CRITICAL INCIDENT STRESS DEBRIEFING IN THE SOUTH AFRICAN POLICE SERVICES: TRAUMA DEBRIEFERS' PERCEPTIONS

BY

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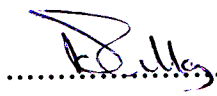
Declaration

Submitted in fulfillment / partial fulfillment of the requirements for the degree of Masters of Social Science (Counseling Psychology), in the Graduate programme in the Faculty of Humanities, Development and Social Science, University of KwaZulu-Natal , Durban, South Africa.

I declare that this dissertation is my own unaided work. All citations, references and borrowed ideas have been duly acknowledged. It is being submitted for the degree of Masters of Social Science (Counseling Psychology) in the Faculty of Humanities, Development and Social Science, University of KwaZulu-Natal, Durban, South Africa. None of the present work has been submitted previously for any degree or examination in any other University.



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ABSTRACT

The experience of trauma has been the focus of much attention in the media and in academic literature. Many of these studies have explored the experiences of rescue and emergency personnel, including the interventions used to help them deal with these experiences. Critical Incident Stress Debriefing (CISD) is one of many preventative interventions that are used with these traumatized personnel. However, there are many inconsistencies relating to the efficacy of this intervention tool. Research that has investigated this issue has focused mostly on the experiences of the traumatized person/s.

The current study adopts a different perspective in that it explores the perceptions of practitioners who this method of intervention. The importance of professionals evaluating their tools cannot be overemphasized. These professionals would be in a better position to make suggestions regarding the use of their tool. A qualitative study was conducted that investigated the perceptions of six psychologists employed by South African Police Services (SAPS) the within the Durban and Pietermaritzburg areas (KwaZulu-Natal). These psychologists were trained by the SAPS to conduct trauma-debriefing sessions using the method of CISD. The results suggested that this method of CISD has value when used as a group intervention with traumatized police officers but due to the continuous exposure to trauma, this method needs to be adapted or changed for police officers. Furthermore, due to continuous use of this method and the fact that it is the only method that is in use by the SAPS to intervene with trauma, many police officers become too familiar with this method and it tends to have less of an impact.

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CHAPTER ONE

INTRODUCTION

1.1 Introduction

The field of trauma and the resultant physiological and psychological sequelae that accompany exposure to traumatic events has been a focus of increased attention both in the media and in academic literature (Dean, Gow & Shakespeare-Finch, 2003). Traumatic experiences are a part of the society that people live in. Such experiences impact on those directly exposed to the trauma and research has revealed that "helpers" of the traumatized victims are also not immune to being affected by these experiences. Emergency and rescue personnel, law enforcement officers, fire fighters and other crisis workers who are considered to be "helpers", are often called upon to deal with traumatic situations. As a result they are at the top of the list of people who are either directly or vicariously affected by these traumatic events. In other words they may experience post trauma reactions either by direct exposure to a traumatic event or whilst assisting and providing support to the traumatized victims.

Critical Incident Stress Debriefing (CISD) is one of many interventions that are commonly used with people who have had traumatic experiences (Berman & Davis-Berman, 2005; Gist & Woodall, 1998; Kenardy, 1998). Previous studies on CISD tended to focus on the experiences of traumatized victims and on whether the intervention was effective in reducing post trauma symptoms (Jonas, 2003). However, there appears to be a paucity of research that focuses on the experiences of trauma debriefers who conduct these debriefing sessions using the CISD model. The importance of exploring the views and perspectives of the people who use these intervention tools cannot be overemphasized. Constantly exploring how professionals' view their tools is important in that it serves to mitigate against complacency (using the tool just because it is there or it is prescribed). Apart from strengthening what works, it also influences the changing of what may be considered as not working well. The focus of the current research is therefore the perceptions of trauma debriefers who conduct the process of critical incident stress debriefing with police personnel. It is hypothesized that such an approach would provide insight into the use of this method as an intervention tool. In a way, this also leads to an evaluation of the perceived efficacy of the CISD model from the perspective of the trauma debriefer.

This chapter begins by discussing the purpose and goals of this study, the research problem and the research question. Thereafter the researcher provides a brief historical background regarding the functioning of the South African Police Services in a culturally diverse country. A discussion is also provided regarding the historical development of the concepts of trauma and Post Traumatic Stress Disorder (PTSD) and finally the chapter ends with a definition of various terms such as a traumatic event, trauma debriefer and the concept of debriefing.

1.2 Purpose and goals of the study

1.2.1 Purpose

The purpose of the study is to explore the perceptions of the South African Police Services' trauma debriefers who use Mitchell's (1983) Critical Incident Stress Debriefing model as an intervention tool with traumatized police officers.

1.2.2 Goals

According to Terre Blanche and Durrheim (1999) the purpose of a research project is reflected in the goals or aims of the study. In other words the researcher envisages achieving a particular goal when conducting a research study. The researcher may either want to explore a phenomenon, describe a phenomenon or explain a particular phenomenon. Hence the goals can be exploratory, descriptive or explanatory in nature. Exploratory studies adopt an open, flexible and inductive approach to research as the researcher attempts to look for new insight into a phenomenon. This study can be regarded as exploratory in nature as this study aims to explore the perceptions of the trauma debriefers regarding the intervention tool that they use with traumatized police officers. It is envisaged that by exploring the impressions, thoughts and feelings of these trauma debriefers, a better understanding of the use of this tool will be achieved.

By implication, the current research also has an evaluative component to it as by exploring the thoughts and feelings of the trauma debriefers about the tool that they use, it also evaluates the efficacy of this tool from their perspective. It is however hoped that results obtained will influence further studies that will utilize proper evaluation strategies and methodologies to assess the efficacy of this model (CISD) as an intervention tool.

1.3 Problem formulation

Police officers, during the course of their daily duties, are often required to act as barriers between society and violence (Chabalala, 2005). Traumatic experiences can therefore not be dissociated from the occupation of being a police officer. From the moment a person becomes a police officer, they are continually placed in high-risk situations where they are threatened with injury and death. In addition to this, these police officers still have to deal with the "normal" stressors of life such as work overload, financial problems, relationship problems etc. Such traumatic experiences can be very stressful for the police officers to cope with (Ebrahim, 2004). As a result, many policing agencies, including the South African Police Services have implemented programmes in order to help police officers deal with traumatic experiences that may be encountered during the execution of their duties. Some of these programmes or interventions include trauma debriefing (such as the CISD model), initial trauma debriefing or psychological first aid and general stress management. Professional psychologists, social workers and chaplains who are employed by the SAPS present these programmes.

The CISD model in particular, has been the focus of much research both within the SAPS and in academic literature. These studies have focused mainly on evaluating the efficacy of the CISD model both quantitatively and qualitatively as experienced by the traumatized participants. There has also been research that has focused on the experiences of the debriefers who conduct the CISD model, but these have focused mainly on secondary traumatization (Jonas, 2003; Ortlepp, 1998; Steed & Bicknell, 2001; Steed & Downing, 1998). There appears to be a paucity of research that focuses on the trauma debriefer's perceptions of the choice of the model itself. At the time of this researcher project, the researcher had not found any literature that explores the thoughts and feelings of the trauma debriefers about the intervention tool that they use, namely the CISD model. This therefore stimulated the researcher's interest in exploring the perceptions of these trauma debriefers regarding their tool.

1.3.1 Research question

According to Breakwell, Hammond and Fife-Schaw (1995) a research question is formulated in order to explicitly state the coherent goal of the research. Furthermore in formulating the question, the appropriate context of interest needs to be stipulated. The research question is:

- **What are the thoughts, impressions, perceptions and feelings of the South African Police Services' trauma debriefers towards, in general, the use of the CISD model as an intervention tool and by extension, the perceived efficacy of such an intervention tool?**

1.4 Historical background

1.4.1 The South African Police Services

South Africa is a country that is politically and culturally diverse and it has long been plagued by violence, poverty and unfairness. According to Hamber and Lewis (1997) South Africa has since the time of colonisation always being characterized by violence and in particular, political violence. This political past has significantly contributed to the attitudes and reactions of people within this country, especially the attitudes of the non-white communities towards the police. The South African Police Force was seen as the "tool" of the apartheid system that was used to maintain inequality. Throughout the past 14 years of democracy, changes had to be made in all institutions of the country including law enforcement. The role of the police has changed from being a "force" to that of providing a service to all communities - a move towards ensuring peace and safety for all people within the country. However, given the previous history of the country, police officers are still not well accepted by all in the community.

Research has indicated that being a police officer is regarded as one of the most stressful types of occupations in comparison to other types of occupations (Gulle, Tredoux & Foster, 1998; Violanti, 1993). The nature of such work is also exhausting, dangerous and traumatic (Marks, 1995). Work-related trauma is one of the major stressors that police officers experience. Such work-related trauma includes exposure to critical incidents of sudden injury or death and these are seen as part of their normal duties (Gersons & Carlier, 1993). In recognizing the importance of preventing the psychological sequelae of exposure to traumatic events, for example Post Traumatic Stress Disorder, organisations have turned to the use of psychological debriefing as a common intervention strategy (Stephens, 1996).

Gulle et al. (1998) argue that the South African Police Services (SAPS) has one of the highest rates of PTSD due to their continued exposure to potentially dangerous and stressful situations. Because of this, they often use coping behaviours that can be effective in helping them to deal

with the stress experienced. These coping behaviours can be positive behaviours such as exercise or negative behaviours such as substance abuse (Colley, 1995). When coping behaviours become ineffective due to the overwhelming stress that is experienced or when ineffective ways of coping are used, this unfortunately creates further problems for the police officer at work and in their personal lives (Young, 2004). Recognizing the impact of stressors on the SAPS personnel, the SAPS have established a department to provide assistance, support and counselling for its personnel. This department is referred to as the Employee Assistance Services (EAS) and comprises of three components; namely Psychological, Spiritual and Social Work Services, all of whom are trained professionals in their respective fields. The SAPS have trained most, if not all these EAS workers to conduct trauma debriefings using the method of Critical Incident Stress Debriefing. There are also educational programmes that are facilitated by these professionals within the SAPS such as Suicide Prevention workshops, Stress Management workshops, Life Skills workshops and the Initial Trauma Debriefing workshops. Management as well as other personnel are educated and trained during these workshops. In particular, the Initial Trauma Debriefing programme aims to train police officers on how to provide immediate support to their colleagues after a traumatic incident. This is one aspect of trauma management within the SAPS. Part of this process also involves that these traumatized members (irrespective of whether they underwent initial trauma debriefing or not) be referred to EAS for formal trauma debriefing or trauma counselling. Although it is mandatory for the SAPS personnel to be given the opportunity to undergo trauma-debriefing sessions, attendance is voluntary.

1.4.2 Historical influences on the concept of trauma

Critical Incident Stress Debriefing is used as an intervention in the treatment of a person who has been exposed to a traumatic event with the aim of acting as a preventative measure against Post Traumatic Stress Disorder or any other psychological consequences. These terms, such as trauma and Post Traumatic Stress Disorder have a long historical development and it would be useful to discuss these terms. Furthermore, providing an overview of trauma would assist in understanding the development of Post Traumatic Stress Disorder and Acute Stress Disorder as a possible consequence of exposure to a traumatic event. A brief overview of these terms will thus be provided.

1.4.2.1 Trauma

Trauma is a term that has been of interest for more than a century. The word trauma literally means wound and as such implies that hurt has been inflicted and that there should be signs of injury (Young, 2004). Some researchers have defined trauma as a physical or mental injury that arises from the experience of a sudden, extraordinary event (Rosenbloom & Williams, 1999; Terr, 1991). The experience of this event overwhelms the person's capacity to cope with the feelings that arise. As a result the person displays particular distressing symptoms associated with this difficult experience. This is emphasized by Leys (2000) who stated that exposure to overwhelming terror can lead to troubling memories of this experience, increased arousal and avoidance symptoms.

Initially, the distressing symptoms that arise from a traumatic experience have been linked to a physical or organic cause. This is highlighted by Young (2004) who argues that such symptoms were identified as early as the 1860`s by British physician John Erichsen. This physician identified the trauma syndrome in victims suffering from the fear of railway accidents. He attributed the cause of the distress experienced to shock or concussion of the spine. Although the symptoms were identified as resulting from physical injury, his work also highlights the role of psychological factors (in particular fear) in the early descriptions of symptoms. Similarly, a neurologist by the name of Paul Opperheim described this trauma syndrome as a disease and named it "traumatic neurosis". He ascribed the cause of symptoms to undetectable organic changes in the brain (Leys, 2000). Hence trauma took on a physical meaning, namely the distressful symptoms experienced by the person are the result of a physical or organic injury. A more psychological meaning of trauma emerged in the works of people like, J.M. Charcot, Pierre Janet, Alfred Binet, Josef Brener and Sigmund Freud who described trauma as the "wounding" of the mind caused by unexpected, sudden, emotional shock. According to Leys (2000, p. 4) the emphasis was now on the "traumatized psyche that is said to be the part that takes on the impact of the emotional shock at an unconscious level". Hypnosis was used as a therapeutic method for retrieving this repressed recollection. The work of Sigmund Freud emphasized this. In the 1890`s Freud saw female hysteria as caused by unconscious repressed memories of sexual trauma. However, in 1897 he later revised his thinking by attributing the cause of hysteria to repressed erotic infantile wishes and fantasies rather than to an actual traumatic situation. Freud referred to the former as anxiety neurosis and the latter as traumatic neurosis.

During the World War I a new term arose to describe the symptoms of hysteria in males who were involved in the war. The term that was used to describe these symptoms was referred to as war neurosis but it was also referred to as shell shock. The interest in trauma declined after World War I, but renewed interest arose in the 1970's as a result of the acknowledgement of the post war sufferings of the Vietnam War Veterans. These post war sufferings included amongst other things, increased suicides and severe psychiatric problems with those who came back from Vietnam. Psychiatrists, social workers and other professionals working in the Veterans Administration medical system were frustrated with the then psychiatric system that attached little importance to the experiences during the war (Bracken, 2003). As a result a campaign emerged that advocated the importance of recognising the suffering of these veterans. This led to the recognition of the traumatic syndrome in the third edition of the American Psychiatric Association's Diagnostic and Statistical Manual, namely the DSM III (APA, 1980).

In summary, the concept of trauma has been viewed as a physical or mental injury that gives rise to distressing symptoms. Furthermore, for such an injury to be inflicted there has to be a cause for example, a sudden, extra ordinary or terrifying event. The experience of this event results in distressing consequences, namely physical, behavioural, psychological and emotional symptoms. The shift in focus to viewing trauma as not only a physical injury but also a mental injury has resulted in acknowledging that people who are exposed to sudden, overwhelming, terrifying events may not necessarily have a physical injury but may have a psychological injury that creates these distressing stress related symptoms.

1.4.2.2 Post Traumatic Stress Disorder (PTSD)

Everly (1993, as cited in Everly & Lating, 1995) argues that posttraumatic stress represents the most severe and incapacitating form of human stress known to man. People diagnosed with PTSD find it difficult to pick up the pieces of their lives after a terrifying experience. These people often have to deal with the distressing stress symptoms, including the complications that these symptoms have caused in their lives and the lives of their families. However, the recognition of such stress related symptoms after a traumatic experience is not something new. The earliest report of symptoms that closely resemble the experience of PTSD was found in a person by the name of Samuel Pepys after his experience of the Great London Fire of 1666 (Gilliland & James, 1993).

The American Psychiatric Association has catalogued PTSD as a disorder in the various editions of the Diagnostic and Statistical Manual. These classifications included "Gross Stress reaction", "Transient Situational Disturbance" and "Anxiety Neurosis" (Bracken, 2003). These categories were expanded in the 1970's when Vietnam War veterans, their families, politicians and mental health professionals campaigned for the recognition of the impact of the horrific experiences of the Vietnam War and the resultant psychiatric conditions of these veterans. These efforts resulted in the recognition of PTSD as a psychiatric condition in the Diagnostic and Statistical Manual Three (APA, 1980). The recognition of PTSD in the Diagnostic and Statistical Manual Three of 1980 represented a shift in that it highlighted the notion that traumatic events in themselves can produce prolonged psychological consequences. Therefore a traumatic event was seen as responsible for the prolonged stress symptoms that occurred in traumatized individuals. In addition pre-trauma psychopathology as a predisposing factor was also acknowledged.

Bracken (2003) maintains that the revised 1987 version of the DSM III (DSM III-R) further emphasized the idea that the traumatic event was the central etiological factor of the symptoms experienced. In the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (APA, 1994), a stronger role is given to the person's individual history and personality. This version also incorporated recent thinking of the stressor criterion and included a new category called Acute Stress Disorder. Acute Stress Disorder and PTSD are different only in terms of the symptom duration, however the diagnosis of Acute Stress Disorder accommodates for those symptoms of a traumatic experience that are within four weeks. Therefore the DSM IV provides categories for short-term stress reactions (Acute Stress Disorder) and long-term stress reactions (PTSD) after the experience of a traumatic event. However the PTSD classification does not adequately accommodate for prolonged exposure to traumatic situations.

Herman (1997) believes that the category of PTSD is not accurate enough to describe a situation of extreme violence or prolonged exposure to traumatic situations. According to Herman (1997, p. 118) the experiences of such people include "anxiety, phobias, panic, somatic symptoms, depression and the degradation of their identity and relational life is not the same as an ordinary anxiety disorder, an ordinary somatoform disorder, an ordinary depressive disorder or an ordinary personality disorder". She further states that the existing diagnostic criteria of PTSD has been derived from the survivors of circumscribed traumatic events (combat, disaster and rape) and that the syndrome that follows prolonged repeated trauma should rather be described as complex PTSD. The symptoms of the survivors of prolonged repeated trauma include

characteristic personality changes, relationship and identity problems and are particularly vulnerable to repeated harm (self inflicted or at the hands of others). According to Herman (1997) the current diagnostic category of PTSD does not take in to account the variable symptoms of prolonged repeated trauma exposure or the deformations of personality that occur in captivity. She stated that the response to trauma should be understood as a spectrum of conditions ranging from brief stress reactions to classic PTSD to the complex syndrome of prolonged repeated trauma. It is therefore important for the diagnostic category of PTSD to be more inclusive as trauma symptomatology is not only as a result of exposure to a single incident but also as a result of prolonged repeated exposure to traumatic situations. A more inclusive definition of PTSD as defined by Herman (1997) would result in a more holistic treatment approach and better quality of life for those affected by traumatic experiences.

1.5 Definition of terms

1.5.1 Trauma debriefer

According to Parkinson (1993, p. 31) a crisis worker or debriefer is someone who is "trained to do crisis intervention work". This can include paraprofessionals, non-mental health professionals and non-professional volunteers that have been trained to implement the principles of psychological debriefing (Aguileria & Messick, 1978; Colley, 1995). Stuhlmiller and Dunning (1994, as cited in Raphael & Wilson, 2000) further state that a debriefer should have an understanding of the psychological debriefing model as he or she helps to co-construct the experience of the traumatized person by directing the verbalization of their experience. In other words the debriefer facilitates the process of debriefing by subtly encouraging the person to talk about their experience. For this current study, the term debriefer will refer to any of the SAPS Employee Assistance Services Personnel (psychologists, social workers and chaplains) who has been trained by the SAPS in the model of Critical Incident Stress Debriefing.

1.5.2 Debriefing

According to Kenardy (1998) debriefing is a structured intervention that promotes the emotional processing of a traumatic event through the expression and normalisation of reactions. It also prepares the person to deal with future experiences. Bisson, McFarlane and Rose (2000) further state that trauma debriefing is a single session semi-structured crisis intervention designed to

reduce and prevent unwanted psychological sequelae after exposure to a traumatic event. It involves the emotional processing of the traumatic event by the ventilation and normalisation of reactions and the preparation for possible future experiences. Again, Dyregrov (1997, p. 589) defines debriefing as a "group meeting to review the impressions and reactions" that survivors, the bereaved or helpers experience during or following critical incidents or disasters. The aim is to reduce unnecessary psychological sequelae. According to the National Trauma Committee of the South African Police Services (1998, p. 5) debriefing is the "emotional unloading or ventilation of feelings in a controlled and safe environment, during which time the reactions to the traumatic experience are normalised". The feelings and symptoms experienced are a normal reaction to an abnormal situation.

Given the various perspectives of trauma debriefing discussed above, the researcher has summarized trauma debriefing as a structured individual or group session that promotes the expression of thoughts, feelings and reactions following the exposure to a traumatic event. This is a single session process that aims to normalise the reactions experienced and to facilitate preparation for possible future experiences.

1.5.3 Traumatic event

Traumatic experiences are a very real part of the society that people live in. Information expressed via the media often contain stories of traumatic experiences ranging from natural disasters (floods, earthquakes) to "man made or unnatural" situations (accidents, shootings, murders). Such events can be seen as a critical incident that is outside the range of normal human experiences (Robinson, 1989).

As discussed above there are various situations that can be construed as a traumatic event. However, it is not only the type of situation that makes an event traumatic but rather other factors also play a role in determining the possibility of a situation as being traumatic. Green (1990, as cited in McNally, 2003) indicates that there are three variables that may play a role in how one defines a traumatic event, namely an objectively defined event, a person's subjective interpretation and the person's emotional reaction to deal with it. In a similar manner, Slaby (1989) maintains that there are six characteristics that make an event traumatic. These are the expectedness versus the unexpectedness of the event, the element of shock that arises and the intensity of the event, the fact that it seems cruel, the element of unfairness, the element of

control verses lack of control as well as the resulting blame that is translated into guilt and intensifies the response to the crisis.

Another factor that plays a role when regarding an event as traumatic is that such an event needs to elicit a particular reaction from those exposed to it. According to Mitchell (1983, as cited in Armstrong, O'Callahan & Marmar, 1991), a critical incident is any situation faced by emergency services personnel (EMS) that elicits unusually strong emotional reactions. These reactions impact on their ability to function on the scene or sometimes later. Similarly, Macy, Behar, Paulson, Delman, Schmid and Smith (2004) state that sudden random events that involve the violent loss of human life and large-scale natural or man-made disasters have been identified as eliciting traumatic responses. Again, McCubbin and Figley (as cited in Aldwin, 1994) argue that "catastrophic stress" (that is experienced after a catastrophic event) is the sudden unexpected feelings of helplessness, disruption and loss for those exposed.

The various factors that have been discussed thus far in relation to a traumatic event can be seen in the 1994 edition of the Diagnostic and Statistical Manual (APA, 1994). This manual gives a clear definition of how a traumatic event is defined. For the purposes of this study this definition will be used, namely a traumatic event will be defined as an unexpected natural or man-made event to which a person is exposed. The person may experience, witness or be confronted with this event. The event may involve actual or threatened death or serious injury to the person or others and the response of the person will involve feelings of shock, denial, helplessness, horror and intense fear.

1.6 Organization of this dissertation

- The current chapter provided an introduction to the research project as well as insight into the motivation and purpose of this study.

- Chapter Two provides a review of literature concerning trauma, exposure to trauma and the use of the CISD method. Furthermore, the inconsistencies surrounding this method are also discussed.

- Chapter Three provides a discussion of the conceptual framework of perception and the theoretical framework of the CISD method.

- Chapter Four discusses the research methodology used in the collection of data as well as the method of data analysis.

- Chapter Five provides a discussion/analysis of results obtained.

- Chapter Six provides conclusions and recommendations for further research.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

Exposure to trauma is very much a part of the society that people live in, especially in societies where conflict and violence are prevalent. Traumatic exposure is particularly common to the people who are involved in high-risk occupations such as rescue and emergency personnel. As a way of intervening with these traumatized people, many organisations and practitioners use a type of crisis intervention strategy known as Critical Incident Stress Debriefing (CISD). Critical Incident Stress Debriefing is one of the more common interventions used following exposure to traumatic incidents. As a result there is a wealth of literature documenting its use with traumatized victims. However, before discussing the literature concerning the use of the CISD model as an intervention tool, it will be important to have an understanding of the context in which traumatic exposure occurs and the impact that it has on the victims as well as those who use this model.

This chapter entails a discussion of trauma within the working environment and the consequences of being exposed to traumatic events. It also highlights the impact that trauma has on law enforcement in general and on the SAPS in particular. Furthermore, the inconsistencies surrounding the use of the CISD model are discussed. Finally, the chapter concludes with an overview of literature concerning the impact that the process of trauma debriefing has on the trauma debriefer who uses this tool.

2.2 Trauma in the work place

Ortlepp (1998) argues that with the increase in violence in our society, there has also been an increase in violence in the work place. The consequences of such episodes of violence can result in employees experiencing posttraumatic stress symptoms or other physical and psychological sequelae. Although the exposure to violence varies from one occupation to the next, a greater risk of exposure to violence stems from occupations where the employees are in close contact with the clients or customers that they serve (Brough, 2005). This means that there are particular types of occupations and hence work environments that place their employees more at risk of

exposure to traumatic events. Such occupations include fire fighters, paramedics and police officers, among others.

Due to the increase in work place violence and the heightened concern for work place safety, organisations have adopted various preventative measures for those employees that may be traumatized (Sacks, Clements & Fay-Hillier, 2001). Williams (1993, as cited in Ortlepp, 1998) differentiated between two forms of organisational interventions when dealing with work place trauma. The first involves strategies concerned with primary intervention. This ideally includes the removal of the stressor or the reduction of its effect. However this is not always possible, especially when it comes to protective services such as the police services or fire fighters. A secondary preventative strategy involves helping the traumatized person to cope with the incident, namely the emotional processing of the incident. This is achieved by using techniques such as Critical Incident Stress Debriefing. Such preventative measures are aimed at reducing the impact of the trauma so that those who are affected are empowered and are able to lead productive lives.

2.3 Stress, trauma and law enforcement

In recent years the concepts of stress and trauma have become unequivocally associated with emergency and rescue occupations. In particular, stress and trauma are common occurrences within the policing environment. Police officers experience various sources of stress that include biological stressors (illness, physical trauma or injury, and fatigue), psychological stressors (threats of violence and physical harm) and social pressures (financial responsibility, noise, overcrowding, problematic relationships) (Sue, Sue & Sue, 1994).

Similarly Patterson (2001) argues that literature on stress indicates that there are four major sources of stress for police officers. These include:

- **External events** that arise outside of the bureaucratic law, for example dissatisfaction with the criminal justice system.
- **Internal events** are those work events and situations that arise due to internal policies and procedures, for example low salaries.
- **Task-related events** are events or situations that arise in the performance of work tasks, for example role conflicts, traumatic events.

- **Individual events** are life events and situations that are outside the work environment, for example marital conflict.

In a similar manner Gulle, Tredoux and Foster (1998) argue that the nature of police work is in itself a source of stress. The duties that are performed can be experienced as frustrating and traumatizing for these officers. Examples of such duties include attending to riot situations, murder scenes, assault cases, theft cases, being shot at and suicide scenes etc. In addition to the above-mentioned stressors, police officers may also experience stress because of the traumatic nature of the duties that they perform. This is argued by Brown and Campbell (1994) who proposed three categories of incidents in law enforcement that can be traumatizing to police officers. These include incidents involving injury to police officers or to other people, incidents of major disasters and incidents involving the management of public disorder. Therefore, as stated by Patterson (2001) traumatic incidents can be reconceptualized as another source of stress within law enforcement.

Interestingly, previous research on the relationship between trauma and law enforcement has been based on the experiences of military personnel (Kopel, 1996). However there are differences between police officers and military personnel. One such difference is attributed to the fact that the exposure to traumatic situations for police officers is frequent and generally not as intense as that of soldiers in combat (Violanti, 1997; Young, 2004). Another difference between soldiers and police officers is that for soldiers the enemy is known whereas with police officers the danger is not always as obvious. Although police officers are not exposed to situations similar to that of soldiers at war, they continually face threats of danger and uncertainty during the performance of their duties. The impact is emotionally and physically exhausting.

Within the South African context, police officers are exposed to a range of traumatic incidents that range from many single episodes such as a suicide scene, a shooting incident to more prolonged exposure such as being in an ambush situation. This exposure to the range of traumatic stressors can be either as direct victims themselves or as helpers of those who are victims of trauma and crime (Kopel, 1996; Stephens, 1996; Violanti, 2001). During the performance of their normal duties, which includes serving and protecting the members of society, exposure to a traumatic event is therefore an unavoidable consequence for these police officers (MacDonald, 2003).

2.4 The consequences of traumatic exposure

One point of view about the consequences of traumatic exposure is that which believes that a traumatic experience impacts on a person's view of themselves and the world. It challenges the beliefs people have about themselves, other people and the world around them. These beliefs that are formed through experiences, give rise to particular sets of assumptions or "rules for living". These assumptions guide people's actions and behaviours. This viewpoint is argued by Janoff-Bulman (1988, as cited in Everly & Lating, 1995) who indicated that we all have our own "assumptive worlds". In other words people have their own set of assumptions or theories about reality or how the world works and these guide people's perceptions and their actions. These assumptions are challenged or revised when an experience or event that is contrary to these assumptions occurs. During this process the person can be said to be experiencing emotional and psychological distress because of the dissonance between their own assumptions and the reality of the experience.

Thus when a traumatic event occurs it may challenge these assumptions thereby creating a sense of disequilibrium for the person (Resick, 2001). The person starts to question their sense of security and trust in others and the world. The person may also find it difficult to move on with their lives. It is as if the traumatic experience has made their life come to a halt making it hard to plan for the future or go back to the "structure" they had in their lives before the traumatic event had occurred (Aldwin, 1994).

Police officers like any other person would have particular assumptions about themselves and about their world. As they are trained to carry out their duties they are also taught that the world is malevolent and that they should expect the unexpected when dealing with people in general, especially the criminal elements. However during this period of training and in their interaction with other seasoned police officers, there is also a tendency for these officers to form particular beliefs about themselves as police officers. Such beliefs may stem partly from their own experiences and from what is referred to as the police subculture of "cowboys don't cry" (Young, 2004). These police officers believe that they are "knights in shining armour" and that they are strong, in control and capable of dealing with any danger, the so-called macho image stereotype. These assumptions guide their actions as police officers. However, when faced with a traumatic event that challenges these assumptions, it leaves them feeling overwhelmed and vulnerable (Young, 2004). The control that they thought they had is now questionable. These

feelings of vulnerability and loss of structure and control that they experience as a result of the trauma, often result in these police officers finding it difficult to cope.

The difficulty of coping with a traumatic experience may result in the development of psychological distress such as anxiety and depressive disorders. The disorders commonly associated with traumatic experiences are that of Acute Stress Disorder and Post Traumatic Stress Disorder (PTSD). The police services as a high-risk occupational group for exposure to traumatic events are also high risk to developing PTSD (Kopel & Friedman, 1997; Violanti, 2001). Similarly in studies by Williams (1987), Stratton (1984) and Gerson (1988) (as cited by Koppel, 1996), it was found that shooting incidents, in which the police officers were involved, resulted in marked emotional reactions and led to the development of Post Traumatic Stress Disorder. Furthermore prior traumatisation may also increase the vulnerability and the risk to developing PTSD (Buchanan, Stephens & Long, 2001). In view of the range of traumatic situations that police officers are exposed to, many single episodes of trauma can increase the risk of police officers developing PTSD.

However, not all police officers that have traumatic experiences are diagnosed with PSTD. A situation like this may occur when police officers do not adequately satisfy the criteria for PSTD as defined by the Diagnostic and Statistical Manual of Mental Disorders. This does not mean that they are not affected by the traumatic experience but rather because of the narrow conceptual definition of PTSD, the impact of the trauma is not diagnosed as a disorder. Summerfield (2001, as cited in Berman & Davis-Berman, 2005) argues that PTSD as a disorder is socially and politically constructed and hence it is limited as a diagnostic category. It is limited in its definition and does not include other symptoms that have arisen from the experience of a traumatic event. This would mean that if the presenting symptoms that a traumatized person displays, does not meet the criteria for PTSD as defined by the Diagnostic and Statistical Manual of Mental Disorders, then it is not considered as pathological. The danger of this is that there would be traumatized police officers that present with trauma symptoms that are not defined as PTSD in the traditional sense. Hence such police officers may not be exposed to intervention or help and as a result they may be walking around with residual trauma symptoms that may accumulate. Thus they become time bombs and this is sometimes observed in their dealings with perpetrators.

Continuous exposure to traumatic situations may not necessarily result in police officers being diagnosed with PTSD, however they may be affected by what is referred to as residual trauma symptoms. These symptoms can still have an impact long after the police officer has been removed from the "traumatic environment" (Buchanan, Stephens & Long, 2001; Violanti, 1997). As a result of long-term exposure to traumatic incidences, there is also a tendency to develop what Horowitz (1986, as cited in Violanti, 1997) refers to as "post-traumatic character disorder" and what Brown and Fromm (1986, as cited in Violanti, 1997) refer to as "complicated PTSD". It is thought that such categories would better explain the symptoms of long-term exposure to trauma. Violanti's paper further highlights that even though there may be a decline in trauma-related symptomatology over time, the psychiatric symptomatology remains stable. Therefore, as stated by Berman and Davis-Berman (2005) PTSD is an expected response to trauma but it is not the inevitable result. Hence increased exposure to traumatic events may or may not result in PTSD but it can increase the police officer's risk status to developing other psychological problems. In addition to the symptoms of PTSD and the increased physiological arousal (Violanti, 1997; 2001) that are consequences of exposure to a traumatic event, there are various other cognitive, behavioural, emotional and social consequences (Everly & Lating, 1995). Chabalala (2005) summarizes some of these consequences. These can be seen as common reactions that people experience following exposure to a traumatic event (See Table 3.1).

Table 2.1. Common reactions to trauma

Physical Reactions	Mental Reactions	Emotional Reactions	Behavioural Reactions
Muscle tension	Inability to concentrate	Fear	Withdrawal from activities
Upset stomach	Memory disturbances	Sadness	Impulsiveness
Rapid heart rate	Flashbacks	Guilt	Heightened or lowered sexual drive
Dizziness	Poor judgement	Depression	Change in eating habits
Lack of energy	Absent mindedness	Anger	Restlessness
Fatigue	Difficulty in making decisions	Frustration	
Nausea	Nightmares	Helplessness	
Dryness of the mouth		Anxiety	
Palpitations			
Shortness of breath			

Adapted from Chabalala (2005, p. 55)

In addition to the above-mentioned consequences, the experience of a traumatic event can give rise to other personal and work related problems. Young (2004) outlines some of these problems such as alcoholism, suicidal or homicidal behaviour, marital dissatisfaction and work related problems (absenteeism, low productivity, conflict). However, the extent of the impact of the traumatic event depends on how the traumatized person copes with the traumatic experience and the resultant distress.

2.5 Coping, support and trauma

2.5.1. Coping with trauma

A traumatic experience can be overwhelming for the victim, leaving him or her feeling helpless isolated, vulnerable and even angry. However, the extent of the impact of a traumatic experience depends on the resources that the victim uses to cope with the experience. These resources can include support from family, friends and mental health professionals as well as the use of their own cognitive coping strategies. According to Lazarus and Folkman (1984), people who are stressed tend to use two types of coping strategies. The first is called problem-focused coping in which efforts and actions are taken to eliminate or modify the stressor. This is done when the person believes that some action can be taken regarding the stressor. The second is called emotion-focused coping in which the person believes that little can be done to alter the stressor and therefore an effort is made to deal with the emotional distress caused by the stressor. In the case of traumatic experiences, most people use emotion-focused coping to deal with the traumatic experience. In other words they try to deal with the emotional distress caused by the traumatic incident. Young (2004) contends that although emotion-focused coping can help a person maintain an emotional balance when faced with the stressor, it can also be seen as maladaptive because of the use of defence mechanisms such as denial. The term denial as used in this context refers to the conscious attempt by the traumatized person to block out the traumatic experience and to behave as if the event had not impacted on them in any way. This would imply that defence mechanisms if used excessively, could prevent the person from working through the experience in a healthy way. Denial is such a defence mechanism that if used excessively would hamper a person's healing from a traumatic experience. However if used appropriately this defence mechanism can be beneficial provided that the person is able to work through the traumatic experience at a later stage.

Although these resultant behaviours and attitudes tend to serve a survival function that protects people against a threatening environment, these behaviours may also cause them to suppress their feelings and creates emotional distancing (Koppel & Friedman, 1997). This is one way in which police officers are able to protect themselves. Using the defence mechanism of denial may be temporarily effective, however if used excessively, it can give rise to further complications for the traumatized police officer such as avoidance behaviour that results in excessive absenteeism at work. The use of the defence mechanism of denial may also have an impact on their interpersonal relationships. By denying or suppressing the negative or painful emotions associated with the traumatic experience, these officers can become withdrawn and distant in their relationships with family members and their partners. This combined with other pre-existing factors such as poor communication and family tension may result in marital or relationship difficulties.

Another strategy that police officers use to cope with difficult and exhausting situations is that of humour. Moran and Massam (1997) point out that humour can be seen as providing some form of tension release, a release for aggression and can facilitate reinterpretation of a given situation. It can be a way of softening the emotional impact of what the police officer has seen or experienced. Moran and Massam (1997) refer to humour that occurs in crisis situations as black humour. To be successful as a team in response to a crisis situation, communication is important. Humour can act as an effective communication tool and can also serve to facilitate emotional bonding among emergency personnel (Moran & Massam, 1997). These researchers further emphasize that humour is a positive, healthy coping strategy in response to traumatic events. However it should be noted that one should be cautious when humour is used, as excessive or inappropriate humour can be an indication of distress.

In addition to the above-mentioned strategies that police officers use to cope with traumatic experiences, it may also be beneficial for them to develop other ways of coping. An alternate way of coping with traumatic stress involves the use of support. The availability and utilization of support especially from their commanders, colleagues, family members and various mental health professionals cannot be overemphasized. This support can take the form of empathic listening, counselling and therapy.

2.5.2 Support

Support is an important facet of coping. Many traumatized victims are able to cope successfully using the support from their family and friends. The importance of support is highlighted by a study conducted by Greenberg, Thomas, Wessely, Hull, Iversen and Unwin (2003). These researchers conducted a cohort study with 1202 UK peace keeping soldiers between the period of April 1991 to October 2000. The soldiers' perceived psychological needs and their view of the requirement of psychological debriefing were investigated. It was found that two thirds of personnel who spoke of their experiences used informal networks (peers and family members) for support. Those that were highly distressed spoke to medical and welfare services. This study highlights the fact that most of these personnel did not make use of psychological debriefing but rather opted to use peer and family support to cope with their traumatic experiences. Hence, for some, psychological debriefing may not be a necessary intervention after exposure to a traumatic experience as other support mechanisms such as friends and family members are just as effective.

However such support may not always be utilized due to the tendency of police officers to isolate themselves from their family and significant others. Often the unexpectedness of a traumatic event leaves the police officer in shock and feeling very overwhelmed by a range of emotions. As a result these officers are unsure of how to deal with this experience. Therefore in an attempt to make sense of this experience and their reactions to this event, combined with the stereotyped macho image that "cowboys don't cry", police officers try to cope with the traumatic experience on their own. This results in them isolating themselves from those that can be a source of support, namely their family and friends.

Furthermore, there are two other possible explanations for police officers isolating themselves from their family and friends. Firstly, police officers isolate themselves in order to protect their family. As stated by Young (2004), isolation can serve as a way for police officers to protect their families from the "abnormality of their world". Police officers are often involved in experiences that are beyond normal human experiences, such as murder scenes, accident scenes, burned bodies, etc. These officers do not talk to their family members about their work or experiences because they do not want to expose their family to the unpleasant nature of their duties. The decision to harbour this "secret" and carry the burden alone further adds to their sense of isolation. Furthermore, given the dangerous nature of their work, police officers prefer

not to discuss the dangerous experiences that they have had because this would cause their family to excessively worry about them when they go out on duty.

Secondly police officers find it uncomfortable to talk to their family and friends (non SAPS members) about their traumatic experience due to their perception that these people may not understand the nature of their work or what they are experiencing and feeling. Hence these police officers keep their experiences to themselves and tend to isolate themselves when it comes to talking about their work, especially when it entails difficult and horrific situations. This isolation is further enhanced by the sense cohesiveness among police officers. Young (2004) and Violanti (1997) speak of a sense of "family togetherness" or a sense of "strong cohesion and dependence on one another" that develops among police officers. This "family togetherness" develops because police officers see themselves as unique people that share common experiences. They belong to a "police sub-culture" that has explicit rules but also implicit codes and rules, which only police officers can understand. Police officers learn to work with and depend on each other for their safety. This togetherness and dependence is also fostered whilst the new recruits are still in the training colleges. This sense of togetherness results in the police officers isolating themselves from family and friends (outsiders) but at the same time establishing their own support system (insiders) by talking to other police officers. This cohesiveness can serve as a buffer against the stress experienced (Violanti, 1997).

Police officers may therefore not feel comfortable talking to their family and friends about their traumatic experiences but they feel supported when talking to those who come from the same type of background as they do. This means talking to their commanders and colleagues. Young (2004) adds that the cohesiveness amongst police officers has contributed to what is referred to as the in-group and out-group mentality within the policing environment. Police officers are seen as the in-group and the rest of the civilian society are regarded as the out-group. Within the "in group" there is support provided by each other as they share similar experiences. In police agencies, support is important especially when it comes from those who are within these agencies. It is believed that such commanders and colleagues have a better understanding of the experiences of being a police officer and therefore are better able to provide support.

Similarly Stephens (1996) argues that managerial support after a traumatic event contributed in fewer posttraumatic stress symptoms and contributed to the recovery of the person. In a study conducted by this researcher with New Zealand Police officers, it was found that greater social

support and the opportunity to talk about the traumatic experience with others in the work place were related to fewer PTSD symptoms. Similar results were found in a study conducted by Brough (2005) in which the types of violent incidents experienced by Australian paramedics were investigated. This researcher found that supervisor and peer support moderated psychological strain experienced as a result of the exposure to violence. It was also found that such support increased job satisfaction. Therefore support is important in helping the police officers cope with the overwhelming experience of a traumatic event.

Support by colleagues and managers are important in facilitating coping after a traumatic experience, however a supportive work environment is not always available. Colleagues or commanders may often blame the traumatized police officer/s for losses resulting from the traumatic event, for example immediately focusing on the damaged police vehicle rather than the traumatized police officer. Their competence and judgement in dealing with the event may also be questioned or criticized. This can be in the form of a direct comment or the displaying of an unsympathetic attitude by the members of the policing agency. This unsupportive environment adds to the already negative feelings created by the traumatic event. The traumatized police officer is already overwhelmed by feelings of shock, anger, frustration etcetera and therefore when an unsympathetic attitude is displayed by their colleagues or commanders, the traumatized police officers may further experience feelings of guilt, anger, frustration. This negatively affects the way that the police officer copes with the traumatic experience. A study conducted by Paton, Smith and Stephens (1998) supported this argument. The results of this study revealed that the lack of understanding by supervisors and an autocratic management style could intensify the stress symptoms experienced.

Therefore it can be concluded that support, especially from those with the same background such as the commanders and colleagues of the traumatized police officer, is important in assisting the person to cope. Furthermore support from family and friends are also just as important. However, it is also important to note that whether these support structures are utilized depends on the police officers themselves. These officers can create an unsupportive environment by not seeking support from family members and friends because them isolating themselves. In addition, the macho image stereotype may also prevent these officers from seeking support from their colleagues due to the fear of appearing weak. Nevertheless, even when there is little or no support, there are various other interventions that can be used to help the traumatized person to cope.

2.6 Interventions and trauma

The previous section outlined the various ways in which people cope with traumatic experiences as well as the importance of support in facilitating coping. However, not all traumatized people are able to cope after their experience. This means that there needs to be some kind of intervention to assist the person to regain his or her previously level or optimal level of functioning. Healthcare practitioners can do this through the use of various types of interventions. These can range from the use of psychopharmacological treatments to various psychotherapeutic interventions or to a combination of the two (Slaby, 1989; Wilson & Raphael, 1993; Williams & Sommer, 1994). Perrin, Smith and Yule (2000) have highlighted some of the treatments that are currently being used in the treatment of trauma such as cognitive behavioural treatment, eye movement desensitisation and reprocessing (EMDR), group therapy and various psychosocial treatments (psychodynamic and family therapy). In spite of the array of interventions that are available in the treatment of trauma, practitioners differ in terms of their perception of the efficacy of the various treatment approaches.

2.6.1. Pathogenic nature of interventions

According to Violanti (2001) interventions after trauma have long been a subject of some controversy. This researcher challenges the conventional methodology of interventions and perceives these interventions as being pathogenic in nature. By using the term pathogenic it is assumed that the intervention is a cure for the "sick" traumatized person. This means that there is a direct link between exposure to a traumatic event and the development of post trauma symptomatology, which indicates that the person is "sick" (Burke & Paton, 2006). Violanti (2001) argues that the pathogenic approaches therefore attempts to "script" the person or police officer into a passive sick role. As a result the interventions based on this approach presuppose that the traumatized person will develop post trauma symptomatology and he or she will need to go to the "doctor" (trauma counsellor) to be "cured" because he or she is "sick". Relief for the distress experienced will only occur once the "doctor" has treated the traumatized person using the principles of a particular intervention method. The adoption of this passive sick role by the traumatized person, as dictated by the pathogenic approach, has a more negative effect on the person's functioning because the person accepts this sick role and does not rely on his or her own strengths, abilities, resilience and immediate support in order to cope with the distress of the traumatic experience. The presupposition of the pathogenic approach also fails to recognise that

many people who have had a traumatic experience never develop long-term post trauma symptoms or they develop mild symptoms that do not impair their day-to-day functioning. These people are able to cope using the support they get as well as their own inner strengths and characteristics. Human beings, especially police officers can be resilient when it comes to dealing with trauma.

Furthermore, Violanti (2001) states that on the basis of the presupposition of the pathogenic model, interventions are designed that provide rigidly defined solutions to the treatment of trauma. These interventions assume that once a person has been exposed to a traumatic event they would develop post trauma symptoms and relief from the resultant distress is brought about through the use of the prescribed principles of these interventions. Psychological debriefing, which is based on the pathogenic approach, is an intervention that is short term and supposed to bring about quick relief to the traumatized person. This would mean that the person is able to get help through the use of this intervention and therefore return at a much faster rate to his or her normal level of functioning. This is beneficial for an organisation as their traumatized staff can be treated in a manner that is quick and cost effective. As a result there is a ready acceptance of the pathogenic approach to interventions by organisations. This is especially true for emergency services due to the assumed "quick fix" solution to the problem of trauma and the resultant financial benefits that accompany the implementation of the intervention.

The availability of an intervention within the organisation in order to assist their traumatized staff to cope serves two purposes, namely the organisation has done its part in taking care of its staff and hence they cannot be held liable for other costs and psychosocial consequences arising from the traumatic exposure. The responsibility rests on the traumatized staff to make use of the interventions that are available. Secondly, implementation of the structured "quick fix" intervention with traumatized staff would bring about quick relief distress and hence an increased expectation that the person/s would go back to their productive level of functioning much faster. As a result the organisation will also benefit economically because fewer staff (especially experienced staff) are lost through excessive absenteeism and medical boarding. This is important especially when considering the high-risk nature of the jobs that are carried out by emergency services in which traumatic exposure is unavoidable. However, these short-term interventions are preventative measures and as such cannot be expected to cure the traumatized person. Although the interventions based on the pathogenic paradigm have their benefits, sadly

the personal positive strength and resiliency of the traumatized person as well as the potential for growth from the experience are ignored.

According to Burke and Paton (2006) the CISD model has also grown out of this pathogenic paradigm. By opting to use this intervention, the traumatized persons bypass the support that could be provided by family and friends. Look (2004) and Van Emmerik, Kamphuis, Hulsbosch and Emmelkamp (2002) support this view and further state that CISD may interfere with the natural processing of the trauma. In other words the traumatized person is forced to deal with the traumatic experience during the debriefing session rather than dealing with the experience in their own time facilitated by the support received from their family and friends.

However, there may be people that do not have the necessary support structures available or the personal strength and appropriate defences to cope with the traumatic experience. Such people would require some type of structured intervention. Therefore the CISD model may still be beneficial to those people who are unable to cope with the traumatic experience. Within the emergency services and in particular within the South African Police Services, the use of CISD has had a positive impact on traumatized police officers (Chabalala, 2005; Colley, 1995).

2.6.2. Police officers' reactions to interventions

Young (2004) reports that there are various factors that hamper what he refers to as 'reactive psychological intervention' in law enforcement. One of these factors is that police officers are very suspicious of other people and they do not trust people easily. They are usually suspicious of others' motives and behaviours. This suspiciousness can be viewed as a characteristic that has developed in the course of the performance of their duties as a police officer. However it is not only directed at suspects or criminals but it extends to other personnel within the policing organisation, especially those that are not seen as the "in-group". In other words this would include police personnel that are not physically involved in policing duties such as administrative and support personnel (Employee Assistance Programme).

In support of this view, Benner (1982, as cited in Young, 2004) further states that police officers are also naturally suspicious of psychological services personnel. The reasons for this are varied. One reason could be that the police officers are concerned that the information shared might be used against them in so far as their career is concerned (an issue of confidentiality). In other

words there is a perception that if these officers consult the EAP, this means that they are not capable and therefore may not be competent when promotional opportunities arise. There is also the possibility that the idea of consulting a "shrink" makes them look weak (MacDonald, 2003). Yet again, another possible reason for the hesitancy to participate in any intervention whether in the form of trauma debriefing or counselling, is the stereotyped macho image of "cowboys don't cry" which is very much part of the police subculture (MacDonald, 2003; White, 1997). In other words the perception is that as a police officer, you are a strong person and in control so therefore there is no need for help because as a police officer you deal with difficult situations on your own.

In the SAPS, some police officers are still reluctant to seek assistance from the Employee Assistance Services. This could be due to some of the reasons outlined above. However, in recent times there has been an identified change in perception with regards to the utilization of the services of the EAS within the SAPS. A possible reason for this change is that police officers can now understand the benefit of early intervention and the importance of being psychologically healthy. This awareness is also as a result of the increased marketing of the services of the EAS professionals. Furthermore Young (2004) maintains that because these EAS professionals are employed as part of the SAPS, they may now be viewed by the some police officers as part of the "in group". This is a change from their initial perception of the EAS alluded to earlier. In other words the professionals may be viewed as "police officers", as coming from the same background and as experiencing the same organisational stressors and problems. As a result they are viewed as having an understanding of the police environment whilst at the same time maintaining their neutrality and professionalism in their treatment approach. Given the researcher's experience as a trauma debriefer within the SAPS, there has been an increase in the number of police officers that utilize the services of the EAS either for trauma support or for counselling related to other psychosocial problems.

2.7 General debates regarding psychological debriefing

As mentioned earlier most research done on trauma debriefing has either focused mainly on the "victims' perspective of the efficacy of the process or on the impact debriefing has on trauma debriefers, for example issues relating to secondary or vicarious traumatization (Chabalala, 2005; Jonas, 2003; Ortlepp & Friedman, 2001; Taylor, 2004). Unfortunately it has not always been possible to compare results as methodologies utilized in these studies varied significantly. In

their extensive review of literature pertaining to psychological debriefing, Arendt and Elklit (2001) reported on some of the flaws identified in some of these studies which made comparison of results virtually impossible. The most consistent that emanated from this review was that there was no consistency in reported results of having participated in the debriefing process. Some researchers reported positive results, whilst others went as far as stating that the process could be dangerous as it makes victims prone to re-traumatization. The section below will explore these inconsistencies in depth.

2.7.1. Inconsistencies regarding the efficacy of psychological debriefing

Kenardy (1998) argues that there have been many anecdotal reports about the effectiveness of psychological debriefing. The problem however is that few of these evaluations have been systematic enough to provide a final word on its efficacy. At the same time, there are studies that promulgate the positive effects of debriefing. These include studies of victims of armed robberies, studies of child and adolescent victims of disasters, studies of emergency personnel and psychiatric workers who had been exposed to a traumatic experience at work (Campfield & Hills, 2001). Other studies that were conducted with military and rescue personnel concluded that debriefing has a positive effect both psychologically and emotionally and even contributed to a reduction in alcohol misuse and the symptoms of anxiety, depression and PTSD (Deahl, Srinivasan, Jones, Neblett & Jolly, 2001; Eid, Johnsen & Weisaeth, 2001; Hokanson & Wirth, 2000; Schubert, Johnson & Green, 2003; Wohlmuth, 2003).

Kenardy (1998) states that psychological debriefing has excellent face validity among practitioners and members of the public. This means that this intervention tool has found favour with both the participants and practitioners that use it. They give a positive, although subjective report of its ability to reduce psychological distress. It is therefore not uncommon for many practitioners and traumatized victims who have utilized this intervention to sing its praises. Psychological debriefing is most often the initial phase when intervening after a traumatic situation. In addition to serving as a source of support to the traumatized person, the process of debriefing can also act as a screening mechanism to identify those people who are severely affected and hence need to be referred for further counselling.

However, on the other side of the spectrum, critics of the CISD model argue that the process of debriefing can be more harmful than beneficial. In a study conducted by Van Emmerik et al.

(2002) it was found that the debriefing had a negative effect. These researchers conducted a meta-analysis of previous studies that measured the outcome of a single session debriefings. These studies were selected from various databases that included Medicine Advanced, PsychInfo, PubMed and articles from the Journal of Traumatic Stress. These researchers concluded that CISD has no effect in reducing post trauma related symptoms and that it has a more detrimental effect. McFarlane's study (1988, as cited in Everly and Mitchell, 2000) revealed similar results. The results revealed that although psychological debriefing was associated with lower levels of acute posttraumatic stress, it was however also associated with higher levels of delayed posttraumatic stress symptoms. In others words the initial support provided could have been effective in easing the acute stress symptoms however, it is also possible that the process of debriefing could have resulted in re-traumatization and hence the higher levels of delayed posttraumatic stress symptoms. These differences could have also been influenced by existence of pre-morbid factors such as previous history of psychiatric disorders, avoidance and neuroticism and a tendency not to confront conflicts. What this means is that factors prior to the experience of the traumatic event may have influenced the way in which the victim experienced and coped with the traumatic event.

McEvoy (2005) supports the view that debriefing is harmful and states that the harm can be iatrogenic. Iatrogenic implies that the anxiety, depression or PTSD worsen after the intervention. Three factors may contribute to the harm caused by CISD namely, mandatory attendance, reliving of the emotional trauma during the session and the "mixing" groups during the debriefing session.

There is also literature that has indicated that psychological debriefing has had little to no effect (Kenardy, 1998; Stephens, 1996). Other studies with similar results include those by Amir et al. (1998, as cited in Kaplan, Iancu & Bodner, 2001) and by Bisson, Jenkins, Alexandra and Bannister (1997, as cited in Everly & Mitchell, 2000). Rose, Bisson and Wessely (2001) reached a similar conclusion when they conducted a study reviewing literature about the effect of psychological debriefing. These researchers found that there was little support for a single session psychological debriefing as a useful treatment for the prevention of Post Traumatic Stress Disorder. Therefore the usefulness of psychological debriefing as a preventative method against PSTD is questionable. In support of this argument, Bower (2003) discussed a report by one RJ MacNally who stated that there is no significant difference between those who go through the process of psychological debriefing and those who do not. In this report it was

further indicated that compulsory psychological debriefing should be stopped and only used for those who request it.

Therefore, in view of the above studies, the inconsistencies regarding the use of psychological debriefing as an intervention tool are apparent. This raises questions as to what factors contribute to these inconsistencies highlighted above. The possible reasons for the inconsistencies relating to psychological debriefing are discussed below.

2.7.2 Possible reasons for the inconsistencies of the reported results of psychological debriefing

2.7.2.1 Methodological inconsistencies: Intended purpose and intended effects

In reviewing the literature above, inconsistencies involving the efficacy of psychological debriefing as an intervention are apparent. There are many reasons for these inconsistencies but before going on to discuss these, it might be appropriate to revisit the purpose of psychological debriefing. This is because the measurement of its efficacy depends on the goal that it is meant to achieve. Taylor (2004) stated that psychological debriefing was originally constructed as a preventative rather than a therapeutic measure, especially when used with emergency personnel after a traumatic experience. Arendt and Elklit (2001) agree and state that psychological debriefing should be seen as a discussion between normal people discussing their normal reactions to an abnormal experience. It is a once-off single session intervention that is aimed at facilitating coping and competence rather than addressing the psychopathology of the traumatized victim. Thus in view of the above, the goals of psychological debriefing are associated with prevention, normalization of reactions and the facilitation of coping mechanisms. Therefore when the efficacy of psychological debriefings are evaluated, cognizance should be taken of the fact that this is not therapy to address the premorbid conditions of the victims or the psychological conditions that may have been exacerbated by the occurrence of the traumatic experience, for example depression. Rather, reports of the efficacy of psychological debriefing should be based on whether the intervention was able to achieve its goal such as the normalization of post trauma stress symptoms, reduction of the resultant distress and an increased capacity to cope (Raphael & Wilson, 2000). In other words the outcome measures must be in line with its initial purpose.

Kenardy (1998) states that psychological debriefing needs to clarify its purpose. Similarly, Arendt and Elklit (2001) argue that there is a lack of clarity in literature concerning the intended effects of psychological debriefing. Therefore the criteria that is used to indicate effectiveness needs to be clearly defined. However, it is precisely the opposite that appears to have contributed to the contradictions involving psychological debriefing. Studies that have investigated the efficacy of this intervention have used varying criteria. Hence these studies provided inconsistent results. Furthermore, the current uses of psychological debriefing diverge from its original form and this also accounts for some of the inconsistencies. These researchers conducted a study in order to investigate these issues. In this study they argued that the controversy about the efficacy of psychological debriefing arises from firstly, the lack of consensus about the relevant evaluation criteria and secondly from the uncertainty as to what the concept of psychological debriefing refers to. They identified literature that reported on the effectiveness of psychological debriefing and analysed the results according to different criteria that were used for success and different uses of the intervention format.

They argued that the inventors of the tool of psychological debriefing had originally identified several different intended effects of this intervention. However the varied use of these different intended effects as criteria has contributed to the controversy surrounding this intervention. As a result four criteria for success were identified and a sample of collected literature was analysed according to these criteria. These criteria are listed below:

- Prevention of psychological sequelae such as PTSD.
- A range of less explicit aims such as normalization of reactions, verbalization of experiences and improved group support/cohesion.
- Screening of people after a traumatic experience with the idea of referral for further psychological counselling.
- Economic gains where the value of psychological debriefing is only seen in terms of its contribution to saving the organisation's resources. In other words psychological debriefing would be seen as being effective if it is able to reduce the financial cost that resulted from the trauma, for example reduced rate of absenteeism, decline in the loss of experienced personnel due psychological injury.

The main argument for the use of psychological debriefing is its preventative effect. When this criterion was analysed, the empirical studies revealed that this objective was not met. In fact there was more evidence of a lack of effect and a negative effect of psychological debriefing.

According to Arendt and Elklit (2001), studies that had some positive outcome had small effect-sizes and methodological problems. It was found that the designs of these studies were generally weak with the use of self-selection for treatment and control groups. Therefore the use of prevention as a criterion and the measurement of the degree of stress symptoms as indicative of this effect can be criticized. Firstly, it can be argued that psychological debriefing can prevent stress-related disorders but this is obscured by methodological problems that have been found in the existing studies. There are problems concerning the use of control groups. Ethically it is problematic to perform randomised controlled trials in situations involving severe trauma. It might be plausible to withhold treatment for frequently occurring or less severe types of trauma but not for severe types of trauma. However the relevance of such studies may not be compared with traumatic events for which psychological debriefing was originally developed, namely the application of this intervention with emergency personnel exposed to disaster and severe traumatic events. Self-selection for debriefing is often the only possibility when severe traumatic events occur. Therefore any comparison between control and treatment groups would be questionable as the treatment and control groups may not match on important variables. Psychological debriefing is mostly done with groups of people that work together or know each other such as emergency services personnel. Thus intervening with people well known to each other runs contrary to the principle of randomisation.

Further, a second reason for the problematic use of prevention as a criterion is the fact that there are other factors that are just as salient as the treatment and hence the isolated effect of the intervention is obscured. Such factors that may influence the outcome of psychological debriefing include neuroticism, age, experience, exposure level, threat to life, previous psychological problems, being a victim of intentional harm, gender, stress during the incident, perceived empathy from others, negative events in the year before the incident, anger directed towards others and alcohol and drug use. Furthermore, people who are traumatized are often evaluated (follow-up periods of investigation) weeks if not months after the intervention. During this time such people may seek additional psychological and pharmacological treatment including the use of their social support systems. Hence it would be difficult to evaluate the isolated effect of the intervention method. Arendt and Elklit (2001) also question the realistic expectation of psychological debriefing by stating that this intervention is only a one-session treatment and hence it is limited in scope. They argue that it is overly optimistic to expect dramatic differences in symptom relief between control and treatment groups after only one session. Hence the preventative effect of psychological debriefing is questionable.

The problem with using the criterion relating to the less explicit aims of psychological debriefing concerns the very general notion for establishing whether these alternative goals are achieved. They stated that many studies report that people find the intervention helpful however, it is unclear whether the helpfulness is attributed to the normalisation of reactions, verbalisation or improved group support. There have been inconsistencies that were found in some of the studies that have examined the value of the different aspects of debriefing (less explicit aims). Nevertheless, part of the process that is thought to be helpful during the debriefing session is the psycho education relating to the stress symptoms. However, talking about the experience appears to be more important rather than information regarding stress reactions. This would imply that there is nothing special about psychological debriefing that would make it different to any other intervention that is used after a traumatic experience. Furthermore, the analysis of this criterion revealed that there is no relationship between level of perceived helpfulness and the objective measure of symptoms. There are two arguments for this complex relationship between these two factors. Firstly, perceived satisfaction does not constitute proof that the intervention is effective as people can achieve satisfaction from doing things that can be potentially dangerous. On the other hand perceived helpfulness can be a better measure of effectiveness because the appraisal of symptoms is more important than the actual presence of the symptoms. In other words as a result of the intervention the person has altered his or her perception about the stress experienced thereby giving the intervention a sense of helpfulness. Therefore the intervention that involved some cognitive restructuring is viewed to be effective. This argument might be valid in cases where the level of symptoms is not severe enough to qualify as a diagnosis. However, given the vague descriptions of these intended effects of psychological debriefing, there is a need to have these goals clearly defined if they are to be used when investigating the efficacy of this method.

The criterion relating to the screening function of psychological debriefing was inconclusive. According to these researchers, although there is a potential for the screening functioning of psychological debriefing, it is uncertain from the sampled studies whether such an objective was met. Although in the early stages after a traumatic experience the stress symptoms may be non-specific and transient, Arendt and Elklit (2001) argue that the level of symptoms can be indicative of those who are at risk to developing problems at a later stage. Therefore screening can have a positive effect indirectly. Screening as a goal may be appropriate however this goal can be achieved provided that the debriefers are sufficiently skilled at their job in order to identify those that need to be referred. However, screening can never be considered as a main argument for the efficacy of psychological debriefing as there are other types of interventions

that can perform the same screening function. This argument could also be raised when considering the economic benefit criterion as a main reason for the efficacy of psychological debriefing. Furthermore, the studies that were analysed according to the economic criterion revealed weak results and hence no firm conclusions could be drawn.

The second reason for the controversy about the efficacy of psychological debriefing is related to the uncertainty as to what the concept of psychological debriefing refers to (Arendt & Elklit, 2001). The original concept of psychological debriefing was designed as a structured group intervention that was developed for professional helpers such as firefighters, soldiers and police officers. The inventors had designed it to be single session that was conducted by professional therapists and trained peers of these traumatized personnel. This intervention was to be conducted within 24-72 hours after a traumatic exposure. These researchers refer to the features of psychological debriefing in its original form as the "defining features". Besides these "defining features" the intervention has a phase-structure consisting of 6-7 phases. These features combined with the phase-structure can be viewed as psychological debriefing in its traditional sense. However, there have been substantial deviations from its original form and hence uncertainty as to what the term denotes. In other words, other than the phase-structure that is a recognisable feature in most variations of psychological debriefing, various changes to the so-called "defining features" add a new meaning to the term psychological debriefing. As a result there is also confusion about whether effectiveness concerns debriefing in its traditional form or in its present uses.

Arendt and Elklit (2001) analysed the sample of efficacy studies and found that the concept of psychological debriefing appears to be used synonymously with the method of acute crisis intervention but it is not clear when, how and with whom this method is to be used. Hence this confusion could possibly be responsible for the failure of the preventative effect of psychological debriefing. As a result these researchers argue that the traditional use of psychological debriefing could possibly be significant for an indication of efficacy.

Traditionally psychological debriefing was developed for professional helpers after experiencing work-related traumatic events. However, current uses involve its use with victims of direct trauma such as road accident victims. The results of their study revealed that psychological debriefing was found to have some positive effect when used with professional helpers rather than when used with other types of victims of trauma. These researchers assume that the reason

for this difference is possibly due to the fact that the professional helpers share certain similarities relating to the experienced trauma such as being members of a group, professionally trained and knowing the risks involved in their job. Furthermore, when the studies involving professional helpers are compared with other studies involving other types of victims of trauma, it was found that the professional helpers reacted differently (more positively) to the intervention. This is because professional helpers represent a distinct group of people who have particular training and experience in their field. Such factors play a protective role in relation to traumatic stress. In addition, professional helpers know each other well and as such support may be generated beyond the debriefing session itself. This could contribute to the positive effect of debriefing experienced by the professional helpers.

The results revealed that there was no positive effect to be found when deviations had occurred from the traditional group format of psychological debriefing. In terms of the number of sessions, it was found that this was the only "defining feature" that was most adhered to. However, the amount of time spent seemed to affect the efficacy. Further, when the amount of time in a session was limited to less than an hour, no effect and negative effect were found. When the session lasted over an hour the effect was found to be more positive. They however warn against using the time limit as conclusive for the efficacy of psychological debriefing as difference may be attributed to other factors other than the time. Nevertheless, it seems that there needs to be a minimum amount of time spent when intervening in order to achieve a positive effect.

When considering the time period in which psychological debriefing should take place, the 24-72 hour time period is criticised as being too soon as it may be harmful (Arendt & Elklit, 2001). The fact that debriefing should take place within this time period has not been substantiated. The reason for this time period was probably due to the fact that psychological debriefing originated within professional organisations where the possibility of personnel experiencing traumatic events were high. Furthermore such personnel were expected to get back to work as soon as possible, hence the 24-72 hour time period. It is now suggested that debriefings should take place between 1 to 10 days after an acute crisis and 3-4 weeks after a major disaster. Leadership of the debriefing process is another factor that has deviated from the traditional format. These researchers stated that when the original team concept is followed, this results in positive effects in contrast to when volunteers and non-professionals are used.

Other researchers have also questioned the efficacy of psychological debriefing and criticized the current uses and methodology of these studies. Kenardy (1998) argues that there is a need for researchers to examine the parameters effecting psychological debriefing. He states that there is heterogeneity of debriefing methods with their own protocols that have developed from older methods without the evaluation of either. Hence it is difficult to determine the adequacy of one method over the other. Protocols of methods that are assumed to be useful and appropriate are maintained based on clinical experience rather than empirical evidence.

Similarly, Rose and Bisson (1998, as cited in Campfield & Hills, 2001) state that caution should be exercised in drawing conclusions about the efficacy of psychological debriefing given the paucity of methodologically sound studies and the different contexts with respect to the type of incident, type of victim and the timing of the intervention. Again, Foy, Eriksson and Trice (2001) also highlight the lack of standardization across interventions that contribute to the inconsistencies as observed in the various studies of the efficacy of psychological debriefing. Kaplan et al. (2001) argue that the lack of adequate control groups, small sample size, lack of prospective design, difficulty in controlling confounding variables, low response rates and sample bias make judging the efficacy of psychological debriefing difficult.

All of the above-mentioned reasons for the inconsistencies are mostly obtained from studies that investigated the efficacy of this method through the eyes of the traumatized person/s. It is important to mention that the current study does not attempt to address these inconsistencies, but identified a major gap in the literature and thus opted to provide a different focus by exploring the perceptions of those who use the tool. One should however exercise caution when interpreting the results of this study as the subjectivity of the trauma debriefer may play a role. This will be explored further in Chapter Six under limitations of the study.

2.7.2.2 Characteristics of the traumatized victim

Adding to the inconsistencies of psychological debriefing are the victims of trauma themselves. It must also be kept in mind that apart from the models of debriefing that may be heterogeneous or similar in their application, the impact of and recovery from trauma depends also on the individual differences of those who are exposed to the traumatic experiences (Eid et al., 2001; Moran, 1998). Such individual differences include stress appraisal, coping styles, personality,

childhood experiences and the cultural background of the individual (Paton, Smith & Stephens, 1998; Silove & Zwi, 2005; Sumathipala & Siribaddana, 2005).

Generally, psychological debriefing may not be helpful for all victims of trauma (Sensky, 2003), but there may be a sub group of people with particular characteristics for which such an intervention is helpful (Belaise, Fava & Marks, 2005). Psychological debriefing therefore has its place as an intervention tool but such a method may be more suited for some people rather than others. It is possible that a factor inherent in the traumatized victim may be responsible for this difference. This difference could be attributed to the personality of the victim and not necessarily the intervention tool. Wagner (2005) argues that there is a particular personality type that is suited for the use of CISD. This researcher states that one of the primary foundations for the development of CISD was the existence of a rescue personality. It is believed that emergency response workers are people that like control over both the situation and themselves and enjoy the feeling of being needed. Mitchell and Bray (1990, as cited in Wagner, 2005) describe such a personality type as inner-directed, action orientated, high standard of performance, socially conservative, highly dedicated and easily bored. Although the existence of a rescue personality type is a possibility, at present there appears to be little evidence supporting its existence (Gist & Woodall, 1998; Wagner, 2005).

2.7.2.3 Cultural sensitivity

Another factor that can account for the inconsistency regarding the efficacy of psychological debriefing is the culture and collective identity of the subjects. When working with pluralistic populations, disaster workers need to be aware of and sensitive to cultural traditions and differences. This is especially true for mental health professionals including trauma debriefers who intervene when a traumatic experience has occurred. It is important to note that different cultural groups have different ways of dealing with stress and stressors. Such groups also have different needs, expectations, and religious orientations and beliefs and have different ways of coping with loss and grief (Doherty, 1999). Communication is also another aspect that can lead to the experience of a trauma debriefing session being positive or negative. As stated by Doherty (1999), it is not only the differences in language but also the fine distinction between specific words and phrases that can be misleading thereby creating an atmosphere that lacks empathy. A goal of psychological debriefing is for the traumatized person to feel that he or she is understood, that someone can empathize with him or her. However if these differences are not taken into

consideration, traumatized people can feel misunderstood and even offended by the well-intentioned attempts of the trauma debriefer. This is especially true for the South African population and in particular for the diverse personnel within the SAPS. Hence the outcome of any intervention conducted will be influenced by these variables and as a result there can be inconsistencies in studies regarding psychological debriefing.

2.7.2.4 Participation in trauma debriefing sessions

The inconsistencies relating to the effectiveness of psychological debriefing are related to the nature of participation of the traumatized victims, namely whether their participation was forced or voluntary (Hokanson & Wirth, 2000; Robbins, 2002). Some people may not need psychological debriefing immediately after exposure to a traumatic event as they have their own way of coping (Belaise et al., 2005; Hamling, 1997). Therefore conducting immediate psychological debriefing with such people can re-traumatize them and hinder their way of coping (Kaplan et al., 2001). If psychological debriefing is offered indiscriminately, this can also contribute to the inconsistency of its effectiveness. This was highlighted by Van Emmerik et al. (2002) who argued that CISD is offered to both victims at risk and to victims not at risk to chronic psychological symptoms. As a result this might obscure the true beneficial effect of CISD for victims at risk because those not at risk may not develop psychological symptoms and this may be attributed to the use of CISD.

2.7.2.5 Characteristics of the debriefer

The characteristics of the person conducting the debriefing session can also impact on the process of debriefing (Arendt & Elklit, 2001; Colley, 1995). Colley (1995) highlights particular characteristics that a successful debriefer should possess. These include emotional maturity, good verbal and non-verbal communication skills, empathy, acceptance, sincerity and basic assessment and referral skills. If such characteristics are not present or if a debriefer is unable to use the model of debriefing correctly, this will have a negative impact on the outcome of psychological debriefing. In addition the manner in which the trauma debriefer conducts the process of debriefing may also have an impact on the debriefing outcome. Part of the process of psychological debriefing requires that the debriefer share information regarding stress symptoms and the impact of trauma. This is done in order to educate the victims as well as to normalize

reactions. However, Kenardy (1998) questions the process of information sharing, by whom it is shared and the time that it is shared. He argues that it may heighten the victim's sense of distress.

Another factor to consider is who facilitates the debriefing. Deahl et al. (2001) suggested that when peers conducted debriefings, it was more effective. This effectiveness is due to the fact that peers are more able to understand the operational and organisational factors as well the particular social circumstances of the traumatized victims (Kenardy, 1998; MacDonald, 2003). However if debriefing is part of a comprehensive trauma management programme then someone more detached from the organisation may be more suitable such as generic (counsellor) or specific professional (psychologist) (Kenardy, 1998).

2.8. Current literature on the experience of trauma debriefers

In the previous section, the inconsistencies regarding psychological debriefing were discussed which highlighted various methodological and individual factors for these inconsistencies. A review of literature has also revealed that these studies have focused mostly on the experiences of the traumatized victims in evaluating psychological debriefings. However, literature about the experiences of the trauma debriefers tends to focus mainly on secondary traumatic stress or vicarious traumatization (Ortlepp & Friedman, 2001; Taylor, 2004). These studies are briefly discussed below.

Steed and Bicknell (2001) investigated the impact of being exposed to traumatic material as a consequence of being a therapist. Their study involved the experiences of sixty-seven therapists who had worked with the traumatic material of sex offenders. It was found that these therapists experienced negative effects such as burnout as well as mild disruptions in the domains of intrusion, avoidance and hyper-arousal. Similarly, a study conducted by Steed and Downing (1998) revealed that therapists who were exposed to their client's traumatic material experienced various negative effects on the personal and professional lives. These effects included anger, pain, frustration, sadness, shock, suspiciousness and distress. In yet another study, Jonas (2003) conducted a qualitative investigation into the experiences of the trauma debriefers of the South African Police Services (Limpopo Province). This researcher used a sample of nine Helping Professions personnel (now called Employee Assistance Services). The results revealed that these trauma debriefers were exposed to trauma on a secondary level and as a result developed emotional, psychological and physical symptoms. Some of these symptoms included headaches

sleep disorders, problems with concentration and memory, anger anxiety, changes in their self-esteem and changes in their lifestyle.

As can be seen from the brief discussion above, literature about the experiences of the trauma debriefers have focused mainly on secondary traumatization. The researcher therefore adopted a different approach by focusing on the perceptions of the trauma debriefers regarding their tool of intervention. It is hoped that insight would be gained about the use of this model and by extension its efficacy within the SAPS.

2.9 Conclusion

In this chapter, the nature of trauma and the impact that it has on traumatized individuals were discussed. In particular, the inconsistencies surrounding the use of Critical Incident Stress Debriefing was explored and possible reasons for these inconsistencies were advocated. It must also be noted that as mentioned earlier, most of these studies have investigated the efficacy of CISD as perceived by the traumatized individual/s. However, there appears to be no studies that have investigated the use of this tool as perceived by the practitioners that use it. These practitioners have an understanding of the theoretical and practical aspects of this method and they might be in a better position to comment on this method. Therefore, the researcher has decided to explore the perceptions of these trauma debriefers. In doing so, it is hoped that the insight gained may stimulate research regarding the appropriateness and usefulness of this model and it may possibly lead to other research projects that will address the inconsistencies of this method that was discussed above.

CHAPTER THREE

CONCEPTUAL AND THEORETICAL FRAMEWORKS

3.1 Introduction

This chapter begins by discussing the concept of perception, its broad definitions, and how it will be conceptualized for the purpose of the current study. Thereafter the theoretical framework underlying the Critical Incidence Stress Debriefing (CISD) model will be discussed. Included in the discussion will be a brief historical development of the Basic Crisis Theory and the Crisis Intervention Model that was based on this theory. The chapter will end with a brief discussion of the CISD model as designed by Mitchell (1983) as well as how this model was adapted for use within the South African Police Services.

3.2 Conceptual framework

3.2.1 Perception

There are a number of different meanings associated with the broad psychological construct known as perception. Below is an example of some of the definitions, ranging from the general understanding of the term to the specific conceptual and operational understanding that will be of relevance to the current study. Psychologists and philosophers have studied the nature of perception for centuries and as a result there are various theories that explain how a person perceives or gives meaning to what he or she is looking at. These include the Gestalt theory of perception, the Directive-State theory of perception, the Topological field theory and many other theories that are beyond the scope of discussion for this particular project.

According to the Collins Concise Dictionary (1999, p. 1097) perception is defined as the process by which an "organism detects and interprets the external world by means of the sensory receptors". Similarly, Pearsall (2002, p. 1059) defines perception as the "state or process of becoming aware of something in such a way as understanding or interpreting it". Reber (1995, p. 549) concurs and further states that perception can be defined as "Collectively, those processes that give coherence and unity to sensory input". This is the most general sense of the term and covers the entire sequence of events from the presentation of a physical stimulus to the

phenomenological experiencing of it. It includes physical, physiological, neurological, sensory, cognitive and affective components.

The process of perception from the physiological to the psychological aspect was discussed by Little (1999) in his description of the theory of perception. According to him the perceptual field of all species includes aspects of the environment that would stimulate the physiological structures of these species via their sense organs such as the eyes or ears. However, not all aspects of the environment are applicable to all species. The perceptual field is species-specific. This means that various species including human beings would focus on relevant aspects of the perceptual field through the use of attention. For example, the sound of a trumpet to a musician would enter the sense organ (the ear) and then be transported from one neuron to the next via chemical and electrical activity to the brain. At this point the process of perception is physical and physiological. Little also argues that there are two levels of perception. The first level involves what he called "immediate perception" which is the physical or physiological aspect and the second level which he describes as the "interpretive level" where our psychology of attention are implicated in the perceptual act. He describes this interpretive level as the unique personal reality of the perceiver.

In addition to this, Little (1999) further states that perception of an event or an object involves the act of "immediate perception" as well as the interpretive process. Warr and Knapper (1968) argued that interpretation is influenced by present stimulus information, present context information and previously stored information about the event or object of perception. This information, combined with the "inference rules" and "combination rules" result in an impression being formed about the object or event. These rules allow for judgements to be made about the object of perception. These judgments are said to have three components, namely an attributive component, an expectancy component and an affective component. Therefore an impression involves the perceivers' thoughts and feelings about the object of perception. It must be noted that although the researcher has provided a simplistic explanation of the process of perception, this process involves a much more complex interaction between the perceiver and the object of perception which is beyond the scope of this study.

It is therefore not only the act of "immediate perception" that is important but also the 'interpretive level" of this process. The researcher is interested in exploring this "interpretive level". According to Warr and Knapper (1968) these perceptions are formed using previous

knowledge, present and past context information as well as the "inferential" and "combination rules" that have developed through life experiences. This knowledge and the various rules help form perceptions that are unique to the perceiver. The current study involves an exploration of the perceptions of the SAPS trauma debriefers and in doing so the researcher is exploring the thoughts and feelings (their perceptions) of these debriefers about the CISD model. This exploration reveals their unique personal realities. Therefore, in this study, perception is defined as the impressions and judgments formed by the SAPS trauma debriefers about the tool that they use. This understanding of perception fits in well with the phenomenological approach adopted by the researcher. This approach will be elaborated on later.

As much as this definition or conceptualisation is important in putting the study in its theoretical context, it is also equally important to highlight the shortcomings that are subsumed in the very definition of this construct. According to Schiffman and Kanuk (1991) there is usually a problem of threshold that exists with perception studies. This is influenced by the fact that two individuals may be subject to the same stimuli under apparently the same condition, but how they recognise, select, organise and interpret them is a highly individual process based on each person's needs, values, expectations and the like. Adding to the difficulty in understanding perception is the fact that perception is largely a study of what we subconsciously add or subtract from raw sensory inputs to produce a private picture of the world. Although each participant will perceive the same model in different ways, it is believed that factors such as the professional training of the participants as psychologists and the years of trauma debriefing experience would allow the participants to make informed comments about the tool that they use. In other words, they would use their theoretical knowledge about trauma, trauma debriefing and their varied practical experiences as a basis for their thoughts and impressions about the CISD model. The personal and unique accounts of the CISD model are important, as this is a qualitative study.

3.3 Theoretical framework

3.3.1 Crisis Theory and Crisis Intervention Model

Kaplan, Iancu and Bodner (2001) argue that psychological debriefing suggests a type of crisis intervention that is designed to relieve and prevent distress after a traumatic event. The traumatic event creates an imbalance in the person's functioning and as a result their way of coping, at that particular time, may be rendered ineffective. Because of this, some kind of intervention is

usually needed in order to address the immediate effects of the traumatic event and assist the traumatized victim to achieve their previous level of functioning, namely their pre-crisis level of functioning.

Critical Incident Stress Debriefing (CISD) can be viewed as a form of crisis intervention that is commonly used to assist traumatized victims (Chabalala, 2005; Colley, 1995; Everly & Mitchell, 2000; Raphael & Wilson, 2000). It is one component within the larger crisis intervention programme called Critical Incident Stress Management (CISM) that was designed by Jeffery Mitchell in 1983 whilst attending to the psychological care of emergency personnel (Hokanson & Wirth, 2000; MacDonald, 2003; Macy et al., 2004; Smith, 2006; Van Emmerik et al., 2002). The CISD model is often used as an intervention on its own to provide such psychological care to emergency services personnel like the SAPS.

The CISD model can therefore be seen as a crisis intervention model that is based on the components of the Basic Crisis Theory. Because of this, it would be useful to review the origins of the Basic Crisis Theory and how this has influenced the CISD model. In addition, the equilibrium model of intervention that has grown out of the basic crisis theory will also be discussed. However, before discussing the Basic Crisis Theory, it is also important to have an understanding of some of the various definitions of the term "crisis' as this term seems to have influenced the development of various models of crisis intervention.

3.3.2 Definition of a crisis

Brammer (1985, as cited in James & Gilliland, 2005) states that a crisis is a state of disorganisation in which the person faces frustration of important life goals or a disruption of their life cycles and methods of coping with stressors. According to this researcher, the feelings of fear, shock and distress about the disruption rather than the disruption itself are referred to as a crisis. Similarly Raphael and Wilson (2000, p. 72) define a crisis as "a state of emotional turmoil wherein a person's usual mechanisms of coping have failed when faced with a perceived challenge or threat". James and Gilliland (2005) describe a crisis as the perception of an event or situation as an intolerable difficulty that exceeds the resources and coping mechanisms of the person. A crisis can therefore be associated with feelings of fear, shock and distress and the disruption that ensues overwhelms the person to such an extent that he or she is unable to cope using their usual resources or coping mechanisms.

Another factor to consider in understanding the concept of a crisis is that there are different types of situations that give rise to what one may refer to as a crisis. James and Gilliland (2005) identify four types of crises. The first is the existential crisis that includes the inner conflicts and anxieties about important human issues of purpose, responsibility, independence, freedom and commitment. The second is the environmental crisis in which a natural or human-caused disaster occurs that overwhelms a person or group of people in a community to such an extent that they are unable to cope with the aftermath of the event. Thirdly a developmental crisis is considered to be events in the normal process of human growth and development such as the birth of a child. Finally, a situational crisis occurs when an uncommon or extraordinary event takes place. This event is unexpected and is not controlled by the person who experiences it. For the purpose of this particular project, a situational crisis, namely an unexpected, extra ordinary or accidental event will be explored. As stated by James and Gilliland (2005, p. 9) "all people experience psychological trauma during some time in their lives. It is neither the stress nor the emergency conditions of the trauma in themselves that constitute a crisis but rather only when the traumatic event is perceived as a threat to need fulfilment, safety, or meaningful existence does a person enter a state of crisis". A crisis state therefore occurs only when the situation or traumatic event is perceived as a threat that overwhelms the person's coping mechanisms to the extent that it creates a state of emotional disequilibrium.

Following from the above arguments, a crisis can therefore be defined comprehensively as the perception of an event or situation (unexpected or accidental) as extremely difficult (stressful) that exceeds the coping resources of the person and thus creates a state of emotional turmoil. This would result in the person experiencing feelings of fear, shock and distress. This definition together with the various types of crises that were discussed above is very similar to the definition of a traumatic event that was discussed in Chapter One. It can therefore be said that the experience of a traumatic event can be seen as the experience of a crisis (Hof, 1978). In other words a traumatic experience becomes a crisis when the traumatic event is perceived as a threat and hence overwhelms the person to the point that they cannot cope. The principles when intervening with a person who has been traumatized would be similar to the method of intervention when dealing with a person in crisis. In other words, stabilize the person and assist them in returning to their pre-crisis level of functioning. Raphael and Wilson (2000) stated the aim of crisis intervention as assisting the person to return to a more steady state of psychological functioning and at the very least, stabilization of acute symptomatology.

3.3.3 Characteristics of a crisis

A crisis also has particular characteristics that are similar to the characteristics of a traumatic event and these should be taken into account when defining a crisis. James and Gilliland (2005) outline some characteristics of a crisis and state that these are expanded definitions of a crisis. One of these characteristics is the view that a crisis can be seen as a danger or an opportunity. According to Aguilera and Messick (1978), the Chinese characters that represent the word "crisis" means both danger and opportunity. A crisis is a danger because it threatens to overwhelm the individual. It can also be seen as an opportunity because during this time (crisis) the individual, is not only receptive to the therapeutic influences but the experience can result in an opportunity to develop better coping skills and tap into resources that they were not previously aware of, namely their resilience. The person can grow from the experience and hence better deal with other stressful situations because new coping patterns have emerged. James and Gilliland (2005) believe that people can react in three ways in order to deal with the crisis. They can cope with it and grow from the experience or they can cope with it in a manner that blocks out the harmful or painful experience only to have the painful experience haunt them at a later stage or they can break down psychologically.

A second characteristic of a crisis is the range of symptoms that arise. A crisis is complex and difficult to understand and the symptoms that arise from it invade a person's life and environment. Furthermore the environment can either facilitate or create difficulties in coping with the crisis. In the case of the SAPS, employers can either facilitate support by providing debriefing services or create difficulties by displaying an unsympathetic attitude towards the traumatized police officers. Thirdly the crisis creates anxiety for the person and this anxiety can be a momentum for change in order to relieve the discomfort experienced. Fourthly, dealing with the crisis is a choice. However, quick fix solutions can create further problems for the person. Lastly, every crisis is accompanied by disequilibrium or disorganisation in the person's life whether the crisis is universal or idiosyncratic. By universal, it is meant that any person can experience a crisis state and have a psychological breakdown given the right constellation of circumstances. By idiosyncratic it is meant that even if two people may have the same set of circumstances and background, how they react or respond to a crisis will always be different. These characteristics highlighted above emphasize that the experience of a traumatic event can be conceptualised as a crisis. Therefore the intervention when dealing with a crisis would be similar to the intervention when dealing with a traumatic event.

3.3.4 Crisis Intervention and the development of the Basic Crisis Theory

As discussed above, the experience of a traumatic event can be conceptualised as a crisis and therefore the intervention with such an event would involve applying the principles of crisis intervention. The principles that were initially developed to deal with people in crisis stemmed from the Basic Crisis Theory that was strongly influenced by the work of Erich Lindemann (1944, 1956, as cited in James & Gilliland, 2005) and Caplan (1964). Eric Lindemann studied the bereavement reactions of survivors of those who had been killed in the 1943 Coconut Grove Night club fire. This researcher felt that the possible psychopathological consequences of unhealthy coping with the crisis of bereavement, could be prevented by the clergy and other community caregivers helping the bereaved to grieve adequately. As a result Lindemann helped professionals and paraprofessionals to recognize that the behavioural responses associated with the crisis of grief are normal, temporary and can be alleviated through short-term intervention techniques (James & Gilliland, 2005). This recognition resulted in a change in perception that the client's reactions to a crisis are normal rather than it necessarily being pathological. The stages in Lindemann's paradigm include (1) disturbed equilibrium, (2) brief therapy or grief work, (3) client's working through the problem or grief and (4) finally the restoration of equilibrium. A further development was the application of Lindemann's constructs to the field of trauma. This was one of the first approaches to dealing with people in a state of crisis.

In 1962 the primary prevention of mental disorders in public health became the focus of attention. This focus led to the development of the Basic Crisis Theory. Caplan (1964, p.26) stated "Primary prevention is a community concept that involves reducing the rate of new cases of mental disorders in the population by counteracting the harmful circumstances before they have a chance to produce illness". Therefore the aim was on the prevention of new cases of mental disorders in the community by intervening before the negative or harmful circumstances of the person had a chance to create a psychological illness. However, Caplan (1964) argued that due to the limited knowledge of the causes of mental disorders at that stage, primary prevention was directed at using non-specific helping resources to reduce these mental conditions. This line of thinking gave rise to the development of a conceptual model for primary prevention and hence the Basic Crisis Theory including the various crisis intervention models.

According to the Basic Crisis Theory, during the course of an individual's general level of functioning, a person operates in certain consistent patterns with minimal effort. This is referred

to as a state of equilibrium. However, when the individual is faced with a problem that causes disruption to this pattern or equilibrium, they resort to using habitual problem-solving strategies and actions that solve the problem with minimum effort within an expected period of time. These problem-solving strategies and actions can be viewed as homeostatic re-equilibrating mechanisms. Therefore when the individual is faced with the problem, the person is in a state of tension just before using the habitual problem-solving strategies to find a solution. However, given the previous experience of dealing with a problem using similar problem-solving strategies and the experience of problems of this nature being solved within a particular time, the person develops an expectation of a successful outcome and is able to cope with the resultant tension using various coping strategies. The tension is therefore kept within a bearable limit and the person is able to function with minimal distress.

Caplan (1964) further stated that the essential factor influencing the occurrence of a crisis is the imbalance between the difficulty and importance of the problem and the available resources to deal with the problem. This therefore means that when a person is faced with a problem or stressor, they experience tension and anxiety. Caplan (1964) believed that when the problem or stressor is larger and the usual problem–solving strategies (re-equilibrating forces) are unable to provide a successful solution in the expected time period the tension and anxiety would increase. This tension is also associated with subjective feelings of discomfort, anxiety, fear, guilt, shame and helplessness. This causes the person to draw on their internal and external coping resources. This includes trying new and unusual methods to solve the problem as well as enlisting the support from other people (Caplan, 1964; Hof, 1978). What usually follows is the assessment or evaluation of the strategies that had been adopted. This process may result in the person accepting certain aspects of the problem as impossible to solve or as not important. Through this process of reviewing the problem, the problem maybe solved or the person finds a way to cope with the problem and hence goes back to a state of equilibrium. However if the problem continues in intensity or with no solution, this increases the tension and the negative subjective feelings that are experienced by the person. Hof (1978) refers to this as the state of active crisis that results when the internal strength and social support are lacking. Hence the problem remains unresolved and the tension and anxiety rise to an unbearable level. This culminates in the person's functioning becoming impaired and negatively affected.

The Basic Crisis Theory laid the foundation for the development of the Equilibrium Model of crisis intervention. James and Gilliland (2005) stated that the Equilibrium Model is the purest

model of crisis intervention and it is mostly likely to be used at the onset of a crisis. Caplan (1964) also used the principles of the equilibrium model when intervening following psychological trauma. This researcher applied Lindemann's concepts and stages to the experience of all developmental and situational events and extended crisis intervention to eliminating the affective, cognitive and behavioural distortions that were caused by the psychological trauma.

James and Gilliland (2005) discuss the experience of a traumatic event within the context of the Equilibrium model. These researchers state that according to Freud when an event confronts a person as being an overwhelming threat, this is referred to as psychic trauma. As a result the person loses the ability to control the disorganising effects of the experience, hence disequilibrium occurs. Erikson (1963, as cited in James & Gilliland, 2005) states that such a threatening experience tears up the person's psychological anchors that are fixed in a secure sense of what has been in the past and what should be in the present. In other words the person's sense of security that was established through past experiences now becomes questionable. The person starts to search for meaning of and explanations for the experience so that they can make sense of the traumatic experience. Once this occurs then only can psychological equilibrium return. This can typically take place over days up to a month. If a person effectively integrates the trauma into conscious awareness and organises it as a past experience, then homeostasis returns. However if this does not take place then there is a possibility that the person will experience psychological problems. In order to achieve this state of homeostasis for the traumatized person, there needs to be some intervention that helps the person to integrate his or her experience and facilitate coping. This is done through using some kind of crisis intervention approach.

However, it must be noted that there are various models of crisis intervention that have been developed since the development of the Basic Crisis Theory such as the Psychosocial Transition Model and the Cognitive Model (James & Gilliland, 2005). These models of crisis intervention, including the Equilibrium Model discussed above have laid the foundation for many different crisis intervention strategies. Crisis intervention refers to the offering of immediate assistance to the person in crisis so that the person can re-establish equilibrium (Aguilera & Messick, 1978). Similarly, Slaikeu (1984) states that crisis intervention refers to the helping process aimed at assisting the individual to survive the crisis so that its devastating effects are minimized and the probability of growth is maximized. Raphael and Wilson (2000) further state that crisis

intervention is geared towards assisting the person in returning to a more steady state of psychological functioning or psychological homeostasis. In summary crisis intervention is aimed at assisting the person to cope with the crisis and in doing so helping him or her to return to their pre-crisis level of functioning or establish new patterns of behaviour that allow him or her to grow and maintain a new level of functioning, namely a new state of equilibrium.

In order to achieve this goal of assisting the person to return to their pre crisis level of functioning, there are certain general methods that can be used to help them utilize healthy coping mechanisms (Aguilera & Messick, 1978; Hof, 1978; James & Gilliland, 2005). These can be summed up as follows:

- Active and sympathetic listen
- Encourage open exploration of feelings
- Help the person gain an understanding of the crisis
- Facilitate the gradual acceptance of reality
- Exploration of methods of coping
- Reopening the social world/ support structures

The principles of the Equilibrium Model of intervention as well as the methods used to assist a person to cope with the crisis are also embodied in goals and aims of the CISD model that will be discussed later in this chapter. The CISD model can be viewed as a way to facilitate coping after a traumatic event (crisis).

3.4 Critical Incident Stress Debriefing Model (CISD)

Debriefing is not something that is new to police officers, soldiers and other emergency personnel. Smith (2006) argues that combat soldiers have been involved in debriefings as early as the First World War (World War I). A chief army historian by the name of Colonel S.L.A. Marshall developed a type of "debriefing" that was used with combat soldiers soon after battle. This model was referred to as Historical Group Debriefing. Its purpose was to strengthen group cohesion and readiness for battle. This process entailed a detailed discussion of the battle that was facilitated by the unit commander. MacDonald (2003) maintains that although this was not primarily intended to be a psychological intervention, it included important elements of cognitive

reconstruction, validation and support. The tenets of this group support system seem similar to Critical Incidence Stress Debriefing (CISD).

Mitchell (1983, as cited in Armstrong et al., 1991) outlined four separate types of debriefings that were part of the comprehensive CISM programme alluded to earlier in this chapter. These included on scene support, initial defusing which is ideally conducted a few hours after the incidence when personnel are more relaxed and in a supportive environment. This is followed by a formal and structured CISD intervention. Should a need arise, there may be a follow-up session which would be undertaken when there appears to be some unresolved material, with an individual or group. CISM highlighted a variety of services that needed to be provided to suit the needs of the people given their varied responses to traumatic stressors (MacDonald, 2003). Of significance is the fact that CISD model was part of this programme. The phases of this model are outlined below:

- Introduction phase
- Facts phase
- Thoughts phase
- Reaction/feelings phase
- Symptoms phase
- Teaching phase
- Re entry phase

A more comprehensive example of how the CISD model is applied is provided in Appendix E.

3.5 The Debriefing Model of the South African Police Services

3.5.1 Goals of debriefing

Before discussing the SAPS model of debriefing, it would be beneficial to outline the goals of debriefing, especially within the SAPS. Ortlepp (1998) highlights these goals, which are listed below:

- To reduce the psychological impact of the traumatic experience
- Facilitate the recovery of the traumatized victims who are experiencing normal but painful reactions to an abnormal overwhelming experience
- To identify and refer those individuals that may need further counselling or therapy

The National Trauma Committee of the South African Police Service (1998, p. 37) summarized the aims of debriefing as follows:

- **To create a safe environment**

This entails providing a safe environment in which the traumatized police officers can be supported by the debriefer as well as other members within the group.

- **To emphasize the normality principle**

This involves emphasis on the fact that the reactions experienced by the traumatized police officers are normal reactions that most people would experience in response to a traumatic incident. This helps to reduce the impression that the experience of the person is abnormal when in fact the symptoms are normal reactions to an abnormal event.

- **To regain control**

When a person experiences a traumatic event, they often feel helpless and powerless. Some describe this feeling as being "on an aeroplane in a nose drive". There is a feeling of not being in control. The trauma debriefing session assists these traumatized officers in re establishing that control over themselves, the symptoms and eventually the traumatic event.

- **Victim versus survivor**

The traumatic experience can leave a person feeling very vulnerable and very much like a victim unable to move past the traumatic experience. Trauma debriefing offers the support that is important in helping the person move from this role as a victim to that of a survivor.

- **Cognitive restructuring**

According to Jonas (2003) the debriefing process facilitates the expression of emotions and as such the experience is given a cognitive structure thereby instilling in the traumatized officer a sense of achievement and a distancing from the experience.

- **To prevent Post Traumatic Stress Disorder**

Finally the aim of trauma debriefing sessions is to act as a preventative measure against the development of Post Traumatic Stress Disorder.

3.5.2 The SAPS Debriefing Model

The debriefing model of the SAPS is based on the model developed by Mitchell that was discussed above. According to Colley (1995) the motivation for the use of the CISD model with the SAPS stemmed from research that examined the theoretical and practical implications of this model as applied to Red Cross disaster personnel following the California earthquake in 1989. Armstrong et al (1991) maintain that based on the individual need of organizations, the model can be modified.

Jacobs (1993, as cited in Colley, 1995) used the CISD model as a framework for the development of the model used by the SAPS. In addition, Jacobs added the principles used by South African Army to deal with trauma to the SAPS model. These principles are embodied in the acronym **IMPRESS A RAVEN** and stand for:

I - Immediacy of action- deal with a member as soon as possible.

M - Military milieu- Stay within the working environment, adaptations can be made and when possible normal operational functions must be completed in uniform.

P - Proximity, traumatised people should receive support as close to their units as possible.

R - Rest and replenishment should be provided.

E - Expectancy, only expectations that normal activities are to continue should be conveyed, i.e. traumatized should not be treated as though they are ill.

S - Simplicity, assistance must be practical and simple.

S - Supervision, the state of the member should be monitored continually.

A - Activity, as far as possible, members should be kept involved in the surrounding activities.

R - Reaction, the member should know what symptoms to expect.

A - Awareness, the member should be aware of his/her feelings and thoughts.

V - Ventilation, emotions should be shared within a group.

E - Encouragement, members should be encouraged to share their feelings

N - Normalisation, members should be made aware that their reactions are normal under the given circumstances.

The phases of the SAPS debriefing model are outlined below:

- On scene debriefing
- Initial trauma debriefing
- Formal trauma debriefing (CISD)
- Follow up

A more comprehensive explanation of this process is provided in Appendix E.

3.6 Conclusion

In this chapter, the researcher looked at the different definitions and conceptualisations of perception as a construct. For the purpose of this study perception was defined as thoughts and feelings of the trauma debriefers about the CISD model as an intervention tool. Furthermore this chapter also outlined the crisis theory and how this related to the development of the CISD model. Lastly the researcher discussed the trauma model that was adapted for the SAPS. Within the SAPS, it is seldom that all four phases of this model are followed. Colley (1995 p. 58) listed possible reasons for all of these phases not being followed. These include logistical problems (incidents are often reported at a later stage to the debriefers), shortage of trauma debriefers given the number of SAPS personnel and individual needs (Follow-ups are voluntary). Nevertheless, the formal trauma-debriefing phase appears to be the most common of all the phases that are being followed.

CHAPTER FOUR

METHODOLOGY

4.1. Introduction

This chapter describes the methodology that was used in the current study. The researcher discusses the research approach and strategy, the type of research and the procedure that was followed when conducting the research. The section on the research procedure outlines the method that was used in data collection and the way in which the data was analysed. Finally the researcher discusses the ethical issues that were considered in conducting this particular study.

4.2. Research approach and strategy

There are two approaches to social research, namely a quantitative approach and a qualitative approach (Denzin & Lincoln, 2000; Terre Blanche & Durrheim, 1999). Terre Blanche and Durrheim (1999) state that the quantitative approach to research involves the researcher using statistical procedures to analyse the data that was collected. In other words, after the relevant variables have been measured, the scores of these variables are transformed using statistical methods so that the data could be described more concisely. Inferences can also be made about the larger population based on the analysis of results of the smaller sample.

In a qualitative approach the researcher is interested in the quality of information from the participants' perspective. In other words rather than the focus on statistical data, the qualitative approach is concerned with the unique perspectives of the participants. Maykut and Morehouse (1994) concur and further state that a qualitative approach is designed to discover what can be learned about a phenomenon of interest, particularly phenomena where people are participants. These researchers believe that qualitative researchers are interested in investigating and responding to exploratory and descriptive questions. The outcomes of such questions are aimed at a deeper understanding of the participants' perspective. Similarly, Schwandt (1997, as cited in Chababala, 2005) is of the opinion that a qualitative approach is concerned with the exploration of feelings, opinions and attitudes of the participants. A qualitative approach is therefore interested in the understanding of peoples' experiences in context. Since in the current study, the

researcher was interested in understanding people's thoughts, feelings and experiences of using a particular tool, a qualitative approach was adopted.

There are various strategies of enquiry that can be used to design qualitative research. Creswell (1998) identifies five of these strategies. These strategies are a case study, biography, grounded theory, ethnography and phenomenology. The strategy of enquiry that was used to design the current study was the phenomenological strategy. Willig (2001) describes phenomenology as concerned with the ways in which human beings gain knowledge of the world around them. It is interested in how the world is experienced by human beings within particular contexts and at particular times. A phenomenological study aims to understand the meaning of experiences of people about a concept or phenomenon. As this researcher is interested in investigating the trauma debriefers' perceptions about the method of intervention that they use with traumatized police officers, the phenomenological strategy of enquiry seemed appropriate.

This approach allowed the researcher to explore the research participants' experience from their own perspective. In other words it is concerned with an individual's personal perception or account of an object or an event, in this particular case, this being the CISD model. The focus is on the trauma debriefers' perceptions about the tool that they use within the context of the South African Police Service. As mentioned in earlier chapters, previous research in the area tended to focus on the person who had gone through trauma debriefing as a client and their evaluation of the efficacy of the process i.e. that it was helpful or unhelpful in alleviating their distress (Chabalala, 2005; Colley, 1995). When debriefers were studied, the tendency was to focus on issues relating to secondary traumatization experienced during the process (Jonas, 2003; Steed & Bicknell, 2001). None of the literature reviewed for the current study presented results obtained from research that explored the views of the professionals who use the CISD as their method of intervention. This was seen as a significant oversight in research since the people who use the tool are at a position to identify what works and what doesn't and can thus have major input on how improvements can be made.

The importance of professionals evaluating their tool cannot be emphasized, especially when considering the culturally diversity in South Africa at large and in the SAPS in particular. Given that the CISD model was designed many years ago for a particular group of people, there is concern about the suitability of this model to the SAPS. It is possible that such a tool may be outdated. Professionals using the CISD model within the SAPS can therefore provide insight into

what works and what does not. These professionals would also be in a better position to make suggestions regarding the use of the CISD model given the experience that they have within the SAPS culture. It is hoped that the results of this exploration would stimulate further interest into how practitioners use the tool of CISD with South African police officers and hence influence the development of alternative or more appropriate intervention strategies.

4.3. Types of research

There are two types of research, namely applied and basic research. This distinction refers to the uses to which the research will be put (Denzin & Lincoln, 2000; Terre Blanche & Durrheim, 1999). According to Terre Blanche and Durrheim (1999) knowledge about the world exists as general theories about how the world operates. Basic research is used to refute or support these theories thereby advancing our knowledge about the world. Applied research on the other hand aims to contribute towards the practical application of problem solving, decision-making, policy analysis and community development. Further, applied research aims to provide information about some form of social action with the aim of providing information to decision makers so that informed decisions can be made based on this information. Chabalala (2005) also believes that applied research is conducted in order to solve practical problems or provide useful answers to questions regarding programs, projects, policies or procedures.

By gaining a deeper understanding of the perceptions of the SAPS trauma debriefers who use the CISD model as an intervention tool, the researcher hopes that this knowledge will facilitate not only a better understanding of debriefing within the SAPS but it will also allow the SAPS trauma managers to make informed decisions regarding the use of this model with traumatized police officers. As mentioned above, these results could contribute to modifications to the CISD model or changes to the intervention tool as a whole, within the context of the SAPS. The current study can therefore be characterised as an applied type of research.

4.4 Research Procedures

The research procedure describes a series of specific steps that were followed in the research study (Neuman, 2000). This particular section will outline the procedure that was followed in data collection and analysis.

4.4.1 Data Collection

Semi- structured interviews were used as a method to collect data (see appendix A). This method of data collection falls under general interviewing but in this case there would be pre-formulated questions that serve to guide the process. According to Maykut and Morehouse (1994) an interview is a conversation with a purpose. This means that the interview with research participants is informal but yet with a particular goal. For the purpose of the current study, the researcher aimed to gather information about the perceptions of the SAPS trauma debriefers in response to pre-formulated questions. By conducting an interview the researcher is able to gain information in a more natural way by interacting with the research participants. In other words the researcher is able to get an opportunity to get to know the participants as the information regarding their thoughts and feelings are elicited (Terre Blanche & Durrheim, 1999; Smith, 1995). This method fitted in well with the phenomenological paradigm as it afforded the researcher an opportunity to get an understanding of the personal perceptions of the trauma debriefers employed in the context of the SAPS.

4.4.2 Data Analysis

According to Maykut and Morehouse (1994), the process of data analysis is mostly a nonmathematical analytical procedure that involves the examination of the meanings of people's words and actions. This process not only involves descriptions but also interpretations of the raw material. The researcher used qualitative content analysis to analyze the data. This is the most basic type of qualitative analysis that aims to report key elements of responses given by participants (Green and Thorogood, 2004; Henning, Van Rensberg & Smit, 2004). According to Henning et al. (2004) this type of analysis is a tool for reducing, condensing and grouping content. In this study the researcher broke down the data into underlying themes and frequencies of occurrences of themes were noted. Information from all interviews was considered as important regardless of the overall frequency of occurrence.

Henning et al. (2004) identify the following steps as involved in qualitative content analysis:

a) After the interviews are transcribed for each participant, the transcripts are read and re read to get an overall impression of the content.

b) During this process, segments of meaning are identified in one or more sentences/ phrases in the text. A marker can be used to indicate segments of meaning. This process is referred to as open coding but although themes may be observed, the process of coding has not started as yet. Opening coding is an inductive process whereby the codes are selected according to what the data mean and therefore it is necessary to have an overview of as much of the content as possible.

c) The next process involves the labeling of these segments of meaning in more than a single word. These labels or codes can be written in the margin of the transcripts.

d) The researcher then looks for possible grouping of the codes within and across transcripts.

e) These codes are then listed and the texts of the various transcripts are read again to ensure that the codes make sense and that they are related to the research question.

f) Finally, the grouped codes are transformed into categories or themes

4.5 Description of research population and sampling method

4.5.1 Research Population

A population is any group of individuals that has one or more characteristics in common that is of interest to the research (Babbie, 1995). Similarly De Vos (1998) defines the research population as the total set from which the individuals or units are chosen for the study. The population is therefore the larger universe of individuals or units who have particular characteristics in common. The researcher is interested in these characteristics and will draw a sample from this universe. The population of interest to the researcher included all the psychologists that are trained as trauma debriefers within the SAPS in KwaZulu-Natal. This includes Durban North, Durban South, Durban Central (Provincial office) and Pietermaritzburg areas. The population amounts to nine psychologists.

4.5.2 Sampling method

The sampling procedure that was used in the current study was purposive sampling. This is a type of non-probability sampling method that selects participants on the basis of a certain type of element or characteristic (Dane, 1990; Nachmias & Nachmias, 1981; Neuman, 1994). The participants selected are based on the judgment of the researcher who chooses the sample that

appears to be representative of the population. According to Neuman (1994), a researcher uses this method of sampling when unique cases that are informative about the topic are needed. This may also be used to select hard to reach specialized populations or when a researcher wants to identify particular types of cases for in-depth exploration where the purpose is to gain a deeper understanding. Further, this method is used mostly in exploratory or field research.

The characteristics that were considered when selecting the sample included the registration as a psychologist and training in the CISD method. From the nine psychologists that formed the population, six psychologists were selected as the sample. Furthermore, there are different categories of psychologists that are employed in KwaZulu-Natal, namely counselling psychologists, industrial psychologists and educational psychologists. The researcher included each category in the sample resulting in a sample of three counselling psychologists, two industrial psychologists and one educational psychologist. One candidate from the nine was used in the pilot study and therefore could not be used in the study proper. The other two psychologists were not available at the time the data was collected.

The profile for the participants can be found in the attached appendix (see appendix B). The responses of these participants were coded using their pseudonym and category of registration.

4.6 Ethical Issues

Ethical clearance to conduct this project was obtained from the Ethics Committee of the University of KwaZulu-Natal.

Various researchers emphasize the importance of conducting ethically sound research (Neuman, 2000; Terr Blanche & Durrheim, 1999). Terr Blanche and Durrheim (1999) state that there are three broad principles on which many ethical guidelines are based. The principle of autonomy refers to the researcher respecting the autonomy of the research participants. This covers issues such as voluntary and informed consent of the participants, the freedom to withdraw from the project at any time and the right of the participants to anonymity in any publication. The second principle of non-maleficence entails that the researcher should do no harm to the participants. This requires the researcher to identify the potential risks of the study and to ensure that no harm (physical, psychological or emotional) occurs to the participants. If there are risks, the researcher has to ensure that the benefits outweigh the risks. Finally, the third principle is that of beneficence. This principle entails that the researcher must design the research in such a way that it is beneficial to the participants and more broadly to society. In this

particular study, the aim is to explore the perceptions of trauma debriefers and as such it is possible that various sensitive issues regarding the use of the intervention tool may arise. Therefore it is important for these principles to be followed. According to Terr Blanche and Durrheim (1999) these three principles are fully expressed in specific ethical guidelines. These are discussed below.

4.6.1 Permission to conduct the study

Permission was requested from the SAPS National Psychological Services head to conduct the study. Permission to conduct the research within the SAPS was granted (see appendix C).

4.6.2 Consent

Written consent was obtained from the research participants with regards to their participation in the study (see appendix D). Furthermore permission was also requested to record the interviews using a tape recorder. Consent was voluntary and informed. In other words the participants were fully informed about the tasks that are expected of them. This was done in a clear manner using simple language, which the participants could understand.

4.6.3 Confidentiality

Confidentiality for the research participants is an important aspect of any type of research. The informed consent forms that the participants signed assure anonymity for the participants should the results of this study are published.

Furthermore, the individual interviews were conducted at times that were convenient for the research participant/s. Both the researcher and the research participants mutually agreed upon the venue to be used. The privacy of each interaction was ensured and at each interview a pseudonym was chosen for each participant in order to ensure that his or her identity in the study is anonymous and thus that his or her participation in the study remains confidential. The recorded interviews were transcribed and both the recorded interviews and transcripts are stored in a safe and secure place.

4.7 Pilot study

As mentioned above, before the study proper was conducted, a pilot study was undertaken. A pilot study involves a process of testing the measuring instrument on a small number of subjects who have similar characteristics to those subjects that are used in the main study itself (Breakwell et al, 1995). This also establishes not only whether the question or instructions are clearly understood but also the relevance of the various questions (Babbie, 1995; Breakwell et al, 1995).

The researcher conducted a one-to one interview with one of the psychologists that formed part of the population. A semi-structured interview schedule was used and this was amended accordingly. Some of the questions were eliminated and others were revised. The amended semi-structured interview schedule was then used with the sample that was selected.

CHAPTER FIVE

RESULTS AND DISCUSSION

5.1 Introduction

To reiterate, the aim of the study was to explore the perceptions of the SAPS trauma debriefers regarding the use of their tool in general and by extension the perceived efficacy of their tool within this organization. Below is a presentation as well as discussion of results obtained. The transcripts of the participants formed the database from which the analysis was done. The themes that emerged as a result of the analysis were along the following broad areas:

- The utilization of CISD within the SAPS
- The suitability of the CISD model within the SAPS
- Aspects of CISD that are reported to be helpful
- The structure of the model
- Modifications/adaptations to the CISD model
- Timing of the intervention
- Competence and flexibility of the trauma debriefer
- Secondary traumatization

5.2 The utilization of CISD within the SAPS

The CISD model or formal trauma debriefing, as it is known in the SAPS, is widely used within this organization to intervene with traumatized police personnel. This formal, structured and in-depth process is based primarily on Mitchell's CISD model as discussed earlier (Chabalala, 2005). Although it forms one part of the SAPS trauma programme, it is often used as an intervention on its own. Two sub themes were identified in relation to this main theme, namely CISD as a method of choice and the purpose of this intervention tool.

5.2.1 CISD as a method of choice for debriefers

Participants asserted that this is not necessarily their method of choice. It is more the fact that they have been trained to use this method by the SAPS and no other alternatives were offered.

The following excerpts illustrate this point:

H.EP: " It's not my choice but the police work with this model and you have to keep to what they working with..."

A. IP: "well we were just trained in it and told to utilize it. So I think that it's not my intervention of choice"

Nevertheless, even though it is not necessarily a method of choice, the participants stated that it is a safe and helpful method that provides a structure to conducting a trauma debriefing. It is used initially as a guide and adaptations (such as the use of drawings or the use of neuro linguistic programming) are added depending on the needs of the traumatized person/s. These adaptations are discussed in a later section in this chapter. Furthermore, participants choose to use it as a method of choice for group trauma debriefings. The following excerpts illustrate these issues:

H.EP: " ...It's not completely bad...but as I said I won't use it alone. I add my own things that I find are useful in helping them to deal with the trauma instead of discarding it completely."

R. IP: " ...I kinda feel safe using it. As an industrial psychologist I would rather use some model than no model to do debriefing which is safer."

S.CP: ".... my first couple of stages are very much in keeping with Mitchell's way of doing things but I find it doesn't always work best. It needs to be adapted depending on who the client is."

T.CP: " ....use it to provide some structure...it would be an intervention of choice for group trauma debriefings. For individual trauma debriefings...use some aspects of Mitchell's model and.... another modality."

5.2.2 The purpose of CISD as an intervention tool

Taylor (2004) stated that psychological debriefing was originally constructed as a preventative rather than a therapeutic measure, especially when used with emergency personnel after a

traumatic experience. Arendt and Elklit (2001) agree and state that psychological debriefing should be seen as a discussion between normal people discussing their normal reactions to an abnormal experience and it is aimed at facilitating coping and competence rather than addressing the psychopathology of the traumatized victim. The original use of CISD is therefore preventative rather than therapeutic. However, when trauma debriefers who use the CISD model deviate from the original intended purpose, one may not necessarily attribute the outcomes to CISD in its original form. It is also possible that the identified inconsistencies in the reviewed literature can be attributed to these different uses.

Further, the preventative effect of psychological debriefing is obscured by the various methodological problems and factors surrounding the traumatized person, traumatic exposure and the trauma debriefer (Arendt & Elklit, 2001). In addition, when psychological debriefing is conducted as a single session, its preventative effect against PTSD is questionable (Rose, Bisson and Wessely, 2001). The participants in this study have provided varied responses in terms of the way that they use the method of CISD. Some use it as a preventative measure, a first line of defense against further psychological problems and PTSD. The following excerpt illustrates this:

R.IP: " the first one, as a preventative measure. .....I would rather just want to do the first...if I see the person needs more intervention, I will refer them on."

Other participants stated that they use it both as a preventative and therapeutic tool. One participant reported that she uses it only as a therapeutic tool. The following excerpts illustrate this:

H.EP: "both,.....here you use it preventative, you hope that by coming in, talking about the incident and debriefing them, it won't lead to PTSD. And then during therapy you would use it again where the person would come in with PTSD and you would use it as part of the treatment process."

T.CP: " ... as a therapeutic tool"

It is however interesting to note that those that use it as a therapeutic tool use only parts of this model during therapy. So in essence, the model that is used for therapeutic purposes is not CISD in its original form. Violanti (2001) was of the opinion that short-term interventions should be perceived as preventative measures and as such should not be expected to cure the traumatized

person. Given the argument of Violanti (2001), CISD should therefore be used as the initial method of intervention when dealing with traumatized police personnel and not as a therapeutic tool. One may, however, not underestimate the importance of that initial contact with the client after a traumatic incidence as this initial process is in itself perceived as therapeutic. As one participant indicated that although she uses the tool as a preventative measure, the process is also therapeutic for the traumatized person/s. It allows a process of catharsis and containment.

5.3 The suitability of the CISD model within the SAPS

This intervention method is applied to personnel of the South African Police Services, namely the police officers and civilian personnel employed by this organization. The SAPS is a unique organization with its own sets of rules and policies, some of which are implicit within this culture (MacDonald, 2003; White, 1997). In addition, the highly traumatic nature of their work highlights not only a need to intervene but also intervention using a suitable method. Various sub themes were identified from the transcripts that were analyzed. These are discussed below:

5.3.1 Group versus individual intervention

Arendt and Elklit (2001) argued that the original concept of psychological debriefing was designed as a structured group intervention that was developed for professional helpers such as firefighters, soldiers and police officers. In their analysis of various efficacy studies about debriefing, it was found that when deviations from the traditional group format of psychological debriefing had occurred, there was no positive effect to be found. Therefore the use of the traditional group format provided more positive results. Within the SAPS this model has been applied both to groups and individuals. Similar results were found when the transcripts of the participants were analysed. Three of the participants used it mostly with groups and three participants used it mostly with individuals. However, five of these participants found that this method is better suited to intervening with groups and yields more favourable outcomes. The following excerpts illustrate this point:

S.CP: "I think it's more effective with groups than individuals."

H.EP: " ...a group trauma debriefing would be better...."

T.CP: " I think it's nice working with groups because it works."

Arendt and Elklit (2001) argued that the reasons given for its effectiveness with groups stem from what has been called the intended or helpful effects of trauma debriefing and these were highlighted and elaborated on in the literature review. They include the normalisation of the experience and symptoms, verbalisation of the experience, group cohesion and building the solidarity of the group or team. At the same time, these researchers also revealed that the studies that reported the intervention to be helpful were unclear about which of the aforementioned attributes contributed to positive results.

Nevertheless, these intended effects of psychological debriefing are in line with the aims of the SAPS trauma-debriefing model as discussed by the National Trauma Committee of the South African Police Service (1998, p. 37). Police personnel often provide support to each other during the group debriefing session. These are people who are like them and who share the same experiences. Young (2004) and Violanti (1997) speak of a sense of "family togetherness" or a sense of "strong cohesion and dependence on one another" that develops among police officers. This develops because police officers see themselves as unique people that share common experiences. It is believed that such commanders and colleagues have a better understanding of the experiences of being a police officer and therefore are better able to provide support. The support that is provided for each other as well as the opportunity to share and normalise their experiences and reactions has contributed to CISD being more suitable to group sessions. The following excerpts illustrate this fact:

S.CP: " I think the stages are more conducive to groups' normalising each others experiences so the 7 steps work a bit better then...more effective with groups because it serves as a self regulating, self-normalizing process."

H.EP: "...a group debriefing would be better where everybody realizes that there is ...they do sort of experience the same sort of feelings and emotions...and somebody says that they are frightened, the other person would respond by saying oh, I didn't realize that you were frightened, I was also feeling that way, so it builds the solidarity of the group in that way."

R.IP: " ...effective in groups because of group cohesion and they supporting each other and just that support you getting from the members, it makes the process so much more valid cause they

kinda validate as you go on...they would say that: ja I have these symptoms and things like that."

In terms of use of CISD with individuals, most participants revealed that they use the model as a guide but some times deviate from the method by adding other therapeutic techniques such as relaxation exercises and hypnosis. It is adapted based on the needs of the individual client. This is not to say that the model is not adapted when doing a group intervention but rather the model is adhered to more strictly, namely all the stages are covered but always taking the groups' needs in to account. Nevertheless, the participants reported that the use of CISD model with individuals has been effective, even when adapted. The following excerpts illustrate this factor:

S.CP: " with individuals, I think it's very much what the needs of the client are at that particular moment"
T.CP: " ...with individuals I would not just stick to Mitchell's model...I would use other therapy concepts...I might include further aspects of therapy within the session but I would not break away completely from Mitchell's model but if I was doing an individual session it could happen that I might break away."

R.IP: " So I think this process is effective in a group but it works for individuals, it does work. I've seen it working but its better in a group where you get support from other people as well and you that you are not alone."

5.3.2 Suitability for the debriefing of police personnel

Given the fact that there are two types of personnel employed by the SAPS, namely the police officers and the support personnel (civilians), it might be beneficial to discuss the suitability of the CISD method to both types of personnel. Support personnel are also exposed to traumatic experiences as a result of their placement at stations and their contact with police officers. This sub theme entails a discussion of the suitability of this model for these two types of personnel as well as the possible reasons for its suitability to these personnel. Most participants have asserted that CISD is better suited to intervening with traumatized police officers as compared to the civilian personnel. These participants feel that this is due to the fact that police officers are most often exposed to traumatic experiences as compared to civilians and the nature of exposure to such incidents is continuous. The following excerpts illustrate this point:

J.CP: " It's applicable to police members. I'm saying...because they are mostly exposed to traumatic incidents...I think 90 percent of the work they do ...they witness such incidents... "

H.EP: "ja because of the continuity of exposure... "

Another factor that can be considered when discussing the suitability of CISD to different types of people is the fact that there are characteristics inherent in the traumatized individuals themselves. In a study conducted by Arendt and Elklit (2001), it was found that psychological debriefing was found to have some positive effect when used with professional helpers rather than when used with other types of victims of trauma. These researchers assume that the reason for this difference is possibly due to the fact that the professional helpers share certain similarities relating to the experienced trauma such as being members of a group, professionally trained and knowing the risks involved in their job. Furthermore, professional helpers represent a distinct group of people who have particular training and experience in their field. Such factors play a protective role in relation to traumatic stress. In addition, professional helpers know each other well and as such support may be generated beyond the debriefing session itself. This could contribute to the positive effect of debriefing experienced by the professional helpers such as police officers. This argument is applicable to police officers in the SAPS as they share certain similarities such as being members of a group who experienced the trauma, professionally trained and knowing, and to a certain extent, expecting the risks involved in their job.

The personality of the traumatized individual may also be another factor in assessing the suitability of CISD to police officers as compared to civilians. Wagner (2005) argues that there is a particular personality type that is suited for the use of CISD, namely the existence of a rescue personality. It is believed that emergency response workers are people who like control over both the situation and themselves and enjoy the feeling of being needed. Although the existence of a rescue personality type is a possibility, at present there appears to be little evidence supporting its existence (Gist & Woodall, 1998; Wagner, 2005). This is similar to one participant's response. She stated that the personality could possibly play a role concerning the suitability of the intervention but there is some uncertainty. The following excerpt illustrates this point:

J.CP: " ...personality I can say maybe it plays a big role but my problem is how are we going to know the SAPS members' personality to determine whether this person is suitable for this kind of intervention or not. "

Some participants implied that the reason for the suitability of the CISD model to police officers stems from the view that police officers are structured and ordered and this model provides a structured way of coping with the traumatic experience. The following excerpts illustrate this fact:

R.IP: " ja, this environment is ordered and structured and this process is quiet structured so you taking the person through a process and they like that, they kind of like order and structure and things like that."

S.CP: "policemen, I think are fairly structured. They like to focus on what happened...I think the structured method of Mitchell's model allows them to go step by step..."

At the same time, there were some conflicting results with regards to this issue. There were other participants who were of the opinion that this method is better suited for civilians. They based this assumption on the fact that civilian personnel are more eager to undergo the process of trauma debriefing and are more in touch with their emotions as compared to police officers. Police officers may not be willing to undergo debriefing due to the perception that if they do they may be viewed as weak (MacDonald, 2003). This belief stems from the macho image or police sub culture of "cowboys don't cry" that makes the expression of emotions difficult (Young, 2004). Furthermore, as stated by Koppel and Friedman (1997), the use of the defense mechanism of denial may result in police officers suppressing their feelings and creating an emotional distance in order to cope with the experience. This structured method that requires the exploration and ventilation of emotions as one of its important components may be unsuitable for some police officers as they may find the exploration of their emotions uncomfortable. The following excerpts illustrate this:

A.IP: " in my experience, you find that the admin person is a bit more eager to go through the trauma debriefing than the policeman. It comes from the culture...promoted within the police. If you go for debriefing.... you obviously look at me as weak. You know the cliché that cowboys don't cry."

S.CP: " .....people are a little bit more in tune with their feelings but police members are a bit reluctant to talk about their feelings or they feel like they need to put on a macho attitude that it

hadn't affected me."

When older or experienced police officers are compared with younger or inexperienced ones, the participants stated that older members benefit less as compared to young or inexperienced police officers. The participants reported that this is due to the fact that older members have developed their own ways of coping and this method of intervention is seen as unnecessary. Participants also stated that another reason is due to the familiarity with the method. Due to numerous traumatic incidents, this method is often used as an intervention with police officers including the older and experienced members and as a result familiarity with the method and process results in it being boring, redundant and hence ineffective The following excerpts illustrate this:

S.CP: " ...effective with your rookies, sergeants and constables. Your seasoned police officers benefit less from this model. They've been there for decades...so they're familiar with the process then it defeats the purpose."

J.CP: "ja, the older people are even worse because the older, I'm talking about the people that have been in the services for the last 16 years...they don't believe in trauma debriefing for one reason: its started now and they have been coping well without it for all of these years."

One participant indicated that the trauma debriefer should use their skills to rephrase questions to counter familiarity with the CISD method. This could possibly be a reason for the adaptations made when using this model, especially when it is used with seasoned and experienced police officers. The following excerpt illustrates this:

T.CP: "Unless you smart enough to rephrase the way you actually ask the question, people become immune to the process..."

5.3.3 Verbal versus non verbal police personnel

Another factor to consider in terms of the perceived suitability of this method to the SAPS is the aspect of verbal versus nonverbal clients. This refers to the fact that some police personnel are more expressive about their feelings than others. Participants asserted that this method is a verbal method of intervention and may work well with verbal police officers but for less verbal police officers this method may not work as well. Police personnel may be less verbal or expressive

because of the overwhelming distress experienced. Not all traumatized police officers are willing to relive the incident due to the emotional turmoil that has been created by the impact of the traumatic experience. As stated by Janoff-Bulman (1988, as cited in Everly & Lating, 1995) the person can be said to be experiencing emotional and psychological distress because of the dissonance between their own assumptions and the reality of the experience. This distress may make it difficult for the traumatized police officer to talk because he or she is still in a state of shock. One participant indicated that in this case verbalisation might not always be helpful. These officers may not be ready emotionally to discuss the incident and hence have difficulty translating their feelings into words.

A second possibility for the traumatized police personnel having difficulty in verbalising the experience may be due to the fact that he or she is unable to adequately express himself or herself in the language of the debriefer. Verbalisation of the experience is an important aspect that can lead to the experience of a trauma debriefing session being positive or negative. However, it is not just about the verbalisation but rather the person also needs to be able to express himself or herself feel understood. As indicated by Doherty (1999) it is not only the differences in language but also the fine distinction between specific words and phrases that can be misleading thereby creating an atmosphere that lacks empathy. A goal of psychological debriefing is for the traumatized person to feel that he or she is understood, that someone can empathize with him or her. However if these differences are not taken into consideration, traumatized people can feel misunderstood and even offended by the well-intentioned attempts of the trauma debriefer.

Given the fact that the trauma debriefers may not have an alternative intervention method available, the use of CISD might not always be suitable for police officers that are less expressive or unable to verbalize their experience due to the distress experienced. The following excerpts illustrate this:

S.CP: "for verbal clients this works better, but.... if clients are less verbal, somebody chooses not to speak, somebody very traumatized that is unable to put into words what they are feeling...I think this model doesn't work well..."

S.CP: " I don't think that asking them to verbalize exactly what happened is always the most helpful thing.

R.IP: " ...people are sometimes not in touch with their feelings."

On the other hand, if a person is unable to talk about their experience, it could lead to him or her having difficulty to cope. According to Aldwin (1994, as cited in Schnurr & Green, 2004) in order to cope with a traumatic experience, the disclosure of the experience is important. This researcher stated that traumatized people who disclose do much better in terms of short and long-term outcomes. Aldwin (1994) further indicated that another aspect of coping with trauma involves the attribution of meaning to the experience. This process involves the reorganization of existing cognitive schema and the reappraisal of the event and the context in which the event occurred. This process involves the active involvement of the person, namely verbalization of the experience and emotions.

Similarly, Resick (2001) stated that when a person is unable to talk about their emotions and cognitions relating to the traumatic experience, they can develop unhealthy coping behaviors such as denial and avoidance. In order to cope with the distress caused the person applies two cognitive processes, namely assimilation and accommodation that facilitates emotional coping. According to Resick (2001, p.127) assimilation is the process of "taking in new information and accommodation involves changing one's beliefs, categories and schemas to accept the new information". These processes involve the person talking about the experience.

Although some police officers may not be ready to verbalize their experience, verbalization is an important aspect in helping the person to cope. Talking about the experience and the opportunity to emote thus needs to be done as soon as possible to prevent the development of other negative or problematic behaviors.

5.3.4 The frequency and severity of traumatic events

The frequency and severity of the traumatic events is another factor to consider when exploring the suitability of the CISD method within the SAPS. Exposure to traumatic experiences is an unavoidable aspect of being a police officer (MacDonald, 2003). Police officers move from one traumatic experience to the next without sometimes having time to fully recover from the previous one. As a result, prior traumatic experiences may also increase the vulnerability and the risk to developing PTSD (Buchanan, Stephens & Long, 2001). These accumulated experiences can therefore impact on the functioning of these officers unless they seek assistance to help them

cope. It has been ascertained that this assistance is provided in the form of CISD but as to whether CISD is appropriate for continuous or repeated trauma is questionable. There appears to be inconsistent responses in terms of this factor. Participants assert that this method is suitable for single traumatic experiences rather than for repeated or continuous exposure to trauma. However, on the other hand some participants felt that this method is effective with police officers exposed to continuous trauma. The following excerpts illustrate this:

T.CP: "I think it's better suited for once off incidents rather than for continuous incidents. It is not suited for policemen that have traumatic experiences often."

S.CP: " The reason why I think that it is not effective with policemen because of repeat trauma that they have to go through. If somebody, a detective...go through incidents on a daily basis or weekly basis..."
H.EP: "Because they are exposed to so many traumatic incidents, I think that it's suited to them because they need to express their feelings and thoughts and allow them to cope..."

Furthermore the severity of traumatic incidents that police officers are exposed to varies. When participants were asked whether the model might be better suited for a particular type of incident, most participants were uncertain about this. Participants did however indicate that this method might be better suited for incidents that are less traumatic in nature. More serious incidents should be dealt with through the use of another form of intervention. Interestingly, one participant reported that if a police officer experiences a traumatic event that is personally related to him/her then the CISD method would not be applicable. The following excerpts illustrate this:

S.CP: " that's a good question. I wouldn't say a certain type of incident." " I think that when you're dealing with somebody that has been through many traumatic incidents, when you dealing with policemen ...involved in the riot or extremely traumatic incidents then Mitchell's model doesn't help to contain them at all."

H.EP: " I think that less severe would be very well addressed.... very serious incidents you have to add more to it."

A.IP: "Maybe the incident that particular gruesome, it might not be effective. Maybe for something lighter it could be effective."

R.IP: "I think that when it's very close to a person, when one of his family members or ...I don't think a normal trauma debriefing would be applicable."

5.3.5 Forced versus voluntary referrals

This sub theme discusses the suitability of the CISD method in terms of referrals for trauma debriefing sessions, namely mandatory versus voluntarily. Various researchers reported on inconsistencies that relate to the efficacy of psychological debriefing due to this very factor e.g. (Hokanson & Wirth, 2000; Robbins, 2002). Literature on individuals exposed to traumatic situations revealed that some people may not need psychological debriefing immediately after exposure to a traumatic event as they have their own way of coping or need more time for processing the event (Belaise et al., 2005; Hamling, 1997). Conducting immediate psychological debriefing with such people can therefore re-traumatize them and hinder their way of coping (Kaplan et al., 2001). Bower (2003) is also of the opinion that compulsory psychological debriefing should be stopped and only used for those who request it.

According to Chabalala (2005), the South African Police National Instruction 18/1998 states that it is compulsory for every police officer involved in a traumatic experience to be given the opportunity for trauma debriefing. However it seems that managers and commanders of the SAPS mistake this as an instruction to attend a debriefing session irrespective of whether the police officer wants to or not. Participants indicated that this is sometimes seen as punishment by the police officers and therefore makes the trauma debriefing ineffective. Furthermore, when police officers are instructed to attend a debriefing session without being given a choice or an explanation about the process, they become negative toward the use of this intervention. Participants did agree that voluntary attendance facilitates a more positive outcome. The following excerpts illustrate this:

S.CP: " If you made it a voluntary process...they're a lot more likely to do it out of their own free will rather feeling they're forced to do it and they become resistant."

R.IP: ...feel they have to be here because their commander told them to be here, they don't have an idea of what's going on..."

J.CP: "so obvious if the commander says go to this kind of intervention, they can't refuse because they comply. They have to comply. That's why it's sometimes not even effective because when they come it's because for them they feel that it is punishment than the intervention that is necessary and the intervention that is going to help them."

5.4 Aspects of CISD that are reported to be helpful

This theme entails a discussion of aspects of the trauma debriefing process that are considered to be helpful by both the trauma debriefer and the traumatized police personnel. Arendt and Elklit (2001) state that many studies report that people find the intervention helpful however, because of numerous methodological flaws or inconsistencies in methodologies used in some of the studies reviewed, it has always been difficult to ascertain whether the helpfulness can be attributed to the normalisation of reactions, verbalisation and/or improved group support. For the studies that reported positive results, it is believed that part of the process that is thought to be helpful during the debriefing session is the psycho education that provides information about stress symptoms. These researchers concur and further stated that talking about the experience appears to be equally important.

Participants were asked about feedback they might have received from traumatized individuals after a trauma debriefing session. This feedback could have been given immediately after the debriefing or during a follow up session. Participants asserted that traumatized police officers had found that the opportunity to talk including making some sense of the traumatic experience was an important factor in making them feel much better. The structure of the model allowed for the traumatized individuals to talk about the incident in a structured way, filling gaps of information that might have been forgotten and hence putting the incident into perspective. In line with the argument by Arendt and Elklit (2001), psycho education regarding the stress reactions and coping were also reported as being helpful. However, a victim's sense of distress can be heightened by the process of sharing information, by whom it is shared and the time that it is shared (Kenardy, 1998). All the participants in the current study found the normalization of stress reactions and emotions to be particularly helpful. The following excerpts illustrate this:

S.CP: "...will have had the opportunity to tell someone what happened step by step and often the structured technique allows them to think...using all of the different senses which they might have omitted in telling people previously. So the advice stage usually helps as well."

R.IP: "...like really venting and talking about it and also the education that you give them of what to expect that helps."

H.EP: " ...they feel good that it's basically normal for those sort of feelings to happen..."

When the participants were specifically asked about what they thought was helpful about CISD, they asserted that the talking about the incident, normalization of the stress symptoms and emotions and the psycho education about stress reactions and coping were very helpful. Furthermore, the process also shows support and concern for the traumatized person. The following excerpts illustrate this:

S.CP: " I think 3 parts...to tell someone...the normalization procedure...and you give them handy hints..."

R.IP: " well, the support you provide them, the empathy and knowing that they are not going crazy."

In addition, there is literature that has documented the potential screening function of psychological debriefing but there is uncertainty about whether such an objective is met (Arendt & Elklit, 2001). Although in the early stages after a traumatic experience the stress symptoms may be non-specific and transient but the level of symptoms can be indicative of those who are at risk to developing problems at a later stage. Therefore screening can have a positive effect indirectly. Screening as a goal may be appropriate however this goal can be achieved provided that the debriefers are sufficiently skilled at their job in order to identify those that need to be referred. However, screening can never be considered as a main argument for the efficacy of psychological debriefing as there are other types of interventions that can perform the same screening function.

Some participants reported that the use of this method does serve a screening function in that those police officers that may need further follow up or referral for therapy are identified. The following excerpts illustrate this point:

R.IP: "If someone needed follow up, I immediately referred them after the session for some counseling or therapy ' cause I could see in the debriefing that they do need more."

H.EP: " ...and you gage where the member is and who needs further help and who is really traumatized by the incident."

5.5 The structure of the Model

5.5.1 CISD as a structured process

In terms of the structure of the model, the participants indicated that firstly the structured nature of CISD has advantages and disadvantages. One advantage of the structure of this intervention method is that it helps the traumatized police officer to go through the process step by step and to organize their thoughts about the experience thereby making some sense of what had happened. A disadvantage of the structure of this method forces the traumatized person to deal with their experience. Literature has documented that the structured method interferes with the natural processing of the traumatic experience by forcing the traumatized person to deal with the traumatic experience during the debriefing session (Look, 2004; Van Emmerik, Kamphuis, Hulsbosch & Emmelkamp, 2002). Further, participants indicated that the structure presents another disadvantage in that it allows the officer to escape by not talking about their feelings. Police officers can often give a detailed factual account of the experience but when it comes to the emotions, this aspect is limited and they use vague descriptions to describe their feelings. The following excerpt illustrates this:

S.CP: " ...structured method allows them to go step by step without thinking...but it can also present a disadvantage ...escape without talking about their feelings...and they more likely to tell you ...not really emotion words."

Participants asserted that the structure also has advantages and disadvantages for the trauma debriefers themselves. An advantage of this method is that the structured phases allow the trauma debriefer to provide not only a consistent method of support but also a safe method that can be used by other helpers within the SAPS that have been trained to provide support. Participants also report that if a trauma debriefer does not have therapeutic or trauma-debriefing experience then the structure of this method is important guide when teaching the inexperienced person how to conduct the debriefing session. The following excerpt illustrates this:

T.CP: " it provides a consistent way of providing support...safe kind of services that can be provided by everybody who is supposed to be a helper in an organization."

T.CP: " ...if you teaching a person that does not have any counseling experience...therapeutic experience...and if you teaching them this model, I think it is very effective."

Another advantage of the structure is that it allows the protection of the trauma debriefer through the introduction of stages. The trauma debriefer is aware of the stages that are to follow and is therefore able to maintain a therapeutic distance between themselves and the traumatized police officers that they are debriefing. This therefore decreases the probability of the trauma debriefer becoming overwhelmed with the information related by the traumatized person/s and becoming traumatized. The following excerpt illustrates this point:

S.CP: " allows some distance from the procedure...you know the stages so you don't get as emotionally involved."

However, as much as the structure allows for a kind of therapeutic distance, a disadvantage of this structured process is that it can cause the trauma debriefer to experience secondary trauma symptoms as a result of the detailed and graphic information required, especially in the fact phase. This phase needs to be well facilitated as it lays the foundation for the thoughts and feeling phases. The thoughts and feeling phases allow for emotional expression and ventilation, which is an important aspect of recovery when using the CISD model. The theme of secondary traumatization is discussed later in this chapter.

5.5.2 The phases of CISD

This sub theme deals with the phases of this intervention method. Participants were asked to comment on the easiest and difficult phases of this method. They responded by stating that the fact phase and even the stress reaction phase were easy to facilitate. However the phases that were considered to be difficult to facilitate included the thoughts and feelings phases. One participant stated that although this model separates the thoughts and feelings phases, people especially traumatized people are unable to do this. They are unable to differentiate between the two, namely their thoughts and feelings. An example of this is provided below:

T.CP: " Mitchell actually differentiates from the stage between perception and emotion, human beings don't. A lot of people think cognitively and feel cognitively, the way they think is supposedly the way they feel...emotion is expressed as a cognition."

T.CP: " that's how he interprets it...if you handle the fact phase very well you'll get everything right to the end...which is impossible when dealing with a person who is traumatized."

The participants further indicated that they often mix the two stages when doing CISD in order to accommodate for the traumatized police officers that are having difficulty discussing their thoughts and feelings. Participants suggested that trauma debriefers need to be flexible when facilitating this model, especially the thoughts and feelings stages. The following quotation illustrates this:

R.IP: " I just facilitate the process of whatever is happening but make sure that everything is covered in that. Even if its one big step, if I combine the thoughts and feelings into one big thing, its fine."

However, it must be noted that most of the participants found this method of intervention relatively easy to implement due to the intensive training they had under gone to conduct debriefing sessions.

T.CP: " ...the model itself is very easy to facilitate because I think that when we go for our training process, when we were learning how to use Mitchell's model, its quiet intensive".

5.6 Modifications/adaptations to the CISD model

This theme discusses the modifications or adaptations that the participants have made to the model when they use it. From the participant's responses, the only change that has been made in terms of the phasic structure of the model is the combining of the thoughts and feeling stages into one stage. The following excerpt illustrates this factor:

T.CP: " I will combine...the cognitions and emotion stages."

Other than the change in terms of the "thought and feeling" phases of CISD, most participants adapted the model to the needs of the traumatized individuals as illustrated by these excerpts:

T.CP: "I will stick with...with whatever they need at that time but I will use Mitchell's model as a guideline to ensure all aspects of the trauma incident..."

S.CP: " but I omit some of them (phases) depending on what the client needs but not changed specifically."

Participants also indicated that the modifications and adaptations that were made to this method were based on their own experience as a trauma debriefer and a psychologist. However, Kenardy (1998) argues that there is a need for researchers to examine the parameters effecting psychological debriefing. This researcher stated that there is heterogeneity of debriefing methods with their own protocols that have developed from older methods without the evaluation of either. Hence it is difficult to determine the adequacy of one method over the other. Protocols of methods that are assumed to be useful and appropriate are maintained based on clinical experience rather than empirical evidence. Therefore modifications and adaptations of the CISD method may be helpful for intervening with traumatized police officers, but then can the method still be called CISD? The following quotations illustrate the participants' responses:

S.CP; " ...it's a bit hard to stick strictly to Mitchell's model. A lot of therapeutic techniques, your own clinical observation, all of those come into play..."

S.CP: "I think from experience you pick up techniques along the way"

The participants also assert that a combination of the CISD method and the neuro linguistic programming method (NLP) work well. The aspects that are used from the NLP method include the relaxation and the forward and rewind technique in order to process the mental images of the traumatic experience and reduce the anxiety associated with these particular images. After the use of the NLP techniques, some aspects of the CISD model are used with the traumatized person, namely the psycho education aspect relating to the stress reactions and coping (the teaching phase). The following are examples of this:

T.CP: "...I use the guidelines of Mitchell's model in terms of getting all the information from the facts...and then move to neuro linguistic programming which is basically putting the person into a state o relaxation...mentally using mental images ...and then go back to talk about the stress aspects, talk about the effects of trauma...looking at stress management as well..."

S.CP: " ...you ask them to think about the story and go through it in their mind as if it were a video and rewind it, forward wind it..."

Another adaptation to the CSD method is the use of drawings to obtain a better idea of the scene that the traumatized police officer is discussing. Often traumatized individuals forget details of the experience when talking about the event. The drawing helps them to remember information that may be forgotten. On the other hand, the trauma debriefer may also be overwhelmed by the amount of information coming through and may experience difficulty in remembering all the details of the experience. They may even forget significant details that may need to be dealt with later in the trauma debriefing session. As a result participants in the study have used drawings done by the traumatized individual/s to get a better perspective of the traumatic incident and also it helps them to remember the details discussed. The drawing may also allow other traumatized individuals within the group to take note of the position and activities of all involved in the incident thereby reducing the possibility of conflict and blame. In other words, it may serve to increase the solidarity of the group. The following quotation illustrates the use of drawings:

A.IP: "...I use a white board and marker to kind of give me an idea of where and what place and stuff like that and in terms of the scene...you getting an accurate picture..."

Participants assert that they have also used relaxation strategies during the stress management phase or at the end of the session. These are practical exercises that are done with the traumatized police officer/s so that they know how to conduct a similar exercise when they go away. Furthermore, the conducting of the relaxation exercise also makes the police officers feel the immediate effects of using a relaxation strategy. It is not something that is theoretical but practical for the traumatized police officer/s. They leave the session, empowered with skills to cope rather than feeling as though they have just talked about the incident. The following are examples of this:

A.IP: " Ja, you do something so they know that there are things that can be done that actually

work because this one here is remarkably relaxing, it is a relaxation exercise but it really does work, they feel it."

H.EP: "ja, relaxation exercises... at the end...with music sometimes, just to allow them to relax and close their eyes and do a whole lot of exercises with them."

The participants felt that an adapted version of CISD would work well with traumatized police officers. When taking into account the diversity of police personnel, a verbal method of intervention like CISD might not always be applicable. Participants stated that a combination of CISD and NLP might work better for those traumatized personnel that are less verbal or have difficulty expressing their thoughts and feelings. The participants also feel that this combination might be effective when used for those that are continuously exposed to traumatic incidents. The following excerpts illustrate this:

S.CP: " I find that by and large Mitchell's model, or sort of an adaptation of Mitchell's model works best."

S.CP: " ...neuro linguistic programming works quiet well especially with people who are not verbal...I think with repeat trauma and people that are not as verbal..."

5.7 Timing of the intervention

The timing of the intervention is another important factor when using the CISD method of intervention. Mitchell (1983, as cited in Armstrong et al., 1991) stated that one or two trained mental health professionals facilitate the debriefing process 24 to 72 hours after the incident. This time is the original time period that was designated for the CISD method. According to The National Trauma Committee of the South African Police Service (1998), trauma debriefing for police personnel must be done within three days. However over time many practitioners have deviated from this.

Arendt and Elklit (2001) argued that when considering the time period in which psychological debriefing should take place, the 24-72 hour time period is criticised as being too soon as it may be harmful. The fact that debriefing should take place within this time period has not been substantiated. They argued that the reason for this time period was probably due to the fact that

psychological debriefing originated within professional organisations where the possibility of personnel experiencing traumatic events was high. Furthermore such personnel were expected to get back to work as soon as possible, hence the 24-72 hour time period. The results of their analysis are similar to the responses of the participants.

Participants reported that the time period of 24 –72 hours is not appropriate and it might be too soon to intervene. Some participants stated that the intervention can take place after 24 hours but it should not be restricted to 72 hours. Traumatized officers are still in a state of shock and they have not had time to process the incident or to experience any symptomatology. As a result, if a debriefing is done too soon they might not benefit from it due to them still being in a state of shock. In addition, when the stress reactions are discussed or the symptoms normalised, it might not make much sense to then, as they have not begun to experience any symptoms as yet. It should also be noted that post trauma symptom presentation can be immediate or delayed. However, within the organization like the SAPS where there is a continuous exposure to trauma, participants feel that a time period is necessary but it should not be limited to 72 hours The following excerpt illustrate these issues:

R.IP: " ...too soon after the incident, their minds or brains haven't had time to process what has happened. Ja...and they understand more what you are talking about if you saying look you going to have nightmares and flashbacks. They'll know its true because they've had it for the past two nights and if you catch them when they didn't even have any symptoms, they going to think you talking nonsense because they will say they haven't experienced it as yet."

T.CP: " ...but in an organization like the SAPS where they have trauma on a constant basis, I think they need to have a time period but not necessarily 72 hours."

Participants also reported that there are practical aspects that need to be considered such as injuries before a trauma debriefing can be done. Therefore if the period for debriefing is later it will allow for such practical issues to be addressed. However, one of the participants stated that if the person comes in after a week then it should be more therapy rather than trauma debriefing. However, this is in contrast to what was suggested by Arendt and Elklit (2001). These researchers indicated that debriefings should take place between 1 to 10 days after an acute crisis and 3-4 weeks after a major disaster. The following excerpt illustrates this:

T.CP: " ...any time after 24 hours but not limited to 72 hours...because often people are injured and they need recovery..."

S.CP: " longer than a week...needs more in depth, it goes into the realm of psychotherapy more than just CISD."

5.8 Competence and flexibility of the trauma debriefer

This theme deals with the competence and flexibility of the trauma debriefer conducting the debriefing sessions. This is of vital importance because if the trauma debriefer is not skilled or flexible at facilitating the session, it can enhance the traumatized individuals' feelings of distress and create a negative perception of the trauma debriefing process. Furthermore, the characteristics of the person conducting the debriefing can also impact on the process of debriefing (Arendt & Elklit, 2001; Colley, 1995). Colley (1995) highlights particular characteristics that a successful debriefer should posses. These include emotional maturity, good verbal and non-verbal communication skills, empathy, acceptance, sincerity and basic assessment and referral skills. If such characteristics are not present or if a debriefer is unable to use the model of debriefing correctly, this will have a negative impact on the outcome of psychological debriefing.

Participants stated that debriefing is effective when a competent person does it. The participants felt that the use of counselling skills and therapeutic experience is an important background when conducting a session. Furthermore, participants assert that if the trauma debriefer is just following the manual without using these skills, it may seem like the debriefer is just going through the stages without displaying a genuine concern or empathy for the traumatized individual/s. The following excerpts illustrate these issues:

R.IP: " ...if a person who flows the model is not really experienced or if they don't have any counselling background...and doesn't do all the other counselling things like empathy...it is not going to be effective."

S.CP; "I think its inflexible to stick to the manual and just go through the stages because I think it makes the process very stilted...the client doesn't always feel like you empathizing with them when you relate to them. They feel like you doing what you've been trained to do...like you

reading a book..."

It is therefore imperative that when training trauma debriefers, it should be people who have necessary counselling skills or they have mastered these skills before conducting a trauma debriefing session.

Leadership of the debriefing process is another factor that has deviated from the traditional format. Arendt and Elklit (2001) stated that when the original team concept is followed, this results in positive effects in contrast to when volunteers and non-professionals are used. The original team concept included professional therapists and trained peers of these helpers. This further emphasizes the importance of people ensuring that the trauma debriefers have the necessary skills to conduct trauma-debriefing sessions. Participants alluded to the fact that people that are trained as trauma debriefers in the SAPS need to be selected carefully. One participant further stated that it is about being a therapist by profession and then trained in the CISD model. This would ensure that trauma debriefings are done competently. The following excerpts illustrate this:

J.CP: " ...because you can't take anyone and expect that person will do justice to these people...train any Tom, Dick and Harry to do such intervention. Obvious to some extent it can be very damaging to them."

S.CP: "...you need to be a therapist not just a debriefer to be able to carry out Mitchell's model and find the most benefit from it... I've seen debriefers who are not therapist by profession, people purely trained as a debriefer...mangle the entire system and sometimes do more damage..."

5.9 Secondary traumatization

This theme discusses the impact that the use of the CISD model has on the trauma debriefers. Given that the fact phase of the CISD model requires as much detail as possible, it is not unlikely that the trauma debriefers will be affected by the content that is facilitated. As a result trauma debriefers can experience various negative effects that impact on their personal and professional lives such as anger, pain, frustration, sadness, shock, suspiciousness and distress (Steed & Downing, 1998). Similarly, Jonas (2003) conducted a qualitative study within the SAPS

regarding the impact of trauma debriefing on the trauma debriefer. The results revealed that these trauma debriefers were exposed to trauma on a secondary level and as a result developed emotional, psychological and physical symptoms. Although none of the participants reported any particular symptoms of secondary traumatization, they did acknowledge that they have been affected by stories of traumatic incidents as relayed by the traumatized individuals. This not only depends on the detail given in the description of the incident/s but also on the type of incidents that are described. Furthermore, participants also report that the more gruesome the nature of the incident, the more it can have an impact. The following excerpts illustrate these issues:

T.CP: " ...the fact phase is expected to be quiet in detail...with Mitchell's model where you need to ask every necessary nitty gritty information..."

S.CP: '.I think it depends on the nature of the incident and how graphic the person is able to describe it."

T.CP: "...a bit unnerved after certain incidents... especially involving little children...or some that is core gruesome..."

Participants further stated that when details of the traumatic event are described, they tend to form their own images of the scene and this has affected some of them emotionally. The following excerpts illustrate these issues

T.CP: "...because of the fact that Mitchell's model is seen to get the complete facts, you will form a visual image. You, yourself as a therapist will tend to form a visual image...it can be quiet unnerving, especially when you given detailed descriptions and colours...'

A.IP: " ...it does affect you emotionally because you ask yourself how do members go through this time after time...'

J.CP: "...the individual is willing to give such details or the specifics of the incident...to some extent you feel that you are emotionally exhausted."

However, participants asserted that this is an occupational hazard and that because this is a verbal method of intervention, vicarious traumatization is expected. Participants felt that trauma

debriefers need to have a coping strategy in place to deal with their feelings. Some participants use family members or other trauma debriefers as a source of support. The most important thing is that vicarious traumatization should be expected as part of their job but they need to have some coping strategy in place to deal with the effects. The following excerpts illustrate these issues:

S.CP: " But I think it's an occupational hazard as a therapist...and you need to be aware of it and deal with it. So yes there have been incidents were I have felt secondarily traumatized during the trauma debriefing process...are not too many ways to deal with that if you following a verbal method of intervention."

H.EP: "...I went home and talked with my husband about it and it sort of eased it because it was a very bad traumatic incident..."

T.CP: "...I would be unnerved in the session but then I have an effective way of de traumatizing myself. So I'll use my de traumatizing method and if you don't have something in place, it can affect you."

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.1 Introduction

This chapter discusses the conclusions that were drawn from the analysis in Chapter 5. Recommendations are made based on these conclusions. The rationale of the study was to explore the perceptions of the SAPS trauma debriefers who use the CISD model with traumatized police personnel. The findings and implications of this study are listed below, and this is in relation to the research question of the study.

6.2 Conclusion

Critical incident stress debriefing has long been the subject of much controversy in academic literature due the various inconsistencies in terms of its efficacy. The reasons documented for these inconsistencies range from methodological flaws to the characteristics of the traumatized person and the trauma debriefer (Arendt & Elklit, 2001; Colley, 1995; Eid et al., 2001; Moran, 1998). Nevertheless, this method of intervention is widely used in intervening with traumatized individuals, especially those with occupations that place them at risk such as emergency services personnel (Berman & Davis-Berman, 2005; Kenardy, 1998). As discussed in Chapter two, such occupations where employees are in close contact with the clients or customers that they serve, the risk of violence and hence traumatic exposure is increased (Brough, 2005). As a result such organisations have adopted various preventative measures for those employees that may be traumatized (Sacks, Clements & Fay-Hillier, 2001).

Within the SAPS, exposure to stress and trauma is an unavoidable consequence of being a police officer (Brown & Campbell, 1994; Gulle, Tredoux & Foster, 1998; Kopel, 1996; Stephens, 1996; Violanti, 2001). As a result the SAPS has implemented the CISD method not only as a way to help traumatized police officers cope with their experiences but also to act as a preventative measure against Post Traumatic Stress Disorder and other psychological consequences. Studies that have been conducted within the SAPS regarding the efficacy of this method have revealed that there are positive benefits to using CISD (Chabalala, 2005; Colley, 1995). However, the studies that have been conducted, generally and within the SAPS have based their results on the experiences of the traumatized victims. This therefore stimulated the researcher's curiosity about

the use of CISD from the perspective of the SAPS trauma debriefers. As a result the researcher explored the perceptions of these trauma debriefers about CISD and by extension the efficacy of this method within the SAPS. The following conclusions can be drawn from this study:

- CISD is a safe and consistent method for intervening with traumatized police officers. It is a method of choice for conducting group trauma debriefing sessions as a result of particular group dynamics, namely the provision of support by other group members, the verbalization of the experience, group cohesiveness, and the normalization of emotions and symptoms. This method is used as a preventative tool and as a result has yielded mostly positive results. Furthermore, the process of CISD has a cathartic effect for these traumatized police officers. Although this method can be used with both police officers and support personnel, it is better suited to police officers, especially new and inexperienced police officers as compared to older and experienced police officers. This is not to say that it is not beneficial for older and experienced officers but rather an alternative method should be used with these officers due to the possible effects of over exposure to the intervention method as well as the fact that they may have learned to develop their own ways of coping as a result of their experiences. Furthermore, this method is more suitable for intervening with police personnel that are better able to talk about their traumatic experiences. CISD seems to be better suited to intervening with intermittent traumatic exposures rather than continuous exposure. There is uncertainty about whether CISD would be better suited to dealing with the different levels of severity of the traumatic event. However, it seems that it may be more suitable to intervene with less severe and gruesome traumatic incidents. Finally, the method is most effective when police officers are given an option to be debriefed as compared to when they are forced to attend.

- There are certain aspects of CISD that are considered to be helpful within the SAPS. These include the opportunity to talk about the incident and put it into perspective, the psycho education regarding the stress reactions and coping, the normalization of stress reactions and emotions and the overall support that is shown during this process by both the trauma debriefers and the other officers within the session. The screening function of CISD is also considered to be helpful in identifying police officers that may need further assistance.

- Overall, the structure of the model has beneficial effects for both the debriefer and the traumatized officers. Even though there are some disadvantages, the advantages make this method a benefit to the SAPS. All phases of the model are easy to implement due to the intensive training of the trauma debriefers. The combination of the thoughts and feeling phases of the CISD method tends to produce positive results but this also depends on the debriefer's flexibility and experience.

- Modifications and adaptations to the CISD method can be helpful but these need to be done by experienced debriefers and therapists. The use of drawings might be useful technique for both the debriefer and the traumatized police officer. Such a technique may help in making sense of the incident but at the same time drawing of the pictures may also increase the risk of re traumatization for the police officer and secondary traumatization for the debriefer. The practical application of relaxation exercises during the stress management phase or at the end of the session gives rise to more positive results as compared to when information is just disseminated. Furthermore, police officers are inclined to feel that they have received something from the session other than just talking or ventilation and this in itself will emphasize that the police officer can take control of his symptoms and life. It also seems that a combination of CISD and NLP works best for both verbal and less verbal police officers and this should be investigated.

- In terms of the timing of the intervention, CISD provides a more positive effect when it is conducted after 24 hours but not limited to 72 hours. Furthermore, the competence, skills and experience of the debriefer are important in ensuring a positive effect of a trauma debriefing session. Therefore trauma debriefers need to be carefully selected within the SAPS and they need to be competent in implementing this intervention.

- Finally, the detailed process of the CISD method can result in secondary traumatization for the trauma debriefer but this is an occupational hazard that debriefers need to be aware of and expect. However, it is important for the debriefers to develop the necessary coping strategies in order to deal with their own reactions.

6.3 Recommendations

In light of the above conclusions the following recommendations are made:

- As an intervention method for group trauma debriefing, CISD is suitable and effective and therefore it should be used mostly to debrief groups. An adapted form of this method or an intervention specifically designed for individuals should be used when conducting individual trauma debriefing sessions. However, other professional therapists should first scrutinize any adaptations that are made before it is used. The use of these adaptations should be substantiated not only through clinical experience but also by literature as well. This is to ensure that the adaptations are valid and beneficial.

- An alternative intervention method that is specifically designed for dealing with people that experience continuous trauma needs to be investigated.

- The NLP is an effective method when it comes to intervening with less verbal traumatized police officers. It is also an important method that can be used to deal with post trauma symptoms such as the flash backs and intrusive images and memories. It can help to make such images less threatening and hence eliminate the anxiety and fear elicited by these images, facilitating better coping. This needs to be explored further.

- The intervention should be conducted after 24 hours with traumatized police officers but it should not be restricted to 72 hours. As stated by Arendt and Elklit (2001), it is now suggested that debriefings should take place between 1 to 10 days after an acute crisis and 3-4 weeks after a major disaster. Therefore the appropriate time of intervention should be investigated and tailored to the environment of the SAPS.

- The selection of trauma debriefers within the SAPS is another factor that needs to be carefully investigated. Not all professionals within the SAPS have the necessary skills to conduct such sessions, therefore the selection and training of trauma debriefers should include those that have some counseling experience but also who are able to adequately use their skills and flexibility in conducting debriefing sessions.

- It is also recommended that trauma debriefers have appropriate coping strategies in place to help them to cope. The development of a support structure among debriefers at different areas and stations might also be beneficial.

- The introduction of practical stress relaxation techniques at the end of the session can be beneficial but this should not be done indiscriminately as the various traumatized individuals have different needs. For some the need to talk might be their primary concern, so in such situations the traumatized person/s could be given an option to come back, during which time the relaxation exercises can be done with them. This can be done a few days after the debriefing session.

- Finally, it is recommended that trauma debriefers be equipped with alternative methods to debrief police officers or taught various techniques that will assist in debriefing sessions. Such techniques could for example include behavioral exposure–based techniques as discussed by Williams and Sommer (1994) or various other CBT techniques to address trauma symptomatology. This issue still needs to be investigated.

6.4 Limitations of this study

- While this qualitative approach provided a wealth of data, the results of the study cannot be generalized beyond the context of this study as the study reflects the experiences of only six trauma debriefers who are psychologists. This is a small sample of psychologists who are representative of psychologists in the Durban and Pietermaritzburg areas but it excludes the many other professionals who are trauma debriefers within the SAPS, namely the social workers and chaplains. The ability to generalize from the results of this study is therefore reduced.
- The influence of the researcher or the researcher effect is another area that needs to be taken into account when analyzing results of this study. The research participants know the researcher who is also a trauma debriefer employed by the SAPS. As a result the researcher could have had a subtle influence on results obtained. For example, participants may have felt that their skills were being analyzed, rather than the research being an evaluation of the tool that they use. Henceforth, they would seek to impress by providing what they perceive as best possible answers. This is elaborated under "social desirability" and researcher reflexivity below. The coding in qualitative content analysis

is an inductive process whereby codes are selected according to the meaning of the data to the researcher (Henning et al., 2004). This implies a certain subjectivity of the researcher when the data was analyzed as the development of the codes was left to the researcher's discretion.

- Another area of concern, which may have an impact on the results, is the social desirability effect. Crowne and Marlowe (1960) define social desirability as the need to obtain approval by responding in a culturally appropriate and acceptable manner. In social research, it is not unknown for respondents to always try to give answers that make them seem well adjusted, open minded and democratic. This suggests that participants may give answers that presented them in a positive light without revealing their own shortcomings in the application of the CISD method.
- Another limitation is the failure of this study to question the impact that cultural diversity has on the use and suitability of the CISD model. Participants were not asked about this aspect during the interview. This is particularly important as it has implications for the use of this model in the SAPS given the fact that trauma debriefing is done with police officers from various cultural backgrounds.
- According to Silverman (2000) when interviews are tape recorded and transcribed, the reliability of the interpretation of the transcripts may have been weakened due to the possibility that apparently trivial but important pauses and overlaps may have not been recorded or regarded as important. In this study the researcher himself recorded and transcribed the interviews.
- In the context of these limitations, further research, involving large and representative samples drawn from the general population would be needed in order to assess the generalizability of the present findings.

6.5 Researcher Reflexivity

As indicated above, in qualitative research, is it important for researchers to reflect on their potential influence on the process of conducting research. Ribbens and Edwards (1998) advocate for the use of principles of feminist research methodology such as (reflexivity, power, participants' voices, researcher's voice, and emotions etc.) focusing on the relationship between the researcher and participant. By uncovering how the researcher and participants perceived their roles in the research process, and how comfortable they felt with disclosing information, the feminist principles provide a valuable tool for enhancing validity. Even though this particular

study was not conceptualized along a feminist paradigm, these issues are important to explore. Key issues emerging from this particular study included the tension experienced by the researcher in identifying his role in the relationship. Roles were in conflict, for example, whilst the researcher might claim to be a neutral observer, he was simultaneously a member of a social group (SAPS employee and counselor), which he shared with the interviewees, and at the same time he was a researcher involved in collecting data for his study.

Participants' perception of the researcher as a professional may have influenced the information disclosed during the interviews. Ribbens and Edwards (1998) suggest that research participants, irrespective of their professional status, operate at the public level of disclosure, reflecting social norms or expectations, and may see the researcher as a 'moral audience'. In order to avoid this, the researcher made conscious efforts not to let his professional role interfere with the process, and was willing to receive and analyze the information obtained as objectively as possible. This was done in order to encourage participants to disclose their personal feelings without feeling that they were judged.

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APPENDIX A

INTERVIEW SCHEDULE

CISD forms one part of the four phase model of trauma management within the SAPS, namely on scene debriefing, initial debriefing, formal debriefing and follow up. In particular the CISD model that is used to conduct the formal debriefing will be explored.

For how long have you been using the CISD model with police officers?

Do you use it with individuals or groups?

With which do you think that it is the most effective, groups or individuals? Please elaborate

Are there any differences in your approach when you apply the model to groups and/or individuals? Elaborate

Do you conduct follow up sessions/interviews with those police officers that have been debriefed? (If yes, how and when is this done? If no, is there a particular reason?

What is it about the debriefing that is reported to be particularly helpful?

Are there certain aspects of the debriefing that you think are particularly helpful?
(talking Vs support Vs Information on stress and stress reactions)

Do you follow the set manual or do you sometimes find the need to improvise? Elaborate

Are there other therapeutic modalities (e.g. CBT etc.) that you use in conjunction with the CISD model? Explain.

What are the advantages of using this model with police officers?

What are the disadvantages of using this model with police officers?

Do you think that the CISD model is effective when used with police officers? Elaborate

Are you happy with the outcomes of using this model with police officers?

Do you think that this method of intervention is necessary for police officers to cope?
(Are there other factors influencing coping?)

What are the responses of police personnel to trauma debriefing sessions using this model?
(commanders Vs juniors, older members Vs new recruits) Elaborate
Do you use CISD as a prevention strategy or as a therapeutic tool? Please explain.
(PTSD Vs other long term psychological sequelae)

Are there phases/stage of the CISD model that you find difficult to facilitate? If yes, please explain.

Are there phases/stage of the CISD model that you find are much easier to facilitate? If yes, please explain.

What do you think is the most appropriate time period to intervene after a traumatic incidence when using this model? *Prompts: 24-72 hours, days later, weeks later*

Have you made any changes or modifications to this model when you use it? Elaborate

How has the use of this model as an intervention tool with the traumatized police officer/s impacted on you? (Physically, psychologically and emotionally)

Do you think that this model is better suited for certain types of traumatic incidents rather than others?

Do you think that this model is better suited for certain types of people rather than others? *Prompts: Police officers Vs Civilian members*

What do you think about the research that has been done on the efficacy of this model as an intervention tool? (What do you think are the reasons for these inconsistencies?)

Is this your intervention of choice or would you rather use something else? Elaborate.
Prompt: Which intervention tool would you prefer to use with traumatized police officers?

APPENDIX B

PROFILE OF RESPONDENTS

The profile of the sample included:

Participant 1: is a 35-year-old Asian female who has been conducting trauma debriefing using the CISD method for the past 9 years. She is a counselling psychologist. This participant was coded as T.CP.

Participant 2: is a 34-year-old black female who has been conducting trauma debriefing using the CISD method for the past 6 years. She is a counselling psychologist. This participant was coded as J.CP.

Participant 3: is a 42-year-old Asian female who has been conducting trauma debriefing using the CISD method for the past 5 years. She is an educational psychologist. This participant was coded as H.EP.

Participant 4: is a 36-year-old white female who has been conducting trauma debriefing using the CISD method for the past 9 years. She is an industrial psychologist. This participant was coded as R.IP.

Participant 5: is a 32-year-old Asian female who has been conducting trauma debriefing using the CISD method for the past 6 years. She is a counselling psychologist. This participant was coded as S.CP.

Participant 6: is a 30-year-old Asian male who has been conducting trauma debriefing using the CISD method for the past 6 years. He is an industrial psychologist. This participant was coded as A.IP.

APPENDIX C

SAP 51

SUID-AFRIKAANSE POLISIEDIENS

SOUTH AFRICAN POLICE SERVICE

Privaatsak X94 Telegramadres KOMPOL
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Verwysing Reference	0465898-1
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THE SECTION HEAD
PSYCHOLOGICAL SERVICES
SPORT AND RECREATION
HEAD OFFICE

PRETORIA

0001

7 June 2007

THE PROVINCIAL HEAD
EMPLOYEE ASSISTANCE SERVICES

REQUEST TO CONDUCT RESEARCH WITHIN THE SAPS: 0465898-1 INSP K PILLAY

1. The written request written by the above-mentioned member dated 2007-05-11 refers.

2. It is requested that the member provide this office with the complete research proposal and a written motivation as to how this research may add value to the South African Police Service.

3. The methodology of Formal Debriefing training is currently changing. Research is urgently needed as to evaluate the impact of the new method of training which will start in September 2007. This research will be ground breaking and valuable to Trauma Management.

4. This research is suggested to the member as an alternative to the current research request due to the usability of such research findings.

5. The member's original or alternative research proposal is eagerly awaited.

DIRECTOR
SECTION HEAD: PSYCHOLOGICAL SERVICES
SPORT AND RECREATION
DR A GROBLER

APPENDIX D

CONSENT FORM

THE SAPS CRITICAL INCIDENT STRESS DEBRIEFING MODEL: TRAUMA COUNSELLORS PERCEPTIONS

Aim of the research: This research is being conducted by the School of Psychology at the University of KwaZulu-Natal, Durban, and is designed to explore the perceptions of trauma counselors within the South African Police Services with respect to the model of critical incident stress debriefing that is currently used within the SAPS.

Project members: Zethu Memela (supervisor) and Krishen Pillay (Researcher)

Contact details: Telephone: 031-2607428 Monday to Friday (8:30am to 16:00pm)

1. The aims of the research project have been explained to me and I have been given the opportunity to ask any questions that are related to this project in respect of the goals, participation and the results of the project.

2. I full understand that my participation in this project is entirely voluntary and should I wish to withdraw from this project at any time, I am allowed to do so.

3. I understand that the interview will be tape-recorded and that it will be transcribed and translated at some later stage at the University of KwaZulu-Natal. No one will have access to the tape recordings apart from the members of the research team.

4. I understand that the information that I provide will be treated in confidence and that any discussions, reports papers resulting from this study, will include any identifying information such as my name or my address.

5. I am free to choose not to answer any questions asked by the interviewer.

6. I understand that there is no compensation of any kind in respect of me participating in this project.

7. I declare that I am freely participating in this project and that the conditions as stated above are fully understood and agreed to.

Signature ..... Name..... Date.....

APPENDIX E

CRITICAL INCIDENT STRESS DEBRIEFING (CISD)

The CISD model is often used in isolation as an intervention with traumatized victims. It is a structured group discussion that is composed of seven stages (Armstrong et al., 1991; Berman & Davis-Berman, 2005; Campfield & Hills, 2001; Chabalaba, 2005; Loo, 2001; MacDonald, 2003; Smith, 2006). The seven stages of the CISD model will now be discussed below.

Phase One: Introduction

During this phase the participants are given a clear explanation about the purpose of the session and it is differentiated from other types of debriefing processes such as an operational debriefing. Group participants introduce themselves and the stage is set for what is to follow further on. Rules of the session are discussed and these include respect, confidentiality, and the debriefing process and participation during the process. Voluntary participation is raised although the importance of attendance is emphasized. The aim in this phase is to establish the rules, create structure and for the debriefers to establish rapport with the participants.

Phase Two: Fact phase

The purpose of this phase is to collect the facts of what had taken place. It is also important to elicit information regarding the occurrence of the event from each participant's point of view thereby building up a comprehensive picture of the incident. This phase focuses not only on what was seen but also on the other senses such as touch, taste and smell. Each person would be given an opportunity to talk, thereby providing a unique perspective of his or her role at the scene. This may also help group participants to be aware of the other group participant's actions that they were not aware of.

Phase Three: Thought Phase

Participants are asked to describe their thoughts before, during and after the incident. This personalizes the incident for each individual. This is a transition into the emotional processing of the incident. This is a difficult process for the participants and it is therefore important for debriefers to pay particular attention to the impact that the incident had on the group so that

themes could be identified as the participants discuss their thoughts. According to Chabalala (2005) this means that the debriefer should ideally be trained within the behavioural sciences in order to understand the group process and to reflect it properly. The themes that are identified are reflected to the group and normalised.

Phase Four: Reaction or Feeling Phase

This phase aims to elicit the emotional reactions of the participants to the event. It covers the emotions experienced during and after the incident as well as what was the worst part for each participant. Emotions such as anger, guilt, frustration, fear, helplessness, shock, sadness, despair and ambivalence can arise. An important aspect of this phase is that the feelings that are discussed by each participant are reflected to the group and normalized.

Phase Five: Symptoms

This phase aims to elicit the various physical, emotional, cognitive and behavioural signs of distress that could have arisen during and immediately after the incident, some times days or weeks after the incident. Symptoms currently experienced are also discussed. Here again, the normalcy of the symptoms is emphasized. According to Chabalala (2005) this will reduce feelings of loneliness and strengthen group solidarity. The debriefer will also use their knowledge of typical stress reactions to encourage the group to share their experiences.

Phase Six: Teaching Phase

During this phase the debriefer's role is to again emphasize the normalcy of the group participants' reactions and to provide education in terms of stress reactions that may currently be present or that may arise in the future. Smith (2001) states that this educative aspect is aimed at helping the traumatized people to understand the stress reactions that are being experienced and to normalise the experience of these unusual symptoms and reactions. Furthermore education regarding coping strategies and community resources may also be provided. Any positive aspects that had arisen from the incident should also be highlighted.

Phase Seven: Re-Entry

The last phase involves the closure of the session. It involves answering any questions that may arise regarding the debriefing process and further counselling. The future plans of the traumatized group are explored, for example going to the memorial service (should there have been a life lost during the traumatic incidence). This phase can also be used as an opportunity for identification of individuals for further referral to specialist mental health professionals and for discussing follow up session(s). Leaflets with additional information that will be of benefit to participants can also be distributed during this phase.

THE SAPS DEBRIEFING MODEL

On Scene Debriefing

This is conducted at the scene of the crisis and is referred to as psychological first aid. The duty officer or senior officer on the scene facilitates this process. It involves an informal discussion of the traumatic event. The support provided is aimed at attending to the psychological and physical needs (blankets, food, water and protection) of the traumatized police officers. Furthermore, during this process a normalisation of experiences and emotions can occur. In order to ensure protection of the traumatized police officers, such police officers may be removed from the scene to minimise the risk of secondary traumatization. This can range from transporting the officers to hospital to making telephone calls on behalf of the victim (Chabalala, 2005).

Initial debriefing

Initial debriefing and defusing are synonymous concepts (Botha, Watson, Volschenk & Van Zyl, 2001). Initial debriefing refers to discussion of the events within five hours of the crisis (Colley, 1995) or at the end of the police officer's shift (Botha et al., 2001). It is a ten to twenty minute structured but informal discussion of the event. Evaluation of the crisis as well as normalisation of the experiences and emotions occurs. According to Chabalala (2005), the aim of this process is the provision of support and to re-establish the solidarity of the group. According to Botha et al. it is conducted by a trauma debriefer and more recently by trained commanders, officers on the scene. A trusting relationship between trauma victims and trauma debriefers develop. It is

also used as a screening measure for those who need to be referred for formal trauma debriefing or to a psychologist or psychiatrist for further trauma counselling.

Formal debriefing

This is a much more formal, structured and in-depth process as compared to the initial debriefing. This process is based primarily on the CISD model of Mitchell as discussed earlier (Chabalala, 2005). It is done between 24-72 hours after the crisis by a trained formal trauma debriefer (usually a psychologist, chaplain or social worker). Although traumatized police officers are voluntarily requested to attend, the South African Police National Instruction 18/1998 states that it is compulsory for every police officer involved in a traumatic experience to be given the opportunity for trauma debriefing. During this phase normalisation of experiences, emotions and symptoms are emphasized. A trusting relationship between trauma victims and trauma debriefers develop and there is the referral of critical cases to psychologists/psychiatrists.

Follow up

This involves a formal discussion that takes place within six weeks after the event (Colley, 1995). It is aimed at following up on the progress of the traumatized police officers. Further referrals are done to internal or external professionals if difficulties arise for these police officers.