

"All that is needed for evil to prosper is for people of good will to do nothing." Edmund Burke.

The Whistle

Newsletter of Whistleblowers Australia Inc.

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The SAEBOW Story - South Australian Employees Bullied Out of Work.

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Contributions please. Articles, letters cartoons or illustrations dealing with any aspect of whistleblowing will be considered for publication, subject to editing. Address material to: The Editor, **The Whistle**, WBA, 7-A Campbell St, Balmain NSW 2041. Please submit material on diskette in ASCII format &/or M/S Word 7.0 or earlier version, plus hard copy. The editorial Committee will provide further publication guidelines in the next edition of **The Whistle**.

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SAEBOW (South Australian Employees Bullied Out of Work)

Help/Information line was founded by Catherine Crout-Habel in March 1999, following her own workplace bullying experience. It is a self-funded service with callers paying for postage and printing of material. Donations are always welcomed.

In 1996, Catherine and three of her colleagues were targeted and forced out of their jobs by a bullying regime. All four reached out for help. No help was forthcoming. During their bullying experiences, Catherine and her colleagues suffered further abuse after speaking of their own experiences - following this, their health broke down and careers were destroyed. Two resigned from their profession because of major health problems are still unable to work. One has moved into a different field of employment in order to manage her health. The fourth colleague has remained within the profession, is on a rehabilitation programme and, four years later, is still only able to work part time.

Catherine was specifically targeted because her role as Harassment Contact person within the workplace required her to provide information to staff who were being harassed. Workplace bullying falls outside of the South Australian Equal Opportunity Act and so "victimisation" protection under the EO Act did not apply.

since its inception. Requests for information from bullied workers, journalists, students, and researchers led to the setting up of the SAEBOW website, "Bullies Down Under" in order to more effectively disseminate information. "Bullies Down Under" was launched on Australia Day, 26th January 2000 and can be accessed on <http://www.caitrin.mtx.net>

The aims of SAEBOW and the "Bullies Down Under" website are to:

- break the silence on workplace bullying
- provide information to challenge workplace bullies
- validate the experiences of those targeted by a bully
- establish links with other websites tackling bullying
- suggest resources and support organisations for the targets of bullies
- provide information for employers to assist in the creation of a bully free work environment.

SAEBOW is also strongly involved in lobbying politicians to introduce effective legislation to stop workplace bullying before people are injured and forced onto the WorkCover scheme.

For further information, please send a stamped self addressed A4 envelope to SAEBOW, PO Box 488, Salisbury, South Australia, 5108 or email caitrin@dove.net.au

Whistleblowers Australia Inc. Annual General Meeting 2000 – Brief Report.

South Australia successfully hosted the Whistleblowers Australian Inc. AGM on the 18/11/00. The event incorporated the 1st SA Whistleblowers Conference "The Cost of Crushing Whistleblowers: personal, social and economic".

Members of the WBA 2000/01

National Committee are:

Jean Lennane, National President;
Christina Schwerin, Vice President;
Avon Lovell, Vice President;
Feliks Perera, National Treasurer;
Rachael Westwood, National Secretary;
Greg McMahon, National Director;
Brian Martin, Director-International;
Matilda Bawden, Committee Member;
Ray Hoser, Committee Member;
Robert Taylor, Committee Member;
Geoff Turner, Committee Member;
John White, Committee Member.

The Chairpersons of the State Branches (Cynthia Kardell, NSW; John Pezy, SA) are automatically represented on the National Committee

The 30+ attendees from as far afield as Brisbane and Perth were swelled by some virtual attendees gathered around a coffee table linked Sydney/Adelaide by tele-conference.

The technology was fairly simple, but it's the first-time out-of-state members have attended a WBA AGM without physically being present. There were speaker-phones in both venues, and these enabled the Sydneysiders to hear and contribute to proceedings in Adelaide. The talks before the AGM and the proceedings of Sunday's conference were also well received in Sydney; although the participants had to use their imaginations when some overhead slides were used (advance copies of graphics will remedy this deficiency in future tele-conferences). The AGM and Conference were videoed by John Pezy for members and posterity.

Cynthia Kardell, NSW President, reported that the tele-conference was

welcomed by those who attended the in person, and added a sense of togetherness to the events. It's hoped that this won't be the last time that WBA members will attend meetings at distant locations. Telephone lines permitting (\$3 for 3 hours), we may have virtual participants from more than one city for the 2001 Sydney AGM!

The AGM minutes plus extracts of the main presentations will be featured in the next issue of *The Whistle*.

Physical and virtual attendees voted thanks to the SA Branch (and particularly to Matilda Bawden, Catherine Crout-Habel, and John Pezy) for organising the AGM and the 1st SA Whistleblowers Conference.
Geoff Turner + Robert Taylor.

WorkCover action against psychological abuse in the workplace:

A precedent has been set. Pressure is required for more widespread enforcement of the objects of the OHS Act.

Extract from the NSW Occupational Health And Safety Act 1983 No 20 - section 5 Objects.

(1) The objects of this Act are:

(a) to secure the health, safety and welfare of persons at work,

(b) to protect persons at a place of work (other than persons at work) against risks to health or safety arising out of the activities of persons at work,

(c) to promote an occupational environment for persons at work which is adapted to their PHYSIOLOGICAL AND PSYCHOLOGICAL needs,

(d) to provide the means whereby the associated comprehensive provisions made by or under this Act may progressively replace occupational health and safety legislation.

(2) Subsection (1) (d) does not apply to the mining legislation declared by Division 4 of Part 4 to be associated occupational health and safety legislation.

(3) The provisions of any paragraph of subsection (1) shall not be construed as limiting or being limited by the operation of any other provision of this Act.

Section 5 of the NSW OHS Act 2000 (not yet proclaimed) promotes similar objects as in the 1983 Act.

workplace bullying; generally employers and WorkCover/OHS authorities fail to sanction take any action against such "white-collar violence" which clearly represents a breach of the OHS legislation.

In 1998 WorkCover set an important precedent in using the OHS Act to halt bullying/victimisation of an employee of the NSW Department of Health.

Unfortunately WorkCover NSW does:

- not properly police the OHS Act in WorkCover's head-office; or
- not comply with the Protected Disclosures Act to protect in-house whistleblowers.

Refer to the text of the facsimile message (see below) and the article by Dr Max Spry (barrister & academic) referred to in the facsimile.

Robert Taylor.

**FAX To: Ann Gardiner,
HACS Team WorkCover NSW
02 9370 6105**

From: Susan Nolan,

Work Fax: 02 926 44 300

Date: 29 May 1998

Total No. of Pages 5.

Re: Health, Aged Care and Allied Industries Committee

1. OHS Implications of Victimisation.

At the April meeting of the HACAI Committee, Frances Waters (NSW Health Department) reported that a WorkCover Inspector had issued a PIN notice, with respect to occupational stress brought about by victimisation or bullying occasioned by an improperly handled grievance of an employee. Francis indicated that this had led to the NSW Health Department considering whether their grievance handling procedures should be re-drafted, taking into account occupational health and safety considerations, such as the requirement to provide safe systems of work militating against the victimisation or bullying of employees in the grievance handling process.

At its last meeting, Terry Hannan

case, in a related matter, where a supervisor subjected an employee to persistent degrading, abusive and belittling behaviour. The employee was awarded \$200,000 (plus interest and costs) and the employer was found to be in breach of its duty to provide its employees with a safe working environment; in breach of its contract of employment (common law, I assume); and in breach of its statutory duty imposed by the WorkPlace Health and Safety Act 1989 (Qld).

In view of Frances Waters having raised the issue at a previous meeting, I would appreciate your assistance in making copies of this report available to members of the HACAI Committee at its next meeting. Also, I thought that it may be of interest to your HACS team.

2. OHSR Council Award to Home Care Organisation. The OHSR Council awarded a certificate of merit to the Home Care Service of NSW's entry for the Occupational Health, Safety & Rehabilitation Council's OHS Performance Recognition Awards. I

thought that the entry may be of interest to your HACS team and, once it is established, to the Health and Community Services IRG. I indicated at Council that I wished to bring the entry and the certificate to the attention of WorkCover's HACS team, through the HACAI Committee. Murray McLachlan may be able to assist with further details about the Home Care entry.

See next item for the Dr Max Spry article cited. Ed.

Workplace Harassment. - Dr Max Spry.

Workplace Harassment. Dr Max Spry, Law Faculty, James Cook University. Australian Journal of Labour Law No. 10, 1997, pages 229 to 231. Carlile v Council of the Shire of Kilkivan and Brietkreutz (Qld District Court, Dodds J, No 12 of 1992, 2 December 1995, unreported).

Although the term 'workplace harassment' may be of relatively recent origin, the conduct it describes is far from new. It is suggested that workplace harassment occurs where, generally speaking, a supervisor subjects a subordinate to persistent degrading behaviour. Such behaviour may be for a very wide range of reasons. The harassment need not be for reasons of sex, sexual preference, race, ethnic origin and so on. **These factors may be the basis for the harassment but they need not be present.** It may be that the person in the more senior position simply takes an active dislike to the person in the subordinate position. Or, as in the instant case, the supervisor may simply find the subordinate's mannerisms irritating. **Guidelines issued by the Commonwealth Public Service Commission on 25 May 1994 describe workplace harassment as a form of employment discrimination, consisting of 'offensive, abusive, belittling or threatening behaviour directed at an individual worker or group of workers which may be a result of some real or perceived attribute or difference'.**

Employees subjected to such behaviour often do not complain formally. In

consequences of such behaviour may be far worse, as Carlile v Council of the Shire of Kilkivan and Brietkreutz (Qld District Court. Dodds J, No 12 of 1992, 2 December 1995, unreported) indicates. **Workplace harassment may be distinguished from legitimate comments on the work performance of a subordinate employee by his or her supervisor. It is acceptable, and indeed good management practice requires, that supervisors inform their subordinates of what is expected of them, the extent to which they meet those expectations, and where they do not, what can be done to overcome my perceived problems.** The differences between workplace harassment and legitimate supervision have been recently discussed by Finn J in Kelson in Forward (1995) 60 FCR 39. As Finn J notes, **'it is not workplace harassment for managers to manage'.**

In Carlile, Carlile sued the Council of the Shire of Kilkivan (his past employer) as well as Brietkreutz, his supervisor while he was employed by the council. Carlile alleged that (the council was in breach of the contract of employment. as well as its duty of care to him. Further. Carlile alleged that the council had breached its statutory duty under s 9(2)(c) of the Work Place Health and Safety Act 1989 (Qld)¹. Section 9 of the Work Place Health and Safety Act 1989 (Qld) provides that it is an offence for an

¹ The Work Place Health and Safety Act 1989 (Qld) has been repealed by the Workplace Health and Safety Act 1995 (Qld) which commenced on 1 July 1995. Readers

employer to 'fail to ensure the health and safety at work of all his employees, save where it is not practicable for him to do so'. Section 9(2)(c) gives as an example, particulars of the offence created by s 9, namely:

"... failure to provide so far so fat as is practicable such information, instruction, training and supervision to such persons as are necessary to enable the employees to perform their work in a manner that is safe and without risks to their health and safety".

Carlile, worked for the council from 1988 until 1991 when he suffered a nervous breakdown. Dodds J found that Carlile's nervous breakdown was a consequence of Brietkreutz's behaviour towards him, and that the council was vicariously liable for the actions of Brietkreutz. **The council was aware of Brietkreutz's behaviour but it had not taken adequate steps to put an end to it.** As a result, Dodds J found in favour of the plaintiff on each of his allegations and awarded him the sum of \$200,000 plus interest and costs.

At the time of the trial Carlile was 49 years old. He was married and had three children. He had a limited education and did not complete primary school. Dodds J found that Carlile's work history was 'unremarkable in the sense that he had always kept himself in employment and was an apparently reliable and conscientious worker'. In 1988, he started work with the council as a labourer. Soon after, he became a roller driver in the employ of the council. In September 1988, he joined the road

1991 when he suffered a nervous breakdown.

Carlile was subjected to a range of harassing and humiliating behaviour by Brietkreutz. For example, in late 1989 while working on the Widgee/Gympie Road, Brietkreutz harassed Carlile for eating an orange. On another occasion, Carlile complained of illness. Again his supervisor harassed him. Carlile returned to work but later lost consciousness. On various separate occasions, **Brietkreutz seems to have said words to the effect that Carlile was 'stupid', and that he wasn't of much use. Carlile was singled out to perform menial tasks**, such as holding the stop/go baton although he was employed as a roller driver. Further, it appears that Brietkreutz also ordered Carlile to perform a number of quite dangerous and seemingly unnecessary tasks. For instance, Brietkreutz on one occasion required Carlile to continue to operate his roller after Carlile had complained that the slope was too steep and that the roller was beginning to slide.

While some of these examples may appear trifling, this writer suggests that they must be understood in the context of the power relationship existing between a supervisor and a subordinate. What is important to appreciate is the cumulative effect of such harassing and humiliating behaviour upon the subordinate employee. In this case, Carlile's health deteriorated. He developed sores and lumps on his face, became irritable at home, had difficulties sleeping and was anxious about going to work. By late 1990, Carlile was suffering stomach

upsets, headaches and repeated flu type illnesses. In June 1991 he suffered a nervous breakdown.

Carlile informed the Shire Clerk in October or November 1989 of Brietkreutz's behaviour towards him. In April or May 1991, the Shire Engineer made aware of the situation. In evidence the Shire Engineer also stated that he had told Carlile that it would be difficult to transfer Carlile to another gang. He admitted that he may have been aware of uneasiness between the Carlile and Brietkreutz, he at no time thought this would have such an impact on Carlile's mental health.

Although Dodds J considered Carlile's personality may have contributed to his breakdown, Brietkreutz's behaviour was such that, but for it, Carlile's nervous breakdown was 'unlikely to have occurred'. Further, Carlile's breakdown was 'compounded by apparent apathy on the part of the first defendant (the council) when he tried to have something done about it'. Dodds J found the council was in breach of its duty to provide its employees with a safe working environment; it was in breach of its contract of employment; and that it was in breach of the statutory duty imposed by the Work Place Health and Safety Act 1989 (Qld). The council was vicariously liable for the actions of Brietkreutz.

Dodds J noted that the council did not have in place any system to record or resolve the type of problem that arose between Carlile and Brietkreutz. The council provided very little training or supervision to its foremen in leading or directing

those working to them. The council, it appeared, had 'not turned its mind to the necessity or the desirability of such a system even though it had a relatively large workforce'. At the very least, Dodds J suggested, employees in the position of the plaintiff should have access to a system that allows them to fully air their concerns. In operating such a system the employer should seek to understand by the problems encountered by the plaintiff 'and to accord them some respect'. Finally the existence of such a system, when in place, needs to be well publicised.

The consequences of the harassing behaviour in this case were severe. Carlile suffered a nervous breakdown. Medical evidence was given that as a result of the breakdown it is unlikely that he will ever work again. **Even in cases that are not so lamentable, workplace harassment is of genuine concern. At the very least it leads to poor productivity, low morale, and higher than acceptable rates of employee turnover. In the longer term, it may even become difficult for an organisation that permits, even tacitly, such behaviour to occur, to recruit competent staff. As Dodds J correctly states:**

"In today's Australian community it is not acceptable (if ever it was) for a Person in authority over another in a work place to harass, belittle or demean that other as a method of enforcing his authority or relieving his frustration."

Psychiatric Aspects of Fitness for Duty.

Psychiatric Aspects of Fitness for Duty. Carroll M. Brodsky, MD, PhD, From the Department of Psychiatry, University of California at San Francisco, San Francisco, California. Occupational Medicine: State of the Art Reviews, Vol. 11, No. 4, October-December 1996. Philadelphia, Hanley & Belfus, Inc. 719 to 726.

A psychiatric fitness for duty evaluation is one form of disability evaluation.

disability, and many of these contain suggestions for the prevention of disability and for compensating disability (7, 8). These papers are useful for students and provide policy considerations for lawmakers and for those who plan large-scale government and private disability programs. Although they address macro problems of dealing with disability, they are of remarkably little use to the clinician who sees one patient at a time and who must

This paper is addressed to the clinician who, on an almost daily basis, is confronted with the issue of the fitness for duty of workers, e.g., when the patient indicates that he or she is too sick to work or when a worker is referred to the physician by the employer for a formal psychiatric fitness for duty evaluation. This paper is addressed to the clinician who accepts the heavy responsibility of doing such evaluations-"heavy" because a worker's

can cause an employer to lose a valuable worker or to continue to have a worker on the job who might be disruptive, unproductive, or unsafe. An incorrect judgement can leave a health professional liable for a lawsuit, claiming that the misjudgement caused losses to the worker or harmed the public. This chapter is addressed also to the social scientist who is not a clinician; it brings data from the clinical arena, from the one-to-one contact with the subject of the fitness for duty evaluation. Although such data are often difficult to quantify, they affect the outcome of the disability process.

The Fitness for Duty Examination.

The Biosocial Nature of Fitness for Duty.

The psychiatric fitness for duty evaluation is a biopsychosocial exercise, and nowhere in psychiatric practice is the concept of the biopsychosocial approach to understanding and altering human behaviour more pertinent. The formula for a psychiatric fitness for duty referral is generally standard. An employer refers an employee to a psychiatrist with the request that the employee be evaluated to determine if he or she is capable of performing a job, the requirements of which are outlined in a job description or in a similar document. In most instances, the employer describes the behaviour or the symptoms or the situation that led to the referral. The reasons for the referrals are numerous.

In most instances, a worker who has in the past been able to perform the duties of the job seems no longer able to do so. Unlike the probationary worker who might never have performed satisfactorily, this worker is reported to have shown a decline in performance after a prolonged period of satisfactory performance. There seems to be no physical explanation for the decline, and the question is raised as to whether the explanation lies in a psychiatric disorder.

A frequent reason for referral is a sudden change in behaviour. A worker seems to be hallucinating or delusional. He becomes contentious whereas he formerly was not so or was less so. He becomes assaultive or threatens

Requests are initiated when a number of people in the workplace complain about a worker's behaviour; for example, co-workers or supervisors complain of a lack of Cupertino, or customers complain of rudeness. Requests sometimes are initiated by a worker's own reporting of dysfunction. A worker requests a demotion because he cannot keep his mind from wandering, and he is the only person on the shift overseeing the operation of a water treatment plant. His employer sends him for a fitness for duty evaluation because there is a question of whether this man would be safe to work even at a lower level or whether he might endanger lives, including his own, and property.

Organisational discomfort can produce the request. A worker no longer fits in this organisation. An example is a police officer who is considered a whistleblower or one who makes false reports.

Other workers are sent because they seem unable to adapt to changes in the organisation. They cannot accept workers of other races or sexes or sexual preference, and they express their resentment. While many in the workplace resent the intrusion of members of groups previously excluded from that workplace, most are able to mask their resentment or to keep it below the threshold for reaction by those they resent or by management. Others seem incapable of controlling themselves and confront or provoke the resented co-workers until there is either an unpleasant physical interaction or a loud and derogatory verbal interaction. A common reason for referral is that the worker seems to be having memory impairment or is neglecting personal hygiene to the extent that others complain.

Underlying many of the reasons for referral is the employer's concern about being held liable by the public for not protecting it against the acts or the consequences of acts by a worker whom they have identified as behaving aberrantly. For that reason, workers who have had psychiatric disorders, especially if they were in a psychiatric hospital, are referred for fitness for duty evaluations in part to determine if the worker has recovered and in part to

worker, his or her co-workers, and the public.

The Psychiatric Examination.

The first element of the fitness for duty examination is the "standard" psychiatric examination, the one used to evaluate an individual for psychiatric treatment or in a consultation requested by a colleague from other specialities. It is the examination described in the textbooks of psychiatry. It is comprehensive and covers all areas of the patient's life. Often the subject or the referring source will inquire about the need to go into background areas such as childhood and adolescent behaviour or military service experiences, which seem unrelated to the present functioning. However, in psychiatry, the past is often prologue, and focusing on the immediate question and ignoring past behaviour might cause us to miss the basis for the true understanding of the subject's present behaviour.

As in all psychiatric examinations, we start with a history of present illness or, in a fitness for duty examination, the history of the present work problem. **We elicit the subject's version of the work problem, going back to its beginning, and we focus on its evolution, including attempts to resolve it, e.g., mental health counselling. We try to learn the process that finally led to the decision to refer the subject for a fitness for duty evaluation.**

We conduct all other parts of the psychiatric history and conduct a mental status examination. We do the psychological testing that is easy to administer and to have scored, e.g., the Minnesota Multiphasic Personality Inventory-2 or the Millon Clinical Multiaxial Inventory.

The ideal situation would be one in which the referring source has provided the examiner with a comprehensive database concerning the subject's work history, performance evaluations, and statements from those with whom the subject works. When this background is available, we can frame questions for the subject and obtain the subject's version of events, both in the past work history

Such questions must be framed carefully because they can make the subject feel anxious or "paranoid" if the questions suggest that some large investigation is being conducted and that people are making statements, whether false, true, or distorted, that the subject has no opportunity to rebut.

The responses to questions based on the employer's data are useful in many ways. Frequently they add data that do not contradict the "fact" of the employer's report but which alter the meaning of those facts in a convincing way, thus constructing a picture that is closer to the "whole" truth.

Sometimes the response to such questions is a behavioural explosion that includes anger, ranting, or making threats to the examiner and others. Some threaten to leave or do leave the examination, stating that it is rigged to support the employer's report. More often the subject discusses the employer's data and often provides a credible explanation for what occurred or for distortions in the reports. Of course, the fact that the explanations of either the employer or the subject are credible does not mean that they are valid. Often the subjects bring documents that the employer has not provided and that shed light on the reasons for the referral.

At the end of the examination, the subject is urged to call in with any other information, including matters that he or she had not recalled during the examination or new information.

After completing the examination and receiving the results of initial psychological testing, the examiner reviews and collates the data from the subject, the referring source (including the medical records that have been provided), and the psychological test results. **The examiner then can decide what additional information is necessary to determine fitness for duty. The examiner can request further psychological tests that measure elements of cognitive capacity, e.g., intelligence, memory, executive function, and judgement.** Projective tests may be ordered to study affective profiles. Not infrequently, a

The examiner may want more information from the employer, either information that should have been provided and was not, or answers to questions raised by the history obtained from the subject.

Drawing Conclusions.

As psychiatrists, we must follow our usual procedures, if only to practice within community standards. We must collate the data and make diagnoses according to the current diagnostic and statistical manual (4).

After that, we must match the psychiatric findings with the job description and determine in what way, if any, the findings would affect the subject's ability to do the job as it is described.

Then we review the "meta" requirements of the job as reported by the subject, as reported by the employer, and as inferred from the reports of others, including co-workers, supervisors, and subordinates. Frequently these "meta" requirements, which are not spelled out in the job description, explain the employer's dissatisfaction with the worker and the reasons for the request for a fitness for duty examination. For example, the job may require a level of tolerance for the demands and impatience of vendors, customers, or co-workers with whom the subject interacts in the organisation. The job may require a tolerance for ambiguity that is not spelled out in the job description.

We must then decide if the subject's present mental state is compatible with the job description and the other requirements and make a recommendation to the referring agency or person.

In addition to making a statement about the subject's fitness for duty, the examiner should try to explain the process by which the worker progressed from being a satisfactory or even highly satisfactory worker to being a worker whose fitness for duty is questioned. A description of this process is important because it might provide a guide to remedial

that make remediation impossible, it might suggest possible changes or actions that would prevent similar problems from occurring with other workers.

Reflections on the Anthropology of the Workplace.

Each fitness for duty evaluation reveals something about the kinds of settings in which people work and the kinds of people who work in those settings. Although few conclusions may be drawn from any one case, a mosaic of the data from these cases contributes to an understanding of the world of work and the people who inhabit it. Such a mosaic raises theoretical issues concerning the fitness for duty examination. What follows is a presentation of some of these issues and the questions they raise. 1

The Reasonable Workplace

A fitness for duty examination is a contextual exercise in which the workplace, the job the worker does, and the worker are matched. Although it asks if the worker matches the workplace, **it seldom inquires if the worker is fit but the workplace is not.**

Frequently, interviews with those in a given workplace reveal a chaotic work environment of arbitrary supervision, irresponsible work demands, rapidly changing supervisors and assignments, good performance evaluations by one supervisor and "improvement needed" ratings from the next. When the situation is bad enough, other workers and sometimes managerial staff are willing to be quoted in the hope that upper management will learn about conditions at lower levels and make changes. The fitness for duty evaluation challenges us to consider what the characteristics of an ideal workplace are and, recognising that workplaces vary, to consider how much the workplace could depart from the ideal and still have us decide that the workplace is fit for workers. [These considerations are not addressed in the Department of Health independent inquiry into HealthQuest (ie the Lowe Report 2000) Ed.]

The Reasonable Worker

limits of tolerance for that designation. Workers are not automated and the job does not always require ideal or maximum performance, but we should be able to set some lower limits of performance below which it is unlikely that the individual can function in that workplace. Such ideals or norms can help the examining psychiatrist consider factors **other than those referring to psychopathology or diagnosis as described in DSM-IV, and they can help us consider a broader image of the "fit" worker and the "fit" workplace. Then we can attempt to quantify the fit between them or the degree of mismatch or misfit.**

Declarations of Unfitness.

Although the declaration of psychiatric unfitness is most often the responsibility of the physician or of other mental health professionals, it is evident that a presumption of unfitness has prompted the formal examination. Although declarations of unfitness are most often made by the employer and sometimes by the worker, such declarations are sometimes made by co-workers who complain that the worker is not doing the job and is therefore burdening them with extra work, that the worker "smells," or that he or she is "crazy." We need to study what makes for employer tolerance in the workplace, what characteristics of the worker make for greater tolerance of unfitness on the part of the employer, and what characteristics reduce tolerance.

Self-Declared Disability.

When the worker declares himself disabled, we must look at the basis for that self-declared disability. Workers use a variety of channels to declare themselves disabled. Physicians, co-workers, and employers sometimes all agree and sometimes disagree that an individual is disabled.

Self-declared disability is more common than is recognised. It is the worker's statement that he or she is unfit for any paid employment and cannot be rehabilitated for any employment that is acceptable and, therefore, that he or she is disabled. Such people are seen in Social Security administrative law hearings in the workers' compensation

When a worker declares himself disabled in the absence of physical or psychiatric findings that support that claim, we must select a diagnosis from a menu that includes malingering, the somatoform disorders, and the factitious disorders. Some somatic delusional states also must be considered. How professionals decide on which of those diagnoses to apply depends in part on their relationship with the subject.

Few primary care physicians or family physicians who identify themselves as the patient's physician will attach the label of malingering or factitious disorder or a diagnosis suggesting a delusional state unless the evidence is overwhelming. Instead they usually attach a label from the somatoform disorders or a label such as chronic pain syndrome or chronic stress syndrome, or they will suggest a physical disorder that cannot be demonstrated or excluded by objective testing. Records of judgements in such cases of self-declared disability show that the relationship between the examiner and the subject or patient affects the label that is applied and affects the judgement that disability exists or that other factors are playing a role, and there is no objective disability. This is not to suggest that the family physician is attempting to deceive anyone or is in collusion with the patient to falsify a declaration of disability or of unfitness. Instead, it points out that the personal relationship between the doctor and the patient will cause the health professional to present his patient's claim in the most favourable light. The physician who does not do so might have to face an angry patient and is likely to lose the patient. Often the physician is treating other family members, and an unfavourable report will alienate the entire family. The independent medical examiner is in a somewhat better position to be objective because he or she is not influenced by a relationship similar to that between the treating doctor and patient.

In most cases, health professionals, employers, co-workers, and family members who might have decided or have been told that the disability or unfitness for duty is self-declared wonder why the subject would be

someone with no basis for the illness or disability behaviour to behave in that fashion. Therefore, they tend to believe that some underlying physical or mental process must exist that is contributing to the subject's declaration or belief that he or she is disabled. These people are unfamiliar with the somatization process, which makes some people feel most comfortable when they and others consider them to be sick or disabled. They are unaware of the subject's secondary gains from being sick or of tertiary gains that serve the needs of families and others who support the notion that the subject is disabled. Some ask how a person who believes that he or she is disabled can be considered capable of working and sent back to work. This raises the question of whether those who believe they are disabled and are not have a mental disorder. Is a somatoform disorder disabling?

The Impact of the Fitness for Duty Examination.

Being referred for a fitness for duty evaluation marks the worker in the same way that being accused of a crime leaves a mark on an individual even if that person is eventually proven innocent. A worker who is referred for psychiatric evaluations will forevermore be seen as different, as mentally unstable, or unpredictable by co-workers and superiors. If the worker's behaviour was considered normal during the previous years of his or her employment and he or she is referred because of depression, he or she will be accepted back into the workplace by many co-workers who have themselves experienced depression at a subclinical or at a clinical level that was not recognised by others. If the reason for referral is a thought disorder, a paranoid condition or a schizophrenia, there will be doubts about the subject's predictability and self-control. The referral affects the worker's self-image more than a self-referral evaluation, in part because being sent by the employer is considered almost as bad as being declared unfit.

In certain workplaces, this kind of referral becomes an occasion for frank harassment by co-workers,

the subject is sensitive as a result of being considered unfit, and those who choose to harass can exploit that sensitivity.

Personality and Psychopathology

Many psychiatric fitness for duty evaluations are made not because of the symptoms and behavioural categories that fall under axis 1 of *DSM-IV*, but rather they emerge from axis H disorders, or **personality disorders**, that make the worker disliked by co-workers and superiors. Sometimes these workers behave in a threatening manner without threatening overtly, and sometimes they make direct threats. They harass or tease. Some break the rules of the workplace. Others are careful not to break the rules but stay close to the breaking point. They challenge authority whenever possible. *(Personality disorders are a favoured 'diagnosis' made by hired-gun psychiatrists used by workers' compensation insurers etc. Ed.)*

Relationships with co-workers fall into three categories. Some workers are considered to be very much a part of the social group by both the employer and the co-workers, do not upset the employer, and generally are regarded as good workers by their co-workers and superiors. A second group of workers could be described as falling into a neutral category. They are not disliked by co-workers or management, but their relationships seem limited to being in the same place with co-workers and interacting with them only when necessary. The third group is composed of those who are "out", who are affirmatively disliked by co-workers and often by management, if only because their co-workers are displeased or angry

with them and do not work well with them.

The dynamics of the movement from one group to another 2 is a study in itself, but a history of having moved from the "in" or neutral group to the "out" group is often seen in the fitness for duty referral. This reflects the fact that the referral is not only the result of the employer's concern and dissatisfaction but also the result of co-workers' reactions.

Family Changes and Fitness for Duty

Often, the changes in behaviour and work function that result in a fitness for duty examination are inexplicable by biologic factors or by events in the workplace. A frequent cause of such referrals is a covert and unsuspected abuse of drugs or alcohol. Seen as often are changes in family dynamics, a separation or divorce, or a child who gets in trouble with the law. Concerns about the fidelity of a spouse while the worker is on the job can alter behaviour sufficiently, even in a formerly good worker, to initiate a referral. Divorce with the prospect of loss of residence, splitting of property, or being burdened by alimony and child support payments can be sufficiently distracting to mimic an agitated depression. Some workers leave the job, stating that there is no point in working because their earnings will be confiscated by their spouses. Or they leave as a reaction to what they see as the injustice of the system. While at work, they are irritable and distracted. Absenteeism increases, resulting in employer and co-worker concerns about the subject's behaviour.

Summary.

The above examples illustrate the complex of biologic, psychological, and social factors that result in a fitness for duty referral. Workplace needs set the tolerance limits within which the worker must operate. They are different for a police officer, for a correctional officer, for a schoolteacher, and for a school custodian. Tolerance limits are affected by factors out of the employer's control, e.g., civil service rules, union contracts, and by the culture of the workplace, the latter being a set of unwritten rules.

Ideally, the psychiatrist who performs the fitness for duty examination would have all of the information described above, but in most cases does not. The psychiatrist who has this information can begin to put in place one part of the mosaic that is the ethnography of work.

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Is WorkCover fraud greater amongst employees or employers?

Tillinghast-Towers Perrin: Overseas Workers' Compensation Headlines, Issue 4, 1997. A Tillinghast summary of overseas issues, mainly from the USA, which may be of interest to the Australasian workers' compensation market.

Oregon's Division of Workers' Compensation has released its 1996 data on abuse in the compensation

commonly cited abuse complaints in the survey were:

- improper claims processing by the insurer or medical provider (23.5%);
- improper reporting by employer, insurer or provider (16.5%);
- workers collecting benefits while being able to work (15.6%); and
- employers pressuring injured workers not to file claim (12.3%).

(On Workers' Compensation. 7/1997).

Employer fraud against WorkCover - Compensation crackdown reaps \$15 million in unpaid premiums (5/2/97).

The Attorney General and Minister for Industrial Relations, Jeff Shaw, QC, today announced \$15 million in employer premiums had been recovered following the Government's successful crackdown on workers compensation dodgers.

Mr Shaw said there had been a surge of

government's three-month amnesty between August and October last year. "This is a spectacular result which will go some way towards relieving the pressure on employer premiums", Mr Shaw said.

"It relieves the pressure on honest employers because they are now subsidising fewer employers who have abrogated this responsibility".

Mr Shaw warned that employers who were still uninsured could expect to be caught in an on-going blitz of premium dodgers.

Since the amnesty ended more than 12,000 businesses have been visited by WorkCover inspectors. Of these 5,211 were issued with notices to produce policy details within 21 days. WorkCover expects to launch up to 700 prosecutions arising from these notices.

"Employers must realise that premium avoidance is not a trifling issue -- it is a crime with penalties up to \$20,000 and six months imprisonment", Mr Shaw said.

"There is no intention of repeating the amnesty. However, WorkCover inspectors will continue to target companies they suspect of avoiding premiums and will from time to time target specific industries.

"We will be maintaining the pressure on illegal employers. For too long they have got away without paying premiums, with discouraging injured workers from making claims as is their right, or when serious injuries occur vanishing into thin air and leaving the rest of the community to pick up the bill."

Contact: Peter Lewis on 02 9228 8188 or 0419 014 135

Employee fraud against WorkCover - Honesty is the Best Policy (18/6/96).

An employee who made a false statement in a workers compensation claim was fined \$500 and placed under a 12-month good behaviour bond.

The process worker who was employed by Steggles Limited completed a workers compensation claim form in January 1995 in which he alleged injuring his left wrist when he "tripped over water hose in turkey dock". He confirmed these details when interviewed by an investigator from MMI Workers Compensation (NSW) Limited. A few days later he provided a further

after a verbal disagreement with another worker.

MMI then referred this matter to the Fraud Investigation and Referral Unit of WorkCover NSW.

At a court hearing on 5 June 1996 the worker pleaded guilty to breaches of Section 92B of the Workers Compensation Act, 1987 but no conviction was recorded as he had voluntarily admitted the offence and had lost his job as a result. The worker was however placed on a 12-month good behaviour bond and ordered to pay \$1,200 including the fine as well as court and professional costs. (Media Contact: Mara Bagaric 02 9370 5692).

WorkCover Inspectors commence a 2-week blitz to audit employers' workers' compensation premiums (November 2000).

In 1996 or 1997 WorkCover carried out a 3-month Amnesty to permit NSW employers to remedy all workers compensation premium failures without penalty. The Amnesty was followed up with a state-wide Blitz to catch recalcitrant employers that had evaded their legal obligation to WorkCover and the WorkCover Scheme.

The Minister, Hon John Della-Bosca, commented:

- in a news story (AFR 17/11/00, page 32) on the passing of another set of "WorkCover reforms" to ensure that employers pay the correct workers compensation premiums and to strengthen measures to combat fraudulent workers' compensation claims; and
- on ABC Radio news, 27/11/00, that WorkCover would mount a renewed Blitz on fraud against the WorkCover Scheme.

The Minister stated that employers that failed to meet their statutory obligations by not fully complying:

- with their duty to make full and proper declarations of their wage-roll (in accord with WorkCover's Wage Definition Guidelines), and/or
- to accurately disclose the nature of their operations (eg ANZSIC industry codes as an indicator of employment risk)

are at risk of statutory penalties.

the policy being cancelled or voided – this is common to any contract of insurance.

WorkCover (and the WorkCover premium-collection and claim paying agents ie GIO, AMP, Mercantile Mutual, OBE, HIH/FAI, etc) require correct wage and rating information:

- 1) to calculate the full and correct workers' compensation premium each year and
- 2) to ensure that the correct workers' compensation premium is levied and paid.

Details of the renewed WorkCover Blitz on fraud against the workers' compensation scheme by employers was publicised in:

- a news item Australian Financial Review Friday 17/11/00, page 32.
- full-page advertisements "Workers' Compensation: what all NSW employers must know and do" in Sun-Herald 26/11/00 (page 91) and Sunday Telegraph 26/11/00 (page 58).
- ABC Radio news on 27/11/00.

The Blitz is a precursor to WorkCover calling for expressions of interest from consultants for strategies to reduce the approximate \$1,674 million deficit in the "bankrupt" NSW workers' compensation insurance scheme (advertisements Australian Financial Review Friday 17/11/00 page 56, also SMH Sat 18/11/00, page 48, as well as the Weekend Australian 18-19/11/00). Presumably the 11/00 reforms to the NSW workers' compensation legislation authorised wider powers to reduce the WorkCover Scheme deficit. This is likely to cause further detriment to injured workers as the WorkCover Scheme holds only around 75 cents of assets to cover each \$1 of claim liabilities. Injured workers, employers, and taxpayers might wonder whether there has ever been a more candid "admission" of the mismanagement of a statutory insurance scheme with which the majority of NSW employers are compelled to insure.

Review continues push for safer workplaces (5 July 1996).

NSW Minister for Industrial Relations, Jeff Shaw (QC, MLC) today endorsed the Upper House review of workplace

"Since taking office, I have overseen a range of important reforms aimed ~ making NSW workplaces safer," Mr Shaw said today.

"These include lifting the maximum penalties under the Occupational Health and Safety Act to \$500,000 and giving court's the discretion to jail negligent employers.

"The Carr Government also successfully argued for the highest ever safety fine in Australia earlier this year, when Theiss Constructions was fined \$175,000 over the deaths of two workers."

Other initiatives have included:

- introducing licensing for demolition contractors and asbestos removal contractors.
- introducing tougher standards for the labelling of hazardous substances.
- erecting an occupational safety code for HIV and hepatitis
- targeting high risk industries such as timber mills.

"The upper house review will be another step in the evolution towards safer workplaces, with a focus on further improving existing legislation and regulations", Mr Shaw said.

"I will be asking Professor Ron McCallum to conduct an independent review of the Occupational Health and Safety Act and report to the standing Committee.

"I will also ask the Committee to consider the role of Victim Impact Statements in OH&S prosecutions to ensure the courts understand the human cost of lapses in workplace safety.

"This initiative is all the more important, given the federal government's decision to slash funding to the national occupational health and safety body, WorkSafe"

Eminent Person Review of WorkCover (27 March 1997).

Mr Richard Grellman, a senior partner with the accounting firm KPMG, has been selected as the eminent business person to conduct an inquiry into the state's workers compensation scheme, NSW Minister for Industrial Relations

special focus on rehabilitation and improved return to work, Mr Shaw said. "I expect the inquiry to make a useful contribution to returning the WorkCover Scheme to a healthy state after it was ravaged by the Fahey Government," Mr Shaw said.

"The review will focus on the important area of getting injured employees back into the workforce.

"It will also build on the significant reforms the government has already undertaken in areas including:

- improved dispute resolution through the establishment of a new conciliation service;
- the review of WorkCover management as recommended by the Council on the Cost of Government;
- the deliberations of the WorkCover Tripartite Working Party on the setting of premium rates.

"Mr Grellman comes with impeccable credentials; he has a distinguished background in business and is currently chairman of the Motor Accidents Authority and a board member of LawCover.

"I wish him a successful inquiry and look forward to considering his report later this year."

For further information contact Peter Lewis on 9228 8188 or 0419 014135

Shaw Quotes Judge on Worker's Death - "No Excuse" (22 April 1997).

The Attorney General and Minister for Industrial Relations, Jeff Shaw, QC, today welcomed the Industrial Relations Court's \$65,000 penalty following the death of a worker.

Mr Shaw said the President of the Industrial Relations Commission, Justice Fisher's comments when handing down the judgement were particularly apposite.

"These words should be engraved in the minds of management across NSW, Justice Fisher said "The duty to ensure the health, safety and welfare is an ABSOLUTE DUTY ... (emphasis by Ed.)

"There is no excuse for any management to operate unguarded machinery ... or to plead ignorance of the circumstances of the transgression ...

"An industrial citizen of this State has died needlessly as a result of the neglect to observe a conventional

Following prosecution by WorkCover NSW, the Inverell-based pet food manufacturer, SuperCoat Feeds Pty Ltd, was fined \$65,000 for breaches of Section 15 of the OH&S Act.

An employee of the company, Mr Murray Symons, was directed to clean driers of produce on the morning of April 6, 1995.

In the course of his work, Mr Symons was caught by the right arm in the auger of a tallow coater.

It appears that while he was cleaning out the tallow coater, a metal tube attached to the air hose had been picked up by the auger and had dragged him over the top of the unit.

According to the agreed statement of facts: "A lug on the screw auger had pinned and dragged his arm around the screw. His face, neck and arm were blown up. Symons had dropped to his knees and his arm pit was against the top of the auger body which contained the shaft".

The maximum penalty for breaches of the OH&S Act at the time of Mr Symons death was \$250,000. Mr Shaw has since doubled the offence to \$500,000 for a first offence and \$750,000 for repeat offences.

Last month, WorkCover NSW gained the highest ever penalty in Australia of \$480,000 against Warman International Pty Ltd.

Contact: Peter Lewis on 9230 2160 or 041 9014135

New Rehab Law to help injured worker recovery (5 June 1997).

The Acting General Manager of WorkCover NSW, John Horder, said today that from 1 July, employers need to prepare individual return to work plans for injured employees who are unable to return to work for 12 weeks or more.

"Previously, there was no legislative requirement to develop a return to work plan for individual workers. However, experience shows that the sooner injured workers return to employment, there is a marked improvement in self-esteem, less likelihood of their joining the unemployment pool and savings for their employers," Mr Horder said.

The return to work plan must be developed by the employer's trained rehabilitation coordinator or by an accredited rehabilitation provider in

suitable employment where practicable and outline the steps which will be taken to facilitate the employee's return to work. The 12-week or more period is cumulative.

As well, new provisions in the Workers Compensation (Workplace Rehabilitation Programs) Amendment Regulation 1997 will link employers' rehabilitation obligations to the level of risk in their industry as reflected in their workers' compensation premiums. The provisions redefine the categories of employers. Those employers who pay a basic tariff premium of more than \$50,000, or are self-insured, or are

insured with a specialised insurer and have more than 20 workers, will be required to appoint a rehabilitation coordinator.

"At this level an employer could expect approximately two workers compensation claims per annum that involve an employee being unable to work for five or more days", Mr Horder said.

"The new provisions ensure that those industries with a high risk of injury to workers have the expertise on hand to help the employer fulfil their rehabilitation obligations.

"For those employers under the \$50,000 cut-off, WorkCover will promote the establishment of industry rehabilitation co-ordinators who would be attached to an employer association or union to provide rehabilitation co-ordination services to a number of employers in that industry."

Mr Horder said that employers requiring further information should contact the WorkCover Information Centre hotline toll free on 13 10 50.

For further information contact Elizabeth Dixon on (02) 9370 5692 or John Sampson on (02) 9370 5693.

Stress, the workplace and the individual:

A guide to finding solutions for workplace managers to prevent and reduce stress.

Stress, the workplace and the individual: A guide to finding solutions for workplace managers to prevent and reduce stress.
WorkCover NSW, ISBN 0 7310 5120 3,
2nd edition 1996, out of print.

Introduction

This guide aims to identify sources of stress and offer solutions for workplace managers to prevent and reduce stress.

While modern medicine has prolonged life spans and improved the quality of life, stress related disorders such as hypertension and depression have become more prevalent.

In a world which has changed more in the last two generations than in the rest of human history, human beings are showing many signs of not coping physically and mentally with their brave new world. Changes are continuing to occur apace in both society and the workplace.

Duty of care

Under the *Occupational Health and Safety Act 1983*:

- Employers must ensure the health safety and welfare of their employees while at work.
- Employees must take reasonable care of the health and safety of others and cooperate with their employer in their efforts to comply with occupational health and safety requirements.

The implementation of management practices which reduce stress in the workplace is a part of the employers' responsibility under duty of care.

Stress

Stress is a psychological and physiological reaction to some form of pressure being applied to the individual. Individuals convert pressure into stress according to their perceptions and personality.

Stress is a strong motivating force. Although too much or too little stress will cause individual work performance to drop a certain amount of stress is needed for optimum work performance.

Every person has a level for the amount and type of pressure which allows them to perform at their best. This varies greatly from person to person and to an extent will determine the kind of job they choose.

The amount of workplace pressure that an individual can manage will also vary according to the amount of pressure they are facing in their private lives. The reduction of workplace pressures can have the effect of easing pressures in the individual's private life and vice versa.

It is therefore essential that the individual look at ways of modifying their lifestyle to reduce pressure in addition to any changes made in the workplace.

1. Situation, individual response

examples of situations commonly occurring in workplaces which can cause stress.

Situational Major Stress

Threat:

- Threat of harm (working in unsafe conditions).
- Threat of dismissal.
- Change.
- Poor relations with supervisor, workmates.
- Harassment
- Discrimination

Pressure:

- Meeting deadlines.
- Meeting production targets.
- Coming to terms with new technology, management style and changes to stated goals and targets.

Frustration:

- Lack of acknowledgement of threat of harm.
- Lack of acknowledgement of achievements.
- No mechanisms in place to listen to ideas for boosting productivity or making the workplace safer.
- Passed over for promotion.
- Not being suited or properly trained for the job.

Individual Major stress

In addition to the situations listed above there are also sudden major occurrences which can produce extreme stress responses. These include:

- Death of a loved one or an end to a marriage or relationship.

- Threat of physical danger, armed hold-up, major industrial or traffic accident.
- Humiliation, loss of job, sudden loss of self-esteem.

Many of the above pressures place the individual in a situation where their instinct is to "fight or flight". In the modern workplace these responses are generally restricted.

Response.

In the absence of the ability to run away or to physically attack the hostile pressures the individual has a number of responses. Below are examples of the physiological or emotional responses which are symptoms of stress.

Physiological change:

- Rise in blood pressure
- Insomnia
- Rise in heart rate
- Stomach ulcers
- Digestive disorders
- Headaches
- Fatigue

Emotional change:

- Tension - Some people get so tense they lose the ability to relax.
- Anxiety
- Depression
- Addiction to alcohol, drugs, foods, sex. Post traumatic stress syndrome
- Conflict - Some people show their stress by confrontation and conflict.

Many of the physiological and emotional changes listed above are linked. For example, those in a state of anxiety will have a rise in heart rate, and those suffering from tension and depression may have bouts of insomnia.

Post traumatic stress

Post traumatic stress can be as the result of a sudden and traumatic incident such as witnessing a major industrial accident, or being the victim of an armed robbery. Each person will react differently to this kind of major stressor but the range of symptoms that characterise post traumatic stress include:

- Increased heart rate
- Insomnia and hypersensitivity
- Muscle tension
- Frightening dreams

- Fear of returning to work
- Phobias
- Re-experiencing the violent event through hallucinations
- Anxiety
- Depression
- Grief
- Guilt

Post traumatic stress symptoms are a normal reaction to a traumatic incident which should be treated with qualified counselling.

However if not treated, symptoms can continue for a long time past the violent event and become worse. If the symptoms persist for more than a month past the event then the condition post traumatic stress syndrome may be diagnosed. Victims are often left with a view that the world is threatening, irrational and unjust and that they are worthless and vulnerable.

2. Workplace stress management

There are many areas where managers can work to reduce stress in order to create a workplace environment where there is higher productivity and fewer stress related claims, sick days and accidents.

To do this managers should:

- Identify all the possible causes of stress.
- Conduct an assessment of all areas of workplace life which could contribute to stress. Determine the frequency and duration of stressors and the health impact on employees.
- Find ways of controlling stress levels by modifying the workplace, work systems or management style.

This process should be on-going. Look at the areas covered below to form a view of your workplace and to develop good management strategies to reduce and manage stress.

Management

Listen and look at what is happening to maintain individual and team dynamics at an optimum level.

Frustration through lack of control can lead to a steady build-up of stress. Those who rate their jobs as demanding but who have little control are more

Ensure that employees feel that they are a worthwhile part of an effective unit. To achieve optimum stress conditions, management should aim for:

- Adequate staffing. Overstaffing will lead to lack of direction and boredom. Under-staffing will result in poor planning and continual time pressure.
- Clearly defined roles. Poorly defined roles leads to conflict and confusion.
- Clearly defined goals and priorities. Without clear goals and priorities there will be a great deal of wasted effort leading to resentment and a lack of pride in work.
- Adequate training. Lack of training will result in frustration from wasted effort with new systems and technology.
- Adequate resources. Frustration will build if employees are required to achieve goals with inadequate tools, machinery and other resources.
- Clear communication. Managers and employees must have a clear understanding of all workplace issues and processes.

Establish ways for employees with ideas for increasing efficiency or who have legitimate concerns about safety or productivity, to be heard. This can be done through staff meetings, by inviting employees to approach senior management and the occupational health and safety committee. Larger organisations could make use of 'quality teams' where all team members in a section have joint responsibility for quality, meeting production targets and occupational health and safety.

Occupational health and safety

Conduct a review of health and safety in your workplace to identify and assess areas of risk. Then decide on appropriate measures to eliminate or control those risks and provide training for those who may be exposed to the risks.

Wherever there is a threat of actual physical harm there is a potential cause of stress. Potential for harm exists in many parts of the workplace including where:

- Hazardous substances are used or stored

- Forklifts, cars, buses, trains, planes, front-end loaders etc. are driven.
- Repetitive tasks are required.
- Manual handling is undertaken.
- Work is carried out in confined spaces.
- There is excessive heat, noise or dust.
- Employees may be subject to violence from clients or criminals.

An oppressive physical environment can place an individual under a great deal of pressure. Make sure that there is adequate:

- Lighting.
- Ventilation and air conditioning.
- Space to carry out the required tasks.
- Tools or machinery which are well maintained and easy to operate.

Conflict resolution

Develop consultation policy and processes to reduce the potential for serious conflict. The policy should include mechanisms for employees to give feedback to their managers which will help to relieve a build up of resentment or frustration.

The resolution of conflict should be achieved by following set procedures where both parties feel that they are being fairly treated. Individuals should not be left to resolve conflict where personalities have tried and failed.

Types of conflict include:

- Sexual harassment.
- Forms of sexual and racial discrimination.
- Ostracism of a worker by their fellow workers.
- Reaction to unfair decisions by supervisors.
- Reaction to failure to obtain a promotion or transfer.

Consider using mediation to resolve difficult conflict in the workplace.

Where conflict between two employees has reached an impasse professional mediators can resolve the issue by giving both parties a hearing and drawing up a written agreement between the two.

Shift work

Evaluate the effects of shift work on

Shift work can cause fatigue, sleep deprivation, disruption of circadian rhythms and may cause gastro-intestinal and cardio-vascular disorders to become worse. Shift work can also cause disruption to social and family life.

Therefore consider negotiating changes to the length and cycle of shifts.

Employees may benefit from increasing the length of shifts from eight or ten, to twelve hours. Longer shifts offer more days off to recover from stress and more time spent with the family.

Change

Where and when major changes are implemented make sure that employees are properly informed and prepared through retraining.

Change can be the most threatening of all workplace pressures. Change can make employees feel as if their expertise now counts for nothing and that they are becoming less relevant. Change includes:

- Introduction of new technology.
- Changes in management and management style.
- Changes to shift work and deadlines.
- Restructuring.

Employee Assistance Programs (EAPs)

Consider the need for an Employee Assistance Program.

An EAP is a confidential counselling service to assist employees resolve personal and work issues that are affecting their work performance. EAP counsellors are qualified psychologists, psychiatrists and social workers. The aim of an EAP is to restore the job performance of an individual.

Employees who feel stressed from personal and/or workplace pressures can be referred by a supervisor to see an EAP counsellor or alternatively access the EAP service of their own accord. EAPs should not be used by managers or employees to replace responsibility for job related stress.

EAPs should be a member of the Employee Assistance Program Professional Association (EAPPA).

Post traumatic stress

staff in how to deal with a major traumatic incident as it occurs and have ready access to a counselling service experienced in post trauma debriefing and counselling.

Counselling should be tailored to the incident. For example, a taxi driver who has been robbed will need individual counselling, while the staff of a bank who have witnessed an armed robbery may need a group counselling session as well as individual treatment.

Workplace social life

Encourage social and sporting activity within the workplace where employees at all levels get to know each other.

Stressful feelings and situations often arise due to misunderstandings in the workplace. Social and sporting occasions provide a setting where healthy relationships and positive feelings can grow.

Facilities

If the resources are available, provide sporting facilities, meal break facilities and a place where employees can go during their break to sit quietly, relax and unwind.

Each individual has their own preferred method of relieving stress. Some enjoy jogging or competitive sports, while others enjoy reading, taking a nap or meditating.

3. Individual stress management

Individuals bring to work a range of personal problems and levels of social support which impact on their ability to cope with workplace pressures.

Employers can only go a part of the way towards optimising the stress levels of their employees. Stressful personal problems include:

- Marriage/relationship problems
- Moving house
- Loss of health
- Financial troubles.

Pressures at home and work are inevitable and are often not under the control of the individual. There are however ways of reducing stress in spite of life circumstances.

Individuals can promote well being by taking adequate exercise, having enough sleep and relaxation and by

It is important not to neglect one of these areas. Exercise on its own may provide some benefits but coupled with poor sleep and diet it is not enough to reduce stress.

Personal fitness

A regular exercise regimen can increase personal fitness and endurance, prevent the build-up of fatty deposits on artery walls, lower heart rate and blood pressure, and provide a regular break from negative thinking patterns.

To be effective exercise should be sustained for 20 minutes or more with heart rate raised to between 70 to 80 per cent of capacity for the whole period. It should be undertaken at least three times per week.

Relaxation

A short time spent every day relaxing will help to relieve & stress which has built up through the day.

Ways of relaxing include taking a nap, meditating, self-hypnosis, listening to music, or simply sitting quietly and day-dreaming. It may be of benefit to do one of the many courses in meditation, self-hypnosis and other relaxation techniques which are available.

Diet

There are many theories about the effects of diet on stress. Although the most effective approach will vary from person to person there are a few do's and don'ts to follow.

A low stress diet should supply the basic ingredients of nutrition, be moderate in intake and should be:

- High in fibre.
- Low in fat, sugar and calories.
- Low in processed foods, particularly those with additives, colourings and preservatives.
- Low in red meat.

Caffeine and alcohol intake should also be kept low and many experts believe that tobacco should be cut out completely.

Social

Social interaction is a way of relieving stress.

Loneliness and the lack of support during times of high stress can add to the intensity and duration of the stress.

4. Managing a stress claim

A workers compensation claim for stress should be managed in the same way as all other occupational injury or illness.

A workplace based rehabilitation plan should be developed to return the employee rapidly and safely to normal duties.

However a stress claim can be a difficult issue for management to deal with effectively because identifying and rectifying the cause of the stress is often not clear cut. For example, in some cases the cause of the stress is a conflict of personalities which involves management.

A claim for occupational stress is often initially disputed by the insurance company. The mix of personal and social factors as well as workplace pressures usually means that stress claims take some time for liability to be determined.

Early intervention with assessment of the employee by an occupational psychologist can significantly reduce the time lost. Early intervention will also promote trust between the employer and worker and reduce the worker's reaction to stress.

Workplace rehabilitation

Effective rehabilitation can help to prevent lengthy absence. The longer a worker is off work on workers compensation the less likely it is they will return to work. A return to work program will also allow the worker to maintain social contacts, work habits and morale.

Rehabilitation based at the workplace involves the use of regular work tasks which are time limited, specifically controlled and upgraded according to the recovery rate of the injured worker.

To develop a rehabilitation plan the person designated to workplace Rehabilitation Co-ordinator should ask:

- Will the worker need help returning to work within minimum time frame?
- Can the worker with a stress-related condition continue working on normal, modified or new duties as part of an on-site rehabilitation

- Is outside help required from a doctor, psychologist, accredited rehabilitation provider, other?

Where appropriate the plan should be developed and monitored by a WorkCover accredited rehabilitation provider. As an outsider a provider should be seen to be impartial and therefore is at an advantage in helping to achieve a solution for a return to work.

Rehabilitation plan

The areas to be covered when developing a rehabilitation plan:

- Assess the worker's ability to continue at work.
- Consult with the employer and treating doctor/psychologist.
- Identify the stressors at work and in the worker's private life.
- Identify any possible modifications to the work system.
- Identify suitable or modified duties.
- Consult with the supervisor and other employees.

A rehabilitation plan can then be developed with the following services: Appropriate support such as counselling, to be given to the worker to enable them to continue their usual tasks.

- Advice about permanent or temporary modifications of work systems and resources to help the worker and to remove sources of stress.
- Suitable duties based on matching tasks to the worker's recovering abilities.
- Monitoring of the return to work and effective liaison with treating practitioners.
- Assistance with job seeking or retraining where return to the original job is not possible.

All rehabilitation information is strictly confidential. Workers with stress related injuries must have the confidence that information relating to their rehabilitation is not discussed with, shown to, or read by anyone who is not directly involved with the worker's rehabilitation.

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Diagnostic and Statistical Manual of Mental Disorders: DSM-IV.

Book Review: Diagnostic and Statistical Manual of Mental Disorders; DSM-IV Sourcebook Study Guide to DSM-IV; DSM-IV Casebook; The Clinical Interview Using DSM-IV.

A. Kenneth Fuller M.D., Southwestern State Hospital, Thomasville, GA 31799. The New England Journal of Medicine, Oct. 27, 1994, Volume 331, Number 17.

The American Psychiatric Association's Diagnostic and Statistical *Manual of Mental Disorders* (DSM) is the most comprehensive and authoritative book devoted to the classification of psychiatric illness. There have been four major revisions since 1950. The fourth edition (DSM-IV) closely follows the format of the third edition (DSM-III; Washington, D. C.: American Psychiatric Press, 1980) and the revised third edition (DSM-III-R; Washington, D.C.: American Psychiatric Press, 1987), but is a third longer than the latter and includes more diagnostic categories.

Why do we need a new edition when the DSM-III-R was published only seven years ago? The answer is simple: scientific knowledge is not static. Previous editions relied heavily on a consensus of experts in the classification of disorders, but the DSM-IV relies more closely on research, including extensive reviews of the literature, reanalyses of data, and results of clinical trials.

With conservatism as its general philosophy, the task force that compiled this edition simplified many diagnostic categories and more precisely defined the differences between similar disorders. Its guiding principle was a reliance on a *systematic* review of the literature and empirical data. The members of the task force added few new categories. Moreover, they retired several categories, including idiopathic alcohol intoxication, identity

childhood, avoidant disorder of childhood, and transsexualism.

The organisation of the manual discourages an approach encompassing mind-body dualism and facilitates the differential diagnosis. The term "organic mental disorders" has been deleted. If a general medical condition or substance (drug of abuse, prescribed medication, or toxin) is responsible for psychiatric symptoms, the DSM-IV labels the disorder as "due to a general medical condition" or as a "substance-induced disorder". Conditions that share certain symptoms are placed together. For instance, organic anxiety disorder was renamed and is now included in the section on anxiety disorders. Thus, under the new system a patient might have anxiety disorder due to hyperthyroidism.

The DSM-IV warns against misdiagnosis due to cultural misunderstandings. In addition to the appendix of "culture-bound syndromes", many descriptions of individual disorders have sections entitled "Specific Culture, Age, and Gender Features".

A major goal in developing the DSM-IV was to make it more compatible with the 10th revision of the *International Statistical Classification of Diseases and Related Health Problems* (ICD-10). The DSM-IV task force took important steps in that direction, but the definitions of several disorders differ in basic and important ways in the two systems. For instance, the ICD-10, which incorporates a broader definition of schizophrenia than the DSM-IV, does not include the concept of prodromal or residual symptoms. The ICD-10 definition of schizophrenia specifies a much shorter duration of symptoms (one month), in contrast to the duration of six months specified by the DSM-IV.

trustworthy information in the accompanying text. No longer is this book a simple rehashing of the diagnostic criteria. The prevalence, age of onset, and clinical course of various disorders are given in much greater detail than in previous versions.

Primary care practitioners, medical specialists, and mental health clinicians will find the DSM-IV useful and beneficial. It has substantially expanded sections on differential diagnosis and provides laboratory data and other relevant information. For example, the section on schizophrenia mentions structural abnormalities of the brain, imaging techniques that may be useful, and neurophysiologic findings.

An appendix entitled "Criteria Sets and Axes Provided for Further Study" was expanded from three categories in the DSM-III-R to more than two dozen. Examples include post-concussional disorder, premenstrual dysphoric disorder, factitious disorder by proxy, and medication-induced movement disorders. This appendix offers a glimpse into the next edition of the book. Factor analysis, a research tool, suggests that the use of dimensional descriptors might be a clinically appropriate way of subtyping certain disorders. For example, the appendix lists three such descriptions for schizophrenia: a psychotic dimension, including hallucinations and delusions; a disorganised dimension; and a negative dimension. Clinical studies show that the severity of the symptoms in each of these dimensions tends to be similar. For example, as hallucinations become more severe, delusions also tend to be more severe. In contrast, the severity of negative symptoms (i.e., flat affect and impoverished thinking) is less closely related to the severity of delusions or hallucinations.

Investigators of psychopathology will be

the controversies and questions about psychiatric nosology, but it does supply a reliable and specific diagnostic system that should encourage clinical research. It also foreshadows future changes by including a brief and somewhat out-of-place discussion of dimensional models for personality disorders, a reference to prototypes, and a proposed axis for defence mechanisms and coping styles.

Clinicians in all specialties can use the DSM-IV as a reference. It is a "must" for every serious mental health and medical library and all mental health clinicians. Primary care physicians, who treat one fourth to one half of people with psychiatric illness, should read the introduction to the manual and the instructions concerning its use.

The DSM-III, published in 1980, provided the first clinically sound and reliable multi-axial set of criteria for identifying mental disorders. A major criticism of the DSM-III and the DSM-III-R was that they created new diagnostic categories, often with little justification. It was thought that adding disorders would promote empirical studies of new and diverse areas that might otherwise be neglected. However, the validity of several of the new categories was not supported by systematic study. The following is a good example of how the task force required substantiation of a diagnostic category. The entry on passive-aggressive personality disorder appeared in the earlier versions of the DSM. Many clinicians will be surprised to learn that there are virtually no empirical studies of this disorder. The DSM-IV demotes it to an appendix.

Volume 1 of the *DSM-IV Sourcebook* is the first instalment of a projected five-volume set that will bring together the research behind the DSM-IV. It consists of 45 chapters covering substance-related disorders; delirium, dementia, and amnesic and other cognitive disorders; schizophrenia and other psychotic disorders; medication-induced movement disorders; and sleep disorders. Each chapter reviews the literature on a topic. The four additional proposed volumes will provide the remainder of the literature searches, summaries of over

In one chapter the *Sourcebook* reviews the classic subtypes of schizophrenia to determine their validity. This chapter clearly shows how literature searches were instrumental in determining the final form of the manual. The classic subtypes were retained because there is evidence that they have prognostic value- the paranoid type has the best prognosis, and the disorganised type the worst outcome.

A weakness of the *Sourcebook* is its limited bibliography. It often lists less than half the references mentioned in the review. Some chapters include a count of the number of journal articles on the proposed diagnostic category; others merely mention the sources of the unnamed articles. The *DSM-IV Sourcebook* was meant to be an archival reference for the decisions of the task force. A more thorough bibliography would have served this purpose better.

Some reviews are sophomoric, and the commentaries less than satisfying. The general outline of the chapters, which includes a statement of the issues and their importance, methods, results, discussion, and recommendations, was not followed consistently. Much information is now dated. In short, the *Sourcebook* will interest serious nosologists but will have little appeal for the average clinician.

How, then, can clinicians learn to use the new official nomenclature without reading the DSM-IV straight through? The DSM-IV, destined to be a best-selling psychiatric work, has spawned three additional books. Released simultaneously by the same publisher, these facilitate an understanding of the concepts and terminology in the DSM-IV.

The *Study Guide to DSM-IV*, will chiefly benefit medical students, psychiatrists in training, and other clinicians seeking introductory information. It serves best as an organised introduction to the criteria for individual DSM-IV categories. Since it specifies diagnostic criteria for each mental disorder, the DSM-IV is a criteria-based, categorical system of diagnosis. The rules defining each disorder specify the type, intensity, duration, and effect of various types of

The categorical classification outlined in the DSM-IV is contrasted with the use of prototypes. Prototypes, a recent innovation in research on psychiatric nosology, are typical cases with many features associated with a category. The *Study Guide* highlights individual disorders with the use of prototypical vignettes. Many researchers believe that prototypes illustrate the diagnosis more vividly than a list of criteria. These clinical vignettes enhance the learning of criteria.

A key issue for primary care practitioners is how best to handle patients who do not fully meet the criteria for specific diagnostic categories. The author of the *Study Guide* highlights common diagnostic problems. He furnishes examples of patients who fulfil most of the diagnostic criteria, of patients who satisfy the diagnostic criteria for more than one disorder, and of psychiatric conditions associated with other psychiatric disorders or general medical conditions. This information helps clarify cases in which patients have conditions that do not meet the threshold for diagnosis or have symptoms that seem to place them in two different categories.

The DSM-IV, like its predecessors, follows a hierarchical structure. For example, if a general medical condition can account for the patient's signs and symptoms, the medical disease is given priority over all mental disorders. To minimise the number of diagnoses a person might have, the manual excludes certain diagnoses if the patient meets the criteria for other mental disorders. The *Study Guide to DSM-IV* provides tables of diagnoses that must be excluded before a specific diagnosis can be made. For example, a neurologic or general medical condition has precedence over somatization disorder, and somatization disorder has precedence over conversion disorder.

The author would have done well to provide a chapter on severity, specifiers of the clinical course, and subtypes. The most recognisable change in the mood-disorders section of the DSM-IV, is the evolution of specifiers to denote

subtypes are included: "With Melancholic Features", "With Atypical Features", and "With Catatonic Features". In addition, longitudinal course modifiers allow the clinician to specify the degree of recovery between episodes. The *Study Guide* addresses these confusing points, although superficially.

The *Study Guide to DSM-IV*, is helpful. Used as a companion to the DSM-IV, as it was intended, it becomes a serviceable resource for medical students and psychiatric residents. Other physicians will find it useful as an occasional quick reference and helpful in reviewing for examinations.

The *DSM-IV, Casebook*, another companion to the DSM-IV, is educational and fun to read and highlights many changes in the DSM-IV. The clinical vignettes focus on information relevant to the differential diagnosis. Each case is followed by a discussion of diagnostic reasoning, according to the DSM-IV. When diagnostic uncertainty resulting from inadequate information or ambiguity rears its head, the editors steer the reader around obstacles.

The DSM-IV is not a cookbook. The assigned diagnosis must make sense. The *DSM-IV Casebook* helps the reader understand how to use clinical decision-making skills to make the best use of the manual.

The DSM-IV abbreviates and streamlines sets of criteria for several categories of disorders. The criteria for somatization disorder, generalised anxiety disorder, antisocial personality disorder, and schizophrenia are simplified in ways that do not materially affect the number of cases diagnosed. The first two chapters of the *DSM-IV, Casebook* deal with mental disorders in adults and children. Chapter 3 takes up the multiaxial system that the DSM-IV, retains. Axis I consists of clinical disorders and other conditions that may be a focus of clinical attention, axis II consists of personality disorders and mental retardation, axis III consists of general medical conditions, axis IV consists of psychosocial and environmental problems, and axis V is a global assessment of functioning. The

considers each axis and summarises the different types of information.

The DSM-IV changed axis IV from a scale to a list of psychosocial and environmental problems. Examples of these problems included in the *DSM-IV Casebook* are unemployment, financial problems, living in a dangerous neighbourhood, knowledge of being positive for the human immunodeficiency virus, problems with a spouse, having a dying sibling, and work-related difficulties. Unfortunately, the editors limited the cases covering multiaxial assessment to 10. The point of having multiple axes is to encourage the clinician to look for certain types of information. The editors should have diagnosed every case in the *DSM-IV Casebook* by the multiaxial system.

The *Casebook* helps elucidate features of categories new to the DSM-IV. Bipolar disorder has been split into two categories --- bipolar I and bipolar II. Two cases of bipolar II disorder illustrate the hypomania and major depressive episode required for this diagnosis. A case of systemic lupus erythematosus shows how the diagnosis of catatonic disorder due to a general medical condition is made. The DSM-IV has added acute stress disorder to describe acute reactions to extreme stress that last no more than one month. The *Casebook* gives attention to variants of autistic disorder, a pervasive developmental disorder, and to childhood disintegrative disorder. However, Rett's disorder, which occurs in girls with deceleration of head growth and difficulty with hand movements, is omitted.

Two personality disorders, sadistic and self-defeating, were included in an appendix of the DSM-III-R, but eliminated in the DSM-IV. In the discussion of a case in the *DSM-IV Casebook*, there is a parenthetical comment that the editors believe sadistic personality disorder was mistakenly eliminated from the DSM-IV. The editors, including Robert L. Spitzer, who spearheaded the task force on the DSM-III and DSM-III-R, are a superb group of experts in psychiatric classification. They have clearly made a conscientious effort to help others learn

The Clinical Interview: Using DSM-IV is recommended reading along with the *DSM-IV Casebook* for physicians preparing for oral examinations in psychiatry. The authors start with an overview of interviewing techniques and lay out a model for establishing rapport, collecting information, and making a diagnosis. They have whittled down the steps of the diagnostic interview to five phases, paying special attention to beginning with open-ended strategies and narrowing the focus as data are collected.

First, the clinician fosters rapport and assesses the problem. By following up on preliminary impressions, the clinician assembles a historical database. Next, the diagnosis is made and feedback is given to the patient. In the last phase, the clinician gives a prognosis, selects a treatment plan, and negotiates a treatment contract.

The authors' method of tackling the large number of DSM-IV categories requires the interviewer to make three lists: diagnoses consistent with the history, categories excluded by the available data, and unexplored disorders. As the diagnostic process unfolds, the long list of unexplored categories dwindles and the list of excluded disorders grows until a diagnosis is made.

Unfortunately, the authors seem incompletely familiar with the DSM-IV. For example, they use a discarded term, multiple personality disorder, interchangeably with the new term, dissociative identity disorder. Similarly, a discussion of stress disorders omitted acute stress disorder from the differential diagnosis. Otherwise, the authors teach interview strategies with skill and insight.

These five books should improve the quality of psychiatric assessment and help readers eliminate idiosyncrasies in their diagnostic habits. Even so, the DSM-IV is not a bible of psychiatric classification. If psychiatric classification is in its toddlerhood, the DSM-IV exemplifies the expanding world of the toddler. In the future, categories will be scrutinised to determine whether they should be deleted. Guided by published and reproducible standards, scientific

hysteria that has dominated past discussions.

With strict guidelines based on clear empirical support, future revisions

should shrink the expanding world of psychiatric classification into a reliable, valid system. In the next century, psychiatric classification can regroup in

its adolescence, reach a solid basis, and be on a par with the rest of medicine.

New Superb Handbook on Anti-Bullying - book review.

***The Anti-bullying Handbook*, by Keith Sullivan, 2000, 250pp. Oxford University Press, 540 Great South Road, Greenlane, Auckland, New Zealand; paperback, A\$19.95 plus postage. Reviewed by Dr. Karl H. Wolf, B.Sc. (Canada), Ph.D. (Australia), D.Sc. (USA)**

Introduction. Several books on bullying have been reviewed in *The Whistle*, all multi-authored – and one might exclaim: why another book on the same human deleterious phenomenon?! Reply: (a) although the earlier books all offered valuable information on bullying, they did not cover numerous aspects; (b) a modern step-by-step overview was needed; and (c) a logical integration of all theoretical and practical aspects was required. The contribution by Sullivan, in my judgement, is indeed one of the best by proffering a superb systematic coverage ranging from introductory ideas to more advanced concepts (e.g. see sociograms and relationship maps). His book is indeed fabulous and definitely highly recommended! If you must confine yourself to one book on bullying, at present I would suggest that by Sullivan – if you can afford two books, also get that by McCarthy, Sheehan & Wilkie (Editors, 1996) reviewed earlier.

An important caveat. I believe that the treatment of human failings, as exemplified by widespread bullying, ought to be counter-balanced by more positive outlooks – hence, read caveats in my last review of a third book in *The Whistle* No. 3/2000, October 2000, p. 18-19.

The author. Sullivan has brought to bear many years of experience in education, anti-bullying research, and human rights obtained in Canada, England, New Zealand, and Australia in the preparation of this book.

Mode of presentation. This needs to be highlighted because the style of presentation of this book can serve as a 'model' for any author! (a) The topics follow a systematic, logical, sequence, seemingly leaving out no information of

sections and subsections; (c) many point-by-point lists are used instead of lengthy sentences or paragraphs; (d) numerous flow-charts and other diagrams, and comparative/contrastive summary tables provide a quick overview and, of course, make it easy to follow the author's arguments; (e) the *References* and *Select Bibliography* cover well the English-language publications on bullying – especially the Americans, British, New Zealanders, and Australians have done quite a bit of research; (f) as modern books require, numerous INTERNET and e-mail addresses are provided; and (g) the *Index* is helpful (although it must be supplemented by the reader scanning the *Contents* and the text's many *subtitles*) in contrast to some books without an *Index*. The diagrams and comparative tables summarise the following: what we know about bullying (B hereafter); B's iceberg; ripple effect of B; downward spirals; a whole-school initiative; school ethos: a continuum; the dysfunctional, conflicted and safe schools; step-by-step guide to handling B; sociogram depicting complex social relationships (a holistic approach) for studying group dynamics (e.g. peer communication); effective peer counsellor; and assertive approach to B.

The book's coverage. Inasmuch as the book deals with several dozen topics, only very brief impressions are possible by listing a few selected main titles, supported by short comments. The book comprises the following (4 Parts, 17 Chapters): **Part I. What is bullying and what we know about it** – with two introductory chapters. Chapter 1. *Four Purposes* and the *Viewpoint* of the book are provided; followed by a detailed comment on the five main groups of readers addressed. 2. Bullying (B hereafter) is defined; types/forms, myths, extent, patterns, personality- & family-characteristics, victims, effects, third-party-influences, dynamics, stages, and potential of stopping of B. are discussed. **II. Planning, Philosophy, and Policy.** 3. How to create an anti-bullying initiative: whole-school approach; six-step anti-B plan. 4. Clarifying a school philosophy; three school ethos: do-little/do-nothing-,

responses. 5. Planning and information gathering: use of SWOT analysis (=Strength, Weaknesses, Environmental Opportunities, and Threats). 6. A school policy on bullying: the Policy is equivalent to an Act of Parliament; Policy creation comprises five stages: consultation, discussion, writing an anti-B policy, implementation, and monitoring & maintenance.

III. Preventive Strategies. 7. Strategies for teachers. Discussion of teacher as ineffective or reflective practitioner; problem-solving creative tools: action research, cooperative learning, and sociometry. 8. Interactive strategies in the classroom: students learning about B through awareness programs, role playing, and scenarios. 9. The school environment: control and identification of B, rights of others, and creation of stimulating/enjoyable environment.

IV. Intervention. 10. Peer strategies: befriending – peer partnering & monitoring, ethics and confidentiality. 11. Peer strategies: counselling & mediation: effective training methods, mediation. 12. The *No Blame* approach. Solve but do not punish B, which requires seven steps: interview, meeting, explaining, sharing, asking, group responding, and final meeting.

Several philosophies to study and deal with bullying are described in the following chapters, identified by the methodologies' names: 13. *A circle of friends* – a Canadian philosophy. 14. *The P.E.A.C.E. Pack* and *Bullying in Schools* are two Australian approaches. 15. *Kia Kaha* and *Stop Bullying* were developed by the New Zealand Police. 16. *The Pikas Method* of shared concern, is the UK approach. 17. Follow-up strategies for students: assertiveness training, anger management, self-defence and martial arts training to increase self-confidence and 'caution'!

Applicability of book: readership. Inasmuch as bullying has been detected ('experienced!') in just about all social settings, it is no exaggeration to recommend this book to every person of every age (above 15 years?) – thus, slightly disagreeing with the author, who

shops, family homes, churches, sport clubs, streets – you name it, bullying has been dished out by the ill-adjusted anywhere! Thus, teachers/professors and students, trainers and trainees/apprentices, therapists/psychologists, sociologists,

researchers, administrators, executives, managers, supervisors, sales personal, parents, priests/ministers, even politicians, ... -- everyone will learn to recognise bullying and hopefully recognise their own and others tendencies to occasionally use 'mean'

ways! Recognition and understanding comes first, then follows prevention. Easy said, I know – but we have to start somewhere!

Letter to the editor: Managerial training avoids disclosure procedures & whistleblowing.

Introduction. During the past few years, hundreds of books and manuals have been released to train/educate corporation, industrial, and other institutional managers, executives, supervisors and the likes. In support of these leaders, additional publications are available on a whole spectrum of topics in administration, globalisation, engineering, etc., as exemplified by the need for training in economic predicting/forecasting, risk management, accident-prevention, among others.

All these training-publications offer advice on how, when, and where to do what. This includes, naturally, recommendations about communication within any institution to ascertain that all operational/bureaucratic hierarchies are successful, and conducted on ethical principles. However, although they may deal with 'conflict resolution' and 'problem solving', what is missing are discussions on the 'obligation' or 'duty' of all employees to identify and make known any 'purposively concocted unprofessional conduct' (a weak euphemism for fraud, rorts, scams, etc.). Let me offer some specifics.

Absence of instructions on disclosure.

Just a few modern examples:

- (a) The excellent businessman's training and reference handbook '*The Fifth Discipline Fieldbook: Strategies & Tools for Building a Learning Organisation*' by Peter M. Senge et al. (1998) lists in the

Contents and Index dozens of keywords that represent the 'leadership philosophy' in an idealistic or perfect social setting.

- (b) The Australian Institution of Engineers' analysis on how to evaluate the expertise of, for example, construction and engineering companies, is outlined in their '*Government as an Informed Buyer: Recognising Technical Expertise as a Crucial Factor in the Success of Engineering Contracts*', by Athol Bates (2000). This report was prepared in response to the numerous recent industrial accident/disasters!
- (c) A good book by a behavioural science-inclined manager guru is that by Eugene F. McKenna (1987) '*Psychology in Business: Theory & Application*'.
- (d) Those interested in analysing the future ought to examine the following: '*Predicting the Future: an Introduction to the Theory of Forecasting*' by Nicholas Rescher (1998); '*The Fortune Seller: the Big Business of Buying & Selling Predictions*' by William A. Sherden (1998); and '*Against the Gods: the Remarkable Story of Risk*' by Peter L. Bernstein (1996).
- (e) As to a critical evaluation of the newest economic trend, see '*The Global Trap: Globalisation & the Assault on Democracy & Prosperity*

by H.P. Martin & H. Schumann (1997).

These books describe and represent various business, industrial, and social environments – and, of course, offer recommendations about accepted professional conduct. Yet, all avoid the necessity of implementing instructions about dealing with misconduct. Whistleblowing is never mentioned!

Suggestions-cum-queries:

- (1) Although many institutions have their *Code of Conduct* publications, others do not. Every company, industry, etc., ought to have such a *Code*.
- (2) Occasional or periodic seminars or meetings discussing the importance of ethical behaviour might be conducive to maintaining a proper 'institutional atmosphere'.
- (3) All employment contracts should contain requests for everyone to adhere to their Code of Conduct – the contract to be signed! Also, the contracts ought to stipulate that the employees consider it to be their duty to 'disclose' any detected wrongdoing.
- (4) It should be made generally known that those involved in training/educating professionals must consider in their publications the need for disclosure procedures. Misbehaviour and whistleblowing must be discussed openly to make everyone aware that it even exists!

Dr. Karl H. Wolf, Eastwood, 2122

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Websites of interest:

www.whistleblowers.org.au

www.uow.edu.au/arts/sts/bmartin/dissent/

www.anti-corruption-network.org.au

<http://www.caitrin.mtx.net>

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Best wishes for the 2000/01 festive season to people of goodwill.

2001 – International Year for whistleblower retribution against workplace bullies.

Committee for Psychological Safety in the Workplace.