

AN ASSESSMENT OF THE NEED OF POLICE OFFICIALS FOR TRAUMA INTERVENTION PROGRAMMES – A QUALITATIVE APPROACH

Pieter Boshoff, Herman Strydom, Karel Botha

Officials in the South African Police Service (SAPS) are exposed to multiple traumatic incidents. The effect of such exposure is aggravated by various contributing factors that may cause intense trauma for the individual, family members and the police service. The risk factors include post-traumatic stress, acute stress, depression, alcohol abuse, suicide and impaired productivity. It is therefore important that officials have direct access to support. The efficacy of the present trauma intervention programmes in the SAPS is questioned, because despite their implementation police officials still present high levels of acute and behavioural problems.

AN ASSESSMENT OF THE NEED OF POLICE OFFICIALS FOR TRAUMA INTERVENTION PROGRAMMES – A QUALITATIVE APPROACH¹

Pieter Boshoff, Herman Strydom, Karel Botha

INTRODUCTION

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 programmes in the SAPS is questioned, because despite the existence of trauma intervention programmes, police officials still present high levels of acute and complex post-traumatic stress reactions.

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. Officials are exposed daily to murder, sexual assault, shooting incidents, car accidents, hostage situations, hijackings, robbery with aggravating circumstances, the death of colleagues, as well as child abuse (Jorgensen & Rothman, 2008:2; McNally, 2012:341; 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, Stephens & Tuffin, 2006:243; Suri, 2013:674).

¹ Some of the contents of this article may be emotionally unsettling for the reader. The South African Police Service granted written permission to publish certain findings contained in this article.

Trauma and stress experienced in the line of duty, although clearly differentiated, are interlinked. MacEachern, Jindal-Snape and Jackson (2011:311) and Young, Koortzen and Oosthuizen (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 officers 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, 2013:759). According to Bonanno, Westphal and Mancini (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 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). The EHW is a multi-professional team consisting of social workers, psychologists and chaplains in the SAPS and management. Deschamps *et al.* (2003:358) and Jorgensen and Rothman (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 wellbeing, 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 (2013:637) 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 wellbeing. Regardless of the different trauma intervention programmes and services offered by EHW, the SAPS Year Review of 2012/2013 still showed a high occurrence of stress-related problems and psychological disorders amongst police officials. Although 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

2013/2014 did not contain any statistics relating to the psychological wellness of police officials.

CENTRAL THEORETICAL STATEMENT

The researcher is of the opinion that a purposeful psycho-social trauma intervention programme 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 is the extent, subjective experience, impact of trauma and police officials' specific needs with regard to support and trauma intervention programmes?

AIM

To conduct a qualitative situational analysis by exploring the experience and specific needs with regards to trauma and trauma intervention of police officials within the North-West Province's specialist units.

RESEARCH METHOD

The researcher made use of the exploratory sequential mixed methods design as proposed by Creswell (2014:4) as part of the first phase of the intervention model. 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 programmes presented by EHW in the SAPS.

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 a smaller group of police officials. These officials were stationed at the specialist units representing three clusters within the North-West Province. Specialist units refer to specialised operational support units focused on planned and targeted deployments to address specific incidents of crime. Examples of such units are the Public Order Police Unit and the Local Criminal Record Centre. According to Yin (2013:4), this strategy 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, and organisational and managerial processes.

The researcher used the purposive sampling method in order to select forty participants (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 programmes. EHW acted as intermediary, as most of these officials were known to them or involved in a therapeutic relationship. EHW clearly communicated the aim of the study to prospective participants and they were given the opportunity to make a decision regarding voluntary participation in the study. The participants were included in three focus groups

representing three clusters in the North-West Province of South Africa (Potchefstroom, Klerksdorp and Rustenburg). The researcher identified fourteen police officials for each of the three clusters to make provision for unexpected circumstances. According to Rubin and Babbie (2010:221), some researchers recommend twelve to fifteen people per focus group. The focus groups allowed the researcher to interact systematically and simultaneously with several individuals. Rubin and Babbie (2010:221) confirm that qualitative interviews can be conducted in focus groups.

A semi-structured interview schedule was used to gather information from officials during these focus groups. This information pertained to the extent of trauma, police officials' subjective experience of trauma, its impact on psychosocial functioning, and specific needs regarding support and intervention. This allowed the researcher to gain insight into participants' beliefs about and perceptions or accounts of a particular topic (Greeff, 2011:351). The researcher specifically concentrated on the following questions:

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

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

ETHICAL ASPECTS

Strydom (2011:114) describes ethics as "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". For the purpose of this study, the researcher obtained ethical approval from the North-West University's ethical committee. The SAPS granted permission to undertake the research study among police officials. The proposed focus group interviews were based on strict scientific guidelines to prevent any harm to participants in the research study or to the SAPS as an organisation. Selected police officials were informed of the purpose, method, possible risks and expectations of the research, after which they were allowed to make a choice to participate in the research. It was explained that research participation within the work context is valuable but not obligatory. Officials were assured that there were no sanctions whatsoever for non-participation. Participants were furthermore encouraged to withdraw from the focus groups at any time should they feel uncomfortable or experience any harm or emotional consequence as a result of participating in the study.

DISCUSSION OF THE FINDINGS

The results of the research project are 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. This included an exploration of police officials' experience and specific needs regarding trauma intervention programmes.

The characteristics of participants for all three of the different groups have been combined in Table 1.

TABLE 1
PARTICIPANTS' CHARACTERISTICS

ITEM	CATEGORY	FREQUENCY	PERCENTAGE
Gender Frequency missing = 0 N = 40	Male Female TOTAL	31 9 40	77.50 22.50 100.00
Rank Frequency missing = 0 N = 40	Constable Sergeant Warrant Officer Officer TOTAL	21 2 15 2 40	52.50 5.00 37.50 5.00 100.00
Language Frequency missing = 0 N = 40	Afrikaans English Tswana S/Sotho Zulu Xhosa Tshivenda TOTAL	11 2 19 2 1 4 1 40	27.50 5.00 47.50 5.00 2.50 10.00 2.50 100.00
Marital Status Frequency missing = 0 N = 40	Married Committed relationship Single Divorced Widow/er TOTAL	21 9 6 4 0 40	52.50 22.50 15.00 10.00 0.0 100.00
Years' service Frequency missing = 0 N = 40	1-4 5-9 10-14 15-19 20-24 25+ TOTAL	5 15 1 3 11 5 40	12.50 37.50 2.50 7.50 27.50 12.50 100.00
Locality Frequency missing = 0 N = 40	LCRC PES FCS POP TRT Detectives TOTAL	10 3 9 6 6 6 40	25.00 7.50 22.50 15.00 15.00 15.00 100.00
N = 40			

*LCRC = Local Criminal Record Centre, PES = Police Emergency Services, FCS = Family Child and Sexual Offences Unit, POP = Public Order Police Unit, TRT = Tactical Response Unit

For the purpose of the first phase of this study the researcher focused only on the three bigger clusters in the North-West Province, namely Potchefstroom, Rustenburg and Klerksdorp, as they accommodate all the specialist units included in the study.

TABLE 2
PRIMARY THEMES AND SUB-THEMES EMERGING FROM THE DATA

THEMES	SUB-THEMES	CATEGORIES OF SUB-THEMES
1. MEANING OF TRAUMA	1.1 Concept of trauma 1.2 Complex trauma 1.3 Trauma reinforcers 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 Organisational 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 - Re-experiencing - Avoidance of stimuli - Negative alterations in cognitions and mood - Alterations in arousal and reactivity 2.2.2 Comorbidity 2.3.1 Suicide ideation 2.3.2 Anger, aggression and violence 2.3.3 Family and relationship problems 2.3.4 Somatic complaints 2.3.5 Work-related problems
3. COPING	3.1 Avoidance coping 3.2 Action-orientated coping	
4. TRAUMA INTERVENTION PROGRAMMES	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 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 intertwined and/or to a great extend in interaction with each other. Subsequently a discussion of the four themes and sub-themes that arose from the three focus group interviews follows.

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 reinforcers; and major police stressors. The sub-themes stemming from the question are subsequently discussed in more detail.

Sub-theme 1: Trauma as concept

Group members had diverse opinions regarding the concept of trauma. The following comments can be regarded as representative of what respondents had to say on this issue.

“...Trauma is something that does not happen every day, such as an ordinary arrest, which we as police officers are used to during the daily execution of our duties. It is exceptional, even extraordinary, accompanied by intense fear and terrifying”;

“...Trauma 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 being bruised or injured”;

“...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, which 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”.

Some group members described trauma as extraordinary, intense and scary. Others described it as suddenly and totally unexpected and involving threatened death. They were of the opinion that a traumatic incident occurs when least expected and usually when you are least prepared for it. The group members believed that a traumatic incident deprives you of control over the situation. In most cases they found themselves powerless and therefore unable to do anything about the situation. Group members agreed that the increasing cruelty associated with traumatic incidents are the worst experience. “Traumatic incidents are explicit as to whether they were experienced directly, witnessed, experienced indirectly or repeatedly” (American Psychiatric

Association, 2013:265). Group members were exposed to various traumatic incidents because of the nature of their work. Therefore they were able to provide first-hand information about the concept itself as well as their experience of it.

Sub-theme 2: Complex trauma

Two categories of the sub-theme that emerged are as follows: trauma originating from the work itself, and trauma originating from personal circumstances. The following examples are cited:

“...I do a lot of diving scenes, the one that stand out, is a church ritual, five guys drowned at once, we 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 a scene and you find thousands of people on the koppie (hill) 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”;

“...at the Family Child and Sexual Offences Unit (FCS) it is the rapes of the small children, you think about your own children, it is very traumatic”;

“...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”.

The above examples confirm that police officials within the specialist units were exposed to a variety of traumatic incidents that were generally different from those experienced in the general population. The group members specifically 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. Some also referred to the death by suicide of a family member and physical injury as a result of their involvement in motor vehicle accidents. These factors have been discussed separately from those traumatic incidents originating from the work itself. These may also have a negative impact on their psycho-social wellbeing, which in turn might have an impact on the work situation as far as productivity is concerned. Courtois (2012:140) defines this type of exposure as complex trauma and disasters that have a human cause, and adds more specifically that these types of trauma “can take place without warning and out of the blue” and are usually perpetrated by a stranger (i.e. a robbery, a physical assault and rape). Ford and Curtouis (2009:13) and Williams and Poijula (2013:16) added that the term “complex trauma” refers to the array of responses and symptoms resulting from overwhelming traumatic exposure.

Sub-theme 3: Trauma reinforcers

Some of the group members indicated that the traumatic incidents they had been exposed to on a daily basis were sometimes not as traumatic as the frequency, intensity,

cumulative exposure and re-traumatisation generally associated with these incidents. Kirschman *et al.* (2014:63) says that although these factors are viewed as part of the officials' work, they reinforce the experience of trauma with specific reference to trauma-related symptomatology. The following narratives are cited to illustrate the above:

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

"...You feel sick because you don't want to see that again. It's getting full now, for the past 15 years I've been exposed to trauma. I can't face it anymore. I think that is building up trauma";

"...you attend the scene, afterwards you go to the mortuary, then you have to compile photo albums. As a result you are exposed to the detail again. You go to court, you're exposed to it again. After that, it's just inside of you".

The above examples are an indication that police officials were exposed to various crime scenes because of the nature and extent of their work. They also faced repeated exposure to intense traumatic incidents and prolonged investigation processes resulting in re-traumatisation increasing trauma-related symptoms.

These factors, in addition to the extraordinary, dangerous and stressful nature of policing, confirm the complex nature of traumatic events and experiences within the SAPS. The definition by Courtois *et al.* (2009:84) bears out this statement, as they 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".

Sub-theme 4: Major police stressors

The following comments are cited to illustrate the four categories of major stressors, namely organisational, external, operational and personal stressors.

"...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";

"...the police is too complex, all the administration, rules, we operate with tunnel vision, the organisation is too inflexible";

"...the media is running wild about the actions of the police";

"...my work is physically and emotionally draining, when I get home I really don't have the time or the energy for my family, I feel so guilty, I find it difficult 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";

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

Group members believed that the continual exposure to stress results in a “snowball effect”. The convergence of multiple stressors on a daily basis built up to such an extent that the police officers lose resistance and control. In some cases suppressed stress leads to a less serious incident acting as a trigger, leading to sudden and unexpected severe stress reactions. Hartley *et al.* (2014:21) and Kirschman *et al.* (2014:63) consider cumulative stress as a risk factor. By and large all these factors fit into Dempsey and Frost’s (2013:170) synthesis of stressors.

Most of the group members mentioned that the bureaucracy within the organisation, coupled with other organisational factors, was challenging. Other factors include 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; poor salaries; victimisation and little recognition for outstanding services rendered by the group members (Hartley *et al.*, 2014:21; McNally, 2012:341).

It was also mentioned that the community had unrealistic expectations and did not understand the working conditions of police officials. The media’s coverage of certain sensational events often concentrates on the negative aspects, which creates a bad image of the police. Carlan and Nored (2008:8), Hartley *et al.* (2014:21) and Patterson (2008:55) explain that police officials are easily noticeable in the execution of their task and therefore become an easy target for the media. Garcia *et al.* (2004:41) are of the opinion that when this happens police officials might feel aggrieved, embittered and sometimes angry.

A variety of personal stressors were also mentioned by participants. Some of the group members reported that the demands of the job, the fact that they experienced financial problems, found it difficult to have a balanced life and to maintain relationships eventually had an impact on the way in which they handled trauma. Others also believed that personal, marital and family factors may have contributed to and could have produced traumatic experiences and traumatic events (Carlan & Nored, 2008:8; McNally, 2012:342; Naude & Rothmann, 2003:92).

Theme 2: Response to trauma

The following sub-themes have been identified, namely initial aftermath, complex traumatic stress disorders and the consequences of PTSD.

Sub-theme 1: Initial aftermath

Group members reported that they experienced certain physical and psychological symptoms immediately after the incident occurred. The following comments 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”;

“...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”;

Many of the group members reported that directly after their exposure to critical incidents they developed some extraordinary stress reactions. These include insomnia, flashbacks, lack of appetite, irritability and anger. The stress reactions caused immense pressure and officials found it difficult to deal with this on an emotional, cognitive, behavioural and physiological level (Friedman, 2012:13,83; Mitchell, 2012:165).

Sub-theme 2: Complex traumatic stress disorders

The following comments can be seen as being representative of the various categories of this sub-theme, namely post-traumatic stress disorder and comorbidity:

“...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, 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”;

“...He grabbed this girl, 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”;

“...it was a gruesome farm attack. After that, the symptoms I experienced just became worse over time. I became anxious and down, nothing made sense anymore”.

Friedman (2012:83) mentions that the symptoms experienced during the initial aftermath might, however, increase over a period of time and develop into complex and long-lasting conditions, for example, post-traumatic stress disorder and comorbidity of PTSD. These responses will be discussed in more detail below.

Some participants reported that they developed long-term responses following their involvement in traumatic incidents which increased in severity over time, making it difficult to cope (Kirschman *et al.*, 2014:63). Anderson *et al.* (2002:399) and Solomon (2011) are of the opinion that if the stress symptoms experienced during the initial aftermath are not addressed during the acute phase, these stress symptoms can increase in intensity. Such members might be at risk of developing PTSD. Traumatic events that may trigger PTSD include violent personal assaults, natural or unnatural disasters, accidents, or military combat (American Psychiatric Association, 2013).

The researcher categorised 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 (American Psychiatric Association, 2013:274-276).

- **Re-experience**

The first cluster relates to the re-experience of the traumatic event. The following comments 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 flashbacks or reliving the incident in their mind, something over which they had 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. 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 physiological reactivity after exposure to trauma-related stimuli (American Psychiatric Association, 2013:275; Godbout & Briere, 2012:485).

- **Avoidance of stimuli**

The second cluster relates to the avoidance of stimuli associated with trauma. The following comments 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 avoided thoughts and feelings associated with the incident. Others reported that they avoided places, conversations or situations as this reminded them of the details of the incident which, according to them, is too painful. According to the DSM-5, the second category is concerned with the persistent effortful avoidance of distressing trauma-related stimuli after the event. The group members' responses greatly corresponded with Godbout and Briere's (2012:485) statement that the avoidance of stimuli can be associated with trauma-related thoughts or feelings, but also with 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. The following comments 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 feel guilty but at the same time angry with yourself and everybody around you”.

Some participants became over-protective of their family, and found it difficult to trust others as they were perceived to be bad. The one member reported that he was constantly blaming himself for the death of a colleague. The DSM-5 refers to the above symptoms as negative alterations in cognitions and mood (American Psychiatric Association, 2013:275). Group members’ opinions in this regard corresponded with Godbout and Briere’s (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.

- **Alterations in arousal and reactivity**

The forth cluster refers to trauma-related alterations in arousal and reactivity that began or worsened after the traumatic event. 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”;

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

Some of the group members reported that they found it difficult to fall or remain asleep. Others mentioned that they easily became irritated, even with minor issues, and that they could not always control their temper. Some of the group members were always on the lookout for danger. This kind of behaviour made family and friends feel uncomfortable. The one group member mentioned that he was easily startled, even when someone behind him suddenly spoke loudly, or when a door blew 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 closely corresponded with the symptoms referred to by Godbout and Briere (2012:485), namely irritable or aggressive behaviour, hypervigilance, exaggerated startled response and sleep disturbance. Some of the participants reported that they were constantly feeling worthless, negative and morbid. They felt totally overwhelmed and were questioning the meaning of life, they abused alcohol or experienced muscle tension (Figley, 2012:452; Friedman, 2012:22; Lawhorne-Scott & Philpott, 2013:76,93).

Sub-theme 3: Consequences of complex trauma

The following comments can be seen as being representative of the consequences of complex trauma, such as suicide ideation, anger, aggression and violence, family and relationship problems, somatic complaints and work-related problems.

“...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”;

“...There is a lot of violence in my home; 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”;

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

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

“...you don’t know how to cope, 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”.

Group members reported different risk factors which have been identified by the researcher as a direct result of complex trauma. These factors might have a negative impact on their overall psycho-social wellbeing and refer to anger, aggression and violence, suicide ideation, family and relationship problems, somatic complaints and work-related problems (Lawhorne-Scott & Philpott, 2013:81; Panagioti, 2011:31). Difficulty in managing anger is not only associated with violent behaviour but is also linked to increased stress, low self-esteem, and family and relationship conflicts (Elbogen *et al.*, 2011:305; Franklin, 2013:323; Kirschman, 2014:171).

Some participants referred to physical illness such as back and chest pain, headaches and muscle tension, which can be regarded as psychosomatic illness (Brosbe & Hoefling, 2012:643; Kirschman, 2014:158). Pienaar and Rothman (2005:58) concur with the above conclusion and indicate that the high number of members who took sick leave as a result of acute stress, depression, PTSD and other stress-related problems as well as the number of members who retired because of medical disability, is an indication of the harmful effect the police environment had on the police official. The research by Watson *et al.* (2012:183) added that police officials’ behaviour lead to a very high employee turnover, absenteeism, sick leave due to stress, death and ill-health retirement.

Theme 3: Coping

Avoidance coping and action-orientated coping can be distinguished as sub-themes in theme 3.

Sub-theme 1: Avoidance coping

Police officials were sometimes deliberately applying avoidance coping mechanisms as a way of escaping from the psychological impact after exposure to trauma. 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”;

“...we start cracking jokes, it’s not disrespectful, it’s our way of releasing”;

“...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”;

“...I just want to be on my own. When I feel better I just put on my radio. When my neighbours hear the loud noise, the radio, they know that she’s back”.

Participants reported the following avoidance coping mechanisms to escape underlying emotions as a result of their exposure to trauma and stress: avoiding reminders, joking, internalising symptoms, social and emotional withdrawal, and denial. Some of them reported that the unique police culture did not allow police officers to show emotions. Others prefer not to talk about it or seek assistance, as confidentiality is not always maintained (Becker *et al.*, 2009:246; Blais & Renshaw, 2013:77). Anshel (2000:389) and Kirschman *et al.* (2014:16) are of the opinion that: “avoidance strategies allow officers to evade underlying problems, or turning away from the stressful source, and are used in an attempt to reduce the emotional strain experienced”.

Sub-theme 2: Action-oriented coping

Group members also reported action-oriented coping mechanisms to manage the demands created by traumatic and stressful events. 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 saw people being shot at. I just want to go home.” That’s most probably the worst thing to do at that moment. It is better to go straight to EHW for counselling”;

“...to whom must I speak in the police if I can’t trust anyone. So now I’m seeking professional help outside the police”.

Some participants were much more aware and realistic about the consequences of trauma and stress and so took positive action to manage possible harmful effects. They strongly relied on the support of their family and peers, but also did not hesitate to consult EHW or external professionals for counselling and support. These officials also attended the trauma intervention programmes and acknowledged the psycho-educational value. Some of the group members actively participated in religion, sport, enjoy music or engaged in some kind of activity or hobby as part of relaxation to find a balance and to maintain psycho-social wellbeing. Carlan and Nored (2008:9), Louw and Viviers (2010:3) and Taylor and Stanton (2007:377) agree that action-oriented coping is part of intra-psychic efforts to manage, confront and control the demands created by stressful events in the hope of reducing the imbalance.

Theme 4: Trauma intervention programmes

The following sub-themes will be distinguished in this section, namely awareness and participation, consumer orientation, consumer satisfaction and core marketing strategy.

Sub-theme 1: Awareness and participation

The following comments can be distinguished as part of awareness and participation:

“...I participated in the stress management and suicide prevention programmes, 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 programmes presented by EHW, but we don’t give ourselves time to visit EHW after the situation”;

“...no, I am not aware of the trauma intervention programmes that are presented by EHW, never heard of it before”.

Some participants indicated that they have already attended one or more of the mentioned trauma intervention programmes. Some of the members had some knowledge of the programmes, although they have not participated in the programmes. A smaller percentage of group members indicated that they did not have any knowledge of these programmes and never heard of them before. This might 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 organisations as it is in other organisations. Kirschman *et al.* (2014:5,6) and Zinkhan and Williams (2007:285) are of the opinion that police officials hold distorted attitudes about mental health professionals.

Sub-theme 2: Consumer orientation

The following comments can be seen as being representative of the viewpoints of participants:

“...we would prefer to give an input or contribution to assist EHW to improve the programmes. We might come up with a strategy as well as a plan of implementation, to make sure it will be a success”;

“...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 programmes on a monthly or quarterly basis, in the form of group sessions, including the whole unit and the duty officers. 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 health issues, and relationship, alcohol and financial problems”.

Participants expressed a variety of needs related to consumer orientation, such as not being consulted with regard to prospective trauma intervention programmes, and feeling that EHW did not work with them at unit level and consequently did not understand police officials' working conditions. They believed that a thorough needs assessment should have been conducted by EHW, consulting members on ground level regarding their unique working conditions and specific needs (Kotler & Armstrong, 2014:28; Solomon, 2011:35; Zeithaml *et al.*, 2009:27).

Most of the group members were ignorant and uninformed regarding trauma and its consequences and there seemed to be 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 posttraumatic 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.

Sub-theme 3: Consumer satisfaction

The following examples of consumer satisfaction are cited in order to illustrate the above factors:

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

“...if EHW come with a group programme, it is fine. But they should also come up with something to evaluate how we experienced the programme; we should also be able to make suggestions”;

“...we would prefer feedback on our evaluation, but instead it is thrown in the dustbin”;

“...my suggestion would be to give the police officials time so it can sink in. Maybe, after a month or two, you can question them again, if you evaluate a

programme, 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 programmes, others were dissatisfied with reference to various factors such as the fact that their needs and inputs were not requested or considered, and the impact of programmes was not measured. Bamrara *et al.* (2012:4), Kotler and Armstrong (2006:35), Lovelock and Wirtz (2007:245) 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. 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 wellbeing.

Sub-theme 4: Core marketing strategy

The following categories emerged as a result of the group members' opinions, namely product, place, price and promotion (Kotler & Armstrong, 2014:429; Zeithaml *et al.*, 2009:24). The following comments illustrate this:

"...It is good to talk in a group, some members will not talk about the incident, but if your partner expresses him/herself, you will go for it. When you are talking about what happened on the scene, what you smell, see, feel and how your body reacted, others will hear that 'we feel and reacted the same. It's not only me that feels the pain'";

"...EHW is part and parcel of the police. We don't trust them. Most of the members feel like EHW can get overruled by management, they have to report to somebody, either a brigadier or higher authority";

"...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";

"...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.".

Some of the participants believed that those trauma intervention programmes were relevant to their unique situation. They were satisfied with the content and the quality and found it easy to understand. These participants stated that they had learned several techniques and skills to help them handle the response to stress and trauma. Police officials experienced groups as particularly positive, especially to those who do not easily speak about their emotions (Orr & Hulse-Killacky, 2006:192). Most participants were, however, of the opinion that the content of the programmes only focused on the individual, and more specifically on trauma and stress, without looking at the person within the social environment. They felt it did not meet their expectations (Penk *et al.*, 2011:174-175).

Confidentiality was one of the major cost factors in general posing a problem for participants. It was difficult for them to trust the social workers, psychologists and chaplains, because it happened in the past that police officials' personal problems were discussed with management or colleagues. The perception existed that EHW was accountable to police management. Therefore group members were afraid that their careers would be negatively affected. 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 such views of senior management in order to facilitate new insights.

Some of the participants mentioned that because of the nature of their work, and more specifically the heavy workload, they did not always have the time to attend trauma intervention programmes. The duration of programmes was sometimes too long, while the time of presentation (day of the week, month or year) was problematic in some cases. According to Lovelock and Wirtz (2007:17), it is important that the time and duration of the presentation of programmes be kept in mind to ensure optimal functioning. 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 conclusion is drawn that trauma intervention programmes were generally not marketed well enough by EHW or management. Participants also had a need for constant awareness through personal visits to different units, flyers or e-mails (Lovelock & Wirtz, 2007:155; Zeithaml *et al.*, 2009:25).

DISCUSSION

The research results of this study revealed the following, namely the meaning of trauma, response to trauma, coping and trauma intervention programmes. Police officials attached to the specialist units of the SAPS in the North-West Province were exposed to several traumatic incidents in the performance of their duties as police officers, as well as their personal lives. The latter varied in incidence and intensity. The frequency, intensity, cumulative nature and re-traumatisation associated with these traumatic incidents reinforced the police officials' experience of trauma. Police officials were furthermore exposed to major stressors as a result of organisational, operational, external and personal factors. These stressors were sometimes so severe that they resulted in a traumatic response or had a negative impact on police officers' 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 had a serious impact on the police officers' social ecology and systems of care, for example, the family, peers and their productivity at work. Police officials cope differently with trauma, such as avoidance and action-orientated coping. Some were 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 denied and avoided dealing with the symptoms of trauma. This might be attributed to the fact that they hid from the painful consequences of the symptoms as they were not prepared to be confronted with 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 EHW and management. It appears that those police officials who attended trauma intervention programmes were, with the exception of certain aspects, mostly satisfied with the product. They were, however, concerned about the fact that their unique needs were not considered. They were also concerned about the fact that the impact and satisfaction with the programmes were not measured or amended accordingly. Members also said little consideration was given to the inconvenience caused as a result of the time and duration of programmes as well as certain psychological cost factors, for example, professional conduct, confidentiality and management support.

CONCLUSION

The researcher did an in-depth exploratory analysis and collected information regarding the police officials' experience of trauma and trauma intervention programmes 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 biggest 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 ascribed to trauma and trauma intervention programmes. As a result of the problem analysis, the following topics were identified as preliminary indicators of the development of a purposeful psycho-social trauma intervention programme to address the problems regarding trauma in the 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 experienced by those police officers who experience complex traumatic stress reactions are basic components of care which must be taken into account by EHW in the SAPS.

REFERENCES

ADAMS, T.F. 2007. **Police field operations** (7th ed). Upper Saddle River, NJ: Prentice-Hall.

AMERICAN PSYCHIATRIC ASSOCIATION. 2013. **Diagnostic and statistical manual of mental disorders** (DSM-5). Text revision (DSM 5) (5th ed). Washington, DC: APA.

ANDERSON, G.S., LITZENBERGER, R. & PLECAS, D. 2002. Physical evidence of police officer stress. **Policing: An International Journal of Police Strategies and Management**, 25(2):399-420.

ANDREW, M.E., HOWSARE, J.L., HARTLEY, T.A., McCANLIES, E.M., BURCHFIEL, C.M. & VIOLANTI, J.M. 2014. Protective attributes: resilience in policing. In: VIOLANTI, J.M. **Dying for the job: police work exposure and health**. Springfield Illinois: Charles C Thomas Publishers, 115-123.

ANSHEL, M.H. 2000. A conceptual model and implications for coping with stressful events in police work. **Criminal Justice Behaviour**, 27(3):375-400.

BECKER, C.B., MEYER, G., PRICE, J.S., GRAHAM, M.M., ARSENA, A. & ARMSTRONG, D. 2009. Law enforcement preferences for PTSD treatment and crisis management alternative. **Behaviour Research and Therapy**, 47:245-253.

BLAIS, R.K. & RENSHAW. 2013. Stigma and demographic correlates of help-seeking intentions in returning service members. **Journal of Traumatic Stress**, 26:77-85.

BONANNO, G.A., WESTPHAL, M. & MANCINI, A.D. 2012. Loss, trauma, and resilience in adulthood. **Annual Review of Gerontology and Geriatrics**, 32:189-211.

BOND, M.A. & KEYS, C.B. 1993. Empowerment, diversity and collaboration: Promoting synergy on community boards. **American Journal of Community Psychology**, 21:37-58.

BROSBE, M.S. & HOEFLING, K. 2012. Somatic complaints. In: FIGLEY, C.R. **Encyclopedia of Trauma: an Interdisciplinary Guide**. Los Angeles: Sage Publications, 643-646.

CARLAN, P.E. & NORED, L.S. 2008. An examination of officer stress: should Police Departments implement mandatory counselling? **Journal of Police and Criminal Psychology**, 23:8-15.

COURTOIS, C.A. 2012. Complex trauma. In: FIGLEY, C.R. **Encyclopedia of Trauma: an Interdisciplinary Guide**. Los Angeles: Sage Publications, 139-142.

COURTOIS, C.A., FORD, J.D. & CLOITRE, M. 2009. Best practices in Psychotherapy for adults. In: COURTOIS, C.A. & Ford, J.D. **Treating complex traumatic stress disorders: scientific foundations and therapeutic models**. New York: The Guilford Press, 82-103.

CRESWELL, J.W. 2014. **Research design qualitative, quantitative & mixed methods approaches** (4th ed). Thousand Oaks: Sage Publications.

DEMPSEY, J.S. & FORST, L.S. 2013. **An introduction to policing** (7th ed). Belmont, KY: Cengage Learning.

DESCHAMPS, F., PAGNON-BADINER, I., MARCHAND, A. & MERLE, C. 2003. Sources and assessment of occupational stress in the police. **Journal of Occupational Health**, 45:358-364.

ELBOGEN, E.B., JOHNSON, S.C. & BECKHAM, J.C. 2011. Anger, aggression and violence. In: MOORE, B.A. & PENK, W.E. **Treating PTSD in Military Personnel**. A Clinical Handbook. New York: The Guilford Press, 305-324.

FIGLEY, C.R. 2012. Posttraumatic stress disorder. In: FIGLEY, C.R. **Encyclopedia of Trauma: an Interdisciplinary Guide**. Los Angeles: Sage Publications, 450-452.

FORD, J.D. & COURTOIS, C.A. 2009. Defining and understanding complex trauma and complex traumatic stress disorders. In: COURTOIS, C.A. & FORD, J.D. (eds),

Treating complex traumatic stress disorders: an evidence-based guide. New York: The Guilford Press, 13-30.

FRANKLIN, K. 2013. Cycle of deployment and family well-being. In: RUBIN, A., WEISS, E.L. & COLL, J.E. 2013. **Handbook of Military Social Work**. Hoboken, NJ: Wiley & Sons, 313-333.

FREWIN, K., STEPHENS, C. & TUFFIN, K. 2006. Re-arranging fear: police officers' discursive constructions of emotion. **Policing and Society**, 16(3):243-260.

FRIEDMAN, M.J. 2012. **Posttraumatic and acute stress disorders** (5th ed). Kansas City, MO: Jones & Bartlett Learning, LLC.

GARCIA, L., NESBARY, D.K. & GU, J. 2004. Perceptual variations of stressors among police officers during an era of decreasing crime. **Journal of Contemporary Criminal Justice**, 20(1):33-50.

GODBOUT, N. & BRIERE, J. 2012. Psychological responses to trauma. In: FIGLEY, C.R. **Encyclopedia of Trauma: an Interdisciplinary Guide**. Los Angeles: Sage Publications, 485-489.

GREEFF, M. 2011. Information collection: interviewing. In: DE VOS, A.S., STRYDOM, H., FOUCHÉ, C.B. & DELPORT, C.S.L. (eds) **Research at grass roots: for the social sciences and human service professions** (4th ed). Pretoria: Van Schaik Publishers, 341-374.

HARTLEY, T.A., FEKEDULEGN, D., BURCHFIEL, C.M., MNATSAKANOVA, A., ANDREW, M.E. & VIOLANTI, J.M. 2014. Health disparities among Police Officers. In: VIOLANTI, J.M. **Dying for the job: police work exposure and health**. Illinois: Charles C Thomas Publishers, 21-35.

JORGENSEN, L.I. & ROTHMANN, S. 2008. Occupational stress ill health and organizational commitment of members of the South African Police Service in the North West Province. **Acta Criminologica**, 21(2):1-15.

KEYES, B.B. 2012. Social support and trauma. In: FIGLEY, C.R. **Encyclopedia of Trauma: an Interdisciplinary Guide**. Los Angeles. Sage Publications, 637-640.

KIRSCHMAN, E., KAMENA, M. & FAY, J. 2014. **Counseling COPS. What clinicians need to know**. New York: The Guilford Press.

KOTLER, P. & ARMSTRONG, G. 2014. **Principles of marketing** (14th ed). United States of America: Pearson Education Inc.

LAWHORNE-SCOTT, C. & PHILPOTT, D. 2013. **Military Mental Health Care**. A guide for service members, veterans, families, and community. Maryland: Rowman & Littlefield Publishers, Inc.

LOUW, G.J. & VIVIERS, A. 2010. An evaluation of a psychosocial stress and coping model in the police work context. **SA Journal of Industrial Psychology**, 36(1):1-11.

LOVELOCK, C. & WIRTZ, J. 2007. **Services marketing. People, technology, strategy** (6th ed). United States of America: Pearson Education Inc.

MacEACHERN, A.D., JINDAL-SNAPE, D. & JACKSON, S. 2011. Child abuse investigation: police officers and secondary traumatic stress. **International Journal of Occupational Safety and Ergonomics** (JOSE), 17(4):329-339.

McNALLY, V.J. 2012. Law enforcement officers. In: FIGLEY, C.R. **Encyclopedia of Trauma: An Interdisciplinary Guide**. Los Angeles: Sage Publications, 341-343.

MILLER, L. 2005. Police officer suicide: causes, prevention and practical intervention strategies. **International Journal for Emergency Mental Health**, 7:101-114.

MITCHELL, J.T. 2012. Critical incident stress. In: FIGLEY, C.R. **Encyclopedia of Trauma: an Interdisciplinary Guide**. Los Angeles: Sage Publications, 165-170.

MMUSHI, K. 2014. Remembering our fallen heroes. **SAPS Magazine**. [Online] Available: http://www.saps.gov.za/resource_centre/publications/police_mag/september_mag.pdf [Retrieved: 10/11/2014].

MORASH, M., HAARR, R. & KWAK, D. 2006. Multilevel influences on police stress. **Journal of Contemporary Criminal Justice**, 22(1):26.

MURPHY, L.R. & SAUTER, S.L. 2004. Work organisation interventions: state of knowledge and future directions. **Soz.-Präventivmed**, 49:79-86.

NAUDÉ, J.L.P. & ROTHMAN, S. 2003. Occupational stress of emergency workers in Gauteng. **SA Journal of Industrial Psychology**, 29(4):92-100.

ORR, J.J. & HULSE-KILLACKY, D. 2006. Using voice, meaning, mutual construction of knowledge, and transfer of learning to apply an ecological perspective to group work training. **Journal for Specialists in Group Work**, 31(3):192.

PANAGIOTI, M. 2011. **Suicidal behavior in posttraumatic stress disorder**. University of Manchester (PhD Thesis)

PATON, D. & NORRIS, K. 2014. Vulnerability to work-related stress: family and organizational influences. In: VIOLANTI, J.M. **Dying for the job. Police work exposure and health**. Springfield, Illinois: Charles C Thomas Publishers.

PATTERSON, G.T. 2008. A framework for facilitating stress management educational groups for police officers. **Social Work with Groups**, 31(1):53-70.

PENK, W.E., LITTLE, D. & AINSPAN, N. 2011. Psychosocial rehabilitation. In: MOORE, B.A. & PENK, W.E. **Treating PTSD in Military Personnel**. A Clinical Handbook. New York: The Guilford Press, 173-194.

PIENAAR, J. & ROTHMAN, S. 2005. Suicide ideation in the South African Police Service. **SA Journal of Psychology**, 35(1):58-72.

RAHMAN, S.M.Z, ISLAM, M.D.S. & AKTER, T. 2013. Demographic profile of the customers and their level of satisfaction: a study on Islami Bank Bangladesh Ltd. (IBBL). **Research Journal of Finance and Accounting**, 4(11):28-38.

RUBIN, A. & BABBIE, E.R. 2010. **Essential research methods for social work**. New York: Brooks/Cole Cengage Learning.

SAPS ANNUAL REPORT. 2012/2013. **SAPS Journal**. [Online] Available: www.saps.gov.za/saps_profile/strategic_framework/annual_report/index. [Accessed: 30/07/2014].

SAPS CRIME STATISTICS. 2013/2014. [Online] Available: http://www.saps.gov.za/resource_centre/publicationsstatistics/crimestats/2014/crime_stats.php [Retrieved: 25/09/2014].

SOLOMON, M.R. 2011. **Consumer behaviour. Buying, having, and being** (9th ed). United States of America: Pearson Education, Inc.

SOLOMON, R. 2011. **Critical incident trauma for law enforcement officers**. [Online] Available: [http://www.thecounselingteam.com/interactive/articles/Critical%20Incident%20Trauma%20\(R.%20Solomon\).pdf](http://www.thecounselingteam.com/interactive/articles/Critical%20Incident%20Trauma%20(R.%20Solomon).pdf) [Retrieved: 09/08/2014].

STRYDOM, H. & DELPORT, C.S.L. 2011. Sampling and pilot study in qualitative research. In: DE VOS, A.S., STRYDOM, H., FOUCHE, C.B. & DELPORT, C.S.L. (eds) **Research at grass roots: for the social sciences and human service professions** (4th ed). Pretoria: Van Schaik Publishers, 390-396.

STRYDOM, H. 2011. Ethical aspects of research in the social sciences and human service professions. In: DE VOS, A.S., STRYDOM, H., FOUCHE, C.B. & DELPORT, C.S.L. (eds) **Research at grass roots: for the social sciences and human service professions** (4th ed). Pretoria: Van Schaik Publishers, 113-130.

SURI, R.V. 2012. Trauma, causes of. In: FIGLEY, C.R. (ed). **Encyclopedia of Trauma: an Interdisciplinary Guide**. Los Angeles: Sage Publications, 674-675.

TAYLOR, S.E. & STANTON, A.L. 2007. Coping resources, coping processes, and mental health. **Clinical Psychology**, 3:377-401.

VIOLANTI, J.M. & GEHRKE, A. 2004. Police trauma encounters: precursors of compassion fatigue. **International Journal of Emergency Mental Health**, 6:75-80.

VIOLANTI, J.M. 2014. Police suicide: a detrimental outcome of psychological work exposures. In: VIOLANTI, J.M. **Dying for the job: police work exposure and health**. Springfield Illinois: Charles C Thomas Publishers, 115-123.

WATSON, R., JORGENSEN, L.I., MEIRING, D. & HILL, C. 2012. The development and evaluation of an emotion competence intervention in the South African Police Service. **Journal of Social Science**, 30(2):183-203.

WESSELY, S., BRYANT, R.A., GREENBERG, N., EARNSHAW, M., SHARPLEY, J. & HUGHES, J.H. 2008. Does psycho-education help prevent post traumatic psychological distress? **Psychiatry**, 71(4):287-302.

WILLIAMS, M.B. & POIJULA, S. 2013. **The PTSD Workbook. Simple, effective techniques for overcoming traumatic stress symptoms** (2nd ed). Oakland: HarperCollins Publishers.

YIN, R.K. 2012. **Applications of case study research** (3rd ed). Thousand Oaks, CA: Sage Publications.

YOUNG, M., KOORTZEN, P. & OOSTHUIZEN, R.M. 2012. Exploring the meaning of trauma in the South African Police Service: A systems psychodynamic perspective. **SA Journal of Industrial Psychology**, 38(2):1-14.

ZEITHAML, V.A., BITNER, M.J. & GREMLER, D.D. 2009. **Services marketing: integrating customer focus across the firm** (5th ed). Singapore: The McGraw-Hill Companies.

ZINKHAN, G.M. & WILLIAMS, B.C. 2007. The New American Marketing Association definition of marketing: an alternative assessment. **Journal of Public Policy & Marketing**, 26(2):284-288.

Mr Pieter Boshoff, doctoral candidate; Prof Herman Strydom, The School for Psychosocial Behavioral Sciences (Social Work); Prof Karel Botha, The School of Psychosocial Behavioural Sciences (Psychology), North-West University (Potchefstroom Campus), Potchefstroom, South Africa.