The Experience of Vicarious Trauma by the Police Officers within the South African Police Service in the Limpopo Province.

By

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ABSTRACT

Police members of the South African Police Service (SAPS) work under constant physical, emotional and psychological stress due to the demands of their work. It is possible to assume that this profession could be more susceptible to trauma, depression and suicide ideation than a less demanding profession. The increase in suicides within the SAPS in the past years has created great concern worldwide. The literature review contributes to the understanding of vicarious trauma by providing evidence of its widespread existence and the impact on all professions that deal with trauma victims, as do the SAPS. A need for further research was highlighted. The aim of the study was to determine the prevalence of vicarious trauma within the SAPS; how rank, marital status, education, duration of service and workload affect the existence of vicarious trauma; and how the experience of vicarious trauma affects the lives of the SAPS member. A quantitative study was done with a sample comprising of 60 SAPS members from the Limpopo Province (Lebowakgomo and Mankweng stations). The inclusion criteria included: participants (both permanent and voluntary) had to be active, field working members of the SAPS and had to be in direct association with trauma victims. The conceptual framework: Trauma Theory guided the description and interpretation of the data. Findings revealed that there exist, at present, high levels of vicarious trauma within the SAPS. The duration of service and the marital status of the individual were found to have an influence on the existence of compassion fatigue, while rank, workload, education level and gender were found to have no direct relationship to the presence of vicarious trauma. Finally, this study concludes with recommendations for future studies into vicarious trauma within the SAPS.

DECLARATION

I declare that the mini-thesis is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other University.

SIGNED AT :_____ON THE _____DAY OF _____2008

_____ **_____**

C.R van Lelyveld **DATE**

DEDICATION

This mini-thesis is dedicated to my loved ones who provided unconditional support throughout my studies. A special thank you to my mom, Suzette Mary van Lelyveld, for being my pillar through it all. To the rest of my family, thank you for believing in me through the years and edging me on.

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TABLE OF CONTENTS

CHAPTER 1

ORIENTATION OF THE STUDY

1.1 INTRODUCTION

Members of the South African Police Service (SAPS) find themselves in constant physical, emotional and psychological challenging situations. Such situations make it possible to assume that professionals working within the SAPS too long could be more susceptible to trauma, depression, suicide ideation than professionals in less demanding situations.

The fact that police are usually the first people at a crime scene makes them first responders and crisis workers who absorb the traumatic stress from acute reactions of those they help (Beaton & Murphy, 1995). This puts them at risk of experiencing vicarious trauma, also known as compassion fatigue, police stress, secondary victimization, secondary traumatic stress, secondary survivor stress and Police Trauma Syndrome.

Few people realise how often police become exposed to traumatic stress incidents. With the occurrence of aggressive crime being on the increase, police officials often become victims of vicarious trauma through dealing with increased number of trauma related cases and trauma victims.

1.2 BACKGROUND

Pearlman (in Haskell, 1999) did a study on the occurrence and experience of indirect traumatization within the SAPS, finding that Police are vulnerable because of some aspects of the nature of the profession they've chosen. Some areas are more vulnerable due to their close contacts with survivors or victims of trauma. Those who work in areas

of child exploitation, victims of crime, major crash, major crime, psychology and welfare are affected by dealing with other people's trauma.

Manolias (1983) put forward the three reasons why stress in the police service should be given special consideration by the police and the public alike. The police fulfil an essential function in society. This requires an effective workforce and stress potentially undermines the effectiveness and efficiency of the police service. The consequences of police stress may have an adverse effect on the development and maintenance of good police relations within the public sector. There exists the possibility that police officers under stress can, in certain situations, constitute a real threat to themselves, their families, their fellow officers, the offenders they deal with, and the general public.

Most studies done on vicarious trauma focus on the 'helping' professions, consisting of counsellors, psychologists, social workers, crises workers, etc with very few having concentrated on the police community. Over the past two decades, numerous studies have recognized vicarious traumatization although some have referred to it in other terms, such as "empathic strain," "secondary victimization" or "compassion fatigue" (Catherell, 2005).

Members of the SAPS are often not considered part of the group that are targeted by vicarious trauma since they are considered tough and seasoned veterans in the field. This view is encouraged by the members of the SAPS since too many officers make the erroneous assumption that reacting to stress in their lives with emotions like anxiety and depression is a sign of weakness to be avoided, or at least hidden, at all cost. Thus warning signs are sometimes ignored (Brown, 2003).

Some police officers might employ avoidance strategies for coping with the traumatic conditions of their work. Avoiding material that is distressing, either by refusing to acknowledge any emotional effect or by pushing it away from awareness, is an understandable response to such significant stresses, especially when threats of violence and death, and encounters with citizens who have been physically and emotionally

traumatized continue to be experienced (Reiser & Geiger, 1984). However, this type of coping strategy (avoidance) may ultimately be maladaptive.

Aaron (2000) argues that officers who employ avoidance strategies to deal with their traumas are more likely to develop subsequent psychological or psychiatric difficulties than those who acknowledge the effect of stressors. This means that those officers who engage in the difficult process of confronting the distressing thoughts and painful feelings can expect healthier results. Thus, strategies that promote more open discussion of stressors, and willingness on the part of police personnel to acknowledge the effects of such stressors, will likely lead to a force of psychologically healthier officers who are more able to function effectively in their work and home lives (Aaron, 2000). Police stress in general has been ignored, misrepresented, and inadequately studied (Brown, 2003).

1.3 PROBLEM STATEMENT

Members of the SAPS are especially susceptible to vicarious trauma since their job deals with all the negative aspects of society. This constant exposure to traumatic and life threatening situations can possibly result in the psychological build-up of cynicism and negativism that come from continuous dealings with crime, criminals and the imperfect court system (Brown & Campbell, 1994).

In recognizing that the police officers are at risk for trauma, the South African Police Service authorities instructed that persons who were involved in trauma-related incidents (like shootings) be referred to helping professionals within the service for debriefing. Bruce (2000) noted that, in 1997 for instance, the SAPS provided 5329 psychological debriefings for police members. One rough estimate was that 70% of those debriefings were for members who had attended crime scenes or vehicle accidents, where a colleague had been killed or they themselves had been shot at. The other 30% of the debriefings were for SAPS members who had been involved in the use of force (Bruce, 2000).

Statistics obtained from the Crime Information Analysis Centre concerning crime in South Africa show that since April 2001 to May 2005, there has been an average of 20393 cases of murder, 30436 cases of attempted murder, 53641 reported rape incidences, 4879 cases of neglect and ill-treatment of children, and 11309 cases of culpable homicide per annum.

When one considers that a minimum of two police officers are required at each of the above crime scenes, one realises just how much exposure the members of the SAPS get to trauma while in the line of duty. Most of the above crime scenes involve gruesome situations, which must be inspected in detail by the attending police officers. The extended exposure to these negative scenes can easily develop into vicarious trauma if debriefing does not occur.

A study done by De Wet (2003) on The Intensity, Frequency, and Severity of Stress Items within the SAPS in the Northern Cape found that having to deal with crisis situations has the highest intensity (5,18), frequency (4,34) and severity (22,48) for the members of the SAPS in the Northern Cape. In the same study, it was found that 36% of the members of the SAPS feel that they are not being supported by Psychological Services. The above statistics show that there is a discrepancy between the amount of support needed by the police force and the amount of support they feel they are being provided.

1.4 SIGNIFICANCE OF THE STUDY

This research study is significant as it aims to highlight the stress and consequences of working in a life-threatening environment. By identifying this, it makes it possible for more successful intervention and prevention methods. This study is purposely directed at the SAPS since these people are responsible for our daily safety and we should therefore try, by what ever means possible, to look after them, both physically and emotionally.

Many studies focus on the helping professions (psychologists, counsellors, social workers) but scanty studies have been conducted to survey the impact of the fact that police members are regularly required to attend gruesome crime scenes and this makes them even more susceptible to vicarious trauma than those dealing with the victims. Police not only have to help the victims, but also face the crime scene and the criminals responsible.

1.5 RESEARCH QUESTIONS

The primary questions in this study were

- to determine what the prevalence is of vicarious trauma within the SAPS at present;
- whether a previous history of trauma makes one more vulnerable to experiencing vicarious trauma than an individual who has never experienced a previous traumatic situation;
- what professional factors influence the experience of vicarious trauma (for example, the duration of service, marital status, etc).

1.6 AIM OF THE STUDY

The aim in this study is to survey the extent of vicarious trauma within the SAPS and to check whether the existence of previous trauma experiences contributes towards negative emotive behavior within individual police officers and whether long exposure to violence has an influence on vicarious trauma.

1.7 OBJECTIVES OF THE STUDY

The objectives of the study:

- To explore the extent of vicarious trauma among the police.

- To determine whether the existence of previous trauma experience as an influence on the experience of vicarious trauma among police individuals.
- To identify what factors influence the experience of vicarious trauma.

1.8 HYPOTHESES

Hypothesis 1: Police experience vicarious trauma through exposure to traumatic situations in their line of work.

Hypothesis 2: The existence of previously experienced trauma contributes negatively towards the prevalence and experience of vicarious trauma within the police official's life.

Hypothesis 3: Various factors (e.g. longer duration of service) will increase the possibility of experiencing vicarious trauma.

1.9 CHAPTER OUTLAY

The chapters following will address the following aspects:

Chapter Two discusses operational definitions and literature pertaining to the development of the concept of vicarious trauma and various studies and information gathered over the years concerning the subject. The impact that vicarious trauma has on those suffering from it are detailed within this chapter.

Chapter Three will look at various existing theories and perspectives concerning trauma and its causes and effects. The theoretical framework that this research is based on is also described in detail.

Chapter Four sets out the details concerning this research. The sample is discussed, as well as the methods used to gather the data and how it was analysed in order to make conclusions.

Chapter Five reports back on the data gathered. Tables of data are given, including the Chi-Square values.

Chapter Six concerns the discussion based on the results of the data gathered. Each aspect is discussed in detail and conclusions and observations are made. Hypothesis's are confirmed or disproved.

Chapter Seven is a conclusion chapter where the limitations of this study and literature are mentioned, as well as recommendations for future research.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter will focus on operational definitions and existing literature as pertaining to the experiencing of trauma within the Police Services; the origins of vicarious trauma; its symptoms and effects that it has on their professions and what influences work satisfaction, burnout and vicarious trauma.

2.2 OPERATIONAL DEFINITIONS

- Vicarious trauma/Compassion Fatigue: a psychological phenomenon with rapid onset of symptoms that occurs when a human-being provides care to another human-being who has been traumatized and is comprised of two separate, but related phenomena, Burnout and Secondary Traumatic Stress. These effects are cumulative and will continue until intervention methods are introduced. For the purpose of this study, vicarious trauma is defined in relation to subscales within Professional Quality Of Life Scale (ProQOL R-III).

- Secondary Traumatic Stress: natural consequent behaviors and emotions that are the result of knowing about a traumatic event experienced by a person and the stress resulting from helping or wanting to help that person with rapid onset of symptoms.

- Burnout: a chronic state of emotional, physical, and mental exhaustion that intensifies over time and is caused by long term involvement in emotionally

demanding situations that has psychosomatic symptoms and may effect one's personal and professional life. For the purpose of this study, vicarious trauma is measured using the Professional Quality Of Life Scale (ProQOL R-III).

- Debriefing: a single session, structured intervention used to treat victims of traumatic events or those providing care for victims of a traumatic event in which participants are allowed to share feelings and thoughts on the traumatic event and are given information regarding stress reaction and stress coping.

2.3 EFFECTS OF VICARIOUS TRAUMA

Compassion Fatigue is the latest in an evolving concept that is known in the field of Traumatology as Secondary traumatic stress. Most often this phenomenon is associated with the "cost of caring" (Figley, 2003) for others in emotional pain.

According to Gentry (2005), one of the earliest references in the scientific literature regarding the cost of caring comes from Carl G. Jung when he discussed the challenges of counter transference — the therapist's conscious and unconscious reactions to the patient in the therapeutic situation — and the particular counter-transference difficulties analysts encounter when working with psychotic patients. Though Jung refers only to the effects of secondary trauma within a therapeutic setting, this eventually led to the identification of the factor vicarious trauma.

The study of the effects of trauma has promoted a better understanding of the negative effects of helping in crises situations. Psychological reactions to trauma have been described over the past one hundred and fifty years by various names such as "shell shock", "combat neurosis", "railroad spine", and "combat fatigue" (Catherell, 2005). However, not until 1980 was the latest designation for these reactions, posttraumatic stress disorder (PTSD), formally recognized as an anxiety disorder in the Diagnostic and Statistical Manual of Mental Disorders-III. Since then, research into posttraumatic stress

and the field of Traumatology has grown at an exponential rate (Figley, 1995; Wilson & Lindy, 1994).

Previous literature on vicarious trauma has largely focused on the development of trauma symptoms. Though similar to PTSD, vicarious trauma does not qualify for the official PTSD diagnosis because the exposure was secondary rather than direct. Instead, the individual has been said to be experiencing 'traumatoid state', also known as Secondary Traumatic Stress Disorder (STSD), vicarious traumatization, compassion fatigue or empathic strain (Gentry, 2005).

As the helping professions are increasingly called upon to deal with the survivors of violent crime, childhood abuse, torture, acts of genocide, political persecution, war, and terrorism, discussion regarding the reactions of all field of helpers (therapists, police, social workers, counsellors) to working with trauma survivors has recently emerged in the traumatology literature (Figley, 1995; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995; Stamm, 1996).

Research in the area of vicarious trauma has produced several generalisations about the effect of working with traumatized persons (Cornille & Meyers, 1999). First, researchers have found that professionals exposed to traumatic material experience the same array of traumatic stress symptoms as those reported by victims of traumatic events. Disturbed sleep, anger, fear, suppression of emotions, nightmares, flashbacks, irritability, anxiety, alienation, feelings of insanity, loss of control, and suicidal thoughts have been experienced by those working with trauma victims.

Second, a number of researchers have reported that similar to primary victims, the longevity and severity of symptoms that professionals experience varies from person to person. In particular, researchers have found a positive correlation between longevity of career, large caseloads, increased contact with clients, and long work hours and the longevity and severity of vicarious trauma symptoms.

There are certain reactions that have been identified in law enforcement members who are suffering from vicarious trauma. Most common are the presence of physical modalities (Janoff-Bulman, 1992). This is where the law enforcement personnel experience vivid sensory memories of the event during an anniversary reaction. These symptoms include sounds, smells, images, and tactile sensations. Individuals may become generally irritable and may have difficulty sleeping. There is also the presence of shattered assumptions (Slover & Tasci, 1999). This is where the individual's beliefs about the safety of the world and the faith in one's ability to protect one-self and others are challenged by traumatic events. Since the ability and desire to protect others are paramount to police work, the loss of this belief is generally destructive to many aspects of the police official's life. The police members comfort zones are shattered since critical incidents tend to be most traumatic when they cross into our comfort zones, places in our world that are supposed to be safe (Janoff-Bulman, 1992). Trauma can shatter these comfort zones, making all places feel unsafe.

Generally, police members experience crossover trauma, which occurs when an individual personalizes other's traumatic situation (Matsakis, 1992). If demographics between the victim and a loved one are similar, the potential for crossover trauma increases. The police official may begin second-guessing, this is where they replay the event over and over and question every decision (Matsakis, 1992). The police member may experience survivor guilt as they are often struck with the randomness of the outcome and this may result in avoidance behavior. Emotional numbness may occur, which is the entire absence of feeling.

While dealing with trauma, danger and violence on a daily basis, the officer must uphold their professional demeanor and stifle feelings of anxiety, anger and frustration, a technique that often trickles into their off-duty personality. Police officers must deal with pain and suffering constantly, and from the first day at the academy to the first day on the road, officers are told over and over again that they cannot get emotionally involved. Family relations tend to suffer as officers gravitate toward spending more time with fellow officers who do not criticize them (Janik, 1995).

In 2004, Bride reviewed 17 quantitative studies that addressed the impact of providing "psychosocial services to traumatized populations" on mental health workers, including the possible risk and protective factors that can affect experience of compassion fatigue and burnout. According to Bride (2004), the most commonly studied variables include age, gender, exposure levels, training, occupation, personal trauma history, and trauma symptoms. The results of his examination reveals mixed results, with no clear patterns with respect to demographics, exposure, or the type of clients. It was suggested that there is some consistency regarding personal trauma and that personal trauma history, particularly in childhood, is a significant risk factor.

A study done in 2002 by Beaton, Murphy, Johnson, and Nemuth on secondary traumatic stress responses in Fire Fighters following the 9/11 incident found that neither the marital status nor the rank of the individual made them partial to the experience of secondary traumatic stress. It was indicated that youth, inexperience, lower rank, and degree of exposure are associated with more emotional stress and that these factors tended to interrelate. In fact, most studies find no correlation with demographic characteristics such as gender, ethnicity or race, marital status, or education (Soderfelt & Soderfelt, 2002; Smets, Oort, & de Haes, 2003). There is some evidence that worker burnout may be related to youth and inexperience, however more than one author suggests that a certain amount of turnover in the early years of ones career may be simply a realization of mismatch in occupational choice rather than burnout (Lacoursiere, 2001). Having children is also a demographic that has some association with burnout and turnover yet this may not be so much a factor of burnout related to occupational stress but rather a general incompatibility of work policies with parenthood (Smets et al., 2003).

Fears have been expressed within the police service that society is becoming more violent and intolerant, the media more hostile, and the laws and procedures with which the police have to work more numerous and complicated (Brown, 2003).

It has been suggested that stress in the police is increasing as they take on more and more of the responsibilities of the rest of the society, and that the police are increasingly being

asked to deal with the effects of high unemployment, political tension, and social deprivation (Brown & Campbell, 1994). This increased workload combined with the stress of dealing with traumatic situations can easily lead to depression within the police service. Role ambiguity and role conflict, bureaucratic constraints on individualization of consumer services, lack of service provider autonomy, inadequate funding, large caseloads, excessive paperwork and concern for the bottom line all create substantial and concrete job stress that leads to burnout (Aderman, 2001; Gomez & Michaelis, 1995; Soderfelt & Soderfelt, 2002; Um & Harrison, 1998).

According to Crank and Caldero (1991) police stress can be conceptualized as any condition which has adverse consequences for a police officer's well-being and has been linked to negative emotional outcomes such as divorce, suicide and alcoholism. Two major categories of stress have been identified in police work. The first one concerns the nature of police work, or the operational factors that are specific to this line of work. Examples of this include exposure to danger, facing the unknown, court appearances, shift work and poor equipment. The second category refers to the organizational structure of police work, e.g. managerial styles, communication system, lack of administrative and supervisor support, lack of confidence in management and inadequate career advancement (Biggam, Power, Macdonald, Carcary & Moodie, 1997; Kop & Euwema, 2001). Lack of training, pay, rotating shifts, equipment, promotions, supervisors, poor communication between officer and supervisor, officer safety issues, decreased manpower, staff shortages, inadequate resources, time pressure and large work overload can also be included in this category (Kop & Euwena, 2001). Research that was done on the sources of stress indicated that the organization was the overwhelming source of stress among police members (Crank & Caldero, 1991; Kop & Euwema, 2001).

Organizational stress is tolerated to a certain level. These vary from officer to officer. One officer's threshold toward stress will be determined by that officers own internal representation of external events, which are more than likely, based on their personality, beliefs, values, and previous law enforcement experiences. Police officers experience stress on a daily basis, but it the organizational stress that causes the greatest harm. All

cops work in bureaucracies, and these bureaucracies can create stress that far exceeds the stress they experience in the line of duty (Kirschman, 1998). Kirschman (1998) also points out that it is hard for police officers to properly serve the public when they believe themselves to be poorly supported by their agencies. Stress is the result of "demands placed on the system", and need not be harmful unless it is mismanaged or presented in large quantities. Organizations need to recognize that there is a limit to the responsibilities; pressures and workload officers can be expected to work. One officer's inability to deal with stress can also infect other officers resulting in pervasive problems for the entire department (Yachnik, 2000).

A study done in 2003 by De Wet, showed that the following factors influenced the amount of work stress experienced by the Police officers within the SAPS: Having to deal with crisis situations; having more paperwork than one person can handle; having to perform tasks that are not part of job description; lack of officers to handle specific tasks; inadequate or poor quality equipment; lack of recognition for work well done; other officers not doing their job; supervisor's support is lacking; negative attitudes experienced towards the organization; lacking opportunities for advancement; other officers poorly motivated; inadequate salary; staff shortages and seeing criminals go free.

To relieve this, one should look at factors that positively influence work satisfaction. Studies have shown that the gender of a person can influence the amount of job satisfaction experienced. Women are found to generally experience more work satisfaction than men (Oswald, 2002). This could be due to the stereotyped view that men should be the 'bread winners' thus putting them in the position of having to provide financially for the whole family. Research has found that regardless of culture, women are more prone than men to symptoms of posttraumatic stress disorder (Norris, Perilla, Ibanez & Murphy, 2001).

Salary is generally the top reason for job satisfaction. When paid adequately for work, people feel valued and appreciated. Money troubles are a common cause of stress and can cause pressure in private lives (Michaels, Smith, Moon, Peterson & Long, 2000). Low

salaries result in demotivation and poor productivity. High relative income gives workers a sense of purpose. Job certainty plays an obvious role in work satisfaction as an increased staff turnover makes workers feel unimportant and expendable.

The working environment is one of the most important influences on compassion satisfaction. Working environment can include the physical surroundings at work such as decor, temperature, smell and social atmosphere (Michaels et al, 2000). The majority proportions of our lives are spent at work and so people want to be in comfortable, pleasant surroundings. If the environment is stressful and filled with conflict, workers experience lower work satisfaction levels and productivity. Allocation of limited resources, restrictive laws, policies, regulations, administrative practices and even unethical behavior of colleagues often create value conflicts and ethical dilemmas for helping professionals.

Feeling challenged by your occupation is also an important factor in work satisfaction. To feel challenged, workers need to be stimulated either creatively, intellectually or psychologically in their work, doing the same tasks day in day out without a spark of dynamism or variation could become mundane, which will end in workers becoming bored and not performing their best (Oswald, 2002).

When an individual is experiencing severe work related stress, they are more likely to develop depression, thus lowering their ability to cope and deal with trauma. Police are vulnerable to work related stress and vicarious trauma due to various aspects of the nature of the profession they've chosen. Some areas are more vulnerable due to their close contacts with survivors or victims of trauma and it has been found that those who work in areas of child exploitation, victims of crime, major crash, major crime, psychology and welfare are more susceptible to being affected by dealing with other people's trauma (Anshel, 2000).

Nelson (2000) established that vicarious trauma is cumulative (grows with time, number of exposures), inevitable (an occupational hazard, not a sign of weakness) and developmental (changes over time through experiences).

Police officers suffering from vicarious trauma may experience intrusive imagery or thoughts, a shift in their frame of reference, disrupted beliefs and relationships, trouble with feelings about self and others, and difficult making decisions (Haskell, 1999).

The South African Police Service suffers since the individual's experience of vicarious trauma results in reduced commitment, motivation and productivity, become cynical and pessimistic, develop issues concerning ethics and boundaries, staff turnover is impaired and there is a cost increase due to all of the above (Haskell, 1999). Police members may also experience burnout.

The experience of police stress differs from other professions like firefighters and Emergency Medical Technicians (EMT's) (McCann & Pearlman, 1990). The public generally responds a lot more positively towards EMT's and firefighters than they do to the police. The public mind set toward the police officer seems to be more negative. Although both firefighting and EMT work can be considered dangerous, the level of danger faced by police officers is significantly different. As the level of violence in this country escalates, the echoes of that violence reverberate throughout the police community.

Unprovoked attacks on police officers are at an all-time high (Volpe & Anderson, 1998). That is why officers are often hyper vigilant; they never know when they have to move into action. The unpredictability of the job of policing is an added stressor. This means that the stress hormones need to remain elevated at some level (Volpe & Anderson, 1998). Shift work and midnight duties are common in other professions but the unpredictability and the violence witnessed and experienced within the SAPS make police work unique. You can add to this, a revolving-door justice system, with the person you locked up today, is back on the street tomorrow (Brown & Campbell, 1994). The members are always under close public scrutiny and their actions are often misinterpreted and can easily lead to civil law suits (Kop & Euwema, 2001).

There is significant stress associated with the use of deadly force - having to kill another human being (Volpe & Anderson, 1998). No officer is ever emotionally ready to kill another human being. Many officers say that the first thing that came to mind after they fired the fatal bullet was "Thou shall not kill." All of these stressors make police work different from other professions. Of course, the on-going, day-to-day exposure to murders, assaults, rapes, child abuse, domestic violence and "man's inhumanity to man" intensifies this stress-related burden.

Vicarious Trauma is a diagnostic term used to depict the cluster of symptoms many police officers suffer as a direct result of the job of policing. In diagnosing trauma-related disorders with police officers, it is very difficult to applying the criteria set forth in both the DSM-III and DSM-IV (Diagnostic and Statistical Manual of Mental Disorders) because they typically do not fit into the Posttraumatic Stress Disorder (PTSD) criteria per se (Volpe & Anderson, 1998). A police officer can witness, inside of one week, more traumas than most people see in a lifetime. Not only is it qualitatively different but also, quantitatively different. They see so many traumas.

If you examine the first of the DSM-IV criterion (for PTSD), it states that the person's response to the event must involve intense fear, helplessness, or horror. Police officers are more often than not, the first responders to a scene. They have been tuned to dissociate from their emotions or suppress their emotions in order to be able to endure the scene. Theoretically, in most cases, police officers would not fulfill this first criterion. They are trained to respond behaviorally (not emotionally).

Responses tend to range between anger or intrusive thoughts and numbing. This does not imply that police officers get used to being exposed to trauma. Chronic, long-term and cumulative stress takes its toll on police officers. VT can result after a single, catastrophic event such as when an officer witnesses his partner being killed, and then having to defend his own life perhaps by killing the assailant. This could precipitate full-blown PTSD or VT in an officer. On the other hand, after years of traumatic exposure, VT can be triggered by an incident that is not immediately life threatening. The important thing

to convey about VT is that when a clinician sees this term, it should immediately be apparent that the individual is suffering from events experienced primarily on the job. It is a direct result of the occupation of policing (Haskell, 1999).

A study done in the US involving a group of 17 officers who have been meeting for four years has defined a five-stage model leading up to vicarious trauma (Volpe & Anderson, 1998):

1 First stage: "Rookie" Stage

An officer is "shocked" by the world he sees - the violence, the neglect and cruelty toward children. He sees a world that he didn't know existed.

2 Second stage: "John Wayne" Stage

Marked by an uncertainty concerning the "balance" of the badge. The officer is filling a role as he/she understands it. The "tough" image portrayed by the media cops is all that officers may know. The officer may take pride in owning all of the police gadgets. Their communicative style is primarily one of "commanding, ordering and directing."

3 Third stage: "Professional" Stage

The officer has a good sense of his or her own identity. No matter how much verbal abuse they encounter, they remain courteous and in control. While for appearance's sake, this may seem problem-free; in actuality what's happening is that the officer may be "numbing" his natural emotions. "Dehumanizing" citizens as a coping mechanism will cost the officer in his personal life. Defense mechanisms that help an officer adapt to the job are maladaptive in their personal life.

4 Fourth stage: "Burnout" Stage

Anger and contempt for the criminal justice system, the Department, politicians, and the citizens highlight this stage. The officer begins to isolate from family and friends - believing that they do not "have a clue" as to what the world is really like.

5 Fifth stage: "Vicarious Trauma" stage

The individual is no longer able to function effectively as a police officer. This state is characterized by sleep problems, anxiety and/or depression, flashbacks, intrusive thoughts, mood swings, rage attacks, social isolation, and deterioration in relationships. The officer may consume alcohol or other drugs or experience an escalation in usage. Suicidal thoughts may arise. This condition is far more pervasive than one might think. Sadly, what usually happens, without intervention, is that the officer retires and disappears into obscurity.

CHAPTER 3

THEORETICAL PERSPECTIVES

3.1 INTRODUCTION

This chapter will take a look at various theories explaining the experience of trauma and its origins, highlighting the basic structures of each model. Trauma related behaviour is explained from the theoretical perspectives point of view.

For the purpose of this study, the Trauma Theory (Constructivist Self Development Theory, CSDT) was used as the guide lining theoretical framework for explaining the experience of vicarious trauma.

3.2 THE HEALTH BELIEF MODEL

The Health Belief Model (HBM) was initially proposed by Rosenstock in the 1950's and modified by Becker. This model highlights the function of beliefs in decision-making. The HBM essentially focuses on how personal orientation or the subjective state of the individual influences their health, instead of history or experience. According to this model, it is assumed that the person's subjective perception of their world determines their behaviour rather than the objective environment in which they find themselves (Conner & Sparks, 1996).

The key factors in this theory are the following (Rosenstock, Strecher & Becker, 1994):

- Perceived Threat: Consists of two parts: perceived susceptibility and perceived severity.
  Perceived Susceptibility: One's subjective perception of the risk of experiencing event
  Perceived Severity: Feelings concerning the seriousness of event

- Perceived Benefits: The believed effectiveness of strategies designed to reduce the threat caused by the event.
- Perceived Barriers: The potential negative consequences that may result from taking particular actions
- Cues to Action: Events, either bodily or environmental that motivate people to take action. This is an aspect of the HBM that has not been systematically studied.
- Other Variables: Diverse demographic, socio-psychological, and structural variables that affect an individual's perceptions and thus indirectly influence behaviour.
- Self-Efficacy: The belief in being able to successfully execute the behaviour required to produce the desired outcomes. (This concept was introduced by Bandura in 1977.)

3.3 FOA'S FEAR NETWORK

This theory was formulated by Foa and Riggs (Foa, Cahill & Boscarino, 2005) and encompasses information about cognitive, behavioural and physiological reactions to an event. Information links these stimulus and response elements together after people have either experienced a traumatic event themselves or have witnessed another person experiencing the event. The perception of death or danger to one's life can lead to a feeling of helplessness (Foa, Cahill & Boscarino, 2005). Among the types of events that may trigger PTSD are shootings, witnessing torture or being tortured, being in a traffic accident, being in a war, being raped, or suffering because of a natural or man-made disaster.

Oldman, Riba & Tasman (1993) mention that the activation of the trauma related fear network is done via cue stimuli i.e. reminders of the trauma or the 're-experiencing' cluster, which includes the recollection of the event in the form of nightmares, flashbacks, and emotional reactivity where in the person is reminded of the event. This causes information to enter on a conscious awareness (the intrusive symptoms of trauma disorders).

The second cluster of symptoms includes avoidance of anything that is likely to remind the person of the trauma, such as attempting to push the event away, avoidance of thinking about the event, or avoiding anything that could be a reminder of the event or that is similar to the event. According to Foa et al (2005), an important group of symptoms are known as the “emotional numbing symptoms", namely detachment from others; loss of interest in once-favored activities; inability to experience the range of emotions one once had; and a feeling of emotional alienation, especially from spouses or children.

The final group of symptoms is classified as hyper arousal symptoms: sleep disturbance, hyper vigilance, startle responses, exaggerated startle responses, irritability, and outbursts of anger. Vicarious trauma is one of the most serious and longest lasting of the human responses to trauma.

According to Oldman, Riba & Tasman (1993), successful resolution of trauma can occur only when the information in the fear network is integrated with existing memory structures.

3.4 COGNITIVE ACTION THEORY

This theory was founded on veterans of the war in Vietnam. Chemtob et al., (1998) argues that in individuals with trauma related disorders, the fear network is never switched off and is permanently activated, therefore causing them to function in a ‘survival mode’. This is a way of functioning that was adaptive during the traumatic incident. This permanent activation results in symptoms of intrusion and hyper-arousal. This theory is limited in that its emphasis is on combat-related trauma and fails to explain why some individuals remain in ‘survival mode’ while others do not.

3.5 JANOFF-BULMAN'S COGNITIVE APPRAISAL THEORY

Current research concerning trauma theories focus in particular on the cognitive model. This model is however philosophically embedded within the existential tradition of philosophy.

Existential philosophy speaks of ultimate meanings that permeate an individual's life. Olson (1979) writes that existentialism is about understanding the human condition. This condition is made up by certain traits that have remained with humankind throughout the ages; they define an individual's existence. According to Olson (1979), these traits include an individual's radical contingency, particularity and freedom. They speak of (Olson, 1979, p.89) "Man's fundamental aspirations; and of the basic ways in which the individual can relate to the world and to other human beings."

Two existential authors, May and Yalom (Corsini, 1984) write that existentialism compels one to ask deep questions about the nature of being human and its accompanying anxiety, despair, grief, loneliness, isolation and anomie. Existential ideas are diverse but are distinguished by their passion for human values.

Trauma elicits deep existential issues (Janoff-Bulman & Frantz, 1997). However these issues and ideas have been couched within formal models within the cognitive tradition of psychological theory. These models in particular focus upon the impact of trauma on belief systems of the individual. It is thought that trauma disrupts the worldviews and emotional attributions of the individuals involved.

The cognitive model emphasizes the effects of trauma on high order implicit basic assumptions that individuals hold. These assumptions include the idea that all people are inherently good, that the universe is meaningful and that the self is worthy (Janoff-Bulman, 1992). It is precisely these beliefs that may change through the experience of trauma to a view that the universe is inherently meaningless but one's own life is infused with personal meaning (Janoff-Bulman & Frantz, 1997).

According to Janoff-Bulman (1992), trauma disorders are a result of basic assumptions about the self and the world being shattered by serious illness, violent crime, accidents or disasters of extreme and physically threatening events. Any unusual events in the life of an individual that leaves their perceptions marked by threat, danger, insecurity, and self-questioning can result in the development of trauma.

Janoff-Bulman maintains that individuals hold three core assumptions:

1. Benevolence of the world: assumptions that other people are basically trustworthy, moral, and compassionate and that misfortunes occur infrequently
2. Meaning in the world: involves people's beliefs about the distribution of outcomes (Janoff-Bulman, 1992). A meaningful world is one in which events unfold systematically (Antonovsky, 1979)
3. Worthiness of the self: contends that people will get what they deserve (Lerner, 1980).

The theory focuses not on the appraisals that occur during the initial confrontation with the traumatic situation, but rather within interpretations and redefinitions of the event that occur over the course of coping and adjustment. These redefinitions are considered to be a natural outcome of the survivor's reflections upon the trauma, rather than the result of deliberate attempts to restore cognitive control.

Three sets of reappraisal strategies are hypothesized:

1. Social comparisons: examining the survivor's own role in allowing the victimization to happen. The survivor's own role in facilitating the trauma involves the questions "why did this happen to me?" (Janoff-Bulman & Frieze, 1983).

2. Behavioral self-blame that follows the death of a close other as the survivor seeks to explain; "why have I lived while others have not?" (Janoff-Bulman, 1992) and "How did I ...fail to do right by the lost one?"

3. Trying to find meaning in the trauma by re-evaluating it as imparting benefits or wisdom (Janoff-Bulman, 1992).

This theory assumes that personal vulnerability, the perception of the world as meaningful or comprehensible, and the view of the self, structures ones life and provides meaning. When confronted with a traumatic event, these cannot be maintained, and the vulnerability and view of the world as meaningful and comprehensible are shattered, thus plunging the individual into a confused state comprising of intrusion, avoidance and hyper arousal.

3.6 COGNITIVE-BEHAVIOURAL THEORIES

The cognitive model of trauma posits that affected people cannot process or rationalize the trauma that precipitated the disorder. They continue to experience the stress and attempts to avoid experiencing it by avoidant techniques. Consistent with their partial ability to cope cognitively with the event, persons experience alternating periods of acknowledging and blocking the vent. The attempt of the brain to process the massive amount of information provoked by the trauma is thought to be responsible for these alternating periods.

The behavioural model of trauma emphasizes two phases in its development. First, the trauma (the unconditioned stimulus) that produces a fear response is paired, through classical conditioning, with a conditioned stimulus (physical or mental reminders). Second, through instrumental learning, the conditioned stimuli elicit the fear response independent of the original unconditioned stimulus, and persons develop a pattern of avoiding both the conditioned stimulus and the unconditioned stimulus. Some persons receive secondary gains from the external world, commonly monetary compensation, increased attention or sympathy, and the satisfaction of dependency needs. These gains reinforce the disorder and its persistence.

3.7 PSYCHODYNAMIC THEORIES

The psychoanalytic model of trauma hypothesizes that the trauma has reactivated a previously quiescent, yet unresolved psychological conflict. The revival of the childhood trauma results in regression and the use of defence mechanisms of repression, denial, reaction formation, and undoing. According to Freud (1923), a pre-existing conflict might be symbolically reawakened by the new traumatic event. The ego relives and thereby tries to master and reduce the anxiety.

Key Concepts of Freud's Psychodynamic Theory

1. Primarily concerned with internal psychological processes
2. Importance of early childhood experiences
3. Existence of unconscious motivation
4. Existence of ego (rationality) & superego (morality)
5. Existence of defense mechanisms

Most recent psychodynamic theory places greater emphasis on conscious experience and its interaction with the unconscious, in addition to the role that social factors play in development.

Psychodynamic theories are in basic agreement that the study of human behaviour should include factors such as internal processes, personality, motivation and drives, and the importance of childhood experiences. Classic theories about the role of the unconscious sexual and aggressive drives have been re-evaluated to focus on conscious experience, resulting in, for example, the birth of ego psychology (McCarthy, 2005)

3.8 THEORETICAL FRAMEWORK

Constructivist Self Development Theory (CSDT) was developed by McCann and Pearlman, and is described as an integrative, developmental, relational theory. They

coined the term vicarious trauma (VT) that they propose describes the negative cognitive schema and behaviour changes that occur in those that experience the negative effects of working with those who have experienced a traumatic event. Pearlman and associates are clear that VT differs conceptually from Secondary Traumatic Stress, Compassion Fatigue or counter transference in that such approaches focus on symptoms rather than considering the individual holistically. The VT approach focuses on the individual as a whole, which includes symptoms in the larger context of adaptation as the individual strives for meaning (Pearlman & Saakvitne, 1995). According to Pearlman & Saakvitne, aspects of the self that may be disrupted as a consequence of experiencing VT are: (1) frame of reference, (2) self capacity, (3) needs, beliefs and relationships, (4) interpersonal relationships, (5) ego resources, and (6) imagery.

Trauma Theory originated within the CSDT and is used as a framework in understanding trauma and its effects on those exposed to it. According to this theory, psychological trauma occurs when a sudden, unexpected, overwhelming intense emotional blow or a series of blows assaults the person from outside and both the person's internal and external resources are inadequate to cope with the external threat (Bloom, 1999). This theory states that traumatic events are external but quickly become incorporated into the mind.

This theory is based on the belief that it is not the trauma itself that is damaging but instead how the persons mind and body reacts in its own unique way to the traumatic experience in combination with the unique response of the individual's social group (Van der Kolk, 1987). A traumatic experience influences the entire person – how they think, how they learn, how they remember things, the way they feel about themselves, the way they feel about other people, and the way they perceive the world, are all profoundly altered by the traumatic experience (Bloom, 1999).

Constructivist Self Development Theory (Pearlman & Saakvitne, 1995) can explain both the negative changes that occur in the aftermath of a traumatic event, as well as the positive changes which occur as a result of adaptation and meaning making.

It is difficult to measure the complexities of an individual's response to a traumatic event. How an individual responds to trauma is sadly often embedded in socio-cultural contexts, often with political and moral overtones.

According to Trauma Theory, the uniqueness of an individual's response to trauma is determined by several factors, namely, the particular meaning ascribed to the trauma by the individual, the individual's experience of self, age and developmental stage, biological and psychological resources, interpersonal experiences and expectations, and his or her social, cultural, and economic status. The similarities of responses across individuals reflect common values, biology, expectations, and needs that would lead to shared attributions, meaning, and adaptations.

Generally, society demands denial of the long-term impact of trauma by urging victims to "get over it and get on with it", and by idealizing those who "bite the bullet," and thus does not recognize complex posttraumatic adaptations (Shay, 1994). In fact, it invites an implicit moral judgment on pain and bias toward sublimation. Thus, it is important that the experience of the survivor not be diminished and not to imply that suffering reflects lack of resiliency (Wolin & Wolin, 1993).

It is widely accepted that trauma is transformative and that in the aftermath of a traumatic event nothing is again the same. Research focuses mostly on the negative aspects of this change: grief and traumatic loss, emotional fragmentation, and psychic devastation. Yet personal narratives, clinical lore, and a growing research base (Harvey, 1996) suggest that trauma also leads to other transformations, including the reconstruction of meaning; the renewal of faith, trust, hope, and connection; and the redefinition of self, self-in-relation, and sense of community. After trauma comes adaptation. Those who physically survive trauma begin to recover even as its full horror is still registering. In our struggle

to survive, man adapts to seemingly impossible circumstances. Adaptation stems from our attempts to survive and to heal in the midst of our suffering. These adaptations frequently carry both benefits and costs to the individual and to society.

Trauma is about devastation and resilience. The most damaged survivor may demonstrate strength that surpasses our expectations. Increasingly, there has emerged the need for a theory of self that explicitly addresses the impact of trauma on self-development. An individual's response to trauma is contextualized by the dynamics of perception, cognition, and affective processing, which include the need to create meaning and construct personal narratives (Van der Kolk & MacFarlane, 1996). Trauma theory (Pearlman & Saakvitne, 1995) is an integrative personality theory that describes the impact of a traumatic event (or traumatic context) on the development of self. By integrating constructs from psychoanalytic and social learning theories, this theory describes personality development as the interaction between core self-capacities (related to early relationships, secure attachments, and ego resources) and constructed beliefs and schemas (related to cumulative experiences and the attribution of meaning to those experiences) that shape perception and experience.

Trauma theory outlines the specific components of self most affected by traumatic events. Using this theory, one can identify specific aspects of self that will be most affected by trauma. These same aspects are then altered and potentially strengthened as an individual heals from a traumatic event. In this way the theory provides a template for identifying both damage and growth after trauma. Trauma theory integrates psychoanalytic theory with constructivist thinking (Mahoney & Lyddon, 1988), social learning theory (Rotter, 1954), and cognitive developmental theory (Piaget, 1971) and emphasizes the influence of the individual's developmental, social, and cultural contexts.

This theory looks at an individual’s adaptation to trauma as an interaction between their personality and personal history and the traumatic event and its context, within the social and cultural contexts for the event and its aftermath. The underlying constructivist assumption is that individuals construct and construe their own realities (Mahoney &

Lyddon, 1988). The clinical implication is that the meaning of the traumatic event is in the survivor's experience of it.

The theory emphasizes a developmental perspective, focusing on the individual's early development as central to an individual's current way of experiencing and interacting with self and others. It also postulates that experiences of trauma are reinterpreted and reconstructed during subsequent developmental stages. Trauma theory views symptoms of trauma as adaptive strategies that develop to manage feelings and thoughts that threaten the integrity and safety of the individual.

Within Trauma Theory, there are five areas that are expected to be affected by traumatic events:

1. Frame of reference: one's usual way of understanding self and world, including spirituality.

2. Self-capacities: defined as the capacity to recognize, tolerate, and integrate affect and maintain a benevolent inner connection with self and others.

3. Ego resources: necessary to meet psychological needs in mature ways; specifically, abilities to be self-observing, and use cognitive and social skills to maintain relationships and protect oneself.

4. Central psychological needs: reflected in disrupted cognitive schemas in five areas: safety, trust, control, esteem, and intimacy.

5. Perceptual and memory system: including biological (neurochemical) adaptations and sensory experience.

According to Trauma Theory (McCann & Pearlman, 1990), as the police officer bears witness to the graphic details of the victims' trauma, disruptions in the psychological

need areas of safety, trust, esteem, power and intimacy occur. Vicarious trauma can result in the police officer portraying cynicism, fear, sadness and despair (Collins, 2001; Stevens-Guille, 2003). Vicarious trauma is a normal response to working with traumatized person and is not a reflection of the police officers inadequacies. The effects of vicarious trauma are unique to each police member, which is consistent with the individual difference premise of Trauma Theory. This uniqueness is dependent on the individuals' personality, defence mechanisms used and inner resources. Based on the theoretical framework used by the researcher in this research, the effects of vicarious trauma are predictable (McCann & Pearlman, 1990; Gentry, Baggerly & Baranowsky, 2004).

In response to a traumatic life event, the individual must integrate the event and its context and consequences into their existing beliefs about self and others. The intensity of the somatic, affective, and interpersonal components of the experience determine the availability of the event for cognitive processing. The more overwhelming or intolerable the traumatic event is in comparison to the individuals self-capacities (ability to tolerate affect and maintain a sense of self in connection), the greater the need for dissociative and amnesiac defenses that preclude conscious processing of the event. The event and its implications must be incorporated into the person's frame of reference and schemas about central psychological needs.

When trauma is experienced in adulthood, the changes are more likely to be short-term and modified over time by the sturdiness of lifelong beliefs. But if recurrent traumas occur during childhood, this could lead to more stable disruptions of frame of reference and schemas that change only slowly. Beliefs developed in childhood are reinforced when they help the child make sense of the experience and protect them from unbearable truths. Beliefs that protect someone from something they cannot bear to know or feel are highly resistant to modification and change. Therefore, due to various factors, such as individual differences in identity, spirituality and psychological need areas, etc different people respond differently to similar events.

CHAPTER 4

RESEARCH METHODOLOGY

4.1 INTRODUCTION

Within this chapter, the research strategy and general description of the format of such a study will be provided. The method of data gathering and data analysis, the sample, the instruments and procedure are discussed.

4.2 RESEARCH DESIGN

The research is in the form of a quantitative descriptive study in that vicarious trauma is a well-defined subject but has not as yet been fully applied to the SAPS setting. Through this descriptive design, an accurate profile of a specific group (the SAPS) in relation to vicarious trauma can be given, the relationship that exists between vicarious trauma and the SAPS's duties and responsibilities can be described, and a numerical picture (e.g. percentages) of the prevalence of vicarious trauma within the SAPS is determined.

Data was gathered by use of a cross-sectional design, whereby a sample is drawn from a population at one time (Shaughnessy & Zechmeister, 1997). Information collected through questionnaires was used to describe the population at that time. This design can be used also to assess interrelationships among variables within a population. According to Shaughnessy and Zechmeister (1997) this design is ideally suited when the aim of the study is descriptive and predictive in nature.

4.3 QUANTITATIVE METHOD

The participants were asked to complete the Compassion Fatigue Survey which is a questionnaire adapted by the University of Limpopo's Health behaviour Research Unit

from scales developed by Stamm (2002). It contains the Professional Quality Of Life Scale (ProQOL R-III) and Stressful Life Experience Screening (SLES), as well as addressing stressful job related events and experience in personal trauma.

4.4 RATIONALE FOR THE CHOICE OF METHODOLOGY

Quantitative research is regarded as objective and the above mentioned tests should provide insight into the existence of vicarious trauma, general morale and stressful life experiences of the members of the SAPS.

4.5 SAMPLE

A convenience sample of 60 field-working police officers was used (N = 60) for the Quantitative data gathering. Data was collected from various ranks, sexes, ages and race's as available. Field-working police members in the Limpopo province, specifically Lebowakgomo and Mankweng stations, were asked to complete the questionnaires.

4.6 BACKGROUND INFORMATION ABOUT THE AREA OF STUDY

This study was conducted within the Limpopo Province. The population of 5.4 million within this province is made up of 97.1% Blacks, 0.1% Coloureds, 0.1% Indians/Asians and 2.7% Whites. Of this, 45.7% are males and 54.3% females (Madu & Poodhun, 2006). People living within these areas generally function under very poor living and medical conditions.

4.7 DEMOGRAPHIC INFORMATION

Basic demographic information was collected from each participant completing the quantitative questionnaires, in order to describe the sample. The following demographic information was gathered:

- Gender
- Marital Status
- Education
- Professional experience in years
- Case load per week
- Breaks taken per year
- Age
- Religion
- Rank
- Nature of police work
- Annual income

4.8 INSTRUMENTS

The following instruments were used in the study:

1. Professional Quality Of Life Scale (ProQOL R-III)

Stamm (2002) developed the Professional Quality of Life: Compassion Satisfaction and Fatigue Subscales –Revision III as a 30-item self administered behavioural assessment for professionals working with survivors of traumatic stress. This measure is the current revision of the original Compassion Fatigue and Satisfaction 66 (CSF 66) item scale (Stamm, 1996), which has not demonstrated adequately the psychometric separation of the concepts of burnout and vicarious traumatization (Larsen, Stamm, & Davis, 2002). The ProQOL consists of three subscales: Compassion Satisfaction, Burnout, and Compassion Fatigue. Respondents rate each item during the past 30 days using a 6-point Likert scale, ranging from 0 (“never”) to 5 (“very often”).

Stamm (2002) established reliability of the ProQOL tool with scores of .87 for Compassion Satisfaction alpha, .72 for Burnout alpha, and .80 for Compassion Fatigue alpha (Stamm, 2002). Despite the fact that the ProQOL has fewer items than the CSF-66 item instrument, the authors report more reliable scores. The major advantage of the ProQOL tool is that it provides for psychometric separation of compassion satisfaction, burnout, and compassion fatigue/secondary trauma. The questions on this 30-item instrument are equally divided among these three categories, and receive separate sub scores.

4.9 DATA ANALYSIS

The statistical analysis was carried out with the help of The Statistical Package for Social Sciences (SPSS) and the chi-square test.

- The Chi-Square Test

According to Charles (1995), chi-square ($X2$) is a nonparametric statistical test that is used when the research data are in the form of frequency counts. These frequency counts can be placed into two or more categories. The chi-square, as Neuman (1997) points out, is used for descriptive statistical purposes, to explain the strength of association between variables, and for inferential statistics, to tell the probability that any association found is likely to be due to chance factors.

CHAPTER 5

FINDINGS

The findings were concluded from data obtained from the Compassion Fatigue Scale which consists of the Professional Quality of Life Scale (ProQOL R-III) and Stressful Life Experience Screening (SLES) as developed by Stamm (2002), as well as addressing the previous experience of personal trauma. The biographical data of the sample are given in order to best describe the sample group. Tables containing the findings of the ProQOL R III (Stamm, 2002) scale are provided and discussed. Also discussed are how the following factors affect the experience of compassion fatigue, work satisfaction and burnout: experience of previous trauma, duration of service, rank, marital status, gender, education, age and religion.

Table 1

Characteristics of the Study Population (n=60)

Item	Category	Frequency	Percentage
Gender	Male	41	68.3
	Female	19	31.7
Age	26 - 31	6	10.0
	32 - 37	21	35.0
	38 - 43	22	36.7
	44 - 49	10	16.7
	50 - 55	1	1.7
Marital Status	Single	14	23.3
	Married	35	58.3
	Divorced	10	16.7
	Living with partner	1	1.7
Religious Affiliation	Christian	36	60.0
	African Traditional	13	21.7
	Both	10	16.7
	None	1	1.7
Highest education level obtained	Grade 12	45	75.0
	Diploma	11	18.3
	Degree	4	6.7
Rank	Constable	7	11.7
	Sergeant	8	13.3
	Detective	14	23.3
	Inspector	29	48.3
	Superintendent	2	3.3
Professional experience in years	1 - 5	10	16.6
	6 - 10	37	61.7

	11 - 15 16 - 20 21 - 25	9 3 1	15.0 5.0 1.7
Nature of work done daily	Arresting Perpetrators Community Patrol Investigations Administration Any other	3 6 41 2 8	5.0 10.0 68.3 3.3 13.3
Case load per week	0 - 1 2 - 5 6 - 10 11 - 15 16 - 20 21 and above	10 22 10 3 5 9	16.9 37.3 16.9 5.1 8.5 15.3
Total Annual Household income	R75,001-R90,000 R90,001-R105,000 R105,001-120,000 R120.001-R150,000 Over R150.001	7 15 33 1 2	12.1 25.9 56.9 1.7 3.4
Breaks taken per year	0 - 1 2 - 5 6 - 10 11 - 15 16 - 20 21 and above	19 21 1 3 3 12	32.2 35.6 1.7 5.1 5.1 20.3

Table 1 above provides a summary of the characteristics of the sample. The gender distribution of the police members who participated in the research was predominantly male (68%). The age groups of participants ranged between 26 to 55 years of age, with the majority falling between 32 and 43 of age. Slightly more than half of the participants were married (58%). The majority of the participants regarded themselves as Christians (60%) and the highest level of education reached was predominantly Grade 12 (75%). Professionally, the majority of participants came from the ranks of Detective and Inspector (23% and 48% respectively) and the general duration of service is estimated around 6 to 10 years. Among the participants, the general nature of work was that of investigations (68%). Economically, it was found that the majority of police members who participated earn less than R120 000 per annum (57%) and 68% use only 5 days annual leave per year while 20% were using more than 21 days leave per annum.

5.1 THE EXPERIENCE OF WORK SATISFACTION, BURNOUT AND COMPASSION FATIGUE

A person's ability to do your work is greatly influenced by your emotional state. How satisfied you are within your occupation, your ability to deal with the demands of your work and your experience of secondary stress due to your work can all influence your productivity at work. The Professional Quality of Life Scale Revised III was used to determine job satisfaction, burnout and VT levels of the sample group.

5.1.1 WORK SATISFACTION

The level of compassion satisfaction was measured and found to be as follows:

Table 2: ***Compassion satisfaction***

Sub-scale	Category	Frequency	Percentage
Compassion Satisfaction	Above 41 (high satisfaction)	1	1.7
	Average (37) (moderate)	9	15.0
	Below 32 (low satisfaction)	50	83.3

Compassion satisfaction refers to the pleasure derived from being able to do your work well. The average scored by the general population for the ProQOL-R III is 37. Around 25% of people scored higher than 41 and about 25% of people score below 32. Scores above 41 imply that a person derives a sense of professional satisfaction from their occupational duties. Scores below 32 reflect the possibility that you are not feeling satisfied professionally from the demands of your work.

This study found that the majority of the sample (83%) derives no satisfaction from their work within the SAPS, 15 % derive average satisfaction and only around 2% of the sample finds their work satisfying. This means that the majority of the SAPS members do not seem to be satisfied within their working environment.

5.1.2 THE PREVALENCE OF BURNOUT

Burnout within the SAPS was found to be the following:

Table 3: ***Burnout***

Sub-scale	Category	Frequency	Percentage
Burnout	Above 28 (high burnout)	18	30.0
	Average (23) (moderate)	31	51.7
	Below 19 (no burnout)	11	18.3

The average person scores around 23, which mean these people generally experience some of the symptoms of burnout but not all of them. About 25% of people scored above 28 and 25% of people scored below 19. Scores below 19, reflect positive feelings about the ability to be effective in your work. Scores above 28 reflect feelings of inadequacy in fulfilling your job demands.

In this study, results show that 30% of the sample is most likely suffering from burnout, around 52% are experiencing moderate degree of burnout symptoms and only 18% of the individuals are currently experiencing no symptoms. This means that the majority of the SAPS are possibly experiencing some degree of burnout at present.

5.1.3 THE OCCURANCE OF COMPASSION FATIGUE

The prevalence of vicarious trauma within the SAPS was found to be as follows:

Table 4: ***Compassion Fatigue***

Sub-scale	Category	Frequency	Percentage
Compassion Fatigue	Above 17 (high compassion fatigue)	49	83.1
	Average (13) (moderate)	8	13.6
	Below 8 (low compassion fatigue)	2	3.4

The average person scores 13, 25% of people score below 8, and about 25% of people score above 17. Scores above 17 imply that there is a strong possibility that you are experiencing VT due to some work related experience.

Significantly, 83% of the members who participated in this research were found to be suffering from compassion fatigue (vicarious trauma), almost 14% were found to be experiencing some of the symptoms and only 3% were symptom free. This means that vicarious trauma is most likely an issue within the SAPS at present.

5.2 THE IMPACT OF PREVIOUS TRAUMA

The influence that pre-existing traumatic experiences in the participant's past has on their current vulnerability towards experiencing vicarious trauma provided the following results:

Table 3

χ2 test of association between the experience of trauma and fatigue

		Fatigue			Total	χ2	df	p
		Above 17	Average (13)	Below 8				
Do you have experience of personal trauma	Yes	28	4	1	33	.172	2	.918
	No	21	4	1	26			
Total		49	8	2	59			

A relationship was sought between the existence of previous trauma and the experience of vicarious trauma using a chi-square test. Findings as indicated in Table 3 above, substantiate that the previous experience of trauma has no significant relationship with the current experience of compassion fatigue ($\chi 2 = .172$, $df = 2$, $p > .05$). This means that in this sample, the experience of trauma was most likely not related to the experience of previous trauma.

5.3 THE IMPACT OF PROFESSIONAL EXPERIENCE

Table 4

c2 test of association between Professional Experience and Compassion Fatigue

		Professional experience in years					Total	χ2	df	p
		1-5	6-10	11-15	16-20	Over 20				
Fatigue	Above 17	6	35	6	1	1	49	18.605	8	.017*
	Average (13)	1	1	3	2	1	8			
	Below 8	1	1	0	0	0	2			
Total		8	37	9	3	2	59			

***** Significant at p < 0.05

This study sought a relationship between the duration of service of the individual and their experience of vicarious trauma. A significant relationship was found between the duration of service and the experience of trauma. The police with 6-10 years showed more fatigue than others (n=35), as indicated in Table 4 above ($\chi 2 = 18.61$, df = 8, $p < .05$). This means that the longer the duration of service, the more likely a persons chances are of suffering from vicarious trauma.

5.4 MARITAL STATUS AND VICARIOUS TRAUMA VICTIMS

When determining whether the marital status of an individual will influence the experience of vicarious trauma, the following was found:

Table 5

c2 test of association between marital status and Compassion Fatigue

		Marital Status				Total	χ2	df	p
		Single	Married	Divorced	Living with partner				
Fatigue	Above 17	13	26	10	0	49	33.039	6	.000 *
	Average (13)	1	7	0	0	8			
	Below 8	0	2	0	1	2			
Total		14	34	10	1	59			

***** Significant at p < 0.05

In looking at the relationship between marital status and the experience of VT, a $\chi 2$ test of significance was computed. Table 5 above summarises the tabular data and shows that a significant correlation exists between the experience of vicarious trauma and the marital status of the police officer ($\chi 2 = 33.04$, df = 6, $p < .05$). More married SAPS members showed trauma than others (n=26). This means that married officers are most likely more prone to experiencing vicarious trauma than those that are single, divorced or living together with their partners.

5.5 THE EXPERIENCE OF VICARIOUS TRAUMA WITHIN THE VARIOUS RANKS OF THE SAPS

There is no existing literature pertaining to the rank of the individual and the experience of vicarious trauma. However, literature does claims that inexperience, youth and lower rank result in increased emotional stress, which can possibly result in increased vulnerability to trauma.

Table 6

c2 test of association between rank and Compassion Fatigue

		Professional Discipline (Rank)					Total	$\chi 2$	df	p
		Constable	Sergeant	Detective	Inspector	Supt				
Fatigue	Above 17	4	8	14	22	1	49	11.412	8	.179
	Average (13)	2	0	0	5	1	8			
	Below 8	1	0	0	1	0	2			
Total		7	8	14	28	2	59			

The results of this study indicate that there is no significant correlation between the experience of compassion fatigue and the rank of the individual ($\chi 2 = 11.41$, df = 8, $p > .05$). A Constable is probably just as likely to experience vicarious trauma as an Inspector. This means that the rank of the individual possibly does not have an affect on the experience of trauma.

5.6 WORKLOAD OF THE SAPS

The participants were requested to clarify the nature of their professional duties as well as the case loads handled by each individual on average per week.

Table 7

c2 test of association between nature of work done and Compassion Fatigue

		Fatigue			
		Above 17	Average (13)	Below 8	Total
Nature of the work done daily	Arresting Perpetrators	3	0	0	3
	Community Patrol	6	0	0	6
	Investigations	36	3	2	41
	Administration	1	1	0	2
	Any other	3	4	0	7
Total		49	8	2	59

The amount of cases addressed every week

	Mean	Std. Deviation	N	p
Case-load per week	2.97	1.691	59	.109
Fatigue	1.20	.484	59	

The sample group (n = 59) reported that their daily work activities are as follows: 5% (3) spend their day arresting perpetrators; 10% (6) do community patrol; 69% (41) are involved in investigations; 3% (2) are doing administrative duties and 11% (7) stipulated their duties under other.

No significance correlation was found between the experience of vicarious trauma and the amount of caseload per week of the SAPS members ($\chi 2 = .109$, $p > .05$). This means that the workload of the police members does not seem to have a direct influence on the experience of compassion fatigue within the SAPS.

5.7 GENDER WITHIN THE SAPS

In order to determine whether the gender of the police officer will have an influence on their vulnerability to experiencing compassion fatigue, the following data was gathered:

Table 8
c2 test of association between gender and Compassion Fatigue

		Gender		Total	χ2	df	p
		Male	Female				
Fatigue	Above 17	32	17	49	1.852	2	.396
	Average (13)	7	1	8			
	Below 8	1	1	2			
Total		40	19	59			

In looking at the relationship between gender and the experience of VT, a $\chi 2$ test of significance was computed. Table 8 above summarises the tabular data and shows that within this study, no significant relationship exists between the experience of vicarious trauma and the gender of the police officer ($\chi 2 = 1.86$, df = 2, $p > .05$). This means that gender does not seem to play a role in the experience of trauma.

5.8 THE INFLUENCE OF EDUCATION

Research participants were asked to divulge the highest level of education that they had studied up to present.

Table 9
c2 test of association between education and Compassion Fatigue

		Highest education level completed			Total	χ2	df	p
		Grade 12	Diploma	Degree				
Fatigue	Above 17	36	10	3	49	3.530	4	.473
	Average (13)	7	0	1	8			
	Below 8	1	1	0	2			
Total		44	11	4	59			

This study found that no significant relationship exists between the education level of the police officer and the experience of vicarious trauma ($\chi 2 = 3.53$, df = 4, $p > .05$). This indicates that a police officer with no further education is just as likely to experience compassion fatigue as the officer who has further education.

5.9 SUMMARY

From this study, the areas of significance that were identified are marital status and the duration of service of the individual. Workload, education, gender, previous trauma and rank were found to have no significant influence on the experience of vicarious trauma.

CHAPTER 6

DISCUSSION

The results obtained in this study have illuminated the extent of vicarious trauma, its influences and consequences within the South African Police Service. A variety of authors have touched on the experience of vicarious trauma affecting police members, but these studies were conducted mostly outside of South Africa. The present research has attempted to highlight the impact and extent of traumatization, if any, on the professional lives of police officers within a South African context.

6.1 THE EXTENT OF VICARIOUS TRAUMA AMONG THE POLICE

In just over the past decade it has become common knowledge that law enforcement personnel, along with other emergency services workers, are a population highly prone to suffering from Posttraumatic Stress Disorder (PTSD) and Secondary trauma (Matsakis, 1992). As a direct result of their work, there is regular involvement with traumatic events over the course of their entire careers. Though most police officers hesitate to admit to suffering secondary trauma is due to work circumstances, it is a known fact that Vicarious Trauma has been called the number one problem facing caregivers today (Smets et al., 2003). Compassion fatigue affects caregivers like nurses, doctors, hospice counselors, long-term health providers, police officers, paramedics, fire personnel; anyone who gives care to troubled people on a consistent basis.

6.1.1 COMPASSION FATIGUE WITHIN THE SAPS

Compassion fatigue, also known as Vicarious Trauma (VT), is all about work-related, secondary exposure to extremely stressful events. Secondary exposure occurs when one is exposed to other people's traumatic events as a result of work. If your work puts you directly in the path of danger, this is not secondary exposure; it is instead called primary exposure. Compassion fatigue is characterized by physical and psychological exhaustion

resulting from excessive professional demands that drain available personal resources. The symptoms are usually rapid in onset and associated with a particular event. They may include being afraid, having difficulty sleeping, having images of the upsetting event pop into your mind, or avoiding things that remind you of the event.

The results in this study indicate that 83% of the sampled police are currently experiencing full symptoms of compassion fatigue, 14 % have moderate symptoms and only 3% of the sample present with no VT symptoms. These results are not surprising when looking at the duties required of a SAPS officer. Existing literature states that any situation in which an officer's expectations of personal infallibility suddenly becomes impaired by imperfection and crude reality can be considered a critical incident that may result in the development of compassion fatigue (Crank & Caldero, 1991). Examples of these could include a line-of-duty death or serious injury of a co-worker, a police suicide, an officer-involved shooting in a combat situation, and a life-threatening assault on an officer, an incident involving multiple deaths or a traumatic death of a child. Officers must often listen to stories of victims or survivors, and witness the aftermath of traumatic events. This study confirms existing literature as obtained from studies conducted elsewhere that police officers should fall within the 'caregivers' category as their work circumstances leave them prone to experiencing vicarious trauma. Thus, is it confirmed that vicarious trauma is a worldwide emotional disorder that can affect all police officers similarly, regardless of continent.

6.1.2 LEVELS OF BURNOUT IN POLICE OFFICERS

Burnout is a state of emotional and physical exhaustion caused by excessive and prolonged stress. It can occur when one feels overwhelmed and unable to meet constant demands. As the stress continues, one begins to lose the interest or motivation that led you to take on a certain role in the first place. Burnout reduces productivity and saps energy, leaving you feeling increasingly hopeless, powerless, cynical, and resentful. The unhappiness burnout causes can eventually threaten your job, relationships, and your health. These negative feelings usually have a gradual onset. They can reflect the feeling

that your efforts make no difference, or they can be associated with a very high workload or a non-supportive work environment.

When looking at the level of burnout within the sample group, it was found that the majority of the sample group (52%) showed moderate burnout symptoms, but not enough to justify a diagnosis. Of the sample, 30% presented with symptoms enough to diagnose burnout and only 18% of the individuals were totally symptom free.

Literature defines job burnout as the continuing sense of frustration and tiredness that often occurs when a person is dedicated to a calling, career, or cause and does not receive the rewards expected. Studies show that not only is the work demands on police officers on the rise, the rate of this increase is steeply accelerating (Constant, 1992). Police officers must do impossible tasks and meet unrealistic deadlines in the worst of working conditions, while staying collectively calm.

Existing research shows that there exists a positive correlation between burnout and cynicism; negativism that can result in an increased vulnerability to vicarious trauma as it lowers the officer's ability to cope with trauma and stress (Constant, 1992). The professional performance, physical body and emotional state of an individual are significantly affected by burnout. Job performance is impacted by lessened productivity, carelessness, and absenteeism. Officers begin to make fewer calls and initiate fewer activities (Aderman, 2001). Recent research within the SAPS concerning burnout in SAPS officers, identified that officer's suffering from burnout are prone to suffer the following symptoms: increased alcohol intake, less sleep, erratic eating, the body begins to give out under the stress, officers have indigestion, ulcers, and body aches; higher blood pressure is common; officers become depressed and despondent; they are often lethargic, apathetic, and tired and they become anxious and irritable (Jonker, 2004; De Wet, 2003).

6.2 WORK RELATED CIRCUMSTANCES

Research shows that vicarious trauma is directly related to the work circumstance of the police officer. Insufficient salaries, lack of appropriate training, rotating shifts, inadequate equipment, lack of promotions, poor supervision, poor communication between officer and supervisor, officer safety issues, decreased manpower, staff shortages, inadequate resources, time pressure and large work overload have been identified in various studies as factors that influence the job performance, motivation and endurance of workers (Crank & Caldero, 1991; Kop & Euwena, 2001).

6.2.1 DURATION OF SERVICE OF THE OFFICERS

The results of this study show that a relationship does exist between the duration of service of the individual and their experience of vicarious trauma. A positive correlation between the two was found, as indicated in Table 4 ($\chi 2 = 18.61$, df = 8, $p < .05$).

The findings could mean that though vicarious trauma symptoms are usually accumulative; therefore the longer duration of service, the more trauma symptoms are accumulated, eventually resulting in vicarious trauma.

The researcher found scanty reports on how the duration of service may impact the experience of vicarious trauma of police officers. Such scanty reporting could mean that the present study could be considered one of the few studies in this direction, warranting need for more research on the impact of duration of service on the experience of trauma by police officers.

6.2.2 RANK OF THE INDIVIDUALS

In this study, it was found that the rank of police officers has no influence on the experience of vicarious trauma ($\chi 2 = 11.41$, df = 8, $p > .05$). This means that a constable is as likely to suffer from vicarious trauma as an inspector.

This is possibly because in the field, all the ranks do the same duties. Both constables and inspectors attend calls, accidents, crime and trauma scenes. No existing studies could be found to confirm or disprove this finding, though literature does mention that youth, inexperience, lower rank, and degree of exposure are associated with more emotional stress and that these factors tend to interrelate. In fact, most studies find no correlation with demographic characteristics such as gender, ethnicity or race, marital status, rank or education (Soderfelt & Soderfelt, 2002; Smets, Oort, & de Haes, 2003).

6.2.3 INFLUENCE OF WORK LOAD

Literature concerning Police agencies throughout the world always make mention of the heavy caseloads forced on their members. New cases are opened daily, adding to the masses of existing cases still open. Insufficient resources and staff contribute towards the increased amount of caseloads provided to each SAPS individual, thereby increasing their work related stress.

The sample group expressed their current duties including: arresting perpetrators, investigations, administration, community patrols etc. The present study found that no significant relationship exists between the workload of the police officials and the experience of vicarious trauma ($\chi 2 = .109$, $p > .05$). It is common knowledge that SAPS are understaffed and all members have a heavy caseload. Various research exists that look at the negative effect that the excessively large workload of the police has on the quality of service, job satisfaction, personal health and the profession (Kop & Euwema, 2001; De Wet, 2003; Haskell, 1999; Bruce, 2000; Crank & Caldero, 1991).

6.2.4 LEVELS OF WORK SATISFACTION IN WORKING FOR THE POLICE

Work satisfaction can be defined as an affective or emotional response towards various facets of an employee's work (Lancero & Gerber, 1995). The probable causes of this work satisfaction include status, supervision, peer relationships, job content, wages and other extrinsic rewards, promotion and physical conditions of work, and possibly

organizational structure. Conversely, organizational structure can also be the source of dissatisfaction (Spector, 1997).

Factors found to contribute towards high work satisfaction include being female, job security, being in a small workplace, high financial income, being self-employed, having tertiary education, being employed within the public sector, having a supervisor and living within reasonable distance from your workplace. Factors found to cause lower job satisfaction are being male, high workload, tight deadlines, working for a boss, low salary, long work hours, high travel distances, conflict with colleagues or boss, insufficient equipment, having no say in decisions and no promotion opportunities.

Within this study, it was found that the majority of the sample (83%) derives no satisfaction from their work within the SAPS, 15 % derive average satisfaction and only around 2% of the sample finds their work satisfying.

Existing research has shown that women generally experience more work satisfaction than men (Oswald, 2002). This research showed that the majority of the sample group earns a yearly salary of less than R120 000 per annum. Literature shows that low salaries are a major cause of stress within the SAPS (Michaels, Smith, Moon, Peterson & Long, 2000), as well as lack of manpower, high workload and lack of material resources, e.g. vehicles (De Wet, 2003).

6.2.5 HOW VICARIOUS TRAUMA AFFECTS THEIR PROFESSIONAL LIVES

If a police officer is experiencing vicarious trauma, literature has identified various aspects of their professional lives that will become impaired (Haskell, 1999; Kirschman, 1998). Their performance in job tasks will decrease in quality and quantity, they will avoid job tasks and the officers will lack motivation. Their morale is affected through loss of confidence and interest, dissatisfaction, detachment, negative attitude, as they feel unappreciated. Interpersonally, they withdraw from colleagues, they become impatient, there is a significant decrease in the quality of work relationships, and increased staff

conflict arises due to poor communication. Behaviourally, the officers starts absenting themselves from work, feel exhausted, are tardy in their dress and bodily care, behave irresponsibly, exhibit faulty judgement, feel overworked and this may then result in frequent job changes.

6.3 PERSONAL INFLUENCES

Vicarious trauma has an undeniably negative influence on the professional lives of police officers, but it also has a severe impact on them personally. This study looked to establish what influence various personal factors have on the experience of vicarious trauma.

6.3.1 GENDER WITHIN THE POLICE SERVICE

Existing research has found that generally, females are more prone to experiencing affective disorders than the male sex. This could be due to the fact that women are more emotionally orientated and empathise easier with others than what men do (McCarrol, Ursano, Fullerton, & Lundy, 1993). This research sought to establish whether this is true; that a relationship does exist between the gender of the officers and their experience of vicarious trauma (by using the Pearson chi-square test).

Symptoms of trauma disorders have been found to be more prevalent among female rather than male trauma workers and other professionals (Kassam-Adams, 1995; McCarroll, Ursano, Fullerton, & Lundy, 1993). In a study of psychotherapists who treat sexual trauma victims, Kassam-Adams (1995) noted that female therapists reported greater trauma symptoms than male therapists. Likewise, in a study of Operation Desert Storm (McCarroll et al., 1993), female solider mortuary workers also reported higher levels of distress than males. Similarly, female police officers were found to be more likely to report symptoms than male officers.

Within this study, it was found that the gender of the police officer was not found to have an effect on their experience of vicarious trauma ($\chi 2 = 1.86$, df = 2, $p > .05$) (table 8). This is in contradiction to existing research possibly because female officers are more prone to reporting symptoms of trauma, while male officers preferably suffer in silence. Though they do not report their trauma symptoms, this does not prove that they are not in fact suffering from vicarious trauma but are keeping it hidden.

6.3.2 MARITAL STATUS AND VICARIOUS TRAUMA

Most existing literature proposes that the marital status of an individual has no significant influence on the experience of vicarious trauma. A study done in Brazil indicated that police officers suffering from a trauma related disorder (21.6%) are 5 times more likely to be divorced than those not experiencing trauma related symptoms (4.3%) (Figueira, Maia, Oliveira, Burger, Mendlowicz & Coutinho, 1992).

Within this study, it was determined that a significant relationship exists between the marital status of the individual and the experience of compassion fatigue ($\chi 2 = 33.04$, df = 6, $p < .05$). This is a contradiction to a study done by De Wet in 2003 which found that police officials' marital status is not related to job stress, coping strategies or suicide ideation. Other research shows that unmarried officers are more prone to experiencing depression and suicidal ideation than married individuals (Jonker, 2004). Another study done by Renck, Weisaeth and Skarbo (2002) investigating stress reaction in police officers, found that older and single officers had more intrusive symptoms than younger and married/cohabitating officers. Further research into this area is needed.

6.3.3 HIGHEST EDUCATION REACHED BY INDIVIDUALS

Existing research is conflicting on whether the education level of an individual as an affect on their experiencing of VT. Some research states that it does have an influence (Napersteck, 2004) while other has shown that it plays no role (Bride, 2004).

No relationship was found to exist within this study between the level of education f the individual and their experience of VT ($\chi 2 = 3.53$, df = 4, $p > .05$). Existing research is conflicting in this area. Education has often been shown to have an impact on the likelihood of developing trauma related disorders. For reasons that are not entirely clear, those with less education are consistently more vulnerable to experiencing trauma related disorders than the well educated (Napersteck, 2004). Other research revealed that level of training (generalised to education), played no role in acquiring traumatic disorders (Bride, 2004). The reason for this may be that individuals with more training and education are typically the persons responding to the worst calls because they can provide the most advanced care. Worst calls at a higher frequency may mean more trauma symptoms regardless of level of training or education.

6.3.4 PREVIOUS EXPERIENCE OF TRAUMA

Conflicting data exists concerning the impact of previous trauma on the experience of compassion fatigue.

One study found that a history of previous trauma, previous psychological well-being, social support, age, gender, educational achievement, socio-economic status and styles of coping mediate the effects of indirect exposure to a traumatic incident. Another study done by Bride (2004) suggests that there is some consistency regarding previous personal trauma and the experience of compassion fatigue.

Conflicting with this is a study done by Marcus and Dubi (2006), looking at the relationship between resilience and compassion fatigue in counselors found that the prior experience of trauma in mental health professionals does not necessarily coincide with experience of psychological consequences such as compassion fatigue, burnout, anxiety and depression.

This study (table 3) provided data indicating that the existence of previously experienced trauma has no significant effect on a person's experience of vicarious trauma ($\chi 2 = .172$,

df = 2, p > .05). This confirms a study done by Marcus and Dubi (2006), looking at the relationship between resilience and compassion fatigue in counselors. This study found that the prior experience of trauma in mental health professionals does not necessarily coincide with experience of psychological consequences such as compassion fatigue, burnout, anxiety and depression.

Various researchers have determined that workers who have experienced a personal trauma are more likely to suffer from severe secondary traumatic stress (STS) symptoms than workers who did not have a personal trauma history (Kassam-Adams, 1995; Moran & Britton, 1994; Pearlman & Saakvitne, 1995; Schauben & Frazier, 1995). Moran and Britton (1994) surveyed 210 Australian State Emergency Services and Volunteer Bushfire Brigade Unit workers. The authors reported that workers who had a personal trauma history experienced higher levels of STS symptoms after responding to disasters than those without a trauma history. Kassam-Adams (1995) reported a relationship between therapists personal trauma history and severity of STS symptoms while Follette, Polusny, and Milbeck (1994), determined both mental health and law enforcement professionals with personal trauma histories had significantly higher levels of trauma-specific symptoms than professionals not reporting prior traumas.

6.3.5 HOW VICARIOUS TRAUMA AFFECTS THEIR PERSONAL LIVES

Literature exists that depicts how the experience of vicarious trauma affects the police officer as a person. Cognitively, officers suffering from vicarious trauma become confused, experience reoccurring trauma imagery, experience self-doubt, may be disorientated and have self harm thoughts (Haskell, 1999). Emotionally, the police officers experience anger outbursts, depression, fear, numbness, and anxiety and survivor guilt (Janik, 1995). They may become clingy with loved ones, experience nightmares, be hyper vigilant, moody and have a change in appetite (Matsakis, 1992). Their religious beliefs suffer as they experience a loss of purpose and feel anger towards God. They withdraw from those close to them, become overprotective, experience decrease in intimacy and sex, mistrust, project their anger and blame and feel lonely (Janoff-Bulman,

1992). Physically they experience aches and pains, dizziness, breathing difficulties, somatic complaints, impaired immune system and rapid heartbeat and increased blood pressure (Cornille & Meyers, 1999).

CHAPTER 7

CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

7.1 CONCLUSION

In conclusion, this study found that vicarious trauma is in fact highly prominent within the SAPS and that the duration of service and marital status of police officers have a significant effect on their vulnerability to experiencing vicarious trauma. Rank, workload, existence of previous trauma, education level and gender was found to have no influence on the experience of vicarious trauma. This research found work satisfaction to be very poor within the work force at present. This could possibly be due to a poor reward system, low public opinion, increase in crime rate and work load, lack of advancement possibilities, insufficient support structures (e.g. debriefing) and under staffing. The increase in negative publicity in the media surrounding the SAPS could be resulting in demoralization of the force. By identifying that vicarious trauma is a significant issue within the SAPS at present, the researcher hopes that more resources and attention will be focused into resolving these issues, thereby increasing productivity and work satisfaction.

7.2 RECOMMENDATIONS

There is a severe lack of available research as pertaining to law enforcement and duration of service, rank and marital status and the influence these factors have on vicarious trauma. Further research into these areas is recommended to fully understand vicarious trauma, its influences, its risks and possible consequences within the SAPS. The researcher recommends that similar studies be done in other Provinces in order to fairly represent the SAPS country wide, taking into consideration the different socio-economic environments of the different districts. Further research should also be done concerning the effect that vicarious trauma in a police mans life affects their family and loved ones.

A qualitative study could be done on the internal processes related to understanding the cognitive effects that police men experience when working with traumatized victims.

7.3 LIMITATIONS

This research was limited in that the sample size was only drawn from 2 stations within the Limpopo province and only 60 members participated, therefore generalisation of these findings is limited. It highlights the need for further investigation into compassion fatigue within the police services country wide. Factors that were not taken into account include race and age of the participants. Other factors such as the law officials coping and personality types, which could have an affect on the cognitive schemas of the participants, were not measured.

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APPENDIX A

ETHICAL CONSIDERATIONS: PROTECTING PARTICIPANTS FROM **PSYCHOLOGICAL AND PHYSICAL HARM**

Conducting ethical research using human participants involves the making of conscious choices that promote fundamental values regarding appropriate treatment of fellow human beings.

The researcher will adhere to ethical values that influence the choices researchers make about conducting health research, including:

- Honesty and openness with research participants
- Respect participants' autonomy and privacy
- Avoidance of harm to participants
- Integrity in conducting the research and reporting the results
- Potential future benefits of the public arising from the research results
- Sensitivity to the cultural and social environment of all stakeholders and conducting herself in a manner appropriate to their environment.
- Confer with the participants on contractual decisions such as confidentiality; privacy, communication, and ownership of findings and reports.

Signed: _____ **on**:

Chantelle R van Lelyveld

At: University of Limpopo (Turfloop Campus)

Polokwane

APPENDIX B

University of Limpopo - Health Behaviour Research Unit

Compassion Fatigue Survey

Section A: Biographical Information

1. Gender: [1] Male [2] Female
2. Highest educational level completed:_____
3. Age (in years):_____
4. Marital status: [1] Single [2] Married [3] Divorced [4] Widow (er) [5] Engaged [6] Living with partner
5. Religious Affiliation: [1] Christianity [2] African Traditional [3] Both [4] None [5] Others: Specify_____

6. Professional Discipline (Rank):_____
7. Professional experience (in years):_____
8. Length of time on the job (in years):_____
9. About how manyhours of "quality time" do you spend per day? (e.g., talking, recreation, etc.):

1. With immediately Family	
2. With extended friends	
3. With Friends alone	
4. Alone all the time	

10. Number of people living in Household (not including yourself)

1. Adults	
2. Children	
3. Elderly	
4. Alone all the time	

11. Total Annual Household Income: Tick **[√]**

1. R 15, 000 or less	
2. R60, 001-R75, 000	
3. R75, 001-R90, 000	
4. R90, 001-R105, 000	
5. R105, 001-R120, 000	
6. R120, 001-R150, 000	
7. Over R150, 001	

13. Describe the nature of work you do daily: Tick **[√]**

1. Arresting Perpetrators	

2.	Community Patrol	
3.	Charge Officer	
4.	Any other (specify):	

14. Amount of breaks taken per year (in days or weeks, please indicate): Tick **[√]**

1.	0-1	
2.	2-5	
3.	6-10	
4.	11-15	
5.	16-20	
6.	21 and above	

15. Resting time in a day: Tick**[√]**

1.	0-1	
2.	2-5	
3.	6-10	
4.	11-15	
5.	16-20	
6.	21 and above	

16. Caseload per week: Tick**[√]**

1.	0-1	
2.	2-5	
3.	6-10	
4.	11-15	
5.	16-20	
6.	21 (and above)	

Section B: STRESSFUL JOB-RELATED EVENTS

Part 1. Instructions: The first event, **ASSIGNMENT OF DIAGREEBLE DUTIES**, was rated by persons in a variety of occupations as producing an average amount of stress. This event has been given a rating of **"5"** and will be used as the standard for evaluating the others. Compare each with this standard. Then assign a number from **"1"** to **"9"** to indicate whether you judge the event to be less stressful than being disagreeable duties.

For the job-related events judged to produce approximately the same amount of as the **ASSIGNMENT OF DIAGREEBLE DUTIES,** fill in the **5**. For those events that you feel are more stressful than the standard, fill in a number proportionately larger than **5**. If you feel an event is less stressful than standard, fill in a number proportionately lower than **5.**

STRESSFUL JOB-RELATED EVENTS	**Amount of stress**								
	Low				**Moderate**				**High**
1A. **ASSIGNMENT OF DISAGREEBLE DUTIES**	1	2	3	4	X	6	7	8	9
2A. Working overtime.	1	2	3	4	5	6	7	8	9
3A. Lack of opportunity of advancement.	1	2	3	4	5	6	7	8	9
4A. Assignment of new or unfamiliar duties.	1	2	3	4	5	6	7	8	9
5A. Fellow workers not doing their job.	1	2	3	4	5	6	7	8	9

6A. Inadequate support by supervisor.	1	2	3	4	5	6	7	8	9
7A. Dealing with crises situation.	1	2	3	4	5	6	7	8	9
8A. Lack of recognition for good work.	1	2	3	4	5	6	7	8	9
9A. Performing tasks not in job description.	1	2	3	4	5	6	7	8	9
10A. Inadequate of poor quality equipment.	1	2	3	4	5	6	7	8	9
11A. Assignment of increased responsibility.	1	2	3	4	5	6	7	8	9
12A. Periods of inactivity.	1	2	3	4	5	6	7	8	9
13A. Difficulty getting along with supervisor.	1	2	3	4	5	6	7	8	9
14A. Experiencing negative attitudes toward the organisation	1	2	3	4	5	6	7	8	9
15A. Insufficient personnel to handle assignment.	1	2	3	4	5	6	7	8	9
16A. Making critical on spot decision.	1	2	3	4	5	6	7	8	9
17A. Personal insult from clients/suspects/colleagues.	1	2	3	4	5	6	7	8	9
18A. Lack of participation in policy-making decisions.	1	2	3	4	5	6	7	8	9
19A. Inadequate salary.	1	2	3	4	5	6	7	8	9
20A. Competition for advancement.	1	2	3	4	5	6	7	8	9
21A. Poor or inadequate supervision.	1	2	3	4	5	6	7	8	9
22A. Noisy work area.	1	2	3	4	5	6	7	8	9
23A. Frequent interruptions.	1	2	3	4	5	6	7	8	9
24A. Frequent changes from boring to demanding activities	1	2	3	4	5	6	7	8	9
25A. Excessive paper work.	1	2	3	4	5	6	7	8	9
26A. Meeting deadlines.	1	2	3	4	5	6	7	8	9
27A. Insufficient personal time (e.g. coffee breaks, lunch).	1	2	3	4	5	6	7	8	9
28A. Covering work for another employee.	1	2	3	4	5	6	7	8	9
29A. Poorly motivated co-workers.	1	2	3	4	5	6	7	8	9
30A. Conflicts with other departments.	1	2	3	4	5	6	7	8	9

Part 2. Instructions: For each of the job-related events listed below, please indicate the approximate number of days during the past **6 months** on which you have personally experienced this event. Fill in **0** if the event did **not** occur; fill in the number **9+** for event you experienced personally on **9 or more days** during the past 6 months.

STRESSFUL JOB-RELATED EVENTS	**Number of days which the Event Occurred During the Pasts 6 Months**								
1B. Assignment of disagreeable duties.	1	2	3	4	5	6	7	8	9+
2B. Working overtime.	1	2	3	4	5	6	7	8	9+
3B. Lack of opportunity of advancement.	1	2	3	4	5	6	7	8	9+
4B. Assignment of new or unfamiliar duties.	1	2	3	4	5	6	7	8	9+
5B. Fellow workers not doing their job.	1	2	3	4	5	6	7	8	9+
6B. Inadequate support by supervisor.	1	2	3	4	5	6	7	8	9+
7B. Dealing with crises situation.	1	2	3	4	5	6	7	8	9+
8B. Lack of recognition for good work.	1	2	3	4	5	6	7	8	9+
9B. Performing tasks not in job description.	1	2	3	4	5	6	7	8	9+
10B. Inadequate of poor quality equipment.	1	2	3	4	5	6	7	8	9+
11B. Assignment of increased responsibility.	1	2	3	4	5	6	7	8	9+
12B. Periods of inactivity.	1	2	3	4	5	6	7	8	9+
13B. Difficulty getting along with supervisor.	1	2	3	4	5	6	7	8	9+
14B. Experiencing negative attitudes toward the organisation	1	2	3	4	5	6	7	8	9+
15B. Insufficient personnel to handle assignment.	1	2	3	4	5	6	7	8	9+

16B. Making critical on spot decision.	1	2	3	4	5	6	7	8	9+
17B. Personal insult from clients/suspects/colleagues.	1	2	3	4	5	6	7	8	9+
18B. Lack of participation in policy-making decisions.	1	2	3	4	5	6	7	8	9+
19B. Inadequate salary.	1	2	3	4	5	6	7	8	9+
20B. Competition for advancement.	1	2	3	4	5	6	7	8	9+
21B. Poor or inadequate supervision.	1	2	3	4	5	6	7	8	9+
22B. Noisy work area.	1	2	3	4	5	6	7	8	9+
23B. Frequent interruptions.	1	2	3	4	5	6	7	8	9+
24B. Frequent changes from boring to demanding activities	1	2	3	4	5	6	7	8	9+
25B. Excessive paper work.	1	2	3	4	5	6	7	8	9+
26B. Meeting deadlines.	1	2	3	4	5	6	7	8	9+
27B. Insufficient personal time (e.g. coffee breaks, lunch).	1	2	3	4	5	6	7	8	9+
28B. Covering work for another employee.	1	2	3	4	5	6	7	8	9+
29B. Poorly motivated co-workers.	1	2	3	4	5	6	7	8	9+
30B. Conflicts with other departments.	1	2	3	4	5	6	7	8	9+

Part 3. Instructions: Kindly indicate by ticking in the box corresponding with the best statement that describes your own situation: Respond by ticking**Strongly Agree (SA), Agree (A), Disagree (D),** or **Strongly Disagree (SD).**

		SA	A	D	SD
1.	I feel emotionally drained from my work.				
2.	I feel used up at the end of the workday.				
3.	I feel fatigue when I get up in the morning and have to face another day on the job.				
4.	Working with people all day is really a strain for me.				
5.	I fell burned up from my work.				
6.	I feel frustrated by my work.				
7.	I feel I'm working too hard on my job.				
8.	I feel at the end of the rope.				
9.	Working with people directly put too much stress on me.				
10.	I feel I treat some recipients as if they were impersonal.				
11.	I've become less caring toward people's suffering since I took this job.				
12.	I worry that this job is hardening me emotionally.				
13.	I don't really care what happens to some recipients.				
14.	I feel some recipients blame me for their problems.				
15.	I can easily understand how my recipients fell about things.				
16.	I deal very effectively with the problems of my recipients.				
17.	I feel I am positively influencing other peoples' lives through my work.				
18.	I feel very energetic.				
19.	I can easily create a relaxed atmosphere with recipients.				
20.	I feel exhilarated (lively) after working closely with recipients.				
21.	I have accomplished many worthwhile things in this job.				
22.	In my work, I deal with emotional problems very calmly.				

<u>Section C:</u> Experience of Personal Trauma

Part 1: Instructions: Please answer all questions on your personal experiences of trauma. Confidentiality is guaranteed.

1. a) Do you have experience of personal trauma? [1] YES [2] NO

   b) If **YES**: tick the appropriate section below:

Do you have personal experience of any trauma of the following? (Tick Yes or No)

	Trauma	Childhood		Adulthood	
a	Physical Abuse	Yes	No	Yes	No
b	Emotional Abuse	Yes	No	Yes	No
c	Sexual Abuse	Yes	No	Yes	No
d	Death of an immediate family member	Yes	No	Yes	No
e	Home being destroyed	Yes	No	Yes	No
f	Any Other Trauma (Specify): **Childhood:** _____ **Adulthood:** _____	Yes	No	Yes	No

2. Activities of Daily Living: Tick **[√]**

	Activities	Duration
a	About how many hours do sleep a night?	
b	About how many hours a week do you spend exercising or working out?	
c	About how many days a month are you sick (even if you keep working)	

3. Please fill in the number that best represent how much the following statements describe your experience: Tick **[√]**

	Statements	Not at all	Somewhat important	Extremely important
a	My religious belief are very important to me			
b	Time with my family is very important to me			
c	Time with my friends is very important to me			
d	Time alone is very important to me			
e	I am very satisfied with my chosen profession			
f	I am very satisfied with my current job			
g	I am very satisfied with my current job setting			
h	I believe my eating habits are very healthy			

4. Tick **[√]** appropriate items from the following list if you are agreeable with the statement:

	Statement	Tick [√]
1.	I generally feel safe from danger.	
2.	I find myself worrying a lot about myself.	
3.	I belief I can protect myself if my thoughts become self-destructive.	
4.	I am reasonably comfortable about the safety of those I care about.	
5.	Sometimes I think I am more concerned about the safety of others than they are.	
6.	I worry a lot about the safety of the loved ones.	
7.	I feel uncertain about my ability to make decisions.	
8.	I have sound judgement.	

9.	I feel confident in my decision-making ability.	
10.	I can depend on my friends to be there when I need them.	
11.	Most people don't keep promises they make.	
12.	Trusting others is generally not very smart.	
13.	I deserve to have good things happen to me.	
14.	I am basically a good person.	
15.	Bad things happen to me because I am bad.	
16.	This world is filled with emotionally disturbed people.	
17.	Most people are basically good at heart.	
18.	I don't have a lot of respect for people closest to me.	
19.	Some of my happiest experiences involve other people.	
20.	There are many people to whom I feel close and connected.	
21.	I often feel cut off and distant from other people.	
22.	Strong people don't need to ask for others' help.	
23.	I feel bad about myself when I need others' help.	
24.	When someone suggests I relax, I feel anxious.	
25.	I don't have much control in relationships.	
26.	I am often involved in conflicts with other people.	
27.	I often feel helpless in my relationships with others	

Part 2. Professional Quality Of Life (ProQOL - R III)

Helping others puts you in direct contact with other people's lives. As you probably have experienced, your compassion for those you help has both positive and negative aspects. We would like to ask you questions about your experiences, both positive and negative, as a helper. Consider each of the following questions about you and your current situation. Tick in the box that honestly shows how often the statement has been true for you *in the last 30 days*

	Never	**Rarely**	**A few times**	**Somewhat Often**	**Often**	**Very Often**
1. I am happy						
2. I am preoccupied with more than one person						
3. I get satisfaction from being able to help						
4. I feel connected to others						
5. I jump or I am startled by unexpected sounds.						
6. I have more energy after working.						
7. I find it difficult to separate my private life from my life as a helper.						
8. I am losing sleep over a person I help's traumatic experience.						
9. I think that I might have been "infected" by the traumatic stress of those I help.						
10. I feel trapped by my work as a helper.						
11. Because of my helping, I have felt "on edge" (nervous) about various things.						
12. I like my work as a helper.						
13. I feel depressed as a result of my work as a helper.						
14. I feel as though I am experiencing the trauma of someone I have helped.						
15. I have beliefs that sustain me.						

16. I am pleased with how I am able to keep up with helping techniques and protocols.						
17. I am the person I always wanted to be.						
18. My work makes me feel satisfied.						
19. Because of my work as a helper, I feel exhausted.						
20. I have happy thoughts and feelings about those I help and how I could help them.						
21. I feel overwhelmed by the amount of work or size of my caseload I have to deal with.						
22. I believe I can make a difference through my work.						
23. I avoid certain activities or situations because they remind m of frightening experiences of the people I help.						
24. I plan to be a helper for a long time.						
25. As a result of my helping, I have sudden, unwanted frightening thoughts.						
26. I feel “bogged down” (too much drawn into my work) by the system.						
27. I have thoughts that I am a “success” as a helper.						
28. I can’t remember important parts of my work with trauma victims.						
29. I am an unduly sensitive person.						
30. I am happy that I chose to do this work.						