

Trauma in the South African Police Service: A Psycho-social Therapeutic Program

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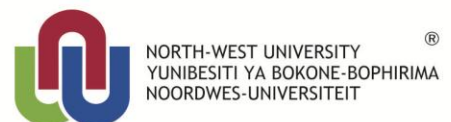
Thesis submitted for the degree Doctor Philosophiae in Social Work at the Potchefstroom Campus of the North-West University

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It all starts here TM



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PREFACE

The thesis is submitted and presented as a unit in the format utilised in the presentation of the research results as stipulated in Rules 5.1.1.2 of the Yearbook of the North-West University (2015: 117). The following articles have already been published in accredited journals according to the guidelines of the concerned journals which are included as addenda. However, the researcher, for the purpose of uniformity, aligned the articles with before-mentioned stipulations prescribed by the North-West University:

Article 2 was published in the accredited journal, *The Social Work Researcher-Practitioner* (Boshoff & Strydom, 2015);

Article 3 was published in the accredited journal, *Maatskaplike Werk/Social Work* (Boshoff, *et al.*, 2015);

Article 4 was published in the accredited journal, *Acta Criminologica* (Boshoff & Strydom, 2015).

DECLARATION

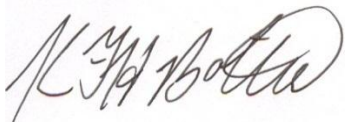
It is herewith declared that the research was conducted by the candidate, P J Boshoff. The authors of the articles agreed that the candidate be indicated as the first author, while the promoter, Prof H. Strydom is indicated as the second author. The assistant-promotor, Prof K.F.H. Botha is indicated as the third author for articles three and six.



P.J. Boshoff



H. Strydom



K.F.H. Botha

LIST OF ACRONYMS

- CIHQ = Critical Incident History Questionnaire
- CISD = Critical Incident Stress Debriefing
- DET = Detective Services
- EHW = Employee Health and Wellness
- FCS = Family Child and Sexual Offences Unit
- IES-R = Impact of Event Scale - Revised
- LCRC = Local Criminal Record Centre
- MHC-SF = Mental Health Continuum - Short Form
- PE = Prolonged Exposure
- PES = Police Emergency Services
- POP = Public Order Policing
- PTCI = Post-Traumatic Cognitions Inventory
- PTP = Psycho-social Therapeutic Program
- PTS = Post-Traumatic Stress
- PTSD = Post-Traumatic Stress Disorder
- SAPS = South African Police Service
- TF-CBT = Trauma Focused – Cognitive Behaviour Therapy
- TST = Trauma Systems Therapy
- TRT = Tactical Response Unit

ABSTRACT

TITLE: Trauma in the South African Police Service: A Psycho-social Therapeutic Program

KEY WORDS: South African Police Service; Trauma; Psycho-social Therapeutic Program

The overarching objective of this study was to develop and empirically evaluate a Psycho-social Therapeutic Program (PTP), empowering police officials to deal with the possible exposure to traumatic events. This thesis comprised five sections:

Section A contains the problem statement, research objectives and the procedures that were followed. Furthermore the limitations of this study were discussed, the definitions of key words were given and an exposition was given of the composition of the research report. The problem statement can be condensed as follows:

The large and growing number of police officials exposed and affected by trauma makes knowledge concerning their needs essential so as to provide effective interventions. A better understanding of the psychological and social needs of police officials exposed to traumatic events is essential. Responses to police officials affected by trauma should address their needs. Program development must be done in response to police official's needs via their active participation in the entire process.

The problem statement led to five research objectives. Both the exploratory sequential as well as the concurrent convergent strategy was used in this study and was implemented with a mixed method design model. Focus group interviews and questionnaires were used to collect qualitative and quantitative data simultaneously. Literature studies were conducted on the themes trauma, the needs of police officials, trauma intervention approaches and group work programs.

Section B consists of six articles that together formed the report on the research outcomes. Each article was a report on a particular sub-project of the research and had, as a self-contained unit, an own research aim, research method and report. Each article was linked to the central aim, the objectives and the content of the umbrella research project. The six articles were:

➤ **Article 1: Trauma in the South African Police Service**

In this article a literature overview was done on the concept trauma, the factors leading to trauma, the impact, consequences and coping strategies. All of the above aspects should be included in the assessment and intervention processes, in an attempt to fully understand the psycho-social functioning of the traumatised police official.

➤ **Article 2: Exploring programs to support police officials exposed to trauma**

The objective of this article was to critically appraise existing trauma intervention approaches to better understand, compare and extrapolate key elements of these approaches, and to reconfigure them for possible inclusion into a comprehensive holistic psycho-social therapeutic program for use among the police in South Africa.

➤ **Article 3: An assessment of the needs of police officials regarding trauma and trauma intervention programs – A Qualitative approach**

The researcher did an indepth exploratory analyses and discussion regarding the needs of police officials attached to the specialised units in the North-West Province who are exposed to or affected by trauma. Various basic and developmental needs of police officials were discussed as well as specific needs they may experience when they are exposed to traumatic events. A total of 40 police officials stationed at the identified specialist units, representing three of the bigger police clusters in the North-West Province were included in three focus groups as part of data collection.

➤ **Article 4: An assessment of the needs of police officials regarding trauma and trauma intervention programs: A Quantitative approach**

Subsequently the findings of the second quantitative phase of the study, namely the questionnaire survey have been discussed. The findings have been structured according to the themes of the qualitative study and included as constructs in a self-developed questionnaire. The aim of the second quantitative phase of the study was to quantitatively verify the opinions and experiences of those police officials who participated in the three focus groups. A total of 332 police officials representing the specialised units in the North-West Province completed the questionnaire.

➤ **Article 5: A Psycho-social Therapeutic Program (PTP) for police officials attached to the specialised units within the South African Police Service**

A psycho-social therapeutic program was developed, preparing police officials for the possible exposure to trauma and empowering them with skills to be able to deal with the impact of exposure. A needs assessment was done on a large number of police officials representing the specialised police units within the North-West Province affected by trauma. The selection of police officials for this program, as well as guidelines for group work with police officials, were discussed. This article focused mainly on the themes and contents of the designed psycho-social therapeutic program.

Article 6: Implementation and evaluation of the Psycho-social Therapeutic Program (PTP)

The program was implemented including 28 police officials stationed at the Public Order Policing Unit in Potchefstroom. A total of 13 police officials have been included in an experimental group and 15 police officials in the comparison group. The Critical Incident History Questionnaire (CIHQ), Impact of Event Scale –Revised (IES-R), the Mental Health Continuum Short Form (MHC-SF) and the Post Traumatic Cognitions Inventory (PTCI) were used as quantitative measuring instruments at two occasions with both groups. The experimental group was also qualitatively and quantitatively evaluated by means of a self-developed questionnaire.

Section C provided a summary of the findings and conclusions of the research report in total and some recommendations are provided.

Section D consisted of various addenda, such as questionnaires and measuring instruments that were used.

Section E contained an integrated bibliography.

OPSOMMING

TITEL: Trauma in die Suid Afrikaanse Polisie diens: 'n Psigososiale Terapeutiese Program

SLEUTELTERME: Suid-Afrikaanse Polisie diens; Trauma; Psigososiale Terapeutiese Program

Die oorkoepelende doel van hierdie studie was om 'n Psigososiale Terapeutiese Program (PTP) te ontwikkel om polisiebeamptes te bemagtig om die moontlike blootstelling aan traumatiese insidente te kan hanteer en dit empiries te evalueer. Hierdie proefskrif is uit vyf afdelings saamgestel:

Afdeling A het die probleemstelling, navorsingsdoelwitte en die prosedures wat gevolg is, bevat. Voorts is die beperkinge van hierdie studie en die definisies van sleutelwoorde bespreek waarna 'n uiteensetting gegee is van die samestelling van die navorsingsverslag. Die probleemstelling kan soos volg saamgevat word:

Die groot en toenemende aantal polisiebeamptes wat aan trauma blootgestel en daardeur geaffekteer word, maak kennis aangaande hulle behoeftes noodsaaklik sodat doeltreffende intervensies ontwikkel kan word. 'n Beter begrip van die psigiese en sosiale behoeftes van polisiebeamptes wat aan trauma blootgestel word is noodsaaklik. Die reaksies van polisiebeamptes wat deur trauma geaffekteer is, behoort 'n aanduiding te gee van hoe hul behoeftes aangespreek moet word. Program ontwikkeling moet in reaksie op polisiebeamptes se behoeftes gedoen word via hul daardwerklike deelname aan die hele proses.

Die probleemstelling het tot vyf navorsingdoelwitte aanleiding gegee. Beide die ondersoekende opeenvolgende sowel as die gelyktydige konvergente strategieë is in hierdie studie gebruik en met 'n gemengde metode ontwerp model geïmplementeer. Fokusgroep onderhoude en vraelyste is gebruik om kwalitatiewe en kwantitatiewe data gelyktydig in te samel. 'n Literatuur studie is uitgevoer oor die temas trauma, die behoeftes van polisiebeamptes, trauma intervensie benaderings en groepwerk program.

Afdeling B het bestaan uit ses artikels wat saam die verslag oor die navorsingsuitkomst uitmaak het. Elke artikel was 'n verslag oor 'n spesifieke subprojek van die navorsing en het, as a selfstandige eenheid, 'n eie navorsingsdoelwit, navorsingsmetode en navorsingsverslag. Elke artikel is gekoppel aan die sentrale doel, die doelwitte en die inhoud van die oorkoepelende navorsingsprojek. Die ses artikels was:

➤ **Artikel 1: Trauma in die Suid-Afrikaanse Polisie diens**

In hierdie artikel is 'n literatuuroorsig gedoen met betrekking tot die konsep trauma, die faktore wat tot trauma aanleiding gee, die impak, gevolge en hanteringstrategieë. Al die bogenoemde aspekte moet ingesluit word in die assessering en intervensie prosesse, in 'n poging om die psigososiale funksionering van die getraumatiseerde polisiebeampte ten volle te verstaan.

➤ **Artikel 2: Verkenning van program om polisiebeamptes wat aan trauma blootgestel word te ondersteun**

Die doel van hierdie artikel was om bestaande trauma intervensie benaderings krities te evalueer ten einde dit beter te verstaan, vergelyk en sleutelemente van hierdie benaderings te oorweeg, vir moontlike insluiting in 'n omvattende holistiese psigososiale terapeutiese program vir gebruik deur die polisie in Suid-Afrika.

➤ **Artikel 3: 'n Assessering van die behoeftes van polisiebeamptes met betrekking tot trauma en trauma intervensieprogram – 'n Kwalitatiewe benadering**

Die navorser het 'n indiepte verkennende ontleding en bespreking van die behoeftes van die polisie beamptes verbonde aan die gespesialiseerde eenhede in die Noordwes-provinsie, wat aan trauma blootgestel of daardeur geraak word, gedoen. Verskeie basiese, ontwikkelings- en spesifieke behoeftes wat hulle mag ervaar wanneer hulle aan traumatiese gebeure blootgestel word, is bespreek. 'n Totaal van 40 polisiebeamptes gestasioneer by die geïdentifiseerde spesialiseerde eenhede, wat drie van die groter polisie areas in die Noordwes-provinsie insluit was betrokke in drie fokusgroepe as deel van data-insameling.

➤ **Artikel 4: 'n Assessering van die behoeftes van polisiebeamptes met betrekking tot trauma en trauma intervensieprogram – 'n Kwantitatiewe benadering**

Gevolgtrek is die bevindinge van die tweede kwantitatiewe fase van die studie, naamlik die opname vraelys bespreek. Die bevindinge is gestruktureer volgens die temas van die kwalitatiewe studie en ingesluit as konstruksie in 'n self-ontwerpte vraelys. Die doel van die tweede kwantitatiewe fase van die studie was om die menings en ervarings van die polisiebeamptes wat deelgeneem het aan die drie fokusgroepe kwantitatief te verifieer. 'n Totaal van 332 polisiebeamptes verteenwoordigend van die gespesialiseerde eenhede in die Noordwes-provinsie het die vraelys voltooi.

➤ **Artikel 5: 'n Psigososiale Terapeutiese Program (PTP) vir polisiebeamptes verbonde aan die gespesialiseerde eenhede binne die Suid-Afrikaanse Polisie diens**

A psigososiale terapeutiese program is ontwikkel, ten einde polisiebeamptes vir die moontlike blootstelling aan trauma voor te berei en hulle met vaardighede toe te rus ten einde hulle in staat te stel om die impak van blootstelling aan trauma beter te kan hanteer. 'n Behoeftebepaling is op 'n groot aantal polisiebeamptes verteenwoordigend van die gespesialiseerde eenhede in die Noordwes provinsie wat deur trauma geaffekteer word gedoen. Die keuring van polisiebeamptes vir hierdie program, sowel as die riglyne vir groepwerk met polisiebeamptes, is bespreek. Hierdie artikel fokus hoofsaaklik op die temas en inhoud van die ontwikkelde PTP.

➤ **Artikel 6: Implementering en evaluering van die Psigososiale Terapeutiese Program (PTP)**

Die program is aan 28 polisiebeamptes verbonde aan die Openbare Orde Polisiëringseenheid in Potchefstroom aangebied. 'n Totaal van 13 polisiebeamptes is in 'n eksperimentele groep en 15 polisiebeamptes in die vergelykende groep ingesluit. Die Critical Incident History Questionnaire (CIHQ), Impact van Event Scale - Revised (IES-R), die Mental Health Continuum Short Form (MHC-SF) en die Post-traumatic Cognitions Inventory (PTCI) is by twee geleenthede as kwantitatiewe meetinstrumente met beide groepe gebruik. Die eksperimentele groep was ook kwalitatief en kwantitatief deur middel van 'n self-ontwerpte vraelys geëvalueer.

Afdeling C het 'n opsomming van die bevindinge en gevolgtrekkings voortspruitend uit die algehele navorsingsverslag voorsien, en enkele aanbevelings is aan die hand daarvan gedoen.

Afdeling D het bestaan uit 'n aantal addenda soos die vraelyste en meetinstrumente wat benut is.

Afdeling E het 'n geïntegreerde bibliografie bevat.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS	I
PREFACE	II
DECLARATION	III
LIST OF ACRONYMS	IV
ABSTRACT	V
OPSOMMING	VIII
SECTION A: GENERAL INTRODUCTION	1
GENERAL INTRODUCTION	2
1. Problem formulation	2
2. Aims and objectives of the study	8
2.1 Aim	8
2.2 Objectives.....	8
3. Central theoretical statement	8
4. Theoretical framework	8
5. Philosophical world view	9
6. Research methods	9
6.1 Literature study.....	9
6.2 Empirical research	10
6.2.1 The research model and design	10
6.2.1.1 Phase 1: Problem analysis and information gathering	11
6.2.1.2 Phase 2: Design, early development and pilot testing.....	12
6.2.1.3 Phase 3: Evaluation and advanced development	14
6.2.1.4 Dissemination.....	14

6.2.2	Population	15
6.2.3	Sampling procedure.....	16
6.2.4	Measuring/data collection instruments, methods and procedure.....	16
6.2.5	Data analysis.....	17
6.2.6	Handling of ethical aspects.....	18
7.	Time frame and process of intervention	19
8.	Limitations of the study	20
9.	Definitions of key concepts	21
9.1	South African Police Service.....	21
9.2	Police Official.....	21
9.3	Specialised units.....	22
9.4	Trauma	22
9.5	Psycho-social Therapeutic Program (PTP)	22
10.	Presentation of the research report	23
10.1	Section A: General introduction	23
10.2	Section B: Articles	23
10.3	Section C: Summary, conclusions and recommendations	24
10.4	Section D: Annexures.....	24
10.5	Section E: Integrated bibliography	24
	SECTION B: ARTICLES.....	34
	ARTICLE 1 TRAUMA IN THE SOUTH AFRICAN POLICE SERVICE	34
1.	Introduction	35
2.	Problem statement	35
3.	Aim	36

4.	Crime in South Africa	36
5.	The South African Police Service	36
6.	The nature of policing in South Africa	37
7.	The South African police culture	38
8.	Trauma	39
8.1	Trauma defined	39
8.2	The philosophy of trauma	40
8.3	Causes of stress and trauma in the South African Police Service	41
8.3.1	Causes originating within the work situation	42
8.3.2	Causes originating outside the work situation	42
8.3.3	Causes originating from the work itself	42
8.3.4	Causes originating from personal stressors	42
8.4	The police official's response to trauma	43
8.4.1	Re-experiencing	43
8.4.2	Avoidance/numbing	44
8.4.3	Hyperarousal	44
8.5	Reactions to complex trauma	44
8.5.1	Post-traumatic stress disorder (PTSD)	46
8.5.2	Acute stress disorder	46
8.5.3	Depression	46
8.5.4	Anxiety disorder	46
8.5.5	Dissociation	47
8.5.6	Substance abuse	47

8.5.7	Somatic reactions	47
8.6	The consequences of trauma	48
8.6.1	Family and Relationship problems	48
8.6.2	Suicide	48
8.6.3	Family Murder-Suicide.....	49
8.6.4	Police Brutality.....	49
8.6.5	Work related problems.....	50
8.7	Coping with trauma in the South African Police Service.....	50
9.	Conclusion.....	51
10.	Recommendations.....	51
	Bibliography	53
	ARTICLE 2 EXPLORING PROGRAMS TO SUPPORT POLICE OFFICIALS EXPOSED TO TRAUMA.....	60
1.	Introduction	61
2.	Problem statement	62
3.	Aim	65
4.	Literature review.....	65
4.1	International trauma intervention approaches	65
4.1.1	Prolonged Exposure Therapy (PE)	66
4.1.2	Trauma Focused Cognitive Behavioural Therapy (TF-CBT)	67
4.1.3	Psycho-education	67
4.1.4	Marital and family therapy.....	69
4.1.5	Psycho-social rehabilitation	70
4.1.6	Relaxation therapy.....	71

4.1.7	The ecosystems perspective	72
4.2	Existing trauma intervention programs presented by SAPS	73
4.2.1	Critical Incident Stress Debriefing (CISD)	73
4.2.2	Suicide prevention program.....	74
4.2.3	Stress management program	75
5.	Discussion	76
6.	Conclusion.....	78
7.	Recommendations.....	79
	Bibliography	80
ARTICLE 3 AN ASSESSMENT OF THE NEEDS OF POLICE OFFICIALS REGARDING TRAUMA AND TRAUMA INTERVENTION PROGRAMS: A QUALITATIVE APPROACH		86
1.	Introduction	87
2.	Problem statement	87
3.	Aim	89
4.	Research methodology	89
5.	Ethical aspects	92
6.	Discussion of the findings	93
6.1	Theme 1: The meaning of trauma.....	97
6.1.1	Sub-theme 1: Trauma as concept.....	98
6.1.2	Sub-theme 2: Complex trauma	99
6.1.2.1	Category 1 of sub-theme 2: Trauma originating from the work itself	99
6.1.2.2	Category 2 of sub-theme 2: Trauma originating from personal circumstances.....	100
6.1.3	Sub-theme 3: Trauma enforcers	101

6.1.4	Sub-theme 4: Major police stressors that aggravate the experience of trauma	102
6.1.4.1	Category 1 of sub-theme 4: Organizational stressors	103
6.1.4.2	Category 2 of sub-theme 4: External stressors	104
6.1.4.3	Category 3 of sub-theme 4: Operational stressors.....	105
6.1.4.4	Category 4 of sub-theme 4: Personal stressors	106
6.2	Theme 2: Response to trauma	107
6.2.1	Sub-theme 1: Initial aftermath.....	107
6.2.2	Sub-theme 2: Complex traumatic stress disorders.....	108
6.2.2.1	Category 1 of sub-theme 2: Post traumatic stress disorder.....	109
6.2.2.2	Category 2 of sub-theme 2: Comorbidity.....	114
6.2.3	Sub-theme 3: Secondary consequences of complex trauma	115
6.2.3.1	Category 1 of sub-theme 3: Alcohol abuse	115
6.2.3.2	Category 2 of sub-theme 3: Suicide ideation	116
6.2.3.3	Category 3 of sub-theme 3: Anger, aggression and violence	117
6.2.3.4	Category 4 of sub-theme 3: Family and relationship problems.....	118
6.2.3.5	Category 5 of sub-theme 3: Psycho-somatic complaints.....	119
6.2.3.6	Category 6 of sub-theme 3: Work related problems.....	120
6.3	Theme 3: Coping	121
6.3.1	Sub-theme 1: Resilience.....	121
6.3.2	Sub-theme 2: Avoidance coping	122
6.3.3	Sub-theme 3: Action-oriented coping.....	123
6.4	Theme 4: Trauma intervention programs	124
6.4.1	Sub-theme 1: Awareness and participation.....	125

6.4.2	Sub-theme 2: Consumer orientation	126
6.4.3	Sub-theme 3: Consumer satisfaction	127
6.4.4	Sub-theme 4: Core marketing strategy	129
6.4.4.1	Category 1 of sub-theme 4: Product	129
6.4.4.2	Category 2 of sub-theme 4: Psychological cost factors.....	131
6.4.4.3	Category 3 of sub-theme 4: Place and time	133
6.4.4.4	Category 4 of sub-theme 4: Promotion	134
7.	Discussion	136
8.	Conclusion.....	136
9.	Recommendations.....	137
	Bibliography	138
	ARTICLE 4 AN ASSESSMENT OF THE NEEDS OF POLICE OFFICIALS REGARDING TRAUMA AND TRAUMA INTERVENTION PROGRAMS: A QUANTITATIVE APPROACH.....	146
1.	Introduction	147
2.	Problem statement	148
3.	Aim	149
4.	Research methodology	150
5.	Ethical aspects	152
6.	Discussion of the findings	153
6.1	Biographical information	153
6.1.1	Age.....	155
6.1.2	Rank.....	155
6.1.3	Gender	156

6.1.4	Race.....	156
6.1.5	Marital status.....	157
6.1.6	Years service.....	158
6.1.7	Specialised units.....	158
6.1.8	Police clusters.....	159
6.1.9	Scope of work.....	160
6.2	The major causes of stress within SAPS.....	161
6.3	The major causes of trauma within SAPS.....	165
6.4	The response to trauma.....	170
6.5	Coping with trauma (CWT-scale).....	173
6.6	Experience of current trauma intervention programs.....	177
7.	Discussion.....	184
8.	Conclusion.....	191
9.	Recommendations.....	191
	Bibliography.....	193
	ARTICLE 5 A PSYCHO-SOCIAL THERAPEUTIC PROGRAM FOR POLICE OFFICIALS ATTACHED TO THE SPECIALISED UNITS WITHIN THE SOUTH AFRICAN POLICE SERVICE.....	197
1.	Introduction.....	198
2.	Problem statement.....	198
3.	Aim.....	200
4.	Research model.....	200
4.1	Phase 3: Design.....	200
4.2	Phase 4: Early development and pilot testing.....	201

5.	Overview of trauma risk management	202
6.	The nature of a psycho-social therapeutic program for police officials ...	205
7.	Guidelines for group work with police officials.....	205
8.	Planning and compilation of the program in group context.....	207
8.1	Therapeutic and psycho-social educational program and process.....	208
8.2	Selection of program activities	209
9.	Screening criteria for inclusion in a psycho-social trauma intervention program.....	210
9.1	The Critical Incident History Questionnaire (CIHQ).....	212
9.2	Impact of Event Scale - Revised (IES-R)	212
9.3	Brief Description of the Mental Health Continuum Short Form (MHC-SF)	213
9.4	Post-Traumatic Cognitions Inventory (PTCI).....	213
10.	Phases of the PTP	214
10.1	Preparation/Pre-group phase.....	214
10.2	The Beginning Phase	215
10.3	The Middle Phase.....	215
10.4	The End Phase.....	216
10.5	The Post-Group Phase	216
11.	Contents of the psycho-social therapeutic program for police officials ..	216
11.1	Pre-testing.....	217
11.2	Session 1: Introduction and psycho-education.....	218
11.2.1	Agenda.....	218
11.2.2	Rationale	218
11.2.3	Content.....	218

11.2.4	AIDS.....	221
11.3	Session 2: Relaxation.....	221
11.3.1	Agenda.....	221
11.3.2	Rationale.....	222
11.3.3	Content.....	222
11.3.4	AIDS.....	223
11.4	Session 3: Trauma narrative.....	223
11.4.1	Agenda.....	223
11.4.2	Rationale.....	224
11.4.3	Content.....	224
11.4.4	AIDS.....	225
11.5	Session 4: Identifying emotions, feelings and thoughts.....	225
11.5.1	Agenda.....	225
11.5.2	Rationale.....	226
11.5.3	Content.....	226
11.5.4	AIDS.....	228
11.6	Session 5: Rating of feelings and affect modulation.....	228
11.6.1	Agenda.....	228
11.6.2	Rationale.....	228
11.6.3	Content.....	228
11.6.4	AIDS.....	230
11.7	Session 6: Altered thinking.....	231
11.7.1	Agenda.....	231

11.7.2	Rationale	231
11.7.3	Content.....	231
11.7.4	Handouts	233
11.8	Session 7: Challenging destructive and self-destructive behaviour	233
11.8.1	Agenda.....	233
11.8.2	Rationale	233
11.8.3	Content.....	233
11.8.4	AIDS.....	236
11.9	Session 8: Problem solving.....	236
11.9.1	Agenda.....	236
11.9.2	Rationale	236
11.9.3	Content.....	236
11.9.4	AIDS.....	238
11.10	Session 9: Managing trigger events.....	238
11.10.1	Agenda.....	238
11.10.2	Rationale	238
11.10.3	Content.....	239
11.10.4	AIDS.....	240
11.11	Session 10: Changes in systems of care	241
11.11.1	Agenda.....	241
11.11.2	Rationale	241
11.11.3	Content.....	241
11.11.4	AIDS.....	244

11.12	Session 11: Systems advocacy	244
11.12.1	Agenda.....	244
11.12.2	Rationale	244
11.12.3	Content.....	245
11.12.4	AIDS.....	246
11.13	Session 12: Relapse prevention	246
11.13.1	Agenda.....	246
11.13.2	Rationale	247
11.13.3	Content.....	247
11.13.4	AIDS.....	249
11.14	Post-treatment assessment	249
12.	Discussion	250
13.	Conclusion.....	251
14.	Recommendations.....	251
	Bibliography	252
	ANNEXURE 1: A PSYCHO-SOCIAL THERAPEUTIC PROGRAM.....	261
	BIBLIOGRAPHY.....	390
	ARTICLE 6 IMPLEMENTATION AND EVALUATION OF THE PSYCHO-SOCIAL THERAPEUTIC PROGRAM (PTP)	393
1.	Introduction	394
2.	Problem statement	394
3.	Objective	395
4.	Research methodology	395
4.1	Research model	395

4.1.1	Phase 3: Evaluation and advanced development	395
4.2	Design	396
4.3	Participants.....	397
4.4	Procedure.....	400
4.5	Data collection and -analysis	401
4.5.1	Quantitative data collection.....	401
4.5.1.1	The Critical Incident History Questionnaire (CIHQ).....	401
4.5.1.2	The Impact of Event Scale - Revised (IES-R)	402
4.5.1.3	The Mental Health Continuum-Short Form (MHC-SF)	403
4.5.1.4	The Post-Traumatic Cognitions Inventory (PTCI).....	404
4.5.2	Quantitative data analysis.....	405
4.5.3	Qualitative data collection	405
4.5.4	Qualitative data analysis.....	406
4.5.5	Trustworthiness of the qualitative data-analysis.....	406
4.5.6	Ethical consideration.....	407
5.	Results	407
5.1	Descriptive statistics	407
5.2	Differences within groups	409
5.3	Differences between groups	412
5.4	Responses from the qualitative measurement – before intervention	415
5.5	Responses from the qualitative measurement –after intervention	420
6.	Discussion	431
7.	Conclusion.....	436

8.	Recommendations.....	437
	Bibliography	438
	SECTION C: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS.....	443
	SUMMARY, CONCLUSIONS AND RECOMMENDATIONS	443
1.	Introduction	443
2.	Summary and conclusions	443
2.1	Aim and objectives of the study	444
2.1.1	General aim.....	444
2.1.2	Objectives.....	444
2.2	Research methodology.....	445
2.2.1	Literature study.....	445
2.2.2	Empirical research.....	445
2.3	Summary of the articles	449
2.3.1	Trauma in the South African Police Service.....	449
2.3.2	Exploring programs to support police officials exposed to trauma.....	449
2.3.3	An assessment of the needs of police officials regarding trauma and trauma intervention programs: a qualitative approach.....	451
2.3.4	An assessment of the needs of police officials regarding trauma and trauma intervention programs: a quantitative approach	452
2.3.5	A Psycho-social Therapeutic Program (PTP) for police officials attached to the specialised units within the South African Police Service	453
2.3.6	Implementation and evaluation of the Psycho-social Therapeutic Intervention Program (PTP).....	454
3.	Testing the central theoretical argument.....	457
4.	Recommendations.....	457

5.	Conclusion.....	459
	Bibliography	460
	SECTION D: ANNEXURES	463
	ANNEXURE A: CORRESPONDENCE WITH SAPS.....	463
	ANNEXURE B: THE EXTENT, SUBJECTIVE EXPERIENCE AND SPECIFIC NEEDS OF POLICE OFFICIALS EXPOSED TO TRAUMA.....	470
	ANNEXURE C: GUIDELINES FOR AUTHORS: THE SOCIAL WORK PRACTITIONER- RESEARCHER	485
	ANNEXURE D: GUIDELINES FOR AUTHORS: JOURNAL FOR SOCIAL WORK/MAATSKAPLIKE WERK.....	489
	ANNEXURE E: GUIDELINES FOR AUTHORS: ACTA CRIMINOLOGICA: SOUTHERN AFRICAN JOURNAL OF CRIMINOLOGY.....	492
	ANNEXURE F: CRITICAL INCIDENT HISTORY QUESTIONNAIRE (CIHQ) (PHASE 3).....	503
	ANNEXURE G: IMPACT OF EVENTS SCALE – REVISED (IES-R).....	509
	ANNEXURE H: BRIEF DESCRIPTION OF THE MENTAL HEALTH CONTINUUM SHORT FORM (MHC-SF).....	510
	ANNEXURE I: POST-TRAUMATIC COGNITIONS INVENTORY (PTCI).....	511
	ANNEXURE J: INFORMED CONCENT.....	514
	ANNEXURE K: QUALITATIVE AND QUANTITATIVE MEASURING INSTRUMENT – BEFORE PROGRAM.....	518
	ANNEXURE L: QUALITATIVE AND QUANTITATIVE MEASURING INSTRUMENT – AFTER PROGRAM.....	524
	ANNEXURE M: ETHICAL APPROVAL	531
	ANNEXURE N: DECLARATION OF LANGUAGE EDITING	532
	SECTION E: INTEGRATED BIBLIOGRAPHY.....	533
	INTEGRATED BIBLIOGRAPHY	534

LIST OF TABLES

Table A1	Time frame and process of intervention	19
Table B3-1:	Participants' characteristics.....	93
Table B3-2:	Primary themes and sub-themes as a result of the data.....	96
Table B4-1:	Total population versus sample	154
Table B4-2:	Impact of the type of work on police official's experience of trauma	160
Table B4-3:	Cronbach's Alphas, Means, and Standards Deviations for Major causes of Stress (MCS-SCALE)	162
Table B4-4:	Means, Standard Deviations, Degrees of freedom (df), mean square (ms), Fisher's F ratio, sig.(one way) and effect size for the MCT-scale.....	163
Table B4-5:	Cronbach's Alphas, Means, and Standards Deviations for Major Causes of Trauma (MCT-SCALE)	165
Table B4-6:	Correlation Coefficient, Sig.(2-tailed) and N for MCT-Scale.....	166
Table B4-7:	Means, Standard Deviations, Degrees of freedom (df), mean square (ms), Fisher's F ratio, sig.(oneway) and effect size for the MCT-scale.....	167
Table B4-8:	The t-value (t), degree of freedom (df), sig. (2-tailed), mean difference, effect size and the 95% confidence intervals (95%CI) of the difference between "lower" to "upper" columns for the MCT-scale	169
Table B4-9:	Cronbach's Alphas, Means, and Standards Deviations for Response to trauma (RTT-Scale).....	170
Table B4-10:	Means, Standard Deviations, Degrees of freedom (df), mean square (ms), Fisher's F ratio, sig.(oneway) and effect size for the MCT-scale.....	172
Table B4-11:	Cronbach's Alphas, Means, and Standards Deviations for Coping with Trauma (CWT-Scale).....	173
Table B4-12:	Means, Standard Deviations, Degrees of freedom (df), mean square (ms), Fisher's F ratio, sig.(one way) and effect size for the MCT-scale.....	175
Table B4-13:	The t-value (t), degree of freedom (df), sig. (2-tailed), mean difference, effect size and the 95% confidence intervals (95%CI) of the difference between "lower" to "upper" columns for the CWT-scale.....	176

Table B4-14:	Reasons for not consulting EHW.....	178
Table B4-15:	Cronbach’s Alphas, Means, and Standards Deviations for experience of trauma intervention programs (ETIP-SCALE)	179
Table B4-16:	Means, Standard Deviations, Degrees of freedom (df), mean square (ms), Fisher’s F ratio, sig.(oneway) and effect size for the MCT-scale.....	181
Table B4-17:	The t-value (t), degree of freedom (df), sig. (2-tailed), Mean difference, effect size and the 95% confidence intervals (95%CI) of the difference between “lower” to “upper” columns for the ETIP-scale.....	183
Table B5-1:	The Trauma Risk Management Operating Procedure.....	203
Table B5-2:	Schematic representation of the psycho-social therapeutic program for police officials.....	217
Table B6-1:	Descriptive biographical statistics by group.....	399
Table B6-2:	Descriptive statistics and reliability	408
Table B6-3:	Descriptive statistics and effect sizes on psychometric constructs within the experimental group on differences between pre- and post-tests	410
Table B6-4:	Descriptive statistics and effect sizes on psychometric constructs within the control group on differences between pre- and post-tests	411
Table B6-5:	Descriptive statistics and effect sizes for differences between the experimental and control groups	413
Table B6-6:	Questions and responses of the qualitative and quantitative measuring instrument – before the program	416
Table B6-7:	Questions and responses of the qualitative and quantitative measuring instrument – after the program	420
Table B6-8:	Results of qualitative and quantitative evaluation (group member’s attitude and knowledge).....	425

LIST OF FIGURES

Figure A-1: Intervention research model and designs 11

Figure B1-1 The impact of trauma 39

Figure B2-1: Psycho-social perspective 78

Figure B3-1: Exploratory Sequential Mixed Methods Design (Creswell: 2014: 220) 90

Figure B4-1: Exploratory Sequential Mixed Methods Design (Creswell:2014:220) 150

Figure B4-2: Age 155

Figure B4-3: Rank 155

Figure B4-4: Race 157

Figure B4-5: Marital Status 157

Figure B4-6: Impact of stress on trauma..... 164

Figure B5-1: Phases of the group work process 214

Figure B6-1: Comparison group pre-test-post-test design 397

LIST OF HISTOGRAMS

Histogram B4-1: Gender156

Histogram B4-2: Years of service158

Histogram B4-3: Specialised unit159

Histogram B4-4: Police clusters159

Histogram B4-5: Trauma intervention programs177

SECTION A:
GENERAL INTRODUCTION

GENERAL INTRODUCTION

1. Problem formulation

Policing is an emotionally and physically dangerous work and various researchers regard it as one of the most stressful careers on the planet (He *et al.*, 2002: 690; Jaramillo *et al.*, 2005: 321). Because of the nature of their work, police officials are continuously exposed to trauma. Stressful work circumstances and the exposure to trauma often negatively affect police officials, who may experience this as critical. The frequent exposure to trauma can negatively influence the police official's feelings of well-being, work performance, family life, the South African Police Service (SAPS) and the community (Patterson, 2008: 54).

The occurrence of crime and especially violent crime is on the increase globally (Ferguson & Bernache, 2008: 1590). South Africa all but an exception is seen as the world's capital where crime takes on serious proportions (Pienaar & Rothman, 2006: 32). The South African crime statistics support this argument and further shows that a total of 2 255 751 crimes were registered during 2014 (Crime Stats SA, 2014). As a result of an increase in crime, the police official is increasingly exposed to unique, demanding and unpleasant traumatic work incidents. The majority of these traumatic incidences are intentional, reckless behaviour, for example, murder, sexual assault, shooting incidences, hostage situations, hijackings, robbery with aggravating circumstances, and the death of a colleague during the course of his/her duties, as well as child abuse (Patterson, 2008: 56).

Various authors identify several contributing factors leading to stress in members of SAPS (Miller, 2005: 101; Morash *et al.*, 2006: 26):

- The bureaucratic structure of SAPS;
- Policing within the community;
- A lack of respect for police officials, with the result that criminals are not afraid to use firearms against police officials, increasing the risk of policing;
- The criminal legal system and co-operation with the community; and
- Police officials' personal circumstances.

Patterson (2008: 56) is of the opinion that traumatic incidents, taking into account the potential negative effect these incidents may have on the psycho-social well-being of police officials, should be added as a sixth category of work stress.

According to the DSM-5 (American Psychiatric Association, 2013: 271), exposure to trauma in itself is not a diagnosable disturbance. It does, however, define a traumatic incident as

exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways: Directly experiencing the traumatic event(s), witnessing, in person, the event(s) as it occurred to others, learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental. Police officials' exposure to traumatic events differs from general work stressors and can be experienced as extremely traumatic. These events are often experienced with intense fear, helplessness and horror (Frewin *et al.*, 2006: 243). Traumatic events are therefore differentiated from general stressors experienced daily by any person in the line of duty. According to the American Psychiatric Association (2013: 289) and Miller's (2008: 17) definition of the consequences of exposure to trauma, it could include the following stress reactions:

- **Depression** is a psychological disturbance which influences a person's mood changes, physical functioning and social interaction.
- **Acute Stress** is characterised by a variety of separate symptoms. These symptoms are usually experienced immediately after the traumatic event, but fades relatively quickly. If these symptoms are not dealt with in a professional manner, it can develop in Post-Traumatic Stress Disorder.
- **Post-Traumatic Stress (PTS)** is subjective stress experienced by all people who were subjected to trauma, but not to the extent that it satisfies the criteria of Post-Traumatic Stress Disorder (PTSD).
- **Post-Traumatic Stress Disorder (PTSD)** includes distinctive psychological and physiological symptoms that may develop after exposure to or the witnessing of an event that involves actual or threatened death or serious injury to the self or another person.

Various research studies have shown that roughly 34% of military troops and rescue personnel who served during the Vietnam and Gulf wars, the Oklahoma bomb attack, the attack on the World Trade Centre in New York on September 11, 2000, and the war in Iraq, were diagnosed with depression, acute stress or post-traumatic stress disorder (Marmar *et al.*, 2006: 328). These stress reactions have a direct influence on their psycho-social functioning, with specific reference to the troops' productivity, relationships and family life. Research further showed that in 14% of these cases, the person's daily life was influenced to such a degree that they committed to alcohol abuse and aggressive behaviour. In extreme cases it led to suicide and/or family murder (Anshel, 2000: 375; Deschamps *et al.*, 2003: 358; He *et al.*, 2002: 687).

The psycho-social well-being of police officials in South Africa correspond to the above research findings. The researcher was a social worker in SAPS for 21 years during which he was trained as a trauma counsellor. The problem, as discussed, was therefore experienced first-hand and

supports his personal experiences in practice. Hosken (2011) refers to the prevalence and intensity of stress related problems within SAPS with the following remark: "The South African Police Service is facing a potentially explosive problem should the extremely high stress levels of police officials not be considered and immediately attended too". Steyn (2011) mentions that roughly 90% of physically injured police officials suffer from PTSD. Bearing this remark in mind, police management fears that the ticking time bomb facing police officials may explode at any time. The following statistics as published in the SAPS's Annual report (2012/2013) and the statements of the Minister of Police (SAPS News: 22 June 2012) support this statement and serve as evidence of the psychological well-being of the police officials in South Africa. (It should be noted that despite many efforts the researcher was not able to obtain more recent official statistics regarding the overall psycho-social well-being of police officials).

- A total of 138 563 police officials took sick leave;
- A total of 8 889 police officials took short to long periods of temporary disability leave;
- A total of 1 013 police officials willingly terminated their services;
- A total of 10 636 police officials were diagnosed with depression;
- A total of 2 763 police officials were diagnosed with PTSD;
- Roughly 3000 to 4 000 police officials received counselling in the form of debriefing;
- A total of 282 police officials were declared medically unfit for work;
- A total of 114 police officials were dismissed as a result of misconduct;
- A total of 2735 police officials terminated their services;
- A total of 727 police officials died; and
- A total of 651 police officials retired.

In addition to the above mentioned, there is a high incidence of police suicides, family murders and aggression. According to (Steyn & Nel, 2008: 11 & 13) the total number of suicides in SAPS is more than double the national number of suicides. Unfortunately the researcher was not able to obtain any official SAPS statistics to support this statement. In order to achieve psychological stability, it is required of police officials to be defensive and have perseverance, but they also depend hugely on the support of police management, Employee Health and Wellness (EHW), consisting of social workers, psychologists and chaplains in service of SAPS, who work together in multi-professional team capacity, colleagues, family and the community.

Because of the critical and important nature of a police official's work in the community and the fact that they find themselves in the first line of the criminal justice system, it is of utmost importance that these members have direct access to psycho-social therapy. This is necessary to support these members and to enable them to hold their own and better their general well-being (Lester *et al.*, 1984: 25).

The government, police management and EHW have become increasingly aware of the occurrence and extent of police officials' exposure to trauma and the consequent stress related problems. Mr Nathi Mthethwa, Police Minister, confirms this in his speech in Pretoria (SAPS News, 2012), during which he uttered his concern about the extent of depression, PTSD, suicide and aggression among police officials. He pleaded with the National Police Commissioner, General Riah Phiyega, to become involved with police officials in order to identify psycho-social problems earlier.

Since 1992 EHW has piloted various trauma intervention programs. These programs' goals are to, (1) be pro-active: make police officials aware of daily stressors and the exposure to trauma, and equip them with the necessary skills to better cope with such trauma and stressors, (2) be reactive by giving the necessary support. Examples of these trauma intervention programs of SAPS are:

- Suicide prevention;
- Stress management;
- Critical Incident Stress debriefing; and
- Psycho-social therapy and counselling by professional EHW personnel.

During 1992 SAPS's Psychological Services developed a stress debriefing model for officials of SAPS who had been exposed to trauma. The model is based on the Critical Incident Stress Debriefing (CISD) model of Mitchell and Everly (1996), and was developed to reduce the impact of trauma on the individual. Stress debriefing is defined as a meeting with a group of people during or after a traumatic event, for example an accident or disaster. During this meeting the focus is on the CISD model of Mitchell and Everly (2001: 3-9) to gain an overview of the event, to talk about feelings and reactions and develop mechanisms to cope with the trauma. During 1998, in support of SAPS members who were exposed to traumatic events, SAPS published an instruction booklet titled, *Debriefing of members exposed to traumatic events*. This document declares that members of SAPS are continuously exposed to traumatic events during the course of duty. According to this document police officials who do not receive debriefing soon after a traumatic event, are in danger of developing PTSD. The goal of the instruction booklet is to prevent PTSD.

In spite of SAPS's debriefing model and the national instruction booklet, there still is a high occurrence of stress-related problems, as mentioned earlier. This could possibly be because of a lack of knowledge about the extent, impact, specific needs of police officials concerning the support and intervention they receive, possible inaccessibility of this program – especially on ground level – or again, a lack of an effective psycho-social therapeutic program.

In recent times, international debate, research projects, opinions and open criticism on the effectiveness of CISD increased. Various researchers found that CISD had no, or even a negative effect, on primary victims of trauma (Addis & Stephens, 2008: 361; Arnetz *et al.*, 2009: 2; Jacobs *et al.*, 2004: 5-14). Saunders (2012), Professor at the National Crime Victims Research and Treatment Centre at the University of South Carolina, mentioned in an e-mail to the author that six research studies discredited CISD as an intervention method. Saunders is also of the opinion that the trauma debriefing model has very few advantages and that the risk for PTSD can even escalate after debriefing. Lilienfeld (2007: 53) supports this viewpoint and refers to the debriefing model as a potential damaging treatment method for some individuals, largely because of the fact that it interferes with the natural healing process of the victims. Further reasons for this is that some victims' risk for unusual stress reactions as a result of early intervention could be increased; some victims might experience secondary trauma because of the repetition of the event and that the debriefing model, which was developed specifically for group intervention is now applied individually (NIMH, 2002: 8).

Saunders (2012) mentions that Trauma Focused Cognitive Processing Therapy (TF-CPT) and Prolonged Exposure Therapy (PE) are currently the most successful approaches used internationally for the treatment of traumatic symptoms with specific reference to adults. Although these treatments seem to be successful, they are not currently used by SAPS. The reason for this may be that members of SAPS have not yet had exposure or training in these therapeutic approaches.

Former provincial commissioner of police in Gauteng, Lieutenant General Mzwandile Petros, mentioned that SAPS must put in place an effective program that compels members to undergo counselling and CISD after exposure to a traumatic event. Petros is of the opinion that if stress-related problems are not diagnosed timely, SAPS will be facing serious problems (Hosken, 2011).

The above-mentioned problematic situation implicitly explains the actual motivation and importance of this study. Fouché and Delport (2011: 107) mention that the researcher should build an argument around the interaction of the research and bigger important theoretical problems (theoretic importance), with reference to social policy, or problems experienced in practice (practical importance).

The study, focused on police officials who satisfy the criteria for PTS, while focusing on the development of a psycho-social therapeutic program as group intervention. Because of overlapping symptoms it is sometimes difficult to identify border cases for PTSD. However, cases that seem to be dysfunctional or seem to be psychiatric cases were excluded. For motivational purposes it is important to distinguish between PTS and PTSD, as fully described

in article one of this thesis. It is also important to take note that PTS can be treated through psycho-social therapy, while diagnosed PTSD should be treated psycho-therapeutically and pharmacologically. Barker's (2014: 345) definition of psycho-social therapy stresses the importance of both internal and external factors in relation to people's capacity to cope with the everyday stresses of modern living. As such, it contradicts the myth that psycho-social approaches are only concerned with people's inner, emotional life: the external world is also an important area of analysis and concern.

The researcher assumed that PTSD as a psychiatric disturbance, as included in the DSM-5, can only be diagnosed by a psychiatrist, psychologist or medical doctor and could possibly necessitate psychotherapy and pharmacological treatment. The study therefore involved developing a program that will enable EHW to focus on psycho-social therapy as part of a multi-professional team.

It is possible to develop a psycho-social therapeutic group program if the extent, subjective experience, the impact of trauma and police officials' specific needs with regard to support and trauma intervention programs could be correctly identified and interpreted. The motivation for such a program is to reach more individuals simultaneously and to ensure that the impact of the intervention is most effective. Such a program will better support police officials to effectively deal with their experience of a traumatic event. It will have a positive effect on both the psycho-social functioning of the individual and ultimately his/her productivity.

With reference to the above statement, this study attempted to answer the following research questions:

- What is trauma and what are the extent, subjective experience and impact of trauma on police officials of SAPS? (Article 1);
- What key elements of existing trauma intervention approaches can be reconfigured into a psycho-social therapeutic program for police officials exposed to trauma? (Article 2);
- What are the extent, subjective experience and specific needs of police officials within the North-West Province, regarding trauma intervention? (Article 3 & 4);
- What aspects arising from the literature study and the empirical research should be included in a proposed psycho-social therapeutic program? (Article 5); and
- How can the effectiveness of the program be empirically evaluated, how can it effectively be implemented to police officials at the specialised units within SAPS, and how can the program be disseminated? (Article 6).

2. Aims and objectives of the study

2.1 Aim

The aim of the study is formulated from the problem statement, namely to develop, implement and evaluate a psycho-social therapeutic program that is sensitive and responsive to the needs of police officials after exposure to traumatic events.

2.2 Objectives

The above-mentioned aim was reached by achieving the following objectives:

- To gather information, with reference to the concept trauma and the extent, subjective experience and impact of trauma on police officials in SAPS (Article 1).
- To explore and critically appraise key elements of existing trauma intervention approaches that can be reconfigured into a PTP for police officials exposed to trauma. (Article 2).
- To conduct a qualitative and quantitative situational analysis as a first and second phase of the explorative sequential design to explore and identify the extent, subjective experience and specific needs of police officials in the North West Province, who have been exposed to trauma. (Articles 3 & 4).
- To develop a PTP, considering specific aspects of the literature study and the empirical research that will enable police officials to better cope with the impact of trauma (Articles 5).
- To test the proposed PTP within the context of SAPS, to evaluate the program empirically (Article 6).

3. Central theoretical statement

Police officials exposed to and affected by trauma can be empowered with knowledge and skills to better deal with the impact of trauma by participating in a psycho-social therapeutic program.

4. Theoretical framework

The following theoretical frameworks shaped the development of the psycho-social therapeutic program and core concepts of these approaches were utilised during the literature study and during the implementation of the psycho-social therapeutic program:

- Trauma focused Cognitive Processing Therapy (TF-CPT) (Baranowsky *et al.*, 2010; Becker *et al.* 2009; Yarvis, 2012);
- Critical Incident Stress Debriefing (Carlier *et al.*, 2000; Mitchell, 1983; Mitchell & Everly, 1996);
- Psycho-education (Fristad, 2006; Pender & Prichard, 2009; Schnyder *et al.*, 2012);

- Prolonged Exposure Therapy (PE) (Cook *et al.*, 2013; Moore & Penk, 2011; Westphal, 2012);
- Marital and family therapy (Gale, 2007; Moore & Penk, 2011; Weis & Santoyo, 2012).
- Suicide Prevention (Hackett & Violanti, 2003; Scneidman, 2005; Violanti, 2004; Violanti, 2007);
- Stress Management (Daniello, 2011; Williams, 2003);
- Psycho-social rehabilitation (Foa, 2009; King *et al.*, 2012; Moore & Penk, 2011);
- Relaxation therapy (Benson & Proctor, 2010; Ruden, 2012);
- The ecosystems perspective (Hepworth *et al.*, 2002; Miley *et al.*, 2004).

The above theoretical frameworks are fully explained in Article 2 of the study and references to these frameworks are found throughout this study in the development of the PTP.

5. Philosophical world view

The researcher approached the study from a pragmatic world view, as this forms the foundation for mixed-method research. Pragmatism includes the application of that which works, the use of diverse approaches and the appreciation of both objective and subjective knowledge. With reference to Tashakkori and Teddlie (2003: 91), the study links pragmatism and mixed-method research formally in the following ways:

- Both qualitative and quantitative research methods were used in a single study;
- The research questions were of primary importance – more important than both the method or the philosophical world view underlying this method;
- A forced dichotomy between positivism and constructivism were renounced; and
- The researcher was guided by a practical and applied research philosophy applicable to this study with regard to choice of methodology.

6. Research methods

6.1 Literature study

In this research, a literature study was conducted to gain a better understanding of the extent, subjective experience and impact of trauma on police officials in SAPS. A literature review was once again conducted after the conclusion of the first qualitative and quantitative phases to compare the findings with published and unpublished research and literature, and vice versa (Creswell, 2009:27). An overview of the literature further focused on gaining a clear understanding of the nature, extent and impact of trauma on police officials (Fouché & Delpont, 2011: 135).

Relevant documentation from SAPS, with specific reference to protocol and policy, national instructions, statistics and existing intervention programs, were used as supplementary research sources. Furthermore the researcher studied successful international models for trauma intervention.

The following sources were consulted: Nexus, SAMedia (newspapers), SaePublications, ProQuest Theses & Dissertations, EbscoHost: Academic Search Premier, Eric, PsycInfo, PsycArticles, SoclIndex, ScienceDirect and Google.

6.2 Empirical research

6.2.1 The research model and design

This study intended to develop, implement and evaluate a psycho-social therapeutic program for police officials in SAPS. Intervention research has been conceptualised by Fraser *et al.* (2009: 3) and divided into three focus areas: identifying, adapting, and implementing. Intervention research (De Vos & Strydom, 2011: 473) within a mixed-methodologies framework, that employed qualitative and quantitative strategies, was found to be most effective in achieving the objectives of the study. This also allowed the researcher to apply triangulation as it enabled the researcher to complement data from qualitative sources with those of quantitative sources, and vice versa (Delport & Fouché, 2011: 442). The major phases of the intervention model and the designs applicable to the different phases of the model were adapted as follows to better suit the needs of this research and to achieve the research objectives:

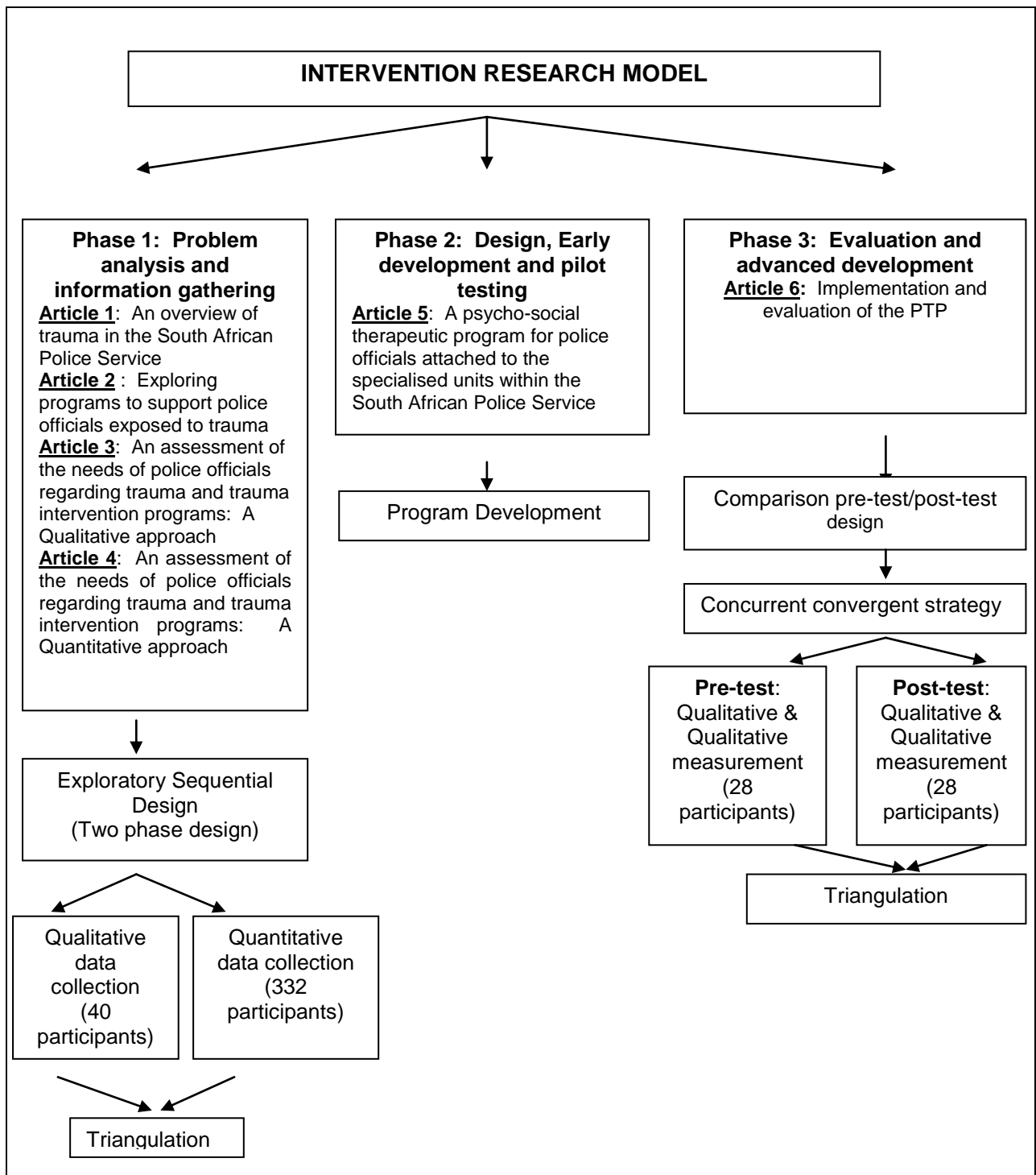


Figure A-1: Intervention research model and designs

6.2.1.1 Phase 1: Problem analysis and information gathering

The researcher gained permission from SAPS (Annexure A), identified and involved police officials of the specialist units in the North-West Province, identified problem areas within the population among whom the proposed therapeutic program was to be carried out and evaluated and analysed identified problems and set certain objectives. Furthermore, the researcher

collected information by using existing information sources and by studying certain functional elements of successful models in order to facilitate the development of the proposed psycho-social therapeutic program (De Vos & Strydom, 2011: 476).

The exploratory sequential mixed-methods design (Creswell, 2014: 225) was used as part of the needs assessment in the first phase of the intervention model to collect information with regard to police official's exposure to traumatic events and their experience of existing trauma intervention programs. Myers and Oetzel (cited in Creswell and Plano Clark, 2011: 122 & 124) describe this design as "a two-phase" design in which the researcher begins by collecting and analysing qualitative data in the first phase, followed by quantitative data collection as part of a second phase. This design allows the researcher to test or generalise the initial qualitative data in the larger population.

The researcher collected qualitative data as part of the first phase of the "two-phase" design. Respondents were divided into three focus groups with the aim of an initial exploration into the extent of the trauma, police officials' subjective experience of trauma, its impact on their psycho-social functioning and their specific needs regarding support and intervention (Greeff, 2011: 361).

The researcher furthermore made use of the quantitative data collection method as part of the second phase of the "two phase" design. Certain themes arising from the focus group interviews were included in the self-designed questionnaire (Annexure B) to police officials of specialist units representing the whole of the North West Province. This questionnaire included specific concepts related to trauma, trauma reactions and specific needs of police officials with regard to support. The above-mentioned were important to explore, analyse, test and generalise the extent of the problem in the broader population. The researcher used triangulation to check the results by comparing the quantitative data with the qualitative data and the findings of the literature review and vice versa.

6.2.1.2 Phase 2: Design, early development and pilot testing

De Vos and Strydom (2011: 482) emphasise the fact that researchers must design a way to naturally observe events related to the phenomenon, as well as a method to detect the problem and its scope. According to the authors this is important in order to monitor the effects following intervention. By observing the problem and studying naturally occurring innovations and other prototypes, researchers can identify procedural elements for use in the intervention. During this second phase of the intervention model the researcher identified the following standardised measurement instruments, namely the Critical Incident History Questionnaire (CIHQ) (Annexure F), Impact of Event Scale (IES-R) (Annexure G), Mental Health Continuum Short Form (MHC-

SF) (Annexre H) and Post Traumatic Cognitions Inventory (PTCI) (Annexure I). These served as observational tools during the process. These instruments are described in more detail in paragraph 6.2.4 of the general introduction.

This phase also included the early development of the PTP, which was the result of a thorough literature review and needs assessment amongst police officials stationed at the specialised units within the North West Province. The researcher analysed the findings and specific elements arising from the combined qualitative/quantitative approach. The findings were compared to each other, interpreted and described. Following this process the researcher developed a preliminary intervention program. The researcher conducted a pilot test as a procedure to determine the effectiveness of the intervention and identified which elements of the proposed program should be revised by using the above-mentioned observational system. De Vos and Strydom (2011: 484) refer to this as the program assessment theory evaluation, which must be based on valid assumptions about the causes of the problem and the rationale of the proposed program.

A total of 11 members of EHW, who are also part of SAPS in the North-West Province, and specifically those who specialise in trauma, were identified. The researcher then introduced these members to the initial measuring instruments and proposed psycho-social therapeutic program during a work session, in order to evaluate, critically judge and give input on the measuring instruments and program. After this process of evaluation, the researcher applied the necessary changes and improvements to refine the program to the satisfaction of EHW. These mostly concentrated on the following: simplifying terms for better understanding, implementation of more activities to promote interactive discussions and participation, aligning the time schedule specifically referring to the length, number of sessions and flexibility, to make it more user friendly, thereby allowing police officials to attend despite their demanding work load.

The researcher started the pre-investigation by hosting the proposed measuring instruments and trauma intervention program to police officials who were selected for the focus group in the Potchefstroom cluster. This procedure compliments the aim of developing a group program as discussed in more detail in the problem statement. The researcher used the standardised measuring instruments before and after intervention to monitor the process. The researcher evaluated the measuring instruments and the content of the program according to that which is successful and less successful and the variables that might affect the success of the intervention program. The researcher prepared the measuring instruments and the proposed PTP for final evaluation by removing any inconsistencies and redundancies. In the process the researcher improved clarity in the formulation of the content of the program to ensure validity, reliability and sensitivity (Strydom, 2011: 237).

6.2.1.3 Phase 3: Evaluation and advanced development

This phase was focused on uncovering information as an integral part of the research innovation process. Evaluation follows development and contributes to further development and design if needed (Fraser *et al.*, 2009: 25). This will ultimately lead to the acceptance and general use of the proposed psycho-social therapeutic program. For the purpose of phase three of this study the concurrent convergent strategy within the broader context of pre-test/post-test comparison group design was used for the evaluation of the program. The purpose of this strategy according to Creswell and Plano Clark (2011: 77) is “to obtain different but complementary data on the same topic”. De Vos and Strydom (2011: 485) are of the opinion that “Experimental designs, whether single-subject or between-group designs, help to demonstrate causal relationships between the intervention and the behaviours and related conditions targeted for change”. The concurrent convergent strategy allowed the researcher to use concurrent timing to implement both the quantitative and qualitative strands during the pre- and the posttest while evaluating the program. Both methods were equally prioritized. The researcher initially kept the strands independent during analysis and then mixed the results during the overall interpretation and triangulation. Triangulation involved the process of comparing qualitative with quantitative data and the literature and vice versa.

The pre-test/post-test comparison group design included two groups namely an experimental group and comparison group. The comparison group received both the pre-test (01) and the post-test (02) at the same time as the experimental group, but did not receive the independent variable (Marlow, 2011: 102). The aim of this evaluation was to determine whether the application of the PTP, focusing on certain empowering cognitive, behavioural and social skills, had an influence on the police official’s psycho-social well-being considering their repeated exposure to traumatic events. Both groups were exposed to pre-testing one week before the onset of the program and were tested again three weeks after the experimental group had completed the group work program. The pre- and post-test was implemented by the social worker, responsible for the Public Order Policing unit (POP) in Potchefstroom, who acted as field worker.

6.2.1.4 Dissemination

Although this phase of the intervention research model has not been included as part of the study, the following outcomes have already been achieved, and are therefore reported. The following articles have been published in accredited journals:

- Article 2: Exploring programs to support police officials exposed to trauma. (Boshoff & Strydom, 2015b) (Published) (Annexure C, Social Work Researcher-Practitioner, Instructions to Authors);
- Article 3: An assessment of the needs of police officials regarding trauma and trauma intervention programs: A qualitative approach. (Boshoff *et al.*, 2015) (Published) (Annexure D, Social Work/Maatskaplike Werk, Instruction to Authors);
- Article 4: An assessment of the needs of police officials regarding trauma and trauma intervention programs: A quantitative approach (Boshoff & Strydom, 2015a) (Published) (Annexure E, Instructions to Authors).

6.2.2 Population

For purpose of this study, the specialist units of SAPS in the North-West Province were geographically demarcated as the whole. These include those units that are possibly subjected to trauma most often, with specific reference to the Public Order Policing Unit (POP), Local Record Centre (LCRC), Detective Services, Tactical Response Unit (TRT), Family Violence, Child Protection and Sexual Offences Unit (FCS) and Provincial Emergency Services (PES). The whole is defined by Grinnell *et al.* (2010: 133) as the “totality of persons, events, organisational units, case records or other sampling units with which the research problem is concerned”.

For purpose of the focus groups the researcher selected a total of 40 police officials stationed at the specialised units and representing three of the bigger clusters in the province, considering their exposure to trauma, resultant symptoms of PTS and their participation in trauma intervention programs. According to Jacobs *et al.* (2016: 440) the ideal size for a group is eight to ten, but the researcher chose 13 to 14 per group to make provision for unexpected circumstances. This was done because of the unique nature of the police officials’ work.

For purpose of quantitative data collection, questionnaires were distributed to quantitatively explore the experiences and psycho-social needs of police officials who are exposed to trauma within the larger population. The researcher selected 332 participants stationed at six specialist units representing nine of the 11 police clusters in the North-West Province. The size of the sample according to Strydom, (2011: 225) is determined according to 10% of the population. However, the researcher selected 23% of the population to make provision for unforeseen circumstances due to the unique and demanding nature of police officials work.

A total of 36 police officials from POP in Potchefstroom were recruited for participation in the experimental phase. All participants were exposed to traumatic events and none of them have been diagnosed with post-traumatic stress- or any co-morbid disorder before. After screening, a total of 28 police officials qualified for participation in the program. One group was purposefully

selected as the comparison group and the other as the experimental group, considering their availability as a result of their responsibilities at work.

6.2.3 Sampling procedure

Purposeful sampling was used to select 40 participants as part of the first qualitative phase, while a total of 332 participants were purposefully selected as part of the second quantitative phase. A total of 28 participants qualified for participation in the experimental phase of the study, after screening. Police officials were purposefully chosen considering the relevance of the topic, specifically referring to their exposure to trauma, resultant symptoms of post-traumatic stress and their participation in trauma intervention programs. None of the participants have been diagnosed with post-traumatic stress- or any co-morbid disorder. For purposes of the implementation and evaluation of the program, the recruited participants were screened for possible inclusion by the Critical Incident History Questionnaire for Police Officials (CIHQ) (Annexure F), Impact of Event Scale – Revised (IES-R) (Annexure G), Brief Description of the Mental Health Continuum Short Form (MHC-SF) (Annexure H) and the Post-Traumatic Cognitions Inventory (PTCI) (Annexure I) one week after recruitment. A total of twenty eight police officials showed minimum risk for PTSD or any co-morbid disorder. The researcher also considered police officials' unique working conditions and unpredictability, specifically referring to overtime and deployment at different times. The researcher was not allowed to interfere with service delivery. A total of six members of EHW acted as fieldworkers and assisted the researcher on ground level with this process, as most of these police officials are known to them or involved in a therapeutic relationship. Personal information was only revealed with the informed consent of the police officials concerned (Annexure J) after which participation in the study was voluntary. Gerrish and Lacey (2010: 149) emphasise that in purposive sampling, each sample element is selected for a purpose and that it may be used to measure the effectiveness of some intervention with clients who have particular characteristics.

6.2.4 Measuring/data collection instruments, methods and procedure

For the purpose of the focus group interviews the researcher used semi-structured interviews consisting of open and closed questions in order to analyse the situation and collect information. The data collected during the needs assessment was collected by means of a self-developed questionnaire (Annexure B), based on the findings of the focus groups, measuring the impact of trauma and respondent's exposure to traumatic events inside and outside the workplace. The researcher quantitatively explored the experiences and psycho-social needs of police officials to determine if the data arising from the three focus groups, in the first qualitative phase, can be generalised to a large sample of police officials stationed at the specialist units within the North West Province (Creswell, 2014: 226). For the evaluation of the program both qualitative and quantitative data were collected by means of the same standardised scales used for the

screening process, namely: The Critical Incident History Questionnaire (CIHQ) (Annexure F) developed by Weiss *et al.* (2010: 736); the Impact of Scale – Revised (IES-R) (Annexure G) developed by Weiss (2007: 219); the Mental Health Continuum Short Form (MHC-SF) (Annexure H) developed by Keyes *et al.* (2008: 186) and the Post-Traumatic Cognitions Inventory (PTCI) (Annexure I) developed by Foa *et al.* (1999: 305). The CIHQ is a standardised self-reporting measuring instrument that indexes cumulative exposure to traumatic incidents in police by examining incident frequency and rated severity. The IES-R is a standardised self-reporting measuring instrument that reflects the DSM-IV criteria for post-traumatic stress disorder (PTSD). The MHC-SF is a standardised self-reporting measuring instrument consisting of 14 items that were chosen as the most prototypical items representing the construct definition for each facet of well-being. The PTCI is a standardised self-reporting instrument measuring trauma-related thoughts and beliefs, as well as two self-developed questionnaires as survey data procedure: Qualitative and Quantitative Measuring Instrument – Before program (Annexure K) and Qualitative and Quantitative Measuring Instrument – After program (Annexure L).

6.2.5 Data analysis

Schurink *et al.* (2011: 402) define data analysis as a process of revising, interpreting and summarising with the aim of explaining the research problem that is being investigated. Qualitative data arising from the focus groups were recorded, after which a verbatim transcription was made of the raw data according to Greeff (2011: 359). Once all the data had been collected, the researcher analysed the data according to the steps suggested by Tesch (cited in Creswell, 2014: 155). Last-mentioned comprised of a process during which the data was prepared, organised and reduced to manageable themes and categorised by making use of figures, tables and codes.

The researcher used triangulation by comparing qualitative data with quantitative data and the literature, and vice versa. This was important to ensure the trustworthiness of the qualitative data analysis. The findings were identified according to themes arising from the data of the various sources and individuals. The findings were then subjected to a literature review to identify certain similarities and contradictions. Contradicting findings confirm the accuracy of the data as in real life we expect findings to not only bring forth positive information (Creswell & Plano Clark, 2011: 211-212).

The quantitative data in this study were captured and statistically analysed by the North-West University's Statistical Consultation Services. The results were interpreted, inferences pertinent to the research were studied and conclusions drawn. In research, the practical significance of results is not only important when results of the population data are reported but also for

commenting on the practical significance of a statistically significant result (Leech *et al.* 2015: 93).

6.2.6 Handling of ethical aspects

Ethics is described by Strydom (2011: 114) as follows: “Ethics implies preferences that influence behaviour in human relations, conforming to a code of principles, the rules of conduct, the responsibility of the researcher and the standards of conduct of a given profession”. The researcher, for the purposes of this study, firstly got ethical approval from the North-West University’s Ethical Committee with no: NWU-0007-13-A1 (Annexure M).

According to Holloway and Wheeler (cited in Adlem 2011: 15), respondents participating in a research study have the following rights, which were strictly followed by the researcher:

- The proposed psycho-social therapeutic program is based on strict scientific guidelines to prevent any damage to participants in the research study or to SAPS as an organisation;
- Permission was obtained from SAPS to undertake the research study among police officials;
- The persons involved with administering the intervention program were qualified social workers in service of SAPS, who are specifically trained in trauma counselling;
- The researcher acted on the assumption that PTSD is a psychiatric disturbance since it is included in the DSM-5, and can only be diagnosed by a qualified psychologist, psychiatrist or medical doctor. This study focused on psycho-social therapy within a multi-professional team situation;
- In cases where a psychologist or psychiatrist, either individually or in a team situation, were consulted, the researcher focused on the following aspects: specialist area, differential diagnoses, team work and evaluation to determine if medication should be prescribed;
- Selected police officials were informed of the purpose, method, possible risks and expectations of the research, after which they gave informed consent to partake in the research (Annexure J);
- Participation in the research study was voluntarily and police officials were allowed to withdraw at any time during the course of the study;
- Selected police officials were assured of confidentiality and anonymity, especially with reference to the processing of the data after it has been recorded on tape. Codes were used instead of the real names of the police officials;
- The termination of the psycho-social therapeutic program was handled with sensitivity. If any further therapy or treatment was necessary, the researcher referred the police official to a qualified psychologist, psychiatrist or medical doctor for further psychotherapy/treatment; and

- As a result of the sensitive nature of the research, the control group was also given the opportunity to participate in the program, post-intervention. Unfortunately none of them were available either due to a lack of interest or because of other responsibilities at work.

Subsequently, the researcher, because of the sensitive nature of the research subject, used EHW responsible for the specialist units in the 11 clusters of the North-West Province, as mediators and field workers to assist with the selection process during information collection and the evaluation of the program. Last-mentioned procedure was followed, because EHW possesses first-hand knowledge regarding the police officials in his/her specific work area, and is in some cases already therapeutically involved with them.

7. Time frame and process of intervention

The timeframe of this study extended over the period from January 2012 until November 2015. It can be outlined as follows:

Table A1: Time frame and process of intervention

Task	Proposed date
Finalise research proposal	2012-12-31
Phase 1: Problem analyses and information gathering	
Plan qualitative research	2013-02-28
Submission of semi-structured interview schedule for checking (control) by promoter	2013-03-31
Finalise selection of prospective respondents (specialist units: Potchefstroom)	2013-04-30
Focus group interviews	2013-06-30
Analyse results of qualitative research	2013-10-31
Plan quantitative research	2013-11-30
Submission of questionnaires arising from the focus group interviews and literature overview to the study leader for checking (control)	2014-01-31
Finalise the selection of prospective respondents (North West Province)	2014-02-28
Administer the completion of the questionnaires	2014-04-30
Analyse the results of the quantitative research	2014-06-30

Literature review	2014-07-31
Phase 2: Design, early development and pilot testing	
Design a psycho-social therapeutic program according to above-mentioned findings	2014-09-30
Early development: Work session with EHW	2014-10-31
Pilot test: Focus group Potchefstroom	2014-11-30
Finalise the adjustments to the psycho-social therapeutic program	2014-04-18
Phase 3: Evaluaton and advanced development	
Pre-test (Evaluation of the concept trauma intervention program)	2015-03-12
Implementation of the program	2015-05-31
Post-test (Evaluation of the concept trauma intervention program)	2015-06-21
Plan the articles	2015-07-31
Finalise the concept report	2015-08-31
Make the necessary adjustments	2015-09-30
Submission of the final thesis	2015-11-06

8. Limitations of the study

An initial challenge was obtaining approval from the National Commissioner of SAPS to solicit participants. The National Commissioner delegated approval to the Provincial Commissioner of the North West Province, with a recommendation of approval. This process was time-consuming.

Some of the Unit Commanders of the different specialised units in the North West Province requested additional approval from their respective provincial heads, in addition to the National Commissioners recommendation and the Provincial Commissioner's approval of the study.

Many police officials, especially commissioned police officers, were reluctant to participate in the study. This may be due to the sensitive nature of the program, the stigma associated with stress and trauma and the distrust associated with questions asked about their experience of trauma. The program therefore had a positive impact on the non-commissioned police officials who participated in the research.

Respondents found it extremely difficult to answer the CIHQ. The two constructs pertaining to incident and coping were confusing and many of the police officials were not able to understand the link. On the other hand, statistical services found it difficult to interpret the data due to the

composition of the questionnaire. The researcher was therefore not able to report on incident frequency and rated severity as it showed no practically significant difference during the experimental phase.

The unique circumstances and unpredictability of police work had a huge impact on the execution of the study. Some of the clusters are remote and the researcher had to travel as far as the borders of the North West Province. In some instances the researcher was only informed on arrival that police officials will not be able to attend due to other responsibilities at work. During the testing and evaluation of the program, sessions had to be postponed several times as a result of deployment. The researcher was allowed to do the research on condition that he does not interfere with service delivery.

As a result of the above-mentioned the researcher was obliged to concentrate on one specialist unit (Public Order Policing, Potchefstroom) only, during the testing and evaluation of the program. The outcome of this phase of the study is therefore only applicable to POP and can therefore not be generalised to the rest of the specialist units in the North West Province.

9. Definitions of key concepts

The following definitions of key concepts directed this study:

9.1 South African Police Service

SAPS are the national police force of the Republic of South Africa. The Constitution of South Africa lays down that SAPS has a responsibility to prevent, combat and investigate crime, maintain public order, protect and secure the inhabitants of the Republic and their property, uphold and enforce the law, create a safe and secure environment for all people in South Africa, prevent anything that may threaten the safety or security of any community, investigate any crimes that threaten the safety or security of any community, ensure criminals are brought to justice and participate in efforts to address the causes of crime (South African Police Service Act 68 of 1995: 5).

9.2 Police Official

A police official is a warranted law employee of a police service. Police officials are generally responsible for the apprehension of criminals and the prevention and detection of crime, protection and assistance of the general public, and the maintenance of public order. Police officials may be sworn to an oath, and have the power to arrest people and detain them for a limited time, along with other duties and powers. Some police officials may also be trained in special duties, such as counter-terrorism, surveillance, child protection, VIP protection, civil law

enforcement, and investigation techniques into major crime including fraud, rape, murder and drug trafficking (Anon, 2015).

9.3 Specialised units

The specialised units in SAPS refer to specially-trained police officials and units designed to provide maximum response efficiency in a variety of customary and unusual situations for example Public Order Policing (POP), responsible for crowd management, Tactical Response Unit (TRT), rendering specialised operational support, Family Violence, Child Protection and Sexual Offences Unit (FCS), providing assistance and support to woman and children that are victims of sexual offences, the Local Criminal Record Centre (LCRC), responsible for taking forensic samples, analysis of exhibits and the presentation of expert evidence as well as the Police Emergency Services (PES) consisting of the 10111 Centres and the Flying Squad, providing a twenty-four-hour immediate emergency telephone service and immediate response to all priority/serious crimes in progress (Booyesen, 2009: 78).

9.4 Trauma

Bubenechik (2014: 3) describes trauma as an overwhelming experience of sudden or catastrophic events in which the response to the event occurs in the often delayed, uncontrolled repetitive appearance of hallucinations or other intrusive phenomena. Valent (2012: 678) confirms that it is caused by stressors severe enough to threaten life or make one believe that one is about to die. Trauma can split and fragment the mind in various bio-psycho-social survival patterns, including various weightings of awareness and unawareness. Disruptions may radiate to any or all levels of human functions, ranging from anatomical and physiological to existential and spiritual. Trauma always leaves an imprint, and even if covered by extra defences, a degree of compromised functioning, sensitivity, and vulnerability remain. Trauma is a state of disruption in which one or more life-enhancing processes are irretrievably lost.

9.5 Psycho-social Therapeutic Program (PTP)

The Oxford English Dictionary (cited in Ahearn, 2000: 4) defines psycho-social as “pertaining to the influence of social factors on an individual’s mind or behaviour, and to the interrelation of behavioural and social factors.” Whitfield and Davidson. (2007: 3) characterise therapy as an intense, emotionally charged, confiding relationship with a helping person. It is a rationale that contains an explanation of the patient’s distress and of the methods for its release. The therapy provides new information about the nature and origins of the patient’s problems and ways of dealing with them. The patient develops the hope that he/she can expect help from therapy. It offers an opportunity for experiences of success during the course of therapy, and a consequent enhancement of the sense of mastery. Therapy offers the facilitation of emotional arousal in the

patient. Birkenmaier *et al.* (2014: 326) describes a group work program as a goal-directed activity with small treatment and task groups aimed at meeting socio-emotional needs and accomplishing tasks.

For the purpose of this study a group work program is the process between a facilitator (social worker) and group members (police officials) in which a systematic pattern is followed to achieve certain goals. A psycho-social therapeutic program is a program in which psycho-social principles and knowledge are converted into skills to facilitate emotional arousal and to better understand and deal with distress. These are very important components for ensuring hope and the enhancement of a sense of mastery.

10. Presentation of the research report

The article format was utilised in the presentation of the research results as stipulated in Rule 5.1.1.2 of the Yearbook of the North-West University (NWU, 2015: 117). The research report is presented in the following five sections:

10.1 Section A: General introduction

The first section serves as a general introduction which includes aspects such as the problem statement, aims and objectives, the general theoretical argument, research methodology, limitations of the study and definitions and key concepts.

10.2 Section B: Articles

The second section contains six articles that are outlined below. Each article is presented as an entity on its own and therefore some information could have been repeated. The section is schematically outlined as follows:

- Article 1: Trauma in the South African Police Service
- Article 2: Exploring programs to support police officials exposed to trauma
- Article 3: An assessment of the needs of police officials regarding trauma and trauma intervention programs: A Qualitative approach
- Article 4: An assessment of the needs of police officials regarding trauma and trauma intervention programs: A Quantitative approach
- Article 5: A Psycho-social Therapeutic Program (PTP) for police officials attached to the specialised units within SAPS
- Article 6: Implementation and evaluation of the PTP

10.3 Section C: Summary, conclusions and recommendations

The third section consists of a comprehensive summary, conclusions and recommendations regarding this study.

10.4 Section D: Annexures

The fourth section comprises various annexures included in the different articles.

10.5 Section E: Integrated bibliography

The final section consists of an integrated list of bibliography used during this study.

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SECTION B:
ARTICLES

ARTICLE 1

TRAUMA IN THE SOUTH AFRICAN POLICE SERVICE

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Key words

Trauma, South African Police Service.

Abstract

Police officials are exposed to multiple traumatic incidents, which are aggravated by various contributing factors that may cause intense trauma for the individual, family members and the police service. Post-traumatic stress, acute stress, depression, alcohol abuse, suicide and impaired productivity are but some of these risk factors. In this article a literature overview is done on the concept trauma, the factors leading to trauma, the impact, consequences and coping strategies. All of the above aspects should be included in the assessment and intervention processes, in an attempt to fully understand the psycho-social functioning of the traumatised police official.

TRAUMA IN THE SOUTH AFRICAN POLICE SERVICE

1. Introduction

SAPS are identified as an especially stressful career (Burke, 1998: 346). Police officials oftentimes encounter horrendous traumatic incidents during the execution of their duty (Zettlemoyer, 2006: 12). Contact involving various types of traumatic or critical incidents may cause intense trauma and stress that may not only affect the police official, his or her family members, but also the police as an organization. Recent research on occupational stress in SAPS and emergency workers was done by Jorgensen and Rothmann (2008), Oosthuizen and Koortzen (2007), and Pienaar and Rothmann (2006). These articles explore the uniqueness of SAPS as profession by discussing the continuum of occupational stress, including general stressors, psychological symptoms, coping mechanisms, to the exhibition of pathological responses. However few articles have been written specifically concentrating on a comprehensive holistic profile of police trauma and the additive and interactive effects of stressors and the impact thereof on the bio-psycho-social well-being of police officials as well as the manner to which they are able to cope with these reactions. This article is an attempt to highlight and obtain a better understanding to some of these aspects with specific reference to trauma.

2. Problem statement

Inherent to policing as career is the potential for exposure to multiple trauma and critical incidents with the accompanying post-traumatic and stress reactions. Traumatic incidents can cause reactions that affect the police official's work, relationships and overall quality of life. Although most police officials are able to recover and continue working with the support of friends, and professional counseling, some responders develop extreme symptoms and need additional assistance. The National Institute of Mental Health (NIMH: 2013) reports that police officials reporting high levels of stress have three times greater health problems, three times greater levels of domestic violence, five times higher rates of alcoholism, and are ten times more likely to suffer from depression than other members of the public. Sadly, more police officials kill themselves than are killed by criminals or die in an on-duty related accident (Hackett & Violanti, 2009: 66).

The researcher is therefore concerned with defining trauma within the context of SAPS, to better understand those factors leading to trauma, thereby wanting to establish to what extent SAPS is at risk to be exposed to traumatic incidents. The researcher is furthermore interested in the risk factors associated with the development of trauma and other related disorders, specifically

referring to the biological, psychological, emotional, spiritual and observable behaviour within the context of SAPS.

This article will therefore attempt to answer the following research question:

- What is trauma and what are the extent, subjective experience and impact of trauma on police officials in SAPS.

3. Aim

The aim of this article is to gather information, with specific reference to the concept trauma and the extent, subjective experience and impact of trauma on police officials within SAPS.

4. Crime in South Africa

Burger (2007: 45) describes crime as: "...an intentional act in violation of the criminal law...commit without defence or excuse, and penalised by the state...". Crime is an international phenomenon and is worldwide on the increase. Crime is a pressing issue in South Africa, and opposed to other countries has one of the highest rates of crime and violence in the world, therefore considered to be the crime capital of the world (Jorgensen & Rothmann, 2008: 2; Kassen & DiLalla, 2008: 263).

According to Seedat *et al.* (2009: 70), violence and injuries are still the second leading cause of death and disability in South Africa. These authors also found that South Africa's injury death rate is nearly twice the global rate average. The extent of the crime statistics in South Africa (Crime Stats SA, 2014) confirms this statement. During this period, a total of 2 255 751 crimes were recorded by SAPS. These cases range from murder, rape, attempted murder, assault with the intention of grievous bodily harm, robbery, housebreaking, hijacking and arson, just to name a few. Crime is increasingly associated with violence and criminals do not hesitate to seriously assault or even kill to succeed in their goal. If the high levels of violent crime in South Africa, the high level of illegal firearms in circulation, the increase on brutality by criminals and the general lack of respect for law and order are taken into consideration, it is small wonder that police officials are, it seems, specifically targeted (Makaudi, 2001: 7).

5. The South African Police Service

SAPS is an organization empowered by the South African government to ensure that the inhabitants keep the peace, to enforce the law, protect property, and preserve order (Burger, 2007: 27). The organization has the responsibility to "protect and serve" the community 24 hours a day, 365 days a year. SAPS responsibilities and duties are regulated by the Constitution of South Africa (Act No. 108 of 1996) and the South African Police Service Act (Act

No. 68 of 1995). This act provides for the establishment, organization, regulation, powers, duties and functions, community policing and control of the SAPS and to provide for matters in connection therewith.

6. The nature of policing in South Africa

According to Colwell *et al.* (2011: 106) policing is a difficult, dangerous, violent and one of the most stressful occupations. Westwood *et al.* (2012: 394-395) is of the opinion that their professional status as peacekeepers and rescuers exposes them to repeated instances of primary and secondary traumatization, any one of which can disrupt an official's functioning and interfere with safe and adequate job performance. In South Africa, various potential stressors, such as high crime levels, organizational transformation and a lack of resources challenge members of the police service (Pienaar & Rothmann, 2005: 58). The enemy is the police official's own civilian population: those who engage in crime, social indignity, and inhumane treatment of others (Violanti & Paton, 1999: 5).

The nature of police work involves patrols, investigations, traffic accidents attendance, scenes of crime and internal disturbance such as riots, violent arrests and gruesome scenes. In an hour of need, danger, crisis and difficulty, when a citizen does not know, what to do and whom to approach, the police station and a police official happens to be the most appropriate and approachable unit and person for him. Phiyega (2013) said the seven months she had spent in the police service made her realize how stressful the job is, and added, "When someone in the community is brutally killed or assaulted the people who go to the scene first to clean up the mess are the police. They are human, they are affected by this and other things". Police officials are often themselves the victims of criminals and also find themselves on the receiving end of this brutality. According to the South African Government News Agency (2015) a total of 1501 police officials have been attacked in the 2014/2015 financial year. During the same period 86 police officials lost their lives. Phiyega (2015) mention that these numbers clearly reflect that there has been an increase in the attacks on and killing of police officials.

The complexity of their work furthermore requires police officials to make complex, high-risk judgments on the spur of the moment, make delicate decisions with fateful consequences, and solve a wide range of problems under difficult circumstances and dangerous situations (Doyle & Johnston, 2011: 71). They must therefore live with doubts and uncertainty about some of what they have done, which can make them question their own adequacy or competence and undermine their self-esteem" (Deschamps *et al.*, 2003: 358; Toch, 2002: 55-56). They need to exhibit leadership, control and assertiveness; think clearly under pressure; and, adhere to the norms of the police sub-culture (Anderson *et al.*, 1995: 117). Police officials have to maintain orders and consequent reporting to the higher police officials and, exhibit restraint and empathy.

They must be able to complete their tasks despite provocation, ambiguity, and the ever-present threat of psychological or physical injury (Sundaram & Kuraman, 2012: 44). Examples of the demanding and unpleasant circumstances to which police officials are exposed daily are plentiful in the media. The following examples are cited:

- “My ma, my ma, help! Tiener sterf na sy vermink, verkrag is” (De Wee, 2013);
- “Voornemende kopers kry boer se lyk op plaas” (Louw-Carstens, 2015);
- “South Africa’s Lonmin Marikana mine clashes killed 34” (Plaut, 2012);
- “Home of horror for kids” (Carstens, 2015);
- “Killed in cold blood at petrol station” (Myburgh, 2015).

7. The South African police culture

In SAPS, police officials are expected to abandon their individuality, uphold the organization’s reputation and honor, and completely conform to the police culture (Koch, 2005: 273). The police culture also emphasises an image of the superhuman, when the reality is police officials are particularly vulnerable because they must always be on guard (Waters & Ussery, 2007: 170). Regardless of the organization or where it is located, culture is deeply embedded into every element of the organization: for example administration, hierarchy, policies and procedures, training, the job itself, and the relationships. Policing is the lens through which the police official views the self and the world. It is the culture that determines which convictions and principles a police official will uphold. For most police officials, policing is not seen as just a job, but as a way of life with a valuable mission (Woody, 2006: 97).

To treat police official’s effectively, one must understand the cultural factors at work in SAPS. Due to stereotypical ideas of “cowboys don’t cry” the police official is taught to reject, deny and/or suppress “normal reactions” to abnormal events (Toch, 2002: 55-56; Waters & Ussery, 2007: 169). Police officials showing emotion and seeking professional assistance are usually labelled as weak. The cultural belief is that the reactions are not appropriate for someone in the emergency professions. Koch (2005: 272) argued that the police culture diminishes the importance of emotion and values action instead of feeling. Feelings are believed to weaken self-control. As a result, the police culture upholds many rules related to emotional expression. Police officials are expected to adhere to neutrality, objectivity, unbiased and calm detachment, emotionless order, and unquestioning respect (Murphy, 2007: 165).

When crisis occurs, police officials disconnect from their emotion in order to handle the situation (Rees & Smith, 2008: 267). The cutoff occurs before and after the event, as well as within the culture where one is expected to be neutral. This unemotional front assumed by police is reinforced not only within the culture, but by the public and the media as well (Ussery & Waters,

2006: 66). The distressed police official may project a facade of competence while harboring a feeling of insecurity and shame. Failure to acknowledge feelings such as sadness and anger may result in poor job performance (Anderson *et al.*, 2002: 399) or may simply allow the job at hand to be completed (Toch, 2002: 55).

8. Trauma

The researcher developed the following illustration of this article with an overview of the critical elements causing a “snowball” effect as a result of the police official’s exposure to trauma.

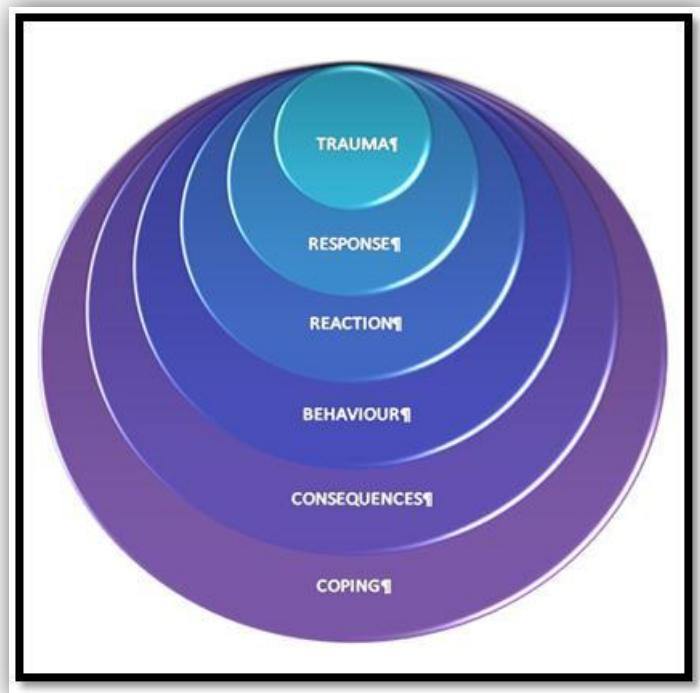


Figure B1-1 The impact of trauma

Each of these elements will be discussed according to the sequence as illustrated above to give an overview of the impact, police officials coping abilities as a result of their exposure to traumatic incidents as well as the consequences due to maladaptive emotion-focused behaviour (coping) for immediate stress reduction.

8.1 Trauma defined

Many difficult life experiences can be extremely hard to face, however, they may not necessarily be traumatic. Situations resulting in psychological trauma essentially have to do with coming face to face with extreme vulnerability.

According to the DSM-5, the exposure to trauma in itself is not a diagnosable disturbance. It does however, define a traumatic event as a direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate, or repeated or extreme exposure to aversive details of the event(s). (American Psychiatric Association, 2013: 271; Courtois & Ford, 2013: 9).

In SAPS, traumatic or stressful events are often referred to as critical incidents. For the purposes of this article, the terms "traumatic event" and "critical incident" will be considered synonymous. Trauma may be experienced by anyone, but the focus of this article will be on police officials.

8.2 The philosophy of trauma

Freud was one of the most notable figures who helped bring trauma into the psychological realm and in conceptualizing the impact trauma has on the individual's development and psychological functioning. He saw trauma as being the encountering of an overwhelming and horrific experience over a short period, overloading the ego and threatening to destroy the previous psychological organization. With this theory of the unconscious, the idea of repressed memories with trauma survivors began. Freud's work inevitably provided the foundation for future research and discourse in trauma. The discourse in trauma also brought about reactions in other philosophies of psychology, such as in behaviouristic, cognivistic and post-cognitivist approaches (Reuther, 2012: 438). For purposes of this study the researcher adopted the post-cognitivist approach and borrowed ideas from the philosopher Martin Heidegger, a German philosopher known for his existential and phenomenological explorations of the "question of Being" (i.e., the individual's way of experiencing or revealing the world).

The post-cognitivist perspective of trauma relies on the assumption that cognitive schemas are "internalized" within the mind and operate as rules for interpreting future experiences. The researcher share the worldview whereby the meaning and intelligibility of the world exists through larger socio-cultural contexts in which individuals are embedded. The world is not understood through internalized, decontextualized schemes but as something embodied through practical actions, discourse, and encounters with the world. In this perspective, contextualized practical engagements are the primary mode by which we come to understand ourselves, others, societal norms, and the like. This world view is much relevant to the study as confrontation with a traumatic event shatters how individuals engage with the world and ruins their orientation to it (Reuther, 2012: 439).

8.3 Causes of stress and trauma in the South African Police Service

Trauma in SAPS refers to the effect of extreme stressors on the individuals who serve in SAPS. This trauma is distinct from other traumas in that it applies to the individuals actively engaged in peacekeeping activities. These stressors arise from police official's active participation in combat activities, but also result from passive acts, such as witnessing acts of violence inflicted on colleagues and civilians. Trauma in SAPS occurs on a continuum of physical and psychological sequelae that range from mild to severe (Westwood *et al.*, 2012: 394). Major types of traumatic incidents might include child abuse, mass interpersonal violence, natural disasters, motor vehicle accidents, witnessing or being confronted with the homicide or suicide of another person, intimate partner violence, torture, crime, just to name a few (Courtois & Ford, 2013: 22).

Police officials are often involved with some of the most tragic aspects of the boundary between life and death, often in a context over which they have little or no control. A number of authors have noted that such situations may produce untoward trauma and stress responses which may play a negative role in their performance (Suri, 2012: 674).

The relatively high crime rate experienced by South African's, impinges negatively on members of the SAPS who, against these odds, are struggling to execute their duties effectively (Makaudi, 2001: 10). A unique source of trauma for this population is the constant risk of exposure to potential traumatic events, a burden that far exceeds that of the average citizen. Although he or she may not encounter such events on a daily basis, a police official always faces the threats of violent, dangerous, tragic and unpredictable situations, any one of which can leave emotional and psychological scars. Their professional status as peacekeepers and rescuers exposes them to primary, secondary and re-traumatization, any one of which can disrupt an official's functioning and interferes with safe and adequate job performance (Carlier *et al.*, 2000: 29; Violanti & Gehrke, 2004: 75). The last mentioned is in accordance with the new definition of trauma as explained in the DSM-5 which has been discussed earlier in this article.

A model of trauma and job stressors of firefighters was compiled after an extensive literature study by Shakespeare-Finch (2002: 275) and Waters (2002: 55). According to these authors stress and trauma can be categorized in two distinguishable areas namely those arising outside and within the work situation. Carlan and Nored (2008: 8-9); Patterson (2008: 55) and Rothmann and Jorgensen (2007: 73) added to these areas and also emphasise those traumatic incidents and stressors relating to the work itself as well as personal trauma and stress. The researcher, for the purpose of this research study, combined and categorized these areas specifically concentrating on those related to the unique situation within SAPS:

8.3.1 Causes originating within the work situation

SAPS as an organization, specifically referring to the structure, unique culture and para-military milieu are often contributing to a highly stressful working environment. Factors for example the bureaucratic and autocratic management style, insufficient training, salary and fringe benefits, limited career and promotion opportunities, administrative procedures and 'red tape', poor equipment, poor work relationships with managers and colleagues, job security, lack of control regarding decision making, uncertainty due to organizational changes, restructuring, are often found to be extremely challenging.

8.3.2 Causes originating outside the work situation

Police official's often experiences external stressors that have a direct impact on the manner to which they are able to execute their job. The justice system, politics, the expectations of SAPS opposed to those of the community, offensiveness of the community towards SAPS, media on the scene, policing within the framework of human rights are some of the examples of above.

8.3.3 Causes originating from the work itself

As a result of the execution of their job, police officials are often exposed to violence, crisis and dangerous life threatening situations. They are responsible for the safety of others, exposed to human loss, they are overloaded, working shifts, unexpectedly deployed, exposed to public opinion and accountable for decisions taken under immense pressure.

8.3.4 Causes originating from personal stressors

Personal stressors are related to fear, incompetency, a degree of uncertainty, inability to find a work-life balance, whereby work interferes with personal and home life, family and relationship problems, financial pressure, life style factors for example a balanced diet, exercise as well as problems in their social lives for example, loss of friends and lower social status.

The research by Young *et al.* (2012: 3) are in agreement with above causes and also supports the believe that more factors than simply trauma may determine the ability of police officials to cope. Occupational stress or workplace stress in this context refers to stress experienced as a direct result of a person's occupation, which may have a profound effect on an individual's well-being (Kutlu *et al.*, 2009: 9). While police work in general (ie, exposure to physical danger) is traumatic and stressful, research indicates that stress can also be as a result of factors originating within or outside the police organizational climate. These factors, although not perceived to be traumatic itself, are often experienced so severely that it has an impact on the manner to which police officials are able to cope with traumatic incidents. Police officials exposed to traumatic incidents might be pushed over the edge considering the sacrifices as mentioned above (Oosthuizen & Koortzen, 2007: 49).

8.4 The police official's response to trauma

Police officials, as other trauma survivors, exposed to traumatic events commonly re-experience their traumas. When an individual encounters a traumatic event the body goes into survival mode; the sympathetic nervous system pumps out adrenaline and/or noradrenaline and changes the heart rate and respiration (Kemeny, 2003: 124). The kinds of events that lead to a sympathetic nervous response can be difficult for people to integrate. The adaptive information processing model posits that traumatic life events may not get fully processed. Instead, they are frequently stored in isolated memory networks, along with the emotions, body sensations, and the many sensory images present at the time of the event (Shapiro, 2001: 30). When anything that resembles that event occurs in the present, that isolated memory network is triggered with no opportunity to view the present day experience from a broader perspective. According to the reaction of the mind and body, it is as if the traumatic event were occurring all over again.

This means that the police official again experiences the same mental, emotional, and physical experiences that occurred during or just after the traumatic event. The related symptoms include thinking about the trauma, seeing images of the event, feeling agitated, and having physical sensations (smell, sound, feeling etc.) like those that occurred during the trauma. Because they are anxious and physically agitated, they may have trouble sleeping and concentrating. In many instances the survivor usually can't control these symptoms or stop them from happening (Oosthuizen & Koortzen, 2007: 50).

How serious the symptoms and problems are depends on many things including: genetics, neurobiological factors, childhood development, type of trauma or stressful life events, personality characteristics, cognitive style, prior history of exposure to stressful events, gender, age, capacity for affect regulation, social support and ego defenses (Gordon & Alpert, 2012: 491).

Kirschman (2007: 180) believes that 85% of emergency responders exposed to trauma experience potential symptoms. Godbout and Briere (2012: 485) are of the opinion that survivors mostly exhibit post-traumatic stress symptoms which can be divided in three different clusters including re-experiencing, avoidance/numbing and hyperarousal:

8.4.1 Re-experiencing

The symptoms associated with the above, is perhaps the most distinctive and readily identifiable. Symptoms include flashbacks, bad dreams and nightmares, feeling as if the trauma is happening again, trouble falling or staying asleep, nightmares, intrusive re-experiences of the traumatic event, which often evoke intense negative psychological or physiological reactions and upsetting memories such as images or thoughts about the trauma.

8.4.2 Avoidance/numbing

The above involves behavioural, cognitive, or emotional responses that reduce the likelihood that the police official will experience trauma-related distress. These include avoiding thoughts, feelings, activities, places, people, or conversations that might arouse recollections of the trauma, social isolation, alienation, and detachment from others, persistent dissociation, including depersonalization, de-realization, and loss of personal continuity and awareness, alienation from or rejection of spirituality and spiritual/religious beliefs, the inability to recall aspects of the trauma, feelings of detachment or estrangement from others, a restricted range of affect, a sense of a foreshortened future, difficulty trusting, concerns over burdening others with problems, sensitivity to signs of abandonment or betrayal, interpersonal conflicts and arguments, guilt, shame, blaming themselves, perceptions of self as bad or unworthy, and distorted views of the perpetrator as benign or blameless.

8.4.3 Hyperarousal

The above reflects hyper activation of the sympathetic nervous system, with associated insomnia, irritability, anger, hypervigilance, unregulated and dysregulated extremes of emotions, getting very startled by loud noises or something or someone coming up on you from behind when you don't expect it, getting upset when reminded about the trauma (by something the person sees, hears, feels, smells, or tastes), an inability to tolerate or recover from even mild emotional distress, feeling agitated and constantly on the lookout for danger, feeling shaky and sweaty, having your heart pound, having trouble breathing, find it difficult to eat, headaches, backaches, chest pains, dysfluency and incoherence in discussing personal events and life history (Courtois & Ford, 2013: 24).

The range of post-traumatic reactions as indicated in the previous point of discussion, are common to almost anyone in the initial aftermath of a traumatizing experience or event. DSM-5 criteria for PTSD require that above symptoms last more than one month and cause significant impairment in social, occupational, or other important areas of functioning. If all other criteria are present but 30 days have not elapsed, and additional, dissociative symptoms are present, the individual may be diagnosed with Acute Stress Disorder (American Psychiatric Association, 2013: 271).

8.5 Reactions to complex trauma

According to Courtois (2012: 140) the term complex trauma refers to the array of responses and symptoms resulting from overwhelming traumatic exposure. When not processed to the point of some emotional resolution (decrease of symptoms and distress), they persist and cause more disruption, eventually reaching criteria for a psychological disorder. The original reactions may

be acute, become chronic or may go dormant, with a delayed onset, usually in response to an event that triggers and reactivates them.

The range of problems police officials experience from overwhelming traumatic exposure is concerning for a number of reasons:

Firstly, the constant stress of the job may interfere with a police official's ability to cope with the traumatic event. Secondly, the process of healing may consume finite stores of mental and emotional energy, leaving fewer resources available for adequate and safe job performance. Third, unlike many other trauma victims, police officials often are unable to avoid future situations similar to the traumatic event. In this sense, traumatic events are recurring. According to Fiorillo and Folette (2012: 186) a number of traumas accumulate, one type of trauma may "layer" on top of another, a pattern found in SAPS. The result is what has been identified by Courtois (2012: 140) as cumulative forms of trauma and re-traumatization with an increase in the trauma-related symptomatology.

Fourth, police officials are constantly exposed to secondary trauma. The DSM 5 (American Psychiatric Association: 2013: 271) describes secondary trauma as indirect exposure to trauma through a firsthand account or narrative of a traumatic event. The recounting of trauma and the subsequent cognitive or emotional representation of that event may result in a set of symptoms and reactions that corresponds with post-traumatic stress disorder. Fifth, although officials often report that the daily hassles of police work (e.g., organizational structure, shift work, lack of support) contribute more to the chronic stress they experience than does the danger associated with the job (Patterson, 2002: 789) the impact of traumatic events can be much more acutely debilitating.

Sixth, the severity of the traumatic incident may also determine the complexity of the trauma. Alone or in combination, it appears that certain types of trauma have greater affects than others do. Typically, human-caused traumas are perceived by victims as most intentional, intrusive and malignant and are associated with more negative psychological outcomes. Lastly it should be noted that police officials often utilize maladaptive coping mechanisms which normally results in internalized stress, avoidance coping and denial stress. As a result this can contribute to the development of trauma-induced adjustment and mental health disorders with potentially substantial implications for police official's health, psychological well-being, and job performance (Carlan & Nored, 2008: 9; Ussery & Waters, 2006: 66).

Individuals exposed to complex (multiple and severe interpersonal traumas) therefore appear to have more complex post-traumatic outcomes. The DSM-5 identified post-traumatic stress

disorder and acute stress disorder as the two main disorders related to psychological trauma, which differ primarily in terms of onset and duration:

8.5.1 Post-traumatic stress disorder (PTSD)

PTSD includes distinctive psychological and physiological symptoms which may develop and intensifies after exposure to or the witnessing of any one of a number of natural or human-assisted or human-caused disasters or other frightening event such as assault, domestic abuse, being a prisoner, sexual assault, war as a civilian or warrior, terrorist attacks, major accidents, fires and other forms of trauma involving the self or another person (American Psychiatric Association, 2013: 271).

8.5.2 Acute stress disorder

Acute Stress Disorder is characterised by a variety of separate symptoms. These symptoms are usually experienced immediately after the traumatic event, but fades relatively quickly. If all the characteristic symptoms of PTSD are present but 30 days have not elapsed, and additional, dissociative symptoms are present, the individual may be diagnosed with Acute Stress Disorder. (American Psychiatric Association, 2013 289; Godbout & Briere, 2012: 485).

PTSD has rarely accurately been diagnosed without another, co-occurring mental disorder. Comorbidity means a clustering of symptoms that suggest both primary and secondary disorders. PTSD comorbidity includes co-occurring mental disorders such as depression, anxiety, dissociation, tension reduction behaviour, interpersonal difficulties, substance abuse and somatic reactions.

8.5.3 Depression

Depression is a psychological disturbance which influences a person's mood changes, physical functioning as well as social interaction. The level of depression varies for each responder. Depression is a chemical imbalance that can create feelings of helplessness and hopelessness (American Psychiatric Association 2013: 289; Oosthuizen & Koortzen, 2007: 50).

8.5.4 Anxiety disorder

Anxiety disorder is periods of intense fear or apprehension that are of sudden onset and of variable duration from minutes to hours. Panic attacks usually begin abruptly, may reach a peak within 10 minutes, but may continue for much longer if the sufferer had the attack triggered by a situation from which they are not able to escape (NIMH, 2013).

8.5.5 Dissociation

Dissociation can be defined as significant changes in normal consciousness or awareness that alters the individual's access to thoughts, feelings, perceptions, and/or memories. The DSM-5 cites trauma as a major etiology in dissociative disorders. Dissociation may manifest in trauma survivors as amnesia or memory disturbances, identity dissociation, emotional constriction, trance states, perceptual distortions, and feelings of depersonalization, disengagement or derealization (American Psychiatric Association 2013: 289; Godbout & Briere, 2012: 487).

8.5.6 Substance abuse

Substance abuse and dependence are relatively common among those exposed to traumatic events. The comorbidity of trauma, PTSD, and substance abuse is widely discussed in both the substance abuse and trauma fields, primarily because such comorbidity can complicate assessment and interfere with treatment. The trauma survivor may seek psychoactive substances as a way to self-medicate post-traumatic distress as a result of which they can be more easily victimized or more vulnerable to trauma exposure (Godbout & Briere, 2012: 487).

8.5.7 Somatic reactions

Numerous studies provide evidence for a positive relationship between trauma exposure and physical health symptoms. Violanti *et al.* (2006: 227) found that police officers with severe traumatic stress, were three times more likely to have clusters of cardiovascular disease risk factors. Somatic reactions typically include:

- Having higher than normal probability of death from certain illnesses specifically cardiac vascular problems;
- Myriad of health problems such as headaches, high blood pressure, gastrointestinal and pulmonary systems as well as cancer, cardiovascular, sexual dysfunction and other devastating illness (Godbout & Briere, 2012: 489; Ussery & Waters, 2006: 66).

Various research studies has shown that roughly 68% of military troops and rescue personnel who served during the Vietnam and Gulf wars, the Oklahoma bomb attack, the attack on the World Trade Centre in New York on September 11, 2000, and the war in Iraq, reported at least one disaster related stress symptom 15-27 months later (Becker *et al.*, 2009: 246). At least 34% of these rescue personnel have been diagnosed with depression, acute stress or post-traumatic stress disorder to such an extent that they were advised to seek further assistance. The psycho-social well-being of police officials in South Africa is in accordance with the above research findings. Mthetwa (2012) confirms that these stress reactions has a direct influence on police officials psycho-social functioning, specifically referring to their productivity at work. This statement is supported by the following quote as cited in the SAPS Annual Report (2012/13):

“For the reporting period the highest number of applications for short term temporary incapacity leave was for respiratory conditions followed by muscular, skeletal, mental and behavioural conditions. For long periods of temporary incapacity leave psychiatric conditions were the leading cause. Psychological and medical conditions were the leading cause for ill health retirement applications”.

8.6 The consequences of trauma

As a result of the severe post-traumatic outcomes as discussed above, maladaptive coping mechanisms and the negligence and carelessness to seek or participate in effective treatment, police officials individual reactions can result in critical, risky and dangerous behaviour. In return the consequences of the police official’s behaviour might have a negative impact on SAPS as an organization specifically referring to productivity and consequently the image of SAPS.

Arnetz *et al.* (2009: 1) and Price (2012: 658) refer to social and behavioural risk factors as aggression, violence, domestic violence, suicide, homicide and family murder-suicide as well as the negative impact on work performance. Research further showed that in 14% of cases involving police officials exposed to traumatic incidents, the person’s daily life was influenced to such a degree that they committed to aggressive behaviour. In extreme cases this led to suicide and or family murder (Anshel, 2000: 375; Deschamps *et al.*, 2003: 358). The social and behaviour risk factors are discussed in more detail:

8.6.1 Family and Relationship problems

Domestic violence is often viewed as problematic within the police culture, yet because of that culture, it is difficult to get accurate statistics. Ussery and Waters (2006: 66) reported domestic violence among police families is rising at a rate more rapid than is the case for the population at large. Gershon *et al.* (2002: 160) indicated that police job related stress, which includes critical incident stress, was strongly associated with domestic violence. Kirschman (2007: 159) acknowledged that when a police official is abusive toward a domestic partner, he or she is considered more lethal because of common police characteristics, such as the need for control, expectations that others will be compliant, possession of a firearm, and having access to shelter locations.

8.6.2 Suicide

Suicide ideation is common correlates of post-traumatic stress disorder among U.S. Iraq and Afghanistan war veterans (Hellmuth *et al.*, 2012: 527). In the United States the suicide rate for law enforcement officers is about 20 per 100 000 (McNally, 2012: 341). Chances are greater for a police official to die by suicide than being killed in the line of duty, with a ratio of 3:1 (Hackett & Violanti, 2009: 66; Ussery & Waters, 2006: 66). SAPS have a large number of members who

commit suicide. The suicide rate in SAPS is more than double the national number of suicides (Webb & Bamford, 2005). A high suicide rate in SAPS is indicative of the distress experienced by its members. The suicide rate among police officials in SAPS is consistently averaging above 100 per 100 000 per annum. In 2009, 73 police members committed suicide, a year later the figure rose to 97 and in 2011 it dropped to 85. In 2012, 98 police officials took their own lives and by June 2013 the figure already stood at 34 (Mthethwa, 2013). These figures are much higher compared with an average of 23.03 per 100 000 reported for the United States, Australia and Germany (Kassen & DiLalla, 2008: 263; Pienaar & Rothmann, 2005: 59).

The Minister of Police expressed his concern during the opening of POLMED's new building in Pretoria on 22 June 2012, about the prevalence of depression and attempted suicide among police officials. Phiyega (2013) said that police suicides were perpetuated by the stressful work they do. The researcher was not able to obtain any official statistics regarding the number of police officials who committed suicide during the past five years.

8.6.3 Family Murder-Suicide

Police officials are considered to be at increased risk for suicide, and such self-aggression may be extended to others. Police experiences with violence and aggression, domestic violence, and availability of lethal weaponry are possible correlates (Violanti, 2007: 97). Risk factors for family murders (murder-suicide) are based on the relationship between the perpetrator and victims, history of domestic violence, sex of perpetrator and victim, age of perpetrator, presence of divorce/separation, use of weapon, and history of mental illness (Eliason, 2009: 371).

According to Godbout and Briere (2012: 488) some studies suggest that above individual reactions in trauma survivors is the result of the distress associated with trauma-specific symptoms. For example, excessive post-traumatic hyper arousal and high levels of intrusive memories appear to be especially predictive of family murder-suicide. Research further shows that anger, violent behaviour, impulsivity and use of cognitive suppression as a coping response to trauma predict suicidal behaviours in trauma survivors.

Unfortunately the researcher was not able to obtain recent official statistics on police family murders.

8.6.4 Police Brutality

Aggressive behaviour is a common presenting problem among veterans with post-traumatic stress and can include verbal threats with or without a weapon, destruction of property, or physical altercations (Hellmuth *et al.*, 2012: 527). Police officials themselves are increasingly guilty of violent and brutal behaviour. Police brutality is associated with the use of excessive force, usually physical, but also in the form of verbal attacks and psychological intimidation

(Matlala & Sinclair, 2013: 129). The researcher was not able to find any official research study stating whether these incidents can be linked directly with police officials' exposure to stress and trauma.

8.6.5 Work related problems

Pienaar and Rothmann (2005: 58) indicates that the high rate of suicide in SAPS, the high number of members booked off sick due to acute stress, depression, PTSD and other stress-related problems as well as the number of members retiring due to medical disability is an indication of the harmful effect of the police environment on the police official. Watson *et al.* (2012: 183) are of the opinion that the police official's behaviour gives rise to a very high employee turnover, absenteeism, sick leave due to stress, death and ill-health retirement. Anderson *et al.* (2002: 399) also added a reduced level of job performance, low morale, tardiness, premature retirement or quitting the police services altogether. It is therefore critically important that police officials are being able to understand their emotions, as well as being able to regulate them by adapting effective coping mechanisms in order for them to cope with their unique circumstances.

8.7 Coping with trauma in the South African Police Service

Patterson (2008: 58) defines coping as the process of reducing the perceived imbalance between demands and the cognitive and behavioural efforts to manage them. Research on trauma and stress has suggested that coping is part of the person–environment transaction that takes place when an individual appraises the situation as demanding.

Police officials necessarily develop coping strategies to manage trauma and stress. Anshel (2000: 375) and Carlan and Nored (2008: 9) differentiate between 'action-orientated' and 'avoidance' coping strategies. Avoidance coping can also be a form of denial that can be adaptive, however, it does not prevent the related emotion and danger experienced from impacting the police official.

According to Anshel (2000: 375) 'action-orientation' strategies are used to confront the problem and to control the situation or improve one's resources in the hope of reducing the imbalance. Examples of action-orientated strategies are the participation in pro-active programs such as stress management and suicide prevention programs in order to be educated with regards to possible reactions, symptoms and behaviours, attend critical incident stress debriefing or seek psychotherapy directly after exposure to a traumatic event, seeking support from peers, police management, Employee Health and Wellness or important others for example family members.

Arnberg *et al.* (2012: 712) proposes that the association between stress and health is greater among individuals who perceive low levels of social support compared to those who perceive high levels of social support. On the other hand, 'avoidance' strategies allow police officials to evade underlying problems and are used in an attempt to reduce the emotional strain experienced. Although the literature on coping strategies among police officials is limited, there is evidence to suggest that police officials utilize avoidance strategies also referred to as maladaptive emotion focused behaviours for immediate stress reduction (Anshel, 2000: 375).

Because thinking about the trauma and feeling as if you are in danger is upsetting, police officials who have been through traumas often try to avoid reminders of the trauma. Sometimes survivors are aware that they are avoiding reminders, but other times survivors do not realize that their behaviour is motivated by the need to avoid reminders of the trauma.

Studies show that police officials reporting symptoms of post-traumatic stress, depression or anxiety report concerns that they will be treated and thought of more negatively if they seek help. Finally, some officials worry about confidentiality and possible threats to their job security (Becker *et al.*, 2009: 246).

The problem is that after exposure to the above traumatic events, there are always those police officials who internalise or hide the symptoms and do not manifest any observable signs of dysfunction (Courtois & Ford, 2013: 25). In fact, once a police official actually comes face to face with job-related violence, it becomes much more difficult to maintain such denial. When this happens, a shattered worldview and extreme internal conflict can occur (Kirschman, 2007 180). Trying to deny or avoid thinking about the trauma and avoiding treatment for trauma-related problems may keep a person from feeling upset in the short term, but avoiding treatment means that in the long term, trauma symptoms will persist which might in the long term have several clinical implications (Sippel & Marshall, 2013: 399).

9. Conclusion

Literature in this article revealed that police officials, as a result of the escalating crime in South Africa as well as the unique and dangerous nature of their work, are constantly exposed to a broad spectrum of horrendous traumatic incidents. It became evident that police officials who go through traumatic experiences often experience a wide variety of initial and long-lasting psychological symptoms as an immediate response to trauma. These experiences further more represent risk factors for subsequent re- and secondary traumatization which might result in more severe and complex responses to further traumatic experiences. As a result of maladaptive emotion focused behaviour for immediate stress reduction, mechanisms for example, avoidance and denial, the trauma are internalized with potential development of

trauma-induced adjustment and mental health disorders with potentially substantial consequences for police officials health, psychological well-being, behaviour, job performance and eventually the SAPS as an organization.

10. Recommendations

It became clear that police officials, as a result of the unique nature of their work, are often exposed to horrendous traumatic incidents during the execution of their work, This exposure may cause intense trauma and stress that may not only affect the police official but also his/her family members and the police as an organization. A broader perspective of police official's circumstances, will allow clinicians to focus more specifically, and direct any interventions towards their unique needs. Based on the conclusion that was drawn, the following recommendations can be made:

- This research can be used as a platform for the development of various interventions with police officials exposed to or affected by trauma;
- Before any intervention program is planned for police officials exposed to trauma, an assessment should be done to determine and verify the population's unique needs with regards to intervention via their active participation in the whole process;
- The unique circumstances in which police officials attached to the specialised units find themselves are difficult and as a group they should be a target population with respect to help and support; and
- A psycho-social therapeutic program (PTP) should be developed to assist police officials exposed to and affected by trauma.

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ARTICLE 2

EXPLORING PROGRAMS TO SUPPORT POLICE OFFICIALS EXPOSED TO TRAUMA

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Key words

Program, support, police officials, trauma

Abstract

As a result of the critical nature of police officials' work, it is of utmost importance that they have direct access to support. The efficacy of the present trauma intervention programs in SAPS is questioned, because despite the implementation of trauma intervention programs, police officials still present high levels of acute and behavioural problems. A literature overview of proposed international trauma intervention approaches concentrating on both the psychological, behavioural and social factors affecting police officials exposed to trauma, as well as those models implemented by SAPS are discussed. The objective of this article is to critically appraise existing trauma intervention approaches to better understand, compare and extrapolate key elements of these approaches, and to reconfigure them into a comprehensive holistic psycho-social therapeutic program (PTP) for use among the police in South Africa. It was found that the trauma focused - cognitive behavioural therapy model (TF-CBT), prolonged exposure (PE) and the eco-systemic perspective, which was specifically developed for social work, dispose some of the best elements to be reconfigured into a holistic psycho-social therapeutic program.

EXPLORING PROGRAMS TO SUPPORT POLICE OFFICIALS EXPOSED TO TRAUMA

1. Introduction

Police officials are continuously confronted by horrendous traumatic incidents, making it of utmost importance that these members have direct access to support. Members need support to maintain psycho-social stability and to prevent post-traumatic stress symptoms from developing into acute and behavioural disorders. The most popular organizational responses in support of traumatised police officials are critical incident stress debriefing (CISD). In addition to this, stress management and suicide prevention programs have also been piloted during the past few years. The goal of these programs is to support police officials to regain or maintain psycho-social stability.

Despite the implementation of the above intervention programs, statistical data confirm that police officials still present with high levels of psycho-social problems. This may be attributed to a lack of knowledge and understanding about the extent, impact of trauma, specific needs of police officials concerning the support they receive, possible inaccessibility of these programs, ignorance, or again, a lack of an effective client oriented psycho-social therapeutic program. If police management and Employee Health and Wellness (EHW) do not continuously adhere to these aspects, one has to ask if this service is at all effective.

This article gives a literature overview of proposed international trauma intervention approaches, concentrating on both the psychological, social and behavioural factors affecting police officials exposed to trauma, as well as those programs implemented by SAPS. The objective is to achieve a holistic exploration and understanding of these approaches for the combination and inclusion in a holistic psycho-social therapeutic program within the context of SAPS. This is important to ensure a multi-component intervention of the problem at both micro and macro levels to reduce the risk of trauma related syndromes for the individual police official on the one hand but also in the broader context to ensure that police officials treat others fairly in their daily lives, whether in the workplace, in the family or in public. In addition such a program will put police officials at the center of development from which they can benefit. This program will therefore, also give recognition to the fact that police officials exposed to trauma interact in groups and society which are directly influenced by such experiences and that the norms that facilitates such interaction, shape development processes.

2. Problem statement

Kassen and DiLalla (2008: 263) emphasise the fact that South Africa is seen as the world's crime capital where crime assumes serious proportions. South Africa's official SAPS crime statistics for 2013/2014 shows an increase in violent crimes. Serious crimes, for example, murder increased from 16,259 murders in 2012/13 to 17,068 in 2013/14 (3.5%), and robbery with aggravating circumstances from 105,888 cases in 2012/13 to 119,351 cases in 2013/14 (12.7%). As a result of an increase in crime in South Africa, the police official is increasingly exposed to unique, demanding and unpleasant traumatic work incidences, for example murders, rape, violent crowds, car accidents, hijackings, housebreakings and other horrific traumatic events. Combine this with the general stressful work circumstances, for example, the bureaucracy of the organization, authority and power as a result of a strong hierarchal structure within the peri-military milieu, personal problems and the unique culture of SAPS related to 'cowboys don't cry' as a result of which police officials contain emotions rather to be labelled as weak, and it might over time negatively influence the police officials feeling of well-being (Waters & ussery, 2007: 169; Wester & Lyubelsky, 2005: 51). According to the DSM-5, the exposure to trauma itself is not a diagnosable disturbance. Qualifying traumatic events are, for example, actual or threatened death, serious injury or sexual violence. Traumatic events are explicit as to whether they were experienced directly, witnessed, experienced indirectly or repeatedly (American Psychiatric Association, 2013: 289). According to Mc Nally (2012: 342) and Valent (2012: 676), the exposure to trauma is strongly associated with psychological difficulties. In some instances police officials experience an array of stress-response syndromes, referred to as acute stress reactions, that occur during the initial aftermath of traumatic events rather than clinically significant distress whose symptoms do not meet criteria for a more discrete disorder (American Psychiatric Association, 2013: 271). If these stress response syndromes are not constructively handled during the emotional aftermath of traumatic events, the above syndromes might develop into trauma and stressor related disorder, for example, reactive attachment-, disinhibited social engagement-, depressive-, somatic symptom-, substance-related-, post-traumatic stress-, acute stress- and adjustment disorders. According to the DSM-5 it is important to note that exposure to a critical event is listed explicitly as a diagnostic criterion (American Psychiatric Association, 2013: 271).

Government and police management are increasingly becoming aware of the impaired psychosocial functioning of police officials. Mthetwa (2013) emphasised the need for a concerted focus on the psychological welfare of SAPS officials and the need for more research to enhance the pro-active programs. The former minister explains that SAPS use an integrated approach to EHW to support police officials exposed to trauma. Support is provided by qualified, experienced and registered psychologists, social workers and chaplains. "Members attend pro-

active programs presented by EHW practitioners based on identified needs prioritized from recurring themes and trends. Groups are dealt with through critical incident stress debriefing, team building interventions and organizational diagnosis processes” (National Assembly, 2013).

One of SAPS Basic Police Development learning Program (2013b) requirements is to be physically and mentally healthy and all applications are subjected to fitness, psychometric and medical evaluations. In addition, recruits are being empowered during the above program by EHW regarding different elements of psycho-social well-being considering possible exposure to traumatic events.

Despite the above, members still find it extremely difficult to maintain a psycho-social equilibrium during the course of their career. The SAPS Annual report (2013a) still indicates a high occurrence of acute and behavioural problems amongst police officials. According to Mthethwa (2012), between 3000 and 4000 police officials received debriefing consultations offered by EHW within the financial year. More than 10 000 members suffer from depression, and a further 2763 suffer from post-traumatic stress disorder at the time. Adding to the before mentioned, the following comments were made in the SAPS Annual Report for the period 2012/2013, referring to incapacity leave and ill-health retirement: “For the reporting period the highest number of applications for short term temporary incapacity leave were for respiratory conditions followed by muscular, skeletal, mental and behavioural conditions. For long periods of temporary incapacity leave psychiatric conditions were the leading cause. Psychological and medical conditions were the leading cause for ill health retirement applications”.

In addition to the before mentioned, there is a high incidence of police suicides, family murders and police brutality. In the U.S. the suicide rate for law enforcement officials is about 20 per 100 000 (McNally, 2012: 341). According to Kassen and DiLalla (2008: 263), Kirschman *et. al.* (2014: 147) and Ussery and Waters (2006: 66), the suicide rate in SAPS is more than double the national number of suicides. Pienaar and Rothmann (2005: 59) indicate that the high suicide rate in SAPS and the figures on psycho-social health is a clear indication of the damaging effects the policing environment has on the police official. Watson *et al.* (2012: 183) are of the opinion that this gives rise to a very high employee turnover, absenteeism, sick leave due to stress and ill–health retirement. Unfortunately the researcher was not able to obtain exact figures regarding the extent of psycho-social problems as well as the present suicide rate in SAPS.

The impaired psycho-social well-being of police officials might be attributed to the following factors:

SAPS place much emphasis on critical incident stress debriefing (CISD) as model for trauma intervention. In recent time international debate, research projects and open critic on the effectiveness of the current debriefing model increased. Various researchers found that Critical Incident Stress Debriefing had no, or a negative effect, on primary victims of trauma (Addis & Stephens, 2008: 361; Arnets et al. 2009: 2).

Trauma intervention in SAPS mainly concentrates on the psychological well-being of the police official with a strong cognitive and behavioural approach, without considering the consequent social risk factors associated with the frequent exposure to trauma. It does, therefore, not fully recognise the traumatised individual as a whole as it does not give recognition to the fact that police officials interact in groups and society or the fact that the norms that facilitates such interaction, shape development processes. A psycho-social model suggests that assimilation of police officials into the police role restricts cognitive flexibility and the use of other life roles, thus impairing their ability to deal with psychological trauma (Violanti & Paton, 1999: 88). This model emphasises the importance of a holistic approach concentrating on the patterns in the police officials thinking and also considering all the transactional layers, for example, social networks, community, family and environment as significant barriers to stabilise the traumatised official.

Miley *et al.* (2004: 33) mention the importance of an ecological perspective with emphasis on viewing people, families and communities as constantly interacting with their environments and through the process of these interactions, being shaped by, and shaping, these environments. According to the author a system should interact in such a way that it maintains its equilibrium. This is a key concept in the psycho-social view. A conducive healing environment can only be built if the psycho-social perspective is integrated into all phases of human response.

In their different programs, EHW concentrates on different aspects to improved psycho-social functioning, but the researcher could not find a single holistic all inclusive psycho-social therapeutic program to address the overall psycho-social well-being of police officials. Kutlu *et al.* (2009: 9), Violanti and Paton (1999: 88) and Williamson and Robinson (2006: 4), suggest that psycho-social programs would target a range of sectors; separating these in program development would not be conducive to the healing process.

Gordon and Alpert (2012: 492) confirm that to date, no treatment program for PTS has received universal acceptance among clinicians. Treatment outcome studies have found that although some approaches do lead to symptom reduction, the full range of psycho-social problems caused by PTS is not addressed by any of the existing treatment programs. In addition, the researcher could not find articles specifically evaluating or assessing the effectiveness of trauma intervention programs currently presented in SAPS.

A variety of existing approaches will thus be studied and critically evaluated to explore and compare elements of these approaches for possible inclusion in a psycho-social therapeutic program. This will be followed by a qualitative and quantitative study focusing on a needs analysis amongst police officials with the aim of integrating the theory and empirical data to develop a holistic program that will be able to address all the various systems in the psycho-social functioning of police officials.

This article will therefore attempt to answer the following research question:

- Which key elements of the different trauma intervention approaches can be reconfigured into a PTP for police officials exposed to trauma?

3. Aim

The aim of this article is to explore and critically appraise elements of existing trauma intervention approaches that can be reconfigured into a PTP for police officials exposed to trauma.

4. Literature review

The researcher will for the purpose of this article, firstly, concentrate on international trauma intervention approaches that concentrate on both the psychological and social well-being of those exposed to trauma, followed by the trauma intervention approaches currently implemented by SAPS. Some of the approaches can be considered to be models to trauma counseling while others can be considered to be full-fledged programs. Literature on these approaches will be discussed by an in depth critique of the context of practice, against the discussion of possible theoretical approaches. The review is important to enable the researcher to understand, compare and identify significant elements of the different approaches, as a result of which a holistic psycho-social therapeutic program might be pursued.

4.1 International trauma intervention approaches

Becker *et al.* (2007: 2861) examined seven therapeutic options: including trauma focused cognitive behaviour therapy (TF-CBT) and prolonged exposure (PE) as proposed by Saunders (2012). The present study relies on a similar core list, but the purpose is to extend these options, in order to develop the proposed psycho-social therapeutic program.

In order to achieve this, the researcher will explore the following evidence-based trauma intervention approaches as theoretical framework, considering elements of some of the above mentioned options as basis for the development of a psycho-social therapeutic program for SAPS. According to Cook *et al.* (2013: 18), the term evidence-based can be defined as a

therapeutic approach, supported by research findings. The research findings are evidence that the therapy is effective.

4.1.1 Prolonged Exposure Therapy (PE)

Prolonged exposure (PE) as a treatment program emerged from the long tradition of exposure therapy for anxiety disorders in which clients are helped to confront safe but anxiety-evoking situations in order to overcome their excessive fear and anxiety. At the same time, PE has emerged from the emotional processing theory of PTSD, which emphasises the central role of successfully processing the traumatic memory in relieving PTSD symptoms. PE includes the following procedures:

- Education about common reactions to trauma;
- Breathing retraining, i.e., teaching the client how to breathe in a calming way;
- Repeated in vivo exposure to situations or objects that the client is avoiding because of trauma-related distress and anxiety; and
- Repeated, prolonged imagery exposure to the traumatic memories (i.e. revisiting and recounting the traumatic memory in imagery).

The aim of in vivo and imagery exposure, as explained to clients in the overall rationale for treatment, is to enhance emotional processing of traumatic events by helping them face the traumatic memories and the situations that are associated with them. In doing so the clients learn that the memories of the trauma, and the situations or activities that are associated with these memories, are not the same as the trauma itself. They learn that they can safely experience reminders to the traumatic event; that the anxiety and distress that initially resulted from confrontations with these reminders decrease over time; and that they can tolerate this distress. Ultimately, the treatment helps PTSD sufferers reclaim their lives from the fear and avoidance that restrict their existence and render them dysfunctional (Cook *et al.*, 2013: 18; Moore & Penk, 2011: 42; Westphal, 2012: 465).

However, van Minnen *et al.* (2010: 312) mention that although prolonged exposure (PE) has received the most empirical support of any treatment for PTSD, clinicians are often hesitant to use PE due to beliefs that it is contraindicated for many patients with PTSD. This is especially true for PTSD patients with comorbid problems specifically referring to depression and alcohol abuse. Because PTSD has high rates of comorbidity, it is important to consider whether PE is indeed contra-indicated for police officials with various comorbid problems. In addition this approach is lacking an ecological perspective as it excludes the police officials interaction with their families and communities, and do not consider that the police official are being shaped by, and shaping, their environments. This approach is important for police officials to interact in

such a way that it maintains its equilibrium. A conducive healing environment can only be built if the psycho-social perspective is integrated into all phases of human response (Miley *et al.*, 2004: 33).

4.1.2 Trauma Focused Cognitive Behavioural Therapy (TF-CBT)

The cognitive model proposes that dysfunctional thinking is common to all psychological disturbances. For lasting improvement in patients' mood and behaviour, cognitive therapists work at a deeper level of cognition: patients' basic beliefs about themselves, their world, and other people. Modification of their underlying dysfunctional beliefs produces more enduring change. For example, if you continually underestimate your abilities you might have an underlying belief of incompetence. Modifying this general belief (i.e. seeing yourself in a more realistic light as having both strengths and weaknesses) can alter your perception of specific situations that you encounter daily. The basic principles of cognitive behaviour therapy are as follows:

- It is based on an ever-evolving formulation of patients' problems and an individual conceptualization of each patient in cognitive terms;
- It requires a sound therapeutic alliance;
- It is goal oriented and problem focused;
- Initial emphasis is on the present;
- It is educative, aims to teach the patient to be her own therapist, and emphasises relapse prevention; and
- It teaches the patient to identify, evaluate, and respond to dysfunctional thoughts and beliefs.

Cognitive behaviour therapy uses a variety of techniques to change thinking, mood, and behaviour (Baranowsky *et al.*, 2010: 15; Becker *et al.*, 2009: 245; Yarvis, 2012: 669). However, CBT only focuses on the police official's capacity to change themselves, and does not address wider problems in systems or families that often have a significant impact on a police official's health and wellbeing. As mentioned before, this approach is important for police officials to interact with their families and the community in such a way that it maintains its equilibrium. Once again the same principle applies that a conducive healing environment can only be built if the psycho-social perspective is integrated into all phases of human response (Miley *et al.*, 2004: 44).

4.1.3 Psycho-education

Psycho-education is education about a certain situation or condition causing psychological stress. There are many ways to combat psychological stressors such as learning about the

condition. Once a person better understands a condition, they feel more in control of the situation and this in turn reduces the stress associated with it.

The format of psycho-education depends entirely on the disorder, the developmental age of the individual and their individual needs. Psycho-education can be group-based, family-based, parent-based or individually implemented. Psycho-education is vital for any person experiencing psychological stressors and hardships due to a condition. It is everybody's right to have information regarding their condition and therefore, no matter what their cognitive or psychological state, a degree of psycho-education should be administered to everyone. If you are participating in a psycho-education program you should expect that all the essential information about your condition will be covered as well as any extra information you require. The common topics that will be focused on are as follows:

- The medical aspects of the condition by identifying and explaining the diagnosis, the prognosis, the biology and psychology;
- The stigma attached to the client's diagnosis, how this is affected by the organization, colleagues and the community and what can be done to combat and manage the stigma;
- Healthy lifestyle behaviours that will help to manage the condition;
- Stress management as to why the client needs to manage his/her stress levels and how high levels of stress worsens symptoms;
- Understanding self-esteem, self-image, self-efficacy; and
- Treatment with specific reference to the types of psychotherapies available and suitable to help the patient deal with the psychological effects of the condition.

Throughout psycho-education a 'no-blame' attitude is presented. Psycho-education conveys the concept that what happened in the past stays there; now is time to learn about your condition and what ways to best manage your future (Baranowsky *et al.*, 2010: 130; Fristad, 2006: 1289; Pender & Prichard, 2009: 179; Schnyder *et al.*, 2012: 710).

A few disadvantages to psycho-education treatment programs do, however, exist. Schnyder *et al.* (2012: 709) mentions that one general disadvantage is giving information about an individual's diagnosis may not be helpful and may even be harmful to the individual. This is particularly true referring to the police culture and the danger associated with labelling police officials. It does, however, depend on how the psycho-education is given. For such information to be helpful, rather than harmful, it needs to be given in a non-pathological way noting the separation of a person from their symptoms, in a balanced manner including a discussion of strengths and limitations and with a focus on not blaming the police official but emphasizing the inherent challenge of recovering from the condition. The current disorder-based way of defining mental illness is also not conducive to the ecological foundation of psycho-education. Miley *et*

al. (2004: 44) emphasise the fact that an ecological approach to assessment focuses on the individual's interaction with the environment rather than on the deficits of the individual. A more ecological approach is likely to be better in a public service setting, for example, SAPS where police officials are not receiving services based on a disorder.

4.1.4 Marital and family therapy

Police families have become used to the demands associated with a family member's work. They continue with life as normal as possible and although they are unconsciously aware of the possible dangers associated with the job they are normally not prepared for a crisis. Johnson (2003: 67) explains that when someone discovers that a member of their family has been exposed to a traumatic event and as a result has developed acute stress reactions or in extreme cases a serious mental illness, they typically are in shock. They are normally not prepared for this life-shattering event. They are puzzled and frightened by strange behaviours, worried about what will happen, and in most cases do not know what to do.

Family therapy is linked to psychotherapy and concentrates on families and couples in intimate relationships to nurture change and development. It tends to view change in terms of the systems of interaction between family members and emphasises family relationships as an important factor in psychological health. Regardless the origin of the problem, or whether the client consider it an "individual" or "family" issue, involving families in solutions often benefits the client. Family involvement is commonly accomplished by their direct participation in the therapy session. The skills of the family therapist therefore include the ability to influence conversations in a way that catalyzes the strengths, wisdom and support of the wider system.

Family therapy uses a range of counseling and other techniques, including communication theory, psycho-education, psychotherapy, relationship education, systemic coaching, systems theory, reality therapy, attachment focused family therapy and the genogram. A family therapist usually meets several members of the family at the same time. Therapy interventions usually focus on relationship patterns rather than analyzing impulses of the unconscious mind or early childhood trauma of individuals as a Freudian therapist would do.

Family therapists tend to be more interested in the maintenance and/or solving of problems rather than in trying to identify a single cause. It is important to note that a circular way of problem evaluation is used as opposed to a linear rout. Using this method, families can be helped by finding patterns of behaviour, what the causes are and what can be done to better their situation (Gale, 2007: 58; Gurman & Fraenkel, 2002; 199; Moore & Penk, 2011: 141; Weiss & Santoyo, 2012: 384).

There are, however, certain limitations to family therapy. According to Mueser *et al.* (2003: 396) not all problems are the result of a serious mental illness caused by the exposure of the police official to a traumatic event/s. In many police families the overall family structure and function are relatively healthy, nevertheless, one member has a problem. In most cases there is a phase of family therapy in which problems may worsen. New symptoms may appear in another family member and all members do not benefit equally. In some instances, the family may try family therapy as a last resort. When the therapy does not produce beneficial change, the family may be worse than at the start, because the members have lost their last hope. In case of marriage counseling, for example, the outcome might be separation or divorce. One might automatically assume that family therapy is designed to hold the family together. Experience does indicate otherwise. Marital therapy allows the partners to examine whether it is to their advantage to stay together, and it gives them permission to separate if that is what they need to do.

4.1.5 Psycho-social rehabilitation

There are many people with mood and anxiety disorders or with personality disorders whose illness has a major and persistent impact on their life functioning. Psycho-social rehabilitation is concerned with interventions designed to assist people whose mental illness has had a major and persistent impact on life functioning, regardless of diagnosis. Psycho-social rehabilitation promotes recovery, full community integration and improved quality of life for persons who have been diagnosed with any mental health condition that seriously impairs their ability to lead meaningful lives. Psycho-social rehabilitation services are collaborative, person directed and individualized. It focuses on helping individuals develop skills and access resources needed to increase their capacity to be successful and satisfied in the living, working, learning, and social environments of their choice (Foa *et al.*, 2009: 388). The core principles of psycho-social rehabilitation according to Stromwall and Hurdle (2003: 208-209) are as follows:

- It helps people re-establish roles in the community and their reintegration into community life;
- It facilitates the development of personal support networks;
- Culture and/or ethnicity play an important role in recovery as sources of strength and enrichment for the person and the services;
- Psycho-social rehabilitation interventions build on the strengths of each person;
- It actively encourages and supports the involvement of people in community activities, such as school and work, throughout the rehabilitation process; and
- The involvement and partnership of people and family members receiving services is an essential ingredient of the process of rehabilitation and recovery (Foa *et al.*, 2009; King *et al.*, 2012: 1-3; Moore & Penk, 2011: 173).

In order to ensure growth and increasing levels of independence in self-care, illness management, interpersonal relationships, residential stability, and meaningful activity amongst police officials in “normalised” community settings, it is of utmost importance that this approach not only concentrate on the police official as individual, but also on the systems of care, for example, family members and other significant support persons. Such involvement must, however, be sensitive to the wishes of the service recipient and their rights to privacy and confidentiality (Arns *et al.*, 2001: 43).

4.1.6 Relaxation therapy

Relaxation techniques are an essential part of the quest for stress management. Relaxation is a process that decreases the wear and tear on the mind and body from the challenges and hassles of daily life. Whether stress is spiralling out of control or tamed, an individual can benefit from learning relaxation techniques. Practicing relaxation techniques can reduce stressful feelings by slowing the heart and breathing rate, increasing blood flow to major muscles, reducing muscle tension, improving concentration, reducing anger and frustration and boosting confidence to handle problems. Health professionals such as doctors, psychologists and social workers can teach various relaxation techniques. In general, relaxation techniques involve refocusing attention on something calming and increasing awareness of the body. It doesn't matter which relaxation technique is chosen. What matters is that the individual try to practice relaxation regularly to reap the benefits. There are several main types of relaxation techniques, including autogenic relaxation, breathing, progressive muscle relaxation and visualization.

As the client learns relaxation techniques, he/she becomes more aware of muscle tension and other physical sensations of stress. Once someone knows what the stress response feels like, they can make a conscious effort to practice a relaxation technique the moment they start to feel stress symptoms. This can prevent stress from spiralling out of control. Relaxation techniques are acquired skills, and as with any skill, an individual's ability to relax improves with practice (Baranowsky *et al.*, 2010: 39; Jha *et al.*, 2007: 109).

It should be noted that some people, especially those with serious psychological issues and a history of abuse, may experience feelings of emotional discomfort during some relaxation techniques. Police officials undergoing relaxation therapy might fear loss of control, feeling like they are floating, and experiencing relaxation-induced anxiety related to these feelings. Therapists should note that some relaxation techniques may result in continued intensification symptoms or the development of altogether new symptoms. It is very important to consider the police official's physiological and psychological status when choosing a specific type of relaxation technique. Active progressive relaxation would not be appropriate for clients with decreased energy reserves as it can amplify their existing fatigue and limit the person's ability to

complete individual sessions and practice. Passive relaxation or guided metaphors are more appropriate for these individuals (Ruden, 2012: 505).

4.1.7 The ecosystems perspective

Mattaini *et al.* (2002: 3) explains that the ecosystems perspective has been almost universally accepted in social work because it provides a framework for thinking about and understanding transactional networks in their complexity. Miley *et al.* (2004: 33) describe humans as very complex and multi-dimensional beings. The authors identify two domains of individual functioning, namely, the biophysical and the psychological. They further divide the psychological into cognitive, affective and behavioural components. Others add spiritual, social and cultural human beings with thoughts, feelings, and observable behaviours to the list. People affect their environments and likewise the social and physical environment affects people.

The ecosystems perspective is a way of seeing the person and the environment in their interconnected and multi-layered reality. A fundamental purpose of all professional practice, including social work, is to individualize the case. In the case of social work, this individualizing process applies to individual persons, families, groups and communities. Because no person can be understood apart from his or her defining social context, an eco-map presents the field of elements in which the person is embedded. The eco-map guides one to see connectedness and to eliminate the hyphen between the person and his or her environment (Hepworth *et al.*, 2002: 87-92).

The transactional focus addresses the person in the environment and it distinguishes social work from other professional disciplines. It implies that individuals and their environments are always actually or potentially adaptive to each other, and that interventions can be carried out in either sphere of the case or directly in the transactions and can be expected to affect other spheres. It directs the vision of client and social worker toward the complex transactions in cases, helping to connect them and recognizing their interactions.

This psycho-social view of systems is of special significance to change processes. Events are not mandates for human behaviour. Each of us may respond to the same events in different ways. The way we see ourselves and others, our previous experiences and our current feelings and thoughts all influence our responses. The psycho-social view of social systems expands the options for social workers and police officials. Workers can help police official's, construct new ways of perceiving and responding to events. The focus of this perspective is "to address the psycho-social matrix of which individuals, families, groups and communities are constituents" (Miley *et al.*, 2004: 44).

Whilst the ecological approach helps practitioners significantly in conceptualizing the essential concerns of social work practice, the approach continues to have some inherent difficulties and problems. It does not, for example, provide clearly laid down sets of procedures and processes for assessment and intervention, as well as strategies and reasoning for their use. Practitioners therefore use the approach for understanding the basic relationships between police officials and their environments but have to thereafter devise and formulate their own assessment and intervention procedures. It has also been found that when social workers intervene in the eco systems of police officials, in this study referred to as the client, users by opening up communication channels with other people in the eco system, such interventions often do not have clarity in terms of outcomes and can lead to negative consequences. Critics of the ecological approach also argue that its application leads practitioners to perceive problems with such broad perspectives that practitioners attempt to plan so comprehensively that actual effectiveness of practice gets jeopardized (Jones, 2010: 67).

4.2 Existing trauma intervention programs presented by SAPS

As mentioned earlier in the article, police management and more particular, EHW, has piloted a continuum of interventions and services, which provides both pro- and re-active support during the past years. A trauma intervention program can be considered to be an early intervention program following crisis and disaster which is short term in nature and focuses on immediate trauma. It has been developed to match the urgent psycho-social needs of people. This helping process is confined within the framework of a program within which assistance is provided (McNally, 2012: 342; Reyes & Elhai, 2004: 400).

Critical incident stress debriefing, suicide prevention and stress management are three national projects which has been aligned with National Instruction 18/1998, debriefing of employees who have experienced traumatic incidents and falls under the auspices of EHW in SAPS. The researcher will give an overview of each of the mentioned programs.

4.2.1 Critical Incident Stress Debriefing (CISD)

In 1992 SAPS psychological services developed a stress debriefing model for police officials who were exposed to trauma. The model is based on the CISD model of Mitchell and Everly (1996), and was developed to reduce the impact of trauma on the individual. CISD is defined as a meeting with a group of people (peer support program) during or after a traumatic event, for example, an accident or disaster (Carlier *et al.*, 2000: 29; Mitchell, 1983: 797). The debriefing session is conducted to gain an overview of the event, to talk about feelings and reactions and develop mechanisms to alleviate the emotional impact of an event, prevent traumatic stress and identify those needing mental health services. CISD is most often administered 72 hours to two weeks following the traumatic event. It is not intended to replace mental health services, but to

be part of the overall continuum of care (Malcolm *et al.*, 2005: 261; Mitchell 2004: 24; Robinson, 2012: 196). Debriefing may be mandatory or voluntary. If a police official is instructed to attend, most likely the superior officer has identified an event as traumatic.

Saunders (2012) mentioned that six research studies discredited the critical incident stress debriefing model as an intervention method. Saunders is also of the opinion that when improperly employed, they may well worsen a person's mental condition, for example, the risk for PTSD can escalate after debriefing and some victims might experience secondary trauma because of the repetition of the event. This, according to Lopez-Ibor *et al.* (2005: 89) is especially true when critical incident stress debriefings are used as standalone therapy with no follow-up, leaving patients to cope on their own with the long-term elements of post-traumatic stress.

4.2.2 Suicide prevention program

Hackett and Violanti (2003:10) argue that the prevention of suicide requires a strong support system. The individual agency should have a plan in place to deal with an emergency employee and to render the necessary support. The prevention of suicide in SAPS was designated to EHW and a national suicide prevention program has been developed by psychological services. The program's goal is to develop the abilities of officials to deal with suicide, develop mutual support and solidarity among members in suicide prevention, provide help for related problems and develop competencies in using existing resources. This program focuses on presenting suicide prevention workshops to members. Police management has a responsibility to create an environment where training of all personnel in suicide prevention and intervention is the norm. Shneidman (2005: 7-12) is convinced that the availability of active suicide prevention services may offer such a person a grasp on life. It offers the possibility of showing that life is not so fatally narrow and that death need not be the only answer. Therefore, if suicide attempts involve other methods and the victim is discovered in time, his/her life could be saved (Violanti, 2004: 277; Violanti, 2007: 97).

The World Health Organization (2004) reported the following findings of 30 types of preventive interventions which were evaluated in published research which covered the whole spectrum of primary and secondary prevention efforts. Suicide-prevention programs for individuals at high risk that focuses on prevention appear to be effective in reducing risk factors, for example, depression, hopelessness, stress, anxiety and anger and enhancing protective factors, for example, personal control, problem-solving skills, self-esteem and network support. Suicide prevention programs furthermore demonstrated lowered suicidal tendencies, improved ego identity, and improved coping ability. Miller (2012: 228) are, however, of the opinion that multi-component interventions in military personnel, for the purpose of this study police official's, is

necessary to reduce the risk of suicide. According to Knox *et al.* (2004: 37) suicide prevention narrowly focus on identifying proximate, individual-level risk factors, rather than thinking about population mental health in terms of complex social and ecological relations. Miley *et al.* (2004: 33) emphasise that the focus of the ecological perspective is “to address the psycho-social matrix of which individuals, families, groups and communities are constituents”, which should also be applied to suicide prevention programs.

4.2.3 Stress management program

Patterson (2008: 54) argues that particular attention should be given to occupational stress in policing, as its potential negative consequences affect society in more direct and critical ways than stress in most other organizations. Police officials operating under severe and chronic stress may well be prone to make mistakes, cause accidents and overreact and in this way compromise their professionalism and jeopardize their safety.

SAPS Social Work Services, decided to emphasise the role of pro-active stress management by developing a needs-based stress management program. The program’s aim is to improve personnel’s practical stress management strategies, coping skills and techniques and thereby enhance the individual’s resilience to stress. The overall outcome of the stress management program is to enable a participant to understand the nature of stress and the importance of improving better stress management behaviour (knowledge), to be committed to adopt improved stress management behaviour (attitude), to be able to utilize acquired knowledge and skills to design and implement a personal stress management program (behaviour).

These outcomes entail that the participants should be able to do the following:

- Identify the core nature of stress during a small group discussion;
- Provide feedback on the issue by means of a symbolic display to identify the physiological aspects of stress by means of a body-drawing exercise; and
- Draw a stress profile by completing a checklist regarding their stress levels, causes of stress, typical stress reactions and type A or B personality styles after participating in a group activity.

Participants receive a hand out to do stress reduction exercises after a demonstration of the exercises and after practicing them to apply stress management strategies and techniques after a facilitative group discussion/session. They are further more encouraged to compile a personal stress management program on the basis of a standard format provided to participants. The program is structured according to these outcomes. Therefore, it enables participants to grasp the full impact of the program, thereby preparing them to follow a suitable personal stress management program (Daniello, 2011: 225; Williams, 2003: 36).

According to Patterson *et al.* (2012: 24) there are two major disadvantages to stress management programs in the police service. The beneficial effects on stress symptoms are often short-lived and the program often ignores important root causes of stress because the program primarily focus on the police official and not the environment. The author furthermore states that actions to reduce job stress should give top priority to organizational change to improve working conditions. But even the most conscientious efforts to improve working conditions are unlikely to eliminate stress completely for all police officials. For this reason, a combination of organizational change and stress management is often the most useful approach for preventing stress at work.

5. Discussion

This article gave an overview of the most important international approaches, but at the same time focused on those trauma intervention programs presented by SAPS. As a result of the above literature review, the researcher was able to critically appraise existing trauma intervention approaches to better understand, compare and consider possible aspects of these approaches, concentrating on both the psychological, behavioural and social factors affecting police officials exposed to trauma. This allowed the researcher to extrapolate key elements of techniques with the aim to reconfigure them into a comprehensive holistic psycho-social therapeutic program for use among the police in South Africa.

The most important elements of critique referring to all of the before mentioned approaches is the fact that they are fragmented into different components which either concentrate on the cognitive, behavioural or social aspects of the police officials life. All of these approaches can be seen as a stand-alone therapy as none of these programs concentrate on police official's mental health in terms of complex psychological, cognitive, affective social and ecological relations. It is important to see the police official and the environment in their interconnected and multi-layered reality. The researchers therefore support a transactional fashion of intervention to avoid viewing people in isolation from their life situations.

The TF-CBT, PE and the eco-systemic perspective, which was specifically developed for social work, dispose some of the best elements to be reconfigured into a holistic psycho-social therapeutic program. Following the literature review, the researcher will by means of a qualitative and quantitative study focus on a needs analysis amongst police officials in the larger population in a next phase, with the aim of integrating the theory and empirical data to develop a holistic program that will be able to address all the various systems in the psycho-social functioning of police officials.

Both the TF-CBT as well as PE is a type of psychotherapeutic treatment that helps patients understand the thoughts and feelings that influence behaviours. It was developed as a guideline for early intervention treatment for acute and post-traumatic stress symptoms experienced during the initial aftermath until four weeks post trauma. The TF-CBT and PE do have some of the elements for inclusion in the proposed psycho-social therapeutic program, for example, psycho-education, prolonged exposure, relaxation, in vivo exposure and cognitive therapy. This early intervention treatment models guide six sessions of structured cognitive behaviour therapy sessions with prolonged exposure. Patients who receive TF-CBT within the initial month after trauma might be at less risk to develop PTSD or otherwise experience less intense PTSD.

The researchers do, however, recommend that the TF-CBT and the PE be grounded in the eco-systemic perspective which is a way of seeing the person and the environment in their interconnected and multi-layered reality. The perspective supports a transactional fashion of intervention to avoid viewing people in isolation from their life situations. It not only consider psychological, cognitive, affective and behavioural components, but also concentrates on the interconnected transactional networks, with specific reference to community, family, environmental, spiritual, social and cultural factors as significant barriers as result of police officials' exposure to trauma.

As a result of the above discussion, the researcher compiled the illustration on the following page:

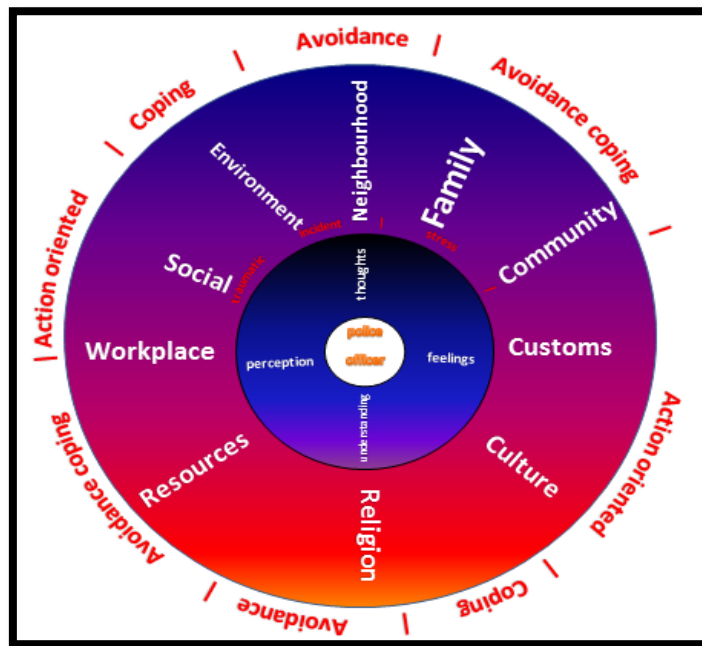


Figure B2-1: Psycho-social perspective

Figure B2-1 illustrates a proposed psycho-social perspective, integrating all phases of human response in terms of complex psychological, social and ecological relations as key elements for police officials to maintain a psycho-social equilibrium, for possible inclusion in a proposed psycho-social therapeutic program. This perspective will ensure a multi-component intervention of the problem at both micro and macro levels specifically referring to the broader context of policing and of the individual police official to reduce the risk of trauma related syndromes. This program will put police officials at the centre of development from which they can benefit. This program will give recognition to the fact that police officials interact in groups and society, and the norms that facilitate such interaction, shape development processes.

6. Conclusion

The combination of the TF-CBT, PE and the eco-systems perspective will ensure a psycho-social focus and guide the researcher considering the inclusion of psychological, behavioural and social elements, as discussed, in one, single psycho-social therapeutic program. The implementation of the proposed psycho-social therapeutic program within the context of SAPS has the potential to serve as a holistic guideline for social workers working in the field of trauma. The suffering and misfortune of police officials who experience trauma and stress are critical components of care which must be obligated by police management and EHW in SAPS. Considering the before mentioned discussions there is no doubt that management and EHW is having a responsibility and important role to play in the development of effective trauma intervention programs with a holistic approach to better the overall psycho-social well-being of police officials.

7. Recommendations

After the critical appraisal of existing trauma intervention approaches the researcher came to the conclusion that TF-CBT, PE and the eco-systems perspective dispose some of the best elements to be reconfigured into a psychosocial therapeutic program. Based on the discussion on the results from this study as well as the conclusion that was drawn, the following recommendation can be made:

- A PTP should be developed based on the exploration of some of the best elements of existing trauma intervention approaches, to assist police officials exposed to and affected by trauma;
- Elements of the TF-CBT, PE and the eco-systems perspective can be reconfigured and included in a single psycho-social therapeutic program to support police officials to better cope with their exposure to trauma; and
- Before any intervention program is planned for police officials exposed to trauma, an assessment should be done to determine and verify the population's unique needs with regards to intervention via their active participation in the whole process.

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ARTICLE 3

AN ASSESSMENT OF THE NEEDS OF POLICE OFFICIALS REGARDING TRAUMA AND TRAUMA INTERVENTION PROGRAMS: A QUALITATIVE APPROACH

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Key words

Assessment, police officials, trauma intervention programs.

Abstract

Police officials are exposed to multiple traumatic incidents, aggravated by various contributing factors that may cause intense trauma for the individual, family members and the police service. The risk factors include acute stress, complex traumatic stress disorders, somatic and social relationship problems, self-destructive behavioural risk factors as well as impaired productivity. As a result of the critical nature of police officials' work in the community, it is of the utmost importance that they have direct access to support. The efficacy of the present trauma intervention program in SAPS is questioned, because despite the existence of trauma intervention programs, police officials still present high levels of acute and complex post-traumatic stress reactions.

AN ASSESSMENT OF THE NEEDS OF POLICE OFFICIALS REGARDING TRAUMA AND TRAUMA INTERVENTION PROGRAMS: A QUALITATIVE APPROACH

1. Introduction

Police officials are exposed to multiple traumatic incidents, which are aggravated by various contributing factors that may cause intense trauma for the individual, family members and the police service. Acute stress, complex traumatic stress disorders, somatic and social relationship problems, self-destructive behavioural risk factors as well as impaired productivity are but some of these risk factors.

As a result of the critical nature of a police official's work in the community, it is of utmost importance that they have direct access to support. The efficacy of the present trauma intervention programs in the SAPS is questioned due to the fact that despite the implementation of trauma intervention programs, police officials still present with high levels of acute and complex traumatic stress reactions.

The focus of this article is to do a situation analysis and information collection as part of phase one of the intervention research model, on a small portion of the police officials stationed at the specialist units in the North-West Province. The researcher will explore, explain and evaluate the extent, subjective experience and impact of trauma as well as the specific needs of police officials with reference to support and intervention programs as a first qualitative phase of the exploratory sequential research design. The results will be used to develop a questionnaire as part of a second phase of the design.

2. Problem statement

Policing is dangerous and one of the most stressful occupations in the world. Police officials are subjected to daily threats of violence and death, and they witness traumatic events while executing their job (Anshel, 2000: 375; Violanti, 2014: 3). The physical and psychological dangers associated with policing, including harmful environmental exposure, stress and trauma, are often not acknowledged by police management or the community at large. Stress is one of the most common of all occupational hazards for police, therefore the adverse health and psychological consequences of policing are much more complicated than those of other occupations (Adams, 2007: 473; Violanti & Gehrke, 2004: 75). South Africa's official crime statistics for 2013/14 show an increase in violent crimes. The number of murders increased by 3.5% from 16 259 murders in 2012/13 to 17 068 in 2013/14. Robberies with aggravating

circumstances increased by 12.7% from 105 888 cases in 2012/13 to 119 351 cases in 2013/14. As a result of an increase in crime in South Africa, police officials are increasingly exposed to unique, demanding and unpleasant traumatic work circumstances. Police officials are exposed daily to murder, sexual assault, shooting incidents, car accidents, hostage situation, hijackings, robbery with aggravating circumstances, the death of colleagues, as well as child abuse (Jorgensen & Rothmann, 2008: 2; McNally, 2012: 341 and Patterson, 2008: 56). The suddenness and unpredictability of the situation or experience are key components in a traumatic experience. These events are often experienced with intense fear, helplessness and horror (Frewin *et al.*, 2006: 243; Suri, 2012: 674).

Trauma and stress experienced in the line of duty, although clearly differentiated, are interlinked. MacEachern *et al.* (2011: 311) and Young *et al.* (2012: 3) indicate that factors such as the bureaucratic structure of the SAPS, policing within the community, community members' lack of respect for police officials, the legal system and attempting to establish co-operation with the community as well as police officials' personal circumstances are major stressors that might have an impact on the way in which police officials experience trauma.

These factors in addition to the extraordinary, frightening and dangerous nature of policing, as mentioned earlier, confirm the complex nature of policing (Keyes *et al.* 2012: 759). According to Bonanno, *et al.* (2012: 190), traumatic events do have the potential to cause psychological harm if not attended to, which in turn can create serious health concerns. Police officials adapt different coping strategies to manage trauma and stress. Carlan and Nored (2008: 9) and Louw and Viviers (2010: 3) describe these as "action-orientated" and "avoidance" coping strategies. Unfortunately most police officials deny and so avoid dealing with the symptoms of trauma (Andrew *et al.*, 2014: 147-149). This might be attributed to several factors, including police officials' denial of the painful consequences of symptoms as they are not prepared to confront them; the unique police culture with specific reference to the "macho image" of the police; the stigma associated with therapeutic intervention; and a lack of trust in Employee Health and Wellness (EHW). EHW is a multi-professional team consisting of social workers, psychologists and chaplains in SAPS and management. Deschamps *et al.* (2003: 358) and Jorgensen and Rothmann (2008: 2) emphasise the fact that if post-traumatic stress symptoms are not attended to at an early stage, police officials might be at risk of developing acute stress, or even more complex traumatic stress disorders, for example, post-traumatic stress disorder (PTSD), depression, anxiety disorder, alcohol abuse, and somatic and other related disorders. This normally does have a negative influence on the police official's feelings of well-being, the relationship with family and peers, and work performance. In extreme situations this might even lead to aggressive behaviour, suicide or family murder-suicide (Patterson, 2008: 54).

The critical and important nature of the police officials' work and the fact that they find themselves in the front line of the criminal justice system necessitate direct access to psycho-social support. Keyes *et al.* (2012: 637) and Paton and Norris (2014: 137) confirm the above by pointing out that when workers are placed at risk in traumatic situations, both organisational and employee support becomes essential in processing the traumatic event. Employee interaction and process-oriented conversation aid in support of coping with work-related stress, and this carries over when that stress is related to trauma. Peer groups, management, family and counselling support are all important factors to enable members to maintain and improve their general well-being. Regardless of the different trauma intervention programs and services offered by EHW, the SAPS Annual report for 2012/13 still showed a high occurrence of stress-related problems and psychological disorders amongst police officials. This report confirmed that long periods of temporary incapacity leave and psychiatric conditions were the leading causes of incapacity leave and ill-health retirement. The SAPS Annual report for 2013/14 did not contain any statistics relating to the psychological wellness of police officials.

The researcher is of the opinion that a purposeful psycho-social therapeutic program might be developed to address problems experienced by police officials. However, in order to achieve this, the extent, subjective experience, impact of trauma and police officials' specific needs with regards to trauma and trauma intervention, should be ascertained.

With reference to the above statement, this article will attempt to answer the following research question:

- What are the extent, subjective experience, and specific needs of police officials' in the North-West Province, regarding trauma intervention?

3. Aim

To conduct a qualitative situational analysis as a first phase of the explorative sequential design to explore and identify the extent, subjective experience and specific needs of police officials in the North-West Province, who have been exposed to trauma.

4. Research methodology

The intervention research model as proposed by De Vos and Strydom (2011: 476) and Rubin and Babbie (2010: 33) seemed to be the most effective to reach the aim and objectives of this research study. During the first phase of the intervention research model, situation analysis and information collection, the researcher used mixed method research. This approach was found to be most suitable as it involves both qualitative and quantitative approaches which allowed the researcher to gain a holistic view and insight to whether the data obtained from a few police

officials can be generalised to a larger sample of police officials stationed at the specialist units within the North West Province. According to Creswell (2014: 4), mixed method research "...is an approach to inquiry involving collecting both quantitative and qualitative data, integrating the two forms of data, and using distinct designs that may involve philosophical assumptions and theoretical frameworks". The core assumption of this form of inquiry is that the combination of qualitative and quantitative approaches provides more complete understanding of a research problem than either approach alone. There are many terms used for this approach, such as integrating, synthesis, quantitative and qualitative methods, multi-method, and mixed methodology but recent writings by Tashakkori *et al.* (cited in Creswell 2014: 217) use the term mixed methods.

The researcher made use of the exploratory sequential mixed methods design proposed by Creswell (2014: 225) as part of the first phase of the intervention model. The researcher began by exploring and analysing the data qualitatively and then used the findings in a second quantitative phase. The second database builds on the results of the initial database. The strategy is that the researcher employs a two-phase procedure with the first phase as exploratory by involving a small sample of police officials in three focus groups representing the different clusters in the North-West Province, the second as developing a questionnaire as a result of the findings of the exploratory phase, and administering the survey to the bigger population which is police officials stationed at the specialist units representing the different clusters within the North-West Province (Creswell, 2014: 226).

For the purpose of this article the researcher will concentrate on the qualitative approach as the first phase of the exploratory sequential design, to understand the meaning that members of focus groups ascribe to trauma and trauma intervention programs presented by EHW in the SAPS (Creswell, 2014: 4).

The conceptualization of the process is illustrated in Figure B3-1:

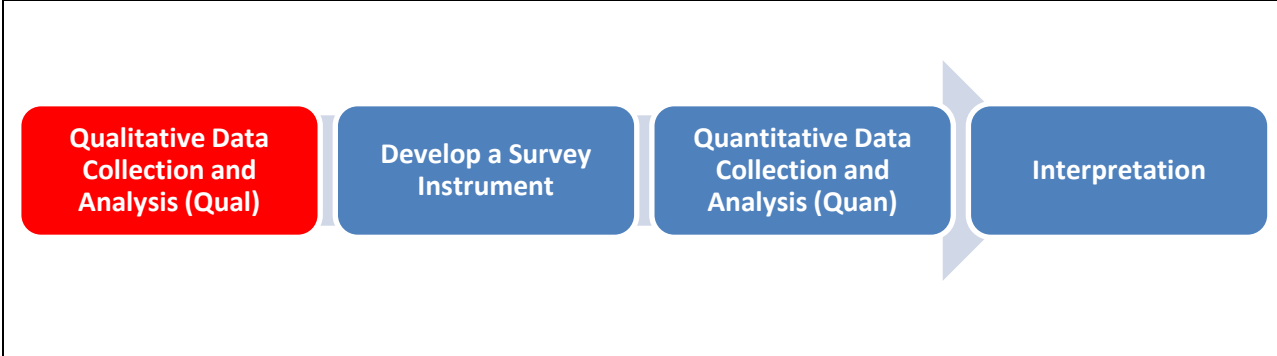


Figure B3-1: Exploratory Sequential Mixed Methods Design (Creswell: 2014: 220)

As part of the qualitative approach the researcher made use of a case study as a research strategy to do an in-depth exploratory analysis of the complexity of trauma within SAPS, a smaller group of police officials stationed at the specialist units were included.

According to Yin (2012: 4) the distinctive need for case study research arises out of the desire to understand complex social phenomena. It allows researchers to focus on a “case” and retain an in-depth, holistic and real world perspective, such as studying individual life cycles, small group behaviour, organizational and managerial processes, etc.

The researcher used the purposive sampling method in order to select forty participants representing three of the bigger clusters in the North-West Province, namely: Rustenburg, Mahikeng and Potchefstroom (Strydom & Delport, 2011: 392). Police officials were purposefully chosen considering the relevance of the topic, specifically referring to their exposure to trauma, resultant symptoms of PTS and their participation in trauma intervention programs. Subsequently the researcher, because of the sensitive nature of the research subject, made use of EHW responsible for the specialist units in the eleven clusters of the North-West Province, to assist with the selection process for the focus groups. Last mentioned procedure was followed, because the EHW possess first-hand knowledge on the members in his/her specific work area, and is in some cases already therapeutically involved with police officials. However, it should be emphasised that participants were informed about the aim of the research after which they gave informed consent and therefore voluntarily participated. According to Jacobs *et al.* (2016: 440) the ideal size for a group is eight to ten, but the researcher chose thirteen to fourteen per group to make provision for unexpected circumstances. This was done because of the unique nature of the police officials’ work. As a result of the size of the focus group the researcher used a co-facilitator, a lecturer at the university, who has been trained in focus group interviewing. The focus groups allowed the facilitators to interact systematically and simultaneously several individuals. Rubin & Babbie (2010: 221) confirm that qualitative interviews can be conducted in focus groups and emphasise the importance of a co-facilitator to observe and direct the attention of the facilitator.

Focus group interviews can be structured, semi-structured, or unstructured. During these focus groups information pertaining to the extent of trauma, police officials’ subjective experience of trauma, the impact thereof on their psycho-social functioning as well as their specific needs regarding support and intervention were gathered by means of a semi-structured interview schedule. A semi-structured interview allow the researcher to gain a detailed picture of participant’s beliefs about, perceptions or accounts of, a particular topic (Greeff, 2011: 351). The interviewer in a semi-structured interview generally has a framework of themes to be explored. The researcher specifically concentrated on the following questions:

- What is your understanding of the concept trauma?
- How do you normally react to trauma?
- How do you cope as a result of exposure to traumatic incidents?
- What programs, if any, are available to support police officials?
- If so, what is your experience of these programs?

The answers to the various questions have been transcribed and analyzed according to the eight steps as proposed by Tesch in Creswell (2014: 198). The findings have been categorized according to the themes resulting from the questions. This allowed the researcher to make interpretations of the meaning of the data (Creswell: 2014: 4). In Table B3-2 the researcher gives an overview of the primary themes and sub-themes and categories of the sub-themes that arose from the data.

5. Ethical aspects

Ethics is described by Strydom (2011: 114) as follows: “Ethics implies preferences that influence behaviour in human relations, conforming to a code of principles, the rules of conduct, the responsibility of the researcher and the standards of conduct of a given profession”.

The researcher, for the purposes of this study, firstly got ethical approval from the North-West University’s Ethical Committee on the ethical clearance number: NWU-00007-13-A1.

According to Holloway *et al.* (cited in Adlem 2011: 15), respondents participating in a research study have the following rights, which were strictly followed by the researcher:

- The proposed focus group interviews were based on strict scientific guidelines to prevent any damage to participants in the research study or to SAPS as an organisation;
- Permission has been obtained from the SAPS in order to undertake the research study among police officials;
- Participants have been purposefully selected in cooperation with EHW. The purpose, method, possible risks and expectations of the study were explained to all participants, after which they were allowed to make a choice to partake in the research or not;
- Participation in the research study was voluntarily and police officials were allowed to withdraw from the focus groups at any time, while written consent forms were signed by participants;
- Selected police officials were assured of confidentiality and anonymity, especially with reference to the processing of the data as it has been recorded on tape. Codes were used instead of real names of the police officials;
- The termination of the focus group interviews were handled with the necessary sensitivity. If any further therapy or treatment was necessary, due to the impact of the study, the

researcher would have referred the police official to a qualified psychologist, psychiatrist or medical doctor for further psychotherapy/treatment.

6. Discussion of the findings

The results of the research project were based on the situation analysis of the police officials stationed at the specialist units, representing three of the eleven clusters in the North-West Province. For the purpose of the first phase of this study the researcher only focused on the three biggest clusters in the North-West Province as they accommodate all the specialist units mentioned earlier under point 4.1 of this article. This included an exploration of police official's experience, impact and their specific needs regarding trauma intervention programs.

The number of participants for the three different focus groups was as follows: Focus group number one, Potchefstroom with a total of 13 participants, focus group number two, Rustenburg with a total of 14 participants and focus group number three, Klerksdorp with a total of 13 participants.

The characteristics of participants for all three the different groups have been combined in the following table:

Table B3-1: Participants' characteristics

Item	Category	Frequency	Percentage
Age Frequency missing = 0 N =40	21-25	1	2.50
	26-30	6	15.00
	31-39	17	42.50
	40+	16	40.00
	Total	40	100.00
Gender Frequency missing = 0 N = 40	Male	31	77.50
	Female	9	22.50
	Total	40	100.00
Rank Frequency missing = 0 N = 40	Constable	21	52.50
	Sergeant	2	5.00
	Warrant Officer1	15	37.50
	Officer	2	5.00
	Total	40	100.00

Language Frequency missing = 0 N = 40	Afrikaans	11	27.50
	English	2	5.00
	Tswana	19	47.50
	S/Sotho	2	5.00
	Zoeloe	1	2.50
	Xhosa	4	10.00
	Tshivenda	1	2.50
	Total	40	100.00
Marital Status Frequency missing = 0 N = 40	Married	21	52.50
	Committed relationship	9	22.50
	Single	6	15.00
	Divorced	4	10.00
	Widow/er	0	0.0
	Total	40	100.00
Years' service Frequency missing = 0 N = 40	1-4	5	12.50
	5-9	15	37.50
	10-14	1	2.50
	15-19	3	7.50
	20-24	11	27.50
	25+	5	12.50
	Total	40	100.00
Locality Frequency missing = 0 N = 40	LCRC	10	25.00
	PES	3	7.50
	FCS	9	22.50
	POP	6	15.00
	TRT	6	15.00
	DET	6	15.00
	Total	40	100.00
N = 40			

Locality refers to all 3 clusters taking into consideration participants from the different sites. LCRC = Local Criminal Record Centre, PES = Police Emergency Services, FCS = Family, Child and Sexual Offences Unit, POP = Public Order Policing, TRT = Tactical Response Unit and DET = Detectives.

The majority of the respondents, namely 17 (42.5%) of the 40 focus group members are in the age group 30-39 followed by 16 (40%) of group members who are 40 years and older. Only one

member (2.50%) is in the age group 21-25. Focus group members were therefore more mature or relatively older. A total of 31 (77.5%) of the group members were males. The SAPS is still a fairly male dominated occupation and the composition of the focus groups is merely representing the demographics of the specialist units in the North West Province. More than half of the group members, a total of 21 (52.5%) were constables, followed by 15 (37.5%) with the rank of Warrant Officer. Only 2 (5%) of the group members were officers. This might be as a result of a tendency of ignorance or lack of commitment, towards psycho-social support and intervention programs within SAPS, amongst senior police officials. Almost the majority of the group members, 19 (47.5%) is Tswana speaking, followed by 11 (27.5%) who were Afrikaans speaking. Only 1 (2.5%) of the group members were Tshivenda speaking. This composition can mainly be contributed to the fact that the two indigenous languages for the North-West Province are mainly Tswana and Afrikaans, which is an indication of the North-West Province as a whole. Just more than half of the group members, a total of 21 (52.5%) are married. Only 4 (10%) are divorced whilst no widow/er participated. More than half of the group members therefore have access to family relationships which encourage support. Half of the group members a total of 20 (50%) does have less than 10 years' service, while the other 50% varies between 10-25 years and longer. The focus groups were as a result well balanced specifically referring to a fairly younger group of participants with little work experience opposed to an older more experienced group of police officials. Most of the group members, a total of 10 (25%) were stationed at LCRC, followed by FCS with a total of 9 (22.5%) whilst there were a relatively fair distribution amongst POP, Detectives and TRT with 15% each. PES represented only 3 (7.5%) of the total group members. Despite the percentage of participation, the focus groups were representative of all the specialist units within three of the bigger clusters representing the North-West Province, namely Potchefstroom, Rustenburg and Klerksdorp.

Table B3-2: Primary themes and sub-themes that emerged from data analysis

Themes	Sub-themes	Categories of sub-themes
1. Meaning of trauma	1.1 Concept Trauma 1.2 Complex Trauma 1.3 Trauma Enforcers 1.4 Major police stressors	1.2.1 Trauma originating from the work itself 1.2.2 Trauma originating from personal circumstances 1.4.1 Organizational stressors 1.4.2 External stressors 1.4.3 Operational stressors 1.4.4 Personal stressors
2. Response to trauma	2.1 Initial aftermath 2.2 Complex traumatic stress disorders 2.3 Consequences of complex trauma	2.2.1 Post-Traumatic Stress Disorder <ul style="list-style-type: none"> – Re-experiencing – Avoidance of stimuli – Negative alterations in cognitions and mood – Alterations in arousal and reactivity 2.2.2 Comorbidity 2.3.1 Alcohol abuse 2.3.2 Suicide Ideation 2.3.3 Anger, aggression and violence 2.3.4 Family and relationship problems 2.3.5 Somatic complaints 2.3.6 Work related problems
3. Coping	3.1 Resilience 3.2 Avoidance coping 3.3 Action orientated coping	
4. Trauma intervention programs	4.1 Awareness and participation 4.2 Consumer orientation 4.3 Consumer satisfaction 4.4 Core marketing strategy	4.4.1 Product 4.4.2 Price 4.4.3 Place and Time 4.4.4 Promotion

Each of the themes, sub-themes and categories of sub-themes will be discussed individually to facilitate conceptual clarity. It is important to notice that the themes, sub-themes and categories of sub-themes are interlocked and/or to a great extent in interaction with each other. The article should therefore be read considering a sense of the whole (Creswell, 2014: 198).

The researcher will focus on each of the themes considering the following questions:

- What is the meaning of the sub-themes and categories of the sub-themes, where applicable, considering the group member's perceptions and experiences?
- How and in which context did group members refer to specific sub-themes and categories of sub-themes?
- To what degree does the literature/research confirm the relevance of the specific sub-theme and category of the sub-theme?

As a result of the extent of the data resulting from the three focus groups, and mostly considering the length of the article, the researcher will only discuss the most important categories of sub-themes. The researcher did, however, find it difficult to consistently discuss each of the sub-themes and categories of the sub-themes in the specific sequence of the questions. The reason for this was because some of the sub-themes and categories of sub-themes have been identified by group members by name whilst others have been deduced as a result of what have been reported by the group members. The researcher discussed each of the sub-themes and the most important categories of sub-themes, by making an interpretation of the findings or results. Several narratives resulting from the raw data forthcoming from the three focus groups have subsequently been quoted to facilitate insight to how the researcher identified and interpreted the specific sub-themes and some of the most important categories of sub-themes. Lastly the researcher will compare the findings with literature and theory which identifies these or similar sub-themes and sub-categories. Creswell (2014: 212) states that the process of interpreting the findings involve stating lessons learned, comparing the findings with past literature and theory, raising questions, and/or advancing an agenda for reform. Quotes from the focus group interviews will be referred to throughout the article in order to complement the findings. Miles and Huberman (cited in Creswell 2014: 211) address the importance of creating a data display and suggest that narrative text has been the most frequent form of display for qualitative data. This is a naturalistic study. Therefore, the results will be presented in descriptive, narrative form.

Subsequently a discussion of the 4 themes and sub-themes that arose from the three focus group interviews follows.

6.1 Theme 1: The meaning of trauma

As a result of the question, "What is the meaning of trauma?" the following sub-themes have been identified. Trauma as concept, complex trauma, trauma enforcers and major police stressors. The sub-themes as a result of the question are subsequently discussed in more detail:

6.1.1 Sub-theme 1: Trauma as concept

Participants have diverse opinions regarding the concept trauma. The different opinions that emerged describe trauma as an abnormal and extraordinary event, an event that cannot be controlled, which is overwhelming and cruel, can be associated with intense fear and helplessness, which might result in a traumatic or stress reaction. The following narratives can be regarded as representative of above categories of the sub-theme:

“...Trauma is something that does not happen every day, such as an ordinary arrest, which we as police officials are used to during the daily execution of our duties. It is exceptional, even extraordinary, accompanied by intense fear and terrifying, it is uncommon. Think of the Marikana incident during which many miners were killed or the rape and murder of a child”;

“...Trauma is something that happens without warning and in most instances is totally unexpected. You find yourself in a situation where you are suddenly involved with criminals, for example, an ATM bombing, who are there on the scene waiting for you, starting to shoot at you”;

“...when you are faced with a situation, for example the drowning of a child, it is beyond your control. You suffer from shock, and you are psychologically and physically been bruised or injured. You are traumatised as a result”;

“...some of the scenes that I have to attend for example a homicide-suicide, is ugly. It becomes too much to such an extent that I find it difficult to cope, it changes you from the person you are”;

“...There are children as well as defenceless old people, that are hurt or injured for no apparent reason at all. People that can't defend themselves, being attacked or murdered, you feel so helpless, there is nothing you can do”

“...We are running on fear, that constant fear, again and again”.

Some participants have experienced trauma as an abnormal event which does not occur in the normal course of a person's life. Others describe trauma as extraordinary, intense, and scary. Group members described trauma as suddenly and totally unexpected. They are of the opinion that a traumatic incident occurs when least expected and usually when you are least prepared for it. The group members believe that a traumatic incident deprives you of controlling the situation. In most cases they find themselves powerless and therefore unable to do anything about the situation. Participants agreed that the worst experience regarding traumatic incidents can be associated with the level of cruelty. The latter also causes the event to be so overwhelming that it is difficult for them to handle the impact thereof on them as a person. The

DSM-5 (American Psychiatric Association, 2013: 271) define trauma as “a direct personal experience of or learning of a violent event that involves actual or threatened death or serious injury, or other threat to one’s physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person or repeated or extreme exposure to aversive details of the event(s)”. Mitchell (2012: 165) and Valent (2012: 676) also refer to traumatic events as critical incidents which is “powerful events that overwhelm an individual’s or a group’s ability to function normally. Disorganised or agitated behaviour may also occur. Traumatic incidents of critical incidents can cause significant psychological damage”.

Although the group members did not consistently and specifically call the sub-theme areas on the name, it was easy for the researcher to make a conclusion as the same core concepts continuously emerged from their reactions. Group members are due to the nature of their work in the specialist units in the North West Province exposed to various traumatic incidents, and they were therefore able to provide first-hand information about the concept itself as well as their experience of it. They were able to discuss the concept from personal experiences. The last-mentioned will be discussed in more detail in the next sub-theme.

6.1.2 Sub-theme 2: Complex trauma

Group members who are representative of all the specialist units in the North West Province were due to the nature of their work exposed to intense traumatic incidents on a regular basis. These incidents are mostly extra-ordinary, violent, dangerous and extremely stressful. Group members are immensely stressed by the brutality associated with crime as well as the little respect for life. The categories of the sub-theme that emerged as a result of this sub-theme are as follows: trauma originating from the work itself and trauma originating from personal circumstances. Each of these categories of the sub-theme will subsequently be discussed in more detail:

6.1.2.1 Category 1 of sub-theme 2: Trauma originating from the work itself

Group members mentioned several examples of incidents too which they are exposed as a result of their work. These incidents are according to them deemed as exceptional and therefore perceived to be traumatic. The following examples are cited:

“...thinking about accidents: In 2006 I saw approximately five people die in one accident. Even two kids, two babies on board that died”;

“...I do a lot of diving scenes, the one that stand out, was three or four years back, it was a church ritual, and five guys drowned at once, so we went and took out five bodies at one time”;

“...a guy was hijacked in Potchefstroom. They took him out of the car and put him in the boot. They took him to the bush and told him to lie on his stomach. The one guy stood above him and shot him from behind, through the head, he killed him;

“...when you get to Marikana and you find thousands of people on the koppie with spears and guns. We were in the front line of fire and we had to approach those people, so we had to see them die in front of us, a lot of people, yes, it traumatised me”.

The above examples confirm that police officials within the specialist units are exposed to a variety of traumatic incidents, more so than in the general population. The group member's, especially emphasised the life threatening situations associated with their work, the brutality with which they are confronted whilst performing their duties and human loss as extremely traumatic. These can be directly linked to extra-ordinary, violent and dangerous incidents within the law enforcement environment. Examples cited by the group members are the sexual abuse of children, severe rape cases, suicides and family murders, contact situations and attacks on police officials, gruesome car accidents, shootings, murders, murder scenes and the handling of corpses. These examples greatly corresponds with the summary of Pienaar and Rothmann (2005: 58) specifically referring to the high crime levels, police officials subsequent exposure to violence, crisis and dangerous life threatening situations, originating within the work situation as discussed earlier in point two. Courtois (2012:140) define this type of exposure as complex trauma and disasters that have a human cause, and more specifically “that these types of trauma can take place without warning and “out of the blue” usually perpetrated by a stranger (i.e., a robbery, a physical assault, a rape), or being an accident caused by human error or neglect. They emphasise that this type of trauma causes more severe symptoms in the victim due to its deliberate causation”.

6.1.2.2 Category 2 of sub-theme 2: Trauma originating from personal circumstances

Some of the participants differentiated between traumas as a result of the work itself and those originating from personal circumstances. They also mentioned several personal and family related factors which are experienced as traumatic. The following examples are cited:

“...My brother was in the police force and he shot himself in the head, whilst in his office. His colleagues only found him the next Monday”;

“...There was a situation where a person was killed. I was the driver of my private vehicle”;

“...I lost my wife in a motor vehicle accident;

“...My second child was born with serious brain damage”.

They referred to the death, suicide of a family member, physical injury as a result of their involvement in motor vehicle accidents, terminal illness of a family member and a mentally disabled child. These factors have been discussed separately from those traumatic incidents originating from the work itself. They may also have a negative impact on their psycho-social well-being which might have an impact on the work situation as far as productivity is concerned. McNally (2012: 341) support the above opinion and mention that law enforcement officials are exposed to trauma and stressors on a daily basis. Couple that with personal and family problems and it is a recipe for crises.

6.1.3 Sub-theme 3: Trauma enforcers

Some of the group members indicated that the traumatic incidents that they are exposed to on a daily basis are sometimes not as traumatic as the frequency, intensity, cumulative exposure and re-traumatization that are generally associated with these incidents. Although viewed as part of their work, these factors enforce their experience of trauma with specific reference to trauma related symptomatology. The following narratives are cited to illustrate the above:

“...what are giving me a lot of stress is the multiple crime scenes. You get them at the same time. You must be everywhere, and there's no back-up”;

“...at FCS it is the rapes of the small children, you think about your own children, it is very traumatic”;

“...you attend the scene, afterwards you go to the mortuary and are exposed to it again. After the mortuary, you have to compile photo albums. You are exposed to it again because now you see the photos that you took. After that, it's just inside of me. You go to court, you're exposed to it again”.

The above examples are an indication that the nature and extent of policing generally exposes police officials to a huge demand involving different kinds of scenes, repeated exposure to intense traumatic incidents as well as prolonged investigation processes resulting in re-traumatization, which increases trauma related symptoms. These factors in addition to the extra-ordinary, dangerous and stressful nature of policing, as mentioned earlier, confirm the complex nature of traumatic events and experiences within SAPS. This concurs with Courtois *et al.* (2009: 84) who are of the opinion that “complex traumatic events are repetitive, prolonged, or cumulative, most often interpersonal, involving direct involvement, exploitation or maltreatment and can occur in conditions of vulnerability associated with disempowerment, dependency and infirmity. Fiorillo and Folette (2012: 188), Leshner *et al.* (2012: 572) and Papazoglou (2012:122) added that the severity of traumatic events that the police official was exposed to constitutes risk factors. According to the authors such traumatic events are comprised of the frequency,

duration, intensity, cumulative exposure, and re-victimization of the traumatic event. It has been found to cause reactions that are more severe”.

6.1.4 Sub-theme 4: Major police stressors that aggravate the experience of trauma

Participants generally found it extremely difficult to distinguish between stress and trauma. The group members mentioned various unique and major stressors to which they are exposed to as police officials in SAPS, which have been found to be traumatic itself or affect their view and ability to cope with trauma. The following narratives are cited to illustrate the above:

“...there is a thin line between the two. Stress is causing trauma. When you can't deal with stress, there is no barrier between the two anymore”;

“...you can't handle the pressure anymore, because it's work, family, the community and the media. You have to respond positively. Everyone is expecting positive feedback from you. And you are alone, I'm going to explode”;

“...this stonewall that you are building around you and then at some stage, something small, for example the shop is not open when you want to buy bread, and you break through the wall”.

Participants believe that the continual exposure to stress result in a “snowball effect”. The convergence of multiple stressors on a daily basis builds up to such a stage that the police official lack resistance and lose control. In some cases restraint stress give rise to the fact that a less serious incident can act as a trigger, upon which police might experience sudden and unexpected severe stress reactions. Kirschman *et al.* (2014: 63) consider cumulative stress as a risk factor. According to the authors “...an official may have been able to cope with similar incidents in the past, but the accumulation of incidents makes the most recent event intolerable, like the proverbial straw that broke the camel's back”. Many of the stressors mentioned, are so intensely experienced that it results in a traumatic reaction and / or in many cases worsen the impact of trauma. Hartley *et al.* (2014: 21) and Naude and Rothmann (2003: 92) emphasises that although other professions also function within bureaucratic environments with limited say, the police official must meet unique requirements. The authors are furthermore of the opinion that the demands they are exposed to lead to a range of bio-psycho-social responses which may be threatening to their well-being. The police official might find him/herself in a position where they are not able to perform the job safely or effectively, unhappy at home, and convinced that this state of mind will never change (Kirschman *et al.*, 2014: 31; Naude & Rothmann, 2003: 92).

After the researcher classified the various stress factors as reported by the group members, it was found that these factors largely, though not specifically by name conform and fit into

Dempsey & Frost (2013: 170) synthesis of stressors. The authors distinguished between organizational stressors, specifically referring to stress caused by different factors within the organization itself, external stressors mainly caused by factors in the community, some of which they have very little to no control, operational stressors which can be associated with the execution of their work, and personal stressors which originates in their personal lives, some of which is a direct result of the work, or might have a negative impact on their productivity at work. These categories will subsequently be discussed in more detail:

6.1.4.1 Category 1 of sub-theme 4: Organizational stressors

Participants referred to causes originating from organizational stressors for example the bureaucracy of the organization, management, para-military environment, salary and fringe benefits that have a direct impact on the manner to which they are able to execute their job. The following narratives can be regarded as representative of this category of the sub-theme:

“...the police is too complex, all the administration, rules, we operate with tunnel vision, the organization is too inflexible”;

“...the management take some decisions that suits them, you can't convince them that the decisions they take is wrong and the suggestions they make is impossible, they have the rank, the power, they instruct and we must follow”;

“...you find that you have to go and obtain a statement but there are no vehicles. Or the vehicle is there, but you need the approval of the province for the itinerary”;

“...we work fourteen years as a warrant or a sergeant, without any promotion”.

Most of the group members mentioned that the bureaucracy within the organization coupled with an autocratic management style, specifically referring to inadequate management skills and style, unfair and ineffective decision-making, lack of support in response to difficult working conditions, victimization and little recognition for outstanding services rendered by the group members, are extremely challenging. The research by Pienaar and Rothmann (2006: 73) support the above findings and states that the lack of confidence in management specifically referring to a lack of supervisory and management skills and a lack of internal communication is a significant source of stress amongst members of the police. Some of the group members are of the opinion that their remuneration packages are not in line with the dangerous work they do and experience that they are not being recognised. They are extremely outspoken about promotional opportunities, and are they of the opinion that the procedures involved are inconsistent, unfair and questionable. Others are complaining about the cumbersome administrative procedures and poor equipment, which avoid them from doing their job properly.

Hartley *et al.* (2014: 21) and McNally (2012: 341) are of the opinion that the autocratic management style, irrelevant departmental policy and procedures, low morale, the deliberate decision making process of the organization, a rigid hierarch and rank structure, lack of confidence in the top management, insufficient training, limited promotional opportunities, poor salaries, insufficient logistical support, is all factors within the category of sub-themes which might be perceived as being stressful by police officials.

6.1.4.2 Category 2 of sub-theme 4: External stressors

Group members mentioned different external stressors for example, the criminal justice system, members of the community, and the image of the police, that have a direct impact on the manner to which they are able to execute their job. The following narratives can be regarded as representative of this category of the sub-theme:

“...the case is withdrawn at court, this causes stress to you as an investigating official, because you must go back to the complainant and tell them”;

“...the media is running wild about the actions of the police”;

“...the image of the police is pretty corrupt”;

“...there’s no respect for the police anymore. The politicians, they are all managers. They don’t know anything about the police”.

All the group members overwhelmingly reported the ineffective legal system, lenient and / or inappropriate sentences imposed on criminals as factors undoing their hard work. In some instances the community does not understand and blame the police officials. Some find that the unrealistic expectations of the public and the complainants regarding their work as police officials is not always fair, and creating a lot of pressure. Others are of the opinion that the media's coverage of certain sensational events only concentrate on negative aspects to portray a bad image of the police. Some are of the opinion that the police are currently managed by politicians. As a result members are uncertain about their actions, whether they are doing right or wrong. The above are all external stressors that affect them negatively. These factors are so intensely experienced that it negatively affects their experience of trauma and the extent to which they are able to deal with it. Shakespeare-Finch and Waters (cited in Oosthuizen & Koortzen 2007: 49) statements correspond with the above and classified the following factors outside the work situation: the justice system, negative public image, politics, the expectations of SAPS opposed to those of the community, media on the scene, policing within the framework of human rights. Garcia *et al.* (2004: 41) identified public criticism as an additional stressor: “What is not routinely stated to police officials, but what they learn very quickly, is that other

citizens, not infrequently, resent their intervention, and other citizens, when treated suspiciously by the police, may react with hostility, resentment, contempt, and occasionally, physical violence". When this happens, they feel aggrieved, embittered and sometimes angry. Even when they are not on duty, they experience prejudice, suspicion and alienated attitude towards others.

6.1.4.3 Category 3 of sub-theme 4: Operational stressors

Group members referred to operational stressors as a result of the execution of their job for example, exposure to horrific scenes and life threatening situations, which might have a direct impact on the manner to which they are able to do their job. The following narratives can be regarded as representative of this category of the sub-theme:

"...we are deployed, but there's no consultation or warning, it's just being done. We are just told to pack as we will be reporting in Rustenburg the next day, for how long, we don't know";

"...the Marikana incident, those people were like animals";

"...the dad reversed over his 2 year old child, he died instantly. Both the father and mother were hysterical, screaming, crying. People are crying about the relatives and we don't know how to handle it";

"...at the end of the day, I have to make a decision, but you don't know whether you are right or wrong? When you act, you are wrong? When you don't act you are still wrong. What do you do?".

Most of the group members reported that the scope of their work specifically referring to a high case load, long working hours and shifts, unexpected deployments far from home for long periods of time to be exhausting and stressful. Some experience their exposure to gruesome and horrific scenes, contact situations often associated with danger and life threatening situations as upsetting. Others find the interaction with relatives especially the confrontation with and handling of emotions as draining. Some are of the opinion that policing within the framework of human rights, and the uncertainty regarding police roles and expectations, does have a profound impact on their decision making abilities. They are afraid that decisions made by themselves might have a negative impact on the situation as well as themselves, which in return might have a negative impact on their experience of trauma. Carlan *et al.* (2008: 8), Patterson (2008: 55), and Rothmann and Jorgensen (2007: 73) concur that the dangerous working conditions, high workload, increasing responsibility for the safety of others, irregular working hours, working shifts, the fear that you might fail in your job, supervisor support, group cohesion, promotion opportunities, the opinion of the public towards SAPS and the

responsibility for decisions made under immense pressure, are all stress factors which are directly related to the work. Hartley *et al.* (2014: 21) explains that police officials are easily noticeable in the execution of their tasks and therefore a target. More important is the fact that because of their perceptibility they are consistently accountable for their actions.

6.1.4.4 Category 4 of sub-theme 4: Personal stressors

Group members mentioned different personal stressors for example the demands of the job, family and relationship problems that might have an impact on the manner in which they are able to execute their job. The following narratives can be regarded as representative of this category of the sub-theme:

“...you are under pressure and confused, you cannot distinguish between right or wrong, you are questioning yourself, can my decisions or actions be justified, what about the consequences”;

“...my work is physically and emotionally draining, when I get home I really don't have the time or the energy to listen to their problems, I feel so guilty, how is it possible to pay attention to both my work and my family, not even thinking about myself”;

“...I am the breadwinner, but I can't provide in my families basic needs, we are suffering, my income is not sufficient enough”;

“..There is a lot of conflict between me and my wife, sometimes it feels as if she don't understand me, always nagging and nagging. I am scared because when we fight I find it difficult to control myself”.

Some of the group members reported that the demands of the job, the fact that they find it difficult to have a balanced life to maintain relationships and financial problems eventually have an impact on the manner in which they are able to handle trauma. Others also believe that personal, marital and family factors may contribute to and can produce traumatic experiences and traumatic events. It comes down to the fact that the workload and everything that goes along with it does have a direct influence on police official's personal life, whilst personal circumstances in return might have an impact on the police officials ability to handle work-related trauma. Naude and Rothmann (2003: 92) confirm this with their statement that emergency workers, tend to experience high levels of stress both in their work and their family lives. The comments by Carlan and Nored (2008: 8) and Patterson (2008: 55) furthermore correspond with the prominent factors that emerged as a result of the group members different opinions. According to these authors personal stressors are related to fear, incompetency, a degree of uncertainty, inability to find a work-life balance, whereby work interferes with personal

and home life, family and relationship problems, financial pressure, life style factors for example a balanced diet, exercise as well as problems in their social lives for example, loss of friends and lower social status. McNally (2012: 342) is also of the opinion that the total living space of police officials is varied by their police roles. He states that “stress factors in the work environment can create symptomatology in individuals which put them in a downward spiral which in return might influence other areas of their lives, especially their relationships with their colleagues and family”.

6.2 Theme 2: Response to trauma

As a result of the question, “How do you normally react to trauma?” the following themes have been identified: Initial aftermath, complex traumatic stress disorders and the consequences of PTSD. The sub-themes as a result of the question are subsequently discussed in more detail:

6.2.1 Sub-theme 1: Initial aftermath

Group members reported that they experience certain physical and psychological symptoms immediately after the incident occurred. According to them, these symptoms are short term in nature and it largely corresponded with the signs and symptoms of critical incident stress. Critical incident stress is routinely used by some mental health professionals as a synonym for terms such as post-traumatic-, traumatic- and acute stress. Military and emergency services personnel prefer critical incident stress, because the term is less clinical and more applicable to their experience (Mitchell, 2012: 165). The following narratives can be regarded as representative of this sub-theme:

“...after I attended the murder scene of that innocent old lady I was not able to eat, I couldn't sleep, I was restless and I felt weak”;

“...the constant fear, when you wake up in the morning what is lying ahead of you”;

“...it was a shock, my heart trembled, I shivered and found it difficult to breath”;

“...Sometimes you feel guilty. After my colleague was shot, I continuously asked myself what I could have done to prevent it, was it my fault?”;

“...I became more protective of myself, my loved ones and my property”;

“...All these things go through your head and it stays there for a while, it's not just something that goes away after a day”.

A large percentage of the group members reported that directly after their exposure to critical incidents they developed some extraordinary stress reactions such as insomnia, flashbacks,

lack of appetite, irritability and anger, that caused so much pressure that they found it difficult to deal with. According to Anderson *et al.* (2002: 400), Friedman (2012: 13), Mitchell (2012: 165) and Schupp (2004: 4) critical incident stress refers to the emotional, cognitive, behavioural, and physiological experience of individuals who are exposed to, or who witness, events that overwhelm their coping and problem-solving abilities. Mitchell (2012: 165) also added behavioural and spiritual symptoms. According Soldatos *et al.* (2006: 248) critical incident stress reactions typically includes symptoms of “accelerated heart rate, trembling or shaking, difficulty breathing, chest pain or discomfort, nausea or abdominal discomfort, de-realization shock, anger, numbness and anxiousness, and temporary loss of speech”. Group members' reactions to their exposure to traumatic incidents differs to a large extend. Some just developed certain symptoms while others experienced a combination of symptoms. The reporting of group members largely corresponded with the categories of symptoms as explained above. The reactions / symptoms experienced are short term in nature, and is experienced quiet intense immediately following the incident, after which it gradually fades over time. Friedman’s (2012: 83) statement that critical incident stress normally results in immediate psychological reaction following exposure to a critical incident therefor corresponds with above conclusion. Gordon (2012: 9) and Shelly (2011: 7) also concur that these symptoms commonly appear to be very intense within the first 48 to 72 hours after the traumatic incident, after which it will lessen within four weeks. Most people recover rapidly after such an incident and do not require formal psychological intervention whilst others might develop long lasting conditions.

6.2.2 Sub-theme 2: Complex traumatic stress disorders

In the previous sub-theme a range of critical incident stress reactions, common to almost anyone in the initial aftermath of a traumatic event, were discussed. When the critical incident stress reactions are not processed to the point of some emotional resolution, these responses can commonly be considered to be a risk factor for the development of complex psycho-social stress reactions for example acute post-traumatic stress disorder, PTSD and comorbid disorders such as depressive disorders, substance use disorders, and anxiety disorders. The following opinions of group members are cited to illustrate the above:

“...ten, twenty cases in a year. But you keep on building up and building up. When are you going to release those emotions”;

“...you put it into files anything that is traumatic to you. You put it in your head, it’s there, but you don’t think of it, and then one day your phone rings, another complaint and you can’t take it anymore, you smash the phone”.

Most of the group members reported that as a result of the nature of their job, and more specifically the fact that traumatic experiences occur repeatedly, often escalating in severity as

they become more chronic over time, many of the symptoms experienced during the initial aftermath of an event, only appear later on in their career, or might be triggered by a minor incident. Courtois (2012: 140-141) refer to complex post-traumatic reactions and disorders as "...the array of responses and symptoms resulting from overwhelming traumatic exposure". Friedman (2012: 83) mentions that most people exposed to traumatic events never develop PTSD. Godbout and Briere (2012: 485), Lawhorne-Scott and Philpott (2013: 17, 32, 76, 93, 121 & 156), Mc Nally (2012: 341) and Sundaram and Kumaran (2012: 44), are however of the opinion that the exposure to trauma is strongly associated with psychological difficulties. In some instances police officials experience an array of stress-response syndromes, called critical incident stress or acute stress that occur after exposure to a traumatic event rather than clinically significant distress whose symptoms do not meet criteria for a more discrete disorder (American Psychiatric Association, 2013: 812). If these stress syndromes are not constructively handled, during the emotional aftermath of critical incidents, the above syndromes might develop into complex long lasting disorders for example, reactive attachment disorder, disinhibited social engagement disorder, depressive disorders, somatic symptom and related disorders substance-related and addictive disorders, PTSD, acute stress disorder, and adjustment disorders. Courtois (2012: 141), Gold and Figley (2012: 454) confirm the above with their statement that the original reactions may be evident at the time of the trauma (critical incident stress) and continue thereby becoming chronic or might even go dormant, have a delayed onset, which usually are accompanied by an event that triggers and reactivates them. Some of the group members' responses greatly corresponded with those of PTSD and the high rate of comorbidity of PTSD and have been categorized accordingly. These responses will subsequently be discussed in more detail:

6.2.2.1 Category 1 of sub-theme 2: Post traumatic stress disorder

Group members reported that they are exposed to several traumatic incidents during the course of their careers as police officials. They mention that they have always been able to deal with the post-traumatic stress reactions as a result of their exposure, until one day when they were suddenly and unexpectedly exposed to an extreme incident, which were so intense that they were suddenly no longer able to cope. The following example is cited to illustrate the above:

"...I am used to gruesome crime scenes, but one incident that totally took me off guard was that of a station commander who snapped. He took out the whole family, the boy, the two girls, his wife, and the cousin, and when we approached the house he shot himself. That scene stays with me, I woke up in sweat. Similar incidents never bothered me before".

Kirschman *et al.* (2014: 63) are of the opinion that some of the police officials will not be able to cope with the post traumatic stress they have encountered. They may have been able to cope

with similar incidents in the past, until such time that they find the most recent event intolerable. The impact of the event suddenly breaks through their ability to cope.

Other group members reported that they develop some long term responses following their involvement in traumatic incidents. They are of the opinion that the critical incident stress symptoms increased in intensity over a period of time. These reactions did according to them develop in some mental and behaviour disorders, of which they had no control, and for which they had to seek assistance in the form of long-term therapy with a psychologist. The following narrative explains group member's opinion in this regard:

"...He just grabbed this girl and dragged her on the bed, hit and raped her. When I arrived there, there was a lot of blood. That child couldn't speak. I experienced severe symptoms, it just got worse, the incident got stuck in my head, I became over protective of my children, and every time I was reminded by the incident I was so disturbed, I couldn't sleep and it was very difficult to concentrate, I even told my commander that I will not be attending similar cases. It affects your whole life".

The researcher concluded that group members experiences corresponds with the opinion of Anderson *et al.* (2002: 399) that if the critical incident stress symptoms experienced during the initial aftermath, are not addressed during the acute phase, these stress symptoms can increase in intensity, and that such members might be at risk to develop PTSD.

According to the American Psychiatric Association (2013: 265) PTSD is defined as an anxiety disorder that may develop after exposure to a terrifying event or ordeal in which severe physical harm occurred or the person was threatened. Friedman (2012: 12) explains that the first diagnostic criteria for PTSD is the actual exposure to a traumatic event in which both of the following were present: "The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others, the person's response involved intense fear, helplessness, or horror". Traumatic events that may trigger PTSD include violent personal assaults, natural or unnatural disasters, accidents, or military combat. The exposure must result from one or more of the following scenarios, in which the individual directly experiences the traumatic event, witnesses the traumatic event in person, learns that the traumatic event occurred to a close family member or close friend (with the actual or threatened death being either violent or accidental), or experiences first-hand repeated or extreme exposure to aversive details of the traumatic event. The disturbance, regardless of its trigger, causes clinically significant distress or impairment in the individual's social interactions, capacity to work or other important areas of functioning (American Psychiatric Association, 2013: 271).

As a result of above definition the researcher concluded that some of the symptoms, as reported by the group members, largely resemble that of PTSD. The researcher therefore categorized the symptoms according to the four clusters as proposed by the DSM-5 which are described as re-experiencing, avoidance, negative cognitions and mood, and arousal. Each of these clusters will be discussed more comprehensively on the basis of practical examples cited by the group members and will be supported by the theory:

- **Re-experience**

The first cluster relates to the re-experience of the traumatic event and is mostly accompanied by recurrent dreams or nightmares, flashbacks and psychological distress during exposure to events that symbolize the traumatic event. The following narratives can be regarded as representative of the above cluster:

“...I was dreaming and I was talking in my sleep, my wife said I was talking to complainants, I was speaking English, I was speaking to a cop or a person I saw”;

“...it often happens when I watch TV, a scene will remind me of one of the cases I attended, my throat will close and I start choking, shivering and sometimes become hysterical, I totally lose control”.

Some group members reported repeated disturbing dreams and nightmares, a constant re-experience and flash backs or reliving the incident in their mind of which they have little control. Others reported symptoms of anxiety when confronted with a situation which reminded them of the traumatic incident for example a discussion, place, something they see or smell. According to the DSM-5 and Godbout and Briere (2012: 485) a traumatic event is persistently re-experienced in the following way(s): recurrent, involuntary, and intrusive memories, traumatic nightmares, dissociative reactions (e.g., flashbacks), intense or prolonged distress after exposure to traumatic reminders and marked physiologic reactivity after exposure to trauma related stimuli.

- **Avoidance of stimuli**

The second cluster relates to the avoidance of stimuli associated with trauma. Symptoms include avoidance of thoughts, feelings or places reminding the victim of the incident, and the withdrawal from others. The following narratives can be regarded as representative of the above cluster:

“...I don't think that I will ever be able to drive down that road without having this fear, this constant reminder that I almost lost my life here”;

“...like my colleague would say, hey, did you watch the news, I don’t want to, it brings all those memories back”.

Group members mentioned different symptoms which can be associated with the avoidance of stimuli. Some of the group members reported that they deliberately avoid thoughts and feelings associated with the incident. Others reported that they avoid places, conversations or situations as this reminds them of the detail of the incident which according to them is too painful. Some also mentioned that they withdraw themselves from friends and family members because they are afraid they might be asked about the incident, which will remind them of the event. According to the DSM-5 (American Psychiatric Association, 2013: 265), the second category is concerned with the persistent effortful avoidance of distressing trauma-related stimuli after the event. The group member’s responses greatly correspond with Godbout and Briere (2012: 485) statement that the avoidance of stimuli can be associated with trauma-related thoughts or feelings but also external reminders for example people, places, conversations, activities, objects or situations.

- **Negative alterations in cognitions and mood**

The third cluster refers to negative alterations in cognitions and mood that began or worsened after the traumatic event. Symptoms amongst other include fear, anger and guilt. The following narratives can be regarded as representative of the above cluster:

“...I became over protective with our children because of the work we do, I am suspicious and don’t trust anyone, I am like an animal”;

“...my colleague is dead, you cannot undo what happened. What’s done is done. You are angry with yourself and everybody around you”;

“...sometimes you feel you didn’t do well, I could have prevented the accident if I only shifted to the left, I feel so guilty, how can I be able to forgive myself”;

“...I find it difficult to remember the details of the shooting, I think I blocked it out of my mind”.

Some of the group members feel that the world is a dangerous place. They became overprotective of their family, and find it difficult to trust others as they are perceived to be bad. Group members reported emotions of anger and fear. The one member reported that he is constantly blaming himself for the death of a colleague. He feels guilty as according to him, he could have prevented it from happening. The DSM-5 (American Psychiatric Association, 2013: 265) refers to the above symptoms as negative alterations in cognitions and mood. Group member’s opinions in this regard correspond with Godbout and Briere (2012: 485) description of

the symptoms as persistent negative trauma-related emotions for example fear, horror, anger, guilt or shame and the inability to recall key features of the traumatic event. The authors also added persistent negative beliefs and expectations about oneself or the world, persistent distorted blame of self or others for causing the traumatic event or for resulting consequences, markedly diminished interest in significant activities, feeling alienated from others and a constricted affect: persistent ability to experience positive emotions.

- **Alterations in arousal and reactivity**

The fourth cluster refers to trauma-related alterations in arousal and reactivity that began or worsened after the traumatic event. Symptoms include amongst others sleep disturbance, hyper vigilance, irritable or aggressive behaviour and startle response. The following narratives can be regarded as representative of the above cluster:

“...it is not easy to sleep, I battle to fall asleep because my brain is active the whole time, I will wake up at two o'clock at night, I won't sleep again”;

“...at work, home or in town even when we are on holiday, I am always on the lookout for danger, I don't trust anyone”;

“...sometimes I get moody, one morning my phone rang, and I was very, very tired. I went out at twelve o'clock at night. I was asleep. Not even. I just went to bed and the phone rang. I was irritated, shouted and smashed the phone”;

“Now, every time I hear a bang, the door closed, or anything, I get a huge fright and it just takes me back to what happened”.

Some of the group members reported that they find it difficult to fall or stay asleep. Others mention that they become easily irritated even with minor issues and that they are not always in a position to control their temper. Some of the group members are always on the lookout for danger. When they find themselves in the community they are alert and ready for any kind of attack. This kind of behaviour makes family and friends feel uncomfortable. The one group member mentioned that he is startled easily even if someone behind him is unexpectedly talking loudly, or when a door is shut by the wind. The DSM-5 refers to the above symptoms as trauma-related alterations in arousal and reactivity. The symptoms mentioned by the group members greatly corresponds with the symptoms referred to by Godbout and Briere (2012: 485) namely irritable or aggressive behaviour, self-destructive or reckless behaviour, hypervigilance, exaggerated startle response, problems in concentration and sleep disturbance. The symptoms reported by group members greatly correspond with those of the author.

6.2.2.2 Category 2 of sub-theme 2: Comorbidity

Some of the group members reported symptoms that differ from the diagnostic criteria for PTSD. According to Figley (2012: 451) comorbidity means a clustering of symptoms that suggest both primary and secondary disorders. PTSD comorbidity includes co-occurring mental disorders such as depression, anxiety, and others such as phobias. Although the group members did not specifically refer to these outcomes as disorders by name the researcher categorized the symptoms accordingly. The following examples are cited to illustrate the above:

“...I find it difficult to get out of bed, because I do not have the energy to face the day, I feel down and it is difficult for me to see the bright side of life, my life just don't have meaning anymore, over weekends I stay in bed, I only wake up on Monday morning”;

“...I am walking around, always busy with something, but with no goal”;

“...I'm always on the lookout, alert and ready for anything that might happen, my shoulders is tense, I am so nervous my tummy is tied like a knot I don't trust other people, always, always tense”.

Some of the group members reported that they are constantly feeling worthless, negative and morbid. They find it difficult to get out of bed, do not have the strength to face the world, feel totally overwhelmed and are questioning the meaning of life. Others reported feelings of fear accompanied by jitteriness and tension, they are constantly on the lookout for danger, and always concerned and worried about situations that directly or indirectly affect them. Some mention physical reactions for example muscle tension. As a result of the above the researcher is of the opinion that a police official as victim of trauma may suffer from comorbid psychiatric disorders in addition to PTSD, or the trauma may result in a disorder that is different from PTSD. There is growing evidence that PTSD may not be the only clinically significant consequence of exposure to a catastrophic event. According to Friedman (2012: 21-22) other types of posttraumatic outcomes as discussed should also receive clinician/researcher attention. Furthermore, some people exposed to traumatic stress never exhibit PTSD. Instead they may develop depression, panic, anxiety, or some other DSM-5 disorder. The symptoms reported by group members greatly corresponds with those of Friedman (2012: 22), Lawhorne-Scott and Philpott (2013: 76 & 93) and Schupp (2004: 26) who respectively describes depression as an episode with all of the classic symptoms of anhedonia, sleep disturbances, lethargy, feelings of worthlessness, despondency, morbid thoughts, and, on occasion, suicide attempts, and anxiety disorder as the presence of unrealistic worry, muscle tension, restlessness, dry mouth, frequent urination, and a lump in the throat.

6.2.3 Sub-theme 3: Secondary consequences of complex trauma

Group members reported different risk factors which have been identified by the researcher as a direct result of complex trauma, which might have a negative impact on their overall psychosocial well-being. These factors refer to alcohol abuse, anger, aggression and violence, suicide ideation, family and relationship problems, somatic complaints, and work-related problems. The risk factors mentioned by the group members have been categorized accordingly. Each of these factors will subsequently be discussed:

6.2.3.1 Category 1 of sub-theme 3: Alcohol abuse

Police officials are repeatedly exposed to extreme traumatic experiences and some use and abuse alcohol as a way of coping with traumatic stress. The following examples are cited to illustrate the above:

“...we will buy a few cases of beer and brandy, make a braai, and drink our sorrows away”;

“...I think about it and I have to go and drink again. Maybe a full week, if I could drink non-stop. Then I'll be okay”;

“...the next morning I will be late for work, I find it difficult to concentrate”.

The feedback received from some of the group members is that alcohol abuse is apparent with the culture of SAPS. It is viewed to deal or to cope with or to numb them from the traumatic stress that they are exposed too. This is a clear indication of the co-occurrence between PTSD and alcohol abuse. Group members mention that they use alcohol when socializing with friends, after operations, or even on their own. Some of them are drinking excessively, taking the substance in larger amounts over longer periods for example the whole weekend, to such an extent that they fail to fulfil their major role obligations at work and at home. Kirschman *et al.* (2014: 134) and Kruse *et al.* (2011: 218) support the above and are of the opinion that there is a high rate of co-occurrence between PTSD and alcohol abuse within military populations. From the information received it is apparent that they drink huge amounts of alcohol over a long period of time to forget or suppress their feelings and emotions. In some instances this does have a negative impact on their productivity at work and can it be experienced as a risk factor. The researcher concluded that alcohol abuse is part of the SAPS culture, and especially in the specialist units police officials are routinely engaging in social activities after work during which alcohol are consumed. Kirschman *et al.* (2014: 132) confirm the ritual of cops drinking together after work. Drinking is acceptable, and sometimes encouraged, in the law enforcement culture. Kruse *et al.* (2011: 221) define substance abuse as a “maladaptive pattern of substance use, leading to clinically significant impairment or distress”. The above reactions from the group

members correspond with Kruse *et al.* (2011: 221) diagnosis of substance abuse. According to the authors substance abuse is determined by the presence of at least one of the following symptoms: recurrent substance use resulting in a failure to fulfil major role obligations at work, or home, recurrent substance use in situations in which it is physically hazardous, recurrent substance-related legal problems, and continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.

6.2.3.2 Category 2 of sub-theme 3: Suicide ideation

There might be more than one reason why police officials consider suicide. In most instances it appears to be a combination of reasons. Post-traumatic stress, in combination with other factors, for example financial and relationship problems, are the main reason for considering suicide. The following examples are cited to illustrate the above:

“...during the cross fire I shot a guy, afterwards I did not receive any support from management, instead they opened a case of murder against me, Yes, I took a life but it was not on purpose, I defended myself, but still I feel so guilty and now I am alone, even my colleagues suddenly treat me differently, I wanted to end my life”;

“...the flashbacks again and again, I am down and irritated, but still have to do my job, all the stress, my commander is instructing me, the complainant wants feedback, my work is piling up, the court is accusing me of poor investigation, and then you still have you're problems at home, it builds up you know, I took my service pistol, but I just thought about my children”;

“...our monthly salary is not enough, my wife do not understand, all the debt, as I am sitting here, my phone can ring at any moment, it will be the bank, my monthly instalment on my car is still outstanding. I would lie if I'd say I haven't considered suicide”.

Some of the group members did have suicidal thoughts and even considered committing suicide at some point during their careers; however none of them attempted suicide. They mentioned several reasons and in most instances a combination of factors for thinking about or considering actual suicide for example trauma and post-traumatic stress factors, depression, financial pressure and relationship problems. Panagioti (2011: 31) confirms the above conclusion with her statement that post-traumatic stress disorder has been widely associated with suicidal behaviour. Research indicates that suicidal ideation corresponds to subsequent self-harm behaviours, including planned and unplanned suicide attempts. Furthermore PTSD is a strong predictor of those individuals who move beyond suicidal ideation to suicide attempts. The research by Kirschman *et al.* (2014: 146) furthermore confirms the most common identifiable reasons for suicide amongst police officials as relationship problems, psychological

problems, and work-related stress. Jakupcak *et al.* (2009: 303-306) found that veterans who screened positive for PTSD were four times as likely to experience suicide ideation. Aamodt and Stalnaker (2006: 1) after reviewing 50 published studies since 1950, arrived at a police suicide rate of about 18/100 000, which is considerably higher than that of the general population. Despite several attempts, the researcher was not able to obtain the suicide rate amongst police officials in the North West Province. The SAPS Annual report 2012/2013 is vague with no statistical data. Violanti (2014: 116) is of the opinion that research on police suicide is hard to do, there are problems gathering data, a general lack of reliable empirical evidence, and problems with agencies covering up suicides.

6.2.3.3 Category 3 of sub-theme 3: Anger, aggression and violence

As a result of the cumulative exposure to trauma and stress police officials, from time to time, do experience unregulated and dysregulated extremes of emotions. These emotions, depending on the intensity of the situation, vary from irritability, anger in extreme cases aggression and violence. This type of behaviour is commonly directed towards suspects and family members. The following examples are cited to illustrate the above comments:

“...sometimes I get irritated at work I will shout and swear at the suspects, I will grab and shake them, I get so frustrated I want to hit them”;

“...There is a lot of violence in my house, If I walk off duty at four I think that, “Hey. Now I’m going back to my wife again. She still does not understand. We will fight and I will grab her”;

“...sometimes I will shout and swear, I will slam the door and walk over everything in my way, I’ll get into my car driving at high speed”;

“...even the kids, they’re doing this or doing that, I become angry and is hitting the kids. Maybe I might kill them or all that stuff”.

Some of the group members reported that they become so frustrated with the cumulative and violent nature of crime, that they lose their temper, become angry, irritated and aggressive towards suspects. Others reported that a lot of the aggression and violence is directed towards the family at home. Above examples greatly corresponds with the explanation of anger by Lawhorne-Scott and Philpott (2013:81) which according to them can sometimes turn into violence or physical abuse. It can also result in emotional and/or verbal abuse that can damage relationships. Abuse can take the form of threats, swearing, criticism, throwing things, conflict, pushing, grabbing and hitting. Empirical research demonstrates that a current diagnosis of PTSD is significantly associated with elevated anger and aggression in military personnel. Difficulty managing anger is not only associated with violent behaviour but is also linked to

increased stress, low self-esteem, and family and relationship conflict (Elbogen *et al.*, 2011: 305). According to Friedman (2012: 11) anger itself is a PTSD hyperarousal symptom and can therefore be categorized as a consequence of PTSD. Recent research suggests that effect sizes between PTSD and anger are even larger among samples of military personnel compared with samples of civilians who had experienced other types of traumatic events. In South Africa aggression amongst police officials appear to be on the increase and are now a significant problem. The link between PTSD and anger/aggression may be due to the association of PTSD with other factors, such as depression, lack of communication, alcohol or drug abuse and dependence, poor marital adjustment, exposure to high levels of atrocities, and heightened anger reactivity. Certain PTSD symptoms are stronger predictors of violent behaviour than others. PTSD symptoms associated with hyperarousal have specifically been related to increased aggression in several studies (Elbogen *et al.*, 2011: 307).

6.2.3.4 Category 4 of sub-theme 3: Family and relationship problems

The police family is unique in the sense that a police official's work does have a direct impact on family life. Family members do not always understand police work and the stress and trauma associated with it. They also lack the knowledge and skills to support their spouses. Because of this the police official and his/her spouse might feel alone and neglected. This creates tension and misunderstanding which might result in relationship problems. The following examples are cited to illustrate the above:

"...sometimes when there are problems at work you tend to take that home and you don't realize the impact, it boils over to our families";

"...You're starting to take out the stress on your kids, you will do as I instruct you!, but they are not part of the police";

"...sometimes I am called out more than twice a week, my husband was accusing me of an affair";

"...when we are deployed my family is left behind for weeks, battling on their own, there is no one to support them".

Group members are of the opinion that their roles as police officials cannot be separated and does have an impact on their families. Some of the members feel that their spouses do not understand their work as well as the trauma and stress associated with their work. Some are of the opinion that the impact of their work and the spill over to their family might cause divorce. One member mention that he treats his children like police officials and expects them to be disciplined at all times. Others are worried about the fact that as a result of their working hours,

over time and deployment, they are not always available to support their families. Franklin (2013:323) and Kirschman (2014: 171) support the researcher's opinion and state that what happens at work spills over to a police official's spouse and children. The opposite is also true. The support of a positive, meaningful relationship is key to balance work stress and maintain a sense of well-being on the job. Police families seem to differ from civilian families in significant ways. It would be a mistake not to acknowledge and understand the police sub culture and how it influences family life. Green (cited in Kirschman 2014: 174) identified the following risk factors within the family: limited knowledge of police work, conflict between job and family priorities, conflict between job roles and family roles and isolation, which greatly corresponds with the examples cited above.

6.2.3.5 Category 5 of sub-theme 3: Psycho-somatic complaints

Police work, specifically referring to the frequency and intensity associated with trauma and stress for example gruesome scenes, the investigation processes, excessive working hours and work load, put a lot of strain on the body. It also seems that physical health problems might be associated with the response of the body after being traumatised. The following examples are cited:

“ “back pain, stomach ulcers, chest pain”;

“...I was having a headache every time when I got back home. My shoulders are tense”;

“...Yes, basically it's a response of the human body, after being traumatised. The muscles and the mind relapses, can't take the situation of stress. Sometimes you feel sick, you cannot function mentally or physically well”.

Group members commonly reported different health problems. The majority of the group members associate physical health problems with the demand of the job and are of the opinion that their bodies cannot keep up to the demand. Some refer to physical illness for example back and chest pain whilst others complain about muscle tension. Brosbe and Hoefling (2012: 643) confirm this conclusion with their statement that the mind and body appear to be more related than previously thought. What affects the mind and psychological health will often have a significant impact on the body and physical health, and vice versa. The authors refer to somatic complaints which are defined as symptoms that are experienced as physical sensations in the body. Examples include pain, headaches, muscle tension, gastrointestinal discomfort, heart palpitations, or fatigue. Kirschman (2014: 158) asserts that the psychological stresses police officials experience at work put them at significantly higher risk than the general population for long-term physical and mental health problems.

6.2.3.6 Category 6 of sub-theme 3: Work related problems

The cumulative and intense nature of trauma and stress in the police as well as the negative impact of the subsequent stress related problems does have a negative impact on police officials' morale. As a result there is a lack of motivation, energy and commitment. Their productivity is poor and they are intentionally looking for an escape route. Police officials are increasingly booking off sick, seeking early retirement or in extreme cases considering resignation. They are also concerned about the processes involved with the application for ill-health retirement and therefore worried about their own position. The following examples are cited to illustrate group member's responses:

"...you don't know how to cope anymore, and then, "I don't want to go to work." I book off sick, even if I'm not sick. I don't want to see the work, I don't want to see my commander, I don't want to view the work anymore. I need to rest";

"...I am aware of members with severe PTSD and depression. They applied for ill-health retirement, but it was not approved. They are a walking time bomb, what if this should happen to me";

"...I will apply for early retirement at the age of 55, I can't continue like this";

Some of the group members reported that as a result of the cumulative and intense trauma and stress and the subsequent stress related symptoms they become demoralized. Others mention that they book off sick for no apparent reason and even referred to a new culture of "sick leave planning". One member was concerned about members applying for ill-health retirement, which were not approved, while others considered resignation. Pienaar and Rothmann (2005: 58) concur with the above conclusion and indicate that the high number of members booking off sick due to acute stress, depression, post-traumatic stress disorder and other stress-related problems as well as the number of members retiring due to medical disability is an indication of the harmful effect of the police environment on the police official. The research by Anshel (2000: 379) and Watson *et al.* (2012: 183) added that the police officials' behaviour gives rise to a very high employee turnover, absenteeism, sick leave due to stress, death and ill-health retirement. Agolla (2009: 64) and Anderson *et al.* (2002: 399) also added poor job performance, low morale, disorientation, disorganization, tardiness, early retirement or resignation. It is therefore critically important that police officials are being able to understand their emotions, as well as being able to regulate them by adapting effective coping mechanisms in order for them to cope with their unique circumstances.

6.3 Theme 3: Coping

The following themes have been identified as a result of the question “how do you normally cope with the impact of trauma”, namely resilience and a clear differentiation between action-orientated coping and avoidance coping as mechanisms for adapting after exposure to trauma and stress. Each of the themes will subsequently be discussed in more detail:

6.3.1 Sub-theme 1: Resilience

Dealing with change or loss is an inevitable part of life. As a result of police work, every police official will at some point, experience varying degrees of challenges. Some of these challenges might be relatively minor, while others are extra-ordinary on a much larger scale. The manner in which police officials deal with these problems can play a major role in not only the outcome, but also the long-term psychological consequences. Many of those who undergo a traumatic experience do not develop PTSD or other psychological problems, or else more easily recover once developing such problems. Resilience factors such as biological factors, early childhood experience, current skills, demographic factors, genetics and biological factors, current attitudes and behaviours, coping styles and social support appear to protect some individuals from many of the harmful outcomes and may encourage healthy post-traumatic growth and development (Spira & Drury, 2012: 557-559). The following examples are cited to explain the above statement:

“...for me, crime scenes are not very stressful. I actually find it interesting. When I see bodies, evidence and stuff, I just want to know more. This is interesting. What happened? How? I'm asking myself questions. I never stress. Maybe it is because of the person I am”;

“...afterwards we will joke about the incident, we don't mean to be disrespectful, but humour is really helping us to cope”;

“...I had so much aggression inside of me, it was difficult to control myself, I wanted the perpetrator to feel the pain and suffering he caused to the victim”;

“...after the exposure to a gruesome crime scene, I was never the same again, I am off balance and I struggle to get on my feet again”.

Some of the group members reported good adaptive behaviour and even indicated that they are able to thrive within the circumstances. Others, however, are of the opinion that they find it difficult to find a balance, and that they are not able to bounce back after exposure to extreme traumatic and stressful events. As a result they find it difficult to cope. They mentioned different factors for example, previous exposure to trauma, their unique personality, the ability to bounce back, the nature and extend of the event which determines the manner to which police officials

are able to cope with the exposure. The findings concur with Bonanno *et al.* (2012: 195) who are of the opinion that whether a person displays one trajectory or another depends on many different factors for example personality, coping style, social support, additional life stressors as well as the degree of exposure and severity.

The researcher also concluded that group members are responding differently after exposure to trauma and stress. Some of the group members are able to adapt positively after exposure by adopting constructive coping mechanisms. Others experience thoughts, emotions and behaviours that produce a negative outcome as they engage in maladaptive coping mechanisms during the aftermath of a traumatic event. Ginzburg's (2012: 547) definition of resilience is in accordance with above conclusions as the author state that "resilience is the ability to adapt physiologically and psychologically to environmental change". It is described as a survival skill. It is often manifested as the difference between individuals' conceptualizing themselves as survivors versus victims, those individuals who can take care of themselves versus those who become unable to care for themselves when subjected to significant stressors. Ginzburg (2012: 547) also refers to good and bad defence mechanisms: He mentions that the good defence mechanisms lead to resilience, and the bad defence mechanisms lead to dysfunctional psychopathology. The author identifies and defines good defences for example, altruism, anticipation, asceticism, humour, sublimation and suppression. He also identifies and defines six bad defences for example projection, dissociation, fantasy, passive-aggressive behaviours, acting out, and hypochondriasis. The cluster that predominates generally reflects good versus bad survival skills and an ability to move forward despite the crisis versus an individual becoming an emotional and physical burden on those around him or her, including the social support system and the health and mental health care system.

6.3.2 Sub-theme 2: Avoidance coping

Police officials are sometimes deliberately applying avoidance coping mechanisms as a way of escaping from the psychological impact after exposure to trauma. These feelings and emotions are experienced to be painful and by denying or suppressing the symptoms can be seen as an effort to protect them from any psychological harm. They are also afraid that if they disclose their underlying emotional problems, they might be labelled as weak, or that their future career prospects might be jeopardized. The following examples are cited to illustrate the above:

"...during the day try to keep yourself busy with other things, it helps me to forget";

"...when I've got a problem I keep the emotions to myself", you never show somebody what you're truly feeling, it is safer, because in the police culture my commander and my colleagues might think I am mad, you can't trust anybody not EHW nor management";

“...one tear dropped, but rolled down. I dropped my guard for that moment. And I said, “Just stop, quickly.” And I stood up and went out, had a smoke, and came back, just to get my guard back again”;

“...the thing that I’m doing now is forcing myself to forget about it, almost like it never happened, maybe one day I will cope”.

Group members randomly reported the following avoidance coping mechanisms to escape underlying emotions as a result of their exposure to trauma and stress: avoiding reminders, joking, internalizing symptoms, social and emotional withdrawal and denial. Some of them reported that the unique police culture does not allow police officials to show emotions. Others prefer not to talk about it or seek assistance as confidentiality is not always maintained. Most of the group members mentioned that confidentiality is not maintained. As a result they rather keep quiet and suppress their emotions as they do not want to be exposed or labelled. Anshel (2000: 389), Kirschman *et al.* (2014: 16) and Ortega *et al.* (2007: 38) are of the opinion that “avoidance strategies allow officials to evade underlying problems, or turning away from the stressful source, and are used in an attempt to reduce the emotional strain experienced”. This statement supports the researcher’s opinion in this regard. Although the literature on coping strategies among police officials is limited, there is evidence to suggest that police officials utilize avoidance strategies for immediate stress reduction. Because thinking about the trauma and feeling as if you are in danger is upsetting, police officials who have been through traumas often try to avoid reminders of the trauma. Sometimes survivors are aware that they are avoiding reminders, but other times survivors do not realize that their behaviour is motivated by the need to avoid reminders of the trauma. According to Blais and Renshaw (2013: 77) and Kirschman *et al.* (2014: 23) studies show that police officials reporting symptoms of post-traumatic stress, depression or anxiety report concerns that they will be treated and thought of more negatively, be rejected, seen as untrustworthy, and worst of all weak, if they seek help. Some police officials worry about confidentiality and possible threats to their job security (Becker *et al.*, 2009: 246). According to Courtois and Ford (2013: 25) those police officials internalise or hide the symptoms and do not manifest any observable signs of dysfunction. Fact is, once a police official actually comes face to face with job-related violence, it becomes much more difficult to maintain such denial.

6.3.3 Sub-theme 3: Action-oriented coping

Group members reported the following action-oriented coping mechanisms to manage the demands created by traumatic and stressful events: participating in pro-active programs, seeking support from family, peers, EHW, external professionals, relaxation and religion. The following examples are cited to illustrate the above:

“...afterwards I attended a debriefing session, it gave me perspective, I was able to understand my emotions, that is was normal to react like that”;

“...I’m always going home, talking about these things to my wife, my children, they are my friends. Even, our relatives, but others, they are not this fortunate”;

“...I take the mountain bike and I go for a fifty, forty kilometre ride, and you feel better when you get back”;

“...My first scene was a girl that was raped, then you ask the Lord to help you”.

Some of the group members are much more aware and realistic about the consequences of trauma and stress. As a result they take positive action to manage possible harmful effects. They strongly rely on the support of their family and peers, but also do not hesitate to consult EHW or external professionals for counselling and support. They also attend the trauma intervention programs and acknowledged the psycho educational value. Some of the group members actively participate in sport, some enjoy music or engage in some kind of activity or hobby as part of relaxation to find a balance and to maintain psycho-social well-being. Most of the group members strongly rely on their religion. They read the word, go to church, listen to gospel music and pray to their God for protection. The definition of action-orientated coping by Taylor and Stanton (2007: 377) as intra-psychic efforts to manage the demands created by stressful events strongly corresponds with the conclusions made by the researcher. These efforts are recognised both for its significant impact on stress-related mental and physical health outcomes and for its intervention potential. Carlan and Nored (2008: 9) and Louw and Viviers (2010: 3) add that action-oriented coping strategies are used to confront the problem and to control the situation or improve one’s resources in the hope of reducing the imbalance. Examples of action-oriented strategies are the participation in pro-active programs in order to be educated with regard to possible reactions, symptoms and behaviours, attend critical incident stress debriefing as a precautionary measure or seek psychotherapy directly after exposure to a traumatic event, seeking support from peers, or important others for example family members. Taylor and Stanton (2007: 381) propose that the association between stress and health is greater among individuals who perceive low levels of social support compared to those who perceive high levels of social support.

6.4 Theme 4: Trauma intervention programs

While dealing with the question “what is your experience of trauma intervention programs” the researcher referred to different trauma intervention programs presented internally by EHW in SAPS. The programs referred too are as follows: critical incident stress debriefing, stress management, suicide prevention and psycho-therapy. Following the analysis of the responses

of the group members, the following themes emerged, namely: awareness and participation, content, time and duration associated with the presentation, venue, style of presentation, effectiveness, marketing, management's attitude towards trauma intervention programs, poor support, lack of confidentiality, the fact that police officials' specific needs are not always addressed as well as the role the police culture play. After studying the literature on the use of programs, it was found that the themes that emerged from the responses of participants can appropriately be categorized according to some basic concepts and guidelines of a marketing approach to the support and utilisation of programs proposed by Kotler and Armstrong (2014: 28-29). This includes the concepts of consumer satisfaction, consumer orientation and a core marketing strategy. Each of these concepts will be discussed in detail.

6.4.1 Sub-theme 1: Awareness and participation

Group members do not know the programs by name, but recognised it after the researcher gave an explanation. The researcher are therefore of the opinion that group members are mostly aware of the programs but do not always participate because they don't know what to expect or how they can benefit from it. The following examples have been cited to illustrate the above:

"...I participated in the stress management and suicide prevention programs, I was invited to a debriefing after the shooting but I did not attend, can I trust them?";

"...not only if not every time there is a traumatic incident EHW comes here to help us or to debrief us, we don't attend because it is not going to change anything";

"...I am aware of the programs presented by EHW, but we don't give ourselves time to visit EHW after the situation. Every time we are reaching out, it's a lot of work";

"...no I am not aware of the trauma prevention programs that are presented by EHW, never heard of that before".

Some of the group members indicated that they have already attended one or more of the mentioned trauma intervention programs. No one has attended all the programs. The largest percentage of group members has never participated to any of these programs before. Some of the members did have some knowledge of the programs, although they have not participated, while a smaller percentage of group members indicated that they do not have any knowledge of these programs and never heard of them before. The last mentioned might also be as a result of a poor marketing strategy. Kotler and Armstrong (2014: 48) recognise that marketing is just as important in the field of non-profit organizations. Zinkhan and Williams (2007: 285) suggested the following definition of marketing: "...marketing is an organizational function and a set of processes for creating, communicating, and delivering value to customers and for

managing customer relationships in ways that benefit the organization and its stakeholders”. Confidentiality is a huge concern and group members do not know whether they can trust the program facilitators. A few members indicated the intention to participate but blame the work load and a lack of personal motivation for not attending. Kirschman *et al.* (2014: 5 & 6) are of the opinion that cops are not eager clients. “It takes a lot for them so seek help and very little to turn them off”. He furthermore states that law enforcement officials hold distorted attitudes about mental health professionals. They are often referred to as “shrinks” who asks weird questions which cops have to answer when they experience emotional problems. A further aspect of interest is the effective marketing of programs. The perceptions mentioned above coupled with the importance of marketing represent conveyable hazards and might be perceived as possible reasons for why group members do not always attend trauma intervention programs.

6.4.2 Sub-theme 2: Consumer orientation

A lack of a thorough needs assessment and the fact that members are not consulted regarding their unique needs within the various units, may lead to programs offered that do not relate to police officials' specific needs/wants at that time. The fact that EHW does not function at unit level leads to distrust by group members hence there is a lack of open communication regarding their expectations and preferences, and they are of the opinion that EHW does not understand their unique demands. As a result their needs, wants and demands are not fulfilled. The following examples are cited to illustrate the above:

“...EHW do not have a clue of what we are doing on ground level, they should attend operations and crime scenes, experience our frustrations. Only then they would be able to assess our unique needs and to come up with a relevant plan of action”;

“...the fact that we as a unit are exposed to so many traumatic incidents, mandate intervention programs on a monthly or quarterly basis, in the form of group sessions, including the whole unit and the duty officials. There should however be regular follow-up sessions, just like we are doing now”;

“...EHW should not only focus on trauma, what you see, a person killed, or an accident. They also have to concentrate on other problems caused by trauma, for example relationship-, alcohol- and financial problems, all of those”;

“...most of us, don't know how our bodies are operating and I think it's very important that you learn. How your spirit, body, and soul, the three dimensions is working together. If they can educate us, for example when we join the police or even during these sessions, so that we can learn how things are working, stress, all this stuff, it can help us”.

Group members expressed a variety of needs related to consumer orientation. Some group members agreed that they are not consulted with regard to prospective trauma intervention programs in advance. The group members have lashed out strongly about the fact that EHW does not work with them at unit level. Consequently, EHW according to the group members does not understand police officials' working conditions. They therefore believe that EHW does not concentrate on the unique working area and problems when deciding on programs, but decide themselves which programs would be beneficial. They believe that a thorough needs assessment should be conducted by EHW, during which members on ground level must be consulted regarding their unique working conditions and specific needs. Kotler and Armstrong (2014: 28) concur with above conclusion: "...customer orientation is based on customer needs, wants, and demands. Solomon (2011: 35) and Zeithaml *et al.* (2009: 27) add to the above and are of the opinion that all strategies should be developed with an eye on the customer and that the marketer should incorporate knowledge about consumers into every facet of a successful program. Napoli (2006: 675) suggests that programs with a higher level of brand orientation are better able to influence others in adopting a brand into practice.

In addition group members expressed a need for regular trauma intervention programs such as every month or quarter at unit level. They believe that the whole unit as a group should be involved in this process and that this type of intervention must be accompanied with regular follow-up sessions. Some group members also believe that EHW should not only focus on trauma and stress, but also on those factors associated with and related to the effects of trauma, such as substance abuse, family and relationship problems, suicide ideation, anger and aggression, physical health problems, place and role within the community as well as work-related problems. Kotler and Armstrong (2014: 30) confirm this statement as they believe that programs with a systemic focus can be assured of a positive impact.

Most of the group members are ignorant and uninformed regarding trauma and its consequences and there is a great need for psycho-education in order to prepare for possible reactions and how to handle it. Wessely *et al.* (2008: 287-302) agree that psycho-education is important as it offers information on the nature and course of post-traumatic stress reactions, affirms that they are understandable and expectable, identifies and helps with ways to cope with trauma reminders, and discusses ways to manage stress.

6.4.3 Sub-theme 3: Consumer satisfaction

Group members opinions refer to the general perception that the program needs are met or not. The researcher concluded that group members are generally not satisfied with the programs because their specific needs, wants and demands are not considered. The following examples are cited in order to illustrate the above factors:

“...surely they must ask us to give inputs and work out a program for a certain section in the police, a specialised unit. They are all different”;

“...if EHW come with a group program, it is fine. But with the questionnaire on how we experienced the program, we should also be able to make suggestions; these should be taken into consideration, so that they can know what the member’s specific needs are”;

“...we would prefer feedback on our evaluation, it’s thrown in the dustbin”;

“...my suggestion would be to give the police official’s time so it can sink in. Maybe, after a month or two, you can question them again, if you evaluate a program, you’re going to evaluate what you’ve learned, did it make any difference in your life”.

A small percentage of group members were generally satisfied with the programs, others gave their dissatisfaction with reference to various factors such as the fact that their needs and inputs are not requested or considered and the impact of programs are not measured. Kotler and Armstrong (2006: 35) and Zeithaml *et al.* (2009: 104) define customer satisfaction as the extent to which a product’s perceived performance matches a buyer’s fulfilment response. Rahman *et al.* (2013: 28) added that a satisfied customer will repeat the purchase of the product and convey positive messages about it to others. These opinions are used as a rationale for the limits of this theme.

One of the most common reasons why the group members who have participated in trauma intervention programs are unhappy is because their specific needs and expectations are not taken into account. This discussion point is therefore closely related to the explanation of consumer orientation and the literature as discussed in the previous paragraph. Lovelock and Wirtz (2007: 245) added that consumer participation is important to ensure satisfaction. According to the authors it refers to the actions and resources supplied by customers during service production and/or delivery, including mental, physical and emotional inputs. Another factor of concern is that it is the police official’s perception that programs are not always constructively evaluated after presentation. Group members believe that their inputs are not required. In some cases, the programs are evaluated through questionnaires at the end of the programs, but group members never receive feedback in this regard. They are not convinced that their inputs are considered or integrated as part of program evaluation.

Some group members also indicated the need that the impact of programs should be measured over a period of time in order to determine their effectiveness. They are concerned with the outcome of the programs, specifically referring to problem solving, the benefits to them as the consumer, and the manner to which it is measured. Bamrara *et al.* (2012: 4), Kotler and Armstrong (2014: 29), Parasuraman *et al.* (1988: 5) and Zeithaml *et al.* (2009: 151), agree that

a sound measure of service quality is necessary for identifying the aspects of service needing performance improvement, assessing how much improvement is needed, and evaluating the impact of improvement efforts. They emphasise that service quality is best captured by surveys that measure customer evaluations of service. Napoli (2006: 677) also points out that non-profit organizations must accept that raising support and utilisation of programs begin with the monitoring and control of stakeholder satisfaction with current services.

The researcher is therefore of the opinion that this does not mean that all the needs of an interest group should be provided for, but if certain aspects of the presentation cannot be changed, the place, the manner in which it will be presented, the price and the introduction of the program should at least link up to the specific unit's needs and living environment to obtain the most positive response. Murphy and Sauter (2004: 79-86) refer to individual/worker level, interventions directed at changing perceptions, attitudes or behaviours at work, as a means of improving worker well-being.

6.4.4 Sub-theme 4: Core marketing strategy

The following sub-themes emerged as a result of the group member's opinions, namely product, place, price and promotion. Although the respondents did not refer to the sub-themes by name, the researcher categorized all the responses considering above core elements of a marketing strategy as proposed by Kotler and Armstrong (2014: 429) and Zeithaml *et al.* (2009: 24) According to the authors the marketing strategy is devised by the marketing manager to reach specific goals. The plan consists of a whole set of tactical actions which has been integrated as a unit and is attuned to the main aim of the service / program. Product, distribution, pricing, and marketing communication decisions are seen as specific tactics to bring the plan into execution. Collectively or as an integrated unit, these tactics form the essence of the marketing strategy for a specific product / program. Each of these sub-themes will subsequently be discussed, based on the opinions of the group members. This will be followed by the researcher's conclusions. Lastly the statements will be conceptualized considering the literature in order to explain how they have been aligned with the sub-themes.

6.4.4.1 Category 1 of sub-theme 4: Product

Kotler and Armstrong (2014: 248) defines product as "...anything that can be offered to a market for attention, acquisition, use, or consumption that might satisfy a want or need". Group members specifically referred to the applicability, quality, design, features and packaging of trauma intervention programs and its intended positioning to reach the target customers. The following examples are cited in order to illustrate the above statements:

“...my experience of the suicide prevention program was that it was possible for me to identify with the content. It is real situations that I am confronted with on a daily basis. It gave me more clarity on how to think and how to cope with certain issues. It was generally very easy to understand”;

“...they should not only focus on trauma, like a murder scene or an accident. Sometimes they also have to concentrate on relationship problems because that can also cause trauma. Basically, targeting every aspect of a human being's life, any kind of issue, because everything around us is affected by trauma”;

“...for me it was not effective, it was not helpful. It was just a total waste of time. I did not understand a word, we are police officials not academics, how do they expect us to apply this in our personal lives, it is easy to talk if you do not find yourself in the situation”;

“...they'll stand up and present. They will not interact with us, you don't want a lecture, you want an interactive type of workshop presentation. The chaplains for example will just ask us for our names, what happened and that is it, off you go”.

Some of the group members believe that those trauma intervention programs attended by them are relevant to their unique situation. They are satisfied with the content and the quality and found it easy to understand. These group members stated that they have learned several techniques and skills to help them to handle the response to stress and trauma. Kotler and Armstrong (2014: 253) refer to product quality as “the ability of a product to perform its functions; it includes the product's overall durability, reliability, precision, ease of operation and repair, and other valued attributes”. Quality has a direct impact on product or service performance; therefore it is closely linked to customer value and satisfaction.

Police officials experience groups as a particularly positive experience, especially to those who do not easily speak their emotions. It provide them with a platform to make a contribution or otherwise just to listen actively. Police officials then realize that their colleagues do have similar problems with the result that post-traumatic stress reactions may largely be normalised. Orr and Hulse-Killacky (2006: 192) concur with the above and are of the opinion that group meetings do not focus on information and facts alone; but more importantly in cultivating interdependence among participants, inviting them to participate. According to the authors, group meetings have several goals. One of the most important goals is to give each of the group members a voice and to make sure that everyone has their voice heard.

Most of the group members were however of the opinion that the content of the programs only focus on the individual and more specifically trauma and stress without looking at the person within their social environment. The following argument by Penk *et al.* (2011: 174-175) supports

the researchers finding "...psycho-social intervention works to restore functioning". Intervention does not only concentrate on psychological factors, but also on social skills training, supported housing, education, and employment family psycho-education and peer counseling just to name a few. The focus should therefore be on the police official within his or her environment and intervention strategies must be aligned accordingly.

Some group members indicated that the programs did not meet their expectations. According to them those programs attended are too theoretical and that the content in some cases should be simplified and presented at the level of police officials. They also prefer a more informal, interactive workshop presentation style rather than a formal theoretical lecture which is sometimes difficult to understand. Participation gives rise to information as more reliable and easier to integrate. As a result it is easier to apply in an actual situation. It appears that group members are very sensitive and frustrated with unprofessional conduct and refers particularly to professionals with expertise, knowledge of the topic, skills and experience in SAPS, as a prerequisite. Most of the group members find that there is a lack of support after trauma intervention programs and they expressed a need for regular follow up sessions. Some of them prefer individual follow-up intervention. Zeithaml *et al.* (2009: 75) define customer expectations as beliefs about service delivery that serve as standards or reference points against which performance is judged.

6.4.4.2 Category 2 of sub-theme 4: Psychological cost factors

Kotler and Armstrong (2014: 312) refer to dynamic pricing and define it as "charging different prices depending on individual customers and situations". Group members reported multiple psychological cost factors for example confidentiality, management support and police culture as factors influencing the intended positioning of the program to reach the target market. The following examples are cited in order to illustrate these aspects:

"...after the incident we had a discussion with EHW about how we felt. She went back to the province and she betrayed us. She told everybody about what we said and how we felt about it. So I don't trust them";

"...EHW is part and parcel of the police. Most of the members feel like EHW can get overruled by management, they have to report to somebody, either a brigadier or higher authority";

"...I'm sorry to say this, but that was the most unprofessional human being I have ever seen in my life. I don't know what it was she tried to do, but the things that she did during our session, her body language";

“...if you tell management that you can't cope, and seek for help, it's your problem, there simply is just no understanding or support. For me to go and approach the brigadier it's like you going to talk to Jesus”;

“...in the police there is a saying that cowboy don't cry. Should you indicate that you cannot cope or seek professional assistance, the commander might think that you cannot do the work or you cannot handle the stress. You are afraid to be left out or that they will discriminate against you”.

Confidentiality is one of the major cost factors which are generally a problem for most of the group members. It is difficult for them to trust the social workers, psychologists and chaplains because in the past it happened that police officials' personal problems were generally discussed with management or colleagues. The perception is that EHW is accountable to police management. Group members are therefore afraid that their careers may be negatively affected.

Group members have a certain expectation of EHW and the service that are rendered. In some cases, their professional conduct is questionable, especially what their attitude and disposition is concerned. As a result police officials do not always have the courage to attend the programs. According to Kirschman *et al.* (2014: 22) confidentiality is the foundation of managing the therapeutic alliance. He quoted the following remark made by a police official “If you want to spread the word, tell a secret to a co-worker. It will be out on the street before you are”. Group members who are afraid that they will be exposed in the process will not share their feelings or perceptions. There is a further perception that the distinctive police culture limit access to trauma intervention programs. Management expects police officials to handle the pressure, and to be at all times in control of their emotions. They are therefore reluctant to show their emotions, because they are afraid they might be labeled as weak. In addition, they feel that they might be treated differently, excluded from their peer group or transferred to a low stress environment only to do administration. The norm is that police officials would rather talk about their issues and sort out emotions during a barbecue with a few beers in the hand. Stevens (2009: 540) confirm the above with the following quote “...after a gunfight, we'd have a few beers and call it a night”. According to the author there is no room for tears in the police. Part of their work is to be tough, to suppress emotions.

The general feeling is that commanders do not support the programs or simply do not take it seriously. They fail to refer or to arrange the necessary intervention after police officials' exposure to traumatic incidents. The latter may be due to ignorance, a lack of interest or a negative attitude attributed towards programs. The result is that members' are deprived from exposure to these programs and opportunities. Police also believe that their specific needs are

ignored and that their personal interests are not taken at heart. Group members believe that commanders themselves must be exposed to the various programs in order to change their attitude towards it and to ensure shared ownership. Bond and Keys (1993: 37-58) agree with the view that the helping professions, should act as a tool to break down the rigid boundaries and views of senior management in order to facilitate new insight.

All of the above factors should be reviewed considering the individual or interest group's frame of reference, to be able to empathetically calculate the perceived physical, psychological and social costs experienced. (Kotler and Armstrong 2014: 307)

6.4.4.3 Category 3 of sub-theme 4: Place and time

Lovelock and Wirtz (2007: 17) state that place and time is concerned with the availability of products of services at a place and time which is convenient. Group members referred to location and time associated with the presentation of trauma intervention programs, channels for access to the programs, location, transportation and logistics as well as the extent to which these factors allows them to attend these programs. The following examples are cited in support of this sub-theme:

"...you're invited to attend a two day workshop. The first thing that comes to mind, is it possible for two days? Management normally instruct EHW, Hey, time out, It should not last for more than an hour. You cannot keep them for a day". Then you ask yourself, how big is the problem?";

"...we don't give ourselves time to visit EHW or attend the programs after the situation. Our workload simply does not allow us to attend a one day workshop";

"...management will first wait for something to happen. Like now, definitely sure, you have been mandated to come to us, because there's been a problem, something happened";

"...the worst part is that the debriefing was at the scene, where the incident took place. It was still fresh. Some of the victims were still at the scene with bandages, their heads were swollen, blood all over, it must be a neutral place".

Some of the group members mentioned that because of the nature of their work, and more specifically the high workload, they do not always have the time to attend trauma intervention programs. The duration of programs are sometimes too long while the time of presentation (day of the week, month or year) is sometimes problematic. According to Lovelock and Wirtz (2007: 17) it is important that the time and duration of the presentation of programs be kept in mind to ensure optimal functioning. A problem directly related to this is the fact that trauma intervention

programs are deliberately scaled down in order to accommodate police officials' workload, as a result of which police officials feel that they do not benefit from the sessions. It also appears that some group members simply do not allow themselves the time to attend the programs. They are informed but there are always other priorities that require more attention. There is a definite need for more regular or structured interventions, such as once a quarter, which is proactive in nature. They have a need to know that they are cared for. Group members prefer the latter rather than re-active intervention, which usually only occurs when there is a serious problem within the unit. Group members prefer the group sessions to take place in a neutral environment away from the scene or the workplace where they cannot be reminded of the incident and where there is no interference. The venue must be accessible. Members of the group mentioned that the programs are sometimes presented at a place which is too far, and that they do not always have the means to get there. Others prefer an environment where they cannot be identified. Kotler and Armstrong (2014: 379) and Zeithaml *et al.* (2009: 24) refer to place as to how the company or organization will make the offer available to target consumers as well as the environment in which the service is delivered. Place involves important aspects that will create and allow access to trauma intervention programs in SAPS for example channels of communication or referral, location specifically referring to accessibility, exposure and, logistics for example the availability of transport. The latter is important considering police officials unique working conditions and extremely high workload.

6.4.4.4 Category 4 of sub-theme 4: Promotion

Kotler and Armstrong (2006: 455) define marketing as a strategy to reach specific goals whilst promotion is the actual presentation and promotion of ideas, goods or services to reach the specific goals". The authors also define the promotion objective "...as a specific communication task to be accomplished with a specific target audience during a specific period of time". Although advertising is used mostly by business firms, it also is used by a wide range of non-profit organizations, professionals and social agencies that advertise their causes to various target publics. Group members refer to advertisement of programs, changing management's attitude towards the programs which in some instances restrict them access to the programs as well as the visibility of EHW at unit level to facilitate such a process to them as target customers. The following examples are cited to illustrate the above.

"...what's that? I don't know what it is." They must advertise. It's like a business";

"...they must have a product and they must inform all the members about the product. Not only today, but monthly, quarterly. By means of pamphlets, e-mails, etc";

“...in all the time that I am stationed here at FCS I have never seen a social worker, not even to mention a program”;

“...our unit commander will inform us a day before that EHW will be presenting a certain program at the unit the following day. You do not have a clue what it is all about”.

Most of the group members, who have not attended the programs or only participated in some of the trauma intervention programs, were of the opinion that the programs are generally not marketed effectively. They said they had never heard of certain trauma intervention programs, because no one has introduced them yet. Those who have noted do not know what the content entails or what benefits it holds for them. According to them, programs are not formally introduced by the helping professions or management. It appears that management's lack of interest and negative attitude is a contributing factor. Some members say that they only happened to hear about the programs from other members, whom already attended before. As a result they cannot make an informed choice regarding participation. Solomon (2011: 34) refers to the above as pre-purchase issues as the first stage in the consumption process during which the client has to decide if he/she needs a product. The author refers to the sources of information to learn more about alternative choices. The conclusion is made that trauma intervention programs are generally not marketed well enough by EHW or management. In some cases EHW are not visible at unit level, or do not market the program properly. Group members have a need for constant awareness through personal visits to different units, flyers or e-mails. Lovelock and Wirtz (2007: 155) and Zeithaml *et al.* (2009: 25) support this view with the statement that marketing communications tools referring to brochures, letterhead, business cards and signage are especially important in service settings because they help create powerful images and a sense of credibility, confidence, and reassurance.

Group members also believe that their commanders have a greater role to play in providing access to these programs. In most cases, group members will only be informed today to participate in some program the next day without discussing the reason, the content and appropriateness. The assumption is made that if the trauma intervention programs can be introduced to police officials specifically based on the content / relevance members would be in a better position to make an informed decision. The researcher concluded that police officials do not necessarily want to participate in all the programs, but would prefer to make a choice based on their unique situation. Kotler and Armstrong (2014: 456) are of the opinion that advertising is a good way to inform and persuade, whether the purpose is to sell a product (program) or to get consumers (police officials) to make use or attend the programs. The authors refer to informative advertising during which the customer must be informed about the product, explain how the product works, describing available services and reducing the consumer's fears.

7. Discussion

The research results of the first qualitative phase of this study revealed the following results namely, the meaning of trauma, response to trauma, coping and trauma intervention programs. Police officials attached to the specialist units of SAPS in the North-West Province are exposed to several traumatic incidents in the performance of their duties as police officials, as well as their personal lives. The latter varies in incidence and intensity. The frequency, intensity, cumulative nature and re-traumatization associated with these traumatic incidents enforce the police official's experience of trauma. Police officials are furthermore exposed to major stressors as a result of organizational, operational, external and personal factors. These stressors are sometimes so severe that it result in a traumatic response or have a negative impact on police official's experience of trauma. Critical incident stress, experienced during the initial aftermath of the traumatic incident may turn into complex traumatic disorders associated with cognitive and behavioural risk factors. The consequences of PTSD or comorbidity disorders also have a serious impact on the police officials' social ecology and systems of care, for example the family, peers and their productivity at work. Police officials cope differently with trauma, otherwise referred to as avoidance and action orientated coping. Some are dependent on the support from important others for example their family, colleagues, peers, management and even EHW or external professionals. Most of the police officials deny and avoid the symptoms of trauma. This might be attributed to the fact that they hide from the painful consequences of the symptoms as they are not prepared to be confronted with it, the unique police culture with specific reference to the "macho image" of the police, the stigma associated with therapeutic intervention as well as a lack of trust in EHW and management. It appears that those police officials whom attended trauma intervention programs are, with the exception of certain aspects, mostly satisfied with the product. They are, however, concerned with the fact that their unique needs are not considered. They are also concerned about the fact that the impact and satisfaction with the programs are not measured or amended accordingly, the inconvenience caused as a result of the time and duration of programs as well as certain psychological cost factors for example, professional conduct, confidentiality, and management support.

8. Conclusion

In this article the researcher did an indepth exploratory analysis and collected information regarding the police official's experience of trauma and trauma intervention programs as the first phase of the intervention research model. A total of forty police officials stationed at the identified specialist units, representing three of the bigger police clusters in the North-West Province were involved in three focus groups as part of data collection. The researcher concentrated on the qualitative approach as the first phase of the exploratory sequential design to understand the meaning that members of the focus groups ascribe to trauma and trauma

intervention programs. As a result of the problem analysis the following topics have been identified as a preliminary indicator to the development of a purposeful psycho-social trauma intervention program to address the problems regarding trauma in SAPS: psycho-education (trauma, stress, impact of trauma) response to trauma (critical incident stress, complex traumatic stress disorders referring to PTSD and comorbidity), consequences of complex trauma (alcohol abuse, suicide, anger, aggression, violence, family and relationship problems, somatic complaints, work related problems), coping strategies (resilience, avoidance-, action-oriented coping), consumer orientation, -satisfaction and promotion. The suffering and adversity of those police officials who experience complex traumatic stress reactions are basic components of care which must be considered by EHW in SAPS.

9. Recommendations

It is evident that police officials attached to the specialised units in the North West Province that are exposed to and affected by trauma have unique circumstances and needs. A broader perspective on these circumstances is important to get a better idea of their specific needs. Based on the discussion of the results from this study and on the conclusion that was drawn, the following recommendations can be made:

- This research can be used as platform for the exploration of police officials needs in the broader population;
- The unique circumstances in which police officials attached to the specialised units find themselves are difficult and as a group they should be a target population with respect to help and support;
- Before any intervention program is planned for police officials exposed to trauma, an assessment should be done to determine and verify the population's unique needs with regards to intervention via their active participation in the whole process;
- Elements of the TF-CBT, PE and the eco-systems perspective can be included in a single psycho-social therapeutic program considering the specific needs of the population; and
- The results with regard to the needs of police officials attached to the specialised units in the North West Province should be utilised in further research regarding program development in the field of trauma.

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ARTICLE 4

**AN ASSESSMENT OF THE NEEDS OF POLICE OFFICIALS
REGARDING TRAUMA AND TRAUMA INTERVENTION PROGRAMS: A
QUANTITATIVE APPROACH**

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Key words

Assessment, police officials, trauma, trauma intervention programs

Abstract

As a result of the critical nature of police officials' work, it is of utmost importance that they have direct access to support. The efficacy of the present trauma intervention programs in the South African Police Service (SAPS) are questioned, because despite the implementation of these programs, police officials still present high levels of acute and behavioural problems. The objective of this article was to do a quantitative situation analysis as second phase of the explorative sequential design. Certain themes arising from the focus group interviews were included in the self-designed questionnaire distributed to police officials of specialist units representing the whole of the North-West Province. This questionnaire included specific concepts on trauma, trauma reactions and specific needs of police officials with regard to support. The before mentioned was important to explore, analyse, test and generalise the extent of the problem in the broader population to establish to what extent the data arising from the focus groups in the first qualitative phase can be generalised to the larger sample of police officials stationed at the specialist units within the North-West Province.

AN ASSESSMENT OF THE NEEDS OF POLICE OFFICIALS REGARDING TRAUMA AND TRAUMA INTERVENTION PROGRAMS: A QUANTITATIVE APPROACH

1. Introduction

Despite the fact that Employee Health and Wellness (EHW) in SAPS apply a multi-professional team approach to provide trauma intervention, statistics confirm that there is still a high occurrence of stress-related problems among police officials. Recent research on trauma and stress within SAPS was done by Jorgensen and Rothmann (2008), Louw and Viviers (2010), and Young *et al.* (2012). However, few articles have been written on a comprehensive holistic profile of police trauma in combination with the additive and interactive effects of stressors as well as the effectiveness of current trauma intervention programs in supporting traumatised police officials.

The aim of this study was to explore the uniqueness of SAPS as profession, by discussing the continuum of trauma and stress, from the traumatic incidents, basic psychological symptoms, coping mechanisms, exhibition of pathological responses and the experience of trauma intervention programs in SAPS. This exploration is important to create guidelines and to make certain recommendations with regard to client-focused programs for police officials attached to the specialist units in the North-West Province. The specialised units in SAPS refer to specially-trained police officials and units designed to provide maximum response efficiency in a variety of customary and unusual situations for example Public Order Policing (POP), responsible for crowd management, Tactical Response Unit (TRT) rendering specialised operational support, Family Violence, Child Protection and Sexual Offences Unit (FCS) providing assistance and support to woman and children that are victims of sexual offences, the Local Criminal Record Centre (LCRC) responsible for taking forensic samples, analyses of exhibits and the presentation of expert evidence as well as the Police Emergency Services (PES): 10111 Centres and Flying Squad, providing a twenty-four-hour immediate emergency telephone service and immediate response to all priority/serious crimes in progress.

For purposes of this article, the researcher will firstly concentrate on the problem statement with reference to trauma exposure and trauma intervention programs in SAPS, where after the purpose of the study will be explained. The researcher will then give a summary of the research methodology as applicable to this study. Subsequently the findings that arose from the second quantitative phase of the study as integrated and compared with the literature will be summarised. This article together with article three is part of a preliminary study (situation

analysis and information collection) that will form the basis for the development, implementation and evaluation of a psycho-social therapeutic program, within the context of SAPS.

2. Problem statement

Police officials are exposed to trauma and stressors on a daily basis. Kassen and DiLalla (2008: 263) are of the opinion that South Africa is seen as the world's crime capital where crime assumes serious proportions. The South African crime statistics for 2013/2014 confirm that crime remains at unacceptably high levels. The police official is therefore continuously exposed to unique, demanding and unpleasant traumatic work incidences for example murders, rape, violent crowds, car accidents, vehicle hijackings, etc. Combine this with the general stressful work circumstances as well as personal problems, and it might over time negatively influence the police officials' feeling of well-being.

According to the DSM-5 the term trauma in itself is not a diagnosable disturbance. It does however refer to and define a traumatic event as any situation that is beyond those of an individual's daily experiences. Qualifying traumatic events are for example actual threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate, which causes unusually strong emotional or physical reactions which might include extreme fear, helplessness, and/or horror. Traumatic incidents are explicit as to whether they were experienced directly, witnessed, experienced indirectly or repeatedly (American Psychiatric Association, 2013: 265).

Although trauma in SAPS is distinct from other traumas, the above explanation greatly corresponds with traumatic events within the police work environment. Police officials are actively engaged in peacekeeping activities. These traumas arise from police official's active participation in combat activities, but also result from passive acts, such as witnessing acts of violence inflicted on colleagues and civilians. Trauma in SAPS occurs on a continuum of physical and psychological sequelae that range from mild to severe (Westwood et al., 2012: 394). Major types of traumatic incidents in SAPS might include child abuse, mass interpersonal violence, natural disasters, motor vehicle accidents, witnessing or being confronted with the homicide or suicide of another person, intimate partner violence, torture, crime, just to name a few (Briere & Scott, 2013: 8; Courtois & Ford, 2013: 22).

According to Godbout and Briere (2012: 485), and McNally (2012: 341), the exposure to trauma is strongly associated with psychological difficulties. In some instances police officials experience an array of stress-response syndromes that occur after exposure to a traumatic

event rather than clinically significant distress whose symptoms do not meet criteria for a more discrete disorder. If these stress response syndromes are not constructively handled, during the emotional aftermath of traumatic incidents, the above syndromes might develop into trauma and stressor related disorders for example, PTSD, depressive-, somatic symptoms and related disorders. It is important to note that exposure to a traumatic event is listed explicitly as a diagnostic criterion (American Psychiatric Association, 2013: 265).

In addition to the afore-mentioned, there is a high incidence of police suicides, family murders and police excessive use of force. According to Steyn and Nel (2008: 11 & 13) the suicide rate in SAPS is more than double the national rate of suicides. According to Mthethwa (2013) 73 members committed suicide in 2009, in 2010 the figure rose to 97 and in 2011 dropped to 85. In 2012, 98 members took their own lives and by June 2013, 34 already committed suicide. Unfortunately the researcher was not able to obtain official figures regarding the extent of psycho-social problems as well as the present suicide rate in SAPS.

In spite of the availability of EHW and the services offered by them, the National Instruction 18/1998 and the different trauma intervention programs, statistical information as mentioned before confirm that police officials still experience a very high degree of psycho-social problems which do have a negative impact on their productivity at work (SAPS Annual Report, 2012/2013). The researcher is of the opinion that if the extent, subjective experience, impact of trauma and police official's specific needs with regards to trauma and trauma intervention programs are known, a purposeful psycho-social trauma intervention program might be developed to address the problems as explained in this section.

With reference to the above statement, this article will attempt to answer the following research question:

- What are the extent, subjective experience, and specific needs of police officials' in the broader population of SAPS in the North-West Province, who have been exposed to trauma?

3. Aim

To conduct a quantitative situational analysis as a second phase of the explorative sequential design to explore and identify the extent, subjective experience and specific needs of police officials, within the larger population of the North West Province, who have been exposed to trauma.

4. Research methodology

The researcher made use of the exploratory sequential mixed methods design as part of the first phase of the intervention research model (Creswell, 2014: 225; De Vos & Strydom, 2011: 476; Rubin & Babbie, 2010: 33). For the purpose of this article the researcher will concentrate on the quantitative approach as the second phase of the exploratory sequential design, to understand the meaning that police officials representing the larger population ascribe to trauma and trauma intervention programs presented by EHW in SAPS (Creswell, 2014: 4).

The conceptualization of the process is illustrated in Figure B4-1:

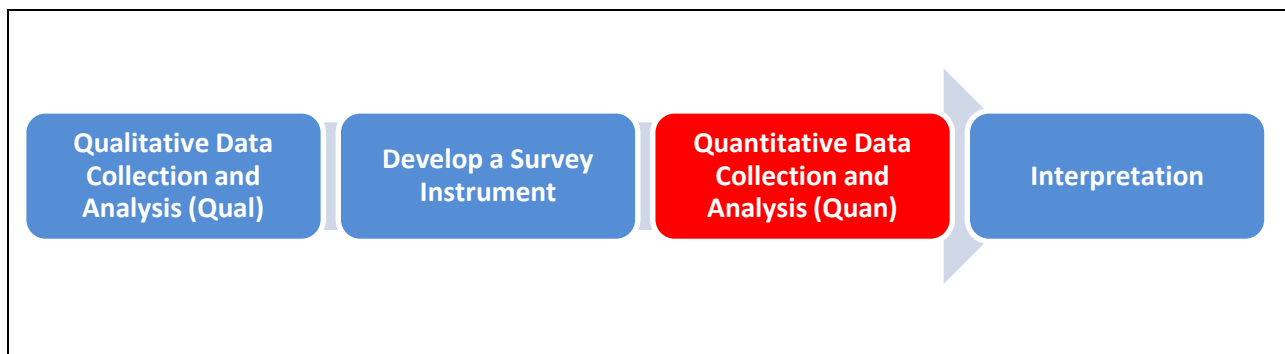


Figure B4-1: Exploratory Sequential Mixed Methods Design (Creswell: 2014: 220)

The researcher used the findings of the first qualitative phase in a second quantitative phase. With reference to this article, the researcher intended to quantitatively explore the experiences and psycho-social needs of police officials who are exposed to trauma within the broader population. Creswell and Plano-Clark (2011: 187) and Grinnell *et al.* (2008: 21) explain that the general goal of an exploratory design are to become familiar with the basic facts, people, and concerns involved, develop a well-grounded mental picture of what is occurring, generate many ideas and develop tentative theories and conjectures. The researcher wanted to determine if data arising from the three focus groups, in the first qualitative phase, can be generalised to a large sample of police officials stationed at the specialist units within the North-West Province (Creswell, 2014: 226).

The researcher made use of an exploratory survey method as a research strategy to measure police official's opinions, knowledge, attitudes, beliefs, behaviours, reactions and attributes concerning certain concepts regarding trauma and trauma intervention programs. According to Rubin and Babbie (2010: 35), the exploratory design is linked to the purpose of the study, with the main aim to explore a topic and to provide a certain level of familiarity with it. The data in this phase of the study was collected by means of a self-developed questionnaire (Annexure B), based on the findings of the first qualitative phase, measuring the impacts of trauma and respondent's exposure to traumatic events inside and outside the workplace. The questionnaire

was firstly pilot tested with five police officials attached to the specialist units in SAPS. Based on the feedback of the pilot study, the questionnaire was revised. Inconsistencies and redundancies were removed to improve the clarity in the formulation of items in the questionnaire.

Following the above process the questionnaire was administered to a sample of the larger population. According to Kreuger and Neumann (2006: 259) the survey is the most widely used data gathering technique in social work. Surveys are applicable to research questions about self-reported beliefs or behaviours. They are especially strong when the answers to questions measure variables. The questionnaire is purpose-designed according to the data arising from the focus groups, structured theoretical knowledge and research questions.

During the process of quantitative data collection the researcher used the purposive sampling method in order to select 332 participants stationed at six specialist units (Strydom & Delpont, 2011: 392) representing nine of the 11 police clusters in the North-West Province. The size of the sample according to Strydom, (2011: 225) is determined according to 10% of the population. However, the researcher selected 23% to make provision for unexpected circumstances as a result of police official's unique and demanding working conditions. Police officials were purposefully chosen considering the relevance of the topic, specifically referring to their exposure to trauma, resultant symptoms of PTS and their participation in trauma intervention programs. EHW responsible for the specialist units in the different clusters in the North-West Province assisted the researcher with the selection process. They were also trained as field workers in order to facilitate the completion of the questionnaires by means of the group administered method. During this process participants were grouped together, and given the opportunity to complete the questionnaires on their own. Each respondent received the same stimuli, and the questionnaires were completed without consultation amongst each other. The group administered method is a combination of the personal interview and a questionnaire that is mailed. The respondents complete the questionnaire, whilst the field worker is present to give certain instructions and to clarify any points of uncertainty (Delpont & Roestenburg, 2011: 189).

Since this was an untested instrument the researcher, as part of the process of quantitative data analysis, conducted appropriate validation techniques to establish the psychometric properties of the instrument (Cook & Beckman, 2006: 9 & 11; Treiman, 2009: 242-243). In order to establish construct validity and to identify underlying empirical dimensions of measurement in the measure used, Exploratory Factor analysis (EFA) was employed; whilst Cronbach's Alpha was used to establish the reliability of the measure used. The Principal Component factoring technique was used with Direct Oblimin rotation, whilst Measures of Sampling Adequacy (MSA) and Correlation Tables were used to select high correlating variables. Each factor was utilised separately to assess group comparisons in respect of different biographical variables by means

of the Spearman's rank order correlation test (Spearman's rho), Analyses of variance (ANOVA), the Tukey post hoc procedure (HSD) and a Statistical hypothesis test (T-Test). The EFA rendered 28 factors grouped into five categories of questioning. The researcher provides an overview of the different factors achieved per category under the names they were given.

5. Ethical aspects

Babbie (2007: 62), Bless *et al.* (2007: 140) and Strydom (2011: 114) define ethics as the preferences that influence behaviour in human relations, conforming to a code of principles, the rules of conduct, the responsibility of the researcher and the standards of conduct of a given profession. The researcher, for the purposes of this study, firstly got ethical approval from the North-West University's Ethical Committee on the ethical clearance number: NWU-00007-13-A1.

According to Holloway *et al.* (cited in Adlem 2011: 15), respondents participating in a research study have the following rights, which were strictly followed by the researcher:

- Permission has been obtained from SAPS to undertake the research study among police officials;
- The questionnaire were based on strict scientific guidelines, purpose designed according to the data arising from the focus groups, structured theoretical knowledge and research questions, to prevent any damage to participants in the research study or to SAPS as an organisation;
- As a result of the sensitive nature of the research subject, the researcher made use of EHW in service of SAPS and responsible for the specialist units in the 11 clusters of the North-West Province, to help him with the sampling process. Last mentioned procedure was followed, because the EHW possess first-hand knowledge on the members in his/her specific work area, and is in some cases already therapeutically involved with police officials;
- Police officials were informed regarding the aim of the research project after which they gave informed consent, and voluntary participated;
- EHW in SAPS, responsible for the different specialist units within the North West Province were trained as field workers;
- During the administration of the questionnaires the participants were grouped together, and given the opportunity to complete the questionnaires on their own;
- Selected police officials have been informed of the purpose, method, possible risks and expectations of the research, after which they were allowed to make a choice to partake in the research or not;

- The respondents completed the questionnaires, whilst the field workers were present to give certain instructions and to clarify any points of uncertainty;
- Participation in the research study was voluntarily and police officials were allowed to withdraw from the study at any time, while written consent forms were signed by participants;
- Selected police officials were assured of confidentiality and anonymity, especially with reference to the processing of the data. No identification particulars have been requested or recorded;
- Each respondent received the same stimuli, and the questionnaires were completed without consultation amongst each other;
- The administration of the questionnaires was handled with the necessary sensitivity. If any further therapy or treatment was necessary, due to the impact of the study, the field worker would have referred the police official to a qualified psychologist, social worker or chaplain in SAPS;
- All electronic documentation/records/questionnaires will be stored on an external hard drive. As this contains confidential information it is critically important to keep it safe; and
- To protect the data from others a password will be set up for the hard drive. Windows 7 protect or lock the hard drive disk and removal drives by its Bit-locker feature. The bit-locker is an encrypting tool, built-in with your Windows 7, which encrypt the whole drive and lock it by a given password. To access into the encrypted drive, one should provide the correct password.

6. Discussion of the findings

The results of the research project were based on the situation analysis of police officials stationed at six specialist units, representing nine of the eleven clusters in the North-West Province. For the purpose of the second phase of this study the researcher focused on the larger population which include nine of the bigger clusters in the North-West Province as they accommodate most of the specialist units mentioned earlier in this article. This included an exploration of police official's experience, impact and their specific needs regarding trauma intervention programs as part of a second quantitative phase of the study.

6.1 Biographical information

The following table give an overview of the total population referring to the nine police clusters and the six specialist units included in the study. The table furthermore give an overview of the total number of police officials selected in comparison to the total number of employees per cluster and specialist unit.

Table B4-1: Total population versus sample

Unit/ cluster	BRS	WMS	RT B	POTC H	MMK	VB	KD	LB	MHK	Total	Total % Selected per Unit	Total % as per Popula tion%
LCRC	21	-	31	26	11	12	28	15	18	162	62 (38.2%)	4.3%
FCS	16	10	33	16	8	13	21	14	16	147	52 (35.3%)	3.6%
PES	2	-	52	54	-	11	13	11	57	200	31 (15.5%)	2.2%
POP	-	-	78	114	-	-	-	-	101	293	57 (19.4%)	3.9%
TRT	-	-	100	-	-	-	70	-	-	170	16 (9.4%)	1.1%
DET	48	47	49	50	47	48	50	48	48	435	90 (20.6%)	6.2%
Other	-	-	-	-	-	-	-	-	-	25	25 (100%)	1.7%
Total	87	57	343	260	66	84	182	88	240	1432	332	23%

***Note: BRS = Brits, WMS = Wolmeranstad, RTB = Rustenburg, POTCH = Potchefstroom, MMK = Mmakau, VB = Vryburg, KD = Klerksdorp, LB = Lichtenburg, MHK = Mahikeng.*Note: LCRC = Local criminal record centre, FCS = Family, child and sexual offences unit, PES = Police emergency services, POP = Public order policing unit, TRT = Tactical response unit, DET = Detective unit.**

The total population consists of 1432 police officials attached to six specialist units, representing nine of the eleven clusters in the North West Province as discussed in paragraph one of this article. The specific specialist units have been included due to the extreme nature of their work and the probability of exposure to traumatic incidents. The specific clusters have been included as the specialist units mentioned above are fairly represented. Other units for example the investigative psychology unit, crime Intelligence and forensic social work, although separately indicated, all have secondary responsibilities at the different units as mentioned above. The researcher made use of the purposive sampling method during which 332 (23%) police officials from the total population have been selected to participate in the study. Please take note that the above table distinguishes between the total percentages of participants selected per unit opposed to the total percentage selected per population.

The biographical information of participants included in the sample is as follows:

6.1.1 Age

The researcher included age as part of the biographical information to get an overview of the age group of police officials representing the specialised police units in the North West Province and also to determine the impact of age on their experience of trauma. The following graphical representation gives a description of the age of the respondents:

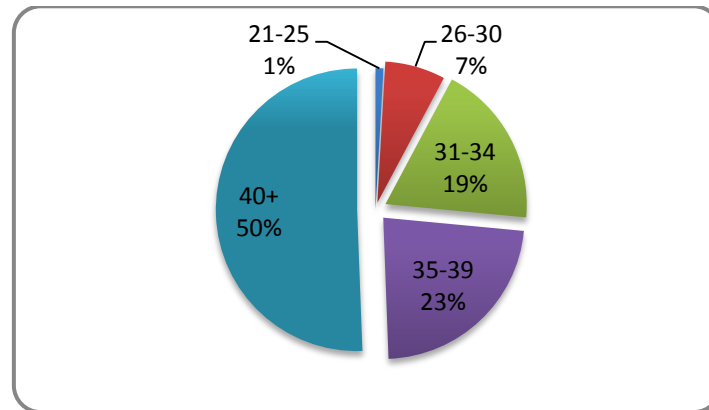


Figure B4-2: Age

Half of the respondents (50%) were above 40 years of age. Approximately 23% of the respondents were between 35-39, 19% between 31-34 and 7% between 26-30 years of age. Only 1% of the respondents were in the age group 21-25. The researcher concluded that the respondents are representative of an older, more mature group of police officials.

6.1.2 Rank

As a result of the para-military milieu of SAPS, the researcher wanted to determine the rank of police officials to get an overview of their status and position within the organization. The researcher also wanted to determine the impact of rank on their experience of trauma. The following graphical representation gives a description of the rank of the respondents:

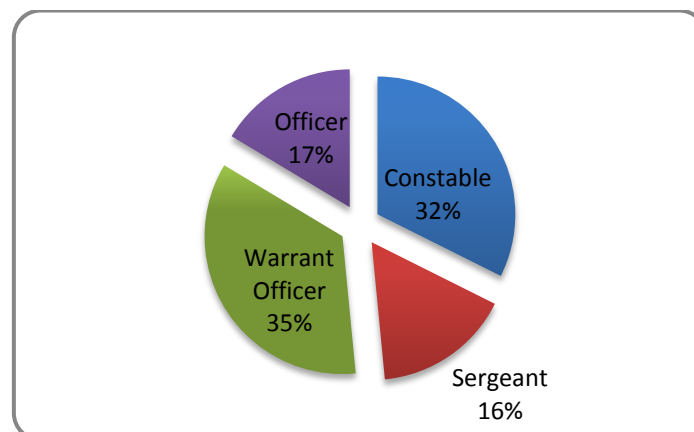
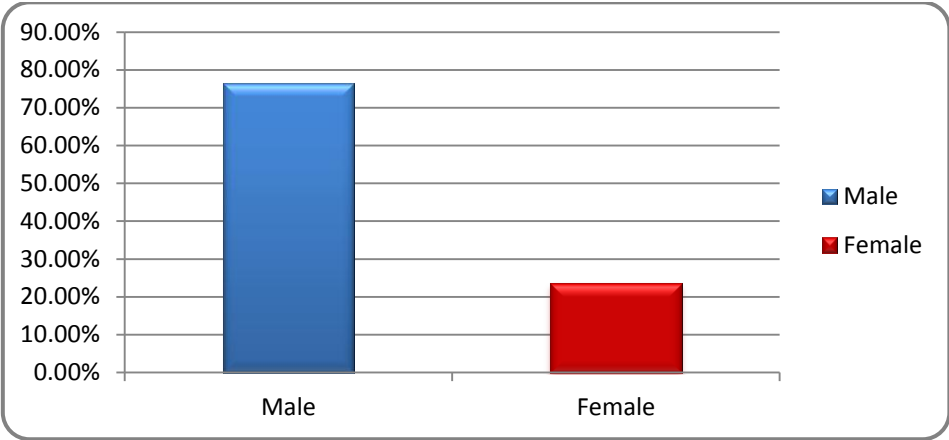


Figure B4-3: Rank

Most of the respondents (35%) were Warrant Officers, followed by Constables (32%). Officers (17%) and Sergeants (16%) were in the minority. Non-commissioned officials (Constable to Warrant Officers) therefore dominated the sample and in total represented 84% of the respondents whilst only 17% were officers. Despite the domination of non-commissioned officials the study included all the different rank structures in SAPS.

6.1.3 Gender

The researcher also included gender as part of the biographical information to get an overview of the percentage male and female police officials representing the respondents and also to determine the impact of gender on their experience of trauma. The following graphical representation gives a description of the gender of the respondents:



Histogram B4-1: Gender

Most of the respondents (76.5%) were males whilst a total of 23.5% were females. SAPS are still a fairly male dominated occupation and the above graph is merely representing the demographics of the specialist units in the North West Province.

6.1.4 Race

The question was asked to determine the race composition of respondents representing police officials stationed at the different specialist units within the North West Province, but also to determine the impact of race on the experience of trauma.

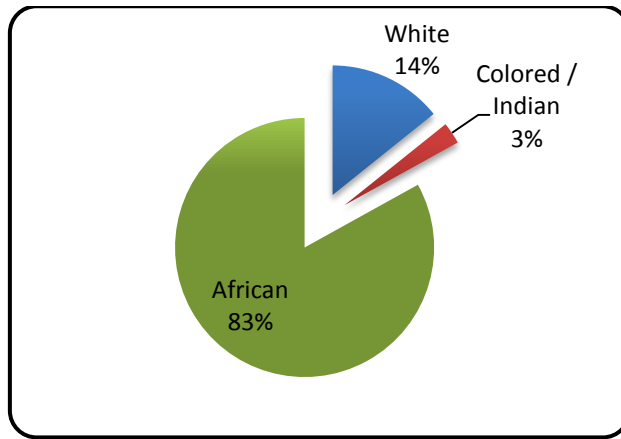


Figure B4-4: Race

Most of the respondents (83%) were Africans followed by a total of 14% whites. Coloured and Indians in total only represented 3% of the respondents. This composition can be contributed to the fact that the two indigenous languages for the North West Province are mainly Tswana and Afrikaans, which is an indication of the North West Province as a whole.

6.1.5 Marital status

The researcher asked this question to determine how many respondents were married and how many were involved in committed relationships opposed to those who were single at the time of the research, but also to determine to what degree marital status has an impact on police officials experience of trauma.

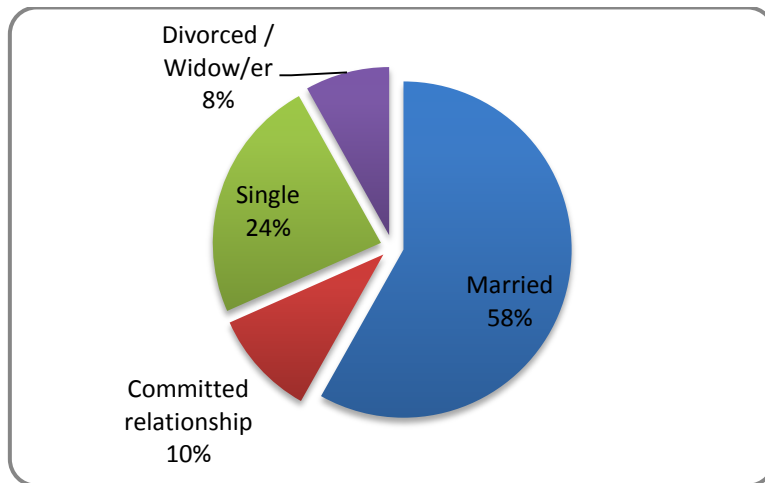
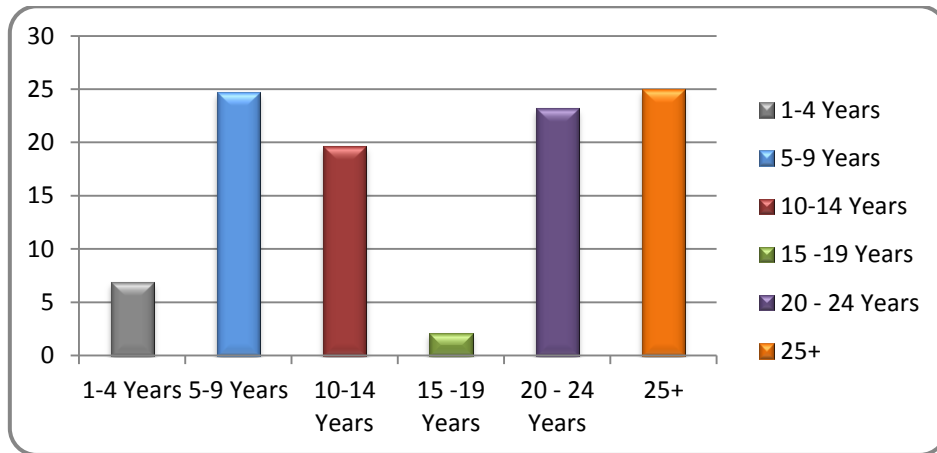


Figure B4-5: Marital Status

More than half of the respondents (58%) were married, a total of 24% of respondents were single, 10% were involved in committed relationships while 8% were divorced or a widow/er. More than half of the group members (68%) have access to a loved one which might encourage support.

6.1.6 Years service

The following chart represents the respondents years of service at the time of the study. The researcher included this question to get an overview of police officials experience in terms of years but also to determine to what extent the years of service does have an impact on police official's experience of trauma.

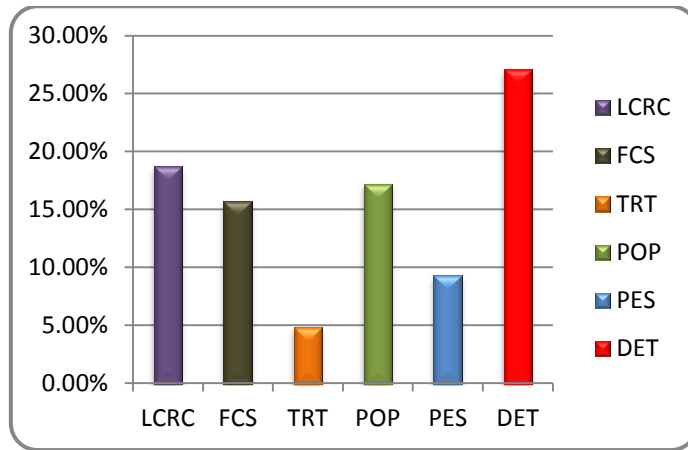


Histogram B4-2: Years of service

Most of the respondents (25%) had more than 25 years of experience, 24% between 5-9 years and 23% between 20-24 years of service in SAPS at the time of the study. Only 7% of respondents had between 1-4 years of service while 2% had between 15-19 years of service. The respondents therefore represented a more experienced group of police officials.

6.1.7 Specialised units

The following chart represents the different specialised units included as part of the study. This overview is important for the researcher to get an overview to the degree of representation as well as the impact of placement, referring to specific specialised units, on the police official's experience of trauma.

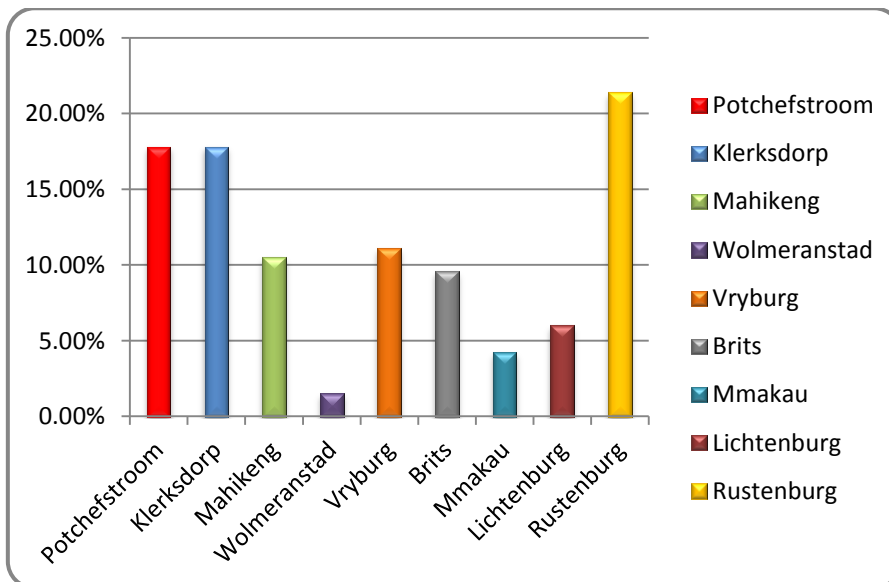


Histogram B4-3: Specialised unit

Most of the respondents (27.1%) were part of the detective services, followed by LCRC (18.7%) and POP (17.2%). TRT only represented 4.8% of the total number of respondents.

6.1.8 Police clusters

The following chart represents the different police clusters involved in the study. The inclusion of this question was important to get an overview of the different police clusters represented in the study, but also to determine to what degree police officials within the different clusters are affected by trauma.



Histogram B4-4: Police clusters

Rustenburg cluster are mostly represented in the study (22%) followed by Potchefstroom and Klerksdorp equally representing 18%. Mmakau represented a total of 4.2% of the police clusters while Wolmaranstad only represented 1.5% of the clusters in the North West Province.

Rustenburg, Potchefstroom and Klerksdorp represent three of the bigger police clusters whilst Mmakau and Wolmaranstad can be considered to be two of the smaller police clusters in the North-West Province not representing all of the specialised units included in the study.

6.1.9 Scope of work

In the table below, the different responsibilities of police officials at the specialised units are presented. The researcher wanted to obtain an overview of the type of work police officials do and also wanted to determine whether the type of work have an effect on their experience of trauma.

Table B4-2: Impact of the type of work on police official's experience of trauma

		N	Almost Never	Seldom	Often	Almost Always
9.1	Vehicle/Foot Patrol	223	66 29.6%	35 15.7%	27 12.1%	95 42.6%
9.2	Investigations	271	44 16.2%	26 9.6%	22 8.1%	179 66.1%
9.3	Photography	199	111 55.8%	15 7.5%	15 7.5%	58 29.2%
9.4	Fingerprints	205	95 46.3%	16 7.8%	17 8.3%	77 37.6%
9.5	Crowd control	203	93 45.8%	31 15.3%	16 7.9%	63 31.0%
9.6	Diving	179	154 86.0%	5 2.8%	4 2.2%	16 9.0%
9.7	Attend to complaints	218	37 16.9%	37 16.9%	47 21.7%	97 44.5%
9.8	Attend post-mortems	211	109 51.7%	31 14.7%	32 15.2%	39 18.4%
9.9	Tactical response	184	98 53.3%	22 11.9%	30 16.3%	34 18.5%
9.10	Specialised operations	197	44 22.3%	46 23.4%	39 19.8%	68 34.5%
9.11	Administration	247	22 8.9%	33 13.4%	56 22.6%	136 55.1%

Most of the respondents (77.7%) indicated that they are often to almost always busy with administration while 74.2% indicated that they are doing investigations and 66.2% are attending to complaints. The above is a clear indication of the major responsibilities of police officials stationed at the specialised units in the North-West Province.

It should be noted that most of the police officials indicated that they have more than one responsibility at work, hence the high response rate at the different responsibilities indicated above. Other additional responsibilities mentioned by the respondents are the attendance of court cases, hostage negotiation, collecting of intelligence on priority crimes, search for missing persons, management, training dogs, facial compositions, reconstruction, escorts and lab work.

6.2 The major causes of stress within SAPS

Data loaded onto four factors measuring major causes of stress within and outside the work place. These factors are provided in Table B4-3. The Cronbach's Alpha for these four factors range between .83 and .92, which according to recognised standards (Pietersen & Maree, 2007: 215) is considered a high level of reliability. Mean scores and standard deviations of the major causes of police stress within, outside the work situation, the work itself and personal stressors is provided for each factor in Table B4-3.

Table B4-3: Cronbach's Alphas, Means, and Standards Deviations for Major causes of Stress (MCS-SCALE)

No	Factor	N	Cronbach's Alpha	Mean	SD
1	SWWS	332	.92	2.05	.59
2	SOWS	332	.88	1.93	.66
3	SOWI	332	.83	2.04	.63
4	PS	332	.91	2.35	.65

Note. SWWS = Stressors within the work situation, SOWS = Stressors outside the work situation, SOWI = Stressors originating from the work itself and PS = Personal stressors.

SWWS (Alpha = .92) measure the extent to which police officials are exposed to stress within the work situation. Aspects such as a huge work load, accountability for decisions taken under immense pressure and the exposure to human loss, reflect some of the aspects measured by this factor.

The second factor, SOWS (Alpha = .88) measure the extent to which police officials are exposed to stress outside the work situation. Aspects such as the offensiveness of the community towards SAPS, the expectations of SAPS opposed to those of the community, the criminal justice system and politics, reflect some of the aspects measured by this factor.

The third factor, SOWI (Alpha = .83) measure the extent to which police officials are exposed to stress as a result of the work itself. Aspects such as workload, accountability for decisions taken under immense pressure, the responsibility for the safety of others and exposure to human loss, reflect some of the aspects measured by this factor.

The fourth factor, PS (Alpha = .91) measure the extent to which police officials are exposed to personal stress. Aspects such as financial pressure, inability to find a work-life balance, fear for the unknown and relationship problems, reflect some of the aspects, measured by this factor.

The mean score for factor SOWS (M = 1.93, SD = .66) were significantly higher compared to the other major causes of stress within SAPS as reflected in the above construct. The result is an indication that SOWS, specifically referring to the offensiveness of the community towards SAPS, the expectations of SAPS opposed to those of the community and the criminal justice system are experienced to be very stressful.

Each factor was utilised separately in the following phase to assess group comparisons in respect of different biographical variables in Section A of the questionnaire by means of the following measuring instruments namely: Spearman's rank order correlation test (Spearman's

rho), Analyses of variance (ANOVA), the Tukey post hoc procedure (HSD) and a Statistical hypothesis test (T-Test). The researcher will only report on those factors indicating construct validity and those that identify underlying empirical dimensions.

Analyses of variance (ANOVA) and the Tukey post hoc procedure (HSD) were conducted to establish if there are significant differences between rank, marital status, place of work and the factors indicated in Section B of the questionnaire. The results of this test are as follows:

Table B4-4: Means, Standard Deviations, Degrees of freedom (df), mean square (ms), Fisher's F ratio, sig.(one way) and effect size for the MCT-scale

					DF	MS	F	SIG. (one way)
SWWS					5	.717	2.09	.066
No	Variables	N	M	SD	Subset for alpha = 0.05		Effect Size	
					1	2		
6	DET	90	1.94	.54	1.9395		.74	
2	FCS	52	2.01	.64	2.0098	2.0098		
5	PES	31	2.08	.65	2.0754	2.0754		
1	LCRC	62	2.08	.55	2.0807	2.0807		
4	POP	57	2.16	.63	2.1566	2.1566		
3	TRT	16	2.37	.46		2.3745		
MS					df	ms	F	Sig.
SOWS					3	1.73	4.01	.008
No	Variables	N	M	SD	Subset for alpha = 0.05		Effect Size	
					1	2		
2	CR	34	1.68	.60	1.6758		.67	
1	M	193	1.89	.64	1.8918	1.8918		
4	D/W	27	1.94	.71	1.9437	1.9437		
3	S	78	2.12	.68		2.1160		

Correlation is significant at the $P < .05$ level.

*Note. SU = Specialised unit, df = degree of freedom, ms = mean square, F = Fisher's F ratio, Sig = Significance, SWWS = Stress within the work situation, DET = Detectives, FCS = Family, child and sexual offences unit, PES = Police emergency services, LCRC =

Local criminal record centre, POP = Public order police unit and TRT = Tactical response unit.

*Note, MS = Marital status, SOWS = Stress outside the work situation, CR = Committed relationship, M = Married, D/W = Divorced/Widow/er, S = Single.

The results indicate a significant correlation between SU and SWWS at the $P < .05$ level for the three conditions [$F(5, 302) = 2.09, P = .066$]. Post hoc comparisons using the Tukey HSD test indicated that the mean score for those stationed at DET ($M = 1.94, SD = .54$), effect size ($R = .74$) are significantly different compared to the other places of work. Secondly the results indicate a significant correlation between MS and SOWS at the $P < .05$ level for the three conditions [$F(3, 328) = 4.01, P = .008$]. Post hoc comparisons using the Tukey HSD test indicated that the mean score for those in CR ($M = 1.68, SD = .60$), effect size ($R = .67$) are significantly different compared to the other forms of relationships.

The researcher also wanted to determine whether stress does have an impact on the police officials' experience of trauma. The question was included in a three point scale varying from a lesser to a great extent to determine to what extent stress does have an impact on police officials experience of trauma.

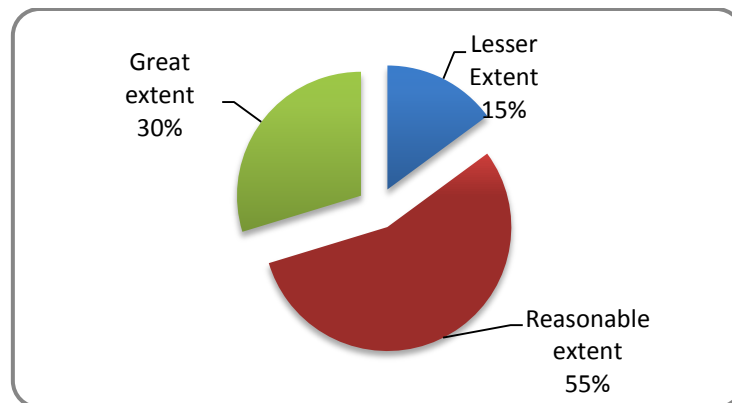


Figure B4-6: Impact of stress on trauma

The majority of police officials (85%) indicated that stress does have a reasonable to a great impact on the manner to which they experience trauma.

In conclusion the results indicated that stress outside the work situation is experienced to be very stressful. The results furthermore indicated that members stationed at the detective unit experience more stress within the work situation. Those police officials within committed relationships experience more stress outside the work situation. Police officials indicated that the stressors that they are being confronted with on a daily basis do have an impact on the manner to which they experience trauma.

6.3 The major causes of trauma within SAPS

Data loaded onto two factors measuring major causes of trauma referring to the frequency of exposure and degree of traumatization. These factors are provided in Table B4-5. The Cronbach's Alpha for these two factors range between .90 and .98, which according to recognised standards (Pietersen & Maree, 2007: 215) is considered a high level of reliability. Mean scores and standard deviations of traumatic incidents, and more specifically the frequency of exposure and degree of traumatization is provided for each factor in Table B4-5.

Table B4-5: Cronbach's Alphas, Means, and Standards Deviations for Major Causes of Trauma (MCT-SCALE)

No	Factor	N	Cronbach's Alpha	M	SD
1	FET	331	.90	2.22	.69
2	IET	324	.98	2.16	.83

Note. NO = Number, N = Total number in a sample, M = Mean, SD = Standard deviation, FET = Frequency of exposure to trauma and IET = Intensity of exposure to trauma.

The *FET* (Alpha = .90) measure the extent to which police officials are exposed to specific traumatic incidents within the work situation. Aspects such as how often police officials are exposed to dealing with corpses, attending horrific accident scenes and attending murder scenes, reflect some of the aspects measured by this factor.

The second factor, *IET* (Alpha = .98) measure the degree to which police officials are traumatised as a result of their frequent exposure to trauma. Aspects such as the degree to which they are traumatised by managing violent crowds, exposure to suicide scenes and involvement in a hostage situation, reflect some of the aspects measured by this factor.

The mean score for factor IET (M = 2.16, SD = .83) were significantly higher compared to the other major causes of trauma within SAPS as reflected in above construct. The result is an indication that the FET does have an impact on the IET, specifically referring to attending a murder scene, attending a horrific accident scene and exposure to dealing with corpses were found to be very traumatic.

Each factor was utilised separately in the following phase to assess group comparisons in respect of different biographical variables in Section A of the questionnaire by means of the following measuring instruments namely: Spearman's rank order correlation test (Spearman's rho), Analyses of variance (ANOVA), the Tukey post hoc procedure (HSD) and A statistical

hypothesis test (T-Test). The researcher will only report on those factors indicating construct validity and those that identify underlying empirical dimensions.

A *Spearman's rank-order* correlation was run to determine the relationship between age, years of service and responsibilities within SAPS and the factors indicated in Section C of the questionnaire. The results of this test are as follows:

Table B4-6: Correlation Coefficient, Sig. (2-tailed) and N for MCT-Scale

Factor FET		A	YSWS
Spearman's rho	Correlation Coefficient	.199**	.317**
	Sig. (2-tailed)	.000	.000
	N	331	325

Factor FET		V/FP	AC	APM	A
Spearman's Rho	Correlation Coefficient	.194**	.241	.342	.180
	Sig. (2-tailed)	.004	.000	.000	.005
	N	223	218	211	247

****Correlation is significant at the 0.01 level (2-tailed)**

***Note: Sig. (2-tailed) = Correlation is significant at the 0.05 level (2-tailed). FET = Frequency of exposure to trauma, A = Age, YSWS = Years' service within the SAPS.**

*** Note: FET = Frequency of exposure to trauma, V/FP = Vehicle foot patrol, AC = Attending complaints, APM = Attending post mortems and Administration.**

There was a positive correlation between A ($r_s(8) = .199, p = .000$), YSWS within the SAPS ($r_s(8) = .317, p = .000$), and FET, which was statistically significant. Secondly there was a positive correlation V/FP ($r_s(8) = .194, p = .004$), AC ($r_s(8) = .241, p = .000$), APM ($r_s(8) = .342, p = .000$), and A ($r_s(8) = .180, p = .005$) and FET which was statistically significant.

Analyses of variance (ANOVA) and the Tukey post hoc test (HSD) were conducted to establish if there are significant differences between rank, marital status, the specialised unit and the factors indicated in Section C of the questionnaire. The results of this test are as follows:

Table B4-7: Means, Standard Deviations, Degrees of freedom (df), mean square (ms), Fisher's F ratio, sig.(oneway) and effect size for the MCT-scale

R				df	ms	F	Sig.
FET				3	2.85	6.17	.00
No	Variables	M	SD	N	Subset for alpha = 0.05		Effect Size
					1	2	
1	C	2.02	.61	104	2.0196		.69
2	S	2.25	.70	52	2.2503	2.2503	
3	WO	2.28	.69	114	2.2820	2.2820	
4	O	2.49	.75	53		2.4908	
MS				df	ms	F	Sig.
FET				3	3.02	6.59	.00
	Variables	N	M	SD	Subset for alpha = 0.05		Effect Size
					1	2	
3	S	77	1.93	.63	1.9324		.60
2	CR	34	2.20	.75	2.2019	2.2019	
4	DW	27	2.25	.76	2.2501	2.2501	
1	M	193	2.34	.67		2.3373	
SU				df	ms	F	Sig.
FET				5	1.79	3.99	.002
	Variables	N	M	SD	Subset for alpha = 0.05		Effect Size
					1	2	
2	FCS	52	1.97	.61	1.9660		.71
3	TRT	16	1.99	.55	1.9921		.67
4	POP	57	2.22	.62	2.2158	2.2158	
1	LCRC	62	2.23	.71	2.2271	2.2271	
5	PES	31	2.35	.68	2.3481	2.3481	
6	DET	89	2.44	.71		2.4433	

SU		df	ms	F	Sig.		
DT		5	2.25	3.42	.005		
No	Variables	N	M	SD	Subset for alpha = 0.05		Effect Size
					1	2	
1	LCRC	59	1.94	.79	1.9375		.61
6	Detectives	87	2.09	.79	2.0859	2.0859	
2	FCS	52	2.09	.85	2.0888	2.0888	
3	TRT	16	2.12	.84	2.1170	2.1170	
5	PES	30	2.40	.76	2.3979	2.3979	
4	POP	57	2.48	.84		2.4807	

Correlation is significant at the $P < .05$ level.

*Note. R = Rank, df = degree of freedom, ms = mean square, F = Fisher's F ratio, FET = Frequency of exposure to trauma, C = Constable, S = Sergeant, WO = Warrant Official and O = Official.

*Note. MS = Marital status, FET = Frequency of exposure to trauma, S = Single, CR = Committed Relationship, DW = Divorced/widow/er, M = Married.

*Note. SU = Specialised unite, FET = Frequency of exposure to trauma, FCS = Family, children and sexual offences unit, TRT = Tactical response unit, POP = Public order police unit, LCRC = Local criminal record centre, PES = Police emergency services, DET = Detective services

*Note. SU = Specialised unit, DT = Degree of traumatization, LCRC = Local criminal record centre, DET = Detectives, FCS = Family and child sexual offences unit, TRT = Tactical response unit, PES = Police emergency services, POP = Public order police unit.

The results indicate a significant correlation between R on FET at the $P < .05$ level for the three conditions [$F(3, 319) = 6.17, P = .00$]. Post hoc comparisons using the Tukey HSD test indicated that the mean score for C ($M = 2.02, SD = .61$), effect size ($R = .69$) are significantly different compared to the other rank structures. Secondly the results indicate a significant correlation between MS on FET at the $P < .05$ level for the three conditions [$F(3, 327) = 6.59, P = .00$]. Post hoc comparisons using the Tukey HSD test indicated that the mean score for S ($M = 1.93, SD = .63$), effect size ($R = .60$) are significantly different compared to the other forms of relationships. Thirdly the results indicate a significant correlation between the SU on factor FET at the $P < .05$ level for the three conditions [$F(5, 301) = 3.99, P = .002$]. Post hoc comparisons using the Tukey HSD test indicated that the mean score for FCS ($M = 1.97, SD = .61$), effect size ($R = .71$) and TRT ($M = 1.99, SD = .55$) effect size ($R = .67$) are significantly different compared to the other specialised units. Lastly the results also indicate a significant correlation

between the SU on factor DET at the $P < .05$ level for the three conditions [$F(5, 295) = 3.42, P = .005$]. Post hoc comparisons using the Tukey HSD test indicated that the mean score for LCRC ($M = 1.94, SD = .79$), effect size ($R = .61$) are significantly different compared to the other specialised units.

A *T-Test* was conducted to establish if there are significant differences between gender, race and the factors indicated in the questionnaire. The results of this test are as follows:

Table B4-8: The t-value (t), degree of freedom (df), sig. (2-tailed), mean difference, effect size and the 95% confidence intervals (95%CI) of the difference between “lower” to “upper” columns for the MCT-scale

FET	Test Value = 4						
	t	df	Sig. (2-tailed)	Mean Difference	Effect Size	95% Confidence interval of the Difference	
						Lower	Upper
Male	4.589	33	0.000	.40215	.59	.22975	.57455
Female	4.810	14	0.000	.40215	-	.23682	.56747
R	Test Value = 4						
	t	df	Sig. (2-tailed)	Mean Difference	Effect Size	95% Confidence interval of the Difference	
						Lower	Upper
White	5.519	32	0.000	.58141	.86	.37413	.78869
African	5.989	68	0.000	.58141	-	.38767	.77515

Correlation is significant at the $P < .05$ level.

*Note: t = computed value of t-test, df = degree of freedom, .Sig. (2-tailed) = Correlation of significance (2-tailed), t = G = Gender, FET = Frequency of exposure to trauma, M = Male and F = Female.

*Note. R = Race, FET = Frequency of exposure to trauma. W = White and A = African.

The results indicate a significant difference between G on factor FET, (0.40, 95% CI [0.57 to 0.23], $t(33) = 4.589, p < .05 = 0.00$) which represent FET. More specifically the effect size of M ($R = .59$) indicate that this group are more likely to be influenced by FET. The results furthermore indicate a significant difference between R on factor FET, (0.58, 95% CI [0.79 to 0.37], $t(32) = 5.519, p < .05 = 0.00$) which represent the FET. More specifically the effect size of W ($R = .86$) indicate that this group are more likely to be traumatised as a result of FET.

In conclusion the results indicated that police officials have been exposed to different traumatic incidents that can be directly associated with the work itself. They have mostly been exposed to murder scenes, horrific accident scenes, dealing with corpses, suicide scenes and the sexual/physical abuse involving a female as the victim. The results furthermore indicated that the frequency of exposure to trauma does have an impact on the intensity of the experience of traumatic events. Older police officials, constables, males, those stationed at the Family, Child and Sexual Offences- and the Tactical Response Units, are more frequently exposed to trauma. The results also indicated that white police officials and those stationed at the Criminal Record Centre are more intensely traumatised as a result of their frequent exposure to traumatic incidents.

6.4 The response to trauma

Data loaded onto six factors measuring the response to trauma referring to re-experience, avoidance, hyperarousal, complex post-traumatic outcomes, social and behavioural risk factors and poor productivity. The Cronbach's Alpha for these six factors range between .91 and .97, which according to recognised standards (Pietersen and Maree, 2007: 215) is considered a high level of reliability. Mean scores and standard deviations for each of the above factors are provided in Table B4-9.

Table B4-9: Cronbach's Alphas, Means, and Standards Deviations for Response to trauma (RTT-Scale)

No	Factor	N	Cronbach's Alpha	M	SD
1.1	RE	330	.95	2.44	.90
1.2	A	330	.97	2.56	.72
1.3	H	329	.97	2.49	.73
2	CPTO	329	.92	1.51	.53
3	SBR	327	.91	1.28	.44
4	PP	330	.94	1.82	.63

Note: No = Number, N = Total number in a sample, M = Mean, SD = Standard deviation, RE = Re-experience, A = Avoidance, H = Hyperarousal, CPTO = Complex posttraumatic outcomes, SBR = Social and Behavioural risk factors and PP = Poor Productivity.

RE (Alpha = .95) measure the extent to which police officials are re-experiencing traumatic events. Aspects such as flashbacks, bad dreams, nightmares and intrusive re-experiences of the traumatic event, reflect some of the aspects measured by this factor.

The second factor, *A* (Alpha = .97) measure the degree to which police officials are avoiding the detail of traumatic events. Aspects such as avoiding thoughts, feelings, activities, places, people or conversations that might arouse recollections of the trauma, difficulty trusting and interpersonal conflicts and arguments, reflect some of the aspects measured by this factor.

The third factor, *H* (Alpha = .97) measure the extent to which police officials experience alterations in arousal and reactivity that began or worsened following exposure to traumatic events. Aspects such as anger, irritability, headaches, backaches and chest pain, reflect some of the aspects measured by this factor.

The forth factor, *CPTO* (Alpha = .92) measure the extent to which police officials develop psychopathology as a result of their exposure to traumatic events. Aspects such as post-traumatic stress disorder, depression and anxiety disorder reflect some of the aspects measured by this factor.

The fifth factor, *SBR* (Alpha = .91) measure the extent to which police officials develop social and behavioural risk factors in response to exposure to traumatic events. Aspects such as aggressive behaviour, domestic violence and suicide are some of the aspects measured by this factor.

The sixth factor, *PP* (Alpha = .94) measure the extent to which police officials productivity at work are influenced as a result of their exposure to traumatic events. Aspects such as a low morale, reduced level of job performance and absenteeism are some of the aspects measured by this factor.

The mean score for factor RE (M = 2.44, SD = .90), H (M = 2.49, SD = .73) and A (M = 2.56, SD = .72) were significantly higher compared to the other responses to trauma as reflected in above construct. The result is an indication that the symptoms reported by the respondents following exposure to trauma, namely RE, and H, largely resemble that of PTSD.

Each factor was utilised separately in the following phase to assess group comparisons in respect of different biographical variables in Section A of the questionnaire by means of the following measuring instruments namely: Spearman's rank order correlation test (Spearman's rho), Analyses of variance (ANOVA), the Tukey post hoc procedure (HSD) and a Statistical hypothesis test (T-Test). The researcher will only report on those factors indicating construct validity and those that identify underlying empirical dimensions.

Analyses of variance (ANOVA) and the Tukey post hoc test (HSD) were conducted to establish if there are significant differences between rank, marital status specialised unit and the factors indicated in Section D of the questionnaire. The test results are as follows:

Table B4-10: Means, Standard Deviations, Degrees of freedom (df), mean square (ms), Fisher's F ratio, sig.(oneway) and effect size for the MCT-scale

MS					df	MS	F	Sig.
CPTO					3	1.02	3.78	.011
	Variables	N	M	SD	Subset for alpha = 0.05		Effect Size	
					1	2		
2	CR	34	1.37	.39	1.3703		.80	
3	S	76	1.44	.53	1.4442		.66	
1	M	192	1.51	.51	1.5144		.53	
4	D/W	27	1.79	.68		1.7877		
R					df	MS	F	Sig.
PP					3	1.04	2.71	.045
	Variables	N	M	SD	Subset for alpha = 0.05		Effect Size	
					1	2		
1	C	104	1.73	.59	1.7310		.46	
2	S	52	1.76	.56	1.7568			
3	WO	113	1.85	.63	1.8462	1.8462		
4	O	53	2.02	.71		2.0155		

Correlation is significant at the $P < .05$ level.

*** Note. MS = Marital status, df = degree of freedom, MS = Mean square, F = Fisher's F ratio, Sig – Correlation of significance, CPTO = Complex posttraumatic outcomes, CR = Committed relationship, S = Single, M = Married and D/W = Divorced / Widow/er.**

***Note. R = Rank, PP = Poor productivity, C = Constable, S = Sergeant, WO = Warrant Official and O = Official.**

The results indicate a significant correlation between MS on CPTO at the $P < .05$ level for the three conditions [$F(3, 325) = 3.78, P = .011$]. Post hoc comparisons using the Tukey HSD test indicated that the mean score for CR ($M = 1.37, SD = .39$), effect size ($R = .80$), single ($M = 1.44, SD = .53$) effect size ($R = .66$) and M ($M = 1.51, SD = .51$) effect size ($R = .53$) are significantly different compared to the other forms of relationships. Secondly the results indicate a significant correlation between R on PP at the $P < .05$ level for the three conditions [$F(3, 318) = 2.71, P = .045$]. Post hoc comparisons using the Tukey HSD test indicated that the mean score for C ($M = 1.73, SD = .59$), effect size ($R = .46$) are significantly different compared to the other ranks.

A Spearman's rank-order correlation (spearman's rho) and a statistical hypothesis test (T-Test) was run but did not indicate any significant correlations between age, years of service, responsibilities at work, race, gender and the factors indicated in Section D of the questionnaire.

In conclusion the results indicated that re-experience, avoidance of stimuli and hyper arousal, are the responses mostly experienced by police officials following their exposure to traumatic events. Those police officials in committed relationships and those who are single are more likely to develop complex post traumatic outcomes. Lastly the results indicated that constables are more prone to poor productivity.

6.5 Coping with trauma (CWT-scale)

Data loaded onto three factors measuring coping styles, action orientated coping and avoidance coping. These factors are provided in Table B4-11. The Cronbach's Alpha for these three factors range between .77 and .97, which according to recognised standards (Pietersen & Maree, 2007: 215) is considered a high level of reliability. Mean scores and standard deviations for each of the above factors are provided in Table B4-11.

Table B4-11: Cronbach's Alphas, Means, and Standards Deviations for Coping with Trauma (CWT-Scale)

No	Factor	N	Cronbach's Alpha	M	SD
1	CS	329	.97	2.49	.73
2	AOC	332	.90	2.15	.64
3	AC	332	.77	2.58	.55

Note. No = number, N = Total number in a sample, M = Mean, SD = Standard deviation, CS = Coping style, AOC = Action orientated coping and AC = Avoidance Coping.

CS (Alpha = .97) measure the extent to which police officials either utilize an action-oriented CS, specifically referring to action-oriented coping mechanisms for example, participation in pro-active programs, seeking support from important others and participation in relaxation activities opposed to that of avoidance coping which refer to avoidance coping mechanisms for example, isolation, internalization of symptoms, avoiding reminders just to name a few.

The second factor, AOC (Alpha = .90) measure the manner to which police officials make use of AOC mechanisms in an attempt to cope after exposure to traumatic events. Aspects such as seeking support from important others, participation in relaxation activities and confidence in God, reflect some of the aspects measured by this factor.

The third factor, AC (Alpha = .77) measure the manner to which police officials make use of AC after exposure to traumatic events. Aspects such as socializing with friends, keeping emotions to oneself, avoidance of reminders of the trauma, reflect some of the aspects measured by this factor.

The mean score for factor AOC (M = 2.16, SD = .54) were significantly higher compared to the other coping styles reflected in above construct.

Each factor was utilised separately in the following phase to assess group comparisons in respect of different biographical variables in Section A of the questionnaire by means of the following measuring instruments namely: Spearman's rank order correlation test (Spearman's rho), Analyses of variance (ANOVA), the Tukey post hoc procedure (HSD) and a Statistical hypothesis test (T-Test). The researcher will only report on those factors indicating construct validity and those that identify underlying empirical dimensions.

Analyses of variance (ANOVA) and the Tukey post hoc test (HSD) were conducted to establish if there are significant differences between rank, marital status, specialised unit and the factors indicated in Section E of the questionnaire. The test results are as follows:

Table B4-12: Means, Standard Deviations, Degrees of freedom (df), mean square (ms), Fisher's F ratio, sig.(one way) and effect size for the MCT-scale

SU					df	MS	F	Sig.
AOCM					5	.962	2.29	.046
	Variables	N	M	SD	Subset for alpha = 0.05		Effect Size	
					1	2		
4	POP	57	1.92	.62	1.9257		.72	
2	FCS	52	2.08	.65	2.0837	2.0837		
6	DET	90	2.19	.59	2.1869	2.1869		
1	LCRC	62	2.22	.62	2.2230	2.2230		
5	PES	31	2.25	.86	2.2505	2.2505		
3	TRT	16	2.39	.67		2.3943		
SU					df	MS	F	Sig.
ACM					5	.861	2.88	.015
	Variables	N	M	SD	Subset for alpha = 0.05		Effect Size	
					1	2		
3	TRT	16	2.31	.35	2.3082			
6	DET	90	2.46	.59	2.4617	2.4617		
2	FCS	52	2.59	.56	2.5865	2.5865		
1	LCRC	62	2.66	.50		2.6591	.64	
4	POP	57	2.71	.55		2.7096	.73	
5	PES	31	2.71	.56		2.7103	.74	

Correlation is significant at the $P < .05$ level.

*Note. SU = Specialised units, df = degree of freedom, MS = Mean square, F = Fisher's F ratio, Sig = Correlation of significance, N = Total number in a sample, M = Mean, SD = Standard deviation, AOCM = Action oriented coping mechanisms, POP = Public order police, FCS = Family, child and sexual offences unit, DET = Detective services, LCRC = Local Criminal Record Centre, PES = Police emergency services, TRT = Tactical response unit.

*Note. SU = Specialised units, ACM = Avoidance coping mechanisms, TRT = Tactical response unit, DET = Detective services, FCS = Family, child and sexual offences unit, LCRC = Local criminal record centre, POP = Public order police unit, PES = Police emergency services.

The results indicate a significant correlation between the SU on AOCM at the $P < .05$ level for the three conditions [$F(5, 302) = 2.29, P = .046$]. Post hoc comparisons using the Tukey HSD test indicated that the mean score for POP ($M = 1.92, SD = .62$), effect size ($R = .72$) are significantly different compared to the other placements. Secondly the results indicate a significant correlation between the SU on ACM at the $P < .05$ level for the three conditions [$F(5, 302) = 2.88, P = .015$]. Post hoc comparisons using the Tukey HSD test indicated that the mean score for LCRC ($M = 2.66, SD = .50$), effect size ($R = .64$), POP ($M = 2.71, SD = .55$) effect size ($R = .73$) and PES ($M = 2.71, SD = .56$) effect size ($R = .74$) are significantly different compared to the other placements.

A *statistical hypothesis (T-Test)* was conducted to establish if there are significant differences between gender, race and the factors indicated in Section E of the questionnaire. The test results are as follows:

Table B4-13: The t-value (t), degree of freedom (df), sig. (2-tailed), mean difference, effect size and the 95% confidence intervals (95%CI) of the difference between “lower” to “upper” columns for the CWT-scale

AOCM	Test Value = 4						
	t	df	Sig. (2-tailed)	MD	Effect Size	95% Confidence interval of the Difference	
						Lower	Upper
W	4.120	32	.000	.41115	.63	.21480	.60749
A	4.879	74	.000	.41115	-	.24325	.57904

Correlation is significant at the $P < .05$ level.

***Note. AOCM = Action oriented coping mechanisms, : t = computed value of t-test, df = degree of freedom, .Sig. (2-tailed) = Correlation of significance (2-tailed), MD = Mean difference, W = White and A = African.**

The results indicate a significant difference between R on AOCM, ($0.41, 95\% \text{ CI } [0.61 \text{ to } 0.21]$, $t(32) = 4.120, P < .05 = 0.00$). More specifically the effect size of W ($R = .63$) indicate that this group are more likely to adopt AOCM to manage the impact and consequences of trauma.

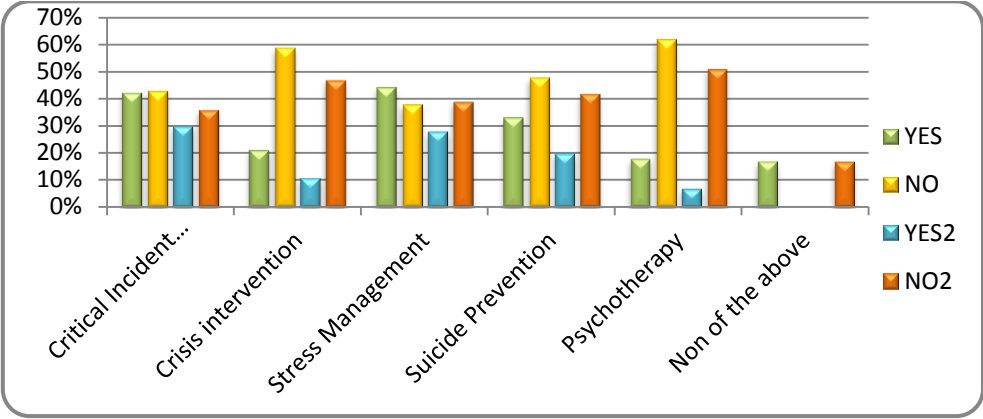
A *Spearman's rank-order* correlation (spearman's rho) was run but did not indicate any significant correlations between age, years of service, responsibilities at work and the factors indicated in Section D of the questionnaire.

In conclusion the results indicated that police officials mostly adopt action oriented coping styles to cope as a result of their exposure to traumatic events. The results furthermore indicated that

white police officials are more likely to adopt action oriented coping mechanisms to manage the impact and consequences of trauma. Secondly police officials attached to the Public Order Policing unit are more likely to adopt action oriented coping styles. In contrast with the last mentioned the results indicated that members attached to the Local Criminal Record Centre and the Police Emergency Services are more likely to make use of avoidance coping mechanisms.

6.6 Experience of current trauma intervention programs

The researcher firstly wanted to determine whether police officials are familiar with the trauma intervention programs presented by EHW in SAPS, and if so to what extend they participated in these programs. The following chart represents the different trauma intervention programs known to the respondents as well as the degree of participation.



Histogram B4-5: Trauma intervention programs

Most of the participants are familiar with the stress management program (44%) but only 28% participated, critical incident stress debriefing (42%) but only 30% participated and the suicide prevention program (33%) opposed to only 20% who participated. Programs least participated are psychotherapy (51%), crisis intervention (47%) and suicide prevention (41.9%). A total of 17% of the respondents indicated that they are not familiar nor participated in any of above programs.

Secondly the researcher wanted to determine the attitude and mind set of police officials towards consulting EHW and the participation in trauma intervention programs and the impact of this mind set on their experience of these programs.

Table B4-14: Reasons for not consulting EHW

No	Factors	N	%
1	All my personal details are kept on file	189	56.9
2	Confidentiality are not always maintained	205	61.7
3	My possibility for future promotions will be at risk	164	49.4
4	EHW do not always maintain professional behaviour	136	41.0
5	The quality of service delivery by EHW is poor	147	44.3
6	EHW are not objective, as they are employed by and part of SAPS Management	160	48.2
7	I do not allow myself sufficient time to consult or attend the programs presented by EHW	157	47.3

Note: No = number, N = Total number in a sample, % = percent.

More than half of the respondents (62%) indicated that confidentiality is not always maintained. Approximately 57% of the respondents are of the opinion that all personal details are kept on file, whilst almost 50% of the respondents indicated that their possibility for future promotions will be at risk should they consult EHW as a result of exposure to trauma.

The rest of the data in Section F of the questionnaire loaded onto six factors measuring the police culture, trauma intervention by EHW, experience of trauma intervention programs, reasons for non-participation, preferences regarding format of trauma intervention programs and preferences regarding content of trauma intervention programs. These factors are provided in Table B4-15. The Cronbach's Alpha for these six factors range between .71 and .96, which according to recognised standards (Pietersen and Maree, 2007: 215) is considered a high level of reliability. Mean scores and standard deviations for each of the above factors are provided in Table B4-15.

Table B4-15: Cronbach's Alphas, Means, and Standards Deviations for experience of trauma intervention programs (ETIP-SCALE)

No	Factor	N	Cronbach's Alpha	M	SD
1	PC	332	.89	1.95	.50
2	EHW	332	.71	1.85	.71
5	ETIP	262	.96	2.26	.72
6	NPTIP	323	.90	2.41	.60
7	PFTIP	332	.88	2.12	.58
8	PFCTIP	329	.97	1.85	.50

Note. No = number, N = Total number in sample, M = Mean, SD = Standard deviation, PC = Police culture, EHW = Employee Health and Wellness, ETIP = Experience of trauma intervention programs, NPTIP = Non-participation in trauma intervention programs, PFTIP = Preferences regarding format of trauma intervention programs, PCTIP = Preferences regarding content of trauma intervention programs.

The *PC* (Alpha = .89) measure the extent to which PC influences the manner to which police officials are willing to participate in trauma intervention programs. Aspects such as the image of the police as “cowboy’s don’t cry”, the perception that police officials showing emotion are usually labelled as weak, emotionless order and the projection of a facade of competence while harbouring a feeling of insecurity, reflect some of the aspects measured by this factor.

The second factor, *TI (EHW)* (Alpha = .71) measure the manner to which police officials experience EHW in facilitating trauma intervention programs. Aspects such as the quality of service delivery, trust and confidentiality reflect some of the aspects measured by this factor.

The third factor, *ETIP* (Alpha = .96) measure the manner to which police officials experience trauma intervention programs presented by EHW. Aspects such as the content of the program, the time and duration of programs, and adherence to specific needs on ground level are some of the aspects measured by this factor.

The forth factor, *RNP* (Alpha = .90) measure some of the reasons for police officials hesitance to participate in trauma intervention programs. Aspects such as ineffective marketing, limited time available to attend and the non-participation in the development of prospective programs are some of the aspects measured by this factor.

The fifth factor, *PFTIP* (Alpha = .88) measure the police officials preferences with regard to the format of trauma intervention programs. Aspects such as individual opposed to group

intervention, interventions at the end of a shift and a structured group intervention on a regular basis are some of the aspects measured by this factor.

The sixth factor, *PCTIP* (Alpha = .97) measure the police officials preferences with regard to the content of trauma intervention programs. Aspects such as psycho-education, relaxation therapy, re-integration into the working environment and couple and family therapy are some of the aspects measured by this factor.

The mean score for factor PC (M = 1.95, SD = .50) and EHW (M = 1.85, SD .71) were significantly higher compared to the other experiences of trauma intervention programs in above construct.

In addition the researcher wanted to determine police official's preferences or needs regarding the content of trauma intervention programs presented by EHW in SAPS. The researcher included all the topics that transpired as a result of the first qualitative phase and the respondents had to answer on a four point scale from strongly agree to strongly disagree. Most of the participants (89%) indicated a need for psycho-education specifically referring to trauma, stress, reactions and coping, dealing with fear (88%), relaxation therapy (87%), re-integration into the working environment (87%), psycho-education specifically referring to trauma, stress, reactions and coping (86%), behavioural risk factors, referring to anger, rage and suicide ideation (86%), problem solving techniques (86%), the impact of stress on the body (86%), spiritual guidance (84%), resilience (83%), re-integration into the community (82%), how to deal with flashbacks (82%), identification of inner resources (81%) and couple therapy (80%). Police officials are least interested in retelling the incident in as much detail as possible (65%) and the modification of negative biased beliefs (69%).

Each of the factors mentioned above was utilised separately in the following phase to assess group comparisons in respect of different biographical variables in Section A of the questionnaire by means of the following measuring instruments namely: Spearman's rank order correlation test (Spearman's rho), Analyses of variance (ANOVA), the Tukey post hoc procedure (HSD) and a Statistical hypothesis test (T-Test). The researcher will only report on those factors indicating construct validity and those that identify underlying empirical dimensions.

Analyses of variance (ANOVA) and the Tukey post hoc test (HSD) were conducted to establish if there are significant differences between rank, marital status, specialised units and the factors indicated in Section F of the questionnaire. The test results are as follows:

Table B4-16: Means, Standard Deviations, Degrees of freedom (df), mean square (ms), Fisher's F ratio, sig.(oneway) and effect size for the MCT-scale

SU					df	MS	F	Sig.
PC					5	.836	3.60	.004
	Variables	N	M	SD	Subset for alpha = 0.05		Effect Size	
					1	2		
3	TRT	16	1.78	.56	1.7760		.77	
6	DET	90	1.82	.51	1.8198		.68	
1	LCRC	52	1.91	.42	1.9072	1.9072		
2	FCS	62	2.01	.49	2.0125	2.0125		
4	POP	57	2.06	.48	2.0574	2.0574		
5	PES	31	2.15	.46		2.1470		
SU					df	MS	F	Sig.
EHW					5	1.34	2.81	.017
	Variables	N	M	SD	Subset for alpha = 0.05		Effect Size	
					1	2		
4	POP	57	1.63	.55	1.6317		.77	
2	FCS	52	1.73	.72	1.7308			
5	PES	31	1.81	.83	1.8065	1.8065		
6	DET	90	1.93	.71	1.9259	1.9259		
1	LCRC	62	1.98	.66	1.9812	1.9812		
3	TRT	16	2.17	.76		2.1667		
MS					df	MS	F	Sig.
NPTIP					3	1.23	3.47	.016
	Variables	N	M	SD	Subset for alpha = 0.05		Effect Size	
					1	2		
2	CR	34	2.31	.35	2.1188		.65	
4	D/W	24	2.46	.59	2.3718	2.3718		
1	M	189	2.59	.56	2.4256	2.4256		
3	S	76	2.71	.56		2.5076		

Correlation is significant at the $P < .05$ level.

*Note. SU = Specialised units, df = degree of freedom, MS = Mean square, F = Fisher's F ratio, Sig. = Correlation of significance, PC = Police culture, TRT = Tactical response unit,

DET = Detective services, LCRC = Local criminal record centre, FCS = Family, child and sexual offences unit, POP = Public order police unit, PES = Police emergency services.

***Note. SU = Specialised units, EHW = Employee Health and Wellness, POP = Public order police unit, FCS = Family, child and sexual offences unit, PES = Police emergency services, DET = Detective services, LCRC = Local criminal record centre and TRT = Tactical response unit.**

***Note. MS = Marital status, NPTIP = Non participation in trauma intervention programs, CR = Committed relationship, D/W = Divorced / Widow/er, M = Married, S = Single.**

The results indicate a significant correlation between the SU on PC at the $P < .05$ level for the three conditions [$F(5, 302) = 3.60, P = .004$]. Post hoc comparisons using the Tukey HSD test indicated that the mean score for LCRC ($M = 1.78, SD = .56$), effect size ($R = .77$) and DET ($M = 1.82, SD = .51$) effect size ($R = .68$) are significantly different compared to the other placements. Secondly the results indicate a significant correlation between MS on NPTIP at the $P < .05$ level for the three conditions [$F(3, 319) = 3.47, P = .016$]. Post hoc comparisons using the Tukey HSD test indicated that the mean score for CR ($M = 2.31, SD = .35$), effect size ($R = .65$) are significantly different compared to the other placements. Thirdly the results indicate a significant correlation between the SU on EHW at the $P < .05$ level for the three conditions [$F(5, 302) = 2.810, P = .017$]. Post hoc comparisons using the Tukey HSD test indicated that the mean score for POP ($M = 1.63, SD = .55$), effect size ($R = .77$) are significantly different compared to the other placements.

A T-Test was conducted to establish if there are significant differences between race, gender and the factors indicated in section F of the questionnaire. The test results are as follows:

Table B4-17: The t-value (t), degree of freedom (df), sig. (2-tailed), Mean difference, effect size and the 95% confidence intervals (95%CI) of the difference between “lower” to “upper” columns for the ETIP-scale.

RCEHW		Test Value = 4						
		t	df	Sig. (2-tailed)	Mean Difference	Effect Size	95% Confidence interval of the Difference	
R							Lower	Upper
W		5.071	32	.000	.54436	.79	.33317	.75555
A		5.408	66	.000	.54436	-	.34339	.74533
NPTIP		Test Value = 4						
		t	df	Sig. (2-tailed)	Mean Difference	Effect Size	95% Confidence interval of the Difference	
R							Lower	Upper
W		-3.256	32	.001	.31589	.52	-.50678	-.12501
A		-4.124	71	.000	.31589	-	-.46862	-.16316
PRF		Test Value = 4						
		t	df	Sig. (2-tailed)	Mean Difference	Effect Size	95% Confidence interval of the Difference	
R							Lower	Upper
W		3.097	32	.002	.28055	.49	.10232	.45879
A		3.166	64	.002	.28055	-	.10352	.45758

Correlation is significant at $P < .05$ level.

*Note. RCEHW = Reasons for not consulting EHW, t = computed value of t test, df = degree of freedom, Sig. (2-tailed) = Correlation of significance (2-tailed), W = White and A = African.

*Note. NPTIP = Non participation in trauma intervention programs, W = White and A = African.

*Note. PRF = Preferences regarding format, W = White and A = African.

The results indicate a significant difference between R on factor RCEHW, (0.54, 95% CI [0.76 to 0.33], $t(32) = 5.071$, $P < .05 = 0.00$) which represent the value of EHW in the SAPS. More specifically the effect size of W ($R = .79$) indicate that this group are more likely to value EHW in the SAPS and the trauma intervention programs presented by them as an important resource to render support following exposure to trauma. Secondly the results indicate a significant

difference between R on factor NPTIP (0.31, 95% CI [-.13 to -.50], $t(32) = -3.256$, $P < .05 = 0.00$). More specifically the effect size of W ($R = .52$) indicate that this group are less likely to participate in trauma intervention programs. Thirdly the results indicate a significant difference between R on factor PRF (0.28, 95% CI [.46 to .10], $t(32) = 3.097$, $p < .05 = 0.00$). More specifically the effect size of W ($R = .49$) indicate that this group are more likely to have specific preferences regarding the format of trauma intervention programs.

A *Spearman's rank-order* correlation (spearman's rho) was run but did not indicate any significant correlations between age, years of service, responsibilities at work and the factors indicated in Section F of the questionnaire.

In conclusion the results indicated that police officials are mostly aware of the stress management and the critical incident stress debriefing programs. Programs least participated are psychotherapy, crisis intervention and suicide prevention. The results also indicated that although police officials are aware of the trauma intervention programs they do not necessarily participate in these programs. The reasons indicated are the police culture, the perceptions regarding EHW in SAPS and police officials experience of trauma intervention programs. Police officials attached to the Local Criminal Record Centre and the Detectives are mostly affected by the police culture. Those police officials involved in committed relationships are more likely to participate in trauma intervention programs. Members attached to the Public Order Policing unit mostly indicated that they doubt consulting EHW or participating in programs presented by EHW. White police officials are more likely to value EHW and the trauma intervention programs. Despite the above result this group are mostly not participating in trauma intervention programs. The result indicated that this group have more specific preferences regarding the format of trauma intervention programs. The last mentioned might be an explanation for this group's non-participation of programs.

7. Discussion

The themes, sub-themes and categories of the sub-themes arising from the first qualitative phase of this study were included as constructs in a self-developed questionnaire in the second quantitative phase. In this article the researcher wanted to determine if data arising from the first qualitative phase can be generalised to a larger sample of police officials stationed at the specialist units within the North West Province. A summary of the findings is given to present a logical conclusion of the combined research approach. The latter will be presented in the logical order of the various themes, namely the meaning of trauma, response to trauma, coping and trauma intervention programs.

- The major causes of stress in SAPS

The findings indicated that police officials experience stressors outside the work situation as much more significant compared to the other major causes of stress in SAPS. The result is an indication that stressors outside the work situation, specifically referring to the offensiveness of the community towards SAPS, the expectations of SAPS opposed to those of the community and the criminal justice system are experienced to be very stressful. Shakespeare-Finch and Waters (cited in Oosthuizen & Koortzen, 2007: 49) statements corresponds with the above and classified the following factors outside the work situation: the justice system, negative public image, politics, the expectations of SAPS opposed to those of the community, media on the scene, policing within the framework of human rights.

The group comparisons in respect of the different biographical variables contained in the questionnaire indicated the following correlations: Firstly the results indicate that police officials stationed at the detective unit experience more stress within the work situation, specifically referring to limited promotional opportunities, an autocratic management style and the bureaucracy of the organization, as more severe or different from the other specialist units. Secondly the findings indicated that those police officials within committed relationships experience more stress outside the work situation, specifically referring to the offensiveness of the community, the expectations of SAPS opposed to those of the community and the criminal justice system. The majority of police officials indicated that the stressors that they are being confronted with on a daily basis does have a reasonable to a great impact on the manner to which they experience trauma as mentioned before. Miller (2005: 101) and Morash *et al.* (2006: 26) concur with the above and are of the opinion that the bureaucratic structure of SAPS, policing within the community, a lack of respect for police officials, the criminal legal system and co-operation with the community as well as police officials' personal circumstances are major stressors that might have an impact on the manner to which police officials experience trauma.

- Major causes of trauma in SAPS

Most of the police officials have to a lesser or greater extend being exposed to different traumatic incidents that can be directly associated with the work itself. Respondents have been most frequently exposed (more than twice during their career) to murder scenes, horrific accident scenes, dealing with corpses, suicide scenes and the sexual/physical abuse involving a female as the victim. Pienaar and Rothmann (2005: 58) support the above findings and specifically refer to the high crime levels, police official's subsequent exposure to violence, crisis and dangerous life threatening situations, originating within the work situation.

The results also indicated that there is a clear relationship between frequency and intensity of specific types of trauma exposure, specifically referring to murder scenes, horrific accident scenes and exposure to dealing with corpses were found to be extremely traumatic (James & Gilliland, 2013: 163). The researcher therefore came to the conclusion that the frequency of exposure to these incidents over a long period of time, combined with the intensity thereof, eventually determine the cumulative impact of the traumatic incident on them. Fiorillo and Follette (2012: 188), Leshner *et al.* (2012: 572) and Papazoglou (2012:122) emphasises that the severity of traumatic events that the police official are exposed to constitutes risk factors. According to the authors such traumatic events are comprised of the frequency, duration, intensity, cumulative exposure, and re-victimization of the traumatic event. It has been found to cause reactions that are more severe. Courtois *et al.* (2009: 85-86) refer to these reactions as complex trauma and although this diagnostic category has so far fallen short of achieving official recognition this category constitutes of somatization, dissociation, and affect dysregulation.

The group comparisons in respect of the different biographical variables contained in the questionnaire indicated the following correlations: Firstly the results indicated that older police officials and having longer years within SAPS are more frequently exposed to trauma. This was expected as more experienced police officials do have a larger probability of exposure to trauma over a long period of time. Secondly the results indicate a significant correlation between the rank of the police officials and the frequency of exposure to trauma. Especially constables are more frequently exposed to trauma. Constables, being the lowest in the rank structure of SAPS, are mainly working on ground level, doing vehicle and foot patrol and attending crime scenes. As a result of this it can be accepted that they will be frequently exposed to traumatic incidents. Thirdly the results indicate that males are more influenced by the frequency of exposure to trauma. The researcher came to the conclusion that male police officials are more likely to be in the frontline than female police officials.

Fourthly the results indicated that white police officials are more traumatised as a result of the execution of their job. This can be linked to their experience of horrific scenes and life threatening situations, which might have a direct impact on the manner to which they are able to do their job. Fifth the results indicated single police officials are more frequently exposed to trauma. This might be attributed to the fact that single police officials are mainly juniors who are not yet married. They mostly form part of the lowest rank structure (constables) who are working on ground level and therefor as a result of the execution of basic policing more frequently exposed to trauma. Sixth it was found that especially those police officials stationed at FCS, and TRT are more frequently exposed to trauma than the other specialised units. This might be attributed to the increase in serious crimes involving, woman and children, as well as more complex criminal activities that are more frequently attended too. Seventh it was found that

members from LCRC experience their exposure to traumatic incidents to be more intense than those of the other specialised units. Police officials from this unit are mostly re-traumatised as a result of the prolonged investigation process, which involve photographs of the scene, attending post mortems, facial compositions, and lastly testimony in court, during which they are repeatedly exposed to the detail of the trauma, causing intense experiences of the traumatic incidents. Lastly the results also indicated that police officials responsible for vehicle and foot patrol, those attending crime scenes and post mortems are more frequently exposed to trauma than those police officials that are doing photography, fingerprints, crowd control and specialised operations. The specific responsibilities as indicated give rise to more frequent exposure to trauma than any of the other responsibilities included in the questionnaire.

- The response to trauma

The results indicated that re-experience, avoidance of stimuli and hyperarousal, are the responses mostly experienced by police officials following their exposure to traumatic events. These factors more specifically refer to flashbacks, bad dreams and nightmares, trouble falling or staying asleep, avoiding thoughts, feelings activities, places, people or conversations that might arouse recollections of the trauma, difficulty trusting, interpersonal conflicts and arguments, anger, headaches, backaches, chest pains and irritability. The symptoms mentioned by the group members greatly corresponds with the explanation by Godbout and Briere (2012: 485) who refer to the symptoms associated with re-experience as recurrent, involuntary, and intrusive memories, traumatic nightmares, dissociative reactions (e.g., flashbacks), the symptoms of avoidance of stimuli as deliberate avoidance thoughts or feelings but also external reminders for example people, places, conversations, activities, objects or situations which remind the individual of such an event, and the symptoms associated with hyperarousal as irritable or aggressive behaviour, self-destructive or reckless behaviour, hypervigilance, exaggerated startle response, problems in concentration and sleep disturbance. The result is an indication that the above symptoms reported by the respondents following exposure to trauma, largely resemble that of PTSD. The above findings are in accordance with the four cluster symptoms as proposed by the DSM-5, which are described as re-experiencing, avoidance, negative cognitions and mood, and arousal (American Psychiatric Association, 2013: 265).

The group comparisons in respect of the different biographical variables contained in the questionnaire indicated the following correlations: Firstly the results indicate a significant correlation between marital status and complex post-traumatic outcomes. It was found that especially those police officials who are single and those in committed relationships are more likely to develop complex post-traumatic outcomes. This group of police officials appear to be more likely to experience depression and PTSD. The results might be an indication that marital status can be associated with emotional support, which might not be as prominent amongst

those that are single or in committed relationships opposed to those that are married. Secondly the results indicate a significant correlation between rank and poor productivity. Especially the constable's production appears to be poor. Constables fall within the category of police officials who are mostly involved with vehicle and foot patrols, and in the frontline of duty, thereby mostly confronted with traumatic incidents over a long period of time. Therefore, the conclusion can be made that constables are more likely to develop burnout which in return are associated with a low morale, a reduced level of job performance and tardiness.

- Coping with trauma

The results indicated that police officials mostly adopt action oriented coping styles to cope as a result of their exposure to traumatic events. The result is an indication that an action orientated coping style, specifically referring to support from important others, participation in relaxation activities and putting one's confidence in God are mostly adopted by police officials to cope as a result of their exposure to traumatic events. The definition of action-oriented coping by Taylor and Stanton (2007: 377) as intra-psychoic efforts to manage the demands created by stressful events strongly corresponds with the findings as indicated above. Louw and Viviers (2010: 3) add that action-oriented coping strategies are used to confront the problem and to control the situation or improve one's resources in the hope of reducing the imbalance.

The group comparisons in respect of the different biographical variables contained in the questionnaire indicated the following correlations: Firstly the results indicate that white police officials are more likely to adopt action oriented coping mechanisms to manage the impact and consequences of trauma. Secondly the results indicated that there is a significant correlation between the specialised units and coping styles. Especially police officials attached to the POP are more likely to adopt action oriented coping styles. These groups indicated that they put their confidence in God, they participate in relaxation activities, seek support from important others especially family members, and participate in pro-active programs presented by EHW. Secondly and in contrast with the above the results indicated that members attached to LCRC and PES are more likely to make use of avoidance coping mechanisms. This group indicated that they socialize with friends, avoid reminders of the trauma and keep emotions to themselves.

- Experience of trauma intervention programs

Some of the police officials indicated that they are not familiar nor participated in any of the trauma intervention programs before. Trauma interventions programs mostly familiar with are the critical incident stress debriefing and stress management programs. Programs least participated are individual psychotherapy, crisis intervention and the suicide prevention program.

As an explanation for the above the results indicated that there is a significant correlation between the police culture, the perceptions regarding EHW in SAPS and police officials experience of trauma intervention programs. Kotler and Armstrong (2014: 312) refer to the above as dynamic pricing and define it as “charging different prices depending on individual customers and situations”. The researcher, for the purpose of this article, refers to the above as psychological cost factors. The result is an indication that the police culture and the negative perception regarding EHW in SAPS are two very important aspects which do have a direct impact on police official’s experience of trauma intervention and the consequent non-participation. Stevens (2009: 540) confirm the significance of the police culture with the following quote “...after a gunfight, we’d have a few beers and call it a night”. According to the author there is no room for tears in the police. Part of their work is to be tough, to suppress emotions. The negative perception regarding EHW is mainly contributed to police official’s perception that confidentiality is not always maintained. According to Kirschman *et al.* (2014: 22) confidentiality is the foundation of managing the therapeutic alliance. He furthermore emphasises the fact that police officials are not eager clients. It takes a lot for them to seek help and very little to turn them off. Therapists who make mistakes with police officials normally do not get second chances.

The group comparisons in respect of the different biographical variables contained in the questionnaire indicated the following correlations: Firstly the results indicate that police officials attached to the LCRC and the Detectives are mostly affected by the police culture. They indicated amongst others that culture is deeply embedded into every element of SAPS that police officials have to adhere to objectivity and neutrality, that the police culture value action instead of feeling and that policing is seen as a way of life instead of that as a job. Secondly the results indicated that those police officials involved in committed relationships are more likely not to participate in trauma intervention programs. This group of police officials indicated that they are not consulted in the development of prospective trauma intervention programs, that the programs are generally not marketed effectively and that police officials are not granted time off to attend these programs. Thirdly the results indicated that members attached to POP doubt consulting EHW or participating in programs presented by EHW. The indication is that confidentiality is not always maintained, personal details are kept on file and future promotions might be at risk.

Forth the results indicated that white police officials are more likely to value EHW and the trauma intervention programs presented by them as an important resource to render support following exposure to trauma. This group indicated that there is a need for intervention by EHW, immediately after exposure to traumatic events and that an ordinary police official can gain by visiting a psychologist, social worker or chaplain. Fifth the results indicated that white police

officials are mostly not participating in trauma intervention programs. Reasons for not participating in trauma intervention programs are due to the fact that they are not consulted in the development of prospective trauma intervention programs, programs are generally not marketed effectively and the general feeling that police management does not really care about the psycho-social well-being of police officials. Sixth the results indicated that white police officials have more specific preference regarding the format of trauma intervention programs. These preferences include individual intervention, structured group intervention on a regular basis (weekly, monthly, quarterly), and group intervention during parades at unit level. The researcher concluded that white police officials do value EHW and the programs presented by them. They do however not participate in the programs as they are not oriented with regards to these programs. They are furthermore not satisfied as their preferences and specific needs regarding the content and the format of these programs are not met.

The themes, sub-themes and categories of the sub-themes arising from the first qualitative phase were included as constructs in a self-developed questionnaire in this second quantitative phase. In this article the researcher wanted to determine if data arising from the first qualitative phase could be generalised to a larger sample of police officials stationed at the specialist units within the whole of the North-West Province in other words to quantitatively verify the opinions and experiences of those police officials who participated in the three focus groups.

It can therefore be confirmed that the needs that have been identified during the second quantitative phase greatly correspond with those obtained during the first qualitative phase. As part of the process of triangulation the data arising from both the qualitative and quantitative phase have been compared, integrated and divided into the following categories: educational-, physical-, psychological, social and spiritual needs. The educational needs include: needs regarding skills to better deal with the signs and symptoms following exposure to a traumatic event, and knowledge regarding trauma and the impact thereof on the individual and those closely related to the individual. The physical needs of police officials include the impact of stress on the body, health, relaxation, economic implications and maintenance of the family, protection, discrimination, stigmatization, safety, and confidentiality. The psychological needs include: exposure to the event, identifying and coping with negative emotions and thoughts and behavioural risk factors. Social needs include relationship with important others, identification of inner and external resources, rights, obligations, security, re-integration into the place of work and the community. Spiritual needs include needs regarding coping, problem solving, resilience, counselling and support from a social worker, psychologist, church minister, medical doctor or psychiatrist. These also include love and support from peers, police management and especially immediate family members.

It was therefore confirmed that the data arising from the three focus groups in the first qualitative phase can to a great extent be generalised to the larger sample of police officials stationed at the specialist units within the North-West Province and can therefore be used as an indicator to the development of a PTP to address the problems regarding trauma in SAPS.

8. Conclusion

In this article the findings of the second quantitative phase of the study, namely the questionnaire survey has been discussed. The findings have been structured according to the themes of the qualitative study's findings namely: the meaning of trauma, response to trauma, coping and trauma intervention programs. The aim of the second quantitative phase of the study was to test the identified themes, sub-themes and categories of sub-themes arising from the qualitative study within the total population, in other words, to quantitatively verify the opinions and experiences of those police officials who participated in the three focus groups. The findings of the second quantitative phase confirm that the data arising from the three focus groups in the first qualitative phase can to a great extent be generalised to the larger sample of police officials stationed at the specialist units within the North West Province.

9. Recommendations

It is evident that the data arising from the first qualitative phase of the study can to a great extent be generalised to the larger population of police officials attached to the specialised units in the North West Province. It was therefore confirmed that police officials attached to these units are exposed to and affected by trauma and do have unique circumstances and needs. A broader perspective on these circumstances is critical to get a better idea of their specific needs. Based on the discussion of the results from this study and on the conclusion that was drawn, the following recommendations can be made:

- This research can be used as platform for the development of various interventions with police officials exposed to or affected by trauma;
- Before any intervention program is planned for police officials exposed to trauma, an assessment should be done to determine and verify the population's unique needs with regards to intervention via their active participation in the whole process;
- Elements of the TF-CBT, PE and the eco-systems perspective can be included in a single psycho-social therapeutic program considering the specific needs of the population;
- The results with regard to the needs of police officials attached to the specialised units in the North-West Province should be utilised in further research regarding program development in the field of trauma; and

- A PTP should be developed based on the exploration of some of the best elements of existing trauma intervention approaches, to assist police officials exposed to and affected by trauma.

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ARTICLE 5

A PSYCHO-SOCIAL THERAPEUTIC PROGRAM FOR POLICE OFFICIALS ATTACHED TO THE SPECIALISED UNITS WITHIN THE SOUTH AFRICAN POLICE SERVICE

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Keywords

Psycho-social Therapeutic Program, Police Officials, Specialised Units, South African Police Service

Abstract

This article focuses on the development of a Psycho-social Therapeutic Program (PTP) for police officials attached to the specialised units in the North West Province. The objective is to prevent the onset of post-traumatic stress disorder and the development of trauma-related stress symptoms soon after exposure to a traumatic event. A needs assessment was conducted on a large number of police officials attached to specialised units that are affected by traumatic events as a result of the high risk involved in their work. During this study members were selected according to specific criteria for inclusion in the program. The aim, screening of members for inclusion in this program, planning and compiling as well as the phases of the psycho-social therapeutic program, are first discussed. The main focus of this article is on the themes and contents of the designed PTP.

A PSYCHO-SOCIAL THERAPEUTIC PROGRAM FOR POLICE OFFICIALS ATTACHED TO THE SPECIALISED UNITS WITHIN THE SOUTH AFRICAN POLICE SERVICE

1. Introduction

Police officials are continuously exposed to job-related trauma and stress such as dealing with unlawful, often dangerous actions of citizens and abusive treatment in the workplace with a lack of social support. Police officials have more stress-related physical complaints and psychological and social needs than workers in most other professions (Anshel, 2000: 375). The exploration of these needs should form the foundation of an effectively designed PTP to act in the best interest of the traumatised police official (Morash *et al.*, 2006: 28). In designing the program it is important to address issues that are relevant to the context of the police officials working demands and its impact on their overall psycho-social wellness. In preventing the onset of post-traumatic stress disorder and development of trauma-related stress symptoms soon after exposure to a traumatic event, it is important that police officials should be guided through a program educating and empowering them with skills and assisting them to cope with their circumstances (Litz *et al.*, 2002: 112). This program was designed to address various psychological and social needs and different aspects police officials have to deal with when they are exposed to traumatic events. This article describes the aim of the study and provides guidelines for the implementation of the PTP. The criteria for the selection and inclusion of police officials as respondents for this program are discussed. The process planning and compilation of the program are explained with reference to the process of program compilation, phases of group work, group work as a process, elements of a therapeutic program, and the selection of program activities. The designed program is then discussed thematically, providing the rationale, agenda and content of each session.

2. Problem statement

Police officials are exposed to a unique work environment facing potentially traumatic events which could have an impact on their physical, emotional and social well-being. The high risk involved in police work and the ever changing role of the police in society impose new work demands on police officials, making this a highly stressful occupation (Ortega *et al.*, 2007: 36). As a result police officials often are confused and uncertain while they are expected to apply good judgment under difficult and dangerous circumstances (Deschamps *et al.*, 2003: 358). Their experience of stress arises from the exposure to specific physical or psycho-social demands at work and the perceived imbalance between those demands and the resources available to meet them. According to Morash *et al.* (2006: 29) there is evidence that some stress

emanates from a lack of support from networks at work and at home. These support networks include family, superiors and peers at work. It is, however, necessary for the police official exposed to trauma, to receive sufficient and effective support based on their specific needs, to prevent the development of trauma-related stress symptoms soon after exposure to a traumatic event.

SAPS place much emphasis on Critical Incident Stress Debriefing (CISD) as model for trauma intervention. According to Mthetwa (2012) between 3000 to 4000 police officials received debriefing consultations via Employee Health and Wellness (EHW) during the period 2011/2012. In spite of this statement SAPS annual report 2013/2014 still indicates a high occurrence of acute and behavioural problems amongst police officials. In recent time's international debate, research projects and open criticism of the effectiveness of the current debriefing model have increased. Various researchers found that CISD had no, or a negative effect, on primary victims of trauma (Addis & Stephens, 2008: 361; Arnetz *et al*, 2009: 2). These authors are of the opinion that the risk for PTSD can escalate after debriefing and that some victims might experience secondary trauma because of the repetition of the event. In SAPS, CISD is mostly a once-off intervention lacking long-term therapeutic trauma intervention.

CISD mainly concentrates on the psychological well-being of the police official with a strong cognitive approach, without considering the consequent social factors of the individual. It therefore doesn't fully recognise the traumatised individual as a whole in his or her environment or the interconnections present within the situation.

It is important to consider that police officials exposed to traumatic events have specific physical, emotional and social needs. Other needs of police officials exposed to trauma include safety, management support, love and support from family and friends and skills to improve resilience and coping abilities. The growing number of affected police officials makes knowledge concerning their specific needs essential so that effective interventions can be provided. Program development must be done by considering the police officials' needs through their active participation in the entire process.

The research question is therefore:

- What aspects arising from the literature study and the empirical research should be included in a proposed psycho-social therapeutic program?

3. Aim

The aim of this article is to develop a PTP considering specific aspects of the literature study and the empirical research that will enable police officials to better cope with the impact of trauma.

4. Research model

The researcher used intervention research (D & D model) for the purpose of this study. The D & D is a model that consists of six phases. (De Vos & Strydom, 2011: 482). The third and fourth phases of the model, namely design, early development and pilot testing, were included as part of the second phase of the study.

4.1 Phase 3: Design

The findings in the problem analysis and information gathering phase lead to the development of the PTP. As a result of an extensive literature review, comprehensively discussed in article two, the researcher found that the different elements of Trauma Focused, Cognitive Behavioural Therapy (TF-CBT), Prolonged Exposure (PE) and the Eco-systemic perspective, which was specifically developed for social work, dispose some of the best elements to use as a theoretical framework to address the identified needs within the frame work of the PTP.

Both the TF-CBT and the PE are types of psychotherapeutic treatment that helps patients understand the thoughts and feelings that influence behaviours. It was developed as a guideline for early intervention treatment for acute and post-traumatic stress symptoms present after an event until four weeks post trauma (Becker *et al.*, 2009: 245; Moore & Penk, 2011: 42). These models do have some of the best elements for inclusion in the PTP, for example psycho education, prolonged exposure, relaxation, in vivo exposure, cognitive therapy, alterations in systems of care, systems advocacy and problem solving.

The eco-systemic perspective is a way of seeing the person and the environment in their interconnected and multi-layered reality. The perspective supports a transactional fashion of intervention to avoid viewing people in isolation from their life situations (Hepworth *et al.*, 2002: 253; Miley *et al.*, 2004: 33). The use of an ecological perspective in group training ensures that leaders and members are aware of the diverse systems outside of the group that interact with the group process. It not only considers psychological, cognitive, affective and behavioural components, but also concentrates on the interconnected transactional networks, with specific reference to the community, family, environment, and spiritual, social and cultural factors as significant barriers as a result of police officials' exposure to trauma (Orr & Hulse-Killacky, 2006: 191).

The combination of the TF-CBT, PE and the eco-systems perspective ensures a psycho-social focus and guides the researcher in considering the inclusion of both psychological and social elements, as discussed, in one single therapeutic psycho-social trauma intervention program. The implementation of the proposed PTP within the context of SAPS has the potential to serve as a holistic guideline for social workers working in the field of trauma.

De Vos and Strydom (2011: 482) emphasise the fact that researchers must design a way to naturally observe events related to the phenomenon, and a method to detect the problem and its scope. According to the authors this is important to monitor the effects following intervention. By observing the problem and studying naturally occurring innovations and other prototypes, researchers can identify procedural elements for use in the intervention. The utilisation of standardised measurement instruments namely the Critical Incident History Questionnaire (CIHQ), Impact of Event Scale (IES-R), Mental Health Continuum Short Form (MHC-SF) and Post Traumatic Cognitions Inventory (PTCI) prior and post-intervention served as observational tools during the process. These instruments are described in more detail in paragraph 5.9 of this article.

4.2 Phase 4: Early development and pilot testing

Early development can be defined as the process through which an innovative intervention is developed, implemented, and tested on a trial basis to determine its validity. Following this process, the intervention process may be refined and redesigned. This phase includes the following important operations of developing a preliminary intervention (De Vos & Strydom, 2011: 484):

- Developing a preliminary intervention
- Conducting a pilot test
- Applying design criteria to the preliminary intervention concept

The early development of the PTP was the result of a thorough literature review and needs assessment amongst police officials stationed at the specialised units within the North West Province. Following this process the researcher developed a preliminary intervention program. The researcher conducted a pilot test to determine the effectiveness of the intervention and to identify which elements of the proposed program need to be revised by using an observational system. De Vos and Strydom (2011: 484) refer to this as program assessment theory evaluation, which must be based on valid assumptions about the causes of the problem and the rationale of the proposed program. The researcher presented the PTP to a group of social workers responsible for the specialised units of SAPS in the North West Province. The researcher exposed the group of social workers to exactly the same procedures and program as planned for the main investigation in order to determine the effectiveness of the intervention and

to identify which elements of the preliminary program may need to be revised. The presentation of the program also intended training the social workers as fieldworkers. This process assisted the researcher to remove any inconsistencies and redundancies to improve the clarity of the formulation of content of the program to ensure validity, reliability and sensitivity (Strydom, 2011: 237). After completion of this process, the PTP was implemented and used on a trial basis to establish whether it can be put to effect directly after police officials' exposure to traumatic events.

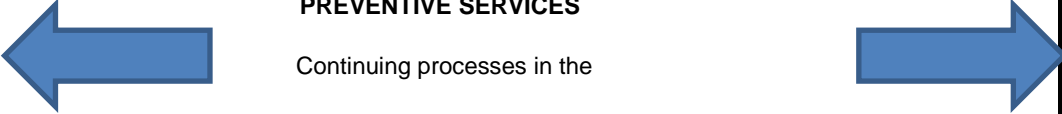
5. Overview of trauma risk management

The SAPS issued National Instruction 18/1998 with specific reference to the debriefing of employees who have experienced traumatic incidents. In 1992 the SAPS's Psychological Services developed a stress debriefing model for police officials exposed to trauma based on the CISD model of Mitchell (1983:36). The instruction acknowledges the fact that police officials are often exposed to traumatic incidents in the performance of policing functions. The instruction stipulates that if such police officials do not receive timeous debriefing, a real danger exists that they may develop post-traumatic stress symptoms. According to the instruction it is imperative that provision is made for the effective and timeous debriefing of traumatised police officials. The above instruction is therefore purely based on the debriefing model. It is therefore per implication a treatment program, rather than a continuum of care.

The researcher compared this instruction with other International Police Trauma Risk Management Standing Operating Procedures, for example the South Wales Police Force (2013), Kent Police (2013) and Nottinghamshire Police (2014). These procedures focus on innovations in early interventions in caring for survivors of trauma rather than a specific treatment model. The Trauma Risk Management strategy is based on the use of volunteer peer practitioners who are trained to assist managers in dealing with the welfare of their staff following a traumatic incident, ideally 24 hours after the incident and during the 28 days following the incident. The peer practitioners are guided in the provision of their support by using a risk assessment which can indicate those personnel that may be more at risk of developing post-traumatic reactions and those that may require treatment. As part of this procedure practitioners are advised that the Trauma Risk Management procedure should not be confused with CISD. The researcher once again refers to the recent debate regarding Critical Incident Debriefing amongst researchers in recent times as mentioned earlier in this article. The Trauma Risk Management Procedure rather emphasise that specialised treatment can be rapidly put into place for identified personnel with medium to longer term distress as a phase of the continuum of care. No specialist treatment should be allocated at least four to six weeks following an incident.

For the purpose of this article the PTP was developed as a specialised treatment program following a needs assessment, to fit into this phase of the trauma risk management procedure as a treatment program for those police officials with medium to longer term distress. The following illustration based on the phases of treatment proposed by Saxe *et al.* (2007: 218) summarise a trauma risk management procedure with specific emphasis on the implementation of the proposed PTP as a specialised treatment within the stages of the procedure:

Table B5-1: The Trauma Risk Management Operating Procedure

Impact on police officials	Model of care	Role players	Indicative time line (days post incident)	Roles of EHW
<p>STRATEGIC MANAGEMENT/PLANNING</p> <p>PREVENTIVE SERVICES</p> <p>Continuing processes in the immediate aftermath of and sequel of critical incidents</p> 				
<p><u>Phase 1:</u></p> <p><u>SURVIVAL</u></p> <p>Transient & Short-Term Distress</p> <p>(Resistant & Resilient Police officials)</p>	<p>-Psychological first aid (PFA).</p>	<p>-EHW (multi-professional team approach);</p> <p>-Commanders and peers trained with the principles of Psychological First Aid;</p> <p>-Family;</p> <p>-Friends;</p> <p>-Neighbours;</p> <p>-Communities; and</p> <p>-Workplace.</p>	<p>Immediately on the scene.</p>	<p>-Provision of specialised advice to the commanders of the specialist units at strategic, tactical and operational levels;</p> <p>-Provision of a liaison psycho-social intervention to police officials.</p>

Phase 2:				
<p><u>STABILISING</u></p> <p>Medium-term distress</p> <p>(Resilient to distressed Police officials)</p>	<p>-PFA;</p> <p>-Family and community services that are informed by the principles of PFA and psycho-education;</p> <p>-Systems Advocacy.</p>	<p>-EHW (multi-professional team approach);</p> <p>-Commanders and peers trained in the principles of Psychological First Aid , psycho-education and systems advocacy under the supervision of EHW.</p>	<p>24h-28 days</p>	<p>-Direction, management and supervision of commanders and peers trained with the principles of Psychological First Aid;</p> <p>-Provision of a liaison psycho-social intervention to police officials and their families.</p>
Phase 3				
<p><u>UNDERSTANDING</u></p> <p>Longer-term distress</p> <p>(Distress to mental disorder)</p>	<p>-Screening/ Assessment;</p> <p>-Psycho-social therapeutic program (PTP);</p> <p>-Reviewing after one month.</p>	<p>-EHW (multi-professional team approach).</p>	<p>28-90 days</p>	<p>-Conducting assessment;</p> <p>-Provision of psycho-social therapy.</p>
Phase 4				
<p><u>TRANSCENDING AND REFERRAL</u></p> <p>Long term distress</p> <p>Police officials with mental disorders</p>	<p>Screening/Assessment repeated after 1 month (Post Traumatic Diagnostic Scale);</p> <p>-Referral of selected police officials to specialist mental health services.</p>	<p>-Specialist Mental Health Care Professionals.</p>	<p>28 days and continuing</p>	<p>-Referral for specialised mental healthcare.</p>

The researcher for the purpose of this article only concentrated on phase three of the above procedure. The PTP has been developed as a specialist group work program including both therapeutic and educational components of treatment, for police officials with medium term distress as part of the continuum of care. The program has been developed according to assessed needs discussed in article's three and four and are based on evidence of the

effectiveness of existing interventions explained in article two. The program is consequently discussed in more detail.

6. The nature of a psycho-social therapeutic program for police officials

- **Prevention:** Preventing distress and disorders such as PTSD. In order for this to be accomplished it is important to promote police officials' psycho-social resilience. Prevention required restoration of individual distress and responsive services that are based on the best evidence that is available.
- **Promoting Resilience:** The psycho-social responses provided recognise the important role police official's recovery of sustaining their resilience and, so far as is possible, of assisting them in their recovery. This means that services should recognise police officials' inherent resourcefulness, but also their need for support and responsive services.
- **Promoting Recovery:** Effective services should be provided that promote police officials' timely recovery when they have distress that is more than transient or of limited duration or a mental disorder. Services should provide assessment, interventions and care that take a positive and holistic approach to their tasks and focus on reducing the possibility of long-term distress and impairments.
- **Systems of care:** The focus of the intervention process should be on all the other parts of the caring system to alleviate the burden that falls on families, friends, peers and the risk factors that relate to them. Helping police officials to identify the impact of distress on their systems of care and the consequent empowerment to minimise the impact will assist in limiting the possibility of these factors spiralling out of control.
- **Attractive, Accessible, Responsive and Safe Services:** Services must be attractive, welcoming and accessible, appropriate for the needs of police officials, and capable of responding to their variable and complex needs. Police officials' own wishes and views must be taken into account, so far as this is possible, in the aftermath of a traumatic event. The program should aim to be capable of establishing relationships with other group members based on trust and should be assertive about any risks and the needs for incisive action that may be required on certain occasions to protect the interests, well-being and health of police officials (Brevan *et al.*, 2008: 76).

7. Guidelines for group work with police officials

Group treatment brings with it the possibility of the restoration of meaning in social participation (Beck, 2004: 230). It is a dynamic and powerful intervention method for police officials who are dissociated as a result of their exposure to trauma. It was chosen as method for this program as it is cost effective, provides social support, facilitates the development of interpersonal skills, offers opportunities for acquiring new information, coping skills and self-expectations and

provides peer feedback. The mutual identifications and mirroring in the group are powerful therapeutic factors. When a group work program is developed and planned for police officials, the following guidelines should be taken into consideration:

- Traumatized police officials were screened for possible inclusion in the PTP. The CIHQ (Weis *et al.*, 2010: 736), IE-R, (Weiss, 2007: 219); MHC-SF, (Keyes *et al.*, 2008:186) and the PTCI, (Foa *et al.* 1999: 307) were utilized to screen police officials' level of distress. Other important screening questions were: Has the person spoken about the trauma before? In what context? What was their experience of the telling of the trauma? Police officials that were excluded are those already diagnosed with PTSD or any other co-morbid disorder, those that are psychotic, homicidal and suicidal. For example, we wouldn't put someone who is suicidal in a group of non-suicidal members, but would add one to a group of suicidal members (Beck, 2004: 236; Yalom & Leszcz, 2005: 233).
- The composition of trauma groups should be homogeneous. When police officials with similar trauma experiences are put in a group together, the group is initially a homogeneous group. The trauma experience could be historical or recent (Rutan *et al.*, 2014: 115).
- For a group to reach its maximum potential it is important that the facilitator of the group work program incorporates preparations of administrative aspects such as venue, time and duration, number of sessions, type and size of the group and functional resources (Garvin, 2010: 28).
- Police officials must be prepared for the group work program by determining the level of motivation, discussing the aim of the group work sessions, establishing group norms and introducing methods and procedures that will be utilized during the program for them to be motivated for and involved in the process to ensure that they attend the sessions, are responsive and are able to contribute (Foy *et al.*, 2010: 534; Rutan *et al.*, 2014: 156).
- Trust and safety are subjective experiences. The primary focus in group work with traumatized police officials is to create a safe space for the work of the group. This is true regardless of the nature of the trauma (Ephross, 2010: 6; Foy *et al.*, 2010: 543).
- The facilitator must be creative and promote spontaneity in groups. Functional aids such as a power point presentation, pictures, handouts and music can be utilized during the group work program, to assist, stimulate, explore, compliment or assess and can be used to stimulate discussion (Gladding, 2010: 383).
- It is important to keep in mind that working with police officials that are affected by traumatic events can be complex and sensitive. According to Foy *et al.*, (2010: 534) and Yalom and Leszcz (2005: 120) it is therefore important to help the group develop dynamics (communication, trust, confidentiality, cohesion, social control mechanisms and group culture) that promote the satisfaction of group members needs while facilitating the accomplishment of group tasks.

- Specific techniques may be particularly useful in trauma groups. Ephross (2010: 9) and Newmeyer (2010: 307) primarily refer to verbal group processes. Their typology is organised under five major headings, namely: Information sharing, support, involvement, self-awareness and task accomplishment.
- Group goals should focus on stabilization, the return of the traumatised police official to their previous level of functioning and the containment of affect (Beck, 2004: 233).
- For the group work program to be meaningful and purposeful, it is important to clarify the type and focus of the group during the development of the program. The trauma group was a short-term trauma focused group with a psycho-social perspective (Keim & Olguin, 2010: 416). The group was therapeutic and psycho-educational in nature. The emphasis was on preventing the onset of post-traumatic stress disorder and the development of trauma-related stress symptoms soon after exposure to a traumatic event (Waldo *et al.*, 2010: 452).
- The facilitator (member of EHW) needs certain skills to present a trauma group, which includes considering the level of intervention, important focus on interventions following disclosure of traumatic material, the stages of group development, working with intense affect, common group problems for example premature self-disclosure, monopolising, silent members and flashbacks triggered by exposure to traumatic group content, grounding, specifically referring to help police officials feel solid, to validate the intensity of their emotions, to work with the dissociated ego state and to find ways to recognise, observe, describe, give meaning to, and integrate these states into a person's awareness and life, working with flashbacks and managing common defences in trauma groups for example denial, projection and repression (Bauman, 2010: 325).
- For facilitators to persevere and conclude the trauma group work program, it is important to have a clear sense of their own identity, receive support from peers and have a good support system and supervision. (Foy *et al.*, 2010: 534).

8. Planning and compilation of the program in group context

Group work requires specific planned activities. These activities are positioned in such a manner as to achieve certain goals. The latter can improve conditions in the group members immediate environment, promote a sense of achievement, provide an opportunity to channel certain impulses, help group members to confront and deal with problems that they otherwise find difficult to verbalise. A program is a concept that provides a whole range of activities, relationships, interactions and intentional experiences that are deliberately planned to sort out the unique needs of the individual and the group with the help of the social worker (Rengasamy, 2011: 29).

The researcher considered the following factors in program planning:

- Structure of the group (open-ended/closed-ended group, number and duration of sessions);
- Nature of the group (different needs of members, atmosphere);
- The facilities and specific culture of the group and the organisation;
- The needs and interest of the police officials;
- The aims of the group (based on mutual experiences/feelings);
- The resources that exist in the organisation and the community;
- The relationship between members and facilitator;
- The procedure of the group (course of each session); and
- The opportunity for all members to participate (Greeff, 2011: 364).

It is important to consider the group work process, which consists of different aspects and phases, during the planning and construction of the program (Trevithick, 2005: 88). A specific process must be followed when educational and therapeutic groups with a psycho-social focus are planned. The choice of topics, activities, presentation style, resources, time and place, is of utmost importance as it plays an important role in the presentation of the program. The planning of the group is therefore based on the program.

8.1 Therapeutic and psycho-social educational program and process

Toseland and Rivas (2014: 269) and Zastrow (2015: 3) identify therapy and educational groups as two of five types of treatment groups, the others being support, growth, and socialisation groups. Intrinsic to the change process is education and counselling. Psycho-educational groups and educational groups are generally used interchangeably in the literature. The concept psycho-education has a medical orientation and therefore refers to therapy which may include pathological conditions. The latter requires treatment by a therapist, therefore the term indirectly also refers to healing (Hatfield, cited in Sands & Solomon, 2003: 7). The groups described here certainly have a therapeutic or healing element to them.

The PTP consists of elements of both a therapeutic and educational group. Lukens and McFarlane (2004: 206) confirm that “psycho-education is a professionally delivered treatment modality that integrates and synergises psychotherapeutic and educational interventions”. The combination of these types of groups provides a platform for the implementation of the theoretical models/perspectives which is underpinning the psycho-social trauma intervention program as discussed in article two. Different helping processes and skills can be identified with special significance for therapy and education.

- Group members learn specific and relevant information and are enabled to develop long-term systematic bodies of knowledge.

- Group members are taught to strengthen internal motivation, discover resources, pay attention to immediate problem situations and investing in personal strengths and energy in changing circumstances.
- Group members learn how to maintain physical stability and to maintain a good self-esteem, and giving group members the opportunity to recognise and share each other's experiences and reduce self-blame.
- They can learn generic problem-solving skills that will help to address members' personal problems both for the present and in the future.
- Group members can explore their feelings, thoughts, and behaviours, come to terms with it, and explore ways stop and replace them for the purpose of lasting change; and
- Group members can bring about social change, not only in the individual but also the different systems within which the individual functions, for example the family, friends, colleagues and broader community (Sands & Solomon, 2003: 6).

8.2 Selection of program activities

The value of program activities is that they serve as a resource within the context of the group that can be used to support individual group members and the group as a whole to achieve the goals (Toseland & Rivas, 2005: 207). They also serve as an aid through which the general functioning of the group members can be evaluated in various areas such as the diffusion of transferences and impaired ego regression, social support and interpersonal skills, acquiring new information, coping skills and self-expectations, peer feedback, which is easier to hear from the mutual identifications, sharing and reflection in the group, which are powerful therapeutic factors (Beck, 2004: 233).

According to Toseland and Rivas (2014: 65) the following aspects should be considered when selecting program activities: Specify program activities that are consistent with group purposes and goals; specify the objectives of program activities; specify program activities that can be done given available facilities, resources and the time available; list potentially relevant program activities based on members' interests and motivation, age, skills level, physical and mental state and attention span; clarify program activities according to its length and structure, physical-, social and psycho-social requirements of the activity, for example fine motor co-ordination, interactional, verbal and social skills; social requirements of the activity, expression of feelings, thoughts, motives; and select the program activity that is less suited to achieve the objectives specified. Toseland and Rivas (2005: 13) also believe that social workers should be fully aware of the history of the group's development and their specific needs when preparing. The preparation of an agenda, developing role plays, choice of program activities, review of the previous group session and the visualisation and training of future activities are effective ways for social workers to prepare for group sessions.

Kirschman *et al.* (2014: 6) are of the opinion that police officials hold distorted attitudes about mental health professionals. Miller (2006: 96) notes: "some police officials would rather swim through boiling oil than sit in a psychologist's office". This attitude can be associated with the unique police culture because it indicates weakness and may not be attractive to the socio-economic class of people who often become police officials. In SAPS group work activities should not presume a pathological condition, but instead be predicated on the idea that people have a lack of knowledge or skills that interfere with competence in living. This is a more acceptable and respectful approach to police officials who have been exposed to trauma (Hatfield, cited in Sands & Solomon, 2003: 7). Police officials will only buy into the PTP if there is concrete benefits and if they are convinced that they can gain something from it.

9. Screening criteria for inclusion in a psycho-social trauma intervention program

The exposure to traumatic events is for some police officials a devastating experience, be it a directly personal experience, witnessing or learning about an event that involves actual or threatened death or serious injury, or other threats to their physical integrity. Situations resulting in psychological trauma essentially have to do with coming face-to-face with extreme vulnerability. Kirschman (2007: 180) believes that 85% of emergency responders exposed to trauma experience potential emotional and social consequences that have a tendency to cause an imbalance in the life of the police official, also influencing other systems directly in contact with the individual. Godbout and Briere (2012: 485) are of the opinion that survivors mostly exhibit post-traumatic stress symptoms that can be divided in three different clusters including re-experiencing, avoidance/numbing and hyperarousal. When not processed to a point of some emotional resolution (decrease of symptoms and distress), they persist and cause more disruption, eventually reaching criteria for a psychological disorder.

The PTP is pro-active in nature with an emphasis on the prevention of psychological disorders and the existence of some of these disorders might influence the research outcome (Beck, 2004: 236). The DSM-5 criteria for PTSD requires that symptoms last more than four weeks and cause significant impairment in social, occupational, or other important areas of functioning (American Association, 2013: 271; Brewin *et al.*, 2008: 5; Figley, 2012: 450). A whole range of post-traumatic reactions are common to almost anyone in the initial aftermath of a traumatic event. It is very important to note that not all police officials develop psychological disorders. For the purposes of this study it is therefore necessary to screen the group of police officials within two to four weeks after exposure to the traumatic event(s) to determine medium to longer term distress for those that are at risk to develop a psychological disorder.

Raphael *et al.* (2001: 587) argue that it is important to screen clients prior to inclusion in a therapeutic program, using valid assessment tools. These authors ask the following questions:

“What systematic, replicable, and valid assessments indicate that intervention is needed, what guidelines should systematically influence what is done; by what measures are outcomes and effectiveness evaluated?” Without screening, interventions will be applied randomly and will be without measurable objectives to be reached (Drenth, 2008: 57).

It is important to note that the police official that was exposed to a traumatic event is an emotionally vulnerable human being. It is therefore important to consider various factors such as ethics, recruitment and inclusion criteria as a participant in the study during the screening process so as not to harm the distressed police official.

The basic ethical principles for professionals namely autonomy, non-maleficence, beneficence, justice, fidelity and veracity as outlined by Cullity (2007: 24) were utilised as guideline in the selection of police officials for inclusion in a psycho-social trauma intervention program. Informed consent has been obtained from all the police officials prior to the screening process as well as the beginning of the program after being selected. In an attempt to avoid causing harm unknowingly and considering the unique police culture, the researcher assess the following potential risks associated with the study: confidentiality, unanticipated disclosure, violation of cultural norms, and the stigmatisation of receiving therapy for not being “able to cope”.

In the recruitment of group members for the psycho-social trauma intervention program it was very important to concentrate on the following issues: who is likely to benefit from group therapy, and what blending of clients will produce the most effective therapy group. Bringing a client into a group therapy commits not only the group therapist to that client, but also commits the other members of the psycho-social group to that individual (Martin *et al.*, 2000: 438). Having relevant criteria for decision making is therefore useful both at the individual and group level, seeing that it may influence the quality of the group work program (Zastrow, 2006: 13). Aspects such as the timing of recruitment, circumstances and the level of physical, psychological and social wellness were taken into consideration during the selection process. The time of the traumatic incident must be at two to four weeks prior to inclusion in the program and police officials must present with elements of medium distress (Valentine & Smith, 2001: 41).

The social worker responsible for the unit acted as mediator and purposefully recruited members that have been exposed to traumatic events. These members have already been taken through phases one and two of the Trauma Risk Management Procedure (TRiM) as indicated in figure B6-1. The recruited police officials have been informed with regards to the aim and the process of the study as well as all the ethical considerations explained above after which they gave informed consent to participate in the study.

The researchers utilised four instruments in the screening process: CIHQ (Annexure F), (IES-R) (Annexure G), MHC-SF (Annexure H) and the PTCI (Annexure I). These tools were not aimed at a diagnosis but allowed the social worker to select police officials by looking at the frequency and rated severity of the traumatic event, risk factors for the development of PTSD, physical-, emotional- and social well-being and trauma-related thoughts and beliefs. These four instruments are discussed in more detail in the following paragraphs.

9.1 The Critical Incident History Questionnaire (CIHQ)

The CIHQ indexes cumulative exposure to traumatic incidents in police by examining incident frequency and rated severity. The questionnaire consists of a set of 34 traumatic incidents that could occur during the course of a police official's duty. The participating police officials were requested to indicate the exact number of times that the traumatic incident was experienced if the frequency was between 0 and 9. For greater frequencies, three additional response options were provided, namely: 10-20, 21-50, and 51+. An additional rating task for each item designed to scale the severity of exposure, is included as additional rating. Using a scale of 0 = not at all to 4 = extremely, police officials were asked to rate each item in response to the following question: "In your opinion, how difficult would it be for police officials to cope with this type of incident?" In this way the scale sought to collect data to give a nomothetic view of the severity of each incident, rather than how each official might have personally responded or imagined they might respond to an incident he or she had never experienced (Weis *et al.*, 2010: 736).

The content validity was assessed by a group of 52 police psychologists individually and anonymously, during which they had to judge the relevance and representativeness of each critical incident item when experienced in the line of duty. The rating scale was anchored as follows: 1 = not at all relevant or representative; 3 = neutral; 5 = very relevant or representative. Weis *et al.* (2010: 740) are of the opinion that the CHIQ demonstrates satisfactory convergent and criterion validity. It is a fairly easy tool to administer.

9.2 Impact of Event Scale - Revised (IES-R)

The IES-R was designed to assess hyperarousal, a criteria for PTSD. Other criteria include exposure to a traumatic event, duration of symptoms and impairment due to symptoms. This scale measures hyperarousal symptoms, for example anger and irritability, heightened startle response, difficulty concentrating and hypervigilance.

The response format in the IES-R measure 'symptom severity' on a five-point scale (0 = not at all = 1 = a little bit, 2 = moderately, 3 = quite a bit and 4 = extremely). The main strengths of the IES-R are, that it is short, quick and easy to administer and score and may be used repeatedly

to assess progress. It is intended to be used as a screening tool, not a diagnostic test (Weiss: 2007: 3).

9.3 Brief Description of the Mental Health Continuum Short Form (MHC-SF)

The use of the MHC-SF as a measure of overall positive mental health was first introduced by Keyes (2002: 207) and recently summarised in Keyes (2007: 95). The MHC-SF consists of 14 items that were chosen as the most prototypical items representing the construct definition for each facet of well-being. Three items were chosen (happy, interested in life, and satisfied) to represent emotional well-being. Six items (one item from each of the six dimensions) were chosen to represent psychological well-being, and five items (one item from each of the five dimensions) were chosen to represent social well-being. Using a scale of 0 = Never to 5 = every day, police officials were asked to rate each item in response to the following question: “during the past month how often did you feel...” The response option for the inventory measures the frequency with which respondents experienced each symptom of positive mental health, and provided a clear standard for the assessment and a categorisation of levels of positive mental health.

The MHC-SF has shown excellent internal consistency and discriminant validity in adolescents and adults in the U.S., in the Netherlands, and in South-Africa (Keyes *et al.*, 2008: 181)

9.4 Post-Traumatic Cognitions Inventory (PTCI)

Many trauma theories hypothesise that traumatic events produce changes in the victim’s thoughts and beliefs and that these changes play an important role in the emotional response to trauma. The items included in the PTCI derived from clinical observations and current theories of post-trauma psychopathology. It measures trauma-related thoughts and beliefs. The items in the PTCI represents the following concepts: General negative view of self (27 items), such as “I am inadequate,” “ I am a wimp”; perceived permanent change (23 items), such as “ I have permanently changed for the worse,” “I will never be able to form close, loving relationships again”; alienation from self and others (4 items), such as “I feel isolated and set apart from others,” I am different from other people”; hopelessness (7 items), e.g., “I have no future,” “Things will never be good again’; negative interpretation of symptoms (7 items), self-trust (5 items); self-blame (17 items), trust in other people (10 items) and unsafe world (10 items). Participants rated each item using a 7-point Likert-type scale from 1 (totally disagree) to 7 (totally agree). Thus, high scores indicate stronger endorsement of negative cognitions (Foa *et al.*, 1999: 305)

The high specificity of the PTCI in identifying PTSD cases and its high correlation with PTSD severity suggests that the scale is useful as a clinical assessment tool for patients with PTSD.

10. Phases of the PTP

The PTP is theoretically supported by the TF-CBT, PE models and the Eco-systemic approach in social work.

The researcher included the following phases of the group work process as part of the PTP as proposed by Glassman (2009: 57) and Zastrow (2015: 18), namely the preparation/pre-group, beginning, middle, end and post-group phases. These phases occur at different times for different types of groups. Whatever the type or length of a group, the group leader is responsible for attending to certain key elements at each of these points.

The following figure was compiled to summarise the social group work process. This summary was used for the composition of the suggested group work program.

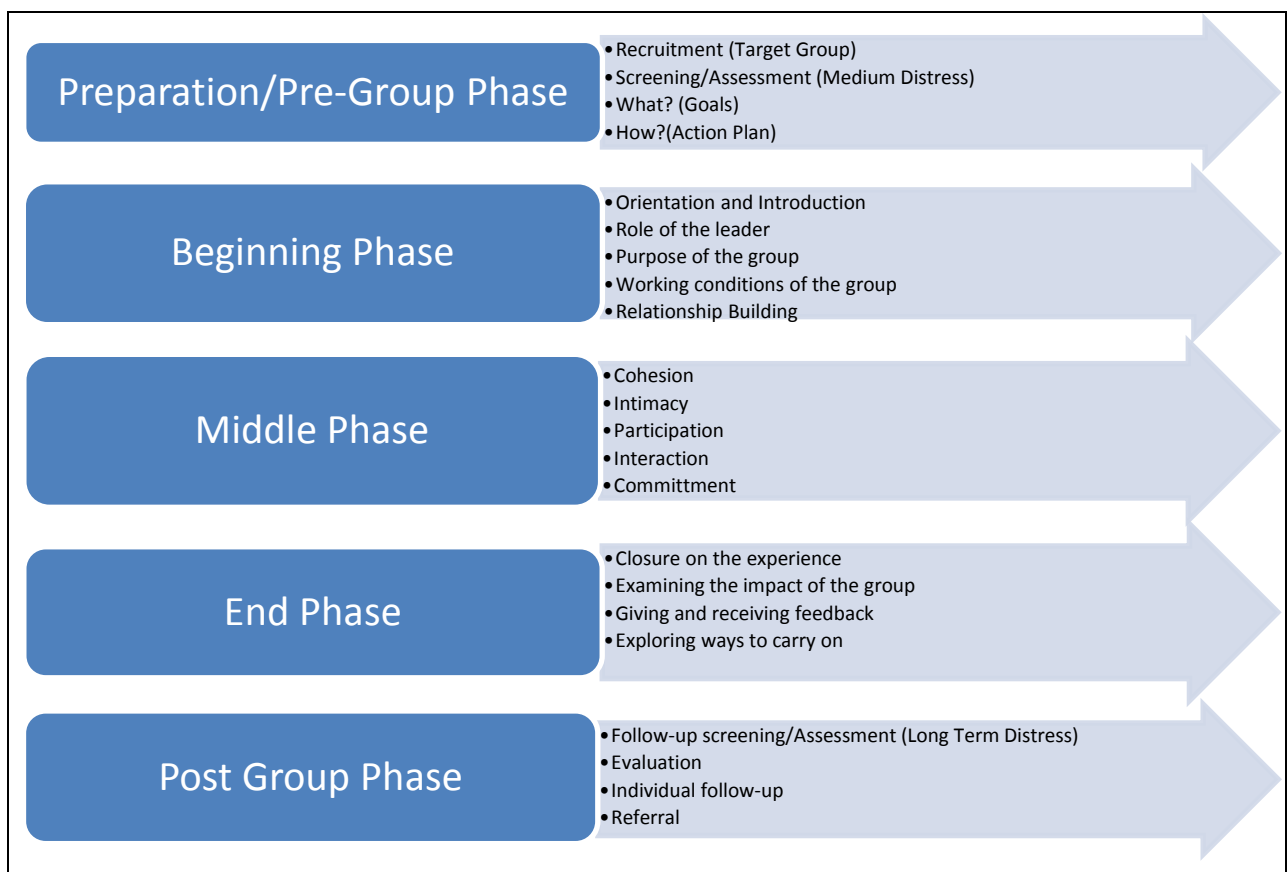


Figure B5-1 Phases of the group work process

A brief description of each of the five phases of the PTP follows:

10.1 Preparation/Pre-group phase

This phase involves the identification, screening, assessment and motivation of police officials who do not recover from medium to longer-term distress after exposure to traumatic events to

participate in the group. It is important that police officials exposed to traumatic events be screened for medium-term distress and possible inclusion in the therapeutic group, two to four weeks after exposure to traumatic event. These are police officials that might be at risk for the development of PTSD or any co-morbid disorder.

The researcher utilised the CIHQ (Weiss *et al.*, 2010), IES-R (Weiss, 2007), MHC-SF (Keyes *et al.*, 2008) and the PTCI (Foa *et al.*, 1999) as comprehensively discussed in point nine of this article to rate the distress and screen police officials for possible inclusion in the program. The aim of the instruments is furthermore to create a baseline from where the intervention will take place, and to serve as an assessment guide following from the baseline during the intervention process. Above instruments guide the social worker through the following aspects: incident frequency, incident severity, emotional, psychological, social well-being, risk factors for the development of PTSD and trauma-related thoughts and beliefs.

10.2 The Beginning Phase

During the beginning phase of group therapy, issues arise around topics such as orientation, beginners' anxiety, and the role of the leader. The purpose of the group is articulated, group norms, working conditions and the desired outcome of the intervention are established, members are introduced, relationships are build, whilst creating an atmosphere of warmth and acceptance. The social worker guides the group members to set objectives and to take responsibility to reach the goal and group work begins (Yalom & Leszcz, 2005: 309).

10.3 The Middle Phase

This beginning phase builds up to the middle phase during which the actual work take place. In this phase the group continues its deliberations and activities concentrating on skills to be able to deal with the distress during the aftermath of the exposure to traumatic events. The group in its middle phase encounters and accomplishes most of the actual work of therapy. This phase involves the transition between the initial uncertainties and actual involvement. Yalom and Leszcz (2005: 345) stipulate that at this stage, group members start to take responsibility for the group. The leader balances content, which is the information and feelings overtly expressed in the group, and process, which is how members interact in the group. The therapy is in both the content and process. Both contribute to the connections between and among group members and it is those connections that are therapeutic. The therapist introduces different therapeutic exercises with illustrations for group members. Burnes and Ross (2011: 93) emphasises the therapeutic value of the program during this phase of the group work process. The group acts as a support network and sounding board. Regularly talking and listening to others also helps you put your own problems in perspective. Diversity is another important benefit of group

therapy. People have different personalities and backgrounds and they look at situations in different ways. Attention to group process is very important. During the group process non-verbal cues are part of the work and need to be explored actively, as it might be indicative and should not be ignored. The group, then, is a forum where clients interact with others. In this give and take of therapy, clients receive feedback that helps them rethink their behaviours and move toward productive changes. The leader helps group members by allocating time to address the issues that arise, by paying attention to relations among group members, and by modelling a healthy interactional style that combines honesty with compassion.

10.4 The End Phase

The ending phase is important to stabilise the group, by reviewing what was learned and to deliberate on practical implementation after the program has ended. Group members get the opportunity to evaluate the performance of the group against the group purpose and goals. Termination is a particularly important opportunity for members to honour the work they have done, to grieve the loss of associations and friendships, and to look forward to a positive future. The group begins this work of termination when the group as a whole reaches its agreed-upon termination point. Termination is a time for putting closure on the experience, examining the impact of the group on each person, acknowledging the feelings triggered by departure, giving and receiving feedback about the group experience and each member's role in it, completing any unfinished business and exploring ways to carry on the learning the group has offered (Shulman, 2009: 109).

10.5 The Post-Group Phase

Activities of this group stage include follow-up screening/assessment (based on the same measurement scales mentioned in point nine of this article), evaluation and individual follow-up within one month following termination of the program, to identify those police officials with long-term distress. These members were as a result referred for more intensive long-term therapy to a psychologist/psychiatrist. Lindsay and Orton (2011: 79) confirms this step and are of the opinion that as people leave the group, they may need alternative sources of support/action/contact, and the group can help each member to plan accordingly. What resources can they access? Do you need to have a reintroduction to the person's individual social worker?

11. Contents of the psycho-social therapeutic program for police officials

The PTP is pro-active in nature with emphasis on the prevention of Post-Traumatic Stress- and any other co-morbid disorders, fully recognising the traumatised individual as a whole in his or her environment or the interconnections present within the situation. This program has been

designed in accordance with the results following the exploratory sequential mixed-methods design as part of the first and second phase of the intervention research model as discussed in Articles 3 and 4. The program is furthermore based on the guidelines of various evidence-based programs, models and perspectives as part of a thorough literature study including different authors such as Baranowsky *et al.* (2010), Miley *et al.* (2004), Saunders (2012), Schnyder *et al.* (2012) and Weiss and Santoyo (2012). The program consists of objectives, aims and contents of an integrated educational and therapeutic group work program consisting of 12 sessions.

The content of the program is schematically presented after which it is discussed in detail according to the subject, aim and content. Attached to this article please find annexure one: The workbook, with a comprehensive explanation of activities.

Table B5-2: Schematic representation of the psycho-social therapeutic program for police officials

Pre-testing (two to four weeks after exposure to traumatic event)	
Session Number	Theme
Session 1	Introduction and psycho-education
Session 2	Relaxation
Session 3	Trauma narrative
Session 4	Identifying emotions, feelings and thoughts
Session 5	Rating of feelings and affect modulation
Session 6	Altered thinking
Session 7	Challenging destructive and self-destructive behaviours
Session 8	Problem solving
Session 9	Managing trigger events
Session 10	Changes in systems of care
Session 11	Systems advocacy
Session 12	Relapse prevention
Post-testing (within one month after termination of program)	

11.1 Pre-testing

The researcher schedules a group session with selected police officials two to four weeks after exposure to traumatic events and after completion of phases one and two of the trauma risk management procedure. Pre-testing must be finalised prior to commencement of the PTP. The process was administered by the social worker in SAPS responsible for POP in Potchefstroom who acted as mediator. The following measurement scales as discussed under point nine of this article will be introduced and completed: CIHQ, IES-R, MHC-SF, PTCI and the self-developed

survey. According to McIntosh-Scott *et al.* (2014: 155) group-administered questionnaires are easy to execute and have benefits in relation to cost and completion rates.

11.2 Session 1: Introduction and psycho-education

11.2.1 Agenda

- Welcoming to therapy
- Introducing group members to one another
- Creating an atmosphere of warmth and acceptance
- To establish and build a relationship of trust
- Clarifying the rationale of the group work program
- Layout the course of treatment
- Establishing group norms
- Elicit treatment compliance
- Group norms and guidelines for participating in the PTP (Handout 1.1)
- Weekly Trauma Systems Therapy (TST) Check-in (Handout 1.2)
- Definition of trauma and other related terms (Handout 1.3)
- The process of trauma (Handout 1.4)
- Fight, flight or freeze response (Handout 1.5)
- Common signs and symptoms following exposure to traumatic events (Handout 1.6)
- Exercise: My symptoms (Handout 1.7)
- Diagnostic Criteria for PTSD (Handout 1.8)
- The linen cupboard metaphor (Handout 1.9)
- Check-in re: police official's reaction to session

11.2.2 Rationale

The rationale for session one was to build rapport with the group members, to lay out the course of treatment, to elicit treatment compliance and to educate the group members about trauma, related symptoms, PTSD and trauma recovery.

11.2.3 Content

The therapist **welcomed** the group members and explained to them that therapy is a safe place to help them feel better about upsetting or confusing traumatic events that they have experienced. They would have the opportunity to draw, write, listen, talk and give their own opinion in therapy. They would learn many important things about: upsetting/confusing events, relaxation, feelings, alternative ways of thinking and doing and how to stay safe. They would

also learn much about themselves, their thoughts, feelings, behaviours, relationships with important others and their strengths (Hendricks, *et al.*, 2006: 5).

The group members had the opportunity to **introduce** themselves to the rest of the group, which provided them with a starting point for interaction. This was done by using an icebreaker, for example each group member identifies him/herself with their favourite vehicle. Group members then introduce themselves by replacing their name with that of the chosen vehicle and explain to the other group members the resemblance between him/her and the vehicle. The name of the vehicle is written on the name tag and each group member will be named accordingly for the remainder of the group session (Hepworth *et al.*, 2010: 298). This was important to eliminate ranks that form part of the hierarchy of SAPS, so that members would find themselves on the same level and might feel safer and more secure to participate.

The facilitator initially had the responsibility to create an **atmosphere of warmth and acceptance** that encourages self-exploration and self-expression and which will allow police officials to heal and learn. A **relationship of trust** can be established with a brief discussion of ethics in group work. Confidentiality must be emphasised by means of an example of a situation/incident these police officials do not wish to share with anybody else. Police officials should be encouraged to be cooperative and productive to gain the maximum from this program (Toseland and Rivas, 2005: 111).

The facilitator should outline the **rationale** of the PTP which is to recognise and modify old thoughts and feelings that may be unhelpful, to accept the reality of the event, to change beliefs enough to accept it without going overboard, to feel their emotions about the event. At this stage the therapist gave a **layout of the course of treatment**. It is also important that the content and structure of the program is explained. They should be given the opportunity to **establish the group norms** for themselves, the facilitator and the group as a whole. These norms must be written down and should be visible for the duration of the program (Kirst-Ashman, 2008: 72).

It is necessary to **elicit treatment compliance** early during the course of therapy because avoidance behaviour can interfere with successful outcomes. Two forms of compliance that one should be most concerned about is attendance and completion of out-of-session practice assignments. It is strongly recommended that police officials attend all sessions and complete all assignments to benefit fully from therapy. The researcher should set the expectation that therapy benefit is dependent on the amount of effort police officials invest through practice assignment compliance and practice with new skills. It was helpful to remind the police officials that what they have been doing has not been working and that it is important to tackle issues head-on rather than continue to avoid. Jin *et al.* (2008: 270) emphasises the fact that avoidance of affective experience and expression should be addressed. The therapist handed out the

group norms and guidelines for participating in the PTP (Handout 1.1). Group members had the opportunity to peruse the document to make sure that they understand the requirements after which they can sign the document.

The therapist introduced the **Weekly TST Check-In Scale (Handout 1.2)** proposed by Saxe et al. (2007: 135). This is very helpful in gathering information from the police official every week about emotion regulation and social-environmental stability. It is often very helpful to assess specific areas of growth and improvement during the intervention process. Group members complete this scale weekly to evaluate psycho-social wellness and to monitor progress with regard to intervention.

As part of psycho-education the therapist discussed the **definition of trauma and other related terms** (Handout 1.3). The therapist emphasised the fact that trauma in itself is not a diagnosable disorder, but rather the reactions following exposure to a traumatic event for example acute stress, PTSD, Depression, Anxiety Disorder or somatic reactions (American Psychiatric Association, 2013: 271). The therapist introduced the **process of trauma** (Handout 1.4) on the basis of an illustration which explains the process starting at the overwhelming event, psychological and physiological responses up to the stage during the individual resort to self-destructive and destructive action (Ackley & Covington, 2008).

The therapist concentrated on the **fight, flight or freeze response**, which is normally experienced during or immediately after exposure to a traumatic event (Handout 1.5). This is a normal defensive response to high threat. According to Perry (cited in Sanderson, 2006: 155), flight is withdrawal and fight is aggression, but freeze is a defeat that results in immobility and submission. Perry proposes that in the presence of danger the person freezes to allow activation of the fight or flight response, but in the absence of being able to fight or flee the person then activates a submission response. It is also important to emphasise that normal defensive responses to high threat can impact treatment and treatment adherence (Sanderson, 2006: 155). The therapist introduced and discussed the **common signs and symptoms** following exposure to traumatic events, for example efforts to avoid thoughts, poor memory, flashbacks, hypervigilance, intrusive thoughts and important others, to raise awareness with emphasis on normal signs and symptoms in reaction to an abnormal event (Handout 1.6). Subsequently, group members were provided with an exercise to identify their own symptoms (Handout 1.7). Firstly, they had to identify a traumatic event as reference point after which they have to answer the questions on a scale of 0-4 specifically concentrating on symptom frequency and severity. Group members were then requested to add together all the numbers from both the frequency and severity columns. The higher the score, the more likely the police official are to have PTSD. Group members were encouraged to discuss their scores voluntarily in the group. Group members should be informed that above exercise cannot be interpreted as a

formal diagnosis of PTSD but rather, the variable only indicates that police officials endorsed enough symptoms necessary to model the criteria for PTSD.

It is important to educate group members with regard to the concept PTSD (Handout 1.8). The therapist give a brief explanation of the **diagnostic criteria for PTSD** as proposed by the DSM-5 mainly concentrating on re-experiencing the event, persistent avoidance and numbing, persistent symptoms of increased arousal and significant distress or impairment with a duration of at least one month (American Psychiatric Association, 2013: 271). Lastly, the therapist concentrated on treatment recovery on the basis of the **linen cupboard metaphor** (Handout 1.9). The clothes in the cupboard are compared with trauma memories, and in the process of unpacking and sorting out the clothes, memories of the traumatic event find their proper place. They can find them if you choose to, but they won't come back so often when you don't want them to.

The session finished by asking about the police official's reactions to the session and whether they have any additional questions with regard to the scope of the program or any of the terms discussed. The therapist should remember to normalise any emotions and praise the police officials for taking this important step toward recovery.

11.2.4 AIDS

- Workbook (Session 1)
- Name tags
- Pencils and pens
- Exam pad
- Standing board
- Flip chart paper
- Laptop (power point presentation)
- Markers
- Workbook

Attached see Annexure 1: Workbook: Session 1

11.3 Session 2: Relaxation

11.3.1 Agenda

- Weekly TST Check-in (Handout 2.1).
- Meaning of relaxation?
- Grounding (Focusing on the present) (Handout 2.2).
- Safe place exercise (Handout 2.3).

- Progressive muscle relaxation (Handout 2.4).
- Deep breathing (Handout 2.5).
- Check-in re: police officials' reaction to session.

11.3.2 Rationale

During the group session police officials were taught specific techniques to relax their body and mind. Relaxation is about feeling calm and peaceful especially during times when we are experiencing episodes of distress. Group members learned how to focus on the present and to find a safe place where after they were exposed to relaxing exercises using their muscles and deep breathing.

11.3.3 Content

The therapist administered the **Weekly TST Check-In Scale** at the beginning of the session to assess the group member's emotional and behavioural challenges during the previous week and monitor growth since the last session (Handout 2.1). At the end of the session, the therapist collected and stored the completed scales (Saxe *et al.*, 2007: 135).

The therapist explained to the group members that relaxation is about feeling calm and peaceful. After exposure to traumatic events police officials often experience symptoms of anxiety, insomnia, hyperventilation, panic attacks, high stress levels and are often worried. We feel better when we learn to relax our bodies and minds. This exercise teaches us how to relax for example, focusing on the present, finding a safe place, using our muscles and deep breathing.

Group members were provided with the following guidelines proposed by Williams and Poijula (2013: 45), who emphasises that it is important that group members practice the **relaxation techniques** they choose regularly, try to focus on the particular muscle groups and specific exercises, combine relaxation with exercise, trust the power of the techniques to bring them some peace. It is furthermore important to choose a quiet environment with as few distractions as possible, to adopt a passive attitude to help you rest and relax without forcing your response, preventing your relaxed response from occurring. Find a comfortable position that is as restful as possible.

The therapist introduced the first technique, which is **grounding, with an emphasis on focusing on the present** (Handout 2.2). Grounding is a tool to help us focus on the present and the external world instead of on the past and the internal world. The group members were provided with some grounding techniques that they can try to help them stay focused on the present. Secondly, the therapist introduced the **safe place exercise** (Handout 2.3). The group members may feel that there is no place, real or imaginary, that is safe, so the therapist has the

group focus on one time in his or her life when they felt safe or on a person they admire who exemplifies positive attributes, such a strength or control. The group members practiced a technique called **progressive muscle relaxation** (Handout 2.4). This is a way to relax by tensing and relaxing various muscle groups in your body (Thompson & Franklin, 2010: 55). This technique helps you tense and then relax your four major muscle groups namely: 1) hands, forearms, biceps(while using a stress ball) ; 2) head, face, throat, shoulders; 3) chest, stomach, lower back; 4) buttocks, thighs, calves and feet.

The next technique is called **deep breathing** (Handout 2.5). Sometimes when we are upset, we forget to breathe. Or we take short, shallow breaths that don't give our bodies the oxygen we need. To help ourselves feel relaxed and calm, we can practice deep breathing. Deep breathing is when you breathe in slowly and deeply as your lungs fill up with air. Then you let the air out, slowly and watch your belly go back in as the air is slowly pushed out (Rosenbloom & Williams, 2010: 21 & 40). This exercise is most effective while playing relaxing music in the background.

The therapist finished the session by asking about the **police officials' reactions to the session** and whether they have any additional questions or comments about relaxation. It is important to normalise any emotions and give credit for participation and progress made between sessions.

11.3.4 AIDS

- Workbook (Session 2)
- Name tags
- Pencils and pens
- Stress balls
- Slow relaxing music

Attached see Annexure 1: Workbook: Session 2

11.4 Session 3: Trauma narrative

11.4.1 Agenda

- Weekly TST Check-In (Handout 3.1)
- Who are you? (Handout 3.2)
- Why remember? (Handout 3.3)
- Telling your story
- Journal exercise: Informal writing (Handout 3.4)
- Constructing a trauma inventory (Handout 3.5)
- Check-in re: police officials' reaction to session

11.4.2 Rationale

In this session the therapist gave the group members the opportunity to tell their story and also to create a trauma inventory. It is also important for group members to understand why it is important to remember. Group member's feelings were rated on a ten-point scale in the beginning, middle and end of the session to describe the intensity of their feelings whilst telling their story.

11.4.3 Content

The therapist administered the **Weekly TST Check-In Scale** (Handout 3.1) at the beginning, middle and end of the session to assess the group member's emotional and behavioural challenges during the past week, but also whilst remembering, verbalising and writing their trauma during the session. (Saxe *et al.*, 2007: 135).

The therapist emphasised that before concentrating on the traumas that have impacted group members, it is important for them to **look at who they are** (Handout 3.2). Their sense of self serves as the reference point for who they want to become and what they want to do with their life. Traumatic experiences can rob them of their sense of self. It is therefore important that they look at what they know about their own core self, their basic identity and whether that self is healthy, partially healthy, or unhealthy (Williams & Poijula, 2013: 22).

The therapist informed the group members that before working on the symptoms that are bothering them, it is important to make sure that they are aware of where they come from – in other words, what they've experienced – without overwhelming or re-traumatising themselves. An important reason why they should **remember** what happened to them is to decrease the fear associated with the traumatic events and to move beyond it (Handout 3.3). Confronting their memories in a safe environment helps them to work through, or process, their traumatic history. Remembering safely will give them a sense of control over the experience and the terror they felt.

Group members were encouraged to **tell their own trauma story**. They had to be aware that expressing traumatic experiences verbally will help them separate the past from the present, where they are safe. It also helps bring closure to traumatic memories by developing a coherent story that becomes the group members own history so that the past is no longer re-enacted in the present. The therapist suggested that some of the group members might wish to write more informally, and introduced a **journal exercise: Informal writing** (Handout 3.4), allowing them to do so. (Bayer, 2014: 120). Group members were reminded that much of the work in this program asks them to focus on reminders of the memory rather than on the actual story.

Group members were consequently asked to identify the traumas they've experienced, without going into much detail, and the stage or stages in their career at which they experienced them, using a **trauma inventory** (Handout 3.5). Whilst doing this exercise group members had to keep in mind that although these traumatic events were negative, they survived them and that they have used many positive character traits to do so. According to Schupp (2015: 74) the trauma inventory provides the group members with an overview of themselves and what happened to them during different stages of their career. This can be seen as a starting point to begin work on any of the symptoms that may be haunting them.

The therapist finished the session by asking about the **police officials' reactions to the session** and whether they have any questions about the content. The therapist paid attention to normalising any negative emotions and disturbing thoughts as a result of remembering and talking about past traumatic events. Giving credit for group members' willingness to share is an important step toward separating the past and the present and to get closure.

11.4.4 AIDS

- Workbook (Session 3)
- Name tags
- Pencils and pens
- Exam pad
- Standing board
- Flip chart paper
- Markers
- Workbook

Attached see Annexure 1: Workbook: Session 3

11.5 Session 4: Identifying emotions, feelings and thoughts

11.5.1 Agenda

- Weekly TST Check-In (Handout 4.1)
- Description of emotions, feelings and thoughts
- ABC's of my emotions (Handout 4.2)
- Recognising emotions diagram (Handout 4.3)
- Experiencing feelings in your body (Handout 4.4)
- Unhelpful thinking habits (Handout 4.5)
- Primary negative emotions and the common thoughts that drive them (Handout 4.6)
- Check-in re: police officials' reaction to session

11.5.2 Rationale

Police officials sometimes find it extremely difficult to identify and name emotions, feelings and thoughts associated with traumatic events. It is therefore important to assist the group members in labelling these emotions/feelings/thoughts in response to events and also to introduce the idea that changing thoughts can change the intensity or type of emotions that are experienced.

11.5.3 Content

The therapist administered the **Weekly TST Check-In Scale** at the beginning of the session to assess the group member's emotional and behavioural challenges during the preceding week and monitor growth since the last session (Handout 4.1). At the end of the session, the therapist collected and stored the completed scales (Saxe *et al.*, 2007: 135).

A brief **description of emotions, feelings and thoughts** and their interconnectedness is important to enable the group members to distinguish between and understand the different concepts, specifically referring to their own personal experience. Pettinelli (2012: 71) explains emotion as follows: "emotion is such a strong feeling that it must be the combination of thoughts and feelings. Since thoughts are conscious and unconscious, emotion could be redefined as the combination of feeling and thought – that you only have emotion when you are thinking about something and feeling something at the same time, and the combination of the two results in individual emotions. Emotions are the result of feelings and thoughts in your brain. All that is in your brain is feelings and thoughts. It is obvious how you can turn off a thought automatically but you can also do that to some feelings. This is so because feelings are in large part triggered by thoughts".

The therapist introduced the **ABC's of emotions** (Handout 4.2) proposed by McGovern *et al.* (2010a: 33). We often say that people aren't struck by lightning to be drunk or sober. The process of using drugs or alcohol, or of relapsing, is the result of a series of events. If you were able to look at the process in a kind of slow motion, you might see that things started with certain decisions made earlier. There is a chain of events. The ABC's of emotions explains the process or series of events that leads to something. The A is the situation, or activating situation, the B is the belief or thought about the situation whilst the C stands for consequence. The consequence could be a feeling or even a behaviour. Group members get the opportunity to map out some of their own ABC's of emotions cycles (Meyers, 2006: 114).

Group members were guided to recognise their emotions (Handout 4.3) following exposure to trauma by providing them with an **exercise: "recognising my emotions"** (Ekman & Friesen, 2003: 10). The exercise comprised of a list of the most common feelings that members might experience after exposure to trauma. Group members had to identify which of the emotional

states they personally know, and which they had felt in the past two weeks. They had to circle those that they had felt and underline those about which they can say that they know how they feel. It is important to identify whether group members were able to identify and imagine or remember having most of them. Most importantly, the therapist would like to determine what completing this exercise taught group members about themselves.

Group members then had to put different colours next to each of the feelings they had identified to describe the feeling. These colours were then used to show **where in the body group members experience each feeling** (Handout 4.4). Our bodies tell us how we are feeling (Hendricks *et al.*, 2006: 15). Members did not have to do all the feelings they had listed, but they could choose which feelings they want to include. For each feeling they choose, group members had to close their eyes and imagine having that feeling right at the moment. They had to explain where in the body they experience the feeling. Members had to colour in the places on the picture of a body where they experience each feeling and then tell the group what it feels like.

Police officials exposed to trauma very often tend to get into **unhelpful thinking habits** just before, during and after distressing situations. Group members received a handout with examples of unhelpful thinking habits (Handout 4.5). They might favour some over others, and there might be some that seem far too familiar. Group members had to identify unhelpful thinking habits to start noticing them. Once they could notice them, they can challenge or distance themselves from those thoughts and see the situation in a different and more helpful way. The red text (*italics*) in the handout helped members to find alternative, more realistic thoughts (Andrews *et al.*, 2003: 124).

The therapist explained the interconnectedness between emotions, feelings and thoughts, by illustrating **primary negative emotions, and the common thoughts that drive them** (Handout 4.6) as introduced by Wilkinson (2015: 54). A practical example of a primary emotion is anxiety and fear. Possible negative feelings might be worry, fear, panic, anxiety. The common thoughts that drive them might be a feeling that I am not safe and in danger, something I don't want is going to happen, I am losing control/falling apart. The group members then got the opportunity to replace the related emotions and thoughts with their own experience of these emotions and thoughts, according to four primary emotions in the afore-mentioned handout.

Finish the session by asking about the **police officials' reactions to the session** and whether they have any additional questions or comments about their emotions, feelings and thoughts. It is important to normalise any emotions/feelings/thoughts and give credit for participation and progress made between sessions.

11.5.4 AIDS

- Workbook (Session 4)
- Name tags
- Exam pad
- Standing board
- Flip chart paper
- Markers
- Colouring pencils and pens

Attached see Annexure 1: Workbook: Session 4

11.6 Session 5: Rating of feelings and affect modulation

11.6.1 Agenda

- Weekly TST Check-In (Handout 5.1)
- Affective Style Questionnaire (Handout 5.2)
- Facial expressions (Handout 5.3)
- Emotion expression exercise (Handout 5.4)
- Negative emotion diagram (Handout 5.5)
- Positive imagery (Handout 5.6)
- The DVD Technique (Handout 5.7)
- Dealing with negative emotions (Handout 5.8)
- STOPP the feeling (Handout 5.9)
- Check-in re: police official's reaction to session

11.6.2 Rationale

This session firstly concentrated on rating the intensity of group member's feelings at the time and their unique style of affect regulation, after which possible alterations in the ability of group members to manage feelings, emotions and impulses were discussed. Group members learned to modulate and control their feelings and regulate their emotion-driven responses using positive imagery, practicing controlling an emotion and dealing with negative emotions using the STOPP worksheet.

11.6.3 Content

The therapist administered the Weekly TST Check-In Scale at the beginning of the session (Saxe *et al.*, 2007: 135). As part of the **weekly TST Check-In** the therapist for the purpose of this session specifically concentrated on the intensity of group members feelings. Group

members were encouraged to explain what feelings they experience right at that moment and to rate each of those feelings on a scale of 1-10 (Handout 5.1).

It is also important to determine how group members experience and manage their emotions (affective style). Members were asked to complete the **affective style questionnaire** (Handout 5.2) during which they had to indicate how they usually experience and manage their emotions on a five-point scale. This was used as a starting point for affect modulation. Group members should be made aware that different situations bring out somewhat different responses, but they should concentrate on what they usually do. All items are scored straight-forward. Higher scores reflect a preference for an affective style. This is followed by a handout with different **facial expressions**. Group members were encouraged to circle the face indicating how they feel right at the moment, with an explanation of the feeling (Handout 5.3). Group members could take turns acting out the different feelings, while the other person tried to guess which feeling the one is acting out. Group members were then encouraged to share in the session what made them feel the feeling they chose. The therapist introduced the **emotion expression exercise** (Handout 5.4). The purpose of this exercise was to help group members identify and express their emotions. This may be difficult for members to do at first so the therapist encouraged them to start by walking through a day from that week. As they described the experiences they had, they could name an emotion that went with the experience. Group members were encouraged to practice this exercise with a loved one every day. Gibbs *et al.* (2002: 127) are of the opinion that group members can gain experience by identifying and paying attention to their emotions and they gain experience communicating these emotions to others, potentially strengthening emotional bonds.

The **negative emotions diagram** designed by Lynch and Mack (2015: 24) represents negative emotions (Handout 5.5). The therapist explained to the group members that the arrow pointing up represents what group members think will happen if they experience fear or any other negative emotions. Their fear will increase and never end. The horizontal bar represents avoidance, which police officials engage in to avoid experiencing uncontrolled fear or negative emotion. This avoidance keeps them from learning what actually happens with emotions, which is that they peak and normally fall down like waves in the ocean.

Group members learned how to work with **positive imagery** (handout 5.6). Those with anxiety often have intrusive images about a feared future event, seeing the worst possible things happening. Police officials, who have suffered trauma, can have flashbacks, reliving the experiences of those traumatic memories. It makes sense that using therapeutic imagery will be most effective to treat distressing imagery. According to Hall *et al.* (2006: 7), the aim of imagery techniques is to change the toxic meaning of the image, reducing the distress. Group members were introduced to different forms of imagery for example, imagery manipulation, thereby

altering aspects of and reducing the distress associated with any image, imagery editing, changing the content and outcome of distressing and intrusive imagery, compassionate and nurturing imagery. Group members were encouraged to **exercise the DVD technique** (Handout 5.7), which involves promoting self-compassion and imagery rehearsal during which group members will mentally rehearse a feared imagined future event.

Group members were provided with a handout for **dealing with negative emotions** (Handout 5.8). The handout will take group members through the process of identifying emotions, resulting feelings, where it is felt in the body, how to think and do differently and how positive imagery can help members to cope with situations that they feel anxious about.

The **STOPP the feeling** worksheet can assist members to feel, think and do differently. According to Williams and Poijula (2013: 199) it is important that group members practice controlling overwhelming negative emotions. Group members were encouraged to think of a situation in which they have had an overwhelming negative emotion, to describe it and to name the initial emotion that arose from it. Members then had to apply the six steps in the **STOPP the feeling worksheet** to guide them with regard to controlling the emotion (Handout 5.9). They had to reflect what these steps teach them about the emotion and were given the opportunity to think about other situations, to help them to deal with negative emotions, which might help them to bring these emotions under control.

The therapist finished the session by asking about the **police officials' reactions to the session** and whether they had any additional questions or comments pertaining to controlling their emotions and regulating their emotion-driven responses. It is important to normalise any emotions discomfort and give credit for participation and progress made between sessions.

11.6.4 AIDS

- Workbook Session 5
- Name tags
- Pencils and pens
- Exam pad
- Standing board
- Flip chart paper
- Markers
- Workbook

Attached see Annexure 1: Workbook: Session 5

11.7 Session 6: Altered thinking

11.7.1 Agenda

- Weekly TST Check-In (Handout 6.1)
- Flexible thinking: The ABCDE of our emotions (Handout 6.2)
- Common styles of thinking (Handout 6.3)
- Positive affirmations around my trauma (Handout 6.4)
- Thought record exercise (Handout 6.5)
- STOPP the thought worksheet (Handout 6.6)
- Check-in re: police official's reaction to session

11.7.2 Rationale

The session concentrated on group members' patterns of problematic thinking. Particularly strong tendencies towards any counterproductive patterns were determined and more specifically how these patterns may have affected their reactions to the trauma. Ultimately group members were guided with regard to altering problematic thinking by replacing them with other, more adaptive, cognitions.

11.7.3 Content

The therapist administers the **Weekly TST Check-In Scale** in the beginning of the session to assess the group member's emotional and behavioural challenges during the preceding week and to monitor growth since the last session (Handout 6.1). At the end of the session, the therapist collected and stored the completed scales (Saxe *et al.*, 2007: 135).

This session built on the ABC's of emotions proposed by McGovern *et al.* (2010b: 33), discussed in session four (Handout 4.2), by adding the cognitive behavioural therapy strategy of disputing the belief. Evaluating the evidence for and against the belief and considering the potential use of a common style of thinking can help loosen the conviction with which troubling beliefs are held and that consequently lead to negative emotions and behaviours.

The therapist introduced the group members to the **ABCDE of emotions** (Handout 6.2) proposed by McGovern *et al.* (2010a: 39), by adding D and E to the alphabet. They received a handout that showed and explained the D and E. The D stands for Disputing the Belief, in other words, this step is to evaluate or challenge the belief or thought about the situation. The therapist invited practical examples of disputing thoughts. These examples were then reviewed. These initial examples became touchstones for the ongoing skill development and internalisation process. Next the therapist focused on E, Entirely new thought or behaviour. In this step, the task is to consider the evaluation of the first thought and to replace it with a new

thought and/or behaviour. The idea is to slow down the process and really evaluate the evidence for the belief or interpretation of a situation. Group members were then given the opportunity to apply the ABCDE to practical examples during the session. This helped group members not only to end up with a new thought, but possibly even a new behaviour or feeling.

The therapist discussed **common styles of thinking** amongst police officials (handout 6.3) specifically pertaining to thinking negatively about themselves and situations over a period of time. This handout assisted members to think more flexibly. Group members learned that they often distort the situation and that can lead to feelings or behaviours that are potentially negative. In addition, they learned that the more flexible our thoughts, the more options we have in both our emotions and behaviour. This got members out of repeating the same things, or feeling the same things, over and over again. Group members were therefore taught to make use of **positive affirmations** (Handout 6.4), using positive statements to help them to change their style of thinking and developing a new attitude towards themselves and their situations. Group members were encouraged to write down three affirmations that they wanted to say to themselves and hoped to believe when they notice that they have negative thoughts. Members then had to practice the skill of immediately turning around negative thoughts by using positive affirmations (Andrews *et al.*, 2003: 124).

The therapist re-inforced flexible thinking practices by introducing the **thought record** exercise (Handout 6.5), using examples from their own lives. This includes the activating situation, belief, consequence, disputing the belief and finding an entirely new thought and behaviour (Allen, 2005:168). You want them to start out with situations that are not too emotionally complicated, situations that are specific and recent. Once the therapist taught the skill, it is recommended to apply this to the group member's real life situations.

Lastly, the group members learned a technique to **STOPP the thought** (Handout 6.6). Group members were provided with a worksheet on which they had to write down a bad thought and by considering the above STOPP technique change it into a positive thought. Those that felt comfortable could practice it in the session by identifying bad thoughts and replacing them with positive ones.

The therapist then reviewed and discussed the therapeutic alliance. This is a good point to remember to **check police officials' reaction** to the session and the process so far, since they had reached the half-way mark. During this phase of the process it might be meaningful to get feedback from the group members with regard to how they are doing and to probe for possible questions, comments or recommendations.

11.7.4 Handouts

- Workbook (Session 6)
- Name tags
- Pencils and pens
- Exam pad
- Standing board
- Flip chart paper
- Markers
- Workbook

Attached please find Annexure 1: Workbook: Session 6.

11.8 Session 7: Challenging destructive and self-destructive behaviour

11.8.1 Agenda

- Weekly TST- Check-In (Handout 7.1)
- The aggression cycle (Handout 7.2)
- Dealing with anger (Handout 7.3)
- Skills for managing anger: Passive, aggressive and assertive concept (Handout 7.4)
- The link between trauma, alcohol and drug abuse (Handout 7.5)
- STOPP substance abuse (Handout 7.6)
- The link between PTSD, suicidal thoughts and actual suicide (Handout 7.7)
- Risk factors for police suicide (Handout 7.8)
- SBQ-R Suicide behaviour questionnaire Revised (Handout 7.9)
- Safety plan for police officials at risk of suicide (Handout 7.10)
- Check-in re: police official's reaction to session

11.8.2 Rationale

This session firstly concentrated on raising awareness of destructive and self-destructive behaviours for example anger, aggression, substance abuse and suicide ideation and actual suicide. Secondly, the therapist assisted group members to identify these types of behaviours. An important aspect of this session was to teach group members to handle the stress stemming from an individual's lack of self-confidence and to assert personal boundaries and help them to find alternative coping mechanisms.

11.8.3 Content

The therapist administered the **Weekly TST Check-In Scale** in the beginning of the session to assess the group member's emotional and behavioural challenges during the previous week

and monitor growth since the last session (Handout 7.1). At the end of the session, the therapist collected and stored the completed scales (Saxe *et al.*, 2007: 135).

The therapist introduced the **aggression cycle** (Handout 7.2), as it is important for the group members to understand it as an important part of managing problem anger. Any episode of anger display starts as a result of a trigger event and builds up through three stages. After being triggered, anger escalates (phase 1), during which our mind and our body give us cues that anger is building up inside of us. These cues are physical, behavioural, emotional and cognitive. If the escalation phase continues unattended, it then passes a point of no return after which an aggressive and often violent expression occurs (phase 2). This is characterised by a violent display of anger that includes either verbal or physical aggression. After the explosion, the individual finds him/herself in the post-expression stage (phase 3) during which they start realising the negative consequences that were the direct result of the verbal or physical aggression (phase 3). The individual might experience feelings of guilt, shame and regret and in some cases are confronted with more external implications such as arrest. In some instances the anger stays dormant until the next trigger comes along, at which point it repeats and intensifies. Group members were encouraged to identify own trigger events, the intensity, frequency and duration of anger in the aggression cycle. The aim of anger management is to prevent members from reaching the expression stage (Videbeck, 2014: 191). The therapist assisted group members to identify effective techniques and practices, for **dealing with anger** (Handout 7.3) before it reaches the expression stage.

Subsequently, group members were introduced to different **skills for managing anger** (Handout 7.4), specifically referring to passive, aggressive and assertive behaviours. The mentioned descriptions describe the extremes although the vast majority of people lie between the extremes. Members got the opportunity to share in session their personal skills for managing anger, with a possible explanation of the consequences. They also discussed the best type of behaviour with an explanation of why. The therapist guided members through the benefits associated with assertive behaviour, which are achieving your goals quicker, building self-confidence and self-esteem, improving our ability to communicate with others, getting the respect of others, increasing your popularity and creating personal happiness (Thomas, 2010: 123).

Group members were made aware of the **link between traumatic events and alcohol/drug abuse** and the reasons why they resorted to these substances (Handout 7.5). Many police officials exposed to traumatic events take drugs and drink to numb them, help them sleep, ease the anxiety and escape the haunting memories of what led them to substance abuse. Unfortunately this comes at a very high price as it will reduce the anxiety in the short term, but it will come back two-fold as the side effects set in. Police officials may find some relief in their

substances, whether its beer or cocaine or prescription drugs. As soon as the effect of the drugs and alcohol wear off, they're back where they started and have to use again to find that relief (Lynch & Mack, 2015: 42). Group members were introduced to the **STOPP substance abuse worksheet** (Handout 7.6), which provided them with self-help information to overcome their cravings. Group members were encouraged to share own experiences and practice different coping skills in the session

Group members were introduced to the **link between post-traumatic stress, suicidal thoughts and actual suicide** (Handout 7.7). Police officials might be of the opinion that as a result of their work they sometimes have a perceived burdensomeness and low belongingness, they feel totally hopeless, helpless and overwhelmed with emotional pain. The pain feels like it will never end and they become depressed. Members might feel that they have run out of ideas, possible solutions or options, and suicide is the only answer left. Suicidal thoughts come to mind, and members might have mixed feelings about these thoughts. For some people suicide is a cry for help, others think of it as a way of getting back at others (Escolas *et al.*, 2010: 293). During this session group members will be encouraged to discuss **the risk factors for police suicide** (Handout 7.8). According to Violanti (2007: 50), research has shown that it is not certain that police work by itself is a suicide risk factor. The author does state that "it serves as a fertile arena for suicide precipitants, including relationship problems, culturally approved alcohol use, firearms availability, and exposure to psychologically adverse incidents". Police work is therefore very likely part of the causal chain of suicide.

Group members were requested to complete the **Suicide Behaviours Questionnaire – Revised** (SBQ-R) (Handout 7.9) developed by Osman *et al.* (2001: 443), with the aim of assessing the frequency of suicidal ideation over the past twelve months, the threat of suicide attempt and the self-reported likelihood of suicidal behaviour in future. The questionnaire assesses four items namely, lifetime suicide ideation and/or suicide attempts, frequency of suicidal ideation over the past twelve months, the threat of suicide attempt and self-reported likelihood of suicidal behaviour in the future. The total score should range from three to 18, which is an indication of low suicide behaviour. The result of the scoring is confidential unless some of the group members would voluntarily like to discuss the outcome in session. The group members were subsequently introduced to a **safety plan** (Handout 7.10) which would guide them to balance the pain and coping resources step-by-step until they feel safe. This plan therefore helped the group members to reduce the pain and increase coping resources. The foundation for the safety plan is that suicide is a permanent solution to a temporary problem and that these feelings will pass. Group members were encouraged to practice the plan in session, but were also advised to keep the plan where they can easily find it during a crisis situation.

The therapist finished the session by asking about the **police officials' reactions to the session** and whether they had any additional questions or comments pertaining to controlling destructive and self-destructive behaviour. It is important to normalise any emotions of discomfort and give credit for their willingness to share.

11.8.4 AIDS

- Workbook (Session 7)
- Name tags
- Pencils and pens
- Exam pad
- Standing board
- Flip chart paper
- Markers
- Workbook

Attached please find Annexure 1: Workbook: Session: 7

11.9 Session 8: Problem solving

11.9.1 Agenda

- Weekly TST Check-In (Handout 8.1)
- What is problem solving and why it is important in therapy?
- Strategies for effective problem solving (Handout 8.2)
- SOLVED: Problem solving exercise (Handout 8.3)
- Pros and Cons (Handout 8.4)
- Positive and negative consequences (Handout 8.5)
- Check-in re: police officials' reaction to session

11.9.2 Rationale

During the session group members were educated with regard to possible indications and contra-indications, and strategies for effective problem solving. To further facilitate the group members' learning, the therapist provided several examples of the SOLVED problem solving exercise by concentrating on the identification of problems in session to assist members to consider multiple perspectives and outcomes before making a decision.

11.9.3 Content

The therapist administered the **Weekly TST Check-In Scale** at the beginning of the session to assess the group member's emotional and behavioural challenges during the past week and to

monitor growth since the last session (Handout 8.1). At the end of the session, the therapist collected and stored the completed scales (Saxe *et al.*, 2007: 135).

The therapist explained that **problem-solving** generally involves a process through which an individual attempts to identify effective means of coping with problems of everyday living. This often involves a set of steps for analysing a problem, identifying options for coping, evaluating the options, deciding upon a plan, and developing strategies for implementing the plan. Problem-solving strategies can be used with a wide range of problems, including anxiety, stress management, coping with medical illness, addiction, family/relationship problems and financial difficulties. Problem-solving techniques teach skills that aid the individual in feeling increased control over life issues that previously felt overwhelming or unmanageable. In this manner, problem solving can help with practical problem resolution and emotion-focused coping (Cully & Teten, 2008: 66).

Problem solving may be used when the root of an issue is a changeable situation, and the thoughts associated with the harmful situation might be accurate. Problem solving is therefore especially effective when a specific problem can be addressed and operationalised. A specific operationalised problem is one that is easily explained, identified, and/or measurable. It works best when a practical solution is available. Examples appropriate for problem solving might for example include how to communicate with a partner about a difficult issue, how best to cope with the functional limitations of a medical condition or how to reduce financial distress (Greenwald, 2013: 153). The therapist is not responsible for finding answers to these questions, but should rather aid the group members in finding their own answers. In this manner you are a facilitator who possesses problem-solving skills.

Group members were first educated about the **problem-solving strategies** that are used during the session (Handout 8.2). Group members were enabled to use the strategies after therapy ends, taught to carefully examine a problem, create a list of solutions, and make decisions about which strategies are appropriate for a variety of problems. General guidelines for using problem-solving strategies are as follows: Training should be tailored according to a specific individual or group, a thorough assessment of the problem should be obtained before proceeding with problem-solving therapy, group members should be encouraged to try as many solutions as possible and a decision should be made whether the group members require more problem-solving work or more emotional work to experience growth through the therapeutic process.

To facilitate learning the therapist explained the **SOLVED problem solving technique** (Handout 8.3), introduced by Cully and Teten (2008: 68), by providing examples of the SOLVED program at work. Group members were encouraged to identify a specific problem in

their personal lives which they would like to solve. It is important to notice that problems need to be specific to effectively use the SOLVED technique. They were guided to list possible solutions after which group members had to open their minds and evaluate the **pros and cons** (Handout 8.4) of each solution. Group members then verified the best solution by circling their choice, after which the solution was enacted. In addition the therapist provided the group members with the **positive and negative consequences worksheet** (Handout 8.5) to help them to evaluate the plan and decide if the plan worked, where after it can be modified if necessary.

Lastly the therapist summarised and checked for police official's reaction to the session, and made recommendations and comments.

11.9.4 AIDS

- Workbook (Session 8)
- Name tags
- Pencils and pens
- Exam pad
- Standing board
- Flip chart paper
- Markers
- Workbook

Attached find Annexure 1: Workbook: Session 8

11.10 Session 9: Managing trigger events

11.10.1 Agenda

- Weekly TST Check-In (Handout 9.1)
- Defining triggers
- Identifying my triggers (Handout 9.2)
- Avoidance and safety behaviours (Handout 9.3)
- My avoidance and safety behaviours (Handout 9.4)
- Checklist with common triggers, avoidance and safety behaviours (Handout 9.5)
- STOPP the trigger worksheet (Handout 9.6)
- Check-in re: police official's reaction to session

11.10.2 Rationale

It is important that group members learn to recognise their avoidance and safety behaviours as a way to escape trigger events that elicit feelings of anxiety, fear, anger, or other types of

distress. Group members were encouraged to identify and represent triggers of their traumatic events. The therapist especially concentrated on members reactions to those triggers when they experience them. Once group members had identified their triggers they learned how to avoid or defuse them in less time. Members were also guided to identify ways that they got past the triggered flashbacks or feelings if they occurred previously.

11.10.3 Content

The therapist administered the **Weekly TST Check-In Scale** at the beginning of the session to assess the group member's emotional and behavioural challenges during the previous week and monitor growth since the last session (Handout 9.1). At the end of the session, the therapist collected and stored the completed scales (Saxe *et al.*, 2007: 135).

The therapist **defined a trigger as an event**, object, or cue that elicited feelings of anxiety, fear, anger, or other types of distress. Triggers are often harmless, but have become associated with the original trauma. For most people with post-traumatic stress, triggers are not inherently dangerous, but they remind them of their traumatic experiences (Krippner *et al.*, 2012: 73). The brain recognises the similarity and – not realising that the danger is over – produces a surge of anxiety that activates the fight or flight response. Certain sights sounds, smells, physical sensations, places, activities, and situations can be triggers for people with post-traumatic stress and can produce a surge of anxiety and a strong urge to escape or avoid. Group members were subsequently encouraged to **identify what triggers** feelings of fear, threat, anger, or general discomfort in them the past week (Handout 9.2).

The therapist gave an explanation of **avoidance and safety behaviours** (Handout 9.3). Avoiding things that make us feel anxious or uncomfortable is only natural. Common avoidance behaviours for police officials include staying away from crowded public spaces, not answering the phone or staying in their room. Avoidance reduces our ability to effectively manage real life challenges and responsibilities. Most triggers are not inherently dangerous, although they feel dangerous. But when you avoid those triggers, you never get to learn that they are actually safe. The brain continues to label them as associated with trauma and they continue to have the power to produce fear. In fact, the fear can grow over time. Avoidance of people and activities leads to isolation, which can contribute to depression and relationship problems (Persons, 2008: 57). Group members should realise that learning to overcome the urge to escape/avoid and to face your fears directly without relying on safety behaviours is what helps make post-traumatic stress better. When presenting the material, it is important to encourage the police official's personal motivation for making behavioural change. One way to do that it is to explicitly discuss the cost of some of their current avoidance behaviours. This is a good opportunity to discuss some of the negative consequences of avoidance and numbing.

The therapist also discussed the fact that it is common to develop safety behaviours, which are rituals and habits intended to reduce distress. Common examples of safety behaviours for police officials included constant visual scanning for threats, carrying a weapon or controlling the perimeter of your home. Avoidance and safety behaviours may make you feel better, but they don't actually make you any safer. Unfortunately, when dealing with triggers, avoidant and safety behaviours do not work to our advantage in the long run. Avoidance and safety may reduce emotional distress for a little while, but in the long run increases the symptoms associated with post-traumatic stress (Bryant, 2006: 220). It is important that group members learn to recognise their avoidance and safety behaviours as an important aspect of this program. Members were encouraged to identify as many as possible of **their own avoidance and safety behaviours** (Handout 9.4). The police officials were asked to complete the worksheet and share examples of their personal avoidance and safety behaviours in the session if they felt comfortable. To assist members they were provided with a **check list with common triggers, avoidance and safety behaviours** (Handout 9.5). Group members were made aware that learning to recognise your triggers is an important part of treatment. Group members were encouraged to start monitoring these behaviours from this week.

The group members were provided with a worksheet to assist them with dealing with their triggers. **The STOPP the trigger worksheet** (Handout 9.6) took group members through the process of identifying the trigger to deliberately expose themselves to the memories and real-life situations that they fear (while resisting the use of avoidance or safety behaviours). Group members were encouraged to repeat the same exposure exercise many times for it to work. This process can assist members to feel, think and do differently and help them to cope with situations that they feel anxious about.

Lastly the therapist summarised and **checked for police officials' reaction to the session**. They were given the opportunity to ask questions and make comments with regard to what they have learned about recognizing their avoidance and safety behaviours as a manner to escape trigger events.

11.10.4 AIDS

- Workbook (Session 9)
- Name tags
- Pencils and pens
- Exam pad
- Standing board
- Flip chart paper
- Markers

- Workbook

Attached please find Annexure 1: Workbook: Session 9

11.11 Session 10: Changes in systems of care

11.11.1 Agenda

- Weekly TST Check-In (Handout 10.1)
- How does PTSD affect families, friends and colleagues?
- My beliefs about trust (Handout 10.2)
- Intimacy and connectedness (Handout 10.3)
- Emotional Boundaries (Handout 10.4)
- Developing a sense of humour and finding positives
- Relationship conflict resolution styles (Handout 10.5)
- Communication techniques (Handout 10.6)
- Styles of communication (Handout 10.7)
- Maintaining good relationships
- Check-in re: police officials' reaction to session

11.11.2 Rationale

Group members were encouraged to discuss the impact of trauma on interpersonal relationships. Enduring and surviving traumatic experiences can lead to problems with attachment, intimacy and interpersonal relationships that were not present before the trauma. In many instances, trauma survivors find it difficult to trust others, the world, and themselves after a traumatic event has occurred. The group members were guided to identify any of the problems and different exercises were introduced to teach group members to build trust and to establish some level of intimacy in relationships.

11.11.3 Content

The therapist administered the **Weekly TST Check-In Scale** at the beginning of the session to assess the group member's emotional and behavioural challenges during the previous week and to monitor growth since the last session (Handout 10.1). At the end of the session, the therapist collected and stored the completed scales (Saxe *et al.*, 2007: 135).

Group members were sensitised with regard to **how PTSD can affect important others, for example families, friends and colleagues**. The symptoms of acute post-traumatic stress, PTSD and other trauma reactions change how a trauma survivor feels and can affect everyone else in the support system. Trauma symptoms can make it extremely difficult to live or being

confronted with. Sometimes police officials withdraw from the support network. When trauma reactions are severe and continue without treatment, they can cause major relationship problems. Family members, friends and colleagues coping with a police official that survived a trauma may find themselves reacting with sympathy, conflict, disconnection and detachment, fear and worry, avoidance, guilt and shame, anger, and stresses for the partner and the relationship (Smith, 2013: 125). Group members were encouraged to reflect on these and other reactions based on their own relationships and to share in the group should they feel comfortable to do so. Group members should realise that all of the reactions described, however, are common in relationships involving an individual who has experienced trauma.

Keeping the above in mind it is important for police officials to build trust and to establish some level of intimacy in relationships. Some of the group members might have been betrayed by people with whom they were very close in the past. Betrayal in the past may lead group members to have difficulties with trust in the present. According to Williams and Poijula (2013: 262) trust involves “your need to feel confident about your own perceptions and judgments about yourself, others, and the world and to be able to depend on others to help meet your emotional physical and psychological needs”. Group members were given the opportunity to examine their own beliefs about trust, to set boundaries, communicate effectively and know when and how to rely on themselves and on others. Group members did a journal exercise: **My beliefs about trust** (Handout 10.2) to find and challenge their beliefs about trust.

Intimacy is the capacity to feel connected to yourself and others. Enduring trauma may lead to a disconnection between you and others. The aim of this part of the session was to teach group members to build healthy attachments that are reciprocal and that are based on a new belief system so that they do not feel vulnerable. These beliefs include beliefs of empowerment and self-acceptance. The therapist introduced an exercise, **my beliefs about intimacy** (Handout 10.3), which may help group members to identify a belief or beliefs about intimacy that they might want to examine or challenge.

A boundary is the way you let yourself know where you end and where someone else begins. If group members are able to set appropriate boundaries, they had a better chance of maintaining good relationships with others. Group members were requested to complete the **exercise: my emotional boundaries** (Handout 10.4). Gehart (2014:126) emphasise that one’s emotional boundaries include your needs for internal safety. If your emotional boundaries are entirely closed, you may not let anyone or anything into your space. If you lack good emotional boundaries you may lose you sense of personal identity.

Papazoglou (2013: 196) states that trauma victims/survivors often develop **a sense of humour and try to find positives** when the world seems to be closing in and your stress level is rising.

Police officials can use humour to cope. Positive responses help to alleviate the pressure and allow you to look at the situation differently without being insensitive. As with any other skill, developing a sense of humour takes some attention and practice. In an attempt to help group members develop a sense of humour, the therapist provides suggestions and other ways to increase positive experience. The therapist helped the group members to explore what makes them laugh, as well as how to identify those people (positive oppose to negative people) who can make them laugh and ways to enjoy life.

Cox and Demmitt (2014: 120) explain that being able to maintain a good relationship means that you and the other person respect each other and accept each other as they are. In order to maintain a good relationship it is furthermore important to be able adopt proper **relationship conflict resolution styles** (Handout 10.5) of which communication with the other person, including communication about what has changed, what could change, what needs to change, what you each want to change without demanding or disrespecting, is very important. The therapist however, concentrated on communication skills. Group members were introduced to **effective communication techniques** (Handout 10.6) which involves active listening, asking questions, describing feelings and behaviour and using “I” messages, as well as certain **styles of communication** (Handout 10.7) for example small talk, control talk and straight talk.. This entails talking directly with another person when something has to be said. Effective communication entails clear messages that say what you mean, are statements rather than asking a question, clearly state your feelings and what you want, do not intend to hurt the other person, and listen and talk actively (Saphiere *et al.*, 2005: 259). Group members were encouraged to practice different communication techniques and styles of communication in session. They furthermore identify specific communication techniques and styles of communication which they would be willing to try in the next week with an important other. After a week of trying, group members had to write the results of their attempts at good communication in their workbook and could give feedback at the next session.

The therapist stressed that the development and **maintenance of good relationships** with one’s spouse, children, peers, comparing co-workers, friends, and close friends are critical. It must be stressed that communication with all these role players are an important source of social support and mentoring. Waldron (2014: 174) found that shared socialising and close proximity, are features of workplace friendship, whereas closer relationships were constituted by activities like talking through important life events, unrelated to work, and sharing major work challenges, all of which are critical aspects in the development and maintenance of good relationships.

Lastly the therapist summarized and checked for police officials' reaction to the session as well and made recommendations and comments with regard to the impact of trauma on interpersonal relationships.

11.11.4 AIDS

- Workbook (Session 10)
- Name tags
- Pencils and pens
- Exam pad
- Standing board
- Flip chart paper
- Markers
- Workbook

Attached find Annexure 1: Workbook: Session 10

11.12 Session 11: Systems advocacy

11.12.1 Agenda

- Weekly TST Check-In (Handout 11.1)
- The meaning of Trauma Systems Advocacy
- Domains that affects families (Handout 11.2)
- Case study: "W/O Bongani" (Handout 11.3)
- The four step advocacy assessment plan (Handout 11.4)
- Systems advocacy screener (Handout 11.5)
- Systems treatment plan (Handout 11.6)
- Check-in re: police official's reaction to session

11.12.2 Rationale

Advocacy is one of the most important tools in psycho-social therapy for addressing instability in the social environment. Systems advocacy is primary used in the surviving and stabilising phases of treatment to remediate key problems in the social environment. During this session the group members had to consider how their families basic needs impact their overall psycho-social well-being and family stability. Group members were introduced to the meaning of systems advocacy and learned how to be an effective advocate.

11.12.3 Content

The therapist administered the **Weekly TST Check-In Scale** at the beginning of the session to assess the group member's emotional and behavioural challenges during the previous week and monitored growth since the last session (Handout 11.1). At the end of the session, the therapist collected and stored the completed scales (Saxe *et al.*, 2007: 135).

Many times police officials and their families do not advocate for themselves because they don't know what their rights are, they don't know how to advocate for what they need, or they have not identified a particular problem as important enough, to advocate for its change. This can be addressed by providing the police official and his/her family with information and education about advocacy. Group members were introduced to **the meaning of systems advocacy**. Advocacy generally means to plead the cause of yourself or another. Saxe *et al.* (2007: 188) explains that "advocacy means providing assistance to an individual or family to gain access to needed services or benefits programs. The advocacy goal is to foster the self-empowerment of individual and their families by educating them about their rights and enabling them to secure needed services and benefits". In essence, advocacy is about changing the trauma system, ensuring that a family's rights and benefits are in place so that the systems designed to help a police official is available to do just that.

Group members were introduced to the ten **domains that affect families** (Handout 10.2). The therapist empowered group members to advocate for themselves and ensure that group members do have a thorough understanding of social, legal, and political systems that might have an impact on the domains that affect families. The therapist introduces a **case scenario of W/O Bongani** that illustrated how he and his family are affected by different domains (Handout 10.3). Group members were guided to view the scenario through an advocacy lens, to identify the different social-environmental issues related to W/O Bongani's basic needs and rights. Group members were guided on how to navigate these respective systems to remedy problems and to effect improvement in overall psycho-social well-being by using the **four-step advocacy assessment plan** (Handout 11.4) as proposed by Sax *et al.* (2007: 190). This four-step advocacy assessment plan helps group members to determine whether a social-environmental condition is contributing to their personal emotional states, whether services and/or benefits to which the police official are entitled are put in place, and what barriers exist that diminish the family's likelihood of accessing them. Group members wrote the answers in their workbooks and a discussion followed in session.

Considering the scenario of W/O Bongani, group members completed the **systems advocacy screener** (Handout 11.5) introduced by Sax *et al.* (2007: 202) to identify those domains affecting their own families which can be addressed by systems advocacy. Clinicians often have

so many areas to cover in an intake that asking about basic needs, such as having enough to eat, is lost. Police officials might not mention problems such as poor housing or hunger because they don't think that the therapist can help or because they are ashamed to mention it. Yet imagine what it must be like to spend an hour in therapy with a therapist about how to help you cope with your trauma while thinking the whole time, "being able to give my family dinner would help more than anything".

As a result group members were introduced to the **systems treatment plan** (Handout 11.6) developed by Sax *et al.* (2007: 202), which they have to develop to maximise their family's likelihood of accessing needed services and benefits. The plan can help families and clinicians discuss and prioritise areas of intervention in the social environment. The systems treatment plan specifies the priority problem to be addressed, the advocacy solution to address it, and what is expected of the police official and the therapist.

Lastly the therapist summarized and **checks for police officials' reaction** to the session and makes recommendations or comments for addressing instability in their social environment.

11.12.4 AIDS

- Workbook (Session 11)
- Name tags
- Pencils and pens
- Exam pad
- Standing board
- Flip chart paper
- Markers
- Workbook

Attached find Annexure 1: Workbook: Session 11

11.13 Session 12: Relapse prevention

11.13.1 Agenda

- Weekly TST Check-In (Handout 12.1)
- Formalise the ending
- Reviewing what was learned and how to maintain progress (Handout 12.2)
- Relapse signs (Handout 12.3)
- Relapse, recovery, and resiliency (Handout 12.4)
- Relapse prevention plan (Handout 12.5)
- Summarise the sessions

- Transition
- Schedule follow-up assessment
- Closure

11.13.2 Rationale

Group members were prepared for ending treatment. This entailed helping the group member's transition from the ending of the face-to-face group meeting with the therapist. Group members were given the opportunity to reflect on progress benefits and disappointments, to acknowledge what has changed and what has not. Lastly, they learned techniques preventing relapse in future.

11.13.3 Content

The therapist administered the **Weekly TST Check-In Scale** at the beginning of the session to assess the group member's emotional and behavioural challenges during the previous week and monitor growth since the last session (Handout 12.1). At the end of the session, the therapist collected and stored the completed scales (Saxe *et al.*, 2007: 135).

It may be important to **formalise the ending** of the psycho-social therapeutic program for several reasons. First, it is a time-limited program. This is what was communicated to the group members at the outset and it is integral to the principle of the approach: To teach group members to become their own personal therapist. Second, the group members have invested a considerable amount of time and effort in this relationship, and this should not go unnoticed. Third, and most important, acute stress and post-traumatic stress are conditions more often neglected and for which treatment is not always sought, especially within the police culture. It takes an enormous amount of courage to do so. Having reached this stage in the program indicates that the group members have stuck with the program. They showed courage and determination, something that should be acknowledged and celebrated (McGovern *et al.*, 2010b: 51).

Group members might be concerned that they will not be able to manage future psycho-social problems or stressors without the aid of therapy. The therapist therefore reviewed what was learned in a process to assist group members with what to do in case of a setback and how to **maintain progress** (Handout 12.2). The therapist pointed out that it is normal for those involved in psycho-social therapy to experience a relapse, but that it is important to know how one recovers from a relapse. It is not unusual to re-experience post-traumatic stress symptoms even after "recovery", especially on occasions like the anniversary of the trauma. Group members were asked to anticipate situations in future that may trigger post-traumatic stress symptoms by introducing the **relapse signs worksheet** (Handout 12.3). These may be thoughts (I am not

safe), feelings (panic, depression) physical symptoms (heart racing, chest pain) and behaviours (making excuses instead of going out).

The therapist then introduced the **relapse, recovery, and resiliency worksheet** (Handout 12.4) by firstly identifying possible old ways of handling problems. The therapist emphasised the road to recovery as group members decide to use new skills instead of continuing the old pattern. The focus was on group member's resiliency by teaching them not to give up and that they are able to overcome what they thought they were not able to overcome. The meaning of the different terms namely relapse, recovery and resiliency were discussed. Members were given the opportunity to discuss their experiences in session. It is, however, important to emphasise that relapse, recovery and resilience are key parts of getting better. Group members should be encouraged to say that it is not how many times you fall down that counts, it is how many times you get back up. Group members were introduced to the **relapse prevention plan** (Handout 12.5) for when they notice the above signs. This plan may include writing and implementing new hierarchies, re-reading resources and forms that they had been used in treatment and the utilisation of resources to keep stress under control.

The therapist **summarized the sessions** and allowed group members to reflect on progress towards the goals that they indicated at the outset of the program and their disappointments and to acknowledge what had changed and which aspects still need some more attention. The therapist tried not to be defensive. If the group member's goals seem more long-term and probably unrealistic, it is fine to express that some goals may take longer to achieve, and progress is best measured one step at a time. Where group members had achieved the goal by doing this behaviour, it was not dismissed or minimized. The participants were encouraged to congratulate one another as this was the point of doing all the hard work. Where group members had clearly not made progress it is important to openly acknowledge this (McGovern *et al.*, 2010b: 51).

During the **transition** phase police officials might be referred or introduced to recovery support groups for ongoing support for both mental health and social issues. An open discussion about the role of the group member's family, other social supports and police management at this juncture is also important. Did the family, social support and police management know about the member's participation in the psycho-social therapeutic group? Do they know it is ending? What is their observation about any changes the member may have displayed? How will the member be re-integrated within the working environment? If the group member is married, or in a committed relationship and if he/she is also a parent it will be important to talk about the effects of the treatment on their marital and parenting behaviour. Is this noticeable to them? Would it be noticeable to their partner and children? What effect will ending the psycho-social therapeutic program have on their relationship with their partner and children? What will the

impact be if the member should continue in the same working environment? It was also important at this stage to be very clear about the nature of mental health recovery. The condition is best understood as a curable condition that will need ongoing monitoring, recovery check-ups and some degree of vigilance. One does, however, need to respect the nature of these conditions and be attentive to signals for relapse. Hopefully, during the course of this treatment these signals became increasingly clear, and skills were provided for successfully coping when they do arise (McGovern *et al.*, 2010b: 52).

The researcher scheduled an appointment within one month after termination of the program for a **follow-up assessment**. Group members once again completed the CIHQ, IES-R, MHC-SF, PTCI and a second self-developed questionnaire as part of the post-test to determine the impact of the program on police officials' psycho-social wellness.

The therapist **closed** the PTP by giving group members the opportunity to say goodbye face-to-face and openly communicating about it. The therapist ensured that there is some sort of closure, thanked the group for their effort, shared admiration for their bravery and acknowledged that they are continuing their journey without you. This should be done in addition to expressing your individualised sense of your collaborative work together.

11.13.4 AIDS

- Workbook (Session 12)
- Name tags
- Pencils and pens
- Exam pad
- Standing board
- Flip chart paper
- Markers
- Workbook

Attached find Annexure 1: Workbook: Session 12

11.14 Post-treatment assessment

Group members, once again completed the CIHQ, IES-R, MHC-SF, PTCI and a second self-developed questionnaire three weeks after termination of the program. The process was administered in a group by an independent therapist. The aim was to determine whether there was an improvement in the participants overall psycho-social well-being after participation in the PTP.

12. Discussion

The specific needs of police officials attached to the specialised units of SAPS in the North West Province, including their emotional and social needs, as obtained through a needs assessment, formed the foundation when the PTP was planned and compiled. The researcher gave an overview of the trauma management risk operating procedure (TRiM) and explained how the PTP, which is a specialised treatment program for those police officials experiencing medium to longer term distress fits into the phases of this procedure. Various evidence-based models, perspectives and existing guidelines regarding group work with traumatised police officials were taken into consideration during the planning process. The screening criteria for inclusion in the program were discussed as well as how the program would be presented in the group. The planning and compilation of a group work program is a complex process and consists of different components.

The different phases in group work namely the preparation/pre-group, beginning, middle, end and post-group phases were taken into consideration in the planning process. The process of a therapeutic program comprises of the following phases: Preparation, contact, assessment, contracting, action, evaluation and termination. Program activities should be considered carefully as it plays an important role in the presentation of the program. Different aspects were considered in the actual planning of the group work program. These aspects included the structure, nature and aims of the group, the preparation of the social worker, the needs to be addressed by the group, relationships between the group members and the facilitator, and the procedure of the group. The program was planned and compiled, taking into account the needs of police officials as discussed in articles three and four.

A PTP is recommended for police officials exposed to traumatic events as it builds a set of skills that enables an individual to relax, remember, and verbalise traumatic events, being able to identify how situations, thoughts and behaviours influence emotions and improve feelings by changing dysfunctional thoughts and behaviours, how to challenge destructive and self-destructive behaviour, manage trigger events, solve problems, change systems of care, use systems advocacy for addressing instability in the social environment, and how to prevent a relapse. The acquisition of new skills not only has a positive impact on the individual, but also on the interconnected systems of care. The process of skills acquisition is collaborative. Skill acquisition and practical activities are what set this kind of therapy apart from "talk therapy". With their psycho-social needs being addressed, these police officials should be more empowered to be able to cope with acute post-traumatic stress reactions and its impact on their systems of care, preventing the possibility of developing long-term distress, for example post-traumatic stress- or any other co-morbid disorders.

13. Conclusion

Police officials exposed to high risk situations can gain important skills to cope with trauma through group work programs. The PTP was designed in correlation with the needs of police officials at risk of developing long-term distress, for example post-traumatic stress- and co-morbid disorders. A therapeutic program can be utilised for police officials exposed to unique work demands to fight the battle against these disorders. The presentation of a therapeutic program can be seen as a structured, constructive and 'non-threatening' way of providing support to vulnerable police officials finding themselves within an environment in which stress-related problems are usually stigmatised. In this article the objective of the study was outlined and related terminology discussed. Guidelines for group work with traumatised police officials were provided and the screening of members for inclusion in a group was discussed. The process of planning and compiling a specialised PTP to be implemented during the third phase of the trauma risk management procedure was explained. The main focus of this article was on the themes and content of the designed PTP.

14. Recommendations

The PTP builds a set of skills that address the psycho-social needs of police officials. They are being empowered to cope with acute post-traumatic stress reactions and the impact thereof on their systems of care, preventing the possibility of developing long term distress for example post-traumatic stress- or any other co-morbid disorders. Based on the discussion of the results from this study and on the conclusion that was drawn, the following recommendations can be made:

- The program is supposed to be presented over a period of 12 weeks, As a result of police officials working demands, often long and different working hours (overtime, deployment) and the unpredictability of their work, the last mentioned seems impossible. It is therefore recommended that the program should be more flexible to accommodate the working demands as explained above;
- Time allocated for the sessions should as a result of the extent of the sessions and the intensity of some of the topics and activities, not be less than two hours per session; and
- The implementation of the PTP should be strictly monitored, to ensure that it is used as a therapeutic intervention process as part of the SAPS trauma risk management operating procedure as explained in article five.

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ANNEXURE 1: A PSYCHO-SOCIAL THERAPEUTIC PROGRAM



*SOUTH
AFRICAN
POLICE
SERVICE*

WORKBOOK

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TABLE OF CONTENTS

SESSION 1 INTRODUCTION AND PSYCHO-EDUCATION

Handout 1.1	Group norms and guidelines for participating in the psycho-social trauma intervention program	269
Handout 1.2	Weekly TST Check-In	271
Handout 1.3	Definition of Trauma and other related terms	272
Handout 1.4	The process of Trauma	274
Handout 1.5	Fight, flight or freeze response	275
Handout 1.6	Common signs and symptoms following exposure to traumatic events	276
Handout 1.7	Exercise: My symptoms	277
Handout 1.8	DSM-5 Diagnostic criteria for PTSD	279
Handout 1.9	Treatment recovery – The linen cupboard metaphor	280

SESSION 2 RELAXATION

Handout 2.1	Weekly TST Check-In	282
Handout 2.2	Grounding (Focusing on the present)	283
Handout 2.3	Safe place exercise	285
Handout 2.4	Progressive muscle relaxation	286
Handout 2.5	Exercise: Deep breathing	287

SESSION 3 TRAUMA NARRATIVE

Handout 3.1	Weekly TST Check-in	289
Handout 3.2	Who are you?	290
Handout 3.3	Why remember	293
Handout 3.4	Journal Exercise: Informal Writing	295
Handout 3.5	Constructing a trauma inventory	296

SESSION 4 IDENTIFYING EMOTIONS, FEELINGS AND THOUGHTS

Handout 4.1	Weekly TST Check-In	299
Handout 4.2	The ABC's of my emotions	300
Handout 4.3	Exercise: Recognizing my emotions	301
Handout 4.4	Experiencing feelings in your body	303
Handout 4.5	Unhelpful thinking habits	304
Handout 4.6	Primary negative emotions and the common thoughts that drive them	307

SESSION 5 RATING OF FEELINGS AND AFFECT MODULATION

Handout 5.1	Weekly TST Check-In	310
Handout 5.2	Affect style questionnaire	311
Handout 5.3	Facial expressions	312
Handout 5.4	Emotion expression exercise	313
Handout 5.5	Negative emotion diagram	314
Handout 5.6	Positive imagery	315
Handout 5.7	Exercise: The DVD technique	317
Handout 5.8	Dealing with negative emotions	318
Handout 5.9	STOPP the feeling worksheet	320

SESSION 6 ALTERED THINKING

Handout 6.1	Weekly TST Check-In	323
Handout 6.2	Flexible thinking: The ABCDE of our emotions	324
Handout 6.3	Common styles of thinking	325
Handout 6.4	Exercise: My affirmations around my trauma	327
Handout 6.5	Thought record	328
Handout 6.6	STOPP the thought worksheet	329

SESSION 7 CHALLENGING DESTRUCTIVE AND SELF-DESTRUCTIVE BEHAVIOUR

Handout 7.1	Weekly TST Check-In	332
Handout 7.2	The aggression cycle	332
Handout 7.3	Dealing with anger	334
Handout 7.4	Skills for managing anger	335
Handout 7.5	The link between trauma, alcohol and drug use	336
Handout 7.6	STOPP Substance abuse	337
Handout 7.7	The link between PTS, suicidal thoughts and actual suicide	339
Handout 7.8	Risk factors for police suicide	340
Handout 7.9	SBQ-R Suicide Behaviours Questionnaire-Revised	341
Handout 7.10	Suicide safety plan	342

SESSION 8 PROBLEM SOLVING

Handout 8.1	Weekly TST Check-In	344
Handout 8.2	Strategies for effective problem solving	345
Handout 8.3	SOLVED: Problem solving exercise	347
Handout 8.4	Pros and cons	348
Handout 8.5	Positive and negative consequences	349

SESSION 9 MANAGING TRIGGER EVENTS

Handout 9.1	Weekly TST Check-In	351
Handout 9.2	Triggers	352
Handout 9.3	Avoidance and safety behaviours	353
Handout 9.4	My avoidance and safety behaviours	354
Handout 9.5	Checklist of triggers, avoidance- and safety behaviours	355
Handout 9.5	STOPP the trigger worksheet	357

SESSION 10 CHANGES IN SYSTEMS OF CARE

Handout 10.1	Weekly TST Check-In	360
Handout 10.2	Exercise: My beliefs about trust	361
Handout 10.3	Exercise: My beliefs about intimacy	362
Handout 10.4	Exercise: My emotional boundaries	363
Handout 10.5	Relationship conflict resolution	364
Handout 10.6	Communication techniques	366
Handout 10.7	Styles of communication	367

SESSION 11 SYSTEMS ADVOCACY

Handout 11.1	Weekly TST Check-In	369
Handout 11.2	Domains that affect families	370
Handout 11.3	Case study: “W/O Bongani”	371
Handout 11.4	The four step advocacy assessment plan	373
Handout 11.5	Systems advocacy screener	374
Handout 11.6	Systems treatment plan	377

SESSION 12 RELAPSE PREVENTION

Handout 12.1	Weekly TST Check-In	382
Handout 12.2	Reviewing what was learned and how to maintain progress	383
Handout 12.3	Relapse signs	385
Handout 12.4	Relapse, Recovery and Resiliency	386
Handout 12.5	Relapse prevention plan	387

A PSYCHO-SOCIAL THERAPEUTIC PROGRAM WORKBOOK FOR POLICE OFFICIALS

Introduction

This workbook is your guide as you do the Psycho-Social Therapeutic Program (PTP).

This workbook has been developed for use with police officials exposed to traumatic events. The activities in the workbook correspond to the treatment components of Trauma-Focused Cognitive Behavioural Therapy (TF-CBT), Prolonged Exposure (PE) and the Echo-Systemic Perspective in Social Work. The intended use of the workbook is by mental health professionals within the South African Police Service (Employee Health and Wellness) who have been trained in the PTP and have read the manual on PTP.

The workbook was created as a supplemental resource to assist therapists as they work through each component of the PTP with police officials and the manual provides an extensive list of activities and other therapeutic aids. There are a total of 80 handouts in this workbook. Some handouts are factsheets that you can read and learn from, other handouts are worksheets that you will be writing things down on. The workbook intends to provide a helpful framework to cover each component of the PTP, but other resources and activities should also be utilised as clinically indicated (i.e., role plays, relaxation exercises, therapeutic games, music). Some of the activities included in the workbook may not be appropriate for all police officials, and flexibility needs to be balanced with fidelity to the treatment model.

The workbook activities were developed for implementing the PRACTICE components of the PTP: psycho-education, relaxation, trauma narrative, identifying emotions, feelings and thoughts, rating of feelings and affect modulation, altered thinking, challenging destructive and self-destructive behaviour, managing trigger events, problem solving, changes in systems of care, systems advocacy and relapse prevention. Police officials will initially need some orientation to PTP, and issues of confidentiality and sharing of the police officials work need to be discussed from the outset. The work can be completed over the course of 12 weeks, depending on the length of each session and the individual and working conditions of the police official. Keep in mind that some traumatised police officials may require other types of treatment before or after PTP. The workbook activities correspond to the components of the PTP as follows:

➤ Introduction and psycho-education	Pages 269-280
➤ Relaxation	Pages 282-287
➤ Trauma narrative	Pages 289-297
➤ Identifying emotions, feelings and thoughts	Pages 299-307
➤ Rating of feelings and affect modulation	Pages 310-320
➤ Altered thinking	Pages 323-329
➤ Challenging destructive and self-destructive behaviour	Pages 332-342
➤ Problem solving	Pages 344-349
➤ Managing trigger events	Pages 351-357
➤ Changes in systems of care	Pages 360-367
➤ Systems advocacy	Pages 369-377
➤ Relapse prevention	Pages 382-387

Following the structure of the PTP, the therapist meets police officials in a group each week to complete the above and other supplemental treatment activities. Your therapist will tell you about the handouts and will explain them while you are in session. Each handout is designed to fit exactly with what you are working on that day, but several of them may be used over and over again throughout the PTP. Homework activities can be assigned each week for the police officials at the discretion of the therapist. The workbook for example includes relaxation activities that require certain techniques. It is therefore important that these techniques be practiced in session and labeled as homework. The therapist may also allocate other types of homework for example thought logs. It is important to be creative, and to concentrate on the police official's strengths and interests when planning interventions.

SESSION 1:
INTRODUCTION AND PSYCHO-EDUCATION



HANDOUT 1.1: GROUP NORMS AND GUIDELINES FOR PARTICIPATING IN THE PSYCHO-SOCIAL THERAPEUTIC PROGRAM

1. You will be expected to attend weekly, be on time, and notify the group leader of anticipated absences.
2. Group members should maintain confidentiality at all times. This means that what is said in the group stays in the group. Confidentiality is mandatory and is extremely important in order to help you feel safe discussing personal issues. Please note that by law, the therapist is obligated to reported child abuse and elder abuse or neglect. The therapist must also take action and notify others if you are planning to harm yourself or another person.
3. Group members should treat each other with respect at all times. Differences of opinion or other differences are worked out within the group.
4. Groups should be safe places to talk, be heard, and be understood. Group members maintain this atmosphere by treating each other with respect, and accepting differences in opinions, attitudes, and beliefs.
5. Turn off all cell phones and pagers at the beginning of the group.
6. Complete your homework assignments and share them with the group.
7. The program is focused on the present. Group discussions are not necessarily a time to talk in detail about past police experiences. They are about discussing applications of the skills learned in the group.

Remember, therapy in this recovery program is time-limited:

1. Therapy is focused on specific goals: to help you manage and reduce PTS symptoms.
2. Therapy requires both at-home practice and participation during the session.
3. Therapy is ultimately about police officials learning to be their own therapist.

I have read and understand the requirements of this Psycho-Social Therapeutic Program.

Signature of Police Official

Date

HANDOUT 1.2: WEEKLY TST CHECK-IN

Emotional and Behavioural Dysregulation

<p>How bad, sad, hurt, angry, guilty, or scared have I been feeling in the last week?</p> <p>9 As much as I can imagine 7 A lot 5 Some 3 A little bit 1a Not at all</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>How much has my behaviour toward myself or others been harmful, destructive, aggressive, or risky in the last week?</p> <p>9 As much as I can imagine 7 A lot 5 Some 3 A little bit 1a Not at all</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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Environmental Stability

<p>In the last week, how much have I been reminded of bad things that have happened to me?</p> <p>9 As much as I can imagine 7 A lot 5 Some 3 A little bit 1a Not at all</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>In the last week, how much did I feel like people around me (managers, colleagues, family, social workers, etc) were able to protect me from experiencing or being reminded of bad things or help me in dealing with my emotions when I was reminded?</p> <p>9 As much as I can imagine 7 A lot 5 Some 3 A little bit 1a Not at all</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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Saxe (2007: 312)

HANDOUT 1.3: DEFINITION OF TRAUMA AND OTHER RELATED TERMS

Trauma:

The DSM-5 defines trauma as an event in which the person experienced witnessed, was confronted or learned about an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others; and exposure to “repeated or extreme exposure to aversive details of the event(s); the person’s response to the trauma involved intense fear, helplessness, or horror (American Psychiatric Association. 2013: 271)

Trauma in itself is not a diagnosable disorder, but the following reactions might be diagnosed shortly after exposure to a traumatic event:

Acute stress:

Acute stress is characterized by a variety of separate symptoms which are usually experienced immediately after the traumatic event, but fades relatively quickly. If all the characteristic symptoms of PTSD are present, 30 days have not lapsed, and additional, dissociative symptoms are present, the individual may be diagnosed with Acute Stress Disorder (Godbout & Brier, 2012: 485)

Post-Traumatic Stress Disorder (PTSD)

PTSD includes distinctive psychological/physiological symptoms which may develop and intensifies after exposure to or the witnessing of any one of a number of natural or human-assisted/caused disasters or other frightening events such as assault, domestic abuse, sexual assault, major accidents, fires and other forms of trauma involving the self or another person (Figley, 2012: 450)

Depression:

Depression is a psychological disturbance which influences a person’s mood, physical functioning and social interaction. The level of depression varies for each responder. Depression is a chemical imbalance that can create feelings of helplessness and hopelessness (Kirschman et al., 2014: 147).

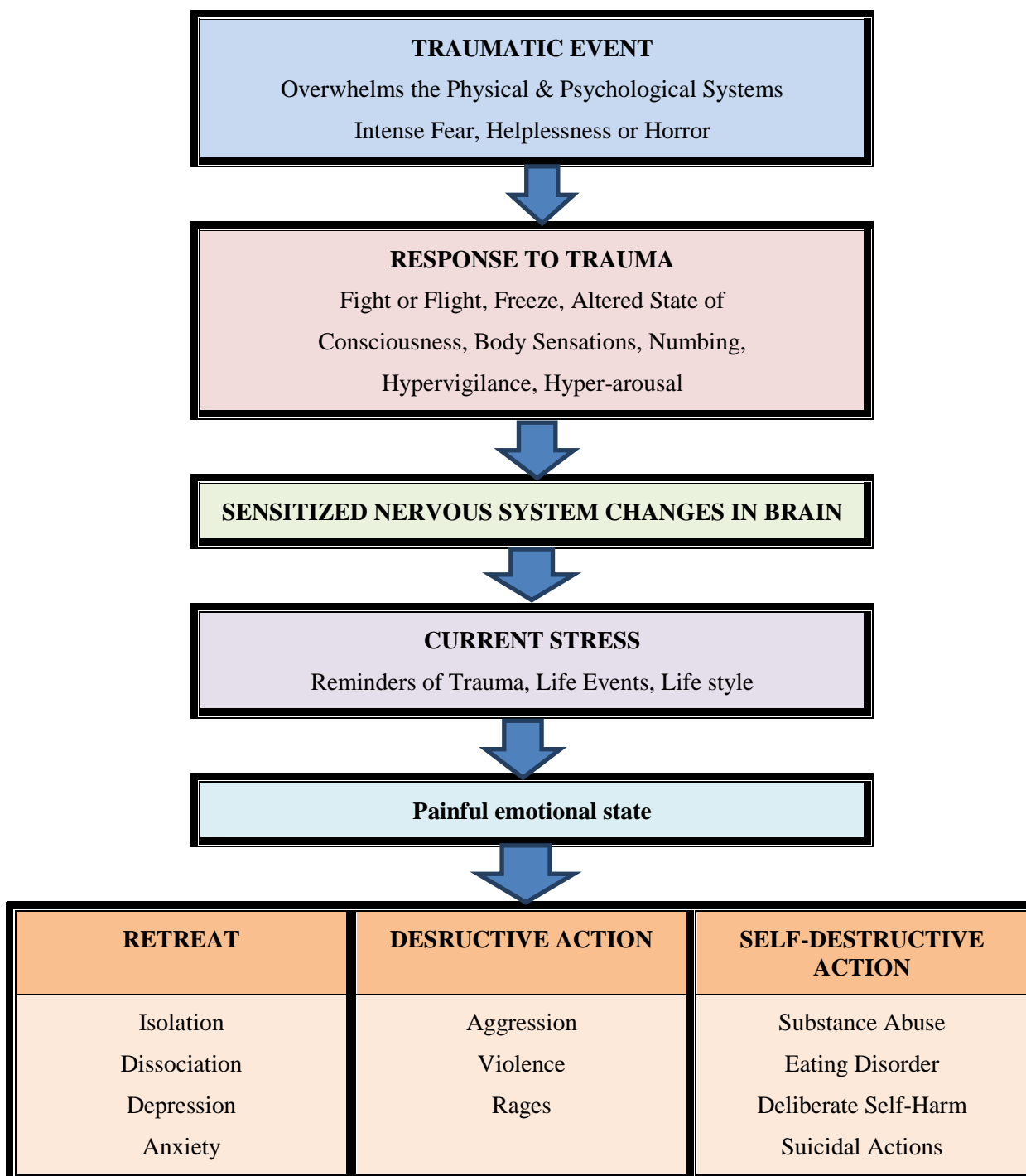
Anxiety disorder

Anxiety disorder is periods of intense fear or apprehension that are of sudden onset and of variable duration from minutes to hours. Panic attacks usually begin abruptly, may reach a peak within 10 minutes, but may continue for much longer if triggered by a situation from which they are not able to escape (NIMH, 2013).

Somatic reactions:

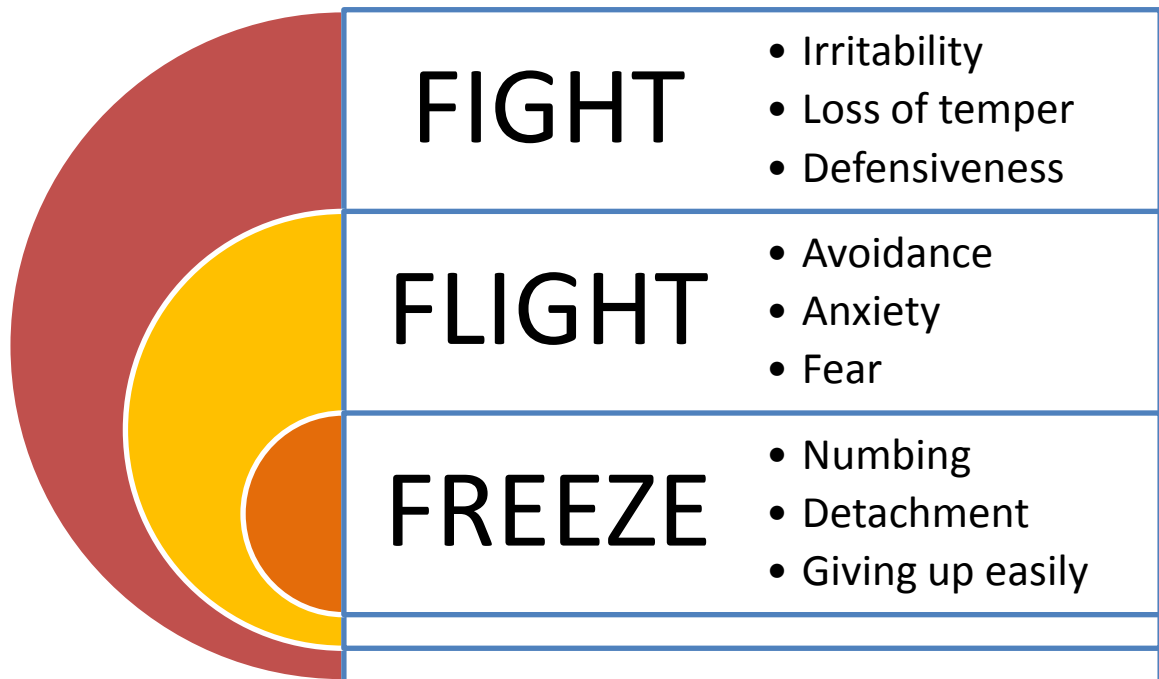
Survivors of trauma often report general preoccupations with bodily concerns, greater self-reported health problems, and increased use of medical services, either for psychological reasons or as a result of anxiety associated with actual physical disease or injury. Somatic reactions typically include cardiac vascular problems, headaches, high blood pressure, gastrointestinal and pulmonary systems as well as cancer and other devastating illness (Godbout & Briere, 2012: 489).

HANDOUT 1.4: THE PROCESS OF TRAUMA



Adapted from Ackley & Covington (2008)

HANDOUT 1.5: FIGHT, FLIGHT OR FREEZE RESPONSE



Normal Defensive Responses to High Threat

Normal defensive responses to high threat can impact treatment and treatment adherence

Sanderson (2006: 155)

HANDOUT 1.6: COMMON SIGNS AND SYMPTOMS
FOLLOWING EXPOSURE TO TRAUMATIC EVENTS

<ul style="list-style-type: none">• Efforts to avoid thoughts	<ul style="list-style-type: none">• Difficulty sleeping
<ul style="list-style-type: none">• Avoids activities	<ul style="list-style-type: none">• Irritability
<ul style="list-style-type: none">• Poor memory	<ul style="list-style-type: none">• Outbursts of anger
<ul style="list-style-type: none">• Anhedonia	<ul style="list-style-type: none">• Hypervigilance
<ul style="list-style-type: none">• Feeling detached	<ul style="list-style-type: none">• Difficulty concentrating
<ul style="list-style-type: none">• Feeling “flat”	<ul style="list-style-type: none">• Exaggerated startle response
<ul style="list-style-type: none">• Sense of a foreshortened future	<ul style="list-style-type: none">• Intrusive thoughts
<ul style="list-style-type: none">• Flashbacks	

Figley (2012: 125)

HANDOUT 1.7: EXERCISE: MY SYMPTOMS

First, identify each trauma you are using as your reference points for PTS. If you have more than one, photocopy these pages and do this exercise once for each trauma.

For each symptom listed, ask yourself how often in the last week the symptom troubled you and how severe your distress was. Then, in the two boxes beside each question, write a number from 0-4 to indicate the frequency and severity of the symptom.

Frequency

- 0 = not at all
- 1 = once only
- 2 = 2 to 3 times
- 3 = 4 to 6 times
- 4 = every day

Severity

- 0 = not at all disturbing
- 1 = minimally distressing
- 2 = moderately distressing
- 3 = markedly distressing
- 4 = extremely distressing

Frequency	Severity	Symptom
		1. painful images, memories, or thoughts of the event
		2. distressing dreams of the event
		3. feeling as if the event were recurring, or that you were reliving it
		4. being upset by something that reminded you of the event
		5. being physically upset by reminders of the event (including sweating, trembling, racing heart, shortness of breath, nausea, diarrhoea)
		6. avoiding any thoughts or feelings about the event
		7. avoiding doing things or going into situations that remind you of the event
		8. inability to recall important parts of the event
		9. difficulty enjoying things
		10. feeling distant or cut off from other people
		11. inability to have sad or loving feelings

		12. difficulty imagining having a long life span and fulfilling your goals
		13. trouble falling asleep or staying asleep
		14. irritability or outbursts of anger
		15. difficulty concentrating
		16. feeling on edge, being easily distracted, or needing to stay on guard
		17. being jumpy or easily startled

Add together all the numbers from both the frequency and severity columns. The higher your score, the more likely you are to have PTSD.

Score: _____

Williams & Poijula (2013: 63)

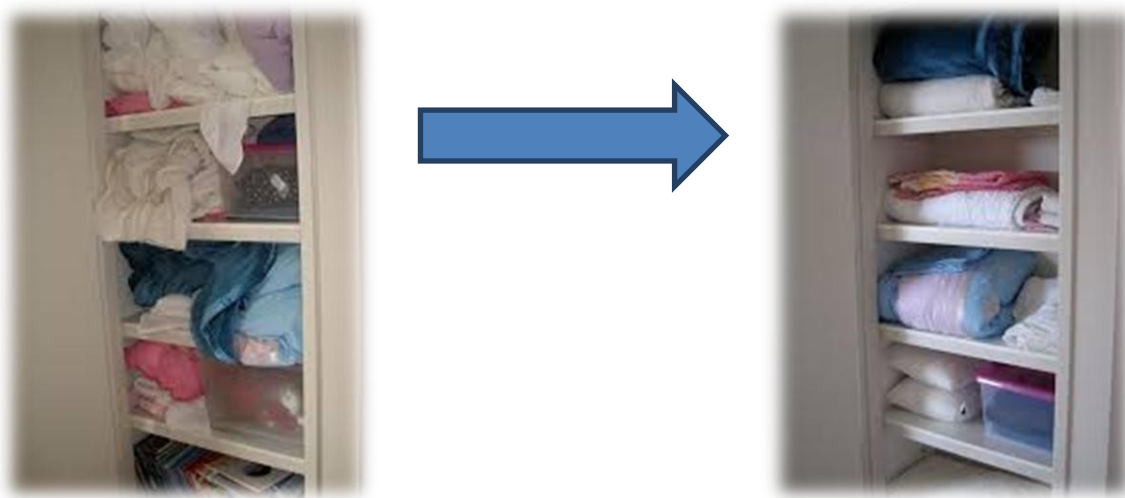
HANDOUT 1.8: DSM-5 DIAGNOSTIC CRITERIA FOR PTSD

- Exposure or learning about a traumatic event and subjective emotional response of fear, helplessness, or horror
- Persistent-re-experiencing of the traumatic event
- Persistent avoidance and numbing
- Persistent symptoms of increased arousal
- Significant distress or impairment
- Duration of at least 1 month

(American psychiatric Association, 2013: 265)

HANDOUT 1.9: TREATMENT OF POST-TRAUMATIC STRESS DISORDER (PTSD): – THE LINEN CUPBOARD METAPHOR

Memories in PTSD are a bit like items stuffed in a messy linen cupboard. Whenever you brush past the cupboard the door flies open and items fall out: in other words, whenever you come across a reminder of the trauma you have flashbacks or intrusive memories, and feel intense fear. A typical response is to try to stuff things back in the cupboard, and to close the door as quickly as possible. But this just keeps the problem going: memories are jammed in the cupboard, and the door will still swing open at the lightest touch.



In this way, memories of the traumatic event find their proper place: you can find them if you choose to, but they won't come back so often when you don't want them to.

Anon. (2015c)

SESSION 2
RELAXATION



HANDOUT 2.1: WEEKLY TST CHECK-IN

Emotional and Behavioural Dysregulation

<p>How bad, sad, hurt, angry, guilty, or scared have I been feeling in the last week?</p> <p>9 As much as I can imagine 7 A lot 5 Some 3 A little bit 1a Not at all</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>How much has my behaviour toward myself or others been harmful, destructive, aggressive, or risky in the last week?</p> <p>9 As much as I can imagine 7 A lot 5 Some 3 A little bit 1a Not at all</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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Environmental Stability

<p>In the last week, how much have I been reminded of bad things that have happened to me?</p> <p>9 As much as I can imagine 7 A lot 5 Some 3 A little bit 1a Not at all</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>In the last week, how much did I feel like people around me (managers, colleagues, family, social workers) were able to protect me from experiencing or being reminded of bad things or help me in dealing with my emotions when I was reminded?</p> <p>9 As much as I can imagine 7 A lot 5 Some 3 A little bit 1a Not at all</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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Saxe (2007: 312)

HANDOUT 2.2: GROUNDING (FOCUSING ON THE PRESENT)

Grounding is a tool to help us focus on the present and the external world instead of on the past and the internal world. Grounding can be especially helpful to manage symptoms from the re-experiencing cluster such as flashbacks, nightmares and intrusive memories but can also be useful to distract oneself from overwhelming emotional pain like anger. Here are some grounding techniques you can try to help you stay focused on the present.

1. Use your five senses to describe your environment. Focus on the non-triggering things around you. Describe your surroundings in detail where ever you are by observing textures, colors or smells. For example, “I’m at the hardware store. I am in the paint aisle. There are 20 paint cans on the shelf in front of me. They have yellow labels with green writing. The floor is made of tiles that have blue and white flecks in them and have a smooth texture.”
2. Say a grounding statement. “My name is _____; I am safe right now. The time is _____; the day of the week today is _____”
3. Listen to a favorite song. Pay attention to the words and the melody. Allow yourself to sing along out loud or to yourself.
4. Pay attention to your breathing by focusing on each inhale and exhale. Each time you exhale, say a calming word to yourself (e.g., “relax”, “safe” or “calm”).
5. Put your hand under a faucet and feel the cool water run over them or splash your face.
6. Touch objects like a pen, keys, your clothing, or the table and notice how they feel. What are textures, colors, materials, weights, temperature of these objects?
7. Put your feet flat on the floor and push your heels into the floor. Remind yourself that you are connected to the ground as you notice the sensation of pressure in your heels.
8. Stretch your muscles.
9. Eat something, describing the flavors in detail to yourself.

Other helpful grounding techniques:

10. _____

11. _____

12. _____

Adapted from Najavits (2002: 335)

HANDOUT 2.3: SAFE PLACE EXERCISE

The group members may feel that there is no place, real or imaginary, that is safe, have the group focus on one time in his or her life when they felt safe or on a person they admires who exemplifies positive attributes, such a strength or control. If the group members still cannot find a safe place, ask them to think of a place where they feel relaxed or comfortable. Sometimes clients become more distressed when they relax and it may take some time before the person is able to identify a positive resource. Ask the group to sit comfortably in their chairs with their feet firmly planted on the floor. Sometimes this exercise is conducted with soothing music and/or background nature sounds. Some therapists tape the exercise with their voice to give to the client to practice at home. The safe-place exercise follows:

Ask the members to identify an image of a safe place that they easily evoke that creates a personal feeling of calm and safety. Use soothing tones to enhance the imagery, asking the group to “see what you see,” “feel what you feel.” “notice the sounds, smells, and colors in your special place.” Once identified, ask the group to focus on the image, feel the emotions, and identify the location of the pleasing physical sensations and where he or she is in the body. “Ask the group members to concentrate on the pleasant sensations in their bodies and just enjoy as they breathe deeply, relaxing and feeling safe.” After you have slowly deepened their experience of this, slowly ask the group to come back and tell you a description of the place. Ask for details so that you can assist the group in accessing this place in the future. Ask how they feel and if the experience has been difficult for the person and/or no positive emotions are experienced, explore other resources that might be helpful. If at any time the group indicates that they are not feeling safe, the exercise should be stopped immediately.

If successful in accessing a safe place, the group is asked for a single word that fits the picture (i.e. beach, forest or mountains) and then asked to repeat the exercise using the person’s words for the experience along with deep breathing. Then ask the group member to repeat on his or her own, bringing up the image, emotions, and body sensations. Reinforce, after this exercise, that his or her safe place can be used as a resource and ask the group to practice over the next week, once a day.

Then ask group members to bring up a minor annoyance and notice the negative feelings while guiding the person through the safe place until the negative feelings have dissipated. Then ask the group to bring up a negative disturbing thought once again and to access the safe place but his time on his or her own without your assistance.

Wheeler (2014: 51)

HANDOUT 2.4: PROGRESSIVE MUSCLE RELAXATION

You also might want to learn to relax by tensing and relaxing various muscle groups in your body. This is done using a technique called progressive muscle relaxation. This technique helps you tense and then relax your four major muscle groups:

1. hands, forearms, biceps
2. head face, throat, shoulders
3. chest, stomach, lower back
4. buttocks, thighs, calves, feet

You may practice this technique while you are lying down or sitting in a chair. The goal is to tense each muscle group for five to seven seconds and then relax that muscle group for twenty to thirty seconds, repeating the whole procedure at least twice. If the muscle group is still tense after you've done the procedure twice, you can repeat it for that group alone up to five times. You also may talk to yourself as you tense and relax, telling yourself anything that has to do with letting go of tension.

Another way to use progressive muscle relaxation is to hold the tension in each of your muscle groups for about five seconds and then release the tension slowly while you say silently, "Relax and let go". Then take a deep breath and, as you breathe out slowly, silently say, "Relax and let go" again.

Williams & Poijula (2013: 47)

HANDOUT 2.5: EXERCISE: DEEP BREATHING

1. Sit on a chair. Move your feet until they are about eight inches apart, with your toes turned slightly outward. Keep your spine as straight as possible;
2. Scan your entire body and identify any places that hold tension;
3. Put one hand on your abdomen and one on your chest;
4. Inhale slowly through your nose into your abdomen so that it pushes your hand up; your chest should move only a little bit. Hold your breath while you count to five;
5. Open your mouth slightly and exhale through your mouth, taking as long as possible. Make a shushing sound as you exhale;
6. Repeat this at least five times, perhaps eventually increasing the amount of time you spend deep breathing to five to ten minutes;
7. When you've finished the exercise, again scan your entire body to see if any tension remains.

Once you are familiar with the technique, you also can use it while you are lying down or standing, whenever you feel tension in your body.

Williams & Poijule (2013: 46)

SESSION 3
TRAUMA NARRATIVE



HANDOUT 3.1: WEEKLY TST CHECK-IN

Emotional and Behavioural Dysregulation

<p>How bad, sad, hurt, angry, guilty, or scared have I been feeling in the last week?</p> <p>9 As much as I can imagine 7 A lot 5 Some 3 A little bit 1a Not at all</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>How much has my behaviour toward myself or others been harmful, destructive, aggressive, or risky in the last week?</p> <p>9 As much as I can imagine 7 A lot 5 Some 3 A little bit 1a Not at all</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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Environmental Stability

<p>In the last week, how much have I been reminded of bad things that have happened to me?</p> <p>9 As much as I can imagine 7 A lot 5 Some 3 A little bit 1a Not at all</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>In the last week, how much did I feel like people around me (managers, colleagues, family, social workers, etc) were able to protect me from experiencing or being reminded of bad things or help me in dealing with my emotions when I was reminded?</p> <p>9 As much as I can imagine 7 A lot 5 Some 3 A little bit 1a Not at all</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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Saxe (2007: 312)

HANDOUT 3.2: WHO ARE YOU?

Before you look at the traumas that have impacted you, it is important for you to look at who you are. Your sense of yourself serves as the reference point for who you want to become and what you want to do with your life. If you find the questions in this exercise difficult or impossible to answer, it may be that much of your self-knowledge is missing, and you may need to look to others to help you. The following exercise is designed to help you look at what you know about your own core self - your basic identity - and whether that self is healthy, partially healthy, or unhealthy.

EXERCISE: AM I A HEALTHY PERSON?

Answer the following questions to get a sense of yourself:

What about me give me a positive sense of who I am?

What facts describe me?

I feel competent about (or in control of):

I have value because:

I am able to be emotionally (and maybe even physically) close to:

My basic values or the truths that govern my life:

I have sense of meaning to or in my life because:

I see myself as a real, authentic person because:

I make the following appropriate, reasonable demands on myself:

I make the following inappropriate, unreasonable demands on myself:

List a few “shoulds” that govern your life and are inflexible:

I should _____

I should _____

I should _____

Which of them would you like to discard or be willing to discard?

Mark with an “X” where you lie on the following continua:

Rigid_____Flexible

Harsh_____Gentle

Critical_____Accepting

Inappropriate_____Appropriate

Overcontrolling_____Undercontrolling

What did you learn about yourself by doing this exercise?

Now that you have done this exercise, how would you describe your core self?

Williams & Poijula (2013: 22)

HANDOUT 3.3: WHY REMEMBER?

An important reason to try to remember what happened to you is to decrease the fear associated with the traumatic events. Memories of trauma are not dangerous in and of themselves, even though they may feel dangerous. Confronting your memories in a safe environment –writing about them, describing them out loud, drawing them, or finding other ways to deal with them– helps you to work through, or process, your traumatic history. Processing memories helps you to integrate them into your past. Continuously avoiding memories of trauma keeps those memories in your present, with all their associated pain, fear, rage, depression, shame, and self-blame. Through the process of remembering, you may come to understand what happened to you. You also may become angry at the way you were violated. Remembering safely will give you a sense of control over the experience and the terror you felt.

If you choose to work on memories of trauma, talk about it in the past tense, not in the present tense. Much of the work in this program asks you to do is on reminders of the memory rather than on the actual story. If you are not willing or able to remember your traumas or if you don't want to work on your trauma narrative with a therapist or (if you are safe to do so) by yourself, do not criticize or blame yourself. This exercise can still help you control the symptoms of PTSD and complex PTSD.

If you are willing to do some work on intrusive memories but you doubt either their relationship to your life or their truth, answer the following questions in the spaces provided.

1. Does your intuition or non-logical insight tell you that what you remember is or was real, no matter how hard you refuse to believe it?

2. Does the memory keep returning, even after you try to forget it?

3. Does the memory fit with your habits, fears, behaviours, symptoms, health problems, or the facts of your life as you know them?

4. Is your memory of certain aspects of the traumatic event clear, even if not necessarily accurate?

5. Are certain aspects of the event cloudy, or is the event in picture images?

6. Does your memory come in fragments or bits and pieces?

7. Does remembering anything about the event bring you a sense of relief, understanding, or increased strength?

8. Can you find corroboration of what you remember from other sources (people, newspaper articles, medical reports)?

9. Do you get more or less distressed when you think or talk about your memory?

Williams & Poijula (2013: 20)

HANDOUT 3.4: JOURNAL EXERCISE: INFORMAL WRITING

Writing therapy, a structured approach to writing, has proved to be effective for helping people process their trauma history. Exposure to the traumatic event and the restructuring of trauma-related thoughts are crucial in this process. To get all the details of a traumatic experience into the open in a more informal way, you can write down the experience. As you do so, ask yourself the following questions:

1. What happened before the traumatic event?
2. How did I first know something was wrong?
3. What happened next?
4. What did I do?
5. How was the damage done?
6. How did I know it was over?
7. What did I do afterward?
8. What did others do afterward?
9. What was the very worst moment?

William & Poijula (2013: 65)

HANDOUT 3.5: CONSTRUCTING A TRAUMA INVENTORY

Before you begin work on any of the symptoms that may be haunting you, it is important for you to have a sense of what you've experienced (both positively and negatively) in your life. Without going into great detail, use the following list to identify which traumas you've experienced and the age or ages at which you experienced them. You also may write a very brief statement about any of the traumas you've experienced. The types of traumas you experience can impact the reactions you have about those events. They can serve as a reference point for writing a trauma narrative.

Event	Age(s)	Description
Surviving a natural disaster (tornado, hurricane)		
Surviving a fire		
Witnessing a natural death		
Witnessing a violent death		
Being in an automobile accident		
Being in a plane crash		
Surviving an assault or mugging		
Surviving a robbery or burglary		
Having a murder in my family		
Experiencing physical violence as a child		
Experiencing neglect as a child		
Being sexually abused as a child		
Experiencing physical violence as an adult		
Being raped by somebody I knew		
Being raped by a stranger		

Experiencing a job related trauma		
Having a traumatic move		
Surviving torture		
Surviving a holocaust or genocide		
Other		

As you think about all the traumatic experiences you have had, remember that you survived them and that you used many positive character traits to do so.

What did completing a trauma inventory tell you about yourself or what happened to you?

Williams & Poijula (2013: 59)

SESSION 4

**IDENTIFYING EMOTIONS, FEELINGS AND
THOUGHTS**



HANDOUT 4.1: WEEKLY TST CHECK-IN

Emotional and Behavioural Dysregulation

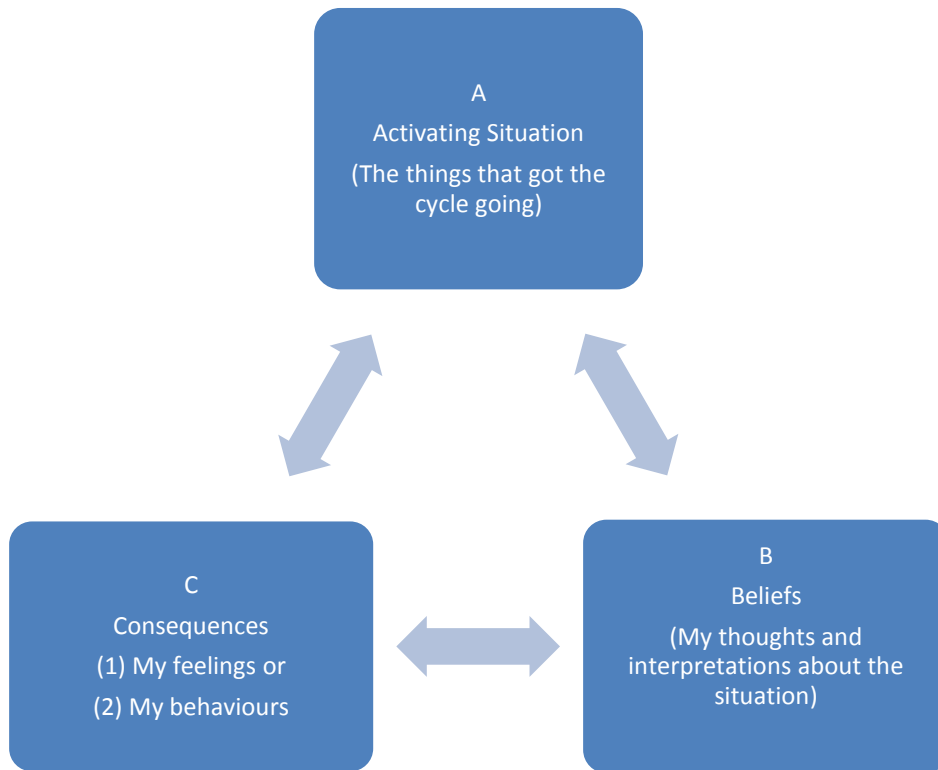
<p>How bad, sad, hurt, angry, guilty, or scared have I been feeling in the last week?</p> <p>9 As much as I can imagine 7 A lot 5 Some 3 A little bit 1a Not at all</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>How much has my behaviour toward myself or others been harmful, destructive, aggressive, or risky in the last week?</p> <p>9 As much as I can imagine 7 A lot 5 Some 3 A little bit 1a Not at all</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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Environmental Stability

<p>In the last week, how much have I been reminded of bad things that have happened to me?</p> <p>9 As much as I can imagine 7 A lot 5 Some 3 A little bit 1a Not at all</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>In the last week, how much did I feel like people around me (managers, colleagues, family, social workers) were able to protect me from experiencing or being reminded of bad things or help me in dealing with my emotions when I was reminded?</p> <p>9 As much as I can imagine 7 A lot 5 Some 3 A little bit 1a Not at all</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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Saxe (2007: 312)

HANDOUT 4.2: THE ABC'S OF MY EMOTIONS



Adapted from McGovern et al. (2010: 23)

HANDOUT 4.3: EXERCISE: RECOGNIZING MY EMOTIONS

Which of the following emotional states do you personally know, and which have you felt in the past two weeks? Please circle those you have felt in the past two weeks and underline all those about which you can say that you know how they feel.

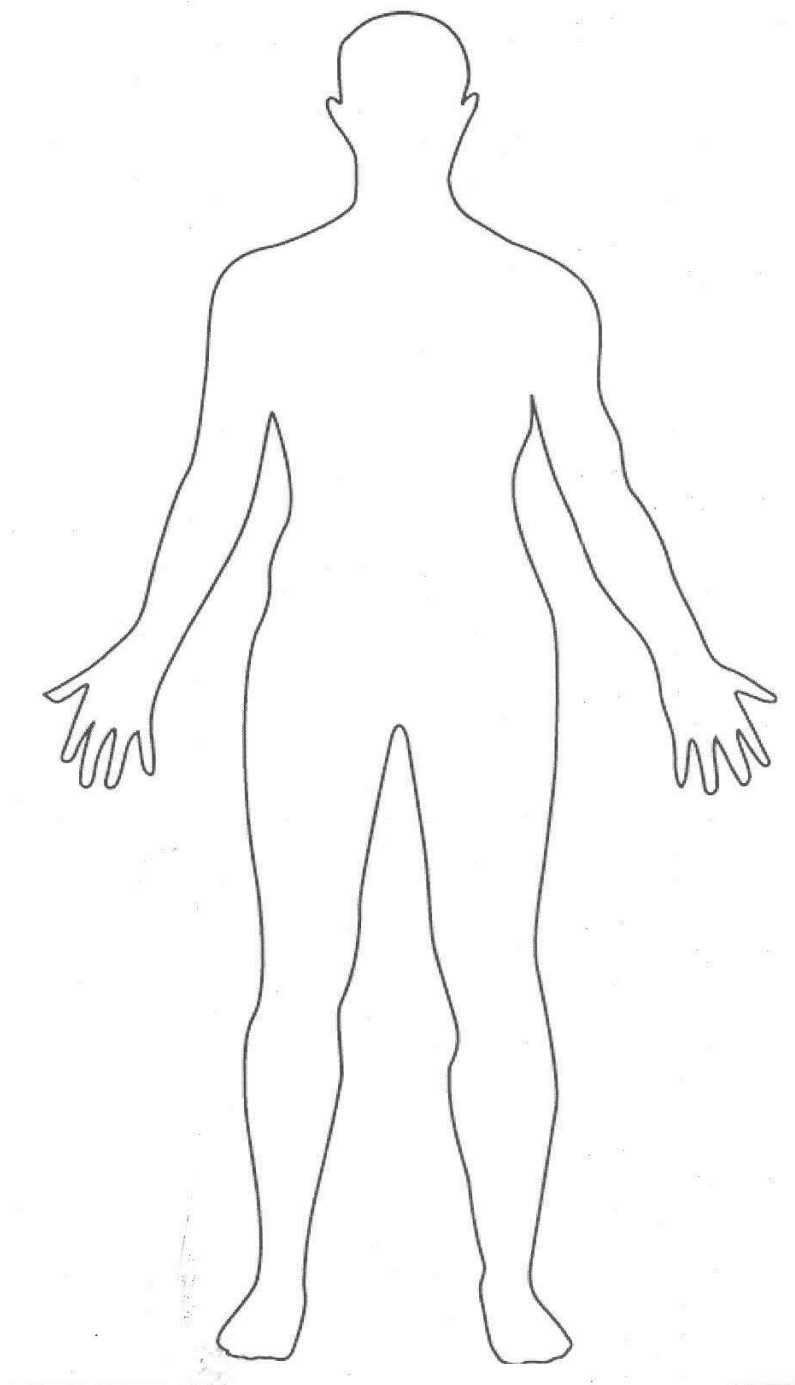
Abandoned	Dependent	Humiliated	Shy
Accepted	Deserted	Hurt	Sorry
Aching	Desirable	Impatient	Stimulated
Affectionate	Desperate	Inadequate	Stunned
Alone	Devastated	Incompetent	Stupid
Aloof	Different	Innocent	Sweet
Amused	Disappointed	Insecure	Sympathetic
Angry	Discouraged	Interested	Tense
Annoyed	Distressed	Irate	Terrified
Anxious	Dominated	Irked	Thrilled
Apologetic	Doomed	Irritated	Tired
At peace	Eager	Isolated	Tolerant
Aware	Easy going	Jealous	Tortured
Betrayed	Ecstatic	Joyful	Trapped in time
Bitter	Elated	Loyal	Troubled
Bored	Embarrassed	Lucky	Trusted
Brave	Enraged	Mad	Ugly
Calm	Excited	Mean	Unappreciated
Capable	Exposed	Miserable	Unaware
Caring	Foolish	Patient	Understood
Cautious	Frantic	Peaceful	Unfriendly
Cheerful	Friendly	Pleased	Unhappy
Composed	Fulfilled	Powerless	Upset
Confident	Full	Preoccupied	Useless
Conflicted	Furious	Proud	Valued
Connected	Giving	Regretful	Victimized
Content	Glad	Rejected	Violated
Courageous	Grateful	Remorseful	Vulnerable

Cranky	Grouchy	Responsible	Warm
Crazy	Grumpy	Revengeful	Weary
Crushed	Guilty	Safe	Whipped
Curious	Happy	Screwed	Wiped out
Defeated	Helpless	Serene	Withdrawn
Dejected	Hopeful	Shamed	Wonderful
Delighted	Hopeless	shocked	Worthwhile

This is only a small proportion of the words that are associated with feelings. Were you able to identify and imagine or remember having most of them? What has completing this exercise taught you about yourself (Williams & Poijula, 2014: 197)?

HANDOUT 4.4: EXPERIENCING FEELINGS IN YOUR BODY









We're going to use colors now to show where in your body you experience each feeling. You don't have to do all the feelings you listed, you can choose which feelings you want to include. For each feeling you choose, close your eyes and imagine having that feeling right now. Where do you experience that feeling in your body? Please color in the places on your body where you experience each feeling and tell your therapist what it feels like.



HANDOUT 4.5: UNHELPFUL THINKING HABITS

Once you can notice unhelpful thinking habits, then that can help you to challenge or distance yourself from those thoughts, and see the situation in a different and more helpful way. Red text (italics) helps us find alternative, more realistic thoughts.

 <p>Mental Filter</p> <p>When we notice only what the filter allows or wants us to notice and we dismiss anything that doesn't 'fit' whilst anything more positive or realistic is dismissed. <i>Am I only noticing the bad stuff? Am I filtering out the positives? What would be more realistic?</i></p>	 <p>Judgments</p> <p>Making evaluations or judgments about events, ourselves, others, or the world, rather than describing what we actually see and have evidence for. <i>I'm making an evaluation about the situation or person, but that doesn't mean my judgments are always right or helpful. Is there another perspective?</i></p>
 <p>Prediction</p> <p>Believing we know what's going to happen in the future. <i>Am I thinking that I can predict the future? How likely is it that that might really happen?</i></p>	 <p>Emotional Reasoning</p> <p>I feel bad so it must be bad! I feel anxious, so I must be in danger. <i>Just because it feels bad, doesn't necessary mean it is bad? My feelings are just a reaction to my thoughts.</i></p>
 <p>Mind-Reading</p> <p>Assuming we know what others are thinking (usually about us). <i>Am I assuming I know what others are thinking? What's the evidence? Those are my own thoughts, not theirs. Is there another, more balanced way of looking at it?</i></p>	 <p>Mountains and Molehills</p> <p>Exaggerating the risk of danger, or the negatives. Minimizing the odds of how things are most likely to turn out, or minimizing positives. <i>Am I exaggerating the bad stuff? How would someone else see it? What's the bigger picture?</i></p>
 <p>Compare and despair</p> <p>Seeing only the good and positive aspects in others, and getting upset when comparing ourselves negatively against them. <i>Am I doing that 'compare and despair' thing? What would be a more balanced and helpful way of looking at it?</i></p>	 <p>Catastrophising</p> <p>Imagining and believing that the worst possible thing will happen. <i>Ok, thinking that the worst possible thing will definitely happen isn't really helpful right now. What's most likely to happen?</i></p>

 <p>Critical self Putting ourselves down, self-criticism, blaming ourselves for events or situations that are not (totally) our responsibility. <i>There I go again. Would most people who really know me say that about me? Is this something that I am totally responsible for?</i></p>	 <p>Black and white thinking Believing that something or someone can be only good or bad, right or wrong, rather than anything in-between or 'shades of grey'. <i>Things aren't either totally white or totally black – there are shades of grey. Where is this on the spectrum?</i></p>
 <p>Shoulds and musts Thinking or saying 'I should' (or shouldn't) and 'I must' puts pressure on ourselves, and sets up unrealistic expectations. <i>Am I putting more pressure on myself, setting up expectations of myself that are almost impossible? What would be more realistic?</i></p>	 <p>Memories Current situations and events can trigger upsetting memories leading us to believe that the danger is here and now, rather than in the past, causing us distress right now. <i>This is just a reminder of the past. Even though this memory makes me feel upset, it's not actually happening again right now.</i></p>
 <p>Overgeneralizing Seeing a pattern based upon a single event or being overly broad in the conclusion we draw. <i>Is it really true that "Everything is always rubbish", or that nothing good ever happens to me". Is it only my opinion.</i></p>	 <p>Disqualifying the positive <i>Discounting the good things that have happened or that you have done for some reason or another. Am I intentionally disqualifying the positive. Let me concentrate on the good things that I do or what I am able to do.</i></p>
 <p>Jumping to conclusions There are two key types of jumping to conclusions : Mind reading: (Imagining we know what others are thinking), Fortune telling (Predicting the future). <i>There is no way that others might really know what I am thinking. The future is in our hands. No one can tell what will happen tomorrow. Only myself can influence the future.</i></p>	 <p>Labelling Assigning labels to ourselves or other people. "I am a loser", "I'm completely useless", "They're such an idiot. <i>Am I putting too much pressure on myself therefor also labeling other people for my own uncertainties. There is no such thing as a loser. It's about who I am and what I can do for others.</i></p>



Personalization

Blaming yourself or taking responsibility for something that wasn't completely your fault. Conversely blaming other people for something that was actually your fault.

Acknowledge when you were wrong and take full responsibility for it without blaming others.

Try to rectify and learn from your mistakes.



Tunnel vision

Focuses only on the negative of something, not the positive ones.

“My boss is awful. She’s demanding, judgmental, and opinionated.” “My life is terrible, nothing is going well”. *Am I intentionally disqualifying the positive. Let me concentrate on the good things that I do or what I am able to do.*

Anon. (2015b)

HANDOUT 4.6: PRIMARY NEGATIVE EMOTIONS AND THE COMMON THOUGHTS THAT DRIVE THEM

Primary emotions	Related emotions	My experience of this emotion	Common thoughts that drive them	My thoughts
Anxiety and fear	Apprehension, worry, scared, panic, agitated, nervous, racing, tense, stressed		<p>I am not safe or in danger</p> <p>Something I don't want is going to happen</p> <p>I am losing control</p> <p>I am going to fall apart</p> <p>I am going to be rejected</p> <p>I am going to be negatively judged</p>	
Depression and sadness	Grief, loss, forlorn, abandoned, worthless, doomed, loser, empty, bored, woeful, inadequate		<p>I am unlovable</p> <p>I am worth nothing</p> <p>I am lost</p> <p>I have been totally rejected</p> <p>I am really undesirable</p> <p>Nothing will ever change for me</p> <p>My life is over</p> <p>Something I don't want has happened</p>	
Shame and guilt	Remorseful, regretful, embarrassed, humiliated, exposed		<p>I have caused irreparable damage to others</p> <p>I have let people down</p> <p>I only have myself to blame</p> <p>I have not lived up to my ideals</p> <p>I am not deserving</p> <p>I have been sinful</p> <p>I am a horrible person</p>	

Irritability and anger	Rage, resentment, vengeful, aggressive		I have been (or am being) disrespected I have been (or am being) wronged I have been (or am being) unfairly treated I have been (or am being) bullied Others are to blame for my situation	
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McGovern et al. (2010: 29)

SESSION 5

RATING OF FEELINGS AND AFFECT

MODULATION



HANDOUT 5.1: WEEKLY TST CHECK-IN

Emotional and Behavioural Dysregulation

<p>How bad, sad, hurt, angry, guilty, or scared have I been feeling in the last week?</p> <p>9 As much as I can imagine 7 A lot 5 Some 3 A little bit 1a Not at all</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>How much has my behaviour toward myself or others been harmful, destructive, aggressive, or risky in the last week?</p> <p>9 As much as I can imagine 7 A lot 5 Some 3 A little bit 1a Not at all</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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Environmental Stability

<p>In the last week, how much have I been reminded of bad things that have happened to me?</p> <p>9 As much as I can imagine 7 A lot 5 Some 3 A little bit 1a Not at all</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>In the last week, how much did I feel like people around me (managers, colleagues, family, social workers) were able to protect me from experiencing or being reminded of bad things or help me in dealing with my emotions when I was reminded?</p> <p>9 As much as I can imagine 7 A lot 5 Some 3 A little bit 1a Not at all</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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Saxe (2007: 312)

HANDOUT 5.2: AFFECT STYLE QUESTIONNAIRE

Instructions: We are interested in how you experience and manage your emotions. Obviously, different situations bring out somewhat different responses, but think about what you usually do. Use the scale below to answer each item

1-----2-----3-----4-----5
 not true of me at all a little bit moderately quite a bit extremely true

- | | | |
|-----|--|-----------|
| 1. | People usually can't tell how I am feeling inside. | 1—2—3—4—5 |
| 2. | I have my emotions well under control | 1—2—3—4—5 |
| 3. | I can tolerate having strong emotions. | 1—2—3—4—5 |
| 4. | I can avoid getting upset by taking a different perspective on things. | 1—2—3—4—5 |
| 5. | I often suppress my emotional reactions to things. | 1—2—3—4—5 |
| 6. | It's ok if people see me being upset. | 1—2—3—4—5 |
| 7. | I can calm down very quickly | 1—2—3—4—5 |
| 8. | I am able to let go of my feelings. | 1—2—3—4—5 |
| 9. | I am good at hiding my feelings. | 1—2—3—4—5 |
| 10. | People usually can't tell when I am upset. | 1—2—3—4—5 |
| 11. | It's ok to feel negative emotions at times. | 1—2—3—4—5 |
| 12. | I can get out of a bad mood very quickly. | 1—2—3—4—5 |
| 13. | People usually can't tell when I am sad. | 1—2—3—4—5 |
| 14. | I can tolerate being upset. | 1—2—3—4—5 |
| 15. | I can act in a way that people don't see me being upset. | 1—2—3—4—5 |
| 16. | I know exactly what to do to get myself into a better mood. | 1—2—3—4—5 |
| 17. | There is nothing wrong with feeling very emotional. | 1—2—3—4—5 |
| 18. | I could easily fake emotions. | 1—2—3—4—5 |
| 19. | I can get into a better mood quite easily. | 1—2—3—4—5 |
| 20. | I can hide my anger well if I have to. | 1—2—3—4—5 |

All items are straight-forward scored. Higher scores reflect a preference for an affective style. Concealing is the sum of items 1, 5, 9, 10, 13, 15, 18, and 20. Adjusting is the sum of items 2, 4, 7, 8, 12, 16, and 19. Tolerating is the sum of items 3, 6, 11, 14, and 17 (Hofmann & Kashdan, 2010: 262).

HANDOUT 5.3: FACIAL EXPRESSIONS

A good way to tell how we feel and how others feel is by noticing facial expressions. Circle the faces to show how you express your feelings on your face:



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How do you feel right now? You can play a game amongst each other called “feelings charade”. Take turns acting out the above feelings; the other person tries to guess which feeling you are acting out. Then you get to tell what makes you feel that way (Anon., 2014a).

HANDOUT 5.4: EMOTION EXPRESSION EXERCISE

Fill in the blanks with events or situations that you expressed this week that made you feel mad, sad, glad, and afraid.

- 1) I felt **MAD** when: _____
- 2) I felt **SAD** when: _____
- 3) I felt **GLAD** when: _____
- 4) I felt **AFRAID** when: _____

The purpose of this exercise is to help you as group member's practice identifying and expressing your emotions. This is especially important as many police officials find it extremely difficult to express their emotions. This way you as group members can gain experiences identifying and paying attention to your emotions and you can gain experience communicating these emotions to others therefore potentially strengthening emotional bonds.

Best-self Statement

Complete the following sentence:

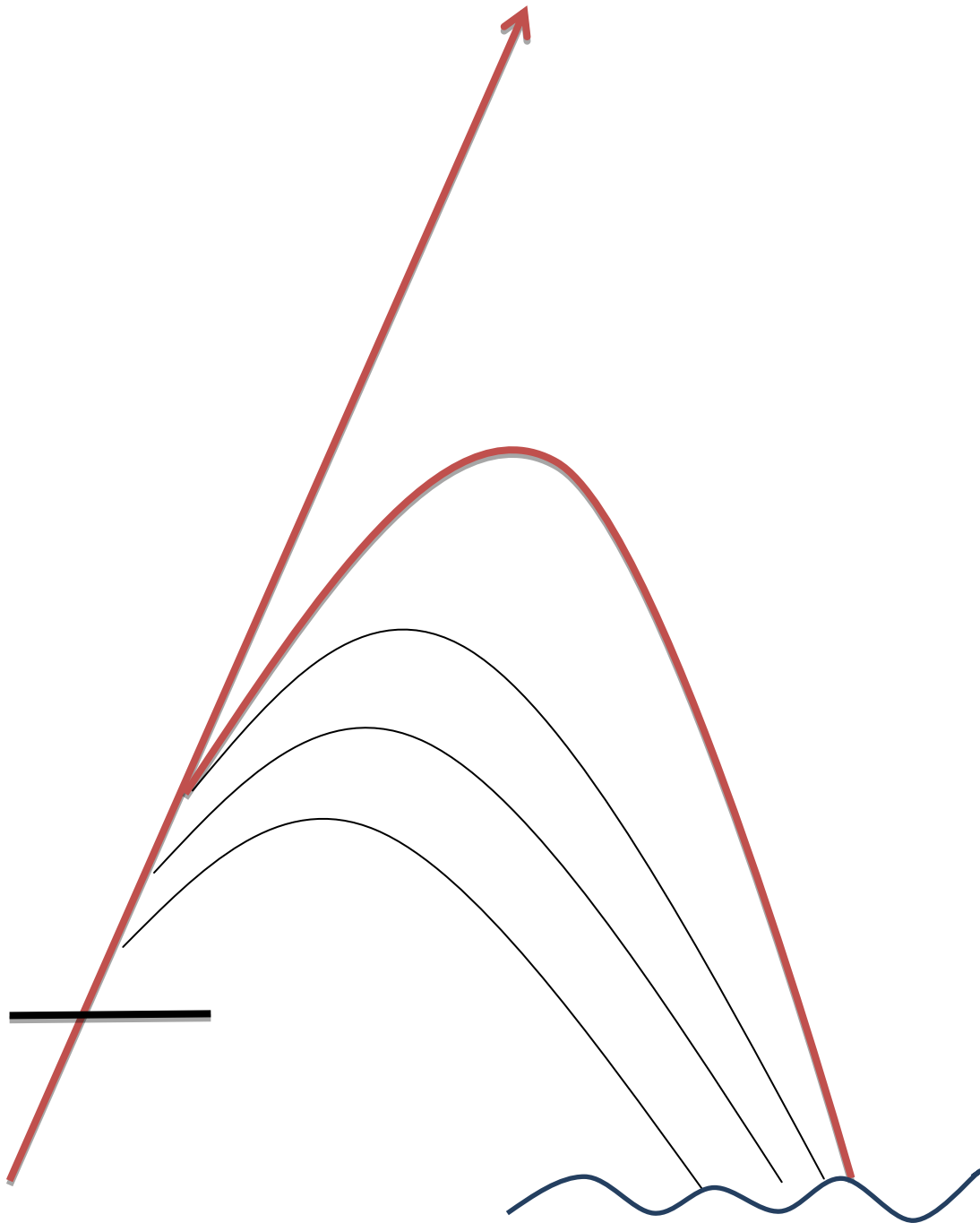
I want to be a person who it _____ that _____

(Example: I want to be a person who is _____ *caring* _____ and _____ *reliable* _____)

This best-self exercise helps to remind you as group members of the person who you want to be. We are capable of being jerks but are also capable of being our best selves. The best-self statement serve as a road map for how they should proceed in a given situation by reminding them to behave in a manner that allows them to be their best self.

Adapted from Lynch & Mack (2015: 40)

HANDOUT 5.5: Negative Emotion Diagram



The diagram represents negative emotions. The arrow pointed up represents what police officials think will happen if they experience fear (or other negative emotions): their fear will increase and never end. The horizontal bar represents avoidance, which police officials engage in to avoid experiencing uncontrolled fear or negative emotion. This avoidance keeps them from learning what actually happens with emotions, which is that they peak and then fall like waves in the ocean.

Adapted from Lynch & Mack (2015: 24)

HANDOUT 5.6: POSITIVE IMAGERY

Imagine going to a place, real or invented, where you feel safe, peaceful and calm. You want to take the time to develop the imagery so you fully experience this place with all your senses.

Start out with a simple check-in of your emotional state, your thoughts, and what you are feeling in your body. Just notice what's happening, without judgment or expectation. Let your breath deepen, and locate a spot in your body where you are starting to feel an opening, a lightness, or a loosening. Allow that to expand with every in-breath and every out-breath, imagining it gradually filling up your entire body. Imagine this relaxing energy moving through your body in waves, reaching every part of you.

Sea Shore

Imagine you are at the sea shore on a beautiful day. It's the perfect time of day, and the perfect time of year for you to be there. Recall the feeling you get in your body when you are at the beach, or what it was like when you were there as a child. Let yourself explore that feeling.

Imagine the warmth of the sun on the top of your head and your shoulders. Allow this image to develop. Perhaps there's a pleasant breeze, which you feel on your face and arms. Imagine the refreshing, salty breeze of the water, and breathe. Maybe you can even taste the salt spray.

Look up and down the beach and notice the expanse of sand, the colour and texture of it, the way it sparkles in the sunlight. Imagine that you are standing in the dry, soft, sand, and feel it beneath your feet and between your toes. Imagine taking a few steps, and feeling what it's like to walk in deep, warm, soft sand. Move closer to the water and walk in the cool, firm sand. Feel it take on the shape of your feet as you walk. Look behind you and see your footprints. Notice the waves gently rolling in and lapping the shore, gradually smoothing those footprints out, rhythmically washing them away as the waves roll back out.

Look at the edge of the water and notice the colour. Notice that colour meeting the sand, and the waves gently lapping on the shore, rolling in, breaking softly, and going back out, over and over, endlessly. Hear the, deep, calming, rhythmic sound of the waves breaking on the beach. Look out to the horizon, and notice the waves as far back as you can see, rolling toward the shore, breaking, glittering in the sunlight. Notice the dancing light moving rhythmically across the whole surface of the water. Notice the place where the surf meets the sky, and see where the colours come together. Notice the light. Let yourself feel the expanse of the sky, and imagine breathing that in, filling yourself with that feeling of spaciousness, brightness and light.

If you like, you might imagine going into the water, and feeling gently carried on the waves, safe in the protected cove, warmed by the sun. Just rolling gently on the surf, carried safely on the waves.

When you come out of the water, find the clean, dry, soft towel you have placed there. Imagine lying down on the towel, feeling the warm sand beneath mold itself to your body. Notice how the warm, firm surface supports your whole body, and allow yourself to relax deeply into it, letting the warmth and comfort fill your body and mind.

When you have finished your guided meditation, take a few minutes to sit quietly, noticing what you are experiencing in your body, what your thoughts and emotions are like.

Other ideas for guided meditation: walking through a meadow, floating in the clouds, snorkelling in a coral reef, sitting by a fire in a cosy cabin, being in lovely, comfortable room, or in bed on a rainy day.

Anon. (2014b)

HANDOUT 5.7: EXERCISE: THE DVD TECHNIQUE

Try to work with the positive memory of above see shore event while you work on a traumatic flashback with this technique.

The event that I am going to use is:

When I fast-forward through this event, I (see, feel, hear, smell, experience)

When I rewind this event, I

When I frame this event with other pictures, I

If I were to use positive images to frame my flashbacks, I would use these:

If you don't feel immediately comfortable with this technique, practice it more, until you are comfortable. Then try it with a traumatic flashback.

The flashback that I am going to use is:

When I fast-forward this event, I


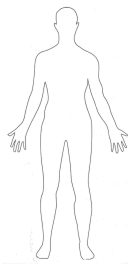

When I rewind the event, I



When I frame the event with other pictures, I

How comfortable was this technique to use with a flashback? Was it more or less comfortable than when you used it with a positive memory?

Williams & Poijula (2013: 72)





HANDOUT 5.8: DEALING WITH NEGATIVE EMOTIONS

Emotion	Body	Thinking differently	Doing differently	Positive Imagery
<p>What emotion am I feeling?</p>  <p>What am I thinking?</p>	<ul style="list-style-type: none"> • What can I notice in my body? • Where do I feel it? 	<p>STOPP! Take a breath</p> <p>What am I reacting to?</p> <p>What's pressing my buttons here?</p> <p>What does this situation mean or say about me? Is this a fact or opinion?</p> <p>How could I see things differently?</p> <p>What would I say to someone else in this situation?</p> <p>How important is this? Is my reaction in proportion to the event?</p>	<p>Do what works!</p> <p>What will be the consequences of my action?</p> <p>What will be the most effective action?</p> <p>What will be best for me, for others and for this situation?</p> <p>Is this in keeping with my principles & values?</p>	<p>Change the content and outcome of distressing and intrusive imagery by:</p> <ul style="list-style-type: none"> • Imagery Manipulation • Imagery Rescripting • Imagery Rehearsal
<p>Depression</p>  <p>I'm worthless. Everything is hopeless</p>				

<p>Anxiety</p>  <p>Something bad is going to happen I won't be able to cope</p>				
<p>Anger</p>  <p>It's not fair. Others are bad. I won't stand for it.</p>				

Adapted from Vivyan (2011)

HANDOUT 5.9: STOPP THE FEELING WORKSHEET

<p>Notice the negative feeling ...</p>	<p>Write your reactions and alternate, healthier responses in this column. What works for you? What will help? What can you tell yourself? What do you need to remember at those times?</p>
<p>STOPP</p> <div style="text-align: center;">  </div>	
<p>Take a breath</p> <div style="text-align: center;">  </div>	
<p>Observe – describe the feelings, images, thoughts, body sensations, triggers</p> <div style="text-align: center;">  </div>	
<p>Pull back / Put in some Perspective. What's the bigger picture? Take the helicopter view. Is this fact or opinion? How would someone else see this? Is there another way of looking at this?</p> <div style="text-align: center;">  </div>	

Ppractice what works. What is the best thing right now – for me, for others, for the situation.



Adapted from Vivyan,(2011)

SESSION 6

ALTERED THINKING



HANDOUT 6.1: WEEKLY TST CHECK-IN

Emotional and Behavioural Dysregulation

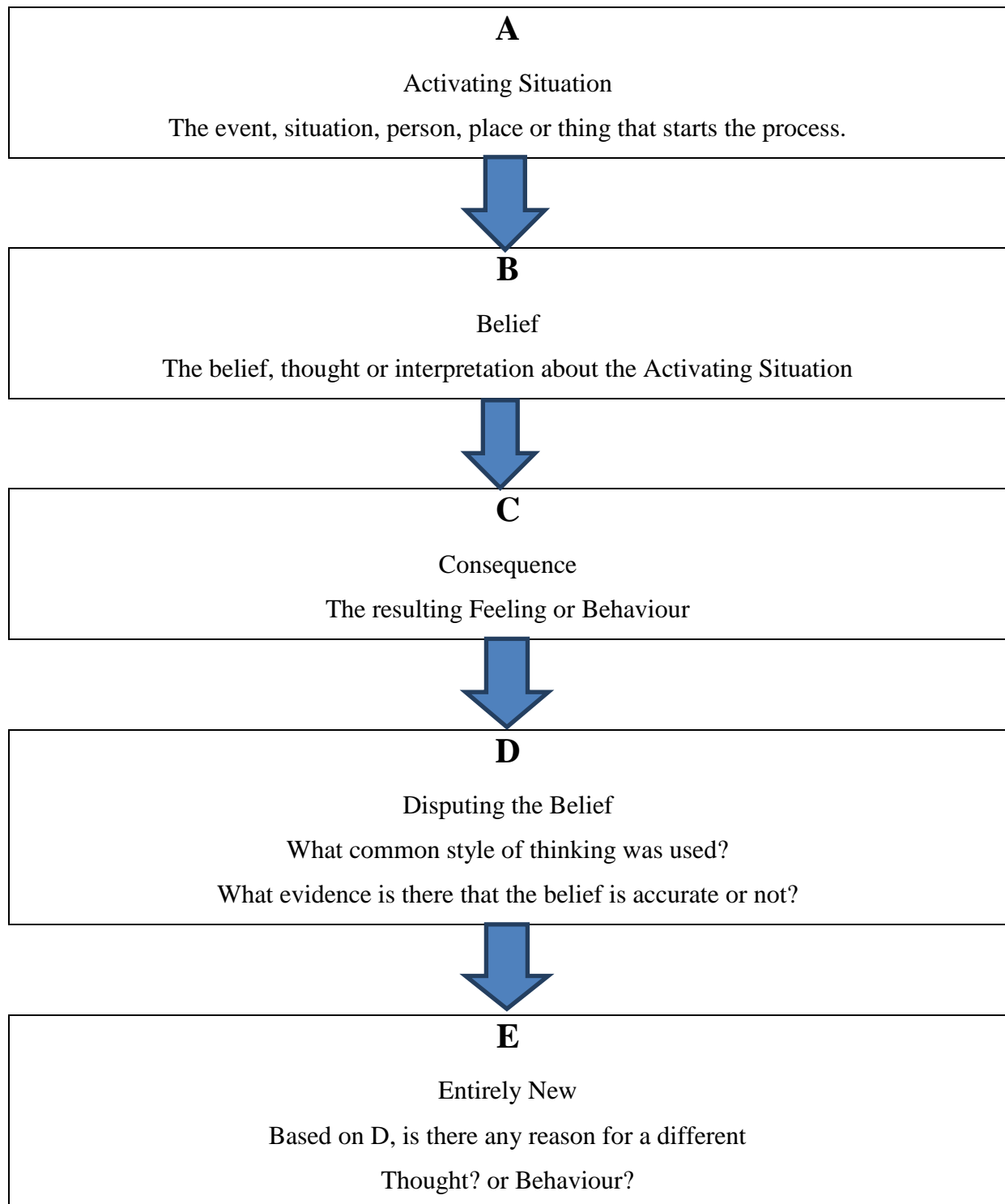
<p>How bad, sad, hurt, angry, guilty, or scared have I been feeling in the last week?</p> <p>9 As much as I can imagine 7 A lot 5 Some 3 A little bit 1a Not at all</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>How much has my behaviour toward myself or others been harmful, destructive, aggressive, or risky in the last week?</p> <p>9 As much as I can imagine 7 A lot 5 Some 3 A little bit 1a Not at all</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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Environmental Stability

<p>In the last week, how much have I been reminded of bad things that have happened to me?</p> <p>9 As much as I can imagine 7 A lot 5 Some 3 A little bit 1a Not at all</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>In the last week, how much did I feel like people around me (managers, colleagues, family, social workers) were able to protect me from experiencing or being reminded of bad things or help me in dealing with my emotions when I was reminded?</p> <p>9 As much as I can imagine 7 A lot 5 Some 3 A little bit 1a Not at all</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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Saxe (2007: 312)

HANDOUT 6.2: FLEXIBLE THINKING: THE ABCDE OF OUR EMOTIONS



Adapted from McGovern (2010: 39)

HANDOUT 6.3: COMMON STYLES OF THINKING

TYPE	DEFINITION	EXAMPLE
Tunnel vision	Focuses only on the negative characteristics of something not the positive ones	“My boss is awful. She’s demanding, judgmental, and opinionated.” “My life is terrible, nothing is going well.”
All or nothing thinking	Looks at things as falling into only two extreme categories (“black or white”) instead of on a continuum (“shades of grey”).	“My boyfriend doesn’t want to live together, so we should break up.” “That table looks messy – my home is a disaster!”
“Should” and “must” statements	Are based on your pre-determined ideas about how things are supposed to be, not on how things really are or could reasonably be.	“I should be more willing to take risks.” I must stop feeling afraid all the time.” “I shouldn’t make mistakes.”
Worst case scenario thinking	Predicts that the absolute worst, most awful outcome will happen. This can make a small problem seem like it will turn into a catastrophe.	“What if someone breaks into my house and rapes me?” “What if I yell at my son and he hates me forever?”
Personalization	When you think you are responsible for things that are actually out of your control, such as how others behave, think, or feel.	“My therapist was late because I said the wrong thing last week.” “My husband only hits me when I’m a bad wife.”
Disqualifying or discounting the positive	Leads you to minimize or downplay positive events because you believe they don’t count (anyone could do it, you got lucky, or it wasn’t that good).	“I’ve been sober for a week, but anyone can last a week.” “I passed my certification, but it was just dumb luck.”
Overgeneralization	Take one bad situation and concludes that it will continue to happen over and over, and will probably get worse	“That man raped me, men will always take advantage of me.” “I had a bad dream; I’ll never get a good night’s sleep.”
Emotional reasoning	Assumes that because you feel a certain way, that’s how it must be in reality.	“I am scared, therefore something bad is about to happen.” “I feel angry so obviously you have treated me terribly.”

Mind reading	Happens when you believe you know what someone else is thinking or feeling, even if you haven't thought about other plausible explanations.	"He thinks I'm stupid because, I didn't know the answer." "She didn't look at me, she doesn't like me anymore."
Labeling	Assigns an overarching characteristic to someone based on one thought, feeling or action, usually in a very negative way.	"She's such a loser." "I'm an idiot." "What a jerk." "He's stupid."
Mental filter	Ignores the many good characteristics and focuses only on one or two bad characteristics	"When I spoke at the AA meeting at first I was really nervous and dry-mouthed, but I got more comfortable as I kept talking, I am sure people remember the first part and think I am a basket case."
Magnificaton/minimization	Emphasises the negative parts of something and downplays the positive parts.	"I'm a bad mother, I yell at my kids at least once a week. They are doing well in school, they must get it from their dad."

Egan et al (2014: 159)

HANDOUT 6.4: EXERCISE: MY AFFIRMATIONS AROUND MY TRAUMA

In the space below, write three affirmations that you want to say to yourself or write to yourself that you eventually hope to believe. Remember to put them in present tense and use the word “I”.

- 1. _____
- 2. _____
- 3. _____

Now write each affirmation five times to begin to get familiar with it:

- 1. _____

- 2. _____

- 3. _____




Roosenbloem & Williams (2010: 8)

HANDOUT 6.5: THOUGHT RECORD

Situation	Automatic Thought(s)	Emotion(s)	Evidence to support thought	Evidence that doesn't support thought	Alternative thought	Rate mood now
What actually happened? Where? What? How? When?	What thought(s) went through your mind? How much did you believe it? (0-10)	What emotion(s) did you feel at the time? Rate how intense were they (0-10)	What has happened to make you believe the thought is true?	What has happened to prove the thought is not true?	What is another way to think of this situation?	(0-10)

Cully & Teten (2008: 59)

HANDOUT 6.6: STOPP THE THOUGHT WORKSHEET

<p>Notice the negative thought...</p>	<p>Write your reactions and alternate, healthier responses in this column. What works for you? What will help? What can you tell yourself? What do you need to remember at those times?</p>
<p>STOPP</p> 	
<p>Take a breath</p> 	
<p>Observe – describe the feelings, images, thoughts, body sensations, triggers</p> 	

Pull back / Put in some Perspective. What's the bigger picture? Take the helicopter view. Is this fact or opinion? How would someone else see this? Is there another way of looking at this?



Practice what works. What is the best thing right now – for me, for others, for the situation.



Adapted from Vivyan,(2011)

SESSION 7

CHALLENGING, DESTRUCTIVE AND SELF-DESTRUCTIVE BEHAVIOUR



HANDOUT 7.1: WEEKLY TST CHECK-IN

Emotional and Behavioural Dysregulation

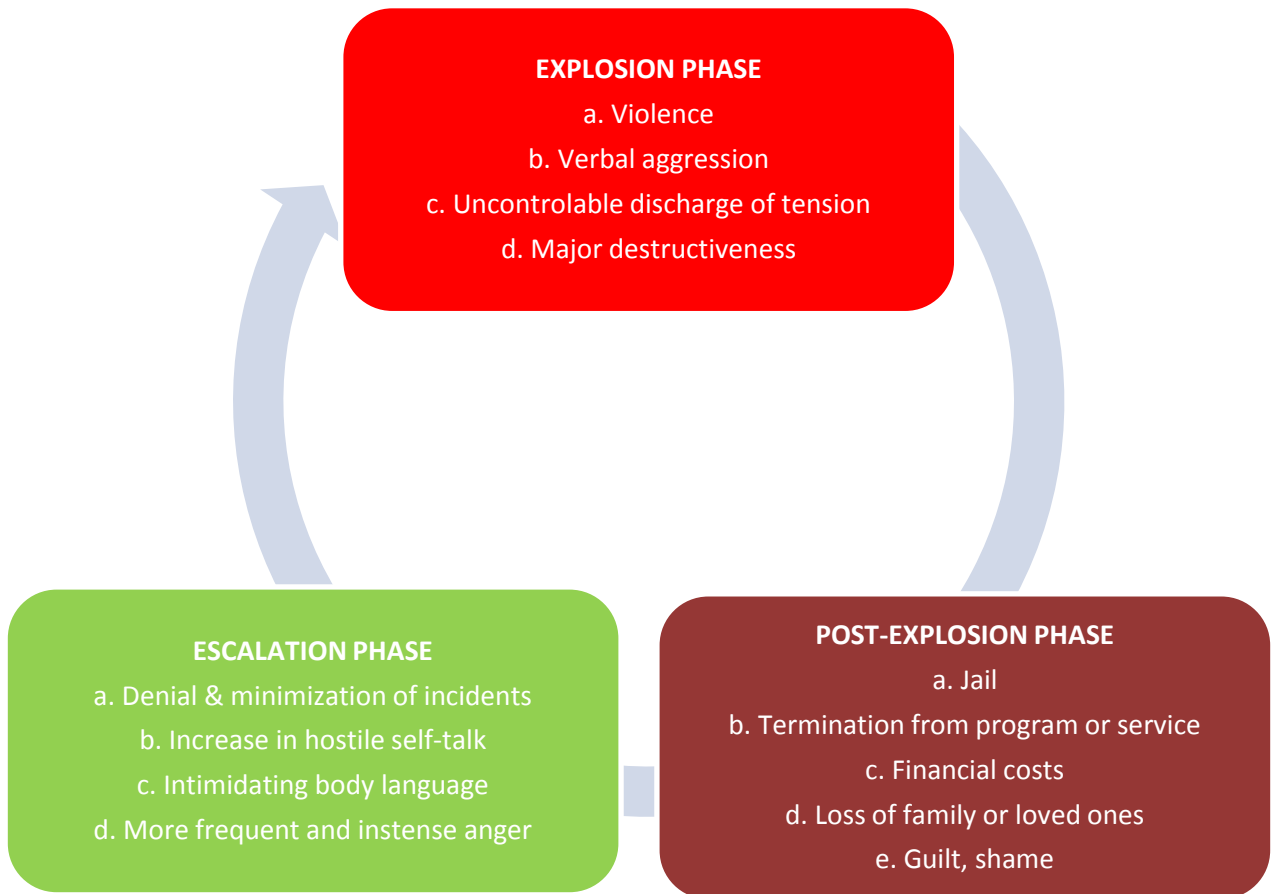
<p>How bad, sad, hurt, angry, guilty, or scared have I been feeling in the last week?</p> <p>9 As much as I can imagine 7 A lot _____ 5 Some _____ 3 A little bit _____ 1a Not at all _____</p>	<p>How much has my behaviour toward myself or others been harmful, destructive, aggressive, or risky in the last week?</p> <p>9 As much as I can imagine 7 A lot _____ 5 Some _____ 3 A little bit _____ 1a Not at all _____</p>
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Environmental Stability

<p>In the last week, how much have I been reminded of bad things that have happened to me?</p> <p>9 As much as I can imagine 7 A lot _____ 5 Some _____ 3 A little bit _____ 1a Not at all _____</p>	<p>In the last week, how much did I feel like people around me (managers, colleagues, family, social workers) were able to protect me from experiencing or being reminded of bad things or help me in dealing with my emotions when I was reminded?</p> <p>9 As much as I can imagine 7 A lot _____ 5 Some _____ 3 A little bit _____ 1a Not at all _____</p>
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Saxe (2007: 312)

HANDOUT 7.2: THE AGGRESSION CYCLE



Adapted from Everett & Aten (2010: 64)

HANDOUT 7.3: DEALING WITH ANGER

1. With whom do you get angry most often? _____

2. What do you really want to be the outcomes from conflict in those relationships?

3. What changes do you need to make you get what you want out of those relationships? _____

4. How do you want the other person to feel about you after the conflict?

5. How do you want to feel about yourself after the conflict? _____

6. What do you fear most when you are angry? _____

7. How do you avoid anger and conflicts? _____

8. What is the result of your avoidance of anger and conflict? _____

9. How have you exploded when you were angry? _____

10. What was the effect on the other person? _____

What are your Body's Warning Signs for Anger?

Breathing _____

Muscle Tightness _____

Temperature _____

Tingling _____

Other _____

Lynch & Mack (2015: 45)

HANDOUT 7.4: SKILLS FOR MANAGING ANGER

The Passive Person	The Aggressive Person	The Assertive Person
Is afraid to speak up	Interrupts and 'talks over' others	Speaks openly
Speaks softly	Speaks loudly	Uses a conversational tone
Avoids looking at people	Glares and stares at others	Makes good eye contact
Show little or no expression	Intimidates by using expressions	Shows expression which matches the message
Slouches and withdraws	Stands rigidly, crosses arms, invades the personal space of others	Relaxes and adopts an open stance and expressions
Isolates self from groups	Controls groups	Participates in Groups
Agrees with others despite personal feelings	Only considers own feelings and/or makes demands of others	Keeps to the point
Values selfless than others	Hurts others to avoid being hurt	Values self, equal to others
Hurts self to avoid hurting others	Reaches goals but hurts others in the process	Tries to hurt no one (including self)
Does not reach goals and may not even know goals	I'm okay, you're not	Usually reaches goals without hurting others
You're okay. I'm not		I'm okay, you're okay

Adapted from White (2005: 113)

HANDOUT 7.5: THE LINK BETWEEN TRAUMA, ALCOHOL AND DRUG USE

In some instances police officials exposed to traumatic events use alcohol and drugs to numb themselves:

- To numb their painful emotions (self-medication)
- To forget about the past
- To go to sleep
- To prevent nightmares
- To cope with physical pain
- To decrease anxiety in order to socialize with other people and feel accepted

Some things to think about when you have been exposed to trauma and you drink or use drugs:

- Do I use substances to cope with the Acute Post Traumatic Stress symptoms?
- Do I drink to change my mood?
- Does anyone else express concern about my drinking?
- Drinking and drugging make my symptoms worse, including sleep disturbance, nightmares, rage, depression, avoidance, numbing of feelings, social isolations, irritability, hypervigilance, paranoia and suicidal ideation.
- Drinking and using drugs may prevent medications from working and may be a dangerous mixture.
- What are the consequences of my drinking and using drugs (health, injuries, relationships, sexual, legal, employment, psychological, financial, birth defects)?
- While drinking and using drugs it may make things seem better in the short term, they always make things worse in the long term.
- Drinking and using drugs are a choice. Nothing that happens has to lead to substance use.
- By using alcohol and or drugs, to numb my feelings, I lock all the symptoms into place.
- To fully heal from the Acute Post Traumatic Stress symptoms in the long term, becoming clean and sober is necessary.
- We have a treatment program called Alcohol Anonymous (AA). You can ask for a referral to the group from your therapist.

Lynch & Mack (2015: 42)

HANDOUT 7.6: STOPP SUBSTANCE ABUSE



- STOPP! Pause, take a breath – (visualise the sign)
- Mindfulness – learn Mindful Breathing
- Remind yourself that cravings only last a few minutes if there is no access to what you crave. Can you remember times when you desperately wanted that drink, drug smoke, but there was none? How did you cope then? You have some same resources now!
- Drink a large glass of water, iced tea or vegetable juice, and pause
- When you have a slip or setback, write down what you drink or use
- Focus your attention fully on another activity – Mindful activity
- Do something different (to what you normally do)
- Relaxation techniques – try lots and find one that works for you
- Put on some music – sing and dance along, or just listen attentively (use music that is likely to help you feel your desired emotion – avoid sad songs if you’re depressed)
- Meditation or Prayer
- Help others
- Be with others – contact a friend, visit family
- Talk to someone
- Grounding techniques – look around you, what do you see, hear, smell, sense? Hold a comforting object.
- Engage in a hobby or other interest – if you don’t have one, find one! What have you enjoyed in the past? What have you sometimes thought about doing but not go around to?
- Write down your thoughts and feelings – get them out of your head
- Just take one step at a time – don’t plan too far ahead
- Pamper yourself – do something you really enjoy, or do something relaxing
- Positive self-talk – encourage yourself, tell yourself: I can do this, I am strong and capable – find an affirmation that works for you (even if you don’t believe it at first!) Write it down and memorise it for when you need it. See Affirmations.
- Do something creative – make a box of items that remind you to use the techniques that help, or put photos on paper, or write and decorate a list
- Use Safe Place, Imagery or other visualisation exercises. If you have nice memories of drinking, replace them with negative ones – when you were at your worst and felt

ashamed. Use exercises to visualise a drink or drug-free positive future, seeing yourself doing the things you want to be doing.

- Do some physical exercise – walk, jog, cycle, swim, dance & sing!
- Tell yourself: “This will pass, it’s only temporary”. “I’ve got through this before, I can do it now” (Cravings only last up to 20 minutes or so). When we’re going through a tunnel and become fearful of being trapped, there’s no point in stopping – we just have to carry on in order to reach the end of the tunnel. That light is there, and waiting!
- Find an alternative and healthier way of dealing with distress.
- If you have a setback – tell yourself it’s ok it’s only once – don’t dwell on it too much (other than see what triggered it so that you can then get back onto your self-help plan)

Once you’ve stopped drinking or using, you can start to tackle problems which contributed to your drinking or drug taking, including:

- Stress
- Sleep
- Anxiety
- Depression
- Anger
- Low Self Esteem
- Bipolar
- Voices & delusions
- Chronic Pain & Chronic Fatigue

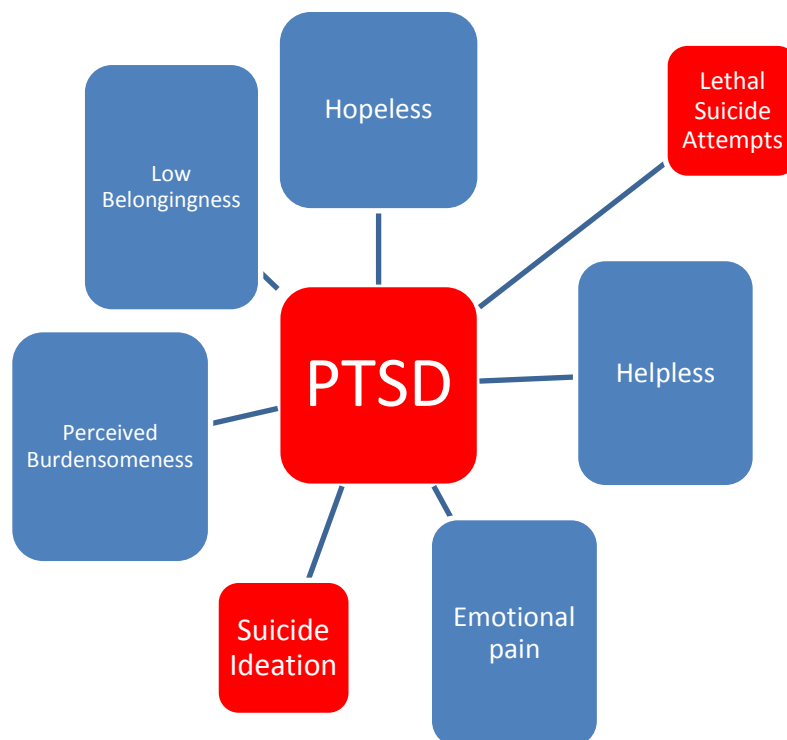
Talk to someone about other difficulties which may include:

- Work
- Relationships
- Finance
- Housing
- Legal

Talk to your therapist about resources and sources of appropriate support.

Vivyan (2011)

HANDOUT 7.7: THE LINK BETWEEN PTSD, SUICIDAL THOUGHTS AND ACTUAL SUICIDE



Adapted from Smith et al. (2014: 126) and Miller & Brock (2010: 65)

HANDOUT 7.8: RISK FACTORS FOR POLICE SUICIDE

<ul style="list-style-type: none">• PTSD• Depression• Alcohol Abuse• Job Stress / Burnout• Relationship Problems• Availability of Firearms	<ul style="list-style-type: none">• Mistrust of Mental Health System• Inability to separate from the “COP” identity• Perception that needing and / or asking for help implies weakness
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Hackett & Violante (2003: 64)

HANDOUT: 7.9: SUICIDE BEHAVIOURS QUESTIONNAIRE-REVISED (SBQ-R)

Instructions: Please check the number beside the statement or phrase that best applies to you.

1. **Have you ever thought about or attempted to kill yourself?** (check one only)
 - 1. Never
 - 2. It was just a brief passing thought
 - 3a. I have had a plan at least once to kill myself but did not try to do it
 - 3b. I have had a plan at least once to kill myself and really wanted to die
 - 4a. I have attempted to kill myself, but did not want to die
 - 4b. I have attempted to kill myself, and really hoped to die

2. How often have you thought about killing yourself in the past year? (check one only)
 - 1. Never
 - 2. Rarely (1 time)
 - 3. Sometimes (twice)
 - 4. Often (3-4 times)
 - 5. Very often (5 or more times)

3. Have you ever told someone that you were going to commit suicide or that you might do it? (check only one)
 - 1. No
 - 2a. Yes, at one time, but did not really want to die
 - 2b. Yes, at some time, and really wanted to die
 - 3a. Yes, more than once, but did not want to do it
 - 3b. Yes, more than once, and really wanted to do it

4. How likely is it that you will attempt suicide someday? (check one only)
 - 0. Never
 - 1. No chance at all
 - 2. Rather unlikely
 - 3. Unlikely
 - 4. Likely
 - 5. Rather likely
 - 6. Very likely

Osman et al. (2001: 443)

SESSION 8
PROBLEM SOLVING



HANDOUT 8.1: WEEKLY TST CHECK-IN

Emotional and Behavioural Dysregulation

<p>How bad, sad, hurt, angry, guilty, or scared have I been feeling in the last week?</p> <p>9 As much as I can imagine 7 A lot 5 Some 3 A little bit 1a Not at all</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>How much has my behaviour toward myself or others been harmful, destructive, aggressive, or risky in the last week?</p> <p>9 As much as I can imagine 7 A lot 5 Some 3 A little bit 1a Not at all</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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Environmental Stability

<p>In the last week, how much have I been reminded of bad things that have happened to me?</p> <p>9 As much as I can imagine 7 A lot 5 Some 3 A little bit 1a Not at all</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>In the last week, how much did I feel like people around me (managers, colleagues, family, social workers, etc) were able to protect me from experiencing or being reminded of bad things or help me in dealing with my emotions when I was reminded?</p> <p>9 As much as I can imagine 7 A lot 5 Some 3 A little bit 1a Not at all</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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Saxe (2007: 312)

HANDOUT 8.2: STRATEGIES FOR EFFECTIVE PROBLEM SOLVING

The **SOLVED** technique helps guide you through the steps to most effectively identify and solve problems in your life.

Selecting a problem group members would like to solve

Ask the group members to think about situations when he or she feels distress or difficulty problem solving. If planning does not seem to be possible, suggest a different therapeutic technique (e.g. changing maladaptive thoughts). The decision to remain with problem solving or move to a different skill is largely dependent on you to detect.

Opening your mind to all solutions

Here, it is important to be as broad as possible. You are encouraged to work with group members to “brainstorm” all possible solutions. Writing may be particularly helpful for some of the members. Even ideas that seem ridiculous at first may generate realistic solutions.

Listing the potential pros and cons of each potential solution

Often, writing options, along with listing pros and cons, can be helpful in considering potential options. Writing allows additional thought, as well as visual images of options. Recommend that group members consider solutions in a logical manner, thus reducing the time spent ruminating. It may also help to identify additional thoughts that might benefit from changes using the techniques, such as changing thoughts. In some cases, identification of pros/cons may require obtaining information from other people, such as lawyers or financial advisors.

Verifying the best solution

Examine the pros and cons of the solutions listed. Group members may wish to “rank order” the solutions based on which solutions are most practical and/or desirable.

Enacting the plan

Identify the steps needed to carry out the solution selected. Group members may need to break actions down into steps small enough to facilitate achievement of goals. Once you and the group finish formulating a specific plan, encourage the group members to carry it out.

Deciding if the plan worked

Follow-up with the group to see how well the chosen solution actually worked. If the solution was effective, give positive reinforcement. If the solution was not effective return to the first step in the SOLVED technique to specify a new problem or move to “O” or “L” to identify other goals or potential solutions for the same problem. The decision to move back and to which step is largely up to you, who might now have additional information about pros and cons and possible solutions.

Cully & Teten (2008: 67)

HANDOUT 8.3: SOLVED: PROBLEM SOLVING EXERCISE

Specific problem: _____

Open your mind

List

The possible Solutions	Pros	Cons
1.		
2.		
3.		
4.		
5.		

Verify the best solution by circling your choice.

Enact the solution.

Steps and Time Frame of Solution:

1. _____ Time: _____

2. _____ Time: _____

3. _____ Time: _____

Decide if your solution worked: [] YES [] NO

Cully & Teten (2008: 70)

HANDOUT 8.4: PROS AND CONS

Behaviour: _____

Positive Effects of Doing the Behaviour	Positive Effects of Not Doing the Behaviour
Negative Effects of Doing the Behaviour	Negative Effects of Not Doing the Behaviour

HANDOUT 8.5: POSITIVE AND NEGATIVE CONSEQUENCES

Short-Term Positive Consequences	Long-term Positive Consequences
Short-Term Negative Consequences	Long-term Negative Consequences

Cully & Teten (2008: 72)

SESSION 9

MANAGING TRIGGER EVENTS



HANDOUT 9.1: WEEKLY TST CHECK-IN

Emotional and Behavioural Dysregulation

<p>How bad, sad, hurt, angry, guilty, or scared have I been feeling in the last week?</p> <p>9 As much as I can imagine 7 A lot 5 Some 3 A little bit 1a Not at all</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>How much has my behaviour toward myself or others been harmful, destructive, aggressive, or risky in the last week?</p> <p>9 As much as I can imagine 7 A lot 5 Some 3 A little bit 1a Not at all</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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Environmental Stability

<p>In the last week, how much have I been reminded of bad things that have happened to me?</p> <p>9 As much as I can imagine 7 A lot 5 Some 3 A little bit 1a Not at all</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>In the last week, how much did I feel like people around me (managers, colleagues, family, social workers) were able to protect me from experiencing or being reminded of bad things or help me in dealing with my emotions when I was reminded?</p> <p>9 As much as I can imagine 7 A lot 5 Some 3 A little bit 1a Not at all</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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Saxe (2007: 312)

HANDOUT 9.2: IDENTIFYING MY TRIGGERS

A Trigger is an event, object, or cue that elicits feelings of anxiety, fear, anger, or other types of distress. Triggers are often harmless, but have become associated with the original trauma.

For most people with Acute Post Traumatic Stress, triggers are not inherently dangerous, but remind them of their traumatic experiences. The amygdala (old brain) recognises the similarity and – not realizing that the danger is over – produces a surge of anxiety which activates the fight or flight response.

Certain sights, sounds, smells, physical sensations, places, activities, and situations can be triggers for people exposed to trauma and can produce a surge of anxiety and a strong urge to escape or avoid. Common examples of triggers for police officials with Acute Post Traumatic Stress symptoms include:

- Unexpected loud noises
- Crowded public places
- People from other ethnic groups
- Trash/objects in the road
- Smell of diesel fuel
- Helicopters flying overhead
- Firecrackers
- Lack of respect

Learning to recognise your triggers is an important part of treatment. Below is a worksheet that will help you start monitoring your triggers this week.

My Triggers

Instructions: Try to notice what triggers feelings of fear, threat, anger, or general discomfort in you this week. Some things will be obvious (e.g., listening to the evening news), but other things may be more subtle (e.g. the smell of certain spices or a blast of heat from the oven when you open the door).

Triggers:

- | | |
|----|-----|
| 1. | 7. |
| 2. | 8. |
| 3. | 9. |
| 4. | 10. |
| 5. | 11. |
| 6. | 12. |

Lynch & Mack (2015: 15)

HANDOUT 9.3: AVOIDANCE AND SAFETY BEHAVIOURS

- Avoiding things that make us feel anxious or uncomfortable is only natural. Unfortunately, when dealing with triggers, avoidant behaviour does not work to our advantage in the long run. Avoidance reduces our ability to effectively manage real life challenges and responsibilities. Avoidance may reduce emotional distress for a little while, but in the long run avoidance worsens the Acute Post Traumatic Stress symptoms.
- Why? Because most triggers are not inherently dangerous. They feel dangerous, but they aren't actually dangerous. But when you avoid those triggers, you never get to learn that they are actually safe. The amygdala continues to label them as associated with trauma and they continue to have the power to produce fear. In fact, the fear can grow over time.
- Avoidance of people and activities leads to isolation, which can contribute to depression and relationship problems.
- Learning to overcome the urge to escape/avoid and to face your fears directly without relying on safety behaviours is what helps make the symptoms better.

What works and What Doesn't

- Avoidance, escape, and the use of safety behaviours may make you feel better in the moment, but in the long run they prevent the symptoms from getting better. That is because they prevent your brain's alarm system from learning what is really dangerous and what isn't.
- In fact, over time, the use of avoidance escape, and safety behaviours can increase fear, irritability, and distress.
- On the other hand, repeated exposure to the memories and real-life situations that we fear (while resisting the use of safety behaviours) makes the symptoms better, because it allows the brain's alarm system to recalibrate.
- You must repeat the same exposure exercise many times for it to work. Our brain's alarm system is stubborn!

Lynch & Mack (2015: 22)

HANDOUT 9.4: MY AVOIDANCE AND SAFETY BEHAVIOURS

Instructions: Pay attention this week and try to notice the situations, places, things, people and activities you intentionally avoid. Also notice safety behaviours you use to try to protect yourself or control your distress. List them in the spaces below.

What I Avoid: (e.g. going to the mall on Saturday, talking on the phone)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Safety Behaviours I use: (e.g. Keep my back to the wall in a restaurant, carry a gun)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Lynch & Mack (2015: 17)

HANDDOUT 9.5: CHECKLIST OF TRIGGERS, AVOIDANCE- AND SAFETY BEHAVIOURS




Check the boxes that apply to you

Interpersonal Interactions	Environmental Factors	Sensory Experiences
○ Family gatherings	Doing work inside/outside the house	Wearing police apparel
○ Having houseguests	Going to the movies	Hearing or seeing fireworks
○ Spending time with other police officials	Going out to a restaurant bar or club	Smelling gasoline
○ Explaining trauma experiences with a trusted person	Going to a store/mall	Hearing helicopters or airplanes
○ Participating in recreational sports teams	Going to a friend's home	Driving by garbage piles, dead animals, or man holes by the side of the road
○ Being in the presence of or talking to unfamiliar people	Visiting a police station	Smelling burning oil
○ Having others stand behind me	Going to the beach, on a cruise, or on vacation	Grilling meat at a family function
○ Participating in church services	Going to an amusement park, zoo, circus, carnival fair, etc.	Looking through memorabilia
○ Allowing someone else to drive	Going to the library, museum, exhibit etc.	Listening to a song that was heard during the traumatic event
○ Playing with children	Going to the hospital for appointments	Watching the news on TV

○ Volunteer work in the community	Playing outside with the dogs	Physical contact with a stranger – e.g., handshake
○ Asking someone for directions	Walking down a street	Seeing and/or hearing children
○ Spending time with neighbours	Being alone at night	Seeing/hearing heavy rain
○ Being in crowds (alone vs friends)	Being in a parking lot	Hearing sudden loud noises (doors slamming, cars backfiring etc.)
○ Feeling love and caring for someone	Riding in elevators	Frequently scanning the environment; perimeter
○ Feeling disrespected by others	Checking and re-checking locked doors and windows	

Lynch & Mack (2015: 26)

HANDOUT 9.6: STOPP THE TRIGGER WORKSHEET

<p>Notice the trigger...</p>	<p>Write your reactions and alternate, healthier responses in this column. What works for you? What will help? What can you tell yourself? What do you need to remember at those times?</p>
<p>STOPP</p> 	
<p>Take a breath</p> 	
<p>Observe – describe the feelings, images, thoughts, body sensations, triggers</p> 	

Pull back / Put in some Perspective. What's the bigger picture? Take the helicopter view. Is this fact or opinion? How would someone else see this? Is there another way of looking at this?



Pactice what works. What is the best thing right now – for me, for others, for the situation.



Adapted from Vivyan,(2011)

SESSION 10
CHANGES IN SYSTEMS OF CARE



HANDOUT 10.1: WEEKLY TST CHECK-IN

Emotional and Behavioural Dysregulation

<p>How bad, sad, hurt, angry, guilty, or scared have I been feeling in the last week?</p> <p>9 As much as I can imagine 7 A lot 5 Some 3 A little bit 1a Not at all</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>How much has my behaviour toward myself or others been harmful, destructive, aggressive, or risky in the last week?</p> <p>9 As much as I can imagine 7 A lot 5 Some 3 A little bit 1a Not at all</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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Environmental Stability

<p>In the last week, how much have I been reminded of bad things that have happened to me?</p> <p>9 As much as I can imagine 7 A lot 5 Some 3 A little bit 1a Not at all</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>In the last week, how much did I feel like people around me (managers, colleagues, family, social workers, etc) were able to protect me from experiencing or being reminded of bad things or help me in dealing with my emotions when I was reminded?</p> <p>9 As much as I can imagine 7 A lot 5 Some 3 A little bit 1a Not at all</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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Saxe (2007: 312)

HANDOUT 10.2: JOURNAL EXERCISE: MY BELIEFS ABOUT TRUST

Ask yourself the following questions and record your answers:

1. What does it mean to me to be able to trust?

2. In what situations do I trust my own thoughts?

3. In what situations do I trust my own judgements or conclusions about a person?

4. In what situations do I trust my own judgements or conclusions about a situation?

5. How do I define the word “intuition”? Is it nonlogical insight?

6. When do I feel that my intuition speaks to me? When do I notice my intuition?

7. How else do I become aware of my feelings, impressions, and beliefs about others or situations?

8. Am I a trustworthy person?

9. When do I keep promises? When do I not keep them?

10. Do I develop trust in someone gradually or all at once?

11. What people or groups do I trust? Which do I distrust?

12. How do I feel when I have to depend on another person?

13. When do I ask others for help with tasks?

14. When do I ask others for help with my emotional needs?

Willilams & Poijula (2013: 263)

HANDOUT 10.3: EXERCISE: MY BELIEFS ABOUT INTIMACY

Answer the following questions or complete the following thoughts:

Do I feel connected to others? If so, to whom _____

To me, an intimate relationship means I _____

At this moment in time, I have an intimate relationship with _____

I believe that the word "love" means _____

I am able to express love safely with _____

From whom and where do I get support? _____

From whom and where do I get love? _____

Do I feel more distant from others now, after the trauma (or after I have begun to work on the trauma)? _____

How do I express love and caring to others? To myself? _____

Am I able to have an intimate sexual relationship with another? _____

Which of the following statements describe you? Check all that apply.

- I stay away from people.
- I avoid certain social activities (such as _____).
- I want to spend my time alone.
- I am afraid to talk to others.
- I am afraid to be physically close to another.
- I try to force others to have physical contact with me.
- I say no to any suggestions of sexual contact with someone whom I have loving feelings.
- I overdo taking care of others.
- I have no one to take care of me.
- I am generally hostile toward others.
- I feel afraid to depend on others.
- I believe others will always let me down.
- I fear touch of any kind.
- I am unable to play.
- I am unable to make friends.
- I am unable to keep friends.
- I have no friends.
- I am unable to disclose my real self to others.
- I am unable to go out to meet others.
- I do not trust that I am okay.
- I am unlovable and undeserving of love.
- I don't believe anything nice that others say about me.
- I cannot make decisions.
- I continue to get in disastrous relationships

The more statements you checked, the more you need to look at ways to challenge and change your beliefs about intimacy and trust. You also need to look at your boundaries and communication skills (Williams & Poijula, 2013: 265)

HANDOUT 10.4: EXERCISE: MY EMOTIONAL BOUNDARIES

I believe my emotional boundaries are rigid, loose, or healthy because:

Look at the following checklist and mark which of these statements are true about you.

I have good boundaries in the following areas:

- I tell others only what makes me comfortable to disclose.
- I do not have an intimate, sexual relationship immediately or shortly after beginning a relationship.
- I take my time to learn to know someone before I decide to trust that person.
- I do not change my behaviour and values to please others.
- I am sexual only when I want to be.
- If someone tries to invade my personal space, I will tell that person to back away.
- I do not accept touch from others when I do not want it.
- I make choices about my own life and the direction in which it is going.
- I do not expect others to anticipate my needs.
- I do not expect others to fulfil my needs.
- I do not fall apart to get others to take care of me.
- I am not self-abusive, if I did self-abuse, I have stopped doing so.
- I consciously try not to repeat patterns of abuse that happened to me in the past.
- I expect realistic assistance from others.
- I have realistic expectations of myself.

How many of these did you check? Ideally, you checked all of them. If your boundaries are good you checked at least twelve or thirteen of these statements. If you left any blank, write that sentence below and look at that belief that lies behind why you did not check it. Then consider what you might do to challenge that belief.

The statements that I did not include:

1. _____
2. _____
3. _____

The beliefs that stopped me from checking each statement:

1. _____
2. _____
3. _____

What I am willing to do to challenge those beliefs:

1. _____
2. _____
3. _____

What did completing these exercises about physical and emotional boundaries teach you about yourself?

Williams & Poijula (2013: 273)

HANDOUT 10.5: RELATIONSHIP CONFLICT RESOLUTION

Focus on the problem, not the person.

When a disagreement turns to personal insults, raised voices, or mocking tone, the conversation is no longer productive. Be careful to focus on the problem without placing blame on the other person. If a disagreement becomes personal, you should pause the conversation.

Use reflective listening.

Outcomes during arguments we focus on getting our own point across rather than listening to the other person. Before responding to the other person, restate what they have said to you in your own words. Continue this process until the other person agrees that you understand. Next, share your side. The other person should reflect back your ideas in their own words until they too understand. Using this technique will help both individuals feel listened to and understood, even if you disagree.

Use “I” statements.

When sharing a concern, begin your sentence with “I”. For example: “I feel hurt when you don’t tell me you’ll be late”. With this sentence format we show that we are taking responsibility for our own emotion rather than blaming other people. The alternative sentence – “You never tell me when you’re going to be late” = will often cause the partner to become defensive.

Know when to take a time-out.

When you and the other person become argumentative, insulting, or aggressive, it’s a good idea to take a time-out. Have a plan in place so you or the other person can call for a break when needed. Spend some time doing something alone that you find relaxing. When you’ve both calmed down, you and the other person can return to solving the problem. Be sure that you do return – it isn’t a good idea to leave these issues unaddressed.

Work toward a resolution.

Disagreement is a normal part of any kind of relationship. If it becomes clear that you and the other person will not agree, focus on a resolution instead. Try to find a compromise that benefits both individuals. Ask yourself if this disagreement really matters to your relationship, and let yourself move on if not.

Doherty & Guyler (2008: 46)

HANDOUT 10.6: EFFECTIVE COMMUNICATION TECHNIQUES

Effective communication involves talking directly with another person when something needs to be said. When you communicate effectively, you use clear messages that say what you mean; make statements when a statement is needed (rather than asking a question), clearly state your wants and feelings, do not intend to hurt the other person, and listen actively as well as talking.

Active listening

When you listen actively, you listen with openness as you try to see the other person's point of view, with empathy as you try to understand the other person's emotional state or feelings, and with awareness, as you try to be aware how what the person says fits with your known facts.

Asking questions

If you want to communicate with another, you may want to ask probing questions to get better information about how that person thinks or feels. Probing questions ask the other person to think and become more aware about what he or she has just said, and to clarify it.

Describing feelings

Another basic communication skill is to describe your feelings by making an "I" statement, such as "I feel happy when I am with you."

Describing behaviour

If you use this skill, you report the specific, observable actions that the other person has done without valuing them as right or wrong, bad or good: "I noticed that every comment I have made in the past two days has been countered with a rude statement or a negative look." The aim of behaviour description also is to open up discussion about how each person affects the other and about their relationship

Using humor

Using humor can help communication by relaxing tension, reducing bad feelings, increasing a feeling of fellowship, or reinforcing a point. Humor also can help you express feelings more openly and spontaneously.

Using "I" messages

An "I" message is a specific, non-judgmental message that focuses on the speaker, not the person listening. "You" messages are hostile and blaming and focus on the listener. When you use an "I" message, you describe what is affecting you without blaming the other person.

Williams & Poijula (2013: 277)

HANDOUT 10.7: STYLES OF COMMUNICATION

After reading the description of each, think of when you use that style and with whom.

Small talk

Small talk tends to be used in social situations in order to build rapport and keep in touch. It is generally relaxed, cordial, and playful and includes greetings, stories, and talk about conventional topics or daily routines.

When do you use small talk, and with whom? Shop talk?

Control talk

Control talk is used to lead, direct, persuade, evaluate, instruct, reinforce, show authority, get compliance or agreement, sell, or caution. The intent of control talk is to show that you are in charge while also being both helpful and persuasive.

How do you use control talk and with whom and when?

Fight talk

Fight talk is when you attempt to force change on or defend yourself against another. It then includes statements that are demanding, attacking, blaming, threatening, or intimidation. The aim of fight talk is to justify yourself, hide your own fear or vulnerability, put the other person down, or use abuse to control.

How do you use fight talk and with whom and when?

Search Talk

If you use search talk, you are trying to get insight, clarify what has happened, look for options or causes, evaluate alternatives, or ask questions. You want to explore, brainstorm, and expand upon what you already know.

When do you use search talk, and with whom?

Straight talk

Straight talk is open, direct, honest, assertive, responsive, and respectful. If you use straight talk, you aim to disclose information, connect with others without trying to control them, collaborate with those others, and look toward the future. Straight talk includes observing, using active listening and the other communication techniques described above, and has a “now” orientation.

When do you use straight talk, and with whom?

SESSION 11

SYSTEMS ADVOCACY



HANDOUT 11.1: WEEKLY TST CHECK-IN

Emotional and Behavioural Dysregulation

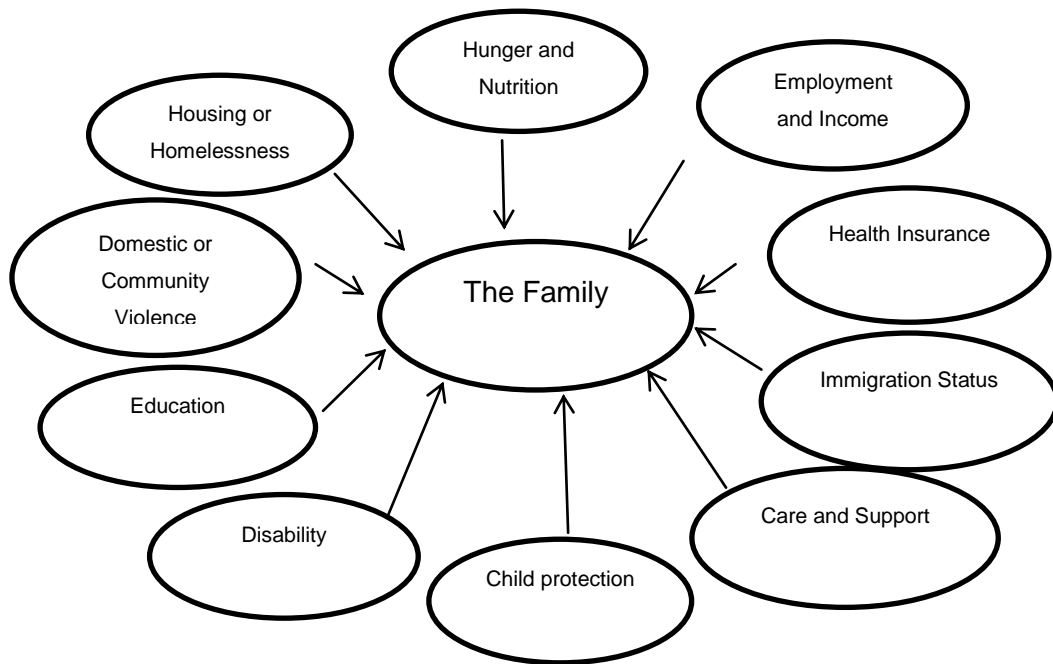
<p>How bad, sad, hurt, angry, guilty, or scared have I been feeling in the last week?</p> <p>9 As much as I can imagine 7 A lot 5 Some 3 A little bit 1a Not at all</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>How much has my behaviour toward myself or others been harmful, destructive, aggressive, or risky in the last week?</p> <p>9 As much as I can imagine 7 A lot 5 Some 3 A little bit 1a Not at all</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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Environmental Stability

<p>In the last week, how much have I been reminded of bad things that have happened to me?</p> <p>9 As much as I can imagine 7 A lot 5 Some 3 A little bit 1a Not at all</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>In the last week, how much did I feel like people around me (managers, colleagues, family, social workers, etc) were able to protect me from experiencing or being reminded of bad things or help me in dealing with my emotions when I was reminded?</p> <p>9 As much as I can imagine 7 A lot 5 Some 3 A little bit 1a Not at all</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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Saxe (2007: 312)

HANDOUT 11.2: DOMAINS THAT AFFECTS FAMILIES



Saxe (2007: 189)

HANDOUT 11.3: CASE STUDY: “W/O BONGANI”

It was a split-second decision.

A distressed man with a baby in tow was pacing back and forth in a manic state and shouting incoherently. The responding police official (W/O Bongani) calmly addressed the man in an attempt to calm him down and defuse the situation, but the man suddenly pulled an object from his side and lunged toward the official. Instinctively, the official raised his gun and squeezed the trigger. It turned out the man was armed with a knife, but W/O Bongani acknowledged he would have fired whether the assailant had a knife, a spoon or an empty hand.

“I didn’t even see it. “It could have been anything in his hand, and I used force to stop him”.

“It all happened so fast,” he added. “You don’t know what they could have in their hand.”

“I walked away with a few things,” W/O Bongani said “Many police officials do not have adequate training and they should not be patrolling by themselves. Having backup would stop them from being skittish and firing their weapon”.

“Also, we have to teach our community that, even if you disagree with the official, do not try to litigate with them on the spot,” he added. “Live to see another day. Don’t let our pride get in the way. Otherwise, you are setting yourself up.”

W/O Bongani, who has been critical of police in Potchefstroom, where the shooting of an unarmed man by a police official last August touched off rioting around the nation, took the test with the police department in the North-West Province. In four scenarios, he had to instantly decide whether to use physical force, a gun or hold his fire.

In another scenario, W/O Bongani fired at a man during a routine traffic stop in which the suspect moved toward him, ignored an order to halt and reached behind his back

“I actually fired six times,” Bongani recalled. “I always questioned why officials fired so many shots in these situations. After going through the training, I think it’s very hard for an official to know how many shots they fired when they are in the moment.”

As a result of W/O Bongani’s exposure to above incidents he developed post-traumatic stress symptoms, anxiety and depression. He was booked off several times. The situation does have a direct impact on his family and he acknowledges the fact that he sometimes becomes violent at home towards his wife and children. According to him he did not receive any support from management instead his fire-arm was confiscated whilst off sick. As a result of the incident in Potchefstroom he was departmentally and criminally charged and suspended without salary, which resulted in severe financial difficulties. He isolated himself because of the negative perceptions by the community. He also experienced that his friends were avoiding him. He lost his faith in God. EHW did visit him once, but did not involve his family members. Since then

there was no follow-up visits. Although he was found not guilty and his suspension uplifted he still experiences nightmares, anxiety and depression. He stopped his treatment as he belief that he will not benefit whilst he is still confronted/exposed to the same working environment.

HANDOUT 11.5: SYSTEMS ADVOCACY SCREENER

1. ECONOMIC AND INCOME SUPPORT		
Do you ever have problems making ends meet?	Y	N
<u>If Yes:</u>		
• Are you of the opinion that your income is not sufficient enough?	Y	N
• Do you have a lot of debt?	Y	N
• Are you responsible to support extended family members?	Y	N
• Can you provide in the basic needs of your family?	Y	N
• Is your spouse employed?	Y	N
2. FAMILY		
Are you concerned about your relationship with your partner and children	Y	N
<u>If Yes:</u>		
• Does your work influence your relationship with your partner?	Y	N
• Is your relationship with your partner healthy?	Y	N
• Have you ever been verbally and physically violent towards your partner?	Y	N
• Have you ever considered a divorce?	Y	N
3. HOUSING		
Are you concerned about the conditions and safety at home	Y	N
<u>If Yes:</u>		
• Do you live in your own house?	Y	N
• Are you concerned about conditions in your home?	Y	N
• Are you facing an impending eviction?	Y	N
• Are you behind in rent or utilities payments?	Y	N
4. COLLEAGUES		
Do you receive support from your colleagues at work?	Y	N
<u>If No:</u>		
• Do you isolate yourself?	Y	N
• Do you feel part of a group?	Y	N
• Do you trust your colleagues?	Y	N
• Do you experience your colleagues to be caring and supportive?	Y	N

5. FRIENDS/NEIGHBOURS		
Do you feel isolated from your friends and neighbours	Y	N
<u>If Yes:</u>		
• Do you isolate yourself?	Y	N
• Do you feel that there is a stigma attached to you as police official?	Y	N
• Do you feel safe in your community?	Y	N
• Do your friends have a positive influence on you?	Y	N
• Do you feel free to talk to your friends about personal problems?	Y	N
• Do you experience your friends to be caring and supportive and Unconditionally accepting you for the person you are?	Y	N
6. RELIGIOUS SUPPORT		
Do you have faith	Y	N
<u>If No:</u>		
• Do you feel that your God has abandoned you?	Y	N
• Do you meet with others in a spiritual fellowship?	Y	N
• Do you turn over your problems to your God for solutions?	Y	N
• Are you involved with any type of compassionate service for others?	Y	N
7. TRAINING		
Do you believe that the police training is sufficient enough	Y	N
<u>If No:</u>		
• Did basic training equip you for your job as a police official?	Y	N
• Do you have specialised training needs?	Y	N
• Do you sometimes feel insecure due to a lack of training?	Y	N
• Can the police do more to train police officials?	Y	N
8. LEGAL SUPPORT		
Have you ever felt the need to consult your union representative or a lawyer as a result of contempt of your human rights within the work place?	Y	N
<u>If Yes:</u>		
• Do you know what your rights are and what you can do to seek expert advice?	Y	N
• Do you feel intimidated by sorting through labour and other laws?	Y	N
• Have you ever felt the need to get direct advice from a professional legal advocate in solving your problem?	Y	N
• Do you have enough legal resources?	Y	N

9. POLICE MANAGEMENT		
Do you receive sufficient support from police management	Y	N
<u>If No:</u>		
• Police management understand the extent of trauma and the impact thereof on police officials	Y	N
• Police management is sensitive and do have empathy with police officials exposed to trauma;	Y	N
• Police management support the trauma intervention programs presented by EHW and do the necessary referrals	Y	N
• Police management are sufficiently trained in the trauma management process	Y	N
10. PROFESSIONAL HEALTH CARE / SOCIAL WORKER / GP		
Have you ever felt the need to consult your GP, social worker, psychologist as a result of your exposure to trauma at work	Y	N
<u>If Yes:</u>		
Do you have any of the following conditions:		
• Marital problems;	Y	N
• Financial problems;	Y	N
• Aggressive behaviour;	Y	N
• Acute Stress;	Y	N
• Post-Traumatic Stress;	Y	N
• Physical reactions (diabetes, high blood pressure, ulcers etc.)	Y	N
• Can you rely on and do you trust EHW regarding above?	Y	N
11. SPECIALISED PSYCHOLOGICAL CARE		
Have you ever felt the need to seek specialised care from a psychiatrist/institution?	Y	N
<u>If Yes:</u>		
Do you have any of the following conditions:		
• Acute Stress Disorder;	Y	N
• Post-Traumatic Stress Disorder;	Y	N
• Anxiety;	Y	N
• Depression;	Y	N
• Alcohol/Drug abuse	Y	N
• Do you have sufficient resources in the community that are available to assist you with above?	Y	N

HANDOUT 11.6: SYSTEMS TREATMENT PLANNING FORM

1. Indicate the “players” on the team

The Team	Name	Ways to reach	Signature
Police official			
Family			
Therapist			
Psychologist			
Psychiatrist			
Legal advocate			
Others			

2. Indicate the recommended treatment phase

	Stable	Distressed	Threatening
Regulated			
Dysregulation of Emotion			
Dysregulation of Behaviour			

3. Indicate the recommended treatment modules

	Surviving	Stabilizing	Enduring	Understanding	Transcending
Stabilization on site	***	***	-	-	-
Services advocacy	***	**	*	*	*
Psychopharmacology	**	**	**	*	*
Emotional regulation	*	**	***	-	-

Cognitive processing	-	-	-	***	-
Meaning making	-	-	-	-	***

Note. *** = essential; ** = often helpful; * = occasionally helpful; - = not used or contraindicated

4a. Identify the TST Priority Problems

TST priority problems:	
<ol style="list-style-type: none"> 1. Identify patterns of links between social-environmental stressor and emotional/behavioural dysregulation. 2. Prioritize those patterns that most interfere with the police official's functioning. (Use point 5b to help decide on the level of priority. It is very important to note that point 5b offers only rough guidelines and should not override clinical discretion.) 	
Priority Problem 1	Priority Problem 2
Priority Problem 3	Priority Problem 4

4b. Guidelines for assigning priority to a problem identified in point 5a

<p>Problems that jeopardize physical safety (e.g., suicide, violence, child abuse).</p> <p>Problems that jeopardize engagement in treatment</p> <p>Problems that jeopardize the police officials position at work</p> <p>Problems that jeopardize healthy development (e.g., drug abuse, antisocial behaviour, sexual activity, eating disturbances).</p> <p>Problems that cause significant distress to the police official and to family members.</p> <p>Problems that can be solved relatively easily and are highly meaningful to the police official or family members</p>

5. Identify the solutions to TST Priority Problems

Who/what does solution address?	Description of solution	Person responsible	When noted	When resolved
Police official (indicate skill/module)				
Social environment				
Therapist (e.g. emotional and/or substance abuse, family violence)				
Wife/husband/partner				
Children				
Housing				
Resources				
SAPS				
Neighbourhood				
Peers				
Other				
Barriers (Describe practical barriers that may interfere with solving priority problems; describe strategies to surmount barriers.)				

Description	Strategy			
Strengths (Describe strengths of police official/assets in social environments that may be engaged to help with solutions to priority problems.)				
Description	Strategy			

Saxe (2007: 309)

SESSION 12
RELAPSE PREVENTION



HANDOUT 12.1: WEEKLY TST CHECK-IN

Emotional and Behavioural Dysregulation

<p>How bad, sad, hurt, angry, guilty, or scared have I been feeling in the last week?</p> <p>9 As much as I can imagine 7 A lot 5 Some 3 A little bit 1a Not at all</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>How much has my behaviour toward myself or others been harmful, destructive, aggressive, or risky in the last week?</p> <p>9 As much as I can imagine 7 A lot 5 Some 3 A little bit 1a Not at all</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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Environmental Stability

<p>In the last week, how much have I been reminded of bad things that have happened to me?</p> <p>9 As much as I can imagine 7 A lot 5 Some 3 A little bit 1a Not at all</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>In the last week, how much did I feel like people around me (managers, colleagues, family, social workers) were able to protect me from experiencing or being reminded of bad things or help me in dealing with my emotions when I was reminded?</p> <p>9 As much as I can imagine 7 A lot 5 Some 3 A little bit 1a Not at all</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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HANDOUT 12.2: REVIEWING WHAT WAS LEARNED AND HOW TO MAINTAIN PROGRESS

Maintaining progress	In case of a setback...
<p>What have I learned?</p>	<p>How can I make sense of this?</p> <p>What events/triggers led up to this setback? How did I react to this? What did I do? What did I think? What did I feel?</p>
<p>What was most useful?</p>	
<p>What can I continue to do to prevent a setback?</p>	
<p>What are my high risk situations of this happening?</p> <p>What events/situations/triggers cause me to be more vulnerable?</p>	<p>What have I learnt from it?</p> <p>Was this a high-risk situation? Are there things that I can identify that are different? What helped and what didn't?</p>
<p>What are the signs?</p> <p>Thoughts/feelings/behaviours</p>	

<p>What can I do to avoid losing control?</p> <p>What could I do differently? What would work best?</p> <p>When I'm struggling or feeling bad, what could I do that will help?</p>	
<p>What could I do if I did lose control?</p> <p>What has helped? What have I learned? Who can help?</p>	<p>With hindsight, what would I do differently?</p> <p>When I think/feel.....what could I do instead?</p>

Vivyan (2011)

HANDOUT 12.3: RELAPSE SIGNS

Unlike with smoking or drinking, relapses can be less obvious with Acute Post Traumatic Stress and you may not notice that you are slipping back into old habits. So be sure to look for signs in your own behaviour and enlist help from others!

1. What I would expect to hear from my partner if I were relapsing:

2. What I would expect to hear from others (co-workers, friends, family) if I were relapsing:

Additional relapse signs to look for:

3. Sleep patterns: _____

4. Anger expressions: _____

5. Memories and nightmares _____

6. Depression, avoidance, safety behaviours _____

7. Relationship and emotional numbing difficulties _____

8. Alcohol and drug use _____

9. Other relapse signs _____

Relapse Plan: If I slip or relapse I will:

- Use my tools: breath, self-talk, and best-self statement
- Re-read the recovery manual
- Set up an appointment with my therapist
- Talk to an old friend or loved one
- _____
- _____
- _____
- _____
- _____

Lynch & Mack (2015: 61)

HANDOUT 12.4: RELAPSE, RECOVERY AND RESILIENCY

A **relapse** is when you go back to your old way of handling problems. For example, if you smoked a pack of cigarettes a day for years and then quit for six months, it would relapse if you went back to smoking a pack of cigarettes a day.

**Important:* Relapses are a normal part of getting better. Relapses are an opportunity to remember and use new skills. We only get better when we are tested. Relapses give us a chance to get better by being tested, using new skills and improving outcomes.

Recovery is when you recognise you have slipped back into your old habits and decide to use new skills instead of continuing the old pattern.

Resiliency is learning not to give up when tested and learning that you can overcome what you thought you could not overcome. Learning is changing your behaviour, in addition to thinking new thoughts. When you use your new skills and resist your old habits and patterns, you learn something new. Resiliency is using new skills when you've started to use the old patterns and habits again.

Relapse, recovery, and resiliency are key parts of getting better.

Remember: It is not how many times you fall down that counts, it is how many times you get back up.

How have you already experienced relapse, recovery and resiliency in your life?

Lynch & Mack (2015: 60)

HANDOUT 12.5: RELAPSE PREVENTION PLAN

What Is Relapse?

Relapse is a process that begins when you start slipping back into old behaviour patterns. Some things that can lead to relapse include:

- feeling that you have the problem under control and taking a chance to use or gamble again
- not working out stresses and problems at home, work or school, and when these build up or a crisis happens,
- not dealing with stresses such as problems with your finances, with your health, or with the legal system
- not handling negative feelings such as boredom, loneliness or anger
- when under stress you can't cope
- not working on your recovery plan or letting it slide (e.g. not going to self-help meetings)

To avoid relapse:

1. Handle day-to-day feelings and problems as they happen. Your plans should involve handling feelings and problems as they happen. This way, pressure and stress do not build up. The stress you may already feel will only get worse if you put off dealing with problems with family, friends or work.
2. Keep your life in balance... a way to reduce stress. It is important to find ways to balance work and relaxation. Having fun with family or friends, without including alcohol, drugs or gambling, can be challenging. Be kind to yourself. Give yourself simple rewards that give you pleasure - a walk, time with a hobby, a chance to read a book. What you eat can affect how well you cope with pressure. Lots of good basic foods like fruit, vegetables, cheese, whole grain cereals and breads, fish, and meat help cut down stress. Food rich in B vitamins helps to reduce craving for alcohol and to keep stress manageable. Caffeine (coffee, soft drinks), nicotine (cigarettes, cigars) and too much sugar can make you tense.
3. Gain support and trust. Family, friends, your boss, a co-worker, a support group or a counsellor can talk with you about the pressures you are feeling in recovery. They can watch with you for the warning signs of relapse and help you handle the stress. Let them know your goals and your plans so that they can help you out.
4. Identify and plan for high-risk situations. Everyone faces high-risk situations at some time - you will find yourself in situations where you are more likely to experience stress, anxiety and depression. These situations can be handled more easily if you know ahead

of time what they will be. Have at least three ways to handle them, so that if one does not work, you do not give up. Practise what you will do or say, so you do not worry about what to do under pressure. You can stay confident and in control.

Managing Your Stress

Stress is a common part of everyone's life. We deal with most of our stressful experiences successfully. It's the small percentage that we have difficulty managing that causes problems.

Because stress is a part of life, it makes sense to develop a variety of ways of handling it. There are many ways - the following are some basic, common sense methods:

- Organize yourself. Take better control of the ways you're spending your time and energy.
- Control what and who is surrounding you. Stay away from people who cause you to doubt your decisions.
- Develop a supportive network of caring people around you. Feeling alone or apart from others builds stress. Being in touch with family and friends reduces it.
- Build up your strength. If you're in good physical condition, you'll be better able to stand up against your stress.
- Find ways to laugh each day. Laughter is one of the purest releases of tension.
- Learn to relax. Do something relaxing for 20 minutes each day. You will think more clearly and will be better prepared for decision-making.

Resources

Because stress affects the whole person, good stress management skills allow you to manage all parts of your life. The following list is things you can do to help keep stress under control.

- **Get Physical:** Build up your strength and stamina.
- **Relax:** Develop a list of activities you find relaxing and do them regularly.
- **Eat Well:** Eat good basic foods such as whole grain cereals and breads, fish, meat, fruits and vegetables. Avoid too much caffeine (coffee, soft drinks), nicotine (cigarettes and cigars), and sugar.
- **Take Care of YOU:** Treat yourself kindly. Don't push beyond your limits.
- **Exercise:** Learn to get the benefits of regular exercise.
- **Use Your Mental Skills:** Use your mind to help cope with stress more effectively.
- **Manage Your Time Well:** Pause to think about what is really important and give time to those things.

- **Organize:** Seek order. Don't let things pile up.
- **Problem Solve:** Address issues as they come up. Don't hesitate to ask others to help.
- **Build a Support Network:** Develop a network of resources and people that you can count on.
- **Use Family and Friends for Support:** Your family and friends may help you solve problems and reduce stress.
- **Keep Life in Balance:** Make sure you set aside time for home as well as work commitments.
- **Enjoy Time with Others:** Spend time with those you care about
- **Settle Conflicts:** Look for solutions where all sides win.
- **Getting Along with Others:** It's important to build relationships that will help you in dealing with stress in your life.
- **Try New Things:** Discovering healthy new ways to have fun is a great way to reduce your tension level. Try new recreational activities and find new hobbies.
- **Stay Open to Change:** Try new approaches.
- **Believe in Yourself:** Trust others. Share and show feelings. Share your burdens with your family and friends. Be direct about your wants, needs, and feelings.
- **Learning:** Take a class. Exercise your mind.
- **Enjoy Music:** Play an instrument. Join a choir.
- **Work:** Volunteer for something worthwhile.
- **Get Away:** Spend more time alone.
- **Play:** Go out with a friend.

The easiest way to add to your methods for handling stress is to develop one new habit at a time. Remember you have the power and ability to decide to deal with stress (Anon., 2015a).

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ARTICLE 6

IMPLEMENTATION AND EVALUATION OF THE PSYCHO-SOCIAL THERAPEUTIC PROGRAM (PTP)

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Keywords

Evaluation, Psycho-social Therapeutic Program

Abstract

In this article a Psycho-social Therapeutic Program (PTP) empowering police officials to better deal with distress and preventing the development of post-traumatic stress- or any other co-morbid disorder, after exposure to traumatic events will be evaluated both quantitatively and qualitatively. The data were obtained by means of the Critical Incident History Questionnaire (CIHQ) (Annexure F), the Impact of Event Scale-Revised (IES-R) (Annexure G), the Mental Health Continuum Short Form (MHC-SF) (Annexure H) and the Post-Traumatic Cognitions Inventory (PTCI) (Annexure I). Qualitative evaluation was also done by means of self-developed questionnaires (Annexure K & L). The guidelines for selection and inclusion of respondents in the comparison and experimental groups will be discussed, followed by an explanation of the measuring instruments. The results from both the quantitative and the qualitative evaluations are then explained. The article concludes with a discussion and recommendations.

IMPLEMENTATION AND EVALUATION OF THE PSYCHO-SOCIAL THERAPEUTIC PROGRAM (PTP)

1. Introduction

The aim of this article is to evaluate and determine the effect of a compiled PTP for police officials from a specialist unit of the SAPS in the North West Province. The Public Order Policing Unit in Potchefstroom was identified for this study, because members attached to this unit provide maximum response efficiency in a variety of customary and unusual situations, which causes the likelihood of repeated exposure to traumatic events. Both qualitative and quantitative approaches (Delpont & Fouché, 2011: 440; Rubin & Babbie, 2010, 33) were used for the purposes of evaluating the PTP. The combination of methodologies is referred to as triangulation. Four structured measuring instruments were utilised for quantitative data collection and the program presenter used two self-developed questionnaires for the qualitative evaluation of the program. According to Cresswell and Plano-Clark (2011: 21) and Delpont and Fouché (2011: 442) the triangulation of measures help us to better understand social phenomena and allow for greater accuracy. This program is based on the following theoretical assumption: If a client oriented PTP, which do not only focus on psychological debriefing as treatment method, but is rather based on a trauma intervention process with both psychological and social components, is developed and implemented in SAPS, the prevalence of PTSD and other co-morbid disorders amongst police officials might be prevented or better managed. The empowerment of police officials through this program includes aspects such as relaxation, trauma narrative, identifying feelings and emotions, rating feelings and affect modulation and dealing with destructive and self-destructive behaviour. Other aspects included are dealing with triggers, problem solving, systems of care, systems advocacy and relapse-prevention.

2. Problem statement

Mthetwa (2013) emphasises the need for a specific focus on the psychological welfare of SAPS officials and the need for more research to enhance the pro-active programs. The before-mentioned implicitly explains the actual motivation and importance of the proposed PTP.

To determine whether the designed PTP as a psycho-social intervention has produced the intended results, it is necessary to evaluate it. Program evaluation includes the systematic collection of information on program activities, characteristics and outcomes of the program to make judgements, improvement of program effectiveness and making suggestions regarding the future use of the program. In the evaluation of a program as a potential method, it should be

borne in mind that it should produce the quantitative and qualitative information required to assess the program's progress towards achieving its desired outcomes.

The research question therefore is:

- How can the effectiveness of the PTP be evaluated, how can it effectively be implemented to police officials at the specialised units within SAPS and how can the program be disseminated?

3. Objective

The objective of this article was to test the proposed PTP within the context of SAPS, to evaluate the program empirically and to disseminate the information.

4. Research methodology

4.1 Research model

The process of intervention research (D & D model) was utilised for this study. D & D is a phase model consisting of six phases (De Vos & Strydom, 2011: 482). According to Fraser *et al.* (2009: 3) intervention research usually involves the design development, implementation and dissemination of an intervention. The third phase, more specifically concentrating on program evaluation, was conducted during this part of the study.

4.1.1 Phase 3: Evaluation and advanced development

This phase of the D & D model comprised the following steps. First the researcher selected a comparison group pre-test and post-test design, to help demonstrate the influencing relationships between the PTP and the behaviours and related conditions targeted for change. During the formal evaluations of the intervention, data were collected and analysed one week before and three weeks after intervention. This was instrumental in the process to confirm or refute the influence of the program. It was important to assess the efficiency of the program after which minor adaptations to the language, content and intervention methods were necessary to produce desired behaviour changes and outcomes. The afore-mentioned procedure was necessary to promote evidence-based practice. (De Vos & Strydom, 2011: 485).

Although dissemination is not included as part of this study, the researcher already published three articles in the following journals: *Social Work/Maatskaplike Werk* (Boshoff *et al.*, 2015: 262-286), *The Social Work Practitioner-Researcher* (Boshoff & Strydom, 2015: 89-117) and *Acta Criminologica* (Boshoff & Strydom, 2015: 12-29). The researcher plan to publish two more articles in international journals for example the *Journal of Psycho-social Rehabilitation*

and Mental Health and the Journal of Social Work and Human Services Practice. (Macfarlane & Bucknall, 2015: 81).

4.2 Design

Mixed-methods research is an approach to inquiry that combines the use of qualitative and quantitative approaches and the mixing of both approaches in a study (Cresswell, 2014: 217). The concurrent convergent strategy was used within the context of the pre-test/post-test comparison group design, during this phase of the study. The purpose of this strategy according to Creswell and Plano-Clark (2011: 77) is “to obtain different but complementary data on the same topic”. The convergent strategy occurs when the researcher uses concurrent timing to implement the quantitative and qualitative strands during the same phase of the research process, prioritises the methods equally, and keeps the strands independent during analysis and then mixes the results during the overall interpretation. The mixed method will at the same time serve as triangulation to improve the validity of the data. Triangulation refers to the researcher using both quantitative and qualitative methods to better understand the phenomenon of interest (Delport & Fouché, 2011: 442). This takes place in the same time frame and with equal weight. During triangulation the strengths and weaknesses of both the quantitative and qualitative methods can be balanced. One can now determine if both methods show the same tendencies (Rubin & Babbie, 2005: 181). For the evaluation of the program the researcher used the pre-test/post-test comparison group design. (Marlow, 2011: 102). This experiment includes two groups namely an experimental group and comparison group. The comparison group received both the pre-test (01) and the post-test (02) at the same time as the experimental group, but did not receive the independent variable.

Grinnell *et al.* (2011: 262) illustrates the comparison group pre-test-post-test-design as follows:

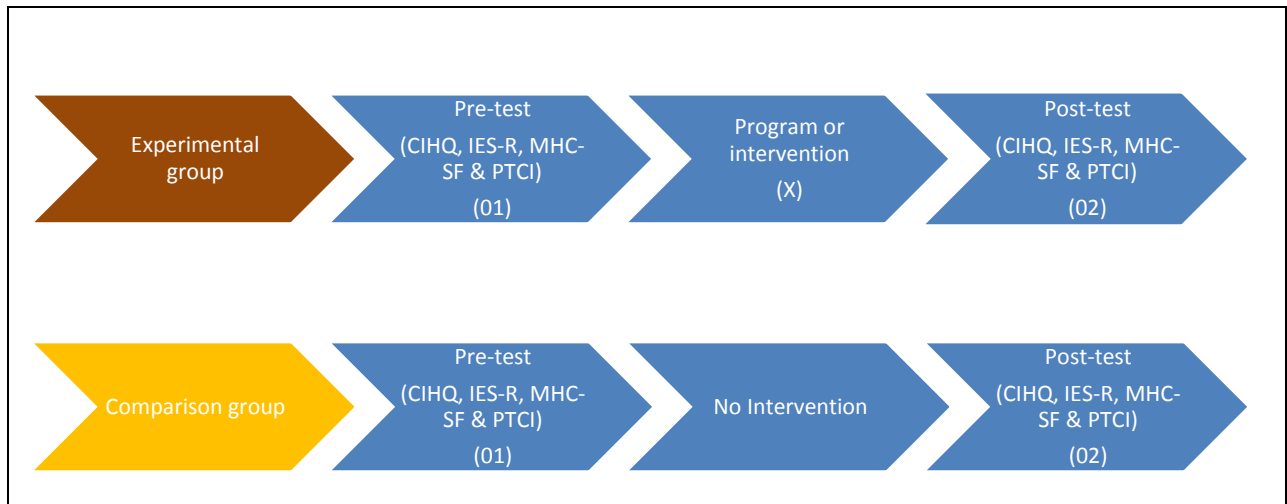


Figure B6-1: Comparison group pre-test-post-test design

The aim of this evaluation was to determine whether the application of the PTP, focusing on certain cognitive, behavioural and social skills to empower, had an influence on the police official's psycho-social well-being considering their repeated exposure to traumatic events. Both groups were exposed to pre-testing one week before the onset of the program and were tested once again within three weeks after the experimental group had completed the group work program.

4.3 Participants

The researcher purposefully selected the Public Order Policing Unit (POP) Potchefstroom for the study. POP is a specialised unit responsible for crowd management in the North West Province and all members are therefore continuously deployed and exposed to traumatic incidents. As a result of different work demands at different times of all the different specialised units within the North West Province and the fact that the researcher was not allowed to interfere with service delivery, it would have been extremely difficult or even unlikely to involve a selection of police officials representing all the different specialised units in the North West Province at one venue and time, hence the selection of POP in Potchefstroom. It should therefore be noted that the outcome of this study is only applicable to POP. A total of 36 police officials stationed at POP in Potchefstroom were purposefully selected based on their availability. They had been exposed to traumatic events and have participated in the first two phases of the Trauma Risk Management Program (TRiM) as discussed in article five. Recruited participants were screened by the Critical Incident History Questionnaire for Police Officials (CIHQ), Impact of Event Scale – Revised (IES-R), Brief Description of the Mental Health Continuum Short Form (MHC-SF) and the Post-traumatic Cognitions Inventory (PTCI) one week

after recruitment. These four instruments are discussed in article five, and are once again discussed in more detail in paragraph 4.5.1 of this article as part of the evaluation of the PTP. The social worker responsible for POP acted as field worker to facilitate the completion of the screening material by means of the group-administered method. The above-mentioned are not diagnostic scales, but gave the researcher an indication of those participants at risk of developing PTSD or any other co-morbid disorders. A total of 28 police officials showed minimum risk for PTSD, therefore qualifying for participation. Patton (2015: 265) describes purposeful sampling as “strategically selecting information-rich cases to study, cases that by their nature and substance will illuminate the inquiry question being investigated”. Strydom (2011: 232) adds that non-probability and specifically purposive sampling as a procedure based entirely on the judgement of the researcher, in that a sample is composed of elements that contain the most characteristic, representative or typical attributes of the population that serve the purpose of the study best. Bell and Waters (2014: 166) are of the opinion that all researchers are dependent on the availability of respondents, and it will probably be difficult for an individual researcher working on a small scale to achieve a true random sample.

For this study, the following criteria were set to identify respondents to be included:

- Respondents should be police official’s attached to POP in Potchefstroom, North West Province;
- Respondents should have been exposed to a traumatic event/s;
- Respondents should have participated in phases one and two of the Trauma Risk Management Procedure (TRiM) as discussed in article five;
- Respondents should not have been diagnosed with PTSD or any co-morbid disorder before;
- Respondents should indicate willingness and be available to participate in the program;
- There should be an equal as possible distribution of respondents for the experimental and comparison groups specifically referring to age, rank, gender, language, qualifications, years of service and marital status as main criteria to have more or less similar groups.

Teddlie and Tashakkori (2009: 186) support the above selection criteria and are of the opinion that the researcher first identifies the subgroups of the population of interest and then selects cases from each sub-group in a purposive manner. This allows the researcher to discover and describe in detail characteristics that are similar or different across the strata of subgroups.” The researcher for the purpose of this article selected respondents from each sub-group according to availability. As a result the subgroups have not exactly been randomly selected.

The descriptive biographical statistics by group is explained in Table B6-1.

Table B6-1: Descriptive biographical statistics by group

ITEM	GROUP 1: EXPERIMENTAL GROUP		GROUP 2: COMPARISON GROUP	
	FREQUENCY	PERCENT	FREQUENCY	PERCENT
AGE				
20-24	-	-	-	-
25-29	-	-	1	6.67%
30-34	6	46.15%	2	13.33%
34-39	2	15.38%	3	20.00%
40+	5	38.46%	9	60.00%
TOTAL	13	100.00%	15	100.00%
RANK	FREQUENCY	PERCENT	FREQUENCY	PERCENT
Constable	9	69.23%	6	40.00%
Sergeant	1	7.69%	-	-
Warrant Officer	3	23.08%	9	60%
Officer	-	-	-	-
TOTAL	13	100.00%	15	100.00%
GENDER	FREQUENCY	PERCENT	FREQUENCY	PERCENT
Male	8	61.54%	12	85.71%
Female	5	38.46%	3	14.29%
TOTAL	13	100.00%	15	100.00%
LANGUAGE	FREQUENCY	PERCENT	FREQUENCY	PERCENT
Afrikaans	1	7.69%	6	40.00%
English	1	7.69%	-	-
Setswana	10	76.92%	8	53.33%
isiXhosa	1	7.69%	1	6.67%
IsiZulu	-	-	-	-
TOTAL	13	100.00%	15	100.00%
QUALIFICATION	FREQUENCY	PERCENT	FREQUENCY	PERCENT
Grade 12	10	76.92%	12	80.00%
Grade 12/higher	3	23.08%	3	20.00%
TOTAL	13	100.00%	15	100.00%

MARITAL STATUS	FREQUENCY	PERCENT	FREQUENCY	PERCENT
Married	6	46.15%	12	80.00%
Committed Relationship	2	15.38%	-	-
Single	3	23.08%	3	20.00%
Divorced	2	15.38%	-	-
Widow/er	-	-	-	-
TOTAL	13	100.00%	15	100.00%
YEARS SERVICE	FREQUENCY	PERCENT	FREQUENCY	PERCENT
1-4	-	-	-	-
5-9	7	53.85%	6	40.00%
10-14	1	7.69%	-	-
15-19	2	15.38%	-	-
20-24	1	7.69%	5	33.33%
25+	2	15.38%	4	26.67%
TOTAL	13	100.00%	15	100.00%

The experimental group consisted of 13 police officials of whom eight were male and five female. Their ages ranged between 30 and 40+. The comparison group consisted of the rest of the police officials (n=15), of which 12 were male and three female, with ages ranging between 25 and 40+. From a total of 28 police officials who participated in the study, the ranks ranged between those of constable to warrant officer, with 15 constables, one sergeant and 12 warrant officers. Non-commissioned officers participated in the study. The largest number of group members, namely 22, had a grade 12 qualification, while six of the police officials have obtained a grade 12 or higher qualification. Most of the group members were in committed relationships, of which 18 were married, two were in committed relationships and one divorced. Only six of the group members were single. Years of experience ranged from five to 25+ years suggesting that this is a more experienced group of police officials. The group was of different ethnic and linguistic origins, with eight white and brown police officials, of which seven were Afrikaans and one English speaking, 20 black police officials of which 18 were Setswana and two were isiXhosa. However, all the participants spoke English well and the program was presented in this language.

4.4 Procedure

The Provincial Head, POP in Potchefstroom has been approached with the aim of obtaining permission for the research project. He acted as gatekeeper whilst the social worker responsible

for POP acted as mediator and assisted the researcher with the initial selection process, during which the process was explained. During this process a total of 36 police officials were purposefully recruited. One week after the above-mentioned process all of these police officials were screened for possible inclusion in the program by using the instruments discussed in point 4.5.1 of this article. A total of 28 police officials met the inclusion criteria. They were then divided into two groups. One group was once again purposefully selected as the comparison group and the other as the experimental group, considering their availability based on their responsibilities at work. All the participants had to sign the informed consent form (Annexure J) provided to them in which they declared their willingness to voluntarily participate in the study. The program (Article five) was preceded by pre-testing one week before intervention and presented over a period of 12 weeks (every Monday or Tuesday). The total duration of the program was 18 hours. The program was presented by the researcher, a social worker and a co-facilitator, the social worker responsible for POP, who also acted as mediator. Feedback was regularly provided to the promoter, who is also a social worker. Post-testing was completed by both the experimental and comparison group three weeks after the last session.

4.5 Data collection and -analysis

For purposes of data collection and analysis for the evaluation of the PTP the researcher used the same measuring instruments as in the screening of participants for inclusion in the PTP as discussed in article five. Data were mostly collected quantitatively by making use of the following standardised scales: Critical Incident History Questionnaire (CIHQ) (Annexure F), the Impact of Event Scale – Revised (IES-Revised) (Annexure G), the Mental Health Continuum Short Form (MHC-SF) (Annexure H) and the Post-Traumatic Cognitions Inventory (PTCI) (Annexure I) and two self-developed questionnaires as survey data procedure, Qualitative and Quantitative Measuring Instrument (Annexure K & L) – Before and after program. Each of these measuring instruments will be discussed in more detail below:

4.5.1 Quantitative data collection

4.5.1.1 The Critical Incident History Questionnaire (CIHQ)

The CIHQ (Annexure F) developed by Weiss *et al.* (2010: 736) is a standardised self-reporting measuring instrument that indexes cumulative exposure to traumatic incidents in police by examining incident frequency and rated severity. In this study the aim of administering the CIHQ was to determine the frequency of exposure to traumatic incidents that could occur over the course of a police official's duty. In response to the above the respondents also had to give an opinion on how difficult it would be for police officials to cope with these types of incidents.

The researchers chose three frequency approaches that were ordered on a continuum of lesser to greater summarisation and categorisation. All preserved zero as a separate response value. Actual Frequency comprised values of 0-9, 15 (midpoint of 10-20), 35.5 (midpoint of 21-50), and 51. Recoded Frequency 4 used an algorithm where 0 = 0, 1-9 = 1, 10-20 = 2, and both 21-50 and 51+ = 3. The last frequency index constructed was termed Variety, as it was conceptualised to emphasise only the variety of types of incidents to which an official had been exposed. Scores on Variety could range from 0-34, with a point given for an item if the official had endorsed any non-zero frequency.

A police official's Nomothetic Severity score summed the average sample severity rating for each item that they had experienced. Idiographic Severity summed the official's own severity rating for each item they had experienced. These two indices were formed to emphasise the discrepancy between police officials' personal views of critical incident impact based on having experienced the incident and a more collected wisdom or normative view for the average official.

As part of a combined approach, one index from the four examined was used. It employed an algorithm that weighted the frequency value of an item by the nomothetic severity rating of that same item; in so doing frequency and severity information was considered simultaneously: Actual Frequency and Nomothetic Severity (Weiss *et al.*, 2010: 737).

In over 700 police official's event severity was negatively correlated ($r_s = .61$) with frequency of exposure. Cumulative exposure indices that varied emphasis on frequency and severity – using both nomothetic and idiographic methods – all showed satisfactory psychometric properties and similar correlates (Weis *et al* 2010: 734).

Both the pre- and post-test data were utilised to determine a link between both frequency and severity and the impact of the PTP.

4.5.1.2 The Impact of Event Scale - Revised (IES-R)

The aim of administering this scale was to measure the respondent's symptom severity for PTSD. The IES-R (Annexure G) is a standardised self-reporting measuring instrument revised by Weiss (2007: 219) that reflects the DSM-IV criteria for post-traumatic stress disorder (PTSD). The original Impact of Events Scale (IES) designed by Horowitz *et al.* (1979) measures two of the four DSM-IV criteria for PTSD; specifically re-experiencing and avoidance. The IES-R was designed to also assess hyperarousal, another of the DSM criteria for PTSD. Other criteria include exposure to a traumatic event, duration of symptoms and impairment due to symptoms.

The IES-R has 22 questions, five of which were added to the original Impact of event scale to better capture the DSM-IV criteria for PTSD. The tool is an appropriate instrument to measure the subjective response to a specific traumatic event especially in the response sets of intrusion (intrusive thoughts, nightmares, intrusive feelings and imagery, dissociative-like re-experiencing), avoidance (numbing of responsiveness, avoidance of feelings, situations, and ideas), and hyperarousal (anger, irritability, hypervigilance, difficulty concentrating, heightened startle), and a total subjective stress IES-R score. The tool can be used with both healthy and frail older adults exposed to any specific traumatic event.

For comparisons with IES scores, some consider using the sum of the avoidance and re-experiencing items. However, the response format in the IES-R assesses symptom severity, 0 = not at all, 1 = a little bit, 2 = moderately, 3 = quite a bit and 4 = extremely). In scoring the IES-R it is important to note that the maximum mean score on each of the three subscales is '4', therefore the maximum 'total mean' IES-R score is 12. Lower scores are better. A total IES-R score of 33 or over from a theoretical maximum of 88 signifies the likely presence of PTSD. The main strengths of this revised measure are that it is short, quick and easy to administer and score and may be used repeatedly to assess progress. It is intended to be used as a screening tool, not a diagnostic test.

The IES-R was designed and validated using a specific traumatic event as a reference in the directions to the patient while administering the tool and while using a specific time frame of the past seven days. The subscales of avoidance and intrusion show good internal consistency. While related, the subscales measure different dimensions of stress response. The hyperarousal subscale added by Weiss *et al.* (2010) has good predictive validity with regard to trauma, while the intrusion and avoidance subscales detect relevant differences in the clinical response to traumatic events of varying severity.

Both the pre- and post-test data were utilised to determine a link between the symptoms of PTSD and the impact of the PTP.

4.5.1.3 The Mental Health Continuum-Short Form (MHC-SF)

The MHC-SF (Annexure H) developed by Keyes *et al.* (2008: 186) is a standardised self-reporting measuring instrument consisting of 14 items that were chosen as the most prototypical items representing the construct definition for each facet of well-being. The items chosen by Keyes *et al.* (2008) for inclusion in the measuring instrument are as follows: three items (happy, interested in life, and satisfied) to represent emotional well-being, six items (one item from each of the six dimensions) to represent psychological well-being, and five items (one item from each of the five dimensions) to represent social well-being. Using a scale of 0 = Never to 5 = every

day, police officials were asked to rate each item in response to the following question: “during the past month how often did you feel...” The response option for the inventory measures the frequency with which respondents experienced each symptom of positive mental health, and provide a clear standard for the assessment and a categorisation of levels of positive mental health. Both the pre- and post-test data were utilised to determine a link between the respondents’ overall positive mental health and the impact of the PTP.

The estimates of internal consistency reliability for each of the three sets of measures – emotional psychological and social well-being has shown excellent internal consistency (>.80) and discriminant validity in adolescents (12-18) and adults in the U.S., in the Netherlands, and in South-Africa (Keyes *et al.*, 2008: 181).

4.5.1.4 The Post-Traumatic Cognitions Inventory (PTCI)

The PTCI (Annexure I) developed by Foa *et al.* (1999: 305) measures respondent’s trauma-related thoughts and beliefs. Many trauma theories hypothesise that traumatic events produce changes in the victim’s thoughts and beliefs and that these changes play an important role in the emotional response to trauma. The items included in the Post-Traumatic Cognitions Inventory (PTCI) derived from clinical observations and current theories of post-trauma psychopathology.

The items in the PTCI represent the following concepts: general negative view of self (27 items), such as “I am inadequate,” “I am a wimp”; perceived permanent change (23 items), such as “I have permanently changed for the worse,” “I will never be able to form close, loving relationships again”; alienation from self and others (4 items), such as “I feel isolated and set apart from others,” “I am different from other people”; hopelessness (7 items), for example, “I have no future,” “Things will never be good again”; negative interpretation of symptoms (7 items), self-trust (5 items); self-blame (17 items), trust in other people (10 items) and unsafe world (10 items). Participants rated each item using a 7 point Likert-type scale from 1 (totally disagree) to 7 (totally agree). Thus, high scores indicate stronger endorsement of negative cognitions (Foa *et al.*, 1999: 305).

Internal consistencies and test-retest reliabilities of the total scale and the three subscales were very good. All PTCI scales predicted PTSD severity, depression, and general anxiety in traumatised individuals. The PTCI discriminated well between traumatised individuals with PTSD and those without PTSD. The latter did not differ from non-traumatised individuals. The results therefore show that the cognitions assessed with the PTCI have a specific association with PTSD. The high specificity of the PTCI in identifying PTSD cases and its high correlation with PTSD severity suggests that the scale is useful as a clinical assessment tool for patients

with PTSD. Both the pre- and post-test data were utilised to determine a link between the respondents' thoughts and beliefs regarding post-trauma exposure and the impact of the PTP.

4.5.2 Quantitative data analysis

The quantitative data in this study were captured and statistically analysed by the North-West University's Statistical Consultation Services. Frequency tables were drawn to describe the socio-demographic variables of the study population. Cronbach alpha reliability coefficients were computed for each measuring instrument's constructs. According to Bajpai (2011: 51) this is important as a measure of internal consistency reliability for multi-item scales. Confirmatory factor analyses (cfa) were done to confirm the construct validity of subtests. According to O'Brien (2007: 142) cfa tests the correlational structure of a data set against the hypothesised structure and rates the "goodness of fit." To formalise the hypothesis that factor analysis is beneficial, Kaiser's measure of sample adequacy (MSA), which is an indicator of factorability for a collection of variables, was computed for each confirmatory factor. According to Coussement *et al.* (2011: 79) the MSA measures whether the strength between the variables is large enough and therefore this index should be at least 0.5 for a satisfactory factor analysis to proceed.

Tailed tests were used because the goal was to determine whether the two groups improved from pre- to post-test, and whether the experimental group fared better than the comparison group after the program. Differences between the experimental and comparison groups were also evaluated before the program and they do differ in most of the variables. A statistical analysis was done so that pre differences between the two groups' would not have an influence on the statistical evaluation of the program on the experimental group. As a result of the fact that the researcher used purposeful sampling based on the availability of respondent's and no random sampling was done, interpretation of comparisons between group means were done according to Cohen's effect sizes, d (Cohen, 1988: 274). Effect sizes indicate practical significance – that is the extent to which a difference is large enough to have an effect in practice (Steyn, 2009: 3). No inferential statistics were interpreted, although p -values are reported as if random sampling was assumed.

The following guidelines were used for d -values regarding differences between means:

- small effect: $d = (0.2)$;
- medium effect (medium effect, noticeable with the naked eye): $d = (0.5)$;
- large effect (practically significant): $d \geq(0.8)$.

4.5.3 Qualitative data collection

Two questionnaires (Annexure K & L) were developed by the researcher for this study with a view to utilise them as qualitative measuring instrument with regard to the PTP. The qualitative

measuring instrument – before program (Annexure K) was developed for pre-testing the experimental group before exposing them to the program specifically referring to their expectations of the program and their overall psycho-social well-being. The second questionnaire, qualitative measuring instrument –after program (Annexure L) was developed for post-testing the experimental group after they had been exposed to the program with a view to evaluate the possible impact of the PTP. It is important to note that the questionnaires are essentially not two separate instruments, but rather questions are set so that the same issues can be measured before and after implementation of the PTP. Open-ended questions (Greeff, 2011: 343) were utilised not to predetermine the answers and they allowed room for the participants to respond in-depth and in their own terms. These questions were developed with the goal to enrich the statistical comparisons by providing possible additional explanations of differences before and after the program. The qualitative focus should therefore be considered as supportive of the quantitative data and findings, to further explore the finer details and nuances of the participants' behaviour which could not be explored by the statistics as indicated. Comments made were therefore very carefully interpreted and used only when clear trends have emerged. The quantitative data and findings therefore remain the main focus of this article. There is strong focus on the extent to which participants were able to integrate the information, look at trauma differently and were able to grow, because it was anticipated that it can give a general impression of participant's ability to apply the focus areas of the PTP to future exposure to traumatic incidents. This commentary has been obtained through the above questionnaires before and after intervention.

4.5.4 Qualitative data analysis

The qualitative data that were collected during this study has been transcribed and analysed according to the eight steps as proposed by Tesch (cited in Cresswell 2014: 198). The findings were categorized according to the themes resulting from the questions. This allowed the researcher to make interpretations of the meaning of the data (Cresswell, 2014: 4). It should once again be emphasised that the qualitative focus should only be considered as supportive of the quantitative data and findings, to further explore the finer details and nuances of the participants' behaviour that could not be explored by the statistics as indicated in paragraph 4.5.3 of this article.

4.5.5 Trustworthiness of the qualitative data-analysis

Rubin and Babbie (2010: 231) are of the opinion that trustworthiness is the prime focus in evaluating the rigour of a qualitative study. It focuses on the extent to which a study can take steps to maximise objectivity and minimise bias. Qualitative data analysis is a particularly subjective procedure and depends largely on the interaction between the participants and the presenter, and the latter's interpretation of verbal and non-verbal communication during the

program. Trustworthiness was therefore increased by mainly applying critical self-reflection, subsequently avoiding subjectivity to influence the interpretation process too much. The researcher furthermore ensured trustworthiness by spending adequate time observing various aspects of the police as an organization, became oriented to their exposure to traumatic incidents as a result of their unique working conditions to appreciate and better understand the context of the situation. In the process the researcher was able to rise above his own preconceptions and was able to build trust. Persistent observation was necessary to identify those characteristics and elements in SAPS that are most relevant to trauma being pursued. Furthermore the researcher made use of member checking to establish the validity of accounts. Preliminary findings were summarised with the intention to ask group members to confirm or refute the accuracy of the research observations and interpretations thereby giving participants the opportunity to correct errors, to volunteer additional information and to assess the adequacy of data and preliminary results. The principle of confirmation is also met by complete recording of reflective notes.

4.5.6 Ethical consideration

The study has been approved by the North-West University, Potchefstroom Campus, ethical committee with approval no: NWU-0007-13-A1 (Annexure M). The allocation of an experimental and comparison group caused problems because police officials attached to POP are as a result of the specialist and sensitive nature of their work, all continuously exposed to traumatic incidents. It would therefore be unethical to expose one group to the program and to deprive the other group. However, it was necessary to use a comparison group to evaluate the program and therefore a group of police officials could not attend the program due to their work conditions were selected as the control group. According to Rodriguez (2013: 360) it is important to note that we need to avoid the unethical, immoral, and impractical traps associated with the concurrent convergent study. This can be accomplished by ensuring that the comparison group participants eventually receive the same benefits of the intervention. The researcher has offered to present the same program to this group of police officials after completion of the intervention process. Unfortunately, no one was interested or available to attend the program.

5. Results

5.1 Descriptive statistics

Descriptive statistics for both groups before and after intervention, as well as the Cronbach's alpha for reliability of the subscales are presented in Table B6-2.

Table B6-2: Descriptive statistics and reliability

CONSTRUCTS	EXPERIMENTAL GROUP				CONTROL GROUP				CRONBACH ALPHA'S
	BEFORE		AFTER		BEFORE		AFTER		
	M	Std	M	Std	M	Std	M	Std	
MHC-SF									
EWB	10.23	3.17	12.23	2.24	10.33	3.90	12.53	1.85	0.74
SWB	13.38	4.91	14.96	5.35	16.60	5.36	16.93	6.77	0.80
PWB	21.69	6.99	24.14	4.85	24.60	3.94	24.27	4.61	0.87
Total	45.35	13.67	51.38	11.32	51.47	10.54	53.68	12.30	0.90
CIHQ									
Incident	49.39	22.02	46.46	12.93	89.38	55.67	81.49	53.88	0.96
Cope	62.44	35.89	69.92	40.93	84.28	29.62	87.54	31.54	0.87
IES-R									
Avoidance	2.03	0.97	1.11	0.75	1.84	0.96	1.28	0.85	0.87
Intrusion	1.63	0.81	1.00	0.66	1.40	0.93	1.23	0.95	0.89
Hyperarousal	1.72	1.07	0.69	0.65	1.07	0.89	1.02	0.91	0.84
Total	5.39	2.68	2.80	1.96	4.31	2.65	3.53	2.62	0.94
PTCI									
Self	2.42	1.36	1.58	0.59	1.77	0.89	1.82	0.80	0.95
World	4.48	1.26	3.59	1.43	4.24	1.42	4.59	1.34	0.71
Selfblame	3.12	1.60	2.23	1.10	2.28	0.91	2.71	1.27	0.73
Total	10.03	3.62	7.40	2.42	8.29	2.56	9.11	2.91	0.77

NOTE – M = Mean; Std = Standard of difference

MHC-SF = Mental Health Continuum (Short Form); CIHQ = Critical Incident History Questionnaire, IES-R = Impact of Event Scale-Revised; PTCI = Posttraumatic Cognitions Inventory

EWB = Emotional Well-being; SWB = Social Well-being, PWB = Psychological Well-being

According to Table B6-2 it is clear that all subscales show satisfactory reliability with reliability coefficients greater than 0.5.

The Cronbach's alpha for the MHC-SF and the different constructs in this study are more or less in agreement with what Keyes *et al.* (2008) found with a group of adolescents (ages 12-18) and adults in the US, in the Netherlands, and in South Africa. In the last mentioned study the MHC-SF has shown excellent internal consistency and validity (>.80).

Cronbach's alpha for the CIHQ and the different constructs in this study are higher than what Weiss *et al.*, (2010: 739) found in a study with 54 police officials. In the last-mentioned study all

alpha coefficients exceeded $>.80$ with the exception of the coefficient of $.75$ for the Variety index. The comparison group in this case also includes police officials which support the suspicion that participant's in this group are more frequently exposed to a wider variety of incidents and that they too find it difficult to cope during the immediate aftermath of traumatic events.

The Cronbach's alpha for the IES-R and the different constructs in this study are more or less in agreement with what Beck *et al.* (2008: 189) found in a study with 182 individuals who had experienced a serious motor vehicle accident. High levels of internal consistency were reported (Intrusion: Cronbach's alpha = $.87-.94$, Avoidance: Cronbach's alpha = $.84-.87$ and Hyperarousal: Cronbach's alpha = $.79-.91$). Although the comparison group in this case did not include members of the police service, it can be anticipated that the impact of the event is more or less the same for participants in SAPS than those exposed to similar traumatic incidents in general.

The Cronbach's alpha for the PTCI and the different constructs in this study are lower on all the constructs in comparison with what Foa *et al.* (1999: 307) found in a study with 601 volunteers who had experienced a traumatic event and had moderate to severe PTSD. Cronbach's alpha for the three PTCI constructs and total scores were as follows: negative cognitions about self = $.97$; negative emotions about the world = $.88$; self-blame = $.86$ with a total score of $.97$. Although the comparison group in this case all experienced traumatic events, they had moderate to severe PTSD. Participants in the study were all exposed to a variety of traumatic events, but they only experienced mild to moderate signs and symptoms of post-traumatic stress. None of the participants had been diagnosed with PTSD which explains the lower average scores.

5.2 Differences within groups

Tables B6-3 and B6-4 respectively indicate the differences within the experimental and comparison groups, more specifically the manner in which dependent groups differ before and after intervention.

Table B6-3: Descriptive statistics and effect sizes on psychometric constructs within the experimental group on differences between pre- and post-tests

Construct	N	Pre-test Mean	Std	Post-test Mean	Std	p-value	d-value
MHC-SF							
EWB	13	10.32	3.17	12.23	2.24	0.05*	0.63 ^Δ
SWB	13	13.38	4.91	14.96	5.35	0.12	0.32
PWB	13	21.69	6.99	24.14	4.85	0.09	0.35
TOTAL	13	45.35	13.67	51.37	11.32	0.03*	0.44
CIHQ							
Incident	11	49.39	22.02	46.46	12.39	0.31	0.11
Cope	11	62.44	35.89	69.92	40.93	0.39	0.12
IES-R							
Avoidance	13	2.03	0.97	1.11	0.75	0.05*	0.96 ^{ΔΔ}
Intrusion	13	1.63	0.81	1.00	0.66	0.05*	0.80 ^{ΔΔ}
Hyperarousal	13	1.72	1.07	0.69	0.65	0.05*	0.96 ^{ΔΔ}
Total	13	5.39	2.68	2.80	1.96	0.05*	0.97 ^{ΔΔ}
PTCI							
Self	13	2.42	1.36	1.58	0.59	0.05*	0.62 ^Δ
World	13	4.48	1.26	3.59	1.43	0.02*	0.71 ^Δ
Self-blame	13	3.12	1.60	2.23	1.10	0.01*	0.56 ^Δ
Total	13	10.03	3.62	7.40	2.42	0.05*	0.73 ^Δ

Note – N = number of participants; Std = standard of difference; p-value = statistical significance; d-value = effect size

MHC-SF = Mental Health Continuum-Short Form; CIHQ = Critical Incident History Questionnaire; IES-R = Impact of event scale-Revised; PTCI = Posttraumatic Cognitions Inventory

EWB = Emotional well-being; SWB = Social well-being; PWB = Psychological well-being

*** = Statistically significant at ≤ 0.05 level according to t-test results within groups**

^Δ = Medium effect in practice

^{ΔΔ} = Practical effect in practice

According to table B6-3 there was a practically significant effect ($d = 0.80$) in the mean differences between the pre- and post-test of the experimental group regarding the total IES-score and all its subtests. This means that the mean differences between the pre- test for total

IES, avoidance (m = 2.03), intrusion (m = 1.63), and hyperarousal (m = 1.72) is significantly higher than total IES, avoidance (m =1.11), intrusion (m = 1.00) and hyperarousal (m = 0.69) for the post-test. Therefore the intervention had a practically significant effect on the decrease of total IES, avoidance, intrusion and hyperarousal.

There was a medium practical effect (d = 0.50) on the mean difference between the pre-and post-test of the experimental group at the construct EWB. This means that the mean difference for EWB (m = 10.32) of the experimental group is higher than the mean difference of EWB (m = 12.23) of the comparison group and therefore noticeable with the naked eye. Therefore the intervention had a medium practical effect on the improvement of the respondents EWB.

There was also a medium practical effect (d = 0.50) on the mean differences between the pre-and post-test of the experimental group regarding the total PTCI score and all the subsets. This means that the mean differences between the pre- test for total PTCI, self (m = 2.42), world (m = 4.48) and self-blame (m = 3.12) is higher than total PTCI self (m = 1.58), world (m = 3.59) and self-blame (m = 2.23) for the post-test. Therefore the intervention had a medium effect on the decrease of self, world and self-blame. These improvements are an indication that the program could succeed to improve some aspects of the respondent’s mental health, impact of the event, and certain negative cognitions of self and the world.

Table B6-4: Descriptive statistics and effect sizes on psychometric constructs within the control group on differences between pre- and post-tests

Construct	N	Pre-test Mean	Std	Post-test Mean	Std	p-value	d-value
MHC-SF							
EWB	15	10.33	3.90	12.53	1.85	0.04*	0.56 ^Δ
SWB	15	16.60	5.36	16.93	6.77	0.41	0.06
PWB	15	24.60	3.94	24.26	4.61	0.39	0.08
Total	15	51.47	10.54	53.68	12.29	0.24	0.21
CIHQ							
Incident	14	89.38	55.67	81.49	53.88	0.27	0.07
Cope	15	84.28	29.62	87.54	31.54	0.28	0.11

IES-R							
Avoidance	13	1.84	0.96	1.28	0.85	0.03*	0.59 ^Δ
Intrusion	13	1.40	0.93	1.23	0.95	0.19	0.19
Hyperarousal	13	1.07	0.89	1.02	0.91	0.43	0.05
Total	13	4.31	2.65	3.53	2.62	0.13	0.30
PTCI							
Self	15	1.77	0.89	1.82	0.80	0.36	0.05
World	15	4.24	1.42	4.59	1.34	0.18	0.25
Self-blame	15	2.28	0.91	2.71	1.27	0.09	0.47
Total	15	8.29	2.56	9.11	2.91	0.10	0.32

Note – N = number of participants; Std = standard of difference; p-value = statistical significance; d-value = effect size

MHC-SF = Mental Health Continuum-Short Form; CIHQ = Critical Incident History Questionnaire; IES-R = Impact of event scale-Revised; PTCI = Posttraumatic Cognitions Inventory

EWB = Emotional well-being; SWB = Social well-being; PWB = Psychological well-being

*** = Statistically significant at ≤ 0.05 level according to t-test results within groups**

^Δ = Medium effect in practice

According to Table B6-4, EWB in the comparison group show an improvement from the pre- to the post-test, with a medium practical effect ($d = 0.56$) – compared with a medium practical effect ($d = 0.63$) in the experimental group. Despite this improvement EWB still show an improvement from the comparison group. Avoidance in the comparison group also improved with a medium practical effect ($d = 0.59$) - compared with a practically significant effect ($d = 0.96$) in the experimental group. Avoidance therefore also shows an improvement from the comparison group. No other differences occurred between pre- and post-testing.

5.3 Differences between groups

Table B6-5 indicates the difference between the experimental and comparison group, more specifically the two groups comparatively changed from the pre-to post-test.

Table B6-5: Descriptive statistics and effect sizes for differences between the experimental and control groups

Construct	Group	N	Mean Difference	Std of difference	p-value	d-value
MHC-SF						
EWB	1	13	2.00	1.47	0.44	0.04
	2	15	2.20	4.54		
SWB	1	13	1.58	4.57	0.26	0.22
	2	15	0.33	5.69		
PWB	1	13	2.45	5.83	0.08	0.50 ^Δ
	2	15	-0.33	4.03		
Total	1	13	6.03	10.55	0.19	0.32
	2	15	2.21	11.91		
CIHQ						
Incident	1	11	-2.43	15.81	0.42	0.07
	2	14	-4.15	24.21		
Cope	1	11	-2.43	-13.05	0.42	0.07
	2	14	-4.15	-18.13		

IES-R						
Avoidance	1	13	-0.93	1.01	0.18	0.35
	2	15	-0.57	1.04		
Intrusion	1	13	-0.63	0.70	0.05*	0.61 ^Δ
	2	15	-0.18	0.76		
Hyperarousal	1	13	-1.03	0.77	0.05*	1.11 ^{ΔΔ}
	2	15	-0.04	0.88		
Total	1	13	-2.59	2.29	0.03*	0.70 ^Δ
	2	15	-0.79	2.57		
PTCI						
Self	1	13	-0.85	1.14	0.01*	0.80 ^{ΔΔ}
	2	15	0.04	0.47		
World	1	13	-0.90	1.32	0.01*	0.85 ^{ΔΔ}
	2	15	0.35	1.47		
Self-Blame	1	13	-0.89	1.16	0.05*	1.11 ^{ΔΔ}
	2	15	0.43	1.19		
Total	1	13	-2.63	3.10	0.05*	1.12 ^{ΔΔ}
	2	15	0.82	2.41		

Note – 1 =experimental group; 2 = control group; N = number of participants; M = Mean difference; Std= standard of difference; p-value = statistical significance; d-value = effect size

EWB = Emotional well-being; SWB = Social well-being; PWB = Psychological well-being

* = Statistically significant at ≤ 0.05 level according to t-test results for independent groups

^Δ = Medium effect in practice

^{ΔΔ} = Practical effect in practice

According to Table B6-5 there was a practically significant effect ($d = 0.80$) in the mean differences between the experimental and control groups at the construct hyperarousal. This

means that the mean difference for hyperarousal ($m = 1.03$) of the experimental group is significantly higher than the mean difference for hyperarousal ($m = 0.04$) of the comparison group.

There was also a practically significant effect ($d = 0.80$) in the mean differences between the experimental and control groups for the total PTCL and all its subsets. This means that the mean differences for the total PTCL, self ($m = 0.85$), world ($m = 0.90$) and self-blame ($m = 0.89$) is significantly higher than total PTCL, self ($m = 0.04$), world ($m = 0.35$) and self-blame ($m = 0.43$) of the comparison group.

Therefore changes in the experimental group's mean score from pre- to post-test for the above-mentioned variables were practically more significant than those in the comparison group.

There was a medium practical effect ($d = 0.50$) in the mean differences between the experimental and comparison groups at the construct PWB. This means that the mean difference for PWB ($m = 2.45$) is higher than the mean difference for PWB ($m = 0.33$) of the comparison group.

There was also a medium practical effect ($d = 0.50$) in the mean differences between the experimental and control groups for the total IES-R and one of its subsets. This means that the mean differences for the total IES-R ($m = 2.59$) and intrusion ($m = 0.63$) are higher than the total IES-R ($m = 0.79$) and intrusion ($m = 0.18$) of the comparison group.

Changes in the experimental groups mean score from pre- to post-test for before-mentioned variables were practically more noticeably visible than those in the comparison group.

These improvements are an indication that the program did succeed to improve some aspects of the respondent's mental health, impact of traumatic events and certain negative cognitions of self and the world.

5.4 Responses from the qualitative measurement – before intervention

As part of Section A and B of the qualitative and quantitative measuring instrument – before program, the respondents had to answer 13 questions regarding their expectations of the program (eight questions) and their overall psycho-social wellbeing (five questions) Examples of respondent's personal views are cited to illustrate the above.

Table B6-6 is a summary of participant's comments. Examples of the group member's personal views are cited to illustrate the above.

Table B6-6: Questions and responses of the qualitative and quantitative measuring instrument – before the program

SECTION A: EXPECTATIONS OF THE PROGRAM	
QUESTIONS	EXAMPLE OF RESPONSES
What do you as a police official expect to gain from the program?	<ul style="list-style-type: none"> • “To learn how to deal with trauma when you don’t get enough support like we do” • “More knowledge and skills to handle trauma in future, how to cope” • “To take SAPS forward not as individuals but as a team. Members will feel safe and secure, it will give us direction and repositioning, gaining knowledge” • “To learn how to free your mind and relax”
What topics would you like to be included in a PTP for police officials?	<ul style="list-style-type: none"> • “Psychological and physical health” • “Relationship with family” • “Conflict in SAPS” • “Financial management” • “Skills to cope with trauma” • “Communication between management and the members” • “Drug abuse” • “Police rights” • “Personal feelings” • “Social support” • “Planning for the future” • “How to deal with contingencies”
How do you envisage that this program will influence your life?	<ul style="list-style-type: none"> • “It will influence my life and health condition positively, it will help me stand up for what I believe in” • “That I will become strong in my job, my life to cope with my family after work, to exclude people who don’t know what I have been going through and to accept life” • “It will really help to put the past in the past and not

	<p>to blame myself for any situation good or bad, no matter the outcome, and help me to be equipped for any traumatic situation that I might encounter in future”</p> <ul style="list-style-type: none"> • “To understand the processes that you go through and help you to understand that trauma is not your fault”
<p>What is your expectations regarding the overall quality of the program?</p>	<ul style="list-style-type: none"> • “To benefit each and every member of this organisation” • “How to live your life after trauma/stress” • “For it to succeed” • “Professional and high quality” • “Honesty, openness and sincerity”
<p>What is your expectations regarding the style of presentation?</p>	<ul style="list-style-type: none"> • “It must be professional and reach the target” • “To be informal” • “Interactive group discussions” • “Good understanding and feedback” • “Informative presentations, so that not only myself can benefit but to enable me to assist other colleagues as well” • “Confidentiality must be maintained”
<p>Are you of the opinion that confidentiality will be maintained?</p>	<ul style="list-style-type: none"> • “I am not sure” • “I hope that confidentiality will be maintained as promised” • “If you are given the insurance, you trust that it will be” • “Yes, I believe professionals must maintain it” • “Not negotiable, confidentiality must be maintained”

<p>What are your expectations regarding the duration of the sessions?</p>	<ul style="list-style-type: none"> • “Two hours at least” • “Police management must allow more time for police officials to attend these programs” • The duration should be of such a nature that members do not get tired or bored” • “To be flexible”
<p>What are your expectations regarding the duration of the program as a whole?</p>	<ul style="list-style-type: none"> • “Continuously, because our problems does not end on a certain time, as we are faced with trauma every day” • “Once a week until the person is fine” • “Not to try to solve problems or do presentations in the shortest possible time, it takes time to heal” • “The program must accommodate my working schedule”

SECTION B: PSYCHO-SOCIAL WELL-BEING

<p>How do you feel about your future?</p>	<ul style="list-style-type: none"> • “I am blessed because I have a job, shelter and food on the table” • “I actually feel my future is bright, but sometimes I am so negative because of all the corruption in our country” • “I try to go on with my life and take it like the previous day, to roll away the stones in my way and continue to be positive” • “There is little prospects”
<p>How do you feel about your overall psycho-social wellness?</p>	<ul style="list-style-type: none"> • “I feel everything is still ok and I am ready for any challenge that may come my way” • “I am in a good state of mind and aware of everyday life situations, that life is full of surprises, that one must be aware of” • “Mentally I am ‘okay’; unfortunately there are a lot of thorns that makes it somewhat difficult. There is always problems at work and it frustrates me a lot” • “My psycho-social well-being is not well cause I have to look after my family and I don’t see any

<p>How do you feel about your work as a police official?</p>	<p>progress for me in the future”</p> <ul style="list-style-type: none"> • “I love my work and I feel I have to serve my community to the best of my ability” • “I am really proud to be a police official, to serve my government and my people. It is however very difficult to be confronted with people who do not recognise SAPS. The environment of a non-compliance society is really stressful” • “I feel overloaded, cause every day I am facing danger, I am not safe even my family too” • “To expect the unexpected at anytime”
<p>How do you feel about your family?</p>	<ul style="list-style-type: none"> • “I love them so much because they support me whenever I’m going through difficult times at work, and most of the time they are the people I open up to when I’m hurt” • “Especially my husband, he listens to me” • “It’s bad for my family. I have to leave them for special duties for a very long time because of unpredictable work. I always work long hours” • “I feel that they are not protected or safe, anything can happen to them as a result of the work that I am doing” • “I want to protect my family because I am all they have & I am also the breadwinner”
<p>What do you think is the biggest problem regarding police official's exposure to traumatic events in SAPS?</p>	<ul style="list-style-type: none"> • “Management do not respond in time and the community does not always understand” • Police end up taking their lives; others will book off sick or abuse alcohol on or off duty. Some are aggressive with their fellow workers and family members. This is because police stress are neither recognised nor understood. They do not get professional help” • “The SAPS is full of inexperienced leadership. They are not pro-active but rather wait for something to happen. It is full of tricks. We are

	<p>always caught off guard, there is poor communication and they are always blaming us”</p> <ul style="list-style-type: none"> • “The organisation must take responsibility and put something in place to support traumatised police officials”
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5.5 Responses from the qualitative measurement –after intervention

As part of Section A and B of the qualitative and quantitative measuring instrument – after program, the respondents had to answer 15 questions regarding their experience of the program (nine questions) and their overall psycho-social wellbeing (six questions). Examples of respondent’s personal views are cited to illustrate the above.

Table B6-7 is a summary of participant’s comments. Examples of the group member’s personal views are cited to illustrate the above.

Table B6-7: Questions and responses of the qualitative measuring instrument – after the program

SECTION A: EXPERIENCE OF THE PROGRAM	
QUESTION	RESPONSES
<p>What did you as a police official gain from the program?</p>	<ul style="list-style-type: none"> • “Skills and knowledge on how to process trauma and better deal with stress and depression” • “Everything has a solution through the information acquired from the program” • “Always do things positive and think positive” • “Knowledge about trauma, stress and the symptoms after exposure” • “How to control your breathing, how to recognise when you need help, how to cope” and not to worry about perceptions”

<p>Which of the topics included in the PTP had the most value for you?</p>	<ul style="list-style-type: none"> • “Identifying feelings and emotions through different faces which will help in terms of identifying a certain personal feeling” • “All the sessions had a positive impact but, the information on trauma and how to handle the symptoms was valuable” • “Challenging maladaptive feelings and thoughts by using the STOPP principle” • “Relapse prevention. It was a summary of all the sessions and it helped me to put everything learned together and how to cope in future”
<p>Which of the topics had the least value to you?</p>	<ul style="list-style-type: none"> • “None, all topics had value to me” • “None, all the topics flow together and form a ‘language’ as a whole”
<p>Which other topics would you have preferred to be included as part of the content of the program?</p>	<ul style="list-style-type: none"> • “Meditation and prayer which will help regarding alleviation of negative feelings” • “All the topics are included in the program” • “To possibly pick up signs earlier with other members before it causes a problem” • “How to deal with a control freak as a leader” • “None”
<p>How did you experience the overall quality of the program?</p>	<ul style="list-style-type: none"> • “It is a very informative program as it uplift the skill of a person to solve overall, or different problems of life, for the person or the other person” • “High quality, it gave us much time to get to know each other since we have different situations in our lives and ideas” • “Of a good standard, life changing” • “The quality of this program was very good because it was clear and understandable, straight to the point”

<p>How did you experience the presentation style?</p>	<ul style="list-style-type: none"> • “Very open for discussion” • “Very active between the tutor and the participants to keep them lively, talkative during the group session” • “It was fantastic and the presenter was so friendly and he tried his best to pay attention to everyone’s problems” • “Fair and professional” • Members had the opportunity to voice their feelings and concerns”
<p>Are you of the opinion that confidentiality has been maintained?</p>	<ul style="list-style-type: none"> • “As a group, definitely” • “Very much, whatever we discussed it ended in the group, didn’t discuss it outside. That was professional” • “Yes and the presenter also promised us that confidentiality will be maintained” • “To me it was maintained as we signed an oath of secrecy, the presenter also promised that no information will be discussed or nobody will be identified”
<p>How did you experience the duration of the sessions?</p>	<ul style="list-style-type: none"> • “The duration of the sessions was somewhat too short, a lot of information, so we need more time for interpretation” • “Reasonable but faces certain challenges due to work related issues of members” • “The duration was very good” • “The duration was enough and helped us to uplift our spirit”
<p>How did you experience the duration of the program as a whole?</p>	<ul style="list-style-type: none"> • “The time between sessions is enough to process everything and take it in and then to apply in our daily lives” • “A pleasant one but we had to always postpone the work due to work related matters” • “This should be an ongoing program not only for those who experienced trauma, but also as a pro-

	<p>active measure”</p> <ul style="list-style-type: none"> • “Management should buy into the program and allow us to attend for the full duration of the program”
SECTION B: PSYCHO-SOCIAL WELL-BEING	
<p>How do you feel about your future?</p>	<ul style="list-style-type: none"> • “I am more than before able to help myself with life pressures” • “My future will be bright because I have gained the knowledge on how to deal with PTS” • “Positive. Have a way of doing and facing the challenges. I have knowledge” • “I feel happy. This program should be presented to all the members of the SAPS and their families, not only after an incident, but regularly during the course of their career”
<p>How do you feel about your overall psycho-social wellness?</p>	<ul style="list-style-type: none"> • “Life is unpredictable but all problems can be overcome” • “Positive. It gave me guidance in dealing with my well-being, situations that I’m facing daily” • “Is very good especially in my organisation, we experience traumatic incidents and come across challenges” • “There were things that I did not understand about myself like feeling of anger, worthlessness, outburst and how to deal with it....Now I know why things happen to people and how to cope with it”
<p>How do you feel about your work as a police official?</p>	<ul style="list-style-type: none"> • “I will always be faced with traumatic events in my work, but I have to be able to process and cope in order for me to continue” • “Good, but still I feel that we as low ranking police officials we are not taken into consideration” • “I love my job and the organisation, the only problem is that there is no communication between top management the workers on the ground”

	<ul style="list-style-type: none"> • “Positive, love my work. I accept that it has it’s unique challenges”
<p>How do you feel about your family?</p>	<ul style="list-style-type: none"> • “I was not talking to much about the trauma at work with my family but now I can tell them why I am in this mood and what happened at work, they understand things better now” • “Positive, the support being there during difficult times” • “My family is always bad with me and upset, there is a gap between me and my family. With the skills of conflict management and good communication I hope to overcome it” • “Feel proud of my family and I feel I’m important to them”
<p>Considering the information gathered during this program, what do you think is the biggest problem regarding police official’s exposure to traumatic events in SAPS?</p>	<ul style="list-style-type: none"> • “Lack of training, lack of information and compensation” • “Lack of support, EHW not responsive in time” • “Lack of information, management expect more from members while they deliver less, mostly we wait until the situation is out of control” • “No management support, traumatic incidents are not taken seriously”
<p>Since you have completed this program, what is different in your life?</p>	<ul style="list-style-type: none"> • “I am more than before able to help myself and life pressures” • “I know how to move ahead, and how to build on the past” • “I am a better person than before” • “I know how to deal with trauma but I will also be able to help other colleagues”

As part of Section C of the quantitative measuring instrument before and after the program, the respondents had to rate their own attitude and knowledge with regard to the different topics included as part of the program.

The values of the ratings for interpretation are the following:

- 1 = very bad
- 3 = average
- 5 = very good

The average of respondent’s ratings is expressed as a percentage (before and after the program) and are discussed together with their qualitative responses - after program in Table B6-8.

Table B6-8: Results of qualitative and quantitative evaluation (group member’s attitude and knowledge)

SECTION C: ATTITUDE AND KNOWLEDGE REGARDING TOPICS			
SUBJECT	AVERAGE SCORE (%) BEFORE PRO-GRAMME	AVERAGE SCORE (%) AFTER PRO-GRAMME	QUALITATIVE RESPONSE AFTER PROGRAM
Trauma	61.5	76.0	<ul style="list-style-type: none"> • “Shooting incidents, motor accidents, murder scenes, rape etc.” • “It can happen anytime, anywhere how to cope with it is important. One must immediately attend to the reactions to prevent more serious problems” • “The traumatic event is the trigger to certain signs and symptoms; I realise that each person will react differently, and even after treatment people will have different outcomes” • “Good attitude I now know how to deal with trauma” • “Normal reaction to an abnormal event”

Relaxation	72.0	78.2	<ul style="list-style-type: none"> • “The muscle exercises is very helpful” • “Make time for yourself” • “Listen to music, watch sport” • “To take a few deep breaths, helps you to relax and to think clearly”
Remembering and re-telling	46.2	51.7	<ul style="list-style-type: none"> • “It helps to talk about it, but one should be careful not to put too much emphasis on the incident. Rather find a way to better deal with the memories” • “We have openly spoken about traumatic incidents in order to differentiate between the now and the past, to put it behind us” • “Traumatic events have to be taken very seriously as it can affect and change your life in a negative way, I am not sure whether sharing with anyone is the best solution” • “Positive, to share is better than keeping it for yourself, it help with the healing process”
Emotions, feelings and thoughts	44.4	75.6	<ul style="list-style-type: none"> • “I normally suppress my emotions, but now I know how to recognise and face them, not to be afraid to talk about it” • “The ABC’s of emotions helped me to look at the chain of events from the actual event to the psychological and social consequences” • “Now I understand the link between emotions, feelings and thoughts” • “One of the exercises helped us to pin point the feelings in our body, it really helped me to feel the emotion”

Negative emotions	64.2	76.8	<ul style="list-style-type: none"> • “Take the present situation as real and not that one happening in the past, stop and breath look at the incident from a distance to get perspective and decide whether the emotions is valid or not” • “It is extremely important to be able to identify and express your emotions” • “Not to avoid but to face your emotions” • “To replace negative emotions and feelings with positive ones” • “Different incidents bring out different responses”
Altered thinking	65.6	72.3	<ul style="list-style-type: none"> • “The ABCDE’s of emotions helped me to look at the chain of events from the situation adding challenging the belief in order to find an entirely new thought or behaviour” • “We always tend to think negatively or surround ourselves with people, doing negative talk, rather think positively and surround yourself with positive people” • “The STOPP the thought technique help you to re-focus your thoughts, to think flexibly and to divert from whatever negative thoughts you might have” • “It is not always easy to stay positive when you feel depressed and find the whole world on your shoulders”
Destructive and self-destructive behaviour	61.2	69.4	<ul style="list-style-type: none"> • “Sometimes you do not have hope, you feel depressed, blame yourself, you have negative thoughts, keep people at a distance, you try to forget by drinking and even consider suicide” • “Be aware of the warning signs and look at your safety plan and get professional help”

			<ul style="list-style-type: none"> • We learned certain techniques and practices to deal with anger and conflict” • “Alcohol abuse is part of the police culture it is a way of coping” unfortunately it destroys people’s lives”, we learned skills to help us cope with the craving” • “Police are at risk for suicide, be on the lookout for the risk factors not only for yourself but also for others”
Problem solving	68.2	76.7	<ul style="list-style-type: none"> • “Talk more to professionals” • “Identify incidents that cause trauma. Ask for help don’t pretend to be strong on trauma attack” • “The COPE exercise shows you step by step how to look at your problems. You decide on possible solutions, look at the pros and cons and afterwards decide whether it was successful or not before your look at alternatives” • “Pray a lot, relax, speak to someone you trust”
Trigger events	65.6	78.2	<ul style="list-style-type: none"> • “Once again the STOPP the trigger worksheet include about six steps to help you to re-focus your thoughts and to divert from whatever reminds you of the incident for example smell, objects or noises” • “Now I understand why the sound of a fire remind me of the person who was burned alive, loud noise remind me of the vehicle collision” • “I got the opportunity to identify my own triggers” • “These reactions is only natural and not dangerous, avoiding it will only

			strengthen your anxiousness and you will never learn that you are safe”
Relationship with others	59.4	74.3	<ul style="list-style-type: none"> • “You distance yourself from others. The sessions concentrating on conflict management and communication styles helped a lot” • “I may be involved in conflict with my family and colleagues at any time so I must be alert and control my anger and know how to manage conflict” • “I have knowledge I know I have to involve the social worker during difficult events in my life to help my family understand and to better my relationships with others” • “Hugh impact on the family, they do not always understand your working conditions and why you act the way you do” • “Pushing them away and isolating from them, is not going to solve the problem”
Systems advocacy	38.5	41.2	<ul style="list-style-type: none"> • “Trauma does have an impact on yourself, your work, colleagues, friends and family like a ripple effect outwards, but the ripple effect might also be from the outside in” • “It is important to be aware of the different resources in SAPS and the community at large, also to be aware of your rights with regards to services and support” • “The society in which I am living church the family and the work I am employed must regard and recognise me as a person” • “Utilise all resources in the police and

			the community to the benefit of myself and my family”
Relapse prevention	49.6	77.9	<ul style="list-style-type: none"> • “When you are faced with a situation, try to process it immediately otherwise it will digest you from the inside. It doesn’t matter whether it is a traumatic incident, financial- or relationship problems. • “Don’t avoid it, socialise, join group therapy, deal with the problem do not bury it” • “Take what was learned and implement in real life” • “Always keep calm, control your breathing, assess the situation and decide on workable solutions” • “STOPP, identify, relax, face the feeling and find a alternative way of dealing with it”
AVERAGE SCORE (ALL SUBJECTS)	58.0	70.7	

All the respondents (n=13) from the experimental group completed Section C of the qualitative measuring instrument – after program. The researcher calculated average scores in Section C, considering the total of all the respondent’s ratings with regard to the 12 subjects. The ratings are expressed in percentages. The narratives can be regarded as representative of what respondents had to say on this issue.

The average scoring regarding the group member’s attitude and knowledge improved with 12.7% from 58.0% to 70.7%. According to the scoring summarised in Table B6-8, there was a perceived improvement regarding group member’s attitude and knowledge on all the topics included in the PTP. The topic on systems advocacy is the only topic showing a small perceived improvement of 2.7%. The topics on remembering/re-telling, relaxation, altered thinking, destructive and self-destructive behaviour and problem solving show an average perceived improvement ranging between 5.5% and 8.5%. The topics on trauma, emotions, feelings and thoughts, negative emotions, trigger events, relationship with others and relapse prevention showed larger perceived improvements ranging from 12.6% to 31.2%

According to the respondents' qualitative responses (as indicated in table B6-8), their attitude and knowledge regarding the following topics improved considerably: Trauma, Relaxation, Identifying emotions, Feelings and thoughts, Dealing with negative emotions, Altered thinking, Challenging destructive and self-destructive behaviour, Effective problem solving, Managing trigger events, Relationship with important others, and Relapse prevention. There was a moderate perceived improvement on remembering/re-telling and systems advocacy.

6. Discussion

The PTP, developed for this study, definitely brought about a significant, positive change with regards to police officials overall knowledge of trauma and the acquisition of knowledge and skills to improve their mental health, better cope with the impact of traumatic events and the ability to change trauma-related thoughts and beliefs. This assumption is made because one construct of the MHC-SF improved with medium practical effect, four constructs of the IES-R scale improved with practical significant effect while four constructs of the PTCL improved with medium practical effect in the experimental group. In addition all these constructs were sustainable three weeks post intervention.

The researcher looked at the results as a whole and therefore integrated and evaluated the quantitative and qualitative data, which contributed to a better understanding of the social phenomena and allowed for greater accuracy which could serve as basis for adjustments to the program for future utilisation.

The reliability of the MHC-SF was calculated and all three the constructs were regarded as reliable. After the program intervention, the experimental group measured a noticeable difference regarding EWB. Not only did EWB visibly improve in the experimental group but also in the comparison group. The comparison group therefore also indicates a medium practical effect on the improvement of the respondent's EWB. It is therefore not clear whether the improvement in the experimental group is due to the program or perhaps due to something else that also occurred in the control group. There are no visibly significant differences in any of the other constructs in the comparison group after post-testing. In the test between groups, psychological well-being showed a medium practical difference after the experimental group had been exposed to the program. None of the other constructs measured any significant differences.

However, from the qualitative observations concerning the experimental group – post intervention, it was clear that some of the respondent's EWB, SWB and PWB had improved significantly. They were positive as they appeared to have gained strategies for effective problem solving. One of the participants mentioned the following: "There were things that I did

not understand about myself like feelings of anger, worthlessness, outbursts and how to deal with it. Now I know why things happen to people and how to cope with it” Aspects of the program that most probably enhanced problem solving was the completion of the pros, cons and positive-negative consequences worksheets. These exercises and worksheets are included in session eight of the PTP, during which group members were educated with regards to possible indications, and contraindications, and strategies for effective problem solving.

Other group members mentioned that they are as a result of the intervention program fully dependent on the support and care of their family, friends and colleagues which is indicative of improvement in SWB. This dependency re-enforces trust in others, the world, and themselves after a traumatic event has occurred. One of the group members quoted the following: “I love my family so much because they support me whenever I’m going through difficult times at work, and most of the time they are the people I open up to when I’m hurt.” Aspects of the program that concentrated on systems of care were psycho-education on how PTSD affects families, friends and colleagues, and exercises about trust and betrayal, intimacy and connectedness and the maintenance of good relationships. During session ten of the PTP group members were informed regarding trust and intimacy in relationships. According to the DSM-5, trauma could cause symptom characteristics that cause clinically significant distress or impairment of emotional, social, psychological or other important areas of functioning (American Psychiatric Association, 2013: 265). In a study by Goetzinger (2008: 134) concerning caregivers well-being and satisfaction, it was confirmed that emotional well-being in particular appear to be enhanced with the use of active coping strategies and when recipients access additional social support. The assumption can thus be made that the intervention did have a perceived improvement regarding the respondents, emotional-, social- and psychological well-being.

All three of the subscales of the IES-R are showing satisfactory reliability. After program intervention, the experimental group measured a practically significant difference regarding avoidance, intrusion and hyperarousal. The total for all three the constructs also measure a practically significant difference. Both intrusion and hyperarousal as constructs in the comparison group measured no statistically significant difference whilst avoidance indicated a medium practical effect. However, the experimental group’s post avoidance score was higher than the comparison groups post-test score, meaning that the intervention on avoidance did have an effect. The total score for the IES-R on differences within the comparison group measured no practical significant difference. In the test between groups hyperarousal measured a statistically significant difference. Intrusion had a medium practical effect while avoidance had no practical effect. The total of the IES-R measure a medium practical difference between groups. In the test between groups there was a medium practical difference after the experimental group had been exposed to the program. The change in the experimental group

scores was significantly larger than those in the comparison group, with medium effect. The qualitative observations, related to the experimental group – post intervention, are in accordance with above quantitative findings. Some of the respondents indicated that relaxation helped them to deal with the impact of the event as they are able to feel calm, peaceful and grounded, especially during times when they experience episodes of distress. One of the group members quoted the following: “To take a few deep breaths, helps you to relax and to think clearly.” Aspects of the program that most probably enhanced relaxation were the grounding and safe place exercises and progressive muscle and deep breathing exercises, dealt with in session two. These exercises taught the group member’s specific techniques to relax their body and mind. Williams and Poijula (2013: 5) support this view and emphasise that it is important that group member’s practice the relaxation techniques they choose regularly, try to focus on the particular muscle groups and specific exercises and trust the power of the techniques to help them to stay in the present.

The qualitative observations in the experimental group – post intervention, also showed a perceived improvement in avoidance, intrusion and hyperarousal and therefore appears to be in accordance with the quantitative results. Most of the respondents indicated that they learned to recognise their avoidance behaviours as a way to escape trigger events that elicits feelings of anxiety, fear, anger, or other types of distress. One of the group members mentioned the following: “These reactions are only natural and not dangerous, avoiding it will only strengthen your anxiousness and you will never learn that you are safe.” Aspects of the program that most probably improved avoidance behaviours were exercises on identifying triggers, avoidance behaviours, checklist for common triggers and the STOPP the trigger worksheet. These exercises are included in session nine of the PTP, during which group members were encouraged to identify and represent triggers and avoidance behaviours following exposure to traumatic events. This study support Monson *et al.* (2014: 63) who emphasises that avoidance symptoms reflect the individual’s attempt to gain physical and psychological distance from the trauma. Some have suggested that avoidance symptoms are a response to re-experiencing symptoms, more specifically referring to trigger events.

Some of the respondents indicated that they acquired awareness with regards to intrusion symptoms such as recurrent distressing memories, dreams and flashbacks (American Psychiatric Association, 2013: 271). They indicated that they understand the importance of remembering and making alterations in their ability to manage feelings, emotions and impulses as a result of these memories. One of the group members quoted the following: “I normally suppress my emotions, but now I know how to recognise and face them, not to be afraid to talk about it.” Another group member said, “The ABC’s of emotions helped me to look at the chain of events from the actual event to the psychological and social consequences.” Aspects of the

program that most probably improved intrusion behaviours were exercises on the importance of remembering, re-telling the story, informal writing and the construction of a trauma inventory as part of session three. The exercises in session four, namely the ABC's of emotions, feelings and thoughts, and primary negative emotions, related to feelings and thoughts that drive them, helped the group members to identify their emotions, feelings and thoughts relating to the event(s). The affective style questionnaire, emotion expression exercise, negative emotion diagram, positive imagery and STOPP the feeling exercises presented in session five contributed to teaching group members to modulate and control their feelings, and to regulate their emotion-driven responses using positive imagery, practicing to control an emotion and dealing with negative emotions following reminders. Williams and Poijula (2013: 22) confirm that before working on the symptoms bothering individuals exposed to trauma, it is important to make sure that you are aware of where they come from. Wilkinson (2015: 54) added to this by emphasising the interconnectedness of the event, primary emotions, negative feelings and the common thoughts that drive them. Pettinelli (2012: 71) therefore indicates that it is important to learn how to turn off a reminder automatically, but stresses that it can also be done to some feelings. This is so because feelings are in large triggered by reminders.

Participants reported marked alterations in arousal associated with the traumatic event(s). They specifically referred to irritability, anger outbursts, hypervigilance, substance abuse and the risk for suicide (American Psychiatric Association, 2013: 271). They indicated an improvement in their ability to handle the stress related to hyperarousal, to assert their personal boundaries and how to find alternative coping mechanisms. One of the group members responded as follows: "Be aware of the warning signs and look at your safety plan and get professional help." Another group member quoted the following: "Police are at risk of suicide, be on the lookout for the risk factors not only for yourself but also for others." Aspects of the program that most probably improved the possibility of destructive and self-destructive behaviour as a result of arousal were information on the aggression cycle, dealing with anger, the link between trauma, substance abuse and suicide and the composition of a safety plan, in session seven. During this session group members were sensitised to the destructive and self-destructive behaviour associated with arousal. Self-destructive behaviour may be used as a coping mechanism, when the pressure is mounting. They were assisted to identify these types of behaviours and guided to balance the pain and coping resources step by step until they feel safe. Escolas *et al.* (2010: 293); Thomas (2010: 123) and Videbeck (2014: 191) emphasise the link between the event, arousal that might lead to anger and violent behaviour, substance abuse and suicidal thoughts and actual suicide. It is therefore important that group members should be provided with self-help information and skills to reduce the pain and increase coping resources. These improvements are an indication that the PTP could succeed to improve some of the signs and symptoms arising as a result of the impact of traumatic events on police officials.

The reliability of the PTCI was calculated and all three constructs were regarded as reliable. After the program intervention, the experimental group measured a medium practical difference regarding self, world and self-blame. The total for the PTCI including all the constructs also indicate a medium practical difference. No statistically significant differences were noted in any of the subtests in the comparison group. Changes in all the subtests from pre- to post-test in the experimental group were practically more significant than changes in the comparison group. The intervention in total had a practical significant effect on the improvement of respondent's thoughts and beliefs specifically referring to self, word and self-blame.

The qualitative findings support the before-mentioned results. Group members reported a perceived improvement regarding persistent negative beliefs about themselves, others and the world (American Psychiatric Association, 2013: 271). One of the group members responded with the following comment: "The thought record help you to re-focus your thoughts, to think flexibly and to divert from whatever negative thoughts you might have." Aspects in the program that most probably improved their negative alterations in cognitions and mood associated after the traumatic event(s) were the exercises regarding unhelpful thinking habits, flexible thinking: the ABCDE's of emotions, positive affirmations as well as the thought record exercise in session six. This session concentrated on group member's patterns of problematic thinking. Particularly strong tendencies toward any counterproductive patterns were determined with an indication on how these patterns may have affected their reactions to the trauma. Ultimately group members were guided on how to alter problematic thinking by replacing them with other, more adaptive, cognitions. The thought record introduced by Cully and Teten (2008: 59) in particular was very helpful in the alteration of thoughts, beginning with the activating situation, belief, consequence, disputing the belief and finding an entirely new thought and behaviour. Siddiqui *et al.* (2009: 304) emphasises that the way in which patients relate to negative thoughts, rather than alteration of content, is key to effectively treating post traumatic symptoms. The authors are furthermore of the opinion that during treatment patients have to be taught to decenter themselves from their negative thoughts and regard thoughts as cognitive events rather than necessary thoughts. These improvements are an indication that the PTP could succeed in improving some aspects of changing the thoughts and beliefs of police officials following exposure to traumatic events.

A medium practical and practically significant effect was reported in the post-test between groups after program intervention. The experimental group visibly improved regarding the impact of the event and improved significantly regarding respondent's thoughts and beliefs, whilst the comparison group showed no significant difference, which indicates no improvement. The self-developed questionnaires were consistently completed by all the respondents of the experimental group and are therefore regarded as reliable. The average scoring regarding the

respondent's perceived attitude and knowledge of the different topics presented in the PTP improved with 12.7% from 58.0% to 70.8%. All the topics presented showed improvement regarding the respondent's attitude and knowledge according to their scorings summarised in table B6-8. Triangulation was reached as the findings generated by the quantitative and qualitative data collection methods were consistent and complementary. It provided the researcher with a greater insight of the same phenomenon (Kielhofner, 2006: 353).

According to the self-developed questionnaires, the program did indeed make an impact and improved the group members' perceived attitude and knowledge regarding the included topics according to the above-mentioned improvements.

The objectives of the group work sessions of the PTP were met in general, but the nature and composition of some of the activities were adjusted to meet the group members' knowledge, level of understanding, and available time, since police officials work is quite flexible or demanding and some of the group work activities took up more time than planned. The PTP was developed and tested to become a tool in service delivery to police officials attached to the specialised units, therefor the dissemination of the program forms an important part of the research project. Further possibilities of utilisation of the program at different specialised units in SAPS indicate that it is considered a useful and complete empowering instrument.

7. Conclusion

The purpose of this article was to evaluate and determine the effect of a compiled PTP for police officials attached to the specialised units in the North West Province, those constantly exposed to traumatic events. A mixed methods research approach was followed with both quantitative and qualitative measuring instruments. Police officials for inclusion in the experimental and comparison groups were selected by means of purposeful sampling from one specialised unit namely, POP in Potchefstroom. After sampling, police officials were screened and once again purposefully divided into two groups based on availability as a result of extreme work demands. This was done considering, gender, age, ethnical background, rank, qualifications, marital status and years of service. For this experiment the concurrent convergent design was utilised and included two groups: experimental and comparison group. For the aim of evaluation the two groups were quantitatively evaluated by means of the CIHQ (Annexure F), IES-R (Annexure G), MHC-SF (Annexure H), and the PTCI (Annexure I). Further qualitative and quantitative evaluation of the experimental group was done by means of self-developed questionnaires (Annexures K & L). It was found that the PTP, developed for this study definitely brought about a significant, positive change with regards to police officials overall knowledge and skills to cope with the signs and symptoms of trauma, their mental health, the impact of

traumatic events and trauma-related thoughts and beliefs to prevent PTSD or any other co-morbid disorder.

8. Recommendations

Based on the discussion of the results of this study, the following recommendations can be made:

- The PTP should also be evaluated with other specialised units, not only in the North West Province, but also in the rest of the country, so that the quantitative and qualitative results of this study can be confirmed or refuted;
- The PTP should also be evaluated with other emergency agencies for example, the fire brigade, ER24 and the metro police to determine its external value;
- Respondents found it extremely difficult to answer the CIHQ. The two constructs pertaining to incident and coping were confusing and many of the police officials were not able to understand the link. It was completed as a group with an interpreter, interpreting every statement. It is therefore recommended that the questionnaire be simplified to accommodate all police officials;
- This program was presented by combining two sessions per week due to time limitations and more specifically the unique and unpredictable nature of police officials work. It is, however, recommended that only one session be presented per week as a result of the extent of the sessions and the intensity of some of the topics;
- It is important to extensively market the program to police management, to sensitise them with regards to police officials unique needs, to have a better understanding, so that they can be pro-active and provide timeously support to those exposed to traumatic events;
- The PTP should include a session on financial management, as many of the respondents complained about promotional opportunities, overtime remuneration, inadequate salaries and the expectations for basic needs posed by family members; and
- The PTP can be adjusted to include family members, for example the spouse, at some stage of the intervention process, so that they can learn to better understand trauma and to strengthen the support system.

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**SECTION C:
SUMMARY, CONCLUSIONS AND
RECOMMENDATIONS**

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

1. Introduction

This article is a summary of the key findings from the study and the conclusions based on the findings. Shortcomings and obstacles that had been encountered during the study are also discussed. Thereafter some recommendations for practice will follow. The research study was executed in three phases. The first phase concentrated on a problem analysis and information gathering by means of an in-depth literature study as discussed in articles 1 and 2 and a qualitative and quantitative needs assessment discussed in articles 3 and 4. The second phase focused on the design, early development and pilot test in article 5, while phase 3 centred on the implementation and evaluation of the PTP as discussed in article 6. The research report includes the following:

SECTION A: GENERAL INTRODUCTION

SECTION B: ARTICLE 1 – Trauma in the South African Police Service

ARTICLE 2 – Exploring programs to support police officials exposed to trauma

ARTICLE 3 – An assessment of the needs of police officials regarding trauma and trauma intervention programs: A Qualitative approach

ARTICLE 4 – An assessment of the needs of police officials regarding trauma and trauma intervention programs: A Quantitative approach

ARTICLE 5 – A psycho-social therapeutic program (PTP) for police officials attached to the specialised units within the South African Police Service

ARTICLE 6 – Implementation and evaluation of the psycho-social therapeutic program (PTP)

SECTION C: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

2. Summary and conclusions

The most important findings and conclusions of this research are summarised with reference to the research methodology and the articles in Section B of this research report.

2.1 Aim and objectives of the study

2.1.1 General aim

The aim of the study was to develop implement and empirically evaluate a PTP that is sensitive and responsive to the needs of police officials after exposure to traumatic events. The program also emphasises the prevention of Post-Traumatic Stress- or any other co-morbid disorder.

2.1.2 Objectives

The above-mentioned aim was reached by achieving the following objectives:

- To gather information, with reference to the concept trauma and the extent, subjective experience and impact of trauma on police officials within SAPS.

This objective was achieved in Article 1 through a comprehensive literature review and analysis to explore the context of trauma and programs to support police officials exposed to trauma.

- To explore and critically appraise key elements of existing trauma intervention approaches that can be reconfigured into a PTP for police officials exposed to trauma. (Article 2).

This objective was achieved in Article 2 through a critical appraisal of the literature concerning different trauma intervention approaches that might be reconfigured and included as part of a PTP for police officials exposed to or affected by trauma.

- To conduct a qualitative and quantitative situational analysis as a first and second phase of the explorative sequential design to explore and identify the extent, subjective experience and specific needs of police officials in the North West Province, who have been exposed to trauma.

This objective was reached in Articles 3 and 4 by doing a needs assessment with regards to trauma and trauma intervention programs on police officials attached to the specialised units in the North West Province.

- To develop a PTP condering specific aspects of the literature study and the empirical research, that will enable police officials to better cope with the impact of trauma.

This objective was reached in Article 5 through the development and compilation of a PTP.

- To test the proposed PTP within the context of SAPS, to evaluate the program empirically.

This objective was reached in Article 6 by implementing and evaluating the designed PTP. Although dissemination has not been included as part of the study, three articles have been published in different accredited journals.

2.2 Research methodology

The main purpose of this study was to design and evaluate a PTP that is sensitive and responsive to the needs of police officials after exposure to traumatic events. These goals were reached by studying literature and by means of an empirical study.

2.2.1 Literature study

For this research it was necessary to do a comprehensive review and analysis of the available literature and research results. The main purpose of the literature review was to identify what is known and unknown about police official's exposure to traumatic events. Secondly the researcher wanted to determine how the impact of trauma on police officials psycho-social well-being can be resolved, managed and prevented based on research evidence. The literature review provides the background and the context within which the research is conducted. It lays down the foundation of the study (Boswell & Cannon, 2014: 149). Literature included books, journals, annual reports, SAPS National Instructions, newspaper articles, statistical data and research reports regarding trauma, the impact of trauma on police officials, SAPS trauma intervention models and programs and other related topics. The literature study led to the demarcation of this research, the development of qualitative and quantitative assessment schedules, the comparison of empirical data with literature and the development and evaluation of a PTP for police officials.

2.2.2 Empirical research

- **Research model**

The process of intervention research (D & D model) was utilised for this study. D & D is a phase model consisting of six phases (De Vos & Strydom, 2011: 476). In this model the major phases of intervention research were adapted as follows to better suit the needs of this research and to achieve the research objectives: phase one (situational analysis and information gathering), phase two (design, early development and pilot testing), and phase three (evaluation, advanced development).

- **Design**

Mixed methods research is an approach to inquiry that combines and involves the use of both qualitative and quantitative approaches in one study (Creswell, 2014: 216). The researcher used the exploratory sequential mixed-methods design as proposed by Creswell (2014: 4) as part of the first phase of the intervention model. Myers and Oetzel (cited in Creswell & Plano-Clark, 2011: 122 & 124) describe this design as "a two-phase" design in which the researcher begins by collecting and analysing qualitative data as part of the first phase of the "two phase"

design. Respondents were divided into three focus groups with the aim of gaining information on the extent of trauma, police officials' subjective experience of trauma, its impact on their psycho-social functioning and their specific needs regarding support and intervention (Greeff, 2011: 361). Following the initial exploratory results, quantitative data as part of the second phase of the "two phase" design were collected by means of a self-designed questionnaire (Annexure B) based on certain themes that arose from the focus group interviews. This questionnaire included specific concepts on trauma, trauma reactions and specific needs of police officials with regard to support. The above-mentioned was of importance to explore, analyse, test and generalise the extent of the problem in the larger population.

For the evaluation of the program in phase 3 of the intervention research model, the researcher used the concurrent convergent strategy within the context of the pre-test/post-test comparison design (Creswell & Plano-Clark, 2011: 77). The researcher used concurrent timing to implement both quantitative and qualitative strands during the pre- and post-test involving both the experimental and comparison groups. Both groups received the pre- and the post-test at the same time, whilst only the experimental group received the independent variable (Grinnell *et al.*, 2011: 262). However, the comparison group were also given the opportunity to be exposed to the program after the experiment. Unfortunately they were either not interested or not available at the time. The researcher used triangulation as he concentrated on more than one method to explore the extent of trauma in SAPS. This enabled the researcher to complement data from qualitative sources with those of quantitative sources, literature and vice versa (Delpont & Fouché, 2011: 442).

- **Participants**

For purpose of this study, the specialist units of SAPS in the North West Province were geographically demarcated as the whole. During the first qualitative phase of the "two phase" model a total of 40 police officials of the different specialised units were purposefully selected to participate in three different focus groups, representing three of the bigger clusters in the North West Province namely: Klerksdorp, Potchefstroom and Rustenburg. According to Jacobs *et al.* (2016: 440) the ideal size for a group is eight to ten, but the researcher chose 13 to 14 per group to make provision for unexpected circumstances. This was done because of the unique and demanding nature of the police officials' work. As part of the second quantitative phase the researcher purposefully selected 332 respondents stationed at six specialist units representing nine of the 11 police clusters in the North West Province to complete the self-developed questionnaire by means of the group administered method (Rovai *et al.*, 2014: 16). The size of the sample according to Strydom (2011: 225) is determined according to 10% of the population. However, the researcher selected more than 23% to make provision for unexpected circumstances as a result of police official's unique and demanding working conditions. A total

of 36 police officials from the Public Order Policing Unit (POP) in Potchefstroom were purposefully recruited for participation in the PTP. All participants were exposed to traumatic events and none of them have been diagnosed with post-traumatic stress- or any co-morbid disorder before. After screening a total of 28 police officials met the inclusion criteria. All of them gave informed consent (Annexure J) after which they participated in the implementation and evaluation of the program. One group was purposefully selected as the comparison group and the other as the experimental group, considering their availability as a result of their responsibilities at work.

- **Sampling procedure**

Purposeful sampling was used to select 40 participants as part of the first qualitative phase, while a total of 332 participants were purposefully selected as part of the second quantitative phase. A total of 36 participants were purposefully selected for the experimental phase of the study. After screening only 28 police officials qualified for inclusion as part of the study. Police officials were purposefully chosen considering the relevance of the topic, specifically referring to their exposure to trauma, resultant symptoms of post-traumatic stress and their participation in trauma intervention programs. None of the participants have been diagnosed with post-traumatic stress- or any co-morbid disorder. Recruited participants, for purposes of the evaluation of the program, have been screened by means of the Critical Incident History Questionnaire for Police Officials (CIHQ) (Annexure F), Impact of Event Scale – Revised (IES-R) (Annexure G), Brief Description of the Mental Health Continuum Short Form (MHC-SF) (Annexure H) and the Post-traumatic Cognitions Inventory (PTCI) (Annexure I) one week after recruitment. The last-mentioned are not diagnostic scales, but gave the researcher an indication of participants at risk of developing PTSD. All recruited participants showed minimum risk for PTSD, therefore qualifying for participation. The researcher also considered police officials unique working conditions and unpredictability specifically referring to overtime and deployment at different times. The researcher was not allowed to interfere with service delivery. EHW who acted as fieldworkers assisted the researcher on ground level regarding this process, as most of these police officials are known to them or they are involved in a therapeutic relationship with them. Personal information was only revealed with the full consent of the police officials concerned after which participation in the study was voluntary. Gerrish and Lacey (2010: 149) emphasise that in purposive sampling, each sample element is selected for a purpose and that it may be used to measure the effectiveness of some intervention with clients who have particular characteristics, such as a specific diagnosis.

- **Data collection**

During the first qualitative phase of the “two phase” model information pertaining to the extent of trauma, police official’s subjective experience of trauma, its impact on their psycho-social functioning and their specific needs regarding support and intervention were gathered by means of a semi-structured interview schedule while conducting focus groups. The data collected during the second quantitative phase was collected by means of a self-developed questionnaire (Annexure B) based on the findings of the first qualitative phase, measuring the impact of trauma and respondent’s exposure to traumatic events inside and outside the workplace. The researcher quantitatively explored the experiences and psycho-social needs of police officials who are exposed to trauma within the larger population. The researcher wanted to determine if the data arising from the three focus groups in the first qualitative phase, can be generalised to a large sample of police officials stationed at the specialist units within the North West Province (Creswell, 2014: 226).

EHW responsible for the specialist units in the different clusters in the North West Province were trained as field workers to facilitate the completion of the questionnaires by means of the group administered method (Leach *et al.*, 2012: 275). For the evaluation of the program both qualitative and quantitative data were collected by means of four standardised scales and two self-developed questionnaires as survey data procedure. The program was preceded by pre-testing including both the experimental and comparison groups one week before intervention. Post-testing was completed by both the groups three weeks after the last session.

- **Measuring instruments**

For the evaluation of the program both qualitative and quantitative data were collected by means of four standardised scales, also used during the screening process, namely: Critical Incident History Questionnaire (CIHQ) developed by Weiss *et al.* (2010: 736) (Annexure F), the Impact of Scale – Revised (IES-R) developed by Weiss (2007: 219) (Annexure G), the Mental Health Continuum Short Form (MHC-SF) (Annexure H) developed by Keyes *et al.* (2008: 186) and the Post-Traumatic Cognitions Inventory (PTCI) developed by Foa *et al.* (1999: 305) (Annexure I) and two self-developed questionnaires as survey data procedure: Qualitative and Quantitative Measuring Instrument – Before program (Annexure K) and Qualitative and Quantitative Measuring Instrument – After program (Annexure L).

- **Data analysis**

The quantitative data in this study were captured and statistically analysed by the North-West University’s Statistical Consultation Services. The results were interpreted, inferences pertinent to the research relations studied were made and conclusions drawn. In research, the practical

significance of results is not only important when results of the population data are reported but also for commenting on the practical significance of a statistically significant result (Leech *et al.*, 2015: 93). The qualitative data collected during this study has been transcribed and analysed according to the eight steps as proposed by Tesch (cited in Creswell, 2014: 198). This allowed the researcher to make interpretations of the meaning of the data (Creswell, 2014: 4). It should be emphasised that the qualitative focus during the evaluation of the program should only be considered as supportive of the quantitative data and findings to further explore the finer details and nuances of the participants' behaviour which could not be explored by the quantitative data.

2.3 Summary of the articles

The following discussion is a summary of each article:

2.3.1 Trauma in the South African Police Service

The aim of this article was to give a literature overview of the extent, subjective experience and impact of trauma on police officials of SAPS. Literature in this article revealed that police officials, as a result of the escalating crime in South Africa and the unique and dangerous nature of their work, are constantly exposed to a broad spectrum of horrendous traumatic events. It became evident that police officials who go through traumatic experiences often experience a wide variety of initial and long-lasting psychological symptoms as an immediate response to trauma. These experiences further more represent risk factors for subsequent re- and secondary traumatisation which may result in more severe and complex responses to further traumatic experiences. As a result of maladaptive emotion-focused behaviour for immediate stress reduction and mechanisms, such as avoidance and denial, the trauma is internalised. This creates the potential to develop trauma-induced adjustment and mental health disorders with potentially substantial consequences for police officials health, psycho-social well-being, behaviour, job performance and eventually for SAPS as an organisation. Although the exposure to trauma is a negative life event that is associated with significant symptomatology, it also became clear that a number of factors, including a person's life experiences before the trauma, own natural ability to cope with trauma, how serious the trauma was, and what kind of help and support a person gets from family, friends, management and professionals immediately following the trauma, can reduce or balance the after-effects of trauma.

2.3.2 Exploring programs to support police officials exposed to trauma

The objective of this article was to critically appraise existing trauma intervention approaches to better understand, compare and consider possible aspects of these approaches. The investigation concentrated on both the psychological, behavioural and social factors affecting

police officials exposed to trauma to extrapolate key elements of techniques and to reconfigure them into a comprehensive PTP for use among the police in South Africa. The article gave an overview of the most important international approaches, but at the same time focused on those trauma intervention programs offered by SAPS.

The most important elements of criticism on all of the above mentioned approaches is the fact that they are fragmented into different components that either concentrate on the cognitive, behavioural or social aspects of the police officials' life. All of these approaches can be seen as a stand-alone therapy as none of these programs concentrate on police officials' mental health in terms of complex psychological, cognitive affective, social and ecological relations. It is important to see the police official and the environment in their interconnected and multi-layered reality. The researcher therefore supports a transactional fashion of intervention to avoid viewing people in isolation from their life situations.

The trauma focused cognitive behavioural therapy model (TF-CBT) (Baranowsky *et al.* 2010: 15, Yarvis, 2012: 669), prolonged exposure (PE) (Cook *et al.*, 2013: 18; Moore & Penk, 2011: 42 & Westphal, 2012: 465) and the eco-systemic perspective (Miley *et al.*, 2004: 33), which was specifically developed for social work, dispose some of the best elements to be reconfigured into a holistic PTP. Both the TF-CBT and PE is a type of psychotherapeutic treatment that helps patients understand the thoughts and feelings that influence behaviours. It was developed as a guideline for early intervention treatment for acute and post-traumatic stress symptoms experienced during the initial aftermath until four weeks after the trauma. The TF-CBT and PE do have some of the elements for inclusion in the proposed PTP, for example, psycho-education, prolonged exposure, relaxation, in vivo exposure and cognitive therapy. Patients who receive TF-CBT within the first month after trauma might be less at risk to develop PTSD or otherwise experience less intense PTSD.

The researcher does, however, recommend that the TF-CBT and the PE be grounded in the eco-systemic perspective, which is a way of seeing the person and the environment in their interconnected and multi-layered reality. The perspective supports a transactional fashion of intervention to avoid viewing people in isolation from their life situations. It not only considers psychological cognitive, affective and behavioural components, but also concentrates on the interconnected transactional networks, with specific reference to community, family, environmental, spiritual, social and cultural factors as significant barriers as a result of police officials' exposure to trauma.

The combination of the TF-CBT, PE and the eco-systems perspective ensures a psycho-social focus and guided the researcher in considering the inclusion of psychological, behavioural and social elements, as discussed, in one single PTP. The implementation of the PTP within the

context of SAPS has the potential to serve as a holistic guideline for social workers working in the field of trauma. Considering the above discussion, there is no doubt that management and EHW has a responsibility and an important role to play in the development of effective trauma intervention programs with a holistic approach to better the overall psycho-social well-being of police officials.

2.3.3 An assessment of the needs of police officials regarding trauma and trauma intervention programs: a qualitative approach

The objective of this article was to conduct an in-depth qualitative situational analysis as a first phase of the explorative sequential design by exploring the extent, subjective experience, impact of trauma and police officials' specific needs with regard to trauma and trauma intervention as part of the first phase of the explorative sequential design. A total of 40 police officials stationed at the identified specialist units, representing three of the biggest police clusters in the North West Province, were involved in three focus groups as part of data collection. The identified police clusters can therefore be seen as representative of the North West Province. Police officials exposed to traumatic events have various needs, according to various sources.

As a result of the problem analysis, the following topics were identified as preliminary indicators of the development of a PTP to address the problems related to trauma in SAPS: psycho-education (trauma, stress, impact of trauma); response to trauma (critical incident stress, complex traumatic stress disorders referring to PTSD and comorbidity); consequences of complex trauma (alcohol abuse, suicide, anger, aggression, violence, family and relationship problems, somatic complaints, work-related problems); coping strategies (resilience, avoidance, action-oriented coping), consumer orientation, satisfaction and promotion.

From this study it became clear that when police officials are exposed or affected by traumatic events it also affects their interconnected transactional networks with specific reference to community, family, environmental, spiritual, social and cultural factors. Trauma therefore disrupts the psychological well-being, social roles, rights and obligations of the individual involved. Police officials find themselves in a sensitive and unique working environment and should therefore be supported and guided as a matter of urgency when exposed to traumatic events. The suffering and adversity experienced by those police officials who experience complex traumatic stress reactions are basic components of care that must be taken into account by EHW in SAPS.

2.3.4 An assessment of the needs of police officials regarding trauma and trauma intervention programs: a quantitative approach

The objective of this article was to do a quantitative situational analysis as part of a second phase of the explorative sequential design by exploring police official's stationed at the specialist units within the whole of the North West Province, experience, the impact of trauma and specific needs regarding support. This exploration was important to create guidelines and to make certain recommendations with regard to the proposed PTP for police officials attached to the specialist units in the North West Province. During the process of quantitative data collection a total of 332 police officials stationed at six specialist units representing nine of the 11 police clusters in the North West Province, participated in the study. Two of the clusters were excluded, because the specialist units identified for the purpose of this article were not fully represented.

The themes, sub-themes and categories of the sub-themes arising from the first qualitative phase were included as constructs in a self-developed questionnaire in this second quantitative phase. In this article the researcher wanted to determine if data arising from the first qualitative phase could be generalised to a larger sample of police officials stationed at the specialist units within the whole of the North West Province. This was done in an effort to quantitatively verify the opinions and experiences of those police officials who participated in the three focus groups.

The needs that were identified during the second quantitative phase greatly corresponded with those revealed during the first qualitative phase. As part of the process of triangulation the data arising from both the qualitative and quantitative phase were compared, integrated and divided into the following categories: Educational-, physical-, psychological, social and spiritual needs. The educational needs include needs regarding skills to better deal with the signs and symptoms following exposure to a traumatic event, and knowledge regarding trauma and its impact on the individual and those closely related to the individual. The physical needs of police officials include the impact of stress on the body, health, relaxation, economic implications and maintenance of the family, protection, discrimination, stigmatisation, safety, and confidentiality. The psychological needs include: exposure to the event, identifying and coping with negative emotions and thoughts and behavioural risk factors. Social needs include relationships with important others, identification of inner and external resources, rights, obligations, security, re-integration into the place of work and the community. Spiritual needs include needs regarding coping, problem solving, resilience, counselling and support from a social worker, psychologist, church minister, medical doctor or psychiatrist. These also include love and support from peers, police management and especially immediate family members.

It was therefore confirmed that the data arising from the three focus groups in the first qualitative phase can to a great extent be generalised to the larger sample of police officials stationed at the specialist units within the North West Province and can therefore be used as an indicator to the development of a PTP to address the problems related to trauma in SAPS.

From this study it became clear that in any intervention with police officials, the discussed needs should be kept in mind and should form the platform from which any therapeutic program should be developed. Trauma disrupts the police official's psycho-social equilibrium to such an extent that they find it extremely difficult to cope. The suffering and misfortune of police officials who experience trauma are critical components of care that must be addressed by police management. Being in a unique and sensitive environment, police officials should be supported and guided to restore psycho-social wellness and prevent post-traumatic stress- or any other co-morbid disorder.

2.3.5 A Psycho-social Therapeutic Program (PTP) for police officials attached to the specialised units within the South African Police Service

The objective of this article was to develop a PTP that is sensitive and responsive to the needs of police officials after exposure to traumatic events. The program aims to empower police officials attached to the specialised units with the necessary knowledge and skills to better cope with the signs and symptoms following exposure to trauma. It is also pro-active in nature with emphasis on the prevention of post-traumatic stress- or any other co-morbid disorder, promotes resilience, recovery and systems of care, is attractive, accessible, and responsive and provides safe services. This article explains the intervention techniques that assist the social worker and the group members to achieve the goal. The specific needs of police officials, including their physical, psychological, social, educational- and spiritual needs, as revealed by a thorough needs assessment, formed the foundation when this group work program was planned and compiled. Existing guidelines regarding group work with police officials were studied and taken into consideration in the planning process. The planning and compilation of a group work program is a process that consists of different aspects. The different phases of group work, including the preparation/pre-group-, the beginning-, middle-, end- and post-group phases were taken into consideration in the planning process.

The process of the PTP consists of the following phases: Preparation, contact, assessment, contracting, action, evaluation and termination. Program activities have been carefully considered, since it plays an important role in the presentation of the program. Guidelines for group work with police officials with specific reference to the screening process, the composition of the group, structure, nature and aim of the group, venue, time, duration, number of sessions, type and size of the group, functional resources, specific techniques that are particularly useful

in trauma groups, the preparation of the social worker, relationships between the group members and the facilitator and the procedure of the group was considered. The program was planned and compiled with the needs of police officials and the empirical data of articles 3 and 4 in mind.

Considering the proposed international trauma intervention approaches concentrating on all phases of human response in terms of complex psychological, social and ecological relations as key elements for police officials to maintain a psycho-social equilibrium, it is possible that these police officials can be empowered to deal with trauma more effectively in future. A comprehensive PTP based on the needs of police officials can assist and enable them to use the knowledge and skills obtained to empower them so that their psychological and social needs can be met more comprehensively and that they can therefore lead a quality life within their given circumstances. With their psycho-social needs being addressed or met, these police officials should be more empowered to be able to cope with the reality of trauma caused by their unique working environment. A PTP is therefore recommended for police officials attached to the specialised units who are involved and affected by trauma as a result of their unique working conditions.

2.3.6 Implementation and evaluation of the Psycho-social Therapeutic Intervention Program (PTP)

The aim of this article was to empirically evaluate the effectiveness of the developed PTP on police officials exposed to and affected by traumatic events as a result of their unique working conditions and to disseminate it. A mixed-methods approach was followed using both quantitative and qualitative measuring instruments and more specifically the concurrent convergent strategy. A total of 28 police officials attached to POP in Potchefstroom participated in the experimental and comparison groups following screening and considering availability. The researcher specifically decided to make use of a comparison group as the comparison group had been exposed to all of the same conditions as the experimental group, except for the variable being tested (McBurney & White, 2010: 194). After sampling, the police officials were divided purposefully into two groups considering age, rank, gender, language, qualification, marital status and years' of service. For this experiment the comparison group pre-test, post-test design was utilised and it included two groups namely an experimental and comparison group. With evaluation in mind, the two groups were quantitatively evaluated by means of the CIHQ (Annexure F), IES-R (Annexure G), MHC-SF (Annexure H) and the PTCI (Annexure I). Further qualitative and quantitative evaluation of the experimental group was done by means of self-developed questionnaires.

The reliability of the MHC-SF was calculated and all three the constructs were regarded as reliable. After program intervention, there was a visibly significant difference in only one of the constructs in the test between the groups. The experimental group measured a visible difference regarding emotional well-being. Not only did emotional well-being visibly improve in the experimental group, but also in the control group. The control group therefore also indicates a medium practical effect on the improvement of the respondent's emotional well-being. It should be noted, however, that although the experimental group's post-EWB score was higher than the control group's post-test score, it was of no practical importance, meaning that the intervention had no practical effect on emotional well-being. There were no visibly significant differences in any of the other constructs in the control group after post-testing. In the test between groups, psychological well-being showed a medium practical difference after the experimental group had been exposed to the program. None of the other constructs measured any significant differences. However, from the qualitative observations concerning the experimental group – post-intervention, it was clear that some of the respondents emotional-, social- and psychological well-being did improve significantly. The assumption can therefore be made that the intervention did bring about an improvement regarding the respondents, emotional-, social and psychological well-being.

All three of the subscales of the IES-R showed satisfactory reliability. After program intervention, there was a practically significant difference regarding all three the subscales in the test between groups. The experimental group measured a practically significant difference regarding avoidance, intrusion and hyperarousal. Both intrusion and hyperarousal as constructs in the control group measured no statistically significant difference whilst avoidance indicated a medium practical effect. However, the experimental group's post-avoidance score was significantly higher than the control groups post-test score, and can therefore be seen as practically important, meaning that the intervention on avoidance had a medium practical effect. In the test between groups hyperarousal measured a statistically significant difference. Intrusion had a medium practical effect while avoidance had no practical effect. Thus the intervention in total had a medium practical effect on the improvement regarding the impact of the event specifically referring to avoidance, intrusion and hyperarousal. The qualitative observations in the experimental group – post-intervention also showed an improvement in avoidance, intrusion and hyperarousal and therefore appears to be in accordance with the quantitative results. These improvements are an indication that the PTP could succeed in approving some of the signs and symptoms arising as a result of the impact of traumatic events on police officials.

The reliability of the PTCI was calculated and all three constructs were regarded as reliable. After the program, there was a visibly significant difference in all three the constructs. In the test between groups, the experimental group measured a medium practical difference regarding

self, world and self-blame. All the constructs in the control group measured no statistically significant difference. In all of the constructs, in the test between groups, there was a practically significant difference after the experimental group had been exposed to the program. Thus the intervention in total had a practical significant effect on the improvement of respondent's thoughts and beliefs specifically referring to self, world and self-blame. The qualitative findings support the before-mentioned results. Group members reported an improvement regarding persistent negative beliefs about themselves others and the world. These improvements are an indication that the PTP could succeed improving some aspects of changing the thoughts and beliefs of police officials following exposure to traumatic events.

In total a medium practical and practically significant effect was reported in the test between groups after program intervention. The experimental group visibly improved regarding the impact of event and improved significantly regarding respondent's thoughts and beliefs, whilst the control group showed no significant difference, which indicated no improvement.

The self-developed questionnaires were regarded as reliable. The average score regarding the group members' attitude and knowledge of the different topics presented in the PTP improved with 12.7% from 58.0% to 70.8%. All the topics presented showed improvement regarding the respondent's attitude and knowledge according to their scorings summarised in Table B6-8. According to the self-developed questionnaire, the program did indeed have an impact and improved the respondent's attitude and knowledge regarding the included topics according to the above-mentioned improvements. The qualitative evaluations as integrated in above-mentioned discussion should also serve as a basis for adjustments to the program for future utilisation. The objectives of the group work sessions of the PTP were met in general, but the nature and composition of some of the activities were adjusted to meet the group members' knowledge, level of understanding, and available time, since police officials' work is quiet flexible and demanding and some of the group work activities took up more time than planned.

The PTP was developed and tested to become a tool in service delivery to police officials attached to the specialised units, therefore the dissemination of the program forms an important part of the research project. Further possibilities of utilisation, implementation and testing of the program at different specialised units in SAPS will indicate its future use as a complete empowering instrument.

3. Testing the central theoretical argument

The research was based on the following theoretical argument:

Police officials exposed to and affected by trauma can be empowered with knowledge and skills to better deal with the impact of trauma by participating in a psycho-social therapeutic program.

The central theoretical argument was proven based on the findings and conclusions of the qualitative and quantitative research study, as discussed previously.

4. Recommendations

- This research can be used as a platform for the development of various interventions with police officials exposed to or affected by trauma;
- The unique circumstances in which police officials attached to the specialised units find themselves are difficult and as a group they should be a target population with respect to help and support;
- A PTP should be developed based on the exploration of some of the best elements of existing trauma intervention approaches, to assist police officials exposed to and affected by trauma;
- Elements of the TF-CBT, PE and the eco-systems perspective can be reconfigured and included in a single psycho-social therapeutic program to support police officials to better cope with their exposure to trauma;
- Elements of the TF-CBT, PE and the eco-systems perspective can be included in a single psycho-social therapeutic program considering the specific needs of the population;
- Before any intervention program is planned for police officials exposed to trauma, an assessment should be done to determine and verify the population's unique needs with regards to intervention via their active participation in the whole process;
- The results with regard to the needs of police officials attached to the specialised units in the North West Province should be utilised in further research regarding program development in the field of trauma;
- The program is supposed to be presented over a period of 12 weeks. As a result of police officials' work demands, often long and inconsistent working hours (overtime, deployment) and the unpredictability of their work, the last-mentioned seems impossible. It is therefore

recommended that the program should be more flexible to accommodate the work demands as explained above;

- This program was presented by combining two sessions per week due to time limitations and more specifically the unique and unpredictable nature of police officials' work. It is, however, recommended that only one session be presented per week as a result of the extent of the sessions and the intensity of some of the topics;
- Time allocated for the sessions should as a result of the extent of the sessions and the intensity of some of the topics and activities, not be less than two hours per session;
- The PTP should also be evaluated with other specialised units, not only in the North West Province, but also in the rest of the country, so that the quantitative and qualitative results of this study can be confirmed or refuted;
- The PTP should also be evaluated with other emergency agencies for example, the fire brigade, ER24 and the metro police to determine its external value;
- Respondents found it extremely difficult to answer the CIHQ. The two constructs pertaining to incident and coping were confusing and many of the police officials did not understand the link. It was completed as a group with an interpreter, interpreting every statement. It is therefore recommended that the questionnaire be simplified to accommodate all police officials;
- It will be important to extensively market the program to police management and to sensitise them to police officials' unique needs. This will give them a better understanding, so that they can become pro-active and provide timely support to those exposed to traumatic events;
- The PTP should include a session on financial management, as many of the respondents complained about promotional opportunities, overtime remuneration, inadequate salaries and the expectations for basic needs posed by family members;
- The PTP can be adjusted to include family members, for example the spouse, at some stage of the intervention process, for them to better understand trauma and to strengthen the support system; and
- The implementation of the PTP should be strictly monitored, to ensure that it is used as a therapeutic intervention process as part of SAPS trauma risk management operating procedure as explained in article five.

5. Conclusion

Through exploring the circumstances of police officials stationed at the specialised units within the North West Province with their unique and dangerous work conditions and their involvement by traumatic events it became obvious that police officials have complex and unique circumstances and needs regarding the organization they function in. The identification and exploration of the needs of police officials and ensuring support for them is an important component of psycho-social interventions for police officials. With regard to the unique working conditions and functioning as part of SAPS involved or affected by traumatic events, a psycho-social therapeutic program can be utilised as part of service delivery in the battle against post-traumatic stress- or any co-morbid disorders. The presentation of a psycho-social therapeutic program can be seen as a constructive and “non-threatening” way of providing psycho-social support and help to vulnerable police officials. This study was successful by empowering police officials by means of the PTP. After a comprehensive literature review, highlighting the prevalence of traumatic incidents, trauma and stress symptoms, complex disorders, social and behavioural risk factors, as well as the impact of trauma on the productivity at work and defining the needs of police officials in the specialised units of SAPS, new technology was developed and implemented and qualitatively and quantitatively evaluated as successful in empowering police officials to deal with the signs and symptoms following exposure to traumatic events to better deal with trauma and prevent post-traumatic stress of any other co-morbid disorders.

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**SECTION D:
ANNEXURES**

ANNEXURE A: CORRESPONDENCE WITH SAPS

2013 Apr 15 12:19 HP LASERJET FAX

p. 1

2013-03-27

FAX COVER SHEET


TO: Col MP Mapolesa
FROM: THE HEAD :STRATEGIC MANAGEMENT: SAPS
TEL.NR: 012-393 3118 FAX 012 -393 3178
PAGES: 3 (Including covering page)

SUBJECT: RESEARCH: Mr Boshoff

Dear Colonel

Receive hereby recommendation letter for the research of Mr Boshoff for your information. The documentation will be forwarded to your office next week.

With kind Regards


.....LT-COL
// HEAD : STRATEGIC MANAGEMENT
G J JOUBERT

082 7785 602

G.P.-S. 002-0222

SAP 21

SUID-AFRIKAANSE POLISIEDIENS



SOUTH AFRICAN POLICE SERVICE

Privaatstuk/Private Dep X94

Reference Nr	3/34/2
Verwysing	
Navrae	Col J Schnatler
Enquiries	Lt Col GJ Joubert
Telefoon	012-393 3177
Telephone	012-393 3118
Faksnommer	012-393 3178
Fax number	

STRATEGIC MANAGEMENT COMPONENT

HEAD OFFICE

PRETORIA

The Provincial Commissioner

(Attention: Col Mapolesa)

NORTH-WEST


RE: RESEARCH REQUEST: TRAUMA IN THE SOUTH AFRICA POLICE SERVICE: A PSYCHOSOCIAL THERAPEUTIC PROGRAMME: PHD-STUDY: RESEARCHER: PJ BOSHOF

1. The research request of Mr PJ Boshoff, (lecturer at the School for psycho-social behavioural science, North-West University) pertaining to the above mentioned topic, refers.
2. The goal of the research is to develop, implement, and evaluate a client orientated psychosocial therapeutic programme within the context of the SAPS. ~~The research group is the specialist units in the North West Province including the Public Order Unit, the Crime Record Centre, the Family Violence, Child Protection and Sexual Offence Unit (FCS) and the IODI Centres.~~ Members will be selected from this units based on the criteria for Post Traumatic Stress.
4. The researcher will make use of qualitative and quantitative data collection methods. With regard to the qualitative method, respondents will participate in focus groups, while the quantitative data will be collected by means of a questionnaire distributed amongst members of the specialist units in the North-West Province.

**RE: RESEARCH REQUEST: TRAUMA IN THE SOUTH AFRICA POLICE SERVICE: A
PSHYCOSOCIAL THERAPEUTIC PROGRAMME: PHD-STUDY: RESEARCHER: PJ
BOSHOFF**

5. The research proposal was recommended by Acting Deputy National Commissioner: Human Resource Management (see letter attached). The study is hereby recommended in terms of National Instruction 1 of 2006, for final approval and further arrangements by the office of the Provincial Commissioner: North West.

With kind regards,



MAJOR GENERAL
HEAD: STRATEGIC MANAGEMENT
M MENZIWA

Date: 2013.03.26

South African Police Service



Tsitsi-Afrikaanse Polisie

INFORMATION NOTE

To: The Head: Strategic Management

**RESEARCH REQUEST: TRAUMA IN THE SOUTH AFRICAN POLICE SERVICE:
PSYCHO SOCIAL THERAPEUTIC PROGRAMME: PHD-STUDY: RESEARCHER:
PJ BOSHOFF**

1. Your previous correspondence with reference 3/34/2, dated 29 January 2013 pertaining to the abovementioned research has bearing.
2. This office hereby recommends that Mr PJ Boshoff pursues his research on the topic of Trauma in the South African Police Service - A psycho social therapeutic programme.
3. It is requested that a copy of the research be submitted to this office after finalization to determine the use of recommendations to benefit SAPS.

Mazibuko LIEUTENANT GENERAL
ACTING DEPUTY NATIONAL COMMISSIONER: HRM
NNH MAZIBUKO

Date: 16/3/2013

Information Note compiled by: Colonel ES Mashilo
Tel: 012 303 1010/2803

SUID-AFRIKAANSE POLISIEDIENS



SOUTH AFRICAN POLICE SERVICE

Private Bag
Privaatsak X 801

Reference number:	3/34/2
Enquiries:	Captain Kgoroeaboco
Telephone number:	018 - 299 7943 / 7197
Fax number:	018 - 299 7090

THE OFFICE OF THE PROVINCIAL
COMMISSIONER
NORTH WEST PROVINCE
POTCHEFSTROOM
2520

2013 -04-16

Mr. Boshoff
Potchefstroom

**RE – RESEARCH REQUEST: TRAUMA IN THE SOUTH AFRICAN POLICE SERVICE:
A PSYCHOSOCIAL THERAPEUTIC PROGRAMME: PHD-STUDY: RESEACHER: PJ
BOSHOFF**

Reference to your application dated 29 January 2013

This office hereby informs you that your application has been approved.

Attached herewith find:

Copy of the Approval from the Office of Provincial commissioner,
Recommendation from the National Strategic Management Office,

National Instruction 1/2006 and

SAPS 512(n) Request to access SAPS records.

Please take a note of paragraph 3 of the Information Note from the **Acting Deputy National Commissioner: HRM.**

Regards

BRIGADIER
PROVINCIAL HEAD: ORGANIZATIONAL DEVELOPMENT AND
STRATEGIC MANAGEMENT NORTH WEST
VN MADIKANE

RE - RESEARCH REQUEST: TRAUMA IN THE SOUTH AFRICAN POLICE SERVICE: A PSYCHOSOCIAL THERAPEUTIC PROGRAMME: PHD-STUDY: RESEACHER: PJ BOSHOF

Regards



LIEUTENANT GENERAL
PROVINCIAL COMMISSIONER: NORTH WEST
MNZ MBOMBO

Ado

Date: 2013/04/12

MAJOR GENERAL (DR)
DEPUTY PROVINCIAL COMMISSIONER: OPERATIONS OFFICER
NORTH WEST PROVINCE
P. MABOQ

**ANNEXURE B: THE EXTENT, SUBJECTIVE EXPERIENCE AND
SPECIFIC NEEDS OF POLICE OFFICIALS EXPOSED TO TRAUMA**

CONFIDENTIAL

PLEASE MARK THE APPROPRIATE BLOCK WITH A CROSS
SECTION A
BACKGROUND INFORMATION

1. Age: _____

2. Rank

Constable	1
Sergeant	2
Warrant Officer	3
Officer	4

3. Gender

Male	1
Female	2

4. Race

White	1
Colored	2
Indian	3
African	4

5. Marital status

Married	1
Committed Relationship	2
Single	3
Divorced	4
Widow/er	5

6. Years' service within the SAPS: _____

7. Where are you stationed?

LCRC	1
FCS	2
TRT	3
POP	4
PES	5
Detectives	6
Other/Specify	7

If other please specify: _____

8. In which city/town are you stationed: _____

9. What does your work entail?

		Almost Never	Seldom	Often	Almost Always
9.1	Vehicle/Foot Patrol	1	2	3	4
9.2	Investigations	1	2	3	4
9.3	Photography	1	2	3	4
9.4	Fingerprints	1	2	3	4
9.5	Crowd control	1	2	3	4
9.6	Diving	1	2	3	4
9.7	Attend to complaints	1	2	3	4
9.8	Attend post-mortems	1	2	3	4
9.9	Tactical response	1	2	3	4
9.10	Specialised operations	1	2	3	4
9.11	Administration	1	2	3	4
9.12	Other/specify	1	2	3	4

SECTION B

THE MAJOR CAUSES OF STRESS WITHIN THE SAPS

1. Below is a list of possible stressors that are originating within the work situation in the SAPS.

	I experience the following stressors at work:	Strongly Agree	Agree	Disagree	Strongly Disagree
1.1	Bureaucracy of the organization (too much official routine/procedures/processes)	1	2	3	4
1.2	Autocratic management style (following instructions with little input in decision making processes)	1	2	3	4
1.3	Victimization by management	1	2	3	4
1.4	Insufficient training	1	2	3	4
1.5	Remuneration package	1	2	3	4
1.6	Limited promotional opportunities	1	2	3	4
1.7	Administrative procedures	1	2	3	4
1.8	Poor equipment (logistical support)	1	2	3	4
1.9	Poor work relationship with colleagues	1	2	3	4
1.10	Job security	1	2	3	4
1.11	Uncertainty due to organizational changes	1	2	3	4
1.12	Restructuring	1	2	3	4
1.13	Other/Specify	1	2	3	4

2. Below is a list of possible stressors that are originating outside the work situation:

	I experience stress due to:	Strongly Agree	Agree	Disagree	Strongly Disagree
2.1	The criminal justice system	1	2	3	4
2.2	Politics	1	2	3	4
2.3	The expectations of the SAPS opposed to those of the community	1	2	3	4
2.4	Offensiveness of the community towards the SAPS	1	2	3	4
2.5	Media on the scene	1	2	3	4
2.6	Policing within the framework of human rights	1	2	3	4
2.7	Other/Specify	1	2	3	4

3. Below is a list of possible stressors that are originating from the work itself.

	I experience stress due to:	Strongly Agree	Agree	Disagree	Strongly Disagree
3.1	The responsibility for the safety of others	1	2	3	4
3.2	Exposure to human loss	1	2	3	4
3.3	Overloading (Huge work load)	1	2	3	4
3.4	Working shifts	1	2	3	4
3.5	Unexpected deployments	1	2	3	4
3.6	Exposure to public opinion	1	2	3	4
3.7	Accountability for decisions taken under immense pressure	1	2	3	4
3.8	Other/Specify	1	2	3	4

4. Below is a list of possible stressors that are originating from personal stressors.

	I experience stress due to:	Strongly Agree	Agree	Disagree	Strongly Disagree
4.1	Fear for the unknown	1	2	3	4
4.2	Incompetency	1	2	3	4
4.3	Uncertainty	1	2	3	4
4.4	Inability to find a work-life balance	1	2	3	4
4.5	Financial pressure	1	2	3	4
4.6	Unhealthy life style factors (diet, exercise)	1	2	3	4
4.7	Relationship problems	1	2	3	4
4.8	Family problems	1	2	3	4
4.9	Loss of friends	1	2	3	4
4.10	Lower social status	1	2	3	4
4.11	Other/Specify	1	2	3	4

5. To what extent do the stressors as indicated in Section B of this questionnaire have an impact on the manner to which you are able to cope with traumatic incidents as a result of your work as a police officer?

Lesser extent	Reasonable Extent	Great Extent
1	2	3

6. Please explain: _____

SECTION C

THE MAJOR CAUSES OF TRAUMA WITHIN THE SAPS

1. Listed below are traumatic events to which police officers may be exposed at some time during their career. Indicate:
 - how often you have been exposed to these incidents (1 = Never and 4 = more than twice);
 - and whether you were traumatised by the incident (1 = Strongly agree and 4 = Strongly disagree).

	TRAUMATIC INCIDENT	HOW OFTEN				I HAVE BEEN TRAUMATISED			
		Never	Once	Twice	More than twice	Strongly Agree	Agree	Dis-agree	Strongly Disagree
1.1	Being shot at	1	2	3	4	1	2	3	4
1.2	Shooting at a suspect/s	1	2	3	4	1	2	3	4
1.3	Involvement in a physical attack	1	2	3	4	1	2	3	4
1.4	Exposure to dealing with corpses	1	2	3	4	1	2	3	4
1.5	Exposure to a suicide scene	1	2	3	4	1	2	3	4
1.6	Exposure to the suicide where a colleague was involved	1	2	3	4	1	2	3	4
1.7	Exposure to a family murder-suicide scene	1	2	3	4	1	2	3	4
1.8	Attending a family murder-suicide scene where a colleague was involved	1	2	3	4	1	2	3	4
1.9	Attending a horrific accident scene	1	2	3	4	1	2	3	4
1.10	Attending a farm murder scene	1	2	3	4	1	2	3	4
	Managing violent crowds	1	2	3	4	1	2	3	4
1.11									
1.12	Answering a call to a sexual/physical abuse scene involving a female as the victim	1	2	3	4	1	2	3	4
1.13	Answering a call to a sexual/physical abuse scene involving a minor as the victim	1	2	3	4	1	2	3	4
1.14	Attending a murder scene	1	2	3	4	1	2	3	4
	Attending a murder scene where a colleague was involved	1	2	3	4	1	2	3	4
1.15									
1.16	Involvement in a hostage situation	1	2	3	4	1	2	3	4
1.17	Participation in a rescue operation	1	2	3	4	1	2	3	4
1.18	Other / Specify	1	2	3	4	1	2	3	4

SECTION D

THE RESPONSE TO TRAUMA

1. Below is a list of post-traumatic stress symptoms usually experienced directly after exposure to a traumatic event.

1.1	I experience the following stress symptoms usually associated with the re-experience of the traumatic event:	Strongly Agree	Agree	Disagree	Strongly Disagree
1.1.1	Flashbacks	1	2	3	4
1.1.2	Bad dreams and nightmares	1	2	3	4
1.1.3	Feeling as if the trauma is happening again	1	2	3	4
1.1.4	Trouble falling or staying asleep	1	2	3	4
1.1.5	Intrusive re-experiences of the traumatic event	1	2	3	4
1.1.6	Other/Specify	1	2	3	4
1.2	I experience the following post-traumatic stress symptoms associated with the avoidance of the traumatic event:	Strongly Agree	Agree	Disagree	Strongly Disagree
1.2.1	Avoiding thoughts, feelings, activities, places, people or conversations that might arouse recollections of the trauma	1	2	3	4
1.2.3	Social isolation and detachment from others	1	2	3	4
1.2.4	Rejection of spirituality and spiritual/religious beliefs	1	2	3	4
1.2.5	The inability to recall aspects of the trauma	1	2	3	4
1.2.6	A sense of foreshortened future	1	2	3	4
1.2.7	Difficulty trusting	1	2	3	4
1.2.8	Concerns over burdening others with problems	1	2	3	4
1.2.9	Sensitivity to signs of abandonment or betrayal	1	2	3	4
1.2.10	Interpersonal conflicts and arguments	1	2	3	4
1.2.11	Feelings of guilt	1	2	3	4
1.2.12	Feelings of shame	1	2	3	4
1.2.13	Blaming yourself	1	2	3	4
1.2.14	Perceptions of self as bad or unworthy	1	2	3	4
1.2.15	Other/Specify	1	2	3	4

1.3	I experience the following post-traumatic stress symptoms associated with hyperarousal as a result of the traumatic event	Strongly Agree	Agree	Disagree	Strongly Disagree
1.3.1	Irritability	1	2	3	4
1.3.2	Anger	1	2	3	4
1.3.3	Hyper vigilance (constantly on the lookout for danger)	1	2	3	4
1.3.4	Unregulated extremes of emotions	1	2	3	4
1.3.5	Getting very startled by loud noises	1	2	3	4
1.3.6	Getting upset when reminded about the trauma (what you see, hear, feel, smell or taste)	1	2	3	4
1.3.7	Inability to tolerate mild emotional distress	1	2	3	4
1.3.8	Feeling shaky and sweaty	1	2	3	4
1.3.9	Having your heart pound	1	2	3	4
1.3.10	Having trouble breathing	1	2	3	4
1.3.11	Find it difficult to eat	1	2	3	4
1.3.12	Headaches, backaches and chest pains	1	2	3	4
1.3.13	Other/specify	1	2	3	4

2. Individuals exposed to multiple and severe interpersonal traumas appear to have more **complex posttraumatic outcomes**. Below is a list of the outcomes usually associated as a result of the exposure to more complex trauma. Indicate to what extent you have experienced the following outcomes at some stage during the course of your career:

		Lesser extent	Reasonable Extent	Great Extent
2.1	Post-traumatic stress disorder	1	2	3
2.2	Acute stress disorder	1	2	3
2.3	Dissociation	1	2	3
2.4	Depression	1	2	3
2.5	Anxiety disorder	1	2	3
2.6	Substance abuse	1	2	3
2.7	Physical health problems (for example cardiac vascular problems, cancer, high blood pressure, gastrointestinal systems)	1	2	3
2.8	Other/specify	1	2	3

3. Below is a list of social and behavioural risk factors usually associated with Post-traumatic stress. Indicate to what extent the following statements are applicable or have been considered by you personally:

	Lesser extent	Reasonable extent	Great extent
3.1 Aggressive behaviour (brutality)	1	2	3
3.2 Domestic violence	1	2	3
3.3 Suicide	1	2	3
3.4 Homicide	1	2	3
3.5 Family murder-suicide	1	2	3
3.6 Other/Specify	1	2	3

4. The consequences of trauma do have a devastating impact on the overall productivity of the SAPS. Listed below are some of the factors contributing to the poor productivity in SAPS. Indicate to what extent the following statements are applicable to you personally:

	Lesser extent	Reasonable extent	Great extent
4.1 Reduced level of job performance	1	2	3
4.2 Low morale	1	2	3
4.3 Tardiness	1	2	3
4.4 Absenteeism without permission	1	2	3
4.5 Sick leave	1	2	3
4.6 Considering premature retirement	1	2	3
4.7 Considering quitting the police service altogether	1	2	3
4.8 Other/specify	1	2	3

SECTION E

COPING WITH TRAUMA

1. Police officer's exposed to traumatic incidents normally utilize the following coping strategies. Indicate whether you agree that the following strategies are applicable to you personally:

	Strongly Agree	Agree	Disagree	Strongly Disagree
1.1	Action-orientated coping (confront the problem and control the situation in the hope of reducing the imbalance)			
	1	2	3	4
1.2	Avoidance coping (Denial and ignorance)			
	1	2	3	4

2. To what extent do you agree with the following action-orientated coping mechanisms indicated below:

	Strongly Agree	Agree	Disagree	Strongly Disagree
2.1	I participate in pro-active programs presented by EHW (Social Workers, Psychologists & Chaplains in the SAPS)			
	1	2	3	4
2.2	I attend critical incident stress debriefing			
	1	2	3	4
2.3	I seek support from:			
	a) My colleagues			
	1	2	3	4
	b) EHW			
	1	2	3	4
	c) Police Management			
	1	2	3	4
	d) An external social worker/ psychologist/religious leader (in private practice)			
	1	2	3	4
	e) Important others (for example family members)			
	1	2	3	4
2.4	I participate in relaxation activities (exercise, reading, singing, music)			
	1	2	3	4
2.5	I put my confidence in God			
	1	2	3	4
2.6	Other/specify			
	1	2	3	4

3. To what extent do you agree with the following avoidance coping mechanisms indicated below:

	Strongly Agree	Agree	Disagree	Strongly Disagree	
3.1	I avoid reminders of the trauma	1	2	3	4
3.2	I socialize with friends	1	2	3	4
3.3	I use alcohol	1	2	3	4
3.4	I joke about the incident	1	2	3	4
3.5	I internalize or hide the symptoms associated with trauma	1	2	3	4
3.6	I keep emotions to myself	1	2	3	4
3.7	I isolate myself	1	2	3	4
3.8	I deny the occurrence of the incident	1	2	3	4
3.9	Other/Specify	1	2	3	4

SECTION F

EXPERIENCE OF CURRENT TRAUMA INTERVENTION PROGRAMS

1. Police officers are expected to honor and completely conform to the police culture. To what extent do you agree with the statements indicated below:

	Strongly Agree	Agree	Disagree	Strongly Disagree	
1.1	Culture is deeply embedded into every element of SAPS, (for example hierarchy, policies, procedures, training, the job itself and relationships)	1	2	3	4
1.2	Policing is a way of life, and not seen as just a job	1	2	3	4
1.3	The image of the SAPS is that "Cowboy's don't cry"	1	2	3	4
1.4	Police officers showing emotion are usually labeled as weak	1	2	3	4
1.5	Police officers seeking professional assistance are usually labeled as weak	1	2	3	4
1.6	The police culture diminishes the importance of emotion	1	2	3	4
1.7	The police culture values action instead of feeling	1	2	3	4
1.8	Police officers are expected to adhere to:				
	a)Neutrality	1	2	3	4
	b)Objectivity	1	2	3	4
	c)Unbiased detachment	1	2	3	4
	d)Emotionless order	1	2	3	4

1.9	The distressed police officer may project a facade of competence while harboring a feeling of insecurity	1	2	3	4
1.10	The distressed police officer may project a facade of competence while harboring a feeling of shame	1	2	3	4
1.11	Police officers has a strong need for:				
	a)Acceptance	1	2	3	4
	b)Respect	1	2	3	4
	c)Approval of peers	1	2	3	4
1.12	Behaviour are strongly influenced by the expectations of peers	1	2	3	4
1.13	Decisions are strongly influenced by the expectations of peers	1	2	3	4

2. To what extent do you agree with the following statements?

		Strongly Agree	Agree	Disagree	Strongly Disagree
2.1	An ordinary police officer can generally gain by visiting a psychologist, social worker or chaplain.	1	2	3	4
2.2	There is a need for intervention by Employee Health and Wellness (EHW) in SAPS, immediately after exposure to traumatic events.	1	2	3	4
2.3	I trust Employee Health and Wellness (EHW) in SAPS.	1	2	3	4

3. If at any stage you have had personal doubts in consulting Employee Health and Wellness (EHW) in SAPS after exposure to a traumatic event, please indicate why. Mark **all** the applicable reasons:

3.1	All my personal details are kept on file	
3.2	Confidentiality are not always maintained	
3.3	My possibility for future promotions will be at risk	
3.4	EHW do not always maintain professional behaviour	
3.5	The quality of service delivery by EHW is poor	
3.6	EHW are not objective, as they are employed by and part of SAPS Management	
3.7	I do not allow myself sufficient time to consult EHW (Always other priorities)	
3.8	Other/specify	

4. Which of the following trauma intervention programs are familiar to you and in which of these programs have you participated:

	TRAUMA INTERVENTION PROGRAM	FAMILIAR		PARTICIPATED	
		Yes	No	Yes	No
4.1	Critical Incident Stress Debriefing	1	2	1	2
4.2	Crisis Intervention	1	2	1	2
4.3	Stress Management	1	2	1	2
4.4	Suicide Prevention	1	2	1	2
4.5	Psychotherapy	1	2	1	2
4.6	None of the above	1	2	1	2
4.7	Other/specify	1	2	1	2

5. If you have participated in any of the trauma intervention programs, how did you experience these programs?

		Strongly Agree	Agree	Disagree	Strongly Disagree
5.1.	The trauma intervention program/s fulfill my expectations/needs, regarding the following:				
	a) The content of the program/s	1	2	3	4
	b) The environment in which the program/s were presented	1	2	3	4
	c) The time at which the presentation/s occurred	1	2	3	4
	d) The duration of the entire program	1	2	3	4
	e) The manner in which the program/s were presented	1	2	3	4
	f) Adhere to my specific needs on ground level	1	2	3	4

6. If you did not participate in one or more of the programs as mentioned in question 6 please indicate why:

		Strongly Agree	Agree	Disagree	Strongly Disagree
6.1	I have never before felt the need to attend trauma intervention programs	1	2	3	4
6.2	Trauma intervention programs are generally not marketed effectively	1	2	3	4
6.3	I do not trust the program facilitators	1	2	3	4
6.4	Members are forced to attend trauma intervention programs which result in negative attitudes	1	2	3	4
6.5	Police officers are not granted time off to attend these programs (crime prevention is priority)	1	2	3	4
6.6	Commanders are limiting the police officer access to these programs	1	2	3	4
6.7	I do not allow myself sufficient time to attend these programs	1	2	3	4
6.8	Programs are not aligned to the needs of police officers attached to specific units	1	2	3	4
6.9	Members are not consulted in the development of prospective trauma intervention programs	1	2	3	4
6.10	Police officers do not benefit from the trauma intervention programs as the working conditions will be left unchanged.	1	2	3	4
6.11	Police management does not really care about the psycho-social well-being of police officers.	1	2	3	4
6.12	Other/Specify	1	2	3	4

7. What is your preferences regarding the format of trauma intervention programs within SAPS?

		Strongly Agree	Agree	Disagree	Strongly Disagree
7.1	Individual intervention	1	2	3	4
7.2	Group intervention	1	2	3	4
7.3	Once off critical incident stress debriefing (Structured discussion regarding the facts, feelings, emotions and symptoms experienced as a result of the incident)	1	2	3	4
7.4	Initial debriefing and 6 follow up sessions	1	2	3	4
7.5	Group intervention during parades at unit level	1	2	3	4
7.6	Group intervention at the end of a shift at unit level	1	2	3	4

7.7	A structured group intervention on a regular basis (weekly/monthly/quarterly) at unit level	1	2	3	4
7.8	A structured trauma group intervention program of at least six sessions according to need	1	2	3	4
7.9	Other/specify	1	2	3	4

8. What is your preferences regarding the content of trauma intervention programs within SAPS?

		Strongly Agree	Agree	Disagree	Strongly Disagree
8.1	Psycho-education (education about a situation causing psychological stress)	1	2	3	4
8.2	Coping with trauma with less avoidance and denial and dissociation	1	2	3	4
8.3	Retelling the incident in as much detail as possible	1	2	3	4
8.4	Modification of:	1	2	3	4
	a) distorted feelings	1	2	3	4
	b) negative thoughts	1	2	3	4
	c) negative biased beliefs	1	2	3	4
8.5	To learn from past trauma and to apply this to future incidents	1	2	3	4
8.6	Identification of unwanted and intrusive reminders of a negative experience (Triggers)	1	2	3	4
8.7	How to deal with flashbacks	1	2	3	4
8.8	Dealing with fear	1	2	3	4
8.9	The impact of stress on the body	1	2	3	4
8.10	Relaxation therapy (exercise, nature, hobbies etc)	1	2	3	4
8.11	Resilience (The ability to bounce back)	1	2	3	4
8.12	Identifying inner resources	1	2	3	4
8.13	Problem solving techniques	1	2	3	4
8.14	Couple therapy	1	2	3	4
8.15	Family therapy	1	2	3	4
8.16	Parental guidance	1	2	3	4
8.17	Relationship with peers/others	1	2	3	4
8.18	Spiritual guidance	1	2	3	4
8.19	Re-integration into the working environment	1	2	3	4

8.20	Re-integration into the community	1	2	3	4
8.21	Behavioural risk factors (Anger, rage, suicide ideation)	1	2	3	4
8.22	Other/specify	1	2	3	4

9. Do you have any further recommendations about how police officers can be assisted to cope with trauma more effectively?

THANK YOU FOR YOUR COOPERATION

P J BOSHOFF (RESEARCHER)

ANNEXURE C: GUIDELINES FOR AUTHORS: THE SOCIAL WORK PRACTITIONER-RESEARCHER

Editorial Scope

The *Social Work Practitioner-Researcher* is a refereed interdisciplinary journal for social workers and social service professionals concerned with the advancement of the theory and practice of social work and social development in Africa and in a changing global world. The purpose of the journal is to promote research and innovation in the practice of helping individuals, families, groups, organisations and communities to promote development and human well-being in society. The journal is committed to the creation of empowered, humane, just and democratic societies.

Manuscripts that would be appropriate are: 1) conceptual analyses and theoretical presentations; 2) literature reviews that provide new insights or new research questions; 3) manuscripts that report empirical work. Topics that will be considered include, but are not limited to, the following: lifespan, populations at risk, poverty, livelihoods, anti-discriminatory practice, welfare systems, development management, social security, social policy, human rights, community-based development, social development, comparative health, mental health, education, urban and rural development, voluntarism, civic service, civil society, social movements and social change.

As it is the intention of this journal to maintain a balance between theory and practice, contributors are encouraged to spell out the practical implications of their work for those involved in social work practice and the social services in the African context.

Ethical Protocol for Submissions

The editorial board assumes no responsibility for opinions expressed by contributors.

A decision to submit an article to this journal means that you will not be able to simultaneously submit the same article, or verbatim sections of the same/original article within another/second article, and then submit that to another journal in South Africa or elsewhere. We require a letter from you/all the authors stating this.

If there is more than one author, we require a letter stating that all the authors agree to submit the article. If a person has contributed to the research of the article and is not going to be included as a co-author, then that person needs to be acknowledged after the reference list.

The reviewing process

Manuscripts should be submitted as *electronic attachments* to the journal administrator, swjournal@uj.ac.za, in Word format. Authors should not be identified anywhere in the article.

The manuscript is sent to the Editor or Assistant Editor for approval. If it is judged suitable for this journal, it is sent to two reviewers for blind peer-review. Based on their recommendations, the editorial committee decides whether the manuscript should be accepted as is, revised or rejected. If the manuscript is published, the author or their institution will be invoiced for page fees at the rate of R130.00 per page.

Presentation

- 1) A *minimum length* of 3 500 words and a *maximum length* of 6 000 words (excluding references). No footnotes, endnotes and annexures are allowed.
- 2) On a separate page, a *title* of not more than ten words should be provided. The author's full name and title, position, institutional affiliation and e-mail address should be supplied.
- 3) An *abstract* of 150 words plus up to six *keywords*, which encapsulate the principal topics of the paper, must be included. The abstract should summarise the key argument/s of the article and locate the article in its theoretical practice and context. Please note that abstracts are not summaries of research studies. No sub-headings should be used in the abstract. For Afrikaans articles, the abstract and keywords must be in English.
- 4) *Headings* must be short, clear and not numbered: main headings to be in bold capitals; first stage subheadings to be in bold lower case, with only the first letter of the first word to be a capital (not underlined, nor in italics); and second stage subheadings in normal type to follow the first stage style.
- 5) *Figures and tables*:

All *figures* (diagrams and line drawings) should be copied and pasted or saved and imported from the origination software into a blank Microsoft Word document and submitted electronically. Figures should be of clear quality, black and white, and numbered consecutively with arabic numerals. Supply succinct and clear captions for all figures. The maximum portrait width should not exceed 110mm and 160mm depth. For landscape, the maximum width is 160mm with a maximum depth of 110mm.

In the text of the paper, the preferred position of all figures should be indicated by typing on a separate line the words, "Place figure (No.) here".

Tables must be numbered consecutively with arabic numerals and a brief title should be provided. In the text, type on a separate line the words, "Place Table (No.) here" should show the position of the table.

6) *References:*

In text, publications are to be cited using one of the following examples: (Adams, 1997), or (Mbatha et al., 2005), or Mercy et al. (2002). Use 'and', not the '&' symbol, for two or more authors, eg. (Weyers and Herbst, 2014)

If a direct quote is used in text, references should include author's name/s, date and page number, eg; "usually to improve the working relationship between members of the group" (Barker, 2003:153). Where there are no direct quotes, page numbers should not be included.

At the end of the paper, the reference list should be in alphabetical order. Do not use indentations when formatting your references.

References to publications must be in modified Harvard style and checked for completeness, accuracy and consistency. Include all authors' names and initials and give the book's, or book chapter's, or journal's title in full.

Please cross check that only references cited in the text are included in the final reference list at the end of the article (and vice versa). Use 'and', not the '&' symbol, for two or more authors as mentioned above. References should follow the style as set out below:

For books:

Surname, Initials. (year). *Title of Book* Place of Publication: Publisher.

Example:

Swanepoel, H. and De Beer, F. (1996). *Community Capacity Building* Johannesburg: Thomson Publishing.

For book chapters:

Surname, Initials. (year). "Chapter Title" in Editor's Surname, Initials. (Ed.). *Title of Book* Place of Publication: Publisher, Edition, pages.

Example:

A Reader in Selected Social Issues Pretoria: Van Schaik Publishers, Second Edition, 41-52.

For journals:

Surname, Initials. (year). "Title of Article" *Journal Name* Volume(number):pages

Example:

Mda, C.J. (2004). "Population Ageing and Survival Challenges in Rural Ghana" *Journal of Social Development in Africa* 19(2):90-112.

For electronic sources:

If available online the full URL should be supplied at the end of the reference.

Example:

Louisiana State Board of Social Work Examiners. (1998). "Guidelines for Child Custody Evaluations", <http://www.labswe.org/child.htm> (Accessed on 23/08/2006).

Content

Manuscripts should contribute to knowledge development in social work, social welfare or related professions and the practice implications of the research should be spelled out. Sufficient and appropriate recent literature should be cited. Where the study is based on empirical research, the research design and methodology, results, discussion and conclusion should be addressed. All manuscripts should locate the issue within its social context and the conceptual and theoretical framework informing the study should be clearly outlined.

The journal will consider articles based on research studies but we will not publish articles which are merely a summary of a research report. The article should have a clear focus that contributes to knowledge building or informs policy and/or practice.

ANNEXURE D: GUIDELINES FOR AUTHORS: JOURNAL FOR SOCIAL WORK/MAATSKAPLIKE WERK

FOCUS AND SCOPE:

This South African academic peer-reviewed journal publishes articles, book reviews and commentary on articles already published from any field of social work. Manuscripts covering the following amongst others, are considered for publication: social work, welfare organizations, society, social welfare, family and child care, community work, substance abuse, substance dependence, welfare law, etc.

PEER REVIEW PROCESS:

1. All contributions will be critically reviewed by at least two referees on whose advice contributions will be accepted or rejected by the editorial committee.
2. All refereeing is strictly confidential (double blind peer-review).
3. Manuscripts may be returned to the authors if extensive revision is required or if the style or presentation does not conform to the Journal practice.

OPEN ACCESS POLICY

This journal provides immediate open access to its content on the principle that making research freely available to the public supports a greater global exchange of knowledge.

Articles from this journal can be submitted to institutional repositories, under the following conditions:

1. Always upload the final publishers' version as published at <http://socialwork.journals.ac.za>
2. Acknowledge Stellenbosch University (SUNJournals) as the Publisher.
3. Cite the article as part of the metadata and include the doi as part of the citation to the article.

SECTION POLICIES:

Editorial, Articles, Book Reviews, Notes from Practice

AUTHOR GUIDELINES:

The Journal publishes articles, book reviews and commentary on articles already published from any field of social work.

1. Contributions may be written in English or Afrikaans.
2. All articles should include an abstract in English of not more than 100 words.
3. All contributions will be critically reviewed by at least two referees on whose advice contributions will be accepted or rejected by the editorial committee.
4. All refereeing is strictly confidential (double blind peer–review).
5. Manuscripts may be returned to the authors if extensive revision is required or if the style or presentation does not conform to the Journal practice.
6. Articles of fewer than 2,000 words or more than 10,000 words are normally not considered for publication.
7. Manuscripts should be typed in 12 pt Times Roman double–spaced on A4 paper size.
8. Use the Harvard system for references.
9. Short references in the text: When word–for–word quotations, facts or arguments from other sources are cited, the surname(s) of the author(s), year of publication and page number(s) must appear in parenthesis in the text, e.g. "... (Berger, 1967:12).
10. More details about sources referred to in the text should appear at the end of the manuscript under the caption "References".
11. The sources must be arranged alphabetically according to the surnames of the authors.
12. Note the use of capitals and punctuation marks in the following examples.

MANUSCRIPT FORMAT AND LAYOUT

1. Contributions may be written in English or Afrikaans.
2. All articles should include an abstract in English of not more than 100 words.

3. All contributions will be critically reviewed by at least two referees on whose advice contributions will be accepted or rejected by the editorial committee.
4. All refereeing is strictly confidential (double blind peer–review).
5. Manuscripts may be returned to the authors if extensive revision is required or if the style or presentation does not conform to the Journal practice.
6. Articles of fewer than 2,000 words or more than 10,000 words are normally not considered for publication.
7. Manuscripts should be typed in 12 pt Times Roman double–spaced on A4 paper size.
8. Use the Harvard system for references.
9. Short references in the text: When word–for–word quotations, facts or arguments from other sources are cited, the surname(s) of the author(s), year of publication and page number(s) must appear in parenthesis in the text, e.g. "... (Berger, 1967:12).
10. More details about sources referred to in the text should appear at the end of the manuscript under the caption "References".
11. The sources must be arranged alphabetically according to the surnames of the authors.
12. Note the use of capitals and punctuation marks in the following examples.

SUBMISSIONS

Registration and login are required to submit items online and to check the status of current submissions.

[REGISTER](#) to obtain Username and Password or [LOGIN](#) if you already have Username and Password for Social Work/Maatskaplike Werk

ANNEXURE E: GUIDELINES FOR AUTHORS: ACTA CRIMINOLOGICA: SOUTHERN AFRICAN JOURNAL OF CRIMINOLOGY

Guidelines for authors
Acta Criminologica: Southern African Journal of Criminology

GUIDELINES FOR AUTHORS

REFERENCING GUIDELINES:

Notes: References and citations should be prepared in accordance with the *Acta Criminologica* adapted APA format (see below examples of various reference listing types). The 'in-text' referencing format is followed by the Journal with full source referencing information listed under the heading: **LIST OF REFERENCES** (uppercase), which list to be placed at the end of your article. All sources in the List of References must be listed alphabetically by author(s)' surname(s), according to the following examples. Please note the indenting of the second and additional lines of a reference listing when longer than one line. Use of full stops in listing: Generally each separate piece of information is standardly followed by a full stop. A comma only used if part of that one piece of information. Exception being the use of the colon [:] – and not a dash [-] or semi-colon [;] – in a split article or book title and after the place of publication before the name of the publisher.

LIST OF REFERENCES [EXAMPLES]:

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NOTES ON EXAMPLES:

List of References: Sources in general

The sources in the list of references must be listed in alphabetical order according to the surnames of the authors. They are not numbered.

Note that all the details of a source are given in the language of the source itself. If you were to use a German book, for instance, its title would be in German [with the English translation after it in square brackets] and the place of publication might be München, not Munich.

If multiple entries for the same author, i.e. different publications/articles etc. then the author must be listed by date (oldest first) of the publication/article. If there are two or more from the same year they are indicated (again first in the year by month). For example: Jones, A. 2004a; Jones, A. 2004b; and Jones, A. 2004c... etc. In the text such additions of a, b, c, ... would then also occur in the text reference accordingly. For example:... (Jones, 2004c: 12).

If authors surnames are the same then the author listed first is the one with the first alphabetic initial, e.g. Brown, B. comes before Brown, D.

Source references in the text:

These are indicated by the surname(s) of the author(s) and the year of publication, as well as the page number from where the reference is cited/sourced. For example:... (Nkosi, 2005: 4) or Nkosi (2005: 4). If you are referencing generally some information (ideas, concepts interpretations) drawn from a publication and paraphrased them, i.e. there is no specific page number or numbers, this can be referenced as: (cf Parsons, 2011: 34-41). It would not be acceptable merely to list this reference as (Parsons, 2011) with no page numbers. A reader must be able to go to the Parsons' publication and see where you obtained the general information being referred to, even if from a number of consecutive pages. If the information is general information extracted from a whole publication then the reference does not need to have page numbers indicated.

Comma or not after author(s) name(s) in bracket:

It is your choice of whether to insert a comma or not after an author(s) name in the bracketed reference. However, whichever style you choose to implement it must be applied consistently throughout your submitted article. Accordingly it can be either as follows:

... (Moffett, 2006: 129). Or: (Moffett 2006: 129).

Secondary referencing:

For example:Morrison (1998) (as cited in Prinsloo, 2001: 7)... This is generally not acceptable in academic terms. Author(s) should go to the primary source, i.e. Morrison (1998), and reference the information used directly from the relevant page numbers in the Morrison publication. However, sometimes in a newspaper or journal article a specific person is quoted. In other words, such person does not have a primary publication from which the information is being quoted but was interviewed by the writer. In such circumstances the person so quoted can be referenced accordingly by name as, for example, ...National Police Commissioner Selebi (as cited in Mashaba, 2008) said that the SAPS must fight drug dealers on the streets....

Three or more authors for one publication: Use of 'et al.'

In the text the first time three or more authors are cited in the text then all authors' names to be indicated in the reference. Thereafter only the first author name and the term 'et al.' to be used. For example: Ammaniti et al, 2000: 12 ('et al.' is not used in the List of References). The term 'et al.', although a Latin term which means 'and others', is no longer italicised.

Also if there are only two authors both authors surnames are used for every in-text reference to them and not et al, in place of the second author's name.

No author identified:

If no author is identified the appellation: Anon. must be used. In newspaper articles cited if there is no author listed for the particular article, then the news source should then be put as the author. For example: SAPA, Reuters or AFP. In the List of References a month date is always added after the newspaper title, e.g. 6 July (year date comes after author), followed by the newspaper page number (if available) where the cited article appeared.

Author(s) initials followed by date of publication

All multiple initials are separated by full stops, but without any spaces in-between. Date of publication follows author(s)'s surname and initials and date is itself followed by a full stop (Note: Alternate option: Date in bracket. You can place the year date in brackets, but this is your choice. Remember, whichever choice you make to apply it consistently throughout.)

Titles of article, chapter or document, place of publication and publisher's name

Titles of article, chapter, document being referenced only has the first letter of the first word (unless a Proper Noun) as a capital (uppercase). This rule also applies to the first word after a colon in the title. However, all words in the title of a journal (except pronouns) have the first letter as a capital. Only book, journal and newspaper titles (not chapters or article titles) are *italicised*.

Place of publication is followed by a colon and then the publisher's name. Note: Little known places of publication: Sometimes the place of publication is not a well-known city/town, so either the country or state is inserted after it. For example: Cullompton, Devon, UK; Baton Rouge, FL; Seven Oaks, CA; Aberdeen, Scotland. The acronym for the American states is usually given in such cases. FL = Florida; CA = California. Sometimes because a city or town occurs in two or more countries, which country it occurs would also be provided. For example: Albany, NY, USA and Albany, UK.

Publishers: You only need to give the publishers name and not for instance 'Pty Ltd', or 'Inc.' or 'Books' or even 'Publishers' (There are a few exceptions to this rule, namely Oxford University Publishers but 'Publishers' would not be added to a publishing company, since that is their only business. For example it would only be 'Sage' and not 'Sage Publishers').

Volume and edition numbers

The volume and/or edition numbers are not part of the Journal title, i.e. are therefore not italicised. Note the volume number is followed by issue/edition number in brackets followed by a colon and the journal page numbers of the specific article. No use is made of the abbreviations: Vol. or No. Journal titles are not abbreviated or given acronyms when referenced in the text for the first time. For example: SAJJC is written out as: *South African Journal of Criminal Justice*, the first time it is used as a reference in the text (and in the List of References) with the acronym in brackets after the full title (when used first time in the text), and thereafter you can use the acronym in the subsequent reference listings to this journal in the text.

Chapter in a publication

Please note the specific listing for a chapter in a publication, as well as the insertion after the chapter title of the page numbers in which it appears in the publication. If only one editor for the publication this is indicated in brackets after the editor's surname (which has a full stop before the bracket) as: (Ed.). ...while multiple editors will be the abbreviation: (Eds). Note editor(s) initials come before their surname in the listing of a chapter. Note no full stop after the abbreviation 'Eds' and the cap 'E' in both usages and a full stop after the last bracket.

The chapter title is followed by the page numbers of the chapter in the publication. The page numbers must also be indicated in brackets immediately after the chapter title and preceded by the letters: 'Pp.'. The page numbers bracket is then closed by a full stop; hence the 'In' (in which publication the chapter appears) has a capital letter.

If a publication has a number of editions the specific edition consulted must be listed. In the example above note the edition number is not written out as 'eighth' but as 8th. Also that it is in brackets after the title full stop, as well as the closing bracket is followed by another full stop. Also 'edition' is abbreviated as 'edn.' to distinguish it from the abbreviation for 'editor' which is 'ed.'

No date or place of publication:

If the date of the publication is unknown, the abbreviation of the Latin expression '*sine anno*' (without a year): sa, is used in square brackets. If the place of publication is unknown, the abbreviation of the Latin expression '*sine loco*' (without place): sl, is used in square brackets, for example:

According to Smith ([sa]: 12) there are...
.. in that regard (Smith [sa]: 9)...

Note: In the list of reference sources, the 'S' of both *sine anno* and *sine loco* is capitalised (upper case) because it introduces a new element of the entry. In the in-text reference, however, the 's' is written with a small letter (lower case).

Referencing information from the internet:

This is treated exactly the same as if it is a publication. In other words, look for an author. Sometimes this is merely the organisation on whose website such information has been found. Then try and establish a date for when the downloaded document was placed on the website or the report (often if in pdf format) published. If the date of the publication is unknown, then use the abbreviation 'sa' and no place of publication indicated then the abbreviation 'sl' (as above example). You must indicate a title for the document – this can be the first heading of the document. Then a publisher, usually the website organisation, e.g. Consumer Goods Council of South Africa (CGCSA). No place of publication (sl) needs to be inserted unless indicated in the report/document downloaded.

Then the use of the terms: 'Available at:' followed by the URL web address for the downloaded document. This is followed (in brackets) with the terms: '(accessed on:' or alternately the term 'retrieved on:' (again your choice of which of these two terms to use. Also your choice whether 'at' and 'on' added to either 'Available' or 'accessed' respectively. Note: colon use after 'at' and 'on'); followed by the date when such internet document was downloaded. The date should be written out as 6 March 2012 (required date format to be: dd-mm-yy) but the format 06/03/2012 can also be used. Whichever form used that should be applied throughout the article.

Note that 'Available' has a cap but 'accessed' lower case used – and that there is no full stop after the URL web address before the bracket (accessed on: ...). But if you choose to

drop the brackets for: (accessed on: ... then a CAP 'A' and a full stop after the web address to be inserted.

Wikipedia references are not a primary source for referencing and are not academically acceptable in this journal's articles.

Referencing of legislative Acts:

Note how legislative Acts are listed (under their own sub-heading: Legislation) with the provision of as much detail as possible. For example: **Domestic Violence Act 116 of 1998**. [the name of the Act to identify the exact piece of legislation (and add in brackets if there have been Amendment Act(s) to the original piece of legislation, i.e. the specific version consulted and quoted from; followed by the country of origin of this particular Act] **South Africa, 1998**, [date of Act's promulgation] *Government Gazette*, [which is italicised – treated as a journal publication] **524(31911)**, [the GG volume and issue no] **Pretoria**: [place of publication] **Government Printers** [as the publishers/printers]. **18 February** [date of GG and/or date Act assented to by the State President]. All this information is available on the actual published Act document in the *Government Gazette*. If the Act is available in pdf on a government department website this URL can be added after the listing as above.

When referencing a piece of legislation (Act) in-text the following format to be followed:

... (Domestic Violence Act (DVA), 1998: s6(1a): 5).

Note the following: The use of the name of the specific Act; first time use the acronym can be placed in brackets, thereafter the acronym can be used in the reference brackets; it is not necessary to insert the number of the Act in the reference; if the piece of information used can be identified by section (s); paragraph (1a), and a page number, then such should be inserted in the reference paragraph. The country of origin is not to be used as the identifier (author) of the reference.

South African Case Law:

Case law (cases and judgments) are usually reported in various so-called (South African) Law Reports. For example:

All SA = All South African Law Reports; **BCLR** = Butterworths Constitutional Law Reports; **SA** = South African Law Reports, etc.

The examples above, if you were referencing information from them, would be listed in your List of References, as exactly as they appear above (under the heading: Case Law in your List of References and listed alphabetically). However, in your in-text referencing they would appear as follows (shortened):(*Holomisa v Argus Newspapers Ltd* [1996]) (If you have a page number from the court records – usually the judgement/decision document as appearing in the specific Law Report, then it can be inserted as part of your reference.)

Note the following: The names of the litigants in the examples of cases are *italicised*. Only first respondents surname is given. Other parties to the case are indicated as 'and another' or 'and others'. The date of the above *Holomisa*... example is in square brackets – only to indicate that 1996 was when the case was first lodged in court and also indicates that [1996] is not the date – which might be a few years after – when the case was finalised and judgement given. Specific **sections** of a case are referred to with reference to either the page(s), for example 263H, where it is indicated in the reported volume, or a paragraph(s) of the judgment (as has become customary for judges in their judgements nowadays). The paragraph is identified by way of square brackets, for example [137]. The letters after the

date indicate in which Law Report (e.g. Butterworths Constitutional Law Reports = BCLR) the case was reported, followed by page numbers of that specific Law Report edition followed in brackets by the Court Division in which the case was heard. The reference to the court is in the letter or letters in the last parenthesis of the citation.

International Case Law

With the digitisation of much of international (Europe, UK and USA) case law the tendency in listing such international cases has been towards more detailed referencing so that researchers can better track and find such international case law. The examples provided are from USA and Europe as preferred referencing examples to be used in this journal for international case law referencing. For example in text referencing as follows:

.... the subsequent decision of the Inter-American Court of Human Rights in the *Haitian Center for Human Rights v. United States* case (Inter-American Commission of Human Rights, 1997)...[or] the Refugee Convention and article 33 fall short of applying on the high seas, (US Supreme Court, 1993: 2549) the subsequent decision of...

Use of footnotes/endnotes

The journal style does not use references in footnotes. But, if necessary, content references in the form of footnotes/endnotes may be used to provide additional information or explanation but all source referencing follows the 'in-text' referencing style.

TECHNICAL AND FORMATTING REQUIREMENTS:

Articles that are submitted for consideration should adhere to the following minimum standards and technical and formatting requirements before submission:

1. An **electronic copy** (computer disk or document sent by e-mail (to the Editor-in-Chief) in MS Word (or Word compatible software programme) may be submitted. If not e-mailed, the file name of the manuscript must be specified on the accompanying computer disk.
2. **Length:** Contributions must be submitted in English and should preferably not exceed **20** typed A4 pages (electronically minimum word count should not be less than **7 000** words (approx. **15** pages) or exceed **10 000** words of **text** (approx. **20** pages) (Extra page fees charged if 20-page limit exceeded.)
3. The **title** of the article (in uppercase) and the **author's full first name and surname**, designation, institutional affiliation, address & contact email should appear on the first page.
4. A **summary/abstract** of approximately 150-300 words on the first page of the submitted article must also be included. The abstract to be **italicised**.
5. **Keywords:** Directly below the abstract paragraph insert **Keywords** (maximum of **TEN** (10) – approximately **TWO** (2) lines).
6. If **funding** has been received from your University/Organisation or external funders for the research on which this article is based, such support funding can be acknowledged in the first footnote.

7. **Line spacing:** The document should be typed in A4 format using **SINGLE (1)** line spacing and 'normal margins' selected. No double spacing between words or after full stops and commas. Only single spacing throughout text. No line space to be inserted between paragraphs except between a paragraph and a heading.
8. **Paragraph indenting.** All paragraphs first line to be indented except for first paragraph after a heading. Please do not use the automated 'space after a paragraph' or 'space before a paragraph' function in MSWord.
9. **Font: Times New Roman 12**
10. **Page numbers:** are also **TNR 12** font and centred in the **footer** section of each page.
11. **Spelling:** Please make use (choose this as your default option) of the UK spellcheck and NOT the USA one. For example replace the 'z' in organization (US spelling) with an 's' = organisation (UK spelling).
12. **Use of quotes and italics:** Long quotes are placed in a separate paragraph and must be indented from both sides, (see below for short quotes usage) as in the following example:

Quotes that are **45 words** long or longer (three lines and more) should be indented from both sides (of the paragraph) as in this example. If the quote is shorter, then it needs to be imbedded in the text of a paragraph and set in between **double** quotation marks, i.e. "inverted commas". Quotes from published information are generally **not italicised**. However, actual words of interviewed respondents are recommended to be italicised. Field note comments by the researcher on the respondent's responses (in the italicised responses) are not italicised but are placed in square brackets [...], note **not** round brackets (...). For example:... "*I did not commit the crime but the policeman [sic.] they abuse us foreigners because me I was just sitting down with my friends and just talking stories, suddenly police came and arrest us.*" An additional use of italics is all non-English words, for e.g. ...Another participant said: "*Ek sal dit nooit vergeet nie*" (I will never forget it) (note the provision of an English translation after such use). All indented quotes need to end with the precise source reference placed in brackets and closed with a full stop (*Acta* Editor, 2013: 7).

13. **Single quotation marks:** Single inverted commas are only used when you want to emphasise a term or a common saying especially when it is not a direct use of words from another author. e.g. 'Zero Tolerance' or ... a 'live-and-let-die' approach. Single quotation marks are also used for a quote within a quote. For example: "It was patently obvious from the research that police officers use of force was not following the regulations. As indicated by one interviewee: '*they shoot wildly in a crime situation*'. This indicated that they needed to be trained to follow the set rules (Mistry, 2003: 6).
14. **Text justification:** Text is always full justified (squared), except for article title, author(s) name and the heading: *ABSTRACT* – all of which are centred – on the first page of the article. One further exception being the numerals in a table that are column centred.
15. **Headings and sub-headings:** All headings and sub-headings must be **bold**. There is **no use of numbering** or **underlining** of headings in this journal. Only three levels of headings' format to be used, namely:

1. Main headings which are: UPPERCASE (CAPS);
2. 2nd level, i.e. sub-heading, only the first letter of the first word in the heading is a CAP unless it is a proper noun, for example: **Crime in Cape Town's informal settlements**
3. 3rd level sub-sub-heading is indicated in bold and italicised with the same CAPS convention for 2nd level heading. For example: ***Crime findings from the Crossroads informal settlement***. All headings do not have a full stop at the end.

Note that there is no line spacing between a heading or sub-heading and the immediate following paragraph, a line spacing is inserted only before a heading and the preceding paragraph.

16. Use of **dates** in text – as follows: 11 September 2001 and not September 11, 2001. Also no use of abbreviations as in 1st, 2nd or 3rd just 1, 2, 3 etc. In the text do not use the date format of 11-09-2001 or 11/09/2011.
17. Use of **tables, figures, graphs and diagrams** in text: These render the layout difficult and should be used **sparingly**. All diagrams and tables must be numbered sequentially and referred to in the text, e.g. In Table 2 the falling statistics for the crime of murder can be discerned over the period 2000/01 to 2005/06. The use of such diagrams or tables must have a heading (also to be made bold) before the table or diagram and not after it. For e.g.

Table 2: Statistics on violent crimes during 2000-2006

CRIMES	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06
Murder	21 758	21 405	21 553	19 824	18 793	18 545
Attempted Murder	28 128	31 293	35 861	30 076	24 576	20 553
Assault GBH	275 289	264 012	266 321	260 082	249 369	276 942
Robbery Aggravating	113 716	116 736	126 905	133 658	126 789	119 726
TOTAL	438 891	433 446	450 640	443 640	419 527	435 766

(SAPS, 2010: 3).

Note the following technical points in the above table: A colon and a tab space to be inserted in the heading after the table/graph/figure/chart number before the title of the table/graph/figure/chart. Also a line space inserted after the heading and before the actual table or diagram/figure/chart. Numbers/figures in columns of a table are centred, as well as the heading/title of each column in which figures appear. The source reference is also right justified to appear at the end of the line below the table. Please do not insert any shading into any table, keep the table cells clear. Table outlines must also be inserted but as single lines not double.

18. Use of **bulleted lists**: when bullets (list of things or ideas not full sentences) are used, each bullet is closed with a semi-colon, except the second last one and the last one that have respectively a semi-colon followed by an 'and', and a full stop at their end. Format wise with bulleted lists, if each bullet or bullet number is only one or possibly two lines, no spacing, but if all bullets in list are consistently longer than two-three lines put in a space in between each bullet. A line space is also inserted before the whole bulleted list and after at the end to create a space between the paragraphs and the list. In your bulleted list please use the symbol:
 - and not symbols such as: », √, *, #, Δ, ∅, ■, etc.

If your list is numbered please use the numbering format as follows:

1. (and not 1[without a fullstop])

19. Use of **footnote/endnote numbers in text**: Footnote/endnote reference numbers must be placed in the text after the full stop and not before it, with no space between the two. The same for after a comma (in the middle of a sentence), i.e. not before but after the comma. Technically footnote/endnote text is TNR 10 font, single spacing, square justified with no space after the footnote text paragraph.

20. **Use of numbers/figures in text**: At the start of a sentence any number is also always written out, e.g. Thirty-three. Also percentages at the beginning of a sentence as: Seventy-five percent.... Note the use of percent and not % when a percentage is written out as well as when used in the text (the percentage symbol % to be used in tables and when placed in brackets in the text). Double figure numbers when written out in the text always have a hyphen, e.g. twenty-five or thirty-six or one-hundred-and-six. No comma is used to indicate thousands – only a space. For example: 100 000 or 12 000 or USD\$1 000 000, and not as 100,000 or 12,000 or USD\$1,000,000. Commas or full stops are only used to indicate fractions (as in percentages) in numbers of a decimal, e.g. 76,25 percent or 76.25 percent (The Journal has a preference for the latter format for a decimal point, i.e. a full stop.) Spacing: no spacing after currency denominator, e.g. USD\$ sign and the figure (amount), e.g. \$5 000 or R1 250. In addition, there is no space between a number and the percentage sign (e.g. 80% and not 80 %). Other use of spaces: No space before a colon but a space after it. For e.g.: The title of the chapter is: Analysis of research findings.... and NOT....The title of the chapter is: Analysis of research findings....

21. **Titles of persons**: if part of a person's name should be abbreviated, e.g. Maj-Gen. Smith, and not as Major-General Smith. Note the hyphen and the full stop at the end of the abbreviation. For abbreviations a full stop is always used unless the abbreviation ends in the same letter as the long version. E.g. Dr for Doctor; Mr for Mister; etc. Other examples: Prof. = Professor; Dir = Director; Capt. = Captain; Maj. = Major.

22. **Surnames** such as Du Plessis, De Villiers, Du Preez, Van de Merwe, Van Vuuren, etc. if used in text or as a bracketed reference without initials will have the first letter as a cap (e.g. 'd' or 'v' would be as a cap 'D' or 'V'), e.g (Du Preez & Van der Merwe, 2008: 4-6). Or in text as: According to Du Preez and Van der Merwe (2008: 4-6) the extreme overcrowding in prisons arose when.... Double-barrelled surnames are hyphenated with both names having the first letter a cap. E.g. Baxter-Bruce or Cole-Niven. An exception to this rule is a surname such as Jansen Van Vuuren.

23. Use of **abbreviations and acronyms**: When used in the text for the first time they are placed in brackets after the full term, e.g. The South African Police Service (SAPS); The South African Revenue Service (SARS); The Private Security Regulatory Authority (PSIRA), Automated Teller Machines (ATMs), etc. Thereafter the abbreviation or acronym can be used. All abbreviations or acronyms are uppercase. Each letter in the abbreviation or acronym does not have a full stop in between or after each letter. For example: Not P.S.I.R.A. but as PSIRA. Also note the small 's' in the last example which indicates plural.

24. Use of the **apostrophe 's'**: There is much confusion about the use of the apostrophe (single inverted comma) before an 's'. For example: ...it was the company's vehicle that

was being used. In this example the apostrophe before the 's' indicates possession. The apostrophe is NOT used when it indicates numbers or plural. For example: ...in the 1980s and 1990s it became common to....;many ATMs were robbed... And NOT as ...in the 1980's and 1990's it became common to....;many ATM's were robbed...

25. The use of a **colon** and not a **hyphen**. The colon should ALWAYS be used in circumstances where you are listing something and not as a hyphen which indicates a break, e.g. Deter: A deterrent factor is.. and not as: Deter – a deterrent factor is.. The colon is also used for instance: ...the following issues will be discussed, namely: ...and not: ...the following issues will be discussed, namely –
26. Use of **e.g.**, **i.e.**, **etc.**. The use of the 'for example' abbreviation always has full stops after each letter = e.g. The same for 'in other words' or 'that is' = i.e. In addition the abbreviation 'etc.' always has a full stop after, irrespective of whether it occurs in the middle of a sentence or at the end. All three abbreviations have a comma before them. For example:there are many factors such as lighting, weather conditions, sun rays, small rodents, etc. that affect an alarm being activated.... It is preferable, however, that all these abbreviations are ONLY used when placed in brackets but if used in a text full sentence or at the beginning of a sentence then to be preferably written out. For example, the written words (e.g. as used in brackets).
27. Use of abbreviation for percentage. If used in a sentence then to be written out as percent but when used in a table or in brackets then the symbol % is to be used. For example: Five percent and as (5% in brackets or in a table).
28. In a sentence only the first letter of the first word is uppercase (CAP) unless it is a proper noun. For example, Cape Town. In other words, when used in a sentence, other than as the first word of the sentence.
29. A legislative Act always has a cap 'A' even when used on its own to refer to or describe a specific Act. For example: The Act clearly states that it is illegal to prescribe such activity.... First letter of Act's title also a cap, (e.g. The Criminal Procedure Act).
30. Use of '**and**' and **ampersand (&)**: The ampersand symbol '&' is not used in the text at all. For example: According to Steyn and Jones (2010: 12) these types of crime were.....; whereas & will be used when authors are placed in brackets as a text reference, e.g.: An analysis of incidents showed that these types of crime were becoming more prominent over the last two years (Steyn & Jones, 2010: 12). The & is also used when listing multiple authors in your List of References. In the list of references there is no comma after the initial (+ fullstop) of an author before the ampersand.

For example: Steyn, L. & Jones, P. 2010. *The research methodology for.....*

ANNEXURE F: CRITICAL INCIDENT HISTORY QUESTIONNAIRE (CIHQ)

INSTRUCTIONS: Below is a list of critical incidents to which police officer may be exposed at sometime during their career. Please read each item and in the left-hand column, give your best estimate of the number of times that you have personally experienced that incident *in the line of duty*. Next, in the right-hand column, please give your opinion about how difficult it would be for police officers to cope with each type of incident, *not how difficult it would be for you personally*. Please make an estimate for each incident, even if you have never been exposed to it.

Please indicate how many times you have experienced each incident in the line of duty by writing in the box the number if it is between 0 and 9, OR if it is more than 10, by circling the appropriate numeric range.

In your opinion, how difficult would it be for police officers to cope with this type of incident?

1. Being seriously injured intentionally.

Write in if
from 0 - 9 ☉ 10 – 20 21 – 50 51+

2. Being seriously injured accidentally.

Write in if
from 0 - 9 ☉ 10 – 20 21 – 50 51+

3. Being present when a fellow officer was killed intentionally.

Write in if
from 0 - 9 ☉ 10 – 20 21 – 50 51+

Not at all	A little bit	Mod- erately	Quite a bit	Extre- mely
---------------	--------------------	-----------------	----------------	----------------

0	1	2	3	4
---	---	---	---	---

0	1	2	3	4
---	---	---	---	---

0	1	2	3	4
---	---	---	---	---

4. Being present when a fellow officer was seriously injured intentionally.

0 1 2 3 4

Write in if
from 0 - 9 ③ 10 – 20 21 – 50 51+

5. Being present when a fellow officer was seriously injured accidentally.

0 1 2 3 4

Write in if
from 0 - 9 ③ 10 – 20 21 – 50 51+

6. Being present when a fellow officer was killed accidentally.

0 1 2 3 4

Write in if
from 0 - 9 ③ 10 – 20 21 – 50 51+

7. Being seriously beaten.

0 1 2 3 4

Write in if
from 0 - 9 ③ 10 – 20 21 – 50 51+

8. Being taken hostage.

0 1 2 3 4

Write in if
from 0 - 9 ③ 10 – 20 21 – 50 51+

9. Receiving threats towards your loved ones as retaliation for your police work.

0 1 2 3 4

Write in if
from 0 - 9 ③ 10 – 20 21 – 50 51+

10. Being shot at.

0 1 2 3 4

Write in if
from 0 - 9 ③ 10 – 20 21 – 50 51+

11. Being threatened with a gun.

0 1 2 3 4

Write in if
from 0 - 9 9 10 – 20 21 – 50 51+

12. Being threatened with a knife or other weapon.

0 1 2 3 4

Write in if
from 0 - 9 9 10 – 20 21 – 50 51+

13. Being trapped in a potentially life-threatening situation.

0 1 2 3 4

Write in if
from 0 - 9 9 10 – 20 21 – 50 51+

14. Being exposed to serious risk of AIDS or other life-threatening diseases.

0 1 2 3 4

Write in if
from 0 - 9 9 10 – 20 21 – 50 51+

15. Having your life threatened by an aggressive and dangerous animal.

0 1 2 3 4

Write in if
from 0 - 9 9 10 – 20 21 – 50 51+

16. Being exposed to a life-threatening toxic substance.

0 1 2 3 4

Write in if
from 0 - 9 9 10 – 20 21 – 50 51+

17. Having to kill or seriously injure someone in the line of duty.

0 1 2 3 4

Write in if
from 0 - 9 0 10 – 20 21 – 50 51+

18. Having to shoot at someone in the line of duty, without injuring them.

0 1 2 3 4

Write in if
from 0 - 9 0 10 – 20 21 – 50 51+

19. Making a mistake that lead to the serious injury or death of a fellow officer.

0 1 2 3 4

Write in if
from 0 - 9 0 10 – 20 21 – 50 51+

20. Making a mistake that lead to the serious injury or death of a bystander.

0 1 2 3 4

Write in if
from 0 - 9 0 10 – 20 21 – 50 51+

21. Being involved in a high-speed chase where lives were in danger.

0 1 2 3 4

Write in if
from 0 - 9 0 10 – 20 21 – 50 51+

22. Seeing someone dying.

0 1 2 3 4

Write in if
from 0 - 9 0 10 – 20 21 – 50 51+

23. Encountering the body of someone recently dead.

0 1 2 3 4

Write in if
from 0 - 9 0 10 – 20 21 – 50 51+

24. Encountering a decaying corpse.

0 1 2 3 4

Write in if
from 0 - 9

☉ 10 – 20 21 – 50 51+

25. Encountering a mutilated body or human remains.

0 1 2 3 4

Write in if
from 0 - 9

☉ 10 – 20 21 – 50 51+

26. Making a death notification.

0 1 2 3 4

Write in if
from 0 - 9

☉ 10 – 20 21 – 50 51+

27. Encountering a child who had been sexually assaulted.

0 1 2 3 4

Write in if
from 0 - 9

☉ 10 – 20 21 – 50 51+

28. Encountering a child who had been badly beaten.

0 1 2 3 4

Write in if
from 0 - 9

☉ 10 – 20 21 – 50 51+

29. Encountering an adult who had been sexually assaulted.

0 1 2 3 4

Write in if
from 0 - 9

☉ 10 – 20 21 – 50 51+

30. Encountering an adult who had been badly beaten.

0 1 2 3 4

Write in if
from 0 - 9

☉ 10 – 20 21 – 50 51+

31. Encountering a child who was severely neglected or in dire need of medical attention because of neglect.

0 1 2 3 4

Write in if
from 0 - 9 10 - 20 21 - 50 51+

32. Seeing animals that had been severely neglected, intentionally injured, or killed.

0 1 2 3 4

Write in if
from 0 - 9 10 - 20 21 - 50 51+

33. Having your life endangered in a large-scale man-made disaster.

0 1 2 3 4

Write in if
from 0 - 9 10 - 20 21 - 50 51+

34. Having your life endangered in a large-scale natural disaster.

Write in if
from 0 - 9 10 - 20 21 - 50 51+

ANNEXURE G: IMPACT OF EVENTS SCALE – REVISED (IES-R)

Name _____

Date: _____

Below is a list of difficulties people sometimes have after stressful life events. Please read each item, and then indicate how distressing each difficulty has been for you DURING THE PAST YEAR with respect to (your problem), how much were you distressed or bothered by these difficulties? This assessment is not intended to be a diagnosis. If you are concerned about your results in any way, please speak with a health professional.

	0 = Not at all	1 = A little bit	2 = Moderately	3 = Quite a bit	4 = Extremely
1. Any reminder brought back feelings about it					
2. I had trouble staying asleep					
3. Other things kept making me think about is					
4. I felt irritable and angry					
5. I avoided letting myself get upset when I thought about it or was reminded of it					
6. I thought about it when I didn't mean to					
7. I felt as if it hadn't happened or wasn't real					
8. I stayed away from reminders about is					
9. Pictures about is popped into my mind					
10. I was jumpy and easily startled					
11. I tried not to think about it					
12. I was aware that I still had a lot of feelings about it, but I didn't deal with them					
13. My feelings about it were kind of numb					
14. I found myself acting or feeling like I was back at that time					
15. I had trouble falling asleep					
16. I had waves of strong feelings about is					
17. I tried to remove it from my memory					
18. I had trouble concentrating					
19. Reminders of it caused me to have physical reactions, such as sweating, trouble breathing, nausea, or a pounding heart					
20. I had dreams about it					
21. I felt watchful and on guard					
22. I tried not to talk about it					

**ANNEXURE H: BRIEF DESCRIPTION OF THE MENTAL HEALTH
CONTINUUM SHORT FORM (MHC-SF)**

During the past month how often did you feel...	NEVER	ONCE OR TWICE	ABOUT ONCE A WEEK	ABOUT 2 OR 3 TIMES A WEEK	ALMOST EVERY DAY	EVERY DAY
1. happy						
2. interested in life						
3. satisfied with life						
4. that you had something important to contribute to society						
5. that you belonged to a community (like a social group, or your neighborhood)						
6. that our society is a good place for you, or is becoming a better place, for all people						
7. that people are basically good						
8. that the way our society works makes sense to you						
9. that you liked most parts of your personality						
10. good at managing the responsibilities of your daily life						
11. that you had warm and trusting relationships with others						
12. that you had experiences that challenged you to grow and become a better person						
13. confident to think or express your own ideas and opinions						
14. that your life has a sense of direction or meaning to it						

ANNEXURE I: POST-TRAUMATIC COGNITIONS INVENTORY (PTCI)

Name: _____

DATE: _____

We are interested in the kind of thoughts which you may have had after a traumatic experience. Below are a number of statements that may or may not be representative of your thinking.

Please read each statement carefully and tell us how much you AGREE or DISAGREE with each statement.

People react to traumatic events in many different ways. There are no right or wrong answers to these statements.

	1 = Totally disagree	2 = Disagree very much	3 = Disagree slightly	4 = Neutral	5 = Agree slightly	6 = Agree very much	7 = Totally agree
1. The event happened because of the way I acted.							
2. I can't trust that I will do the right thing.							
3. I am a weak person.							
4. I will not be able to control my anger and will do something terrible.							
5. I can't deal with even the slightest upset.							
6. I used to be a happy person but now I am always miserable.							
7. People can't be trusted.							
8. I have to be on guard all the time.							
9. I feel dead inside.							
10. You can never know who will harm you.							
11. I have to be especially careful because you never know what can happen next.							
12. I am inadequate.							
13. I will not be able to							

control my emotions, and something terrible will happen.							
14. If I think about the event I will not be able to handle it.							
15. The event happened to me because of the sort of person I am.							
16. My reactions since the event mean that I am going crazy.							
17. I will never be able to feel normal emotions again							
18. The world is a dangerous place							
19. Somebody else would have stopped the event from happening							
20. I have permanently changed for the worse.							
21. I feel like an object, not like a person.							
22. Somebody else would not have gotten into this situation.							
23. I can't rely on other people.							
24. I feel isolated and apart from others.							
25. I have no future.							
26. I can't stop bad things from happening to me.							
27. People are not what they seem.							
28. My life has been destroyed by the trauma.							
29. There is something wrong with me as a person.							
30. My reactions since the event show that I am a lousy copper.							

31. There is something about me that made the event happen.							
32. I will not be able to tolerate my thoughts about the event, and I will fall apart.							
33. I feel like I don't know myself anymore.							
34. You never know when something terrible will happen.							
35. I can't rely on myself.							
36. Nothing good can happen to me anymore							

By signing the consent form below, you indicate that you have read and understand the document and that you voluntarily agree to participate in the study.

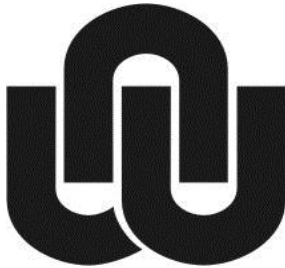
Full name of participant: _____

Signature of participant: _____

Date: _____

THANK YOU

ANNEXURE J: INFORMED CONCENT



NORTH-WEST UNIVERSITY
YUNIBESITI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT
POTCHEFSTROOM CAMPUS

TITLE OF RESEARCH PROJECT: Trauma in the South African Police Service – A Psycho-social Therapeutic Program

CONSENT OF POLICE OFFICIALS TO BE A RESEARCH PARTICIPANT

I am a PhD student in Social Work at the North-West University conducting research on police officials stationed at the specialised units in the North-West Province experience of trauma and trauma intervention programs. My study leader is Professor H Strydom. The following is information about the study and what it will entail so that you can make an informed decision about participating in the study.

AIM OF THE RESEARCH:

The aim of the study is to develop, implement and evaluate a client oriented psycho-social therapeutic trauma intervention program within the context of the SAPS.

DATA COLLECTION

For the purpose of this research data will be collected by means of four standardised and one self-developed questionnaire pre- and post the implementation of a Psycho-Social Trauma Intervention Program. The questionnaires will focus on the following primary aspects:

Post-Traumatic Stress	Critical Incident History Questionnaire (CIHQ)
-----------------------	--

	Impact of event Scale – Revised (IES-R)
Psychological Wellness Social Wellness Emotional Wellness	Brief Description of the Mental Health Continuum Short Form (MHC-SF)
Post-Traumatic Cognitions	Post Traumatic Cognitions Inventory (PTCI)
Evaluation of the Psycho-social Trauma Intervention Program	Self-developed semi-structured questions

PROCEDURES

A total of 28 respondents, meeting the specific inclusion criteria, will form part of the study. Inclusion criteria are as follows: 1) respondents must be police officials stationed at one of the specialised units in the North-West Province, and 2) had previously been exposed to trauma. A very important exclusion criterion is that none of the respondents should have been diagnosed with Post-Traumatic Stress Disorder or any other comorbid disorder. Respondents should also not receive treatment from a medical doctor, psychiatrist or psychologist.

From above respondents, fourteen will be randomly selected to form part of an experimental group, while the other fourteen respondents will form part of a control group. Those participating in the experimental group will be exposed to the program whilst those in the control group will not be part of the intervention process. All of the respondents including those in the control group will complete above mentioned questionnaires before the program commences.

The Psycho-Social Trauma Intervention Program consisting of twelve sessions will be presented to those police officials selected to be part of the experimental group. Evaluation of the success or failure of the program will be done at regular intervals during the intervention period.

After the program has been presented all participants including those in the control group not exposed to the program will participate in post-testing, using the same questionnaires. Following this process those police officials included as part of the control group will also be exposed to the same program.

All information gathered in this study will be disclosed only with your permission. I promise to protect your confidentiality so that no reports/quotes that result from this

study will identify you as having been a respondent. Participation is voluntary and even if you give your consent, you are free to withdraw from the study at any time without prejudice.

The termination of the proposed psycho-social therapeutic trauma intervention program will be handled with sensitivity and care. Should any one of you as respondents require continuous therapy or treatment the researcher will refer such respondent to Employee Health and Wellness (EHW) for further intervention.

The National Commissioner of the SAPS (3/34/2 dated 2013-03-26) as well as the Provincial Commissioner of the Northwest Province (3/34/2 dated 2013-04-16) approved the research.

The research has also been reviewed by a committee of the mentioned university which also approved the research. Ethical approval number: **NWU-00007-13A1**.

RELEASE AND PUBLICATION OF THE FINDINGS:

The National Commissioner of the police will be provided with a copy of study after completion for possible implementation of the Psycho-Social Trauma Intervention Program in the SAPS.

The findings of the study will be introduced to the reading public in written format by means of an article in an accredited journal.

Once again confidentiality will be maintained as information provided to the National Commissioner and the articles will be based on statistical data only without providing personal details of respondents.

COST AND REMUNERATION:

Respondents engaging in this particular study will not directly benefit from it as no remuneration will be offered. There will be no cost to participants as a result of their participation in this study. The researcher will take into consideration the possibility of reimbursing any respondentt who might have had traveling expenses due to participating in the study.

QUESTIONS

You are welcome to ask any questions to the researcher before you decide to give consent. You are also welcome to contact me as student or my study leader if you have any further questions concerning your participation in this study.

Researcher: Mr P J Boshoff (0827712413)

Study leader: Prof H Strydom (0825809312)

You may also contact Mrs Carolien van Zyl of the Health Research Ethics Committee at 018-299 2094.

I want to thank you for your kind consideration of this request.

Kind regards.

P J Boshoff

STUDENT: PhD: SOCIAL WORK

By signing the consent form below, you indicate that you have read and understand the document and that you voluntarily agree to participate in the study.

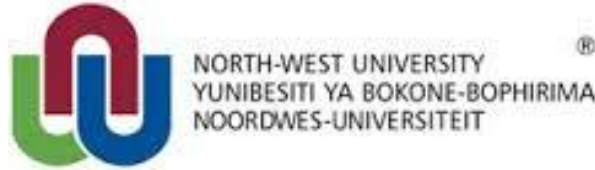
Full name of participant: _____

Signature of participant: _____

Date: _____

THANK YOU

**ANNEXURE K: QUALITATIVE AND QUANTITATIVE MEASURING
INSTRUMENT – BEFORE PROGRAM**



**SCHOOL FOR PSYCHO-SOCIAL BEHAVIOURAL
SCIENCES
SUBJECT GROUP: SOCIAL WORK**

**QUALITATIVE AND QUANTITATIVE
MEASURING INSTRUMENT –
BEFORE PROGRAM**

The main focus of this questionnaire is on your expectations regarding the psycho-social therapeutic program (PTP), your overall psycho-social well-being before attending the program and your attitude and knowledge regarding the topics that will be presented during the course of the program. Please try to answer all the questions as honestly as possible.

SECTION A: EXPECTATIONS OF THE PROGRAM

1. What do you as a police official expect to gain from the program?

2. What topics would you like to be included in a TPTIP for police officials?

3. How do you envisage that this program will influence your life?

4. What is your expectations regarding the overall quality of the program?

5. What is your expectations regarding the style of presentation?

6. Are you of the opinion that confidentiality will be maintained?

7. What are your expectations regarding the duration of the sessions?

8. What are your expectations regarding the duration of the program as a whole?

SECTION B: PSYCHO-SOCIAL WELL-BEING

9. How do you feel about your future?

10. How do you feel about your overall psycho-social wellness?

11. How do you feel about your work as a police official?

12. How do you feel about your family?

13. What do you think is the biggest problem regarding police official's exposure to traumatic events in SAPS?

SECTION C: ATTITUDE AND KNOWLEDGE REGARDING TOPICS

14. On a scale from one to five, how do you regard your **attitude** and **knowledge** regarding the following matters?

(1 = very bad, 3 = average, 5 = very good)

14.1 Trauma

1	2	3	4	5
---	---	---	---	---

Motivate:

14.2 The process of trauma

1	2	3	4	5
---	---	---	---	---

Motivate:

14.3 Common signs and symptoms following exposure to traumatic events

1	2	3	4	5
---	---	---	---	---

Motivate:

14.4 Relaxation techniques to help you cope after exposure to a traumatic event

1	2	3	4	5
---	---	---	---	---

Motivate:

14.5 Remembering and re-telling your trauma story

--	--	--	--	--

Motivate:

14.6 Identifying emotions, feelings and thoughts as a result of exposure to a traumatic event

--	--	--	--	--

Motivate:

14.7 Dealing with negative emotions as a result of exposure to a traumatic event

--	--	--	--	--

Motivate:

14.8 Altered thinking after exposure to a traumatic event

--	--	--	--	--

Motivate:

14.9 Challenging destructive and self-destructive behaviour following exposure to a traumatic event

--	--	--	--	--

Motivate:

14.10 Effective problem solving following exposure to a traumatic event

--	--	--	--	--

Motivate:

14.11 Managing trigger events following exposure to a traumatic event

--	--	--	--	--

Motivate:

14.12 Relationships with others following exposure to a traumatic event

--	--	--	--	--

Motivate:

14.13 Systems advocacy (to improve systemic responses to victims of trauma and their communities for example the workplace and family)

--	--	--	--	--

Motivate:

14.14 Relapse prevention after termination of the program

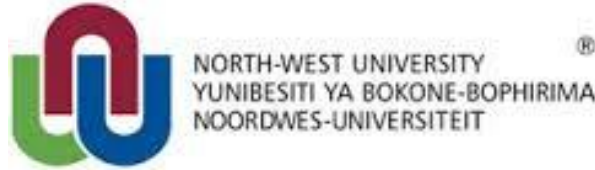
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Motivate:

Thank you for completing the questionnaire.

P J BOSHOFF, PhD STUDENT

**ANNEXURE L: QUALITATIVE AND QUANTITATIVE MEASURING
INSTRUMENT – AFTER PROGRAM**



**SCHOOL FOR PSYCHO-SOCIAL BEHAVIOURAL
SCIENCES
SUBJECT GROUP: SOCIAL WORK**

**QUALITATIVE AND QUANTITATIVE
MEASURING INSTRUMENT –
AFTER PROGRAM**

The main focus of this questionnaire is on your experience of the psycho-social therapeutic program (PTP), your overall psycho-social well-being after attending the program and your attitude and knowledge regarding the topics that were presented during the course of the program. Please try to answer all the questions as honestly as possible.

SECTION A: EXPERIENCE OF THE PROGRAM

1. What did you as a police official gain from the program?

2. Which of the topics included in the TPTIP had the most value to you?

3. Which of the topics had the least value to you?

4. Which other topics would you have preferred to be included as part of the content of the program?

5. How did you experience the overall quality of the program?

6. How did you experience the presentation style?

7. Are you of the opinion that confidentiality will be maintained?

8. How did you experience the duration of the sessions?

9. How did you experience the duration of the program as a whole?

SECTION B: PSYCHO-SOCIAL WELL-BEING

10. How do you feel about your future?

11. How do you feel about your overall psycho-social wellness?

12. How do you feel about your work as a police official?

13. How do you feel about your family?

14. Considering the information gathered during this program, what do you think is the biggest problem regarding police official's exposure to traumatic events in SAPS?

15. Since you have completed this program, what is different in your life?

SECTION C: ATTITUDE AND KNOWLEDGE REGARDING THE TOPICS

16. On a scale from one to five, how do you regard your **attitude** and **knowledge** regarding the following matters after you completed the program?

(1 = very bad, 3 = average, 5 = very good)

16.1 Trauma

1	2	3	4	5
---	---	---	---	---

Motivate:

16.2 The process of trauma

1	2	3	4	5
---	---	---	---	---

Motivate:

16.3 Common signs and symptoms following exposure to traumatic events

1	2	3	4	5
---	---	---	---	---

Motivate:

16.4 Relaxation techniques to help you cope after exposure to a traumatic event

1	2	3	4	5
---	---	---	---	---

Motivate:

16.5 Remembering and re-telling your trauma story

--	--	--	--	--

Motivate:

16.6 Identifying emotions, feelings and thoughts as a result of exposure to a traumatic event

--	--	--	--	--

Motivate:

16.7 Dealing with negative emotions as a result of exposure to a traumatic event

--	--	--	--	--

Motivate:

16.8 Altered thinking after exposure to a traumatic event

--	--	--	--	--

Motivate:

16.9 Challenging destructive and self-destructive behaviour following exposure to a traumatic event

--	--	--	--	--

Motivate:

16.10 Effective problem solving following exposure to a traumatic event

--	--	--	--	--

Motivate:

16.11 Managing trigger events following exposure to a traumatic event

--	--	--	--	--

Motivate:

16.12 Relationships with others following exposure to a traumatic event

--	--	--	--	--

Motivate:

16.13 Systems advocacy (to improve systemic responses to victims of trauma and their communities for example the workplace and family)

--	--	--	--	--

Motivate:

16.14 Relapse prevention after termination of the program

--	--	--	--	--

Motivate:

Thank you for completing the questionnaire.

P J BOSHOFF, PhD STUDENT

ANNEXURE M: ETHICAL APPROVAL



NORTH-WEST UNIVERSITY
YUNIBESITHI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT

Private Bag X6001, Potchefstroom
South Africa 2520

Tel: (018) 299-4900
Faks: (018) 299-4910
Web: <http://www.nwu.ac.za>

Ethics Committee

Tel +27 18 299 4852
Email Ethics@nwu.ac.za

Prof Herman Strydom

2013/04/23

ETHICS APPROVAL OF PROJECT

The North-West University Ethics Committee (NWU-EC) hereby approves your project as indicated below. This implies that the NWU-EC grants its permission that, provided the special conditions specified below are met and pending any other authorisation that may be necessary, the project may be initiated, using the ethics number below.

Project title: Trauma in the South African Police Service - A Psychosocial Therapeutic Programme																	
Project Leader: Prof H Strydom																	
Ethics number:	N	W	U	-	0	0	0	0	7	-	1	3	-	A	1		
	Institution				Project Number						Year			Status			
	STATUS: S = Submission; R = Re-Submission; P = Provisional Authorisation; A = Authorisation																
Approval date: 2013/04/12						Expiry date: 2018/04/11											

Special conditions of the approval (if any): None

<p>General conditions:</p> <p><i>While this ethics approval is subject to all declarations, undertakings and agreements incorporated and signed in the application form, please note the following:</i></p> <ul style="list-style-type: none"> The project leader (principle investigator) must report in the prescribed format to the NWU-EC: <ul style="list-style-type: none"> - annually (or as otherwise requested) on the progress of the project, - without any delay in case of any adverse event (or any matter that interrupts sound ethical principles) during the course of the project. The approval applies strictly to the protocol as stipulated in the application form. Would any changes to the protocol be deemed necessary during the course of the project, the project leader must apply for approval of these changes at the NWU-EC. Would there be deviated from the project protocol without the necessary approval of such changes, the ethics approval is immediately and automatically forfeited. The date of approval indicates the first date that the project may be started. Would the project have to continue after the expiry date, a new application must be made to the NWU-EC and new approval received before or on the expiry date. in the interest of ethical responsibility the NWU-EC retains the right to: <ul style="list-style-type: none"> - request access to any information or data at any time during the course or after completion of the project; - withdraw or postpone approval if: <ul style="list-style-type: none"> any unethical principles or practices of the project are revealed or suspected, it becomes apparent that any relevant information was withheld from the NWU-EC or that information has been false or misrepresented, the required annual report and reporting of adverse events was not done timely and accurately, new institutional rules, national legislation or international conventions deem it necessary.

The Ethics Committee would like to remain at your service as scientist and researcher, and wishes you well with your project. Please do not hesitate to contact the Ethics Committee for any further enquiries or requests for assistance.

Yours sincerely

Prof Amanda Lourens
(chair NWU Ethics Committee)

ANNEXURE N: DECLARATION OF LANGUAGE EDITING

cumlaude
languagepractitioners

Director: CME Terblanche - BA (Pol Sc), BA Hons (Eng), MA (Eng), TEFL

22 Strydom Street
Baillie Park, 2531

Tel 082 821 3083
cumlaudelanguage@gmail.com

DECLARATION OF LANGUAGE EDITING

I, Christina Maria Etrechia Terblanche, hereby declare that I edited the following sections:

Section A
Section C
Article 5
Article 6

of the research study titled:

**Trauma in the South African Police Service - A Psychosocial
Therapeutic Programme**

for PJ Boshoff for the purpose of submission as a postgraduate thesis.
Changes were suggested and implementation was left to the discretion of
the author.

Regards,

CME Terblanche

Cum Laude Language Practitioners (CC)

SATI accr nr: 1001066

PEG registered

SECTION E:
INTEGRATED
BIBLIOGRAPHY

INTEGRATED BIBLIOGRAPHY

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