with PTSD. My Winston Churchill Fellowship has been very successful.
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1 Introduction

Post-Traumatic Stress Disorder (PTSD) is not a choice for which people are responsible. It is the unfortunate consequence of being exposed to an extreme traumatic event or events. The person is no more to blame than the individual afflicted with cancer!

In the workplace, community and among family and friends physical injuries or illness are easy to identify and widely accepted. Flowers, gifts and visits to those in hospital, the signing of get well cards or plaster casts, fund-raising events and light duties implemented at work, all these gestures demonstrate to the injured or unwell individual that they are worthy, respected and valued as a person.

Psychological injuries and illnesses however are far more complex as there is lesser amount of empathy and compassion for those with mental illness. In fact, society often blames those for their condition, implying a personal weakness or a problem they brought onto themselves or perhaps their upbringing. This is due to the ‘stigma’ attached to mental illness. Society’s reactions to those identified with a mental health problem have often been described at times as more damaging and painful than the initial diagnosis. Stigma against people with a mental illness includes inaccurate and hurtful depictions of them as being violent, unpredictable, incompetent and dangerous, just to name a few. Stigma prevents those experiencing difficulties from stepping forward and seeking support and assistance.

*Post-Traumatic Stress Disorder (PTSD) is a psychological injury that brings with it a tremendous ‘stigma’. As with any illness and injury that cannot be seen it fetches speculation and false beliefs that an individual is faking, weak or trying to swindle the system. PTSD has many negative stereotypical connotations that accompany the label.*

Uniformed personnel are a collection of people who are susceptible to PTSD due to the nature of their work! They are repeatedly exposed to horrific scenes and traumas, sometimes on a daily basis. Military serving in the theatre of war are being exposed to gun-fire, death and degradation; police and emergency service personnel are dealing with tragic events such as horrific and brutal murders, child fatalities, fatal motor vehicle accidents, natural disasters and terrorist attacks. The trauma that many of our uniformed personnel experience while performing their duties could only be described as horrifying, and sadly it is estimated between 15-30 percent of these service members will suffer psychological distress at some point of time in their career.
Like physical illness, research demonstrates that the earlier PTSD is identified and treated the probabilities of a full recovery improve dramatically, however due to the stigma associated, and the prevalence of PTSD in the police and defence forces and emergency services; an overwhelming number of PTSD casualties and their families suffer silently because of their fear that accessing professional help will negatively affect their career. Many are slipping through the cracks and going undetected or not receiving adequate treatment or support for themselves or their family. It’s usually not until breaking point or a performance or conduct issue arises that they are then identified. By then alcohol issues have developed, relationships broken down, careers are in disarray and suicide is a very real possibility.

An overview of the report

This report is has four main sections.

Section 2 describes ‘the journey’ I made during my Fellowship:

- the highlights,
- the key informants I met
- the discussions and main learnings from these meetings and experiences

Sections 3 and 4 summarise the research I undertook:

- ‘What is PTSD’, its symptoms and impact on relationships.
- Stigma – its negative effects including self-imposed stigma
- Combating the stigma against mental illness in the culture of the emergency services and in the media
- The challenge of challenging stigma

Section 5 completes the report with some conclusions, recommendations and attachments of articles of interest.
2 The Fellowship journey, its highlights, key meetings and learnings.

2.1 Highlights

- Meeting Professor Jonathon Bisson at the Cardiff University School of Medicine.
- Attending the 5th World Stigma Conference in Ottawa, Canada:
  - Listening to key note speaker Glenn Close (academy award winning actress and mental illness advocate)
  - Hearing the personal stories and lived experience from those diagnosed with mental illness.
- Meeting Shannon Pennington, Director and Founder of the North American Firefighter Veteran Network, and establishing an international partnership and friendship.
- Meeting with Peggy Sweeney, Founder and President of the Grieving Behind the Badge Program and forming an international partnership and friendship.

Attending the Illinois Institute of Technology in Chicago and directly meeting and sharing the vision of our organisation *Picking Up The Peaces* with Professor Patrick Corrigan. Professor Corrrigan spoke highly of our PTSD Education and Literacy program and commended us on the model used. (Utilising people with the ‘lived’ experience is a researched and proven evidence-based model in decreasing the stigma attached to mental illness.)

- Attending the Winston Churchill Memorial Trust in London and being in the very room Sir Winston Churchill worked from.
- Meeting with the many people who share my vision, goals and who also understand and appreciate the vital importance of this work
- Being able to call myself a Winston Churchill Fellow: what an honour!
2.2 Key informants, discussion topics and key learnings.

Further details about the people and programs mentioned here may be found in Attachment 1.

Kings College London
The Weston Education Centre

Kings College London
10 Cutcombe Road London
SE5 9RJ

Key learnings:

Professor Neil Greenberg

- Through good mental health leadership, organisations can reduce the incidents of psychological injury.

- Preventative screenings just the same as we would with the dentist—through regular mental health checks-ups, problems can be early identified and treated accordingly.

- For operational efficiency high-risk organisations must have their staff at full capacity; investing in mental health education and literacy programs is essential and far less costly than the costs associated with a critical incident or continued psychological stress claims.

- Discussed the possibility of those exposed to trauma regularly being educated in simple stress reduction techniques as part of their initial training.


For further information regarding the TRiM model please visit TRiM - Traumatic Risk Management
Cardiff University School of Medicine

Dean of Medicine Office
Cardiff University School of Medicine
UHW Main Building
Heath Park
Cardiff CF14 4XN

Professor Jonathon Bisson, Dave and Kate Tonacia

Discussions

- Stigma is a societal problem. Education throughout schools will assist in changing the negative views towards people who battle with mental health problems.

- In terms of high-risk environments, organisations need to invest in solid mental health leadership and implement strong mental health policy.

Professor Jonathon Bisson

Key Learnings

- Mental Health Leadership and a solid Mental Health Strategy for high-risk environments is essential.

- The highest of leaders, including government, must sign up to a public health campaign.

- Education in schools assists with changing society’s viewpoint on Mental Health Issues.

- High level policy needs to be implemented into high-risk workplaces.

- Strong social support following a critical incident is vital in preventing psychological injury or during the recovery phase. The workplace must provide a supportive environment.

- Pathways for recovery need to be clearly identified and support systems easily accessible.

- Discussed in length the PUTP education and literacy program. Prof Bisson remarked we are definitely on the correct path.

- Discussed the TRIM Model addressing the issues of stigma.

- Media to relay sensible messages.

- There appears to be less stigma among military in the UK and a shift in attitudes, possibly due to advertisements on TV.
Key Learnings

**Liz Royle** : *Liz is completing a Ph.D. on the culture of police officers who have originated from a military background.*

- The social identity of police officers and the culture and attitudes towards mental health creates more complexity than just stigma, but also loss of control and loss of social identity.
- Discussed identity transition. The identity of those in military and uniformed services is very powerful.
- Discussed in length the different stages of the PTSD Cycle. Exposure, existential crisis, the road to recovery.
- Recovery: Some people recover to lead very fulfilling lives, work and function very well, while others may not recover. Recovery is different for everyone.
- How workplaces can minimize the impact of trauma by having policies and procedures in-place prior to potential disasters. Preparing staff and proactive training will empower both individuals and Managers for when a potentially traumatizing incident occurs.

**Post-traumatic growth**

- Second identity – new path - people gain more skills from the experience, create a new identity and can become advocates for mental health.
Illinois Institute of Technology, Chicago

IIT College of Psychology
3300 S Federal St Chicago,
IL 60616, United States

IIT College of Psychology

Professor Patrick Corrigan and Katie Tonacia

Discussions

- Coping with the stigma of mental illness.

- Ways to challenge stigma in an emergency service environment.

- Using the model of the lived experience to breakdown stigma.

- Mental Health Leadership within high-risk organisations.

- Picking up the Peaces’ organisation and future programs. Integrating those with the lived experience into education and literacy programs directed towards emergency service work-place environments.

Key Learnings

- Contact between those with a PTSD diagnosis and those without is one of the most effective ways to reduce the stigma among uniformed personnel. Those who have suffered and recovered demonstrate to peers “Yes I was unwell, but then I recovered”—removing the perceived fear that accompanies a PTSD diagnosis. This contact is particularly powerful if an individual remains in the workforce and is supported by solid leadership.

- ‘Recovery’ and the definition of what this means. Those with a PTSD diagnosis can be valuable resources for their organisations.

- Changing society’s reactions through ‘contact, education, and protest’.

- Challenging stigma and discrimination. Instigating positive conversations surrounding mental health within emergency service organisations.

- Peer to Peer education. Police to Police – Fire service to fire service etc, and utilising those with the lived experience of mental illness will assist in reducing stigma.
North American Fire-fighter Veteran Network,
Alberta Canada.

Website: North American Firefighter Veteran Network

Shannon Pennington is the Executive Director of the North American Firefighter Veteran Network and author of several working papers on stress in the first responder community in Canada and the United States. He is a retired PTSD survivor after serving in the Canadian military (regular and reserves) and as a 26 year career line firefighter/medic. He currently runs the web site for NAFFVN as an educational outreach to first responders with information that is up-to-date regarding occupational stress and recovery from Post-Traumatic Stress. NAFFVN has offices in Washington State and Alberta Canada.

Terri-Lynn, Shannon, Katie and David enjoying some down time in Banff, Canada.
Key Discussions.

Shannon and I have been communicating and sharing ideas regarding PTSD, stigma and the effects on our emergency service personnel (or first responders as they are known in Canada and North America) for approximately four years. It was a privilege to finally meet with Shannon face to face. It was clearly evident we share a common goal and extreme passion to educate those who work in high-risk environments to recognise early signs and symptoms of trauma related distress. We discussed many ideas during the sigma conference, and later back in Alberta, Canada we met again. Shannon has many years’ experience in assisting those with PTSD in the North American and Canadian Fire Service. His work consists of PTSD education, suicide prevention and depression. His focus is driven towards prevention, recovery and regaining a sense of health and wellbeing following a PTSD Diagnosis. I am proud to say we have now formed an international frontline partnership working towards building a credible international resource for all uniformed personnel psychologically injured in the line of duty.

Current promotional material initiated by NAFFVN & Sweeny Alliance – Grieving behind the badge
Sweeney Alliance,
1601 Quinlan Creek Drive
Kerrville, TX 78028

Grieving Behind the Badge

Pictured – Katie Tonacia, Peggy Sweeney and Sue Endsley - meeting in Dallas, Texas

Peggy Sweeny is the founder and president of the Sweeney Alliance, a non-profit company providing educational programs, resources, and support services for families and professionals coping with traumatic events. Since 1997, she has taught her Grieving Behind the Badge program for firefighters/EMS, police and correctional officers, emergency dispatchers, their families, and department chaplains throughout the United States and Canada. Peggy is a highly published author and has written many articles on grief, trauma, recovery, and suicide loss. Peggy and I have spoken at length since our short meeting in Dallas, Texas. I look forward to working closely with Peggy in the future as we too partner up our organisations together.
Peggy’s work is invaluable, especially her incredible knowledge about those suffering tremendous grief. I am proud to say we have also now formed an international frontline partnership working towards building resources for all uniformed personnel. The combined knowledge from the united organisations will in time provide an incredible resource for all those in uniform suffering from PTSD and associated illness.

Peggy’s speciality is in grief, suicide, prevention of suicide, and PTSD and Depression education to emergency first responders.

Peggy provides a free online study program about different types of loss and grief issues, and also provides monthly newsletters.

Coursework in Grief – Visit this link to see the outline of the program

It is without doubt the grief experienced by the culmination of traumatic events significantly impacts the health and wellbeing of our frontline uniformed service personnel.

The grief experienced when those are forced out of their chosen career due to PTSD and associated illness, and the loss of identity that accompanies this grief, definitely requires further investigation.

Image provided by the Grieving behind the badge website. Peggy Sweeny
5th World Stigma Conference 2012: Together Against Stigma—changing how we see mental illness, was held at the Delta Ottawa City Centre in Ottawa, Canada.

**5th World Stigma Conference**

On June 4-6, the Section on Stigma and Mental Health of the World Psychiatric Association co-hosted the 5th International Together Against Stigma Conference with the Mental Health Commission of Canada through their Opening Minds anti-stigma initiative. The theme for this year’s congress was: *Changing the Way We See Mental Illness*. The conference was held in Ottawa, Canada with 670 delegates from 28 countries making this the largest stigma conference to date. The Stigma and Mental Health Section has co-sponsored previous congresses in Leipzig, Germany, Kingston, Canada, Istanbul, Turkey, London, England.

“Plenary speakers addressed stigma and the family, lessons learned from anti-stigma programming, building better practices targeting youth, media depictions, workplace mental health, military mental health, and human rights. Over 156 presentations were made with 95 poster sessions on issues ranging from global perspectives on stigma, the importance of social enterprises, personal recovery stories, and use of language. The Mental Health Commission of Canada sponsored 64 people with experience of a mental illness to attend the conference by waiving registration fees or providing full bursaries. Evening activities featured performers who had experienced a mental illness and a silent art auction raised close to $3,000 for the artists, all of whom had experienced a mental illness.”

A detailed report of the congress is available on the Mental Health Commission of Canada’s website at: [Mental Health Commission of Canada’s website](#)

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1 Heather Stuart, Chair, WPA Section on Stigma and Mental Health World Psychiatric Association
Keynote speakers included:

- Graham Thornicroft, PhD, Professor of Community Psychiatry, Head of the Health Service and Population Research Department, Institute of Psychiatry, King's College, London, U.K.
- Norman Sartorius, MD, President of the Association for the Improvement of Mental Health Programs and a member of the Geneva Prize Foundation for Human Rights in Psychiatry.
- Patrick Corrigan, Psy.D., Distinguished Professor and Associate Dean of Research Psychology, College of Psychology, Illinois Institute of Technology, and editor-in-chief of the *American Journal of Psychiatric Rehabilitation*.
- Heather Stuart, PhD, Professor in the Department of Community Health and Epidemiology, Chair and Co-founder of the World Psychiatric Association's Scientific Section on Stigma and Mental Disorders, and the Bell Mental Health and Anti-Stigma Research Chair at Queen's University, Kingston, Ontario.

The conference was co-hosted by the World Psychiatric Association Scientific Section on Stigma and Mental Illness and the Mental Health Commission of Canada. The commission presently leads the largest systematic effort in Canadian history to reduce the stigma surrounding mental illnesses.

Highlights of the conference

There were many highlights from attending this conference; it was exceptionally educational, professionally organised and particularly beneficial. Some of these highlights were:

- Meeting with Michael Pietrus, Director of the Opening Minds Program (Mental Health Commission Canada).
- Chatting with Betty Kitchner, Founder of Mental Health First Aid Australia and comparing the similarities of the way our organisations were founded.
- Listening to the many key note speakers, especially Patrick Corrigan and Tony Jorm.
- Canada has recognised that to improve their Mental Health System it is a big job, and too big for one organisation alone. The Mental Health Commission of Canada is collaborating with people and organisations all over their country. By working together they are sparking the changes that will help improve the mental health system for all Canadians. Many organisations are partnering up and working together to ensure there are changes in the home, workplace, communities, and in the health, housing, education and justice systems. Canada has recognised how stigma plays a colossal role in preventing people from seeking treatment for Mental illness, and has now made this a priority. The conference was called *Together Against Stigma: changing how we see mental illness*. Brilliant!
Some of the workshops I attended:

- Working within the Cultural context to understand and challenge Mental Illness Stigma
- Mental Health Reform and Stigma Reduction: Critical Success factors for Public Education Campaigns
- Why Human Rights Matter in Reducing Stigma
- Reducing the Stigma of Mental Illness Among Work Supervisors – Implementation and Evaluation of one workplace Program
- Understanding the Stigma of Mental Disorders in the Workplace: An examination of three different methodological approaches.

- The focus was on effective interventions to reduce stigma and discrimination
- Stigma refers to relating negative qualities with having a mental illness. For example, a person with a mental health problem may be falsely viewed or even view themselves, as being weak or "damaged," leading to feelings of shame, guilt and embarrassment. Many experiencing mental health problems are reluctant to step forward.
- The Together Against Stigma; changing how we see mental illness focused on collaborating together with people and organisations to combat stigma.
- The lived experience of those living with mental illness and sharing their stories, from the bottom of despair to being successful and living life to the full again, is such a great tool in educating others and in reducing the stigma associated to mental illness.
3 What is Post-traumatic Stress Disorder

Post-traumatic Stress Disorder or PTSD as it is more broadly known is the psychological and physiological response to an event of an intensely traumatic nature. It can arguably be called a ‘normal’ reaction to an abnormal and extreme event. According to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) by definition, PTSD always follows a traumatic event, which causes intense fear and/or helplessness in an individual. Typically the symptoms develop shortly after the event, but may take many years. The duration for symptoms is at least one month for a diagnosis.

Research demonstrates it is more likely to be a culmination of many traumatic events for those who work in environments such as our military emergency service and policing type roles!

A vast majority of people associate PTSD with wounded soldiers from the Vietnam War—but any overwhelming life experience can trigger PTSD, especially if the event feels volatile and disturbing. PTSD can affect those who personally experience a horrifying event, those who witness it, and those who pick up the pieces afterwards, including our frontline emergency service workers.

Some traumatic events that can trigger PTSD include;

- Natural disasters
- Crashes – car - plane - train
- War and conflict
- Assault - Sexual or Physical abuse
- Terrorist attacks
- Kidnapping
- Childhood neglect and trauma

Following a traumatic event, it’s perfectly normal to experience at least some of the symptoms of PTSD. When a sense of safety and trust are jeopardised, it’s usual to feel disconnected, or numb. Distressing dreams are common, and an individual may find it difficult to stop thinking about what happened. These are normal reactions to abnormal events. For most people these symptoms are typical and short-lived. They may last for a few days or even a couple of weeks, however in time disappear. PTSD can be diagnosed if the symptoms don’t decrease and the individual’s activities of daily living become compromised.
3.1 Symptoms

Symptoms of fall into three main categories

Intrusive symptoms - Reliving the event

- Flashback episodes, where the individual feels like they’re reliving the trauma again
- Repeated upsetting memories or images of the event.
- Repeated nightmares and night terrors
- Triggers, uncomfortable reactions to situations that are reminders of the event
- Physical symptoms, such as heart palpitations, sweating and muscle tension

Avoidance and numbing

- Emotional “numbing,” feeling detached as though the individual doesn’t care
- Being unable to remember important aspects of the trauma
- Having a lack of interest in normal activities – feeling flat or numb
- Avoiding places, people, thoughts, feelings, conversations that are reminders
- Feeling like there’s a limited future or no future

Arousal

- Difficulty concentrating
- Having an exaggerated response to things that startle the individual – loud noises
- Hypervigilance - Feeling more aware, scouting for danger – extreme alertness
- Feeling irritable or having anger outbursts
- Sleep disturbance - having trouble falling or staying asleep

Other common symptoms associated with PTSD

Anger and irritability - guilt, shame, or self-blame - substance abuse and addiction- feelings of mistrust and betrayal - depression and hopelessness - Suicidal thoughts and feelings - Feeling alienated and alone - physical aches and pains – physical illness such as gastric problems, early onset of cancers, diabetes and heart disease.
The effect of PTSD on family can be significant. Relationships can either positively or negatively impact on a loved one’s PTSD symptoms. The first step in living with and helping a loved one is learning about the symptoms and understanding how these symptoms may impact on relationships and behavior.

Research demonstrates that good solid relationships and having strong social support networks is critical in the recovery and in the prevention of relapses for those experiencing PTSD, and associated illness. Sadly, even the very strongest of relationships can be tested when a family member is experiencing PTSD difficulties.

PTSD is not contagious; however family can suffer as a consequence. Changes in the capacity to function as a parent and partner can lead to family needs being unmet, placing further stress on the family as a whole. Since PTSD affects the whole family unit it can be particularly beneficial for the family to seek assistance together. It can also help the family communicate better and work through relationship difficulties. Family members can become extremely distressed when witnessing the assortment of symptoms that accompany PTSD, such as night-terrors or anger outbursts, and it often results in families requiring assistance at some point in time; the earlier, the better the outcome for all. It has often been cited that families where a parent has PTSD experience more anxiety, unhappiness, marital problems, and behavioral problems among children compared to families where a parent does not have PTSD.

When struggling with tiring reactions, emotions and traumatic memories, self-medication with alcohol and drugs is tempting and can temporarily make those experiencing difficulties feel better, however it is proven they make PTSD worse in the long run. Substance use worsens many symptoms of PTSD, including emotional numbing, social isolation, anger, and depression. It also interferes with treatment and can add to problems at home and difficulties in the workplace. Emotional numbing or disassociation is a common symptom of PTSD; it’s extremely difficult for family, friends and also work colleagues. It may appear the individual is disinterested or distant, as they show little emotion. This can be excruciatingly hurtful for loved ones, especially children. Work colleagues can further isolate an individual believing they are rude or a loner. A lack of energy due to sleep disturbance or alcohol abuse can also contribute to social issues, leading to further anxiety and marital issues. Intimacy and sexual dysfunction is a common problem, however rarely talked about. This places further strain on relationships. Medication can contribute to this problem also.

Portions of the above information have been sourced from Matthew Tull\(^2\)

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\(^2\) Matthew Tull PhD - Coping with a loved one’s PTSD
3.3 Statistics

- The World Health Organisation (WHO) predicts depression (which occurs in approximately 80% of people with PTSD) to be the leading contributor to the disease burden internationally amongst all illnesses by 2020.

- Depression and anxiety disorders are the leading cause of disability and mortality in Australia.³

- ABS states (these figures are noted to be under-estimated) that suicide represents a quarter of Male deaths between the ages of 15-40 and 20 percent of Female deaths in their early 20’s.

Other facts about the impacts of depression and anxiety in the workplace are summarised below:

- Preliminary research shows businesses lose over $6.5 billion each year by failing to provide early intervention and treatment for employees with mental health conditions.⁴

- 3-4 days off work per month for each person experiencing depression.⁵

- Over 6 million working days lost each year in Australia - 12 Million days of reduced productivity each year.⁶

- $9,660 in absenteeism and lost productivity costs per full-time employee with untreated depression each year ($650,000 per annum per 1000 employees).⁷

- Job-related depression costs the economy $730 million every year. This includes lost productivity due to absenteeism and presenteeism and government subsidised medical care, including counselling and antidepressants. This equates to $11.8 billion over the average working lifetime, with the biggest loss accruing to employers through lost productivity.⁸

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⁴ Professor Allan Fels AO, Chair, National Mental Health Commission - Speech to the press club- How do you measure a contributing life?
⁶ Beyondblue – Mental health in the workplace. Participant workbook for the beyondblue National Workplace Program
⁷ Hilton, M (2004). Assessing the financial return of investment of good management strategies and the WORC Project. The university of Queensland and the Queensland Centre for Mental Health Research, 2004
Prevalence of 12 month mental disorders: PTSD stands out!

Prevalence of mental disorders is the proportion of people in a given population who met the criteria for diagnosis of a mental disorder at a point in time.

- The 2007 National Survey of Mental Health and Wellbeing (SMHWB) found that 14.4% (2.3 million) of Australians aged 16-85 years had a 12-month Anxiety Disorder, 6.2% (995,900) had a 12-month Affective Disorder and 5.1% (819,800) had a 12-month Substance Use Disorder. Post-Traumatic Stress Disorder had the highest individual statistic of any of the 12 mental illnesses specified – 6.4%. In addition, 10 of the remaining 11 disorders are documented in Diagnostic and Statistics Manual -IV (DSM-IV) as symptoms of PTSD. By contrast, depressive episodes occurred in 4.1%

The following diagram from the Australian Bureau of Statistics (ABS) shows the 12-month prevalence rates for each of the major disorder groups (Anxiety, Affective and Substance Use) and prevalence rates for each of the mental disorders within each group:

Figure: Prevalence of 12 month mental disorders (ABS 2007)
Prevalence of 12-month anxiety disorders continued

Australia’s 2007 National Survey of Mental Health and Wellbeing provided the following statistics on 12-month anxiety disorders.

Anxiety disorders generally involve feelings of tension, distress or nervousness. A person may avoid, or endure with dread, situations, which cause these types of feelings. Anxiety disorders comprise: Panic Disorder, Agoraphobia, Social Phobia, Generalised Anxiety Disorder (GAD), Obsessive-Compulsive Disorder (OCD) and Post-Traumatic Stress Disorder (PTSD). PTSD and Social Phobia were the most prevalent Anxiety disorders (6.4% and 4.7% respectively). Women experienced higher rates of PTSD than men (8.3% compared with 4.6% respectively) and also Social Phobia (5.7% compared with 3.8%).

![Figure 2: Prevalence of 12 month anxiety disorders (NSMH&W 2007)](image)

(a) Persons who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview. A person may have had more than one Anxiety disorder.

It is believed Women have a higher rate of PTSD as they are more likely to seek assistance when experiencing difficulties and are more at risk of sexual and physical assault.

Figure 2: Prevalence of 12 month anxiety disorders (NSMH&W 2007)

3.4 Costs of Mental Health Injury

Not investing in education and early intervention for those at risk of psychological injury or PTSD is very costly!

Post-traumatic stress disorder has had a substantial impact on employer liability for workplace psychological injury.

Comcare, an Australian leading government work-place insurance scheme, states:

“Costs of psychological injury claims are considerably higher than other injuries because they tend to involve longer periods of time off work and higher medical, legal and other claim payments.”
These costs do not take into account the organisational costs associated with:

- Absenteeism
- Labour turnover
- Workplace conflict
- Loss of productivity – (presenteeism)
- The impact on the psychological and physical wellbeing of individuals and their families.
- The average cost per mental stress claims between 2010 – 2011 = $205,000, however some PTSD claims can blow out into the millions for an individual claim.

**Employers can influence these costs through a focus on prevention and early intervention, such as by training managers to recognise the early warning signs of psychological distress.” (Comcare)⁹.**

3.5 Repeated exposure to traumatic events and Suicide. The cost and damage to those who serve to protect, community and country.

We know many uniformed personnel are exposed to traumatic experiences through their work. They face dangerous situations constantly, which can be life threatening, they deal with death, loss, sadness, pain, grief and witness horrific scenes. Does this make this collection of people more susceptible to suicide? Please see attachment 3 at the end of the report to draw on your own conclusions.

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⁹ Comcare Australian Government
4 Post-traumatic Stress Disorder and Stigma

“People with mental disabilities and their families fail to seek the care and support that they require for fear of being stigmatized”
World Health Organization, 2007

Stigma is a Greek word that in its origins referred to a type of marking or tattoo that was cut or burned into the skin of criminals, slaves, or traitors in order to visibly identify them as blemished or morally polluted persons. These individuals were to be avoided or shunned, particularly in public places.  

Social stigma is the extreme disapproval of, or discontent with, a person on the grounds of characteristics that distinguish them from other members of a society. Stigma may attach to a person, who differs from social or cultural norms. Erving Goffman defined stigma as ‘the process by which the reaction of others spoils normal identity’.  

The most often cited reason for why people do not seek counselling and other mental health services is the stigma associated with mental illness and seeking treatment.

For more than thirty years since it was first defined, the battle to improve the life of those living with Post-Traumatic Stress Disorder has been marked by the enormous advances in research, by the introduction of health services and healthcare providers, and by specific PTSD treatment programs and facilities. There is now a greater understanding of how to treat and better support those who are living with PTSD and associated illness. However, despite great progress, many individuals continue to fall through the cracks and not receive adequate treatment or support. Research demonstrates that ‘stigma’ and the fear of social disapproval are found to be an enormous barrier preventing individuals from engaging in mental health services. One of the biggest consequences of stigma is the negative effect on early detection and intervention strategies. People often wait too long to seek support and assistance. Stigma deprives those experiencing difficulties the opportunity to pursue treatment, or to even disclose they are experiencing problems.

In the prevention, detection and early intervention of PTSD and associated illnesses, a better understanding of the problem of stigma is critical and should be addressed as a priority.

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10 Healthline Network Inc., 2007
12 (Corrigan, 2004).
4.1 What are the negative effects of stigma on the individual diagnosed with PTSD?

Most often, PTSD stigma comes across as demeaning comments or behaviour that blames or shames someone because it is not completely understood. There are many false beliefs and fears about those living with PTSD (and associated illness) such as assuming that they are likely to be unproductive, unreliable, violent or unable to handle workplace pressures.

Negative comments that are commonly attached to PTSD

“It’s just an excuse for bad behavior”

“He’s just trying to fraud the system”

“Public mental illness stigma” is the reaction that the general population displays towards those with mental illness. Stigma is as a label that associates a person to a set of unwanted characteristics that form a stereotype.

“Self-stigma” is the prejudice which people with mental illness turn against themselves.

The impact of self-stigma: Self-stigma is what an individual believes the world thinks of them. Many people who have been on the end of stigma feel as though they are altering from a “normal” person to a tainted one. They feel different and devalued by others. This can happen in the workplace, school, by healthcare providers, and even in their own family. People start to internalise society’s beliefs. “I’m a mental case” – “a nutter” – “a whack job” – “I must be useless” – “it’s my fault we don’t get invited to family functions” – “I am a liability” – “people must be scared of me” – “who’d want to be friends with me” – “who’d want to employ me”… the list goes on. Confidence and self-image is one of the ways self-stigma starts to encroach into someone’s life. As self-confidence and self-image become distorted, those suffering become withdrawn feeling worthless as they start to experience very low self-esteem. They feel a burden on society. The consequences of self-stigma can be devastating for those experiencing problems. It is reported that self-stigma is the more dangerous type of stigma, and is a contributing factor to suicide.

I have often heard those with PTSD say the stigma they’ve faced is just as wounding as their initial trauma!
4.2 Self-imposed stigma in the emergency service environment

There are many reasons to address stigma in the workplace, but none more than the social impact it places on the individual experiencing difficulties. Stigma promotes injustices and deprives workplaces of an invaluable resource; experience and corporate knowledge is costly to replace.

The quality of an organisation’s culture and how it values its employees’ health and wellbeing become apparent in many ways; no more so than the attitudes and behaviours modeled by the highest leadership within the organisation\(^\text{13}\). Attitudes toward mental health and wellbeing can make an enormous difference for all employees, especially for those more at risk of being exposed to potentially traumatic incidents.

In order to attain operational efficiency, high-risk organisations need to invest in mental health leadership; it is the key to breaking down stigma and minimising the impact of stress related injury. *Organisations should strive to create a supportive, healthy, emotionally safe work environment. Research indicates that work and the workplace impact on a person’s mental health, either positively or negatively.*\(^\text{14}\)

Working in a uniformed environment brings with it a ‘social identity’ – our members put their life on the line to protect and serve, and their occupations are some of the most trusted and respected careers. From a young age we are imprinted by the fact that when we need urgent help it is usually a fireman, police officer, nurse, doctor, paramedic or someone from a uniformed service role who assists us. Our military serving overseas, although indirectly, are still helping us. There is a powerful message and a social identity that accompanies these occupations and it starts from a young age prior to even joining the service. You often hear children say when they grow up “I want to be a policeman” or “I want to be a fireman”.

\(^{13}\) Mental health works - Canadian Mental Health Association (CMHA)

\(^{14}\) Beyondblue – Mental health in the workplace. Participant workbook for the beyondblue National Workplace Program
When it comes to the recruitment process to join such careers, again these positive messages are reinforced. Below I have highlighted the examples of the language and messages given out through a recruitment advertisement for a police and fire and rescue service.

Advertisement to join a police force

“Do you want to do something worthwhile? Are you looking for a career that provides new and challenging situations daily? The .... Police Department is the place for hard-working men and women who thrive on challenges. There is no doubt that this can be a tough and unpredictable job, but it is also the most rewarding career you will ever have. Every day when you put on your uniform, you will go to work making life safer and more secure for your friends and neighbours”.

Advertisement to join Fire and Rescue

“Fire & Rescue ... is seeking intelligent, fit, healthy and community-minded men and women to join its permanent fire-fighter ranks. Our world-class emergency service organisation relies on highly skilled, ethical and professional individuals from a variety of backgrounds. We are looking for people who can commit to Fire & Rescue ... values and contribute to fire prevention and emergency responses. Fire fighting is one of the most important and rewarding careers you could have. Fire-fighters are respected community members; and being a fire-fighter provides you with the opportunity to make a real and ongoing difference to the community of....”

The recruitment process is highly competitive and the training rigorous: this is necessary as these occupations must attract the most suitable persons to fulfill these types of careers. I would like to make it very clear that it would be unrealistic to advertise these careers in any other manner, and am merely highlighting the social identity of the men or women in uniform that is reflected.

I believe as the recruitment process commences the “identity transition” continues. By the end of the recruitment process, if the individual succeeds and graduates, they view themselves as “this is who I am”. A strong message has been given that they are now (what was highlighted in the advertisements, and also what they’ve believed from a young age). Tough, strong, intelligent, fit, healthy, hard-working, world-class, highly skilled, ethical and professional individuals, etc.

The public rely on our uniformed service members in a time of crisis; they are very well respected throughout the community. Strong messages are given; we all know our uniformed personnel have to
be tough, brave, and resilient, after-all they run into danger when we are scampering in the other direction. It takes tremendous strength, dedication and bravery to face some of the distressing traumas these members face in their careers, sometimes daily. Sadly, though, this tough identity and exterior can be a double-edged sword; members not coping or experiencing difficulties will be reluctant to step forward as they face the self-imposed stigma that accompanies the feelings of not fitting the mold any longer. Those affected fear their peers will think less of them or see them as weak, unreliable and hot-headed, inadvertently preventing the early detection and treatment required to assist in a full recovery. If a member goes off work with trauma-related distress or can no longer perform their duties, they can start to internalize and believe the opposite to the messages they originally believed, they no longer see themselves as who they were: Elite, tough, strong, intelligent, fit, healthy, hard-working, world-class, highly skilled, ethical and professional individuals. They don’t even feel worthy members of the community. This is when self-imposed stigma can start to creep in and become damaging.

Example of self-talk and self-imposed stigma

<table>
<thead>
<tr>
<th>Original Belief</th>
<th>Stigma</th>
<th>Distorted Belief</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strong</td>
<td>Weak</td>
<td></td>
</tr>
<tr>
<td>Fit</td>
<td>Unhealthy</td>
<td>cowardly</td>
</tr>
<tr>
<td>Courageous</td>
<td>cowardly</td>
<td>Stupid</td>
</tr>
<tr>
<td>Intelligent</td>
<td>Disregarded</td>
<td>Low-life</td>
</tr>
<tr>
<td>Respected</td>
<td>Useless</td>
<td>Amateur</td>
</tr>
<tr>
<td>World class</td>
<td>Unemployable</td>
<td>Worthless</td>
</tr>
<tr>
<td>Highly skilled</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hard working</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Worthwhile</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Low self esteem - no confidence - low self worth- fear- anger -
sadness - withdrawal - depression - addiction -
guilt - suicidal ideation
The following diagrams and Wordle picture\textsuperscript{15} illustrate how this process can happen.

\textsuperscript{15} http://www.wordle.net/create
4.3 Combating Mental Illness Stigma in a Uniformed Service Environment:

The culture of an emergency service or uniformed environment:

The definition of culture: “the arts and other manifestations of human intellectual achievement regarded collectively”

Realistically, attempting to change the culture of our uniformed services would be impossible and very counterproductive, if not extremely detrimental. Uniformed service organisations build their foundations on the very fact that this strong culture exists. Mate-ship, trust, camaraderie, friendship, humour, honour and knowing they can count on their mates, brings an organisation together collectively and builds a spirited workforce. We don’t need to change the entire culture of an organisation; however research demonstrates we do need to change the culture in regard to how mental health is viewed. Eliminating mental health stigma and promoting good mental health and wellbeing must be prioritised. We need to change how those in the services view themselves and their colleagues when battling with mental health problems such as PTSD and associated illness.

So how do we instigate change?

One of the most effective ways to begin changing the culture of an organisation to be more ‘mental health orientated and supportive’ is to change the nature of the conversations about mental health in general. This means changing the conversation to a more positive view, directed towards frontline emergency service employees—through to middle management—and more importantly executive level. Change needs to stem from good mental health leadership. The idea is to create an environment that is open to employees having the confidence to discuss their physical and mental health to their supervisors and colleagues without fear of negative ramifications toward them or their career. The message we need to relay is that “your mental health is as important as your physical health” and “PTSD is an injury, not a weakness”.

Mental illness education by utilising those with the ‘lived’ experience of mental health conditions has been a proven, researched and evidence-based method of breaking down the stigma among our society. To instigate a change of culture and move towards a more positive view of how those
affected by PTSD are received within high-risk workplaces, it would make sense to implement a PTSD Education and Literacy program targeted towards recruits. Current research demonstrates that utilising those with the lived experience is proven to reduce mental illness stigma.

The ‘suck it up’ culture has been in high-risk organisations since conception. Investing in peer to peer education, delivered by those with the lived experience during recruit training prior to any potentially traumatic exposure, is a sure way to change the old school trend of thought. It will also assist those working in uniformed service environments to recognise the early signs and symptoms of PTSD before difficulties of addiction, relationship breakdown and the many associated health problems become imbedded.

Using specific targeted education activities that are designed to provide employees and recruits with factual information about potential mental health and wellbeing problems, and to suggest strategies for minimising the impact following a critical incident, are ways to enhance and enrich overall mental health. There is evidence that individuals who possess more information about mental illness are less stigmatising than individuals who are misinformed about mental illness.

The availability of educational material and resources regarding mental health and wellbeing must be readily available. For high-risk organisations, preventative strategies such as mental health checkups or education on basic stress reduction techniques can be invaluable and reduce the impact of psychological injury also.

We need to normalise and view mental health injury as we would a physical injury. Realistically, this is not quite possible. A mental health injury is not the same as a physical injury. You can’t see it. It fetches speculation that people are trying to fraud the system, and more importantly the costs associated far outweigh those of physical injuries. However, changing the conversation to normalise the fact it happens and implementing early strategies to minimise the impact will have a far better outcome than waiting for the many accumulated stresses our uniform service members encounter to compound.

Workplaces also need to try and keep their employees in productive fulfilling work environments when early signs and symptoms are detected. (That is if the member is well enough to do so.). The isolation from being off work, and the challenging stigma, both from colleagues and the self-imposed

stigma, makes the return back into the workplace very difficult. Remaining in work also debugs the myth that people are malingers and don’t want to work. There are many advantages to keeping those displaying early symptoms in stable workplace environments.

Having the ability to signpost those service members who are potentially at risk of trauma and providing regular mental health checks-ups, problems can then be early identified and treated accordingly before PTSD becomes entrenched and more difficult to treat.

There are many reasons the workplace may not wish to become involved or support mental health and wellbeing activities: the cost involved, they don’t know what to do, it’s not their problem, it’s too personal, they feel they’re infringing on people’s privacy or believe people should just behave better. It is now widely understood that organisations that proactively address overall mental health in the workplace can gain significant benefits\(^\text{18}\). Promoting good mental health and wellbeing practices can bring greater productivity, reduced insurance premiums, and improved staff retention. They can, in fact, affect the entire culture of the workforce.

Uniformed service personnel are predominantly male. In saying this, many woman are employed in these services, and also suffer from traumatic exposures; however it is widely known that woman are more likely to seek assistance than men. (Statistics are provided earlier in the report.)

A recommended reading in this area is *Referring Men to Seek Help: The Influence of Gender Role Conflict and Stigma*, a study by Vogel, Ester, Hammer and Downing (2013). “These authors show that even when distressed, the majority of men do not seek mental health services.\(^\text{19}\) One widely cited explanation for this underuse of mental health services is that men may view these services as conflicting with traditional Western male gender roles and thus shun these services so as to avoid appearing weak or unmanly.\(^\text{20}\) Western culture demands that men be strong, in control of their emotions and their problems, and able to competently handle life stresses without having to ask for help.\(^\text{21}\) Hence, they may avoid seeking help even in the face of significant distress.”\(^\text{22}\).

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All workplaces are heavily impacted by mental health, especially those who expose their staff to potentially traumatic environments. Mental health is a substantial issue that requires the commitment of workplaces to address the significant impact mental health problems can place on employees and their family. People who experience mental health issues face incredible challenges in the workplace. Many are misjudged, avoided and undervalued.

Addressing workplace mental health is well and truly overdue.

4.4 Stigma and PTSD: the role of the media

How the media sensationalises PTSD

People with PTSD, or any mental illness for that matter, suffer public shame and discrimination due to the stigma that is portrayed through the media. Newspaper articles, magazines, TV shows, books and radio programs have all been methods for communicating the experience of mental illness.

For many years PTSD has been largely misinterpreted and misrepresented by the Hollywood film industry. Movies such as Full Metal Jacket, Platoon, Rambo, and countless others have portrayed the image of the soldier—war veteran or cop (Lethal Weapon)—as violent unpredictable, socially inept criminals. The media is responsible for many of the fallacies which continue shape the ideas society places on people with mental illnesses, particularly PTSD. Newspapers, meticulously stress a history of mental illness in the backgrounds of people who commit crimes of violence. Television news programs dramatise crimes where persons with mental illnesses are involved.

Comedians make fun of people with mental illnesses, using their disability as a source of laughter and jokes and advertising agencies use stigmatising images as promotional gimmicks to sell products. We are never going to change society’s belief about people with mental illness until they are represented by the media accurately and without prejudice.

Attachment 2 contains an American article that demonstrates accurately how the media are slow to understand the impact they have on our serving personnel and those diagnosed with PTSD. It is no different here in Australia. The image portrayed globally is that people with PTSD are violent, unpredictable, dangerous and should be feared. In reality this is a fallacy: people with PTSD need
support and understanding. It would be a great help if the media could share the stories of post traumatic a growth, and cover the good news stories of those who've grown through their PTSD experiences.

Ironically, the media also offers our greatest opportunity for eradicating stigma because the control to educate and influence public opinion.23

The information below has been acquired from the SANE website:

“SANE Australia is a national charity helping all Australians affected by mental illness lead a better life – through campaigning, education and research. In order to tackle the media in regards to accurate and responsible reporting, SANE now has an initiative to ensure that media report mental illness in an accurate and responsible way.

“Throughout 2012 SANE “StigmaWatch” worked with national news groups, metropolitan media outlets, regional newsrooms, businesses and celebrities to reduce stigma and encourage responsible reporting of suicide-related issues.

StigmaWatch received 200 StigmaWatch Reports and 38 Good News nominations across Australia.

Media outlets contacted included Channel 9, Channel 7, the ABC, The Australian, The Age, 6PR, and Fox FM.

Quarterly Stigma Bulletins were sent to over 2,000 members, updating members on activity undertaken throughout the year.

If you have seen a positive or stigmatising report in the media you can nominate stories for consideration online, or if you want to subscribe to the mailing list, visit the Join StigmaWatch page.

It is important to remember that SANE StigmaWatch does not aim to stop media reports on issues such as mental illness and suicide, rather, StigmaWatch encourages more accurate and responsible reporting of these complex and sensitive issues”.

23 5th World stigma conference 2012, Ottawa, Canada
4.5 Challenging stigma

Addressing Misconceptions about PTSD—De bugging the MYTHS

**Myth:** It spells the end of your career if diagnosed with PTSD.

**Fact:** Being diagnosed with PTSD should not end anyone’s career. There are plenty of examples where service members have sought treatment and continued in their chosen field. A failure to seek early psychological treatment and a lack of social and workplace support is more likely to cut short someone’s career, as it can lead to more serious psychological problems. The longer PTSD is untreated, the more entrenched it becomes, making recovery more difficult. Seeking support to address psychological health concerns shows inner strength and should be looked on favorably. Mental health checkups through the workplace should be encouraged.

**Myth:** People with PTSD have a week character or flawed personality, or are trying to fraud the system.

**Fact:** PTSD is an injury that derives from a human response to markedly abnormal situations that involve intense fear and helplessness. Chemical changes within the brain occur; it has nothing to do with personality, character or being fraudulent.

**Myth:** People with PTSD are malingerers and don’t want to work or are looking for an easy way out of work.

**Fact:** More often than not PTSD symptoms are exacerbated when the person cannot work. Further stress such as lack or reduced income, isolation from peers, loss of self-worth and social identity directly contribute to an increase in PTSD symptoms.

**Myth:** People with PTSD are dangerous, unpredictable and violent.

**Fact:** The vast majority of people with PTSD are not violent or dangerous. In cases where violence occurs, the incidence typically results from the same reasons as with the general public such as feeling threatened or excessive use of drugs and alcohol.

**Myth:** People with PTSD cannot work.

**Fact:** Chances are you work with someone who has PTSD!

**Myth:** People diagnosed with PTSD who need psychiatric care can never recover or return back to work.

**Fact:** Most people if detected early enough, supported in recovery and treated correctly can go onto lead productive lives! – They work, hold down positions within their communities, and thanks to a variety of supports, programs and if necessary medication, lead a very fulfilling life.
4.6 How can we challenge mental illness stigma?

Information provided by the WA Mental Health Commission

“"We all have a role in creating a mentally healthy community that supports recovery and social inclusion and reduces discrimination. Simple ways to help include:"

- learn and share the facts about mental health and illness
- get to know people with personal experiences of mental illness
- speak up in protest when friends, family, colleagues or the media display false beliefs and negative stereotypes
- offer the same support to people when they are physically or mentally unwell
- don't label or judge people with a mental illness, treat them with respect and dignity as you would anyone else
- don’t discriminate when it comes to participation, housing and employment
- talk openly of your own experience of mental illness. The more hidden mental illness remains, the more people continue to believe that it is shameful and needs to be concealed”.

24 Government of Western Australian Mental Health Commission
5 Conclusions and recommendations

Research proves beyond reasonable doubt the chances of a full recovery diminish the longer PTSD symptoms continue untreated.

My Fellowship travels gave me the opportunity to investigate various methods for reducing the stigma surrounding PTSD. One of the key findings identified is that high-risk organisations must demonstrate commitment to best practice in the workplace through solid mental health leadership in the prevention and education for those more susceptible to psychological injuries. The reduction of stigma associated with PTSD will directly assist with injury and disease prevention and early intervention, significantly reducing the burden of disease costs associated, human and financially. Education, awareness raising activities and stigma reduction programs are going to be far less costly than the continuation of chronic and lengthy psychological injuries.

So what can help to combat stigma and discrimination to ease the path to support for our uniformed services personnel?

“There are few randomized controlled trials and no systemic reviews on the effectiveness of anti-discrimination activities. The majority of the evidence is found in attitudinal surveys or review papers.”

Professor Corrigan and his colleagues have examined the effectiveness of three strategies for changing stigmatising attitudes – education, contact, and protest – and found that all three strategies could affect stigmatising attitudes positively.

- **Education replaces myths about mental illness with facts.** In Critical Incident Stress Management normalising PTSD reactions rather than pathologizing them is crucial. The use of peers in delivering this message further normalises and reduces stigma.

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26 Patrick Corrigan – Robert Lundin – Don’t call me nuts- Coping with the stigma of Mental Illness – 2001 Recovery Press
Contact involves a direct interaction between the public and people with mental health issues. Utilising those with the lived experience of PTSD who have suffered and recovered demonstrate to peers “Yes I was unwell, but then I recovered”—removing the perceived fear that accompanies a PTSD diagnosis. This contact is particularly powerful if an individual remains in the workforce and is supported by solid leadership.

Protesting against stigma. Stigma is reinforced by society’s attitude and stereotypes, the media and by the use of inequitable terms such as “whack job”, "psycho", "crazy", “schizo”, "nutter" and “bludger”. Those who witness stigma and those who are stigmatized should try and protest against such behavior. Easier said than done! – There are organisations that now work tirelessly on looking at ways to break down the stigma within society, please follow this link. Organisations that fight against stigma.

The first logical step in addressing stigma and discrimination is to make them visible – Patrick Corrigan

Current research demonstrates that organisations need to form part of the solution in reducing the negative effects of PTSD stigma. This can be done by:

- “Focusing on education, awareness and communication can reduce fear, stigma and discrimination
- Ensuring the organisational culture is conducive to supporting employees’ overall mental health
- Encouraging senior executives to show demonstrable leadership around mental health
- Engaging in prevention and early intervention strategies”

The workplace must own the ‘responsibility’ that PTSD will occur for some of those who work in trauma related environments, however education, prevention strategies, early detection and treatment strategies the risks and associated costs, either human or financially, can be significantly reduced. Organisations have a duty of care to invest in mental health leadership and it must be supported from the very highest leaders within the organisation.

Many careers are cut short unnecessarily as a lack of understanding, lack of education and the stigma of PTSD continue; sadly so are many lives! – Just because an individual has a PTSD diagnosis doesn’t mean they cannot contribute to their chosen career.

No one should have to choose between the career they love and their mental health and wellbeing!

27 Patrick Corrigan – Robert Lundin – Don’t call me nuts- Coping with the stigma of Mental Illness – 2001 Recovery Press
5.1 The case for government funding for a National PTSD Impact of Trauma awareness campaign

PTSD and associated health problems affect a significant proportion of our Australian community, including our military and emergency service personnel, and contributes significantly to the burden of disease costs nationwide. Estimating the costs of alcohol and drug abuse, family breakdown, the impact of suicide, depression, and the many various mental health problems people can suffer as a direct consequence of trauma would be immeasurable. Depression and anxiety disorders are the leading cause of disability in Australia\(^{28}\). Add to this the economic loss incurred by the impact on the workplace. According to the Vic Health and Melbourne university study\(^ {29}\) job related depression alone costs the economy $730 Million. According to the ABS\(^ {30}\) more people suffer from PTSD than depression, as shown in statistics elsewhere in my report. Research also demonstrates that early onset of physical illness such as cancers; diabetes and heart disease can also be directly linked back to traumatic and stressful experiences.

Awareness campaigns educate our community about significant health issues that can directly affect our wellbeing. Breast cancer has more than halved since the introduction of an awareness campaign, people now know the damage the sun can cause, and anti-smoking awareness campaigns have significantly reduced the incidence of the many serious illnesses associated with smoking.

The impact of trauma undoubtedly places a substantial strain on our Australian economy, more importantly the human costs surrounding trauma is immeasurable.

I believe if the Australian population as a whole were educated through a public health campaign, and made aware of the symptoms, and how trauma can impact on our health, then perhaps we would see a decrease in some of the associated problems, for example; If the shop-keeper who’s had a gun held to his head knows in advance that his mental health can be impacted by this traumatic event, and seeking treatment will lessen this impact, this may stop the alcohol addiction and breakdown of family relationships in the future. – If those who experience natural disasters, such as Victorian Bushfires, understand automatically that such traumatic incidents can impact significantly on their health, then perhaps we can reduce the burden of disease costs surrounding PTSD and associated health problems.

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\(^{30}\) ABS (2007) National Survey of Mental Health and wellbeing.(SMHWB)
5.2 Recommendations

“To combat stigma and discrimination we first have to make them visible” – Patrick Corrigan

Recommendations for Government

1. Improve data collection for high-risk organisations on the combined incidence of PTSD (and associated health difficulties) to assist with improving health services and identifying clear pathways for accessing help for all uniformed personnel and their families.

2. Address the issue of the difficulties that can be experienced by personnel suffering with PTSD in the process of applying for benefits. More often than not the lengthy time to process these claims compounds the injury.

3. Take actions to raise awareness amongst GPs of the symptoms of PTSD and the vulnerability of our uniformed service personnel. It is reported that PTSD is often misdiagnosed.

4. Mental Health now forms part of the curriculum in some schools: Encompassing education on the impact of trauma would have a dual outcome. Reduce stigma, and educate students on what to look for if they experience a significant traumatic event. Understanding that people can turn to alcohol and drugs following a traumatic incident, which in-turn can lead to addiction and crime; understanding that traumatic incidents can cause family breakdown, and realising that seeking treatment before the problems become entrenched can minimize the impact of trauma. Education will reduce some of the associated problems that can develop following a traumatic experience - lessening the burden of disease costs.

5. Provide further funding for high-risk work environments aimed at addressing mental health and wellbeing in the workplace. PTSD education and literacy programs must be incorporated.

6. Work with service charities to disseminate information about PTSD and associated illness and to assist with raising national awareness. Any such information should also seek to reduce associated stigma.
Recommendations for high-risk workplaces

7. Organisations at risk of exposure to potentially traumatic incidents must provide demonstrated leadership in promoting overall good mental health and wellbeing.

8. Although stigma is a societal issue; the workplace must address ‘stigma’ and the negative effects it places on those employees who are potentially at risk. Changing the culture of an organisation and promoting positive conversations surrounding mental health and wellbeing must be instigated from the highest level of leadership within an organisation and filtered down through the various ranks into frontline emergency service personnel. The change of culture surrounding mental health and how those who suffer PTSD are viewed will directly assist in breaking down the stigma. Training and education throughout high-risk workplaces is essential.

9. Organisations need to foresee and manage the possible traumatic exposures that may affect their workforce. The adverse mental health outcomes in some personnel following a critical incident are inevitable; having a strong mental health strategy and policies in place to detect those who are potentially at risk and to also identify them early, must be implemented. There must also be policies in place to anticipate and manage the repercussion of such events. Understanding that employees exposed to potentially traumatic incidents can also have a negative effect on families is also critical. Families of those more susceptible to PTSD need good information and support as it is often they who spot the first signs that someone is feeling the effects of trauma. Early detection, which can often be the result of those signs being picked up, is key to the individual’s treatment and recovery.

10. Clear pathways to evidence-based treatments must be easily identifiable and accessible.

11. Employers should be educated and aware that distress may present incidentally in a similar way to conflict with management or peers, poor work performance, poor general health and workplace conduct issues.

12. Continuous screening and yearly mental health ‘check-ups’ should be considered for high-risk individuals, and particularly following a major traumatic event or cumulative exposures.
13. Given the prevalence of substance misuse, especially of alcohol, and the incidence of this and PTSD co-occurring, it is vital that the workplace makes a particular priority of ensuring that those potentially at risk of PTSD also have timely access to substance misuse treatment.

14. For organisations that utilise the Critical Incident Stress Management Peer Support model to assist individuals following a traumatic incident, it is recommended they follow the guidelines on Peer Support, using the Delphi Methodology developed by the Australian Centre for Posttraumatic Mental Health. ACPMH - Peer Support Guidelines.


*Education is what you know, not what's in the book.* – Egyptian proverb
References


Haynie M (2012) As Attitudes Shift on P.T.S.D, Media Slow to Remove Stigma. IVMF Executive Director & Founder: [http://vets.syr.edu/as-attitudes-shift-on-p-t-s-d-media-slow-to-remove-stigma/]

Healthline Network Inc. (2007)


Recommended Reading- Helpful Resources

Useful Books

Why People Die by Suicide

Useful Websites

PTSD and Trauma Research ACPMH

www.beyondblue.org.au

www.blackdoginstitute.org.au

www.copmi.net.au – For children of parents living with mental illness

www.relationships.org.au – 1300 364 277

www.carersaustralia.com.au

www.parentline.com.au

SANE Australia

COPMI
Attachment 1: Further details about the People I met and their Programs that address PTSD or Mental Health Stigma.

Professor Neil Greenberg, Weston Education Centre, London

Professor Neil Greenberg is an occupational psychiatrist and a Professor of Mental Health at King’s College London. He regularly provides clinical assessments and treatment service for a wide variety of patients and is a lead researcher in the field of organisational mental health and traumatology.

Professor Greenberg studied medicine at Southampton University, graduating in 1993. During his time in the Royal Navy he served as a medical officer in ships, submarines and, having earned the coveted Green Beret himself, with the Royal Marines Commandos. Neil has been at the forefront of organisational and traumatological research for many years; he has been secretary of the European Society of Traumatic Stress and is a member of the UK Psychological Trauma Society. He is a Fellow at the Royal College of Psychiatrists and a Member of the Faculty of Forensic and Legal Medicine and is listed on the GMC register as a specialist in General Adult, Forensic and Liaison Psychiatry.

Since 1997 Neil has been part of the team at the forefront of developing a novel, peer-led traumatic stress support package. The use of Trauma Risk Management, or TRIM, began in the Royal Marines and Neil has been instrumental in helping numerous other organisations to follow suit, including the Foreign and Commonwealth Office; the BBC; numerous UK police forces and the London Ambulance Service. He has provided psychological input for Foreign Office personnel after the events of September 11th 2001 and in Bali after 12th October 2002. He also has been a key advisor to the London Ambulance Service helping them manage their staff support in the wake of the London Bombings of 2005. More recently Neil has advised a number of other governmental and private companies about the psychological consequences of operating in high-risk environments and about hostage repatriation.

Neil has published over 100 scientific papers and book chapters and presents to national and international audiences on a regular basis. (marchonstress.com n.d.)

Professor Jonathon Bisson, Cardiff University School of Medicine and Vale University Board

Professor Jonathan Bisson is Director of Research and Development for Cardiff University School of Medicine and Cardiff and Vale University Health Board. His main research interests are in the field of traumatic stress. He has conducted various studies including two widely cited randomised controlled trials...
of early psychological interventions (psychological debriefing and trauma focused cognitive behavioural therapy) following traumatic events and three Cochrane systematic reviews in the traumatic stress field. His work on early interventions following traumatic events has shaped thinking internationally.

Professor Bisson developed his interest in traumatic stress during his time in the British Army and is an active researcher, clinician and teacher in this area. He founded and leads the Traumatic Stress Research Group in the School of Medicine’s Clinical Epidemiology Interdisciplinary Group and the Mental Health Research Network Cymru’s Traumatic Stress Clinical Research Group. He is also a member of Cardiff University’s Violence Research Group led by Professor Jonathan Shepherd which won a 2009 Queen’s Anniversary Prize.

His research concerning the prevention of psychiatric disorder, in particular post-traumatic stress disorder, following traumatic events has contributed to the current guidance regarding single session psychological interventions following traumatic events and the adoption of a stepped care model to detect and treat those affected who go on to develop psychiatric disorder. (Prof Jonathon Bisson n.d.)

Whilst attending the Cardiff University School of Medicine I also had the privilege of being introduced to other members of the Research Team.

Neil Kitchener

Neil has over 25 years’ experience of working in NHS mental health services within the UK (England & Wales) and Australia. His core profession in mental health nursing started in 1985. Neil has worked in forensic inpatient and out-patient settings before completing his clinical psychological training in Cognitive Behavioural Psychotherapy in 1997 at Sheffield Hallam University and the Sheffield Specialist Psychotherapy Service. He completed a PhD at Cardiff University 2011.

Neil Roberts

Dr Neil Roberts is a Consultant Clinical Psychologist with Cardiff & Vale University Health Board and an Honorary Senior Research Fellow with the Institute of Psychological Medicine and Clinical Neurosciences. Neil has had a clinical interest and involvement in PTSD since joining Cardiff and Vale Traumatic Stress Service in 1998.

Liz Royle, KR Trauma support, Bolton Lancashire

As an experienced trauma psychotherapist and now EMDR Europe Approved Consultant, Liz Royle has worked for the past 12 years with clients suffering from Post-Traumatic Stress Disorder and trauma reactions including those following multiple fatalities, serious assaults, accidents, child sexual abuse and
major incidents. As Senior Welfare Officer for Greater Manchester Police up to 2004, Liz was responsible for leading a team of police welfare officers in the provision of 24 hour trauma support for police officers. She has personally managed that force’s response to 3 separate murders of police officers. She is now the lead person for the European Society for Traumatic Stress Studies’ task force on “Managing Psychological Trauma in the Uniformed Services.”

Liz specialises in crisis intervention and the treatment of complex PTSD and is a founder member of the UK Psychological Trauma Society. Liz worked with affected organisations following the London bombings and the Asian Tsunami. She is an approved trainer for the International Critical Incident Stress Foundation and a member of Chester University’s employer advisory panel for their MSc in Psychological Trauma.

She is a published author with a book and many journal articles to her credit and is currently completing her PhD at the University of Manchester researching how the social identity of police officers with a military background affects their care-seeking behaviour for PTSD.

I also had the opportunity to meet with her co-founder Catherine Kerr and Mark Wooland

Shannon Pennington, Founder North American Fire Fighters Veterans Network, Alberta Canada

Shannon Pennington is a retired, 26 year, career fire fighter veteran. He is a member of the International Critical Incident Stress Foundation, a past member of the American Academy of Experts in Traumatic Stress. He is also a retired Warrant Officer in the Canadian Armed Forces (Regular and Reserve component) and a former Military Engineer. He is currently a Senior Chief with the North American Fire Fighter Veterans Network, assisting fire fighter veterans in Canada and the United States. Shannon is also a former member of I.A.F.F. (International Association of Fire Fighters) in Calgary, Alberta, Canada; Shannon left the fire service as an acting Lt/Senior Fire Fighter/Nozzelman after serving for 26 years on the front lines.

Peggy Sweeney, Grieving behind the badge; Sweeney Alliance, Kerville Texas

Peggy Sweeney is a mortician (retired) and bereavement educator and the president of the Sweeney Alliance. She has developed and taught countless workshops for coping with grief and trauma, including How to Understand Grief Seminars and the Grieving Behind the Badge program for emergency response professionals. She has reached out to her community through Halo of Love, a support group for bereaved parents, and Comfort and Conversation for bereaved adults and teens. She has written numerous award-winning articles and is the editor of the Journeys Through Grief Newsletters. Peggy is a member of the Texas Line of Duty Death Task Force, secretary of the Comfort (TX) Volunteer Fire Department and a former EMT-B.
Patrick Corrigan, Illinois Institute of Technology,

Patrick Corrigan is Distinguished Professor of Psychology at the Illinois Institute of Technology. Prior to this, Corrigan was professor of Psychiatry and Executive Director of the Center for Psychiatric Rehabilitation at the University of Chicago, being there for 14 years. Corrigan has been principal investigator of federally funded studies on rehabilitation, the stigma of mental illness, and consumer operated services. He has written more than ten books and more than 200 papers specialising in issues related to mental illness and the stigma of mental illness.

Kristen Sokel, Illinois Institute of Technology,

Kristin is a Rehabilitation Counseling Education doctoral student at the Illinois Institute of Technology. Her research interests include stigma, empowerment, and self-determination of individuals with mental illness and intellectual disabilities. Kristin is also Program Coordinator for the Center on Adherence and Self-Determination (CASD), and NIMH-funded center investigating the issues of adherence and self-determination of individuals with serious mental illnesses.

I met many other wonderful people throughout my travels who were very welcoming and supportive of the work we are conducting here at Picking Up The Peaces.
Attachment 2: Article on Media and Stigma

As Attitudes Shift on P.T.S.D, Media Slow to Remove Stigma by MIKE HAYNIE

Mike Haynie, Ph.D - Dr Haynie is a veteran of the Air Force and executive director of the Institute for Veterans and Military Families at Syracuse University.

“In 1999, President Bill Clinton convened the first White House Summit on Mental Health. The aim of the conference and the public campaign that followed was, in part, to educate the media on the moral and ethical imperative related to dispelling the stigma associated with mental illness. In a radio address to announce the conference, Mr. Clinton said, “Mental illness is nothing to be ashamed of, but stigma and bias shame us all.”

In recent years, the Department of Defense has made unprecedented progress toward eliminating the stigma associated with post-traumatic stress disorder and other mental health issues affecting service members. This cultural shift within the military is a sea change, as more and more of our service members are seeking and receiving the support they need and deserve from a grateful nation. In the face of that progress, it’s unfortunate that some in the media continue to perpetuate a stigma linking military service to mental illness and violence.

This is seen in news articles throughout the country, with some referring to veterans as “ticking time bombs.” By describing vets as “time bombs” who are highly trained in “guerrilla warfare,” media outlets prove far too careless with regard to providing societal context for isolated acts of violence committed by people who sometimes happen to be veterans.

Reporting has been biased toward paper-selling sensationalism that perpetuates the stigma of a dangerous combat veteran akin to Rambo, invading our neighborhoods and homes. Consider the media coverage of the case of Itzcoatl Ocampo, who has been charged with the murders of several homeless men in California. Some news outlets went as far as to identify him as a former Marine before even mentioning his name. Others were sure to immediately identify him as an Iraq war veteran, and then described how the victims were tracked in a meticulous manner, blatantly attempting to portray Mr. Ocampo as if he believed he was still on mission. Mr. Ocampo has even been called an “Iraq war veteran” and a “monster” in the same paragraph, connecting the two.

31 IVMF Executive Director & Founder: http://vets.syr.edu/attitudes-shift-on-p-t-s-d-media-slow-to-remove-stigma/
If the charges against Mr. Ocampo are proved true, it’s very likely he is a monster and a terrible threat – no different from a serial killer who is not a veteran. However, the unfortunate reality is that the message that far too many Americans take away from stories crafted in this way is a stigma that paints all veterans with the same brush, and the color of the paint is disturbing and dangerous.

Most unfortunate, and misleading, are the links these reporters imply between military service, mental health and an increased propensity for extreme violence. In 2008, The New York Times published a series of articles focused on “veterans of the wars in Iraq and Afghanistan who have committed killings, or been charged with them, after coming home.” The Times found “121 cases in which veterans of Iraq and Afghanistan committed a killing, or were charged with one, after their return from war.” At the time those articles were published, the population of post-9/11 veterans was about 750,000, an offender rate of 16 homicides per 100,000 veterans.

Data from the Department of Justice indicates that the homicide offender rate in the civilian population during that same period varied between 25 and 28 homicides per 100,000 young American males – implying that veterans might actually be less likely than their non-veteran, age-group peers to commit a violent homicide.

Also not supported by facts is the link often implied by the media between combat stress and crime in general. A recent study published in the British Medical Journal indicates that veterans with combat trauma are no more likely than other people to end up in prison. Further, data from state and federal prisons highlights that the number of incarcerated veterans has at worst remained unchanged, and in many states declined, throughout the past decade of war.

For better or worse, the media will play a large and important role in shaping the cultural narrative that defines this generation of veterans. Unfortunately, that narrative has been a story of extremes to date. At one extreme, it’s the story of the veteran as the superhero – unstoppable and iconic. At the other extreme, it’s a narrative that frames the veteran as “broken,” whose life course will be defined by post-traumatic stress, domestic violence, suicide, unemployment and homelessness. The result is a caricature of the American veteran as someone who exclusively represents one of these extremes.

The reality is 99 percent of veterans do not represent either extreme. Instead we live our lives in the middle of this continuum. We are teachers, plumbers, doctors, pilots and bus drivers. We’re your neighbors. On behalf of this 99 percent, I appeal to the media to keep that in mind while shaping the public narrative that the entire community of veterans will ultimately inherit.”
Attachment 3: An Article Reviewed by Danette Gibbs, MA

Why people die by suicide?

Why People Die By Suicide by Thomas Joiner, Ph.D.

If Joiner’s new theory regarding suicide is correct, and we know many uniformed personnel are exposed to multiple traumatic experiences through their work, does this make this collection of people more susceptible to suicide? - They face dangerous situations constantly, which can be life threatening, they deal with death, loss, sadness, pain and witness horrific scenes. Does this type of work provide an emotional numbing that assists some to overcome the powerful fear of death?

Why People die from suicide, a review by Danette Gibbs.

“As researchers, clinicians, and others with an interest in suicidal behavior, many of us did not enter into this area of study by pure scientific curiosity. Often times, our research questions and clinical interests are propelled by experiences from our personal lives or professional interactions with clients. Acknowledging that the “confluence of the personal and scientific” has influenced his own work, Thomas Joiner presents his new book, Why People Die By Suicide.

Speaking with heartfelt sincerity, Joiner begins his book on a deeply personal note, recounting the details of the suicide of his own father. It is this event that led him to the question posed in the book: What leads people to cross the threshold from psychache to suicide? Although motivated in part by the intensely personal, Joiner has pursued scholarly answers for himself and the thousands of others who ask the same question, hoping to uncover meaning in the tragic deaths of their loved ones.

Written with the purpose of reaching both the layperson with little to no knowledge of suicide as well as the seasoned scientist or clinician with years of experience and study, Joiner provides an informative and engaging fresh look at this perplexing social problem. He begins with a review of what is known about suicidal behavior, including a wealth of anecdotes from pop culture as well as clinical experience. He addresses existing theories and epidemiological and empirical data, but also incorporates the perspectives of philosophers, poets, and musicians in a rare blend of the scientific with the culturally relevant that will appeal to readers from all backgrounds.

Basing his theory on a primarily cognitive-behavioral framework, Joiner explains that for an individual to die by suicide, he or she must have both the desire for death as well as the capability for lethal self-injury. The desire for death is brought about by perceptions of burdensomeness and low belongingness. Joiner believes these two states encompass the myriad of psychological characteristics that have been correlated with suicidal behavior,
such as impulsivity, hopelessness, mental illness, substance use, poor problem-solving, and hopelessness. Without the presence of both components, one does not truly desire or seek death.

**New Theory**

Presenting a novel twist on suicide theory, Joiner goes on to state that desire for suicide is not enough, but that the individual must also have the capability for suicide. An individual must work himself up to being able to overcome mankind’s most basic instinct: to survive. Whether through provocative experiences such as multiple life-threatening accidents and injuries, self-injurious behavior ranging from cutting to extreme eating behaviors, mental practice, or repetitive exposure to the pain and suffering of others, Joiner maintains that the accrual of these types of experiences habituates the individual so that he is able to overcome the powerful fear of death. He further explains how many individuals choosing suicide may even view death as a positive experience in which they believe their needs for belongingness and effectiveness can be met.

Joiner has finally provided therapists and physicians with a theory of suicide, supported by research, which is comprehensive yet succinct enough to easily apply in practical settings. Indeed, he effectively sought to provide a broad enough explanation that it had at least some applicability to all deaths by suicide, worldwide. Joiner gives recommendations for targeted risk assessment, intervention, and prevention. By targeting the anguish caused by the perceptions leading to desire for death, clinicians may hope to decrease suicidal behavior in their patients, which in turn, may also decrease capability for lethal self-injury. Although measurement instruments need to be developed in order to determine how much desire and experience is enough to send someone over the edge into lethal self-injury, Joiner has provided practical suggestions for everyday application and an excellent foundation on which to pursue future research.

But Joiner aims to do more with this book than just provide guidance to those who deal with suicidal patients on a regular basis. He also desires to give comfort to those who long to understand the circumstances that led their loved one to the decision of suicide. In his effort to eliminate both the stigma and mystery that surround suicide, Joiner presents an explanation for why people die by suicide that judges neither the victim nor the victim’s loved ones. He insists that although death by suicide is tragic like any other death, it is not mysterious.

**In Closing**

As the book closes, Joiner returns to his experience of his father’s death. Although his understanding of suicide has helped him to accept this tragedy, Joiner shares with the reader the continued loss he feels. Undoubtedly his writing is motivated by the pain and suffering his own family has gone through and his desire to alleviate some of that anguish for others. Indeed, one cannot help but read through Joiner’s own experiences and the numerous case examples throughout the book without reflecting on his or her own clinical and/or personal encounters with suicidality.
Joiner leaves the reader feeling hopefully optimistic, looking resolutely ahead toward the prevention of similar deaths in the future.

The American Association of Suicidology’s Publication Review Committee reviews books for the purpose of informing the membership of the latest and most relevant material devoted to the understanding, treatment, prevention, and postvention of suicide”.

32 This review was printed in the Summer 2006 edition of Newslink (Vol. 33, No. 2).Article by Danette Gibbs - http://www.suicidology.org/c/document_library/get_file?folderId=236&name=DLFE-65.pdf