TRAUMATIC EXPERIENCES AND PASTORAL CARE IN THE DISCIPLINED FORCES IN BOTSWANA

by

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Declaration

I, Letlhogonolo Edward Thabalaka, hereby certify that this dissertation is a result of my own original work and has not been submitted by me for a degree at this university or any other university. I am submitting it for the MTh (Practical Theology) at the University of Pretoria. All of the sources I consulted are listed, and they have all received full citations.

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Summary

Disciplined forces such as the military and police are frequently exposed to severe experiences of trauma which often leads to psychological effects that take effect in and outside their workplaces. Due to the nature of their work, stress and trauma can have a significant effect on an officer's health and wellbeing as there are times they are even exposed to situations that challenge their morals and hence the significance of pastoral care and chaplaincy in military and policing. It is essential for officers to receive psychological support in order to maintain their mental health and effectively carry out their duties. However, officers frequently hesitate to seek for psychological assistance while others are not aware of it. The role of chaplaincy must not be neglected and hence there is need to enforce it to reduce post-traumatic stress disorder which is common among officers in the disciplined forces. This study investigates the different traumas experienced by officers, their types as well as effects and the role of pastoral care in their wellbeing and dealing with trauma. The research focuses on Botswana Defence Force and Botswana Police Service personnel.

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CHAPTER ONE
INTRODUCTION

1.1 Background

Trauma can be defined as an inescapably stressful event that overwhelms people to the extent that their coping skills are insufficient for dealing with the situation as explained by (Perrotta, 2019). Krupnik (2020:3) emphasises that trauma is not an event, but a stress response of an individual to a subjective experience. Trauma becomes evident when the response to an event is that of intense fear, helplessness, a sense of the loss of control, or the threat of annihilation. According to (Perrotta, 2019), trauma can take place repeatedly and lead to chronic effects. Individuals in the disciplined forces are highly exposed to frequency of potentially traumatic incidents in their workplaces. Trauma exposure can therefore alter their psychic system hence affecting their psychological, mental and emotional functioning. Disciplined forces are, for example, exposed to danger, the threat of physical injury and even the loss of life. Law enforcement officers encounter dangerous people such as violent inmates and witness accident scenes. According to (Leonard, 2020:1), trauma can have a long-term impact on a person's health, and if symptoms continue and do not lessen in intensity, it is possible that the trauma has turned into the mental health problem known as post-traumatic stress syndrome (PTSS) (Sparks, 2018:1). Symptoms include emotional dysregulation problems, despair, hostility and irritability (Krupnik, 2020).

The exposure to trauma can be a primary or secondary experience. A primary traumatic experience, according to Leonard (2020), is when a person experiences a traumatic event first hand, it happens to or is done to the individual person. Secondary trauma is experienced when someone witnesses a horrific event, watching helplessly as it takes place (Sparks, 2018). In certain traumatic situations, such as war, a person may simultaneously be the victim and the traumatizer. For instance, a soldier serving in a combat zone might be exposed to the harm and death of others, sustains injuries, and participates in killing “the enemy” (Krupnik, 2020), and a police officer may experience frequent involvement in violent and unpredictable events in the line of duty. It is also possible that a war-zone experience can cause inner conflict between a people’s sense of patriotism and their faith and morality. This creates ambiguity over the best course of action. Inherent to policing as career is the potential for exposure to

multiple trauma and critical incidents that are accompanied by post-traumatic and stress reactions (Schorr et al., 2018:2).

Traumatic incidents can cause reactions that affect the police official's work, associations and life's general quality. With the help of friends and professional counselling, the majority of police officers are able to recover and continue working, but some responders experience severe symptoms and require additional care (Leonard 2020). These exposures can result in to enduring spiritual confusion and moral injury (Schorr et al., 2018). As a result, one may experience a loss of faith, guilt-related emotions, self-blame, and emotional seclusion from both God and other people. People may feel disconnected from their upbringing's ideas and their expectations for the services in the disciplined forces would entail, and their actual service experiences (Leonard, 2020).

In difficult times when people are exposed to traumatic events, chaplains play a critical role in the emotional healing of those who have been adversely affected by traumas. According to Leonard (2020) chaplains provide their services following pastoral care strategies that are derived from Reconstruction Theology in Christian ministry or theological motivation, where pastoral care promotes social and communal reform. According to Schorr et al. (2018), pastoral care is a type of Christian social activism that aims to alter systems and structures through public theology. Chaplains provide confidential counselling to men and women in military, police and other professions such as nursing and fire fighters. These individuals primarily focus on meeting the religious and spiritual requirements of the police and armed services while also supporting the mental health of service members.

Military and police chaplains, examines the psychological health of officers and in diagnosing they are involved in treating mental health problems of the officers in these forces. The ability of the caregiver to develop a therapeutic or healing mode of interaction and style of speech with the person receiving care is emphasized in pastoral dialogue (Schorr et al., 2018). Healthcare chaplaincy and pastoral care are frequently set apart from one another as ministerial specializations. When this difference is recognized, pastoral counselling is frequently referred to as a specific kind of ministry marked by an intentional contract between the pastoral caregiver and the person or family seeking aid, typically involving a series of prepared counselling sessions (Schorr et al., 2018).

Military personnel regularly report having post-traumatic stress disorder (PTSD), particularly if they have suffered an injury and exposure to crimes and war. According to estimates 10% to 35% of first responders worldwide, including the military and police officers, experience mental disorders. This study explores the traumatic experiences of officers in the military and police service and the role that chaplaincy and pastoral care can play with regard to their mental health. The focus is on the context of the Botswana Defence Force and Botswana Police Service units. The point of departure is that:

- there is high experience of traumatic experiences among the military and police officers due to the nature of their work;
- the traumatic experiences prevalent among disciplinary forces include death related trauma;
- officers can be vulnerable to posttraumatic stress as an effect of what they experience;
- not all individual military and police officers utilise the services of chaplains to help them to deal with the trauma they have experienced;
- chaplains can experience secondary trauma as they engage with the first-hand traumatic experiences of the officers they are counselling.

1.2 Research Problem

Disciplined forces in Botswana address the country's most pressing crimes and security issues. They are therefore exposed to events that can result in psychological trauma. Botswana has three major disciplined forces, namely the Botswana Defence Force which is the country's military, the Botswana Police Services, and the Botswana Prisons Service which is a correctional institution. The persons who serve in these forces experience traumatic events in the line of duty. These include traffic fatalities, homicides and war. Mental health problems due to psychological stress can manifest in the form of severe emotional and behavioural reactions (Connell et al., 2013). Some seek help from pastoral caregivers. This kind of care is provided through the chaplaincy office. Pastoral care includes the spiritual perspective on people's existential situations (see McClure, 2012). Pastoral care usually refers to the assistance provided by spiritual leaders in specified religious roles. They aim is to

provide guidance to people in order that they can experience as fully as possible the reality of God's presence and love in their life through words, deeds, and relationships. Chaplaincy is a relatively new profession in Botswana. It is not wide-spread in the major government and public services. Only a few hospitals and schools that partner with churches, the Botswana Defence Force and the Botswana Police Service employ chaplains.

Chaplaincy does not exist in the private sector in Botswana. Where chaplaincy does exist, it is not always understood fully by either the leaders or the staff. Since it is relatively new there is shortage of personnel and those who do chaplaincy work often have insufficient experience in dealing with trauma. Hence the attention given to both people who went through trauma and the pastoral caregivers tends to be insufficient. Botswana Defence Force and Botswana Police Service both have chaplaincy offices that provide counselling, both to individuals and groups. According to the Botswana Police Report of 2017, the Occupational Health, Chaplaincy Safety and Social Welfare Unit of the Botswana Police Service were under-staffed. This made it difficult to deal effectively with work-related stress and trauma.

Several studies have been done in Southern Africa on the trauma experiences among disciplined forces and the relevance of pastoral care. A study conducted by Connell et al. (2013) assessed the effect of Border Wars on veterans' psychological health. The study found a significant prevalence of PTSD (some 33%) among former national servicemen in South Africa which was traced to psychological trauma experiences during duty. In a study on the effect of traumatic experiences on the South African Police Service, police officials with high levels of stress were three times more likely to have health issues, three times more prone to domestic violence, five times more likely to use substances (especially alcohol), and ten times more likely to suffer from depression (NIMH 2018). A study showed that members of the Botswana Defence Force (BDF) as a military organisation were not receive sufficient guidance during their military training to deal with stress effectively.

As is the case in all military environments, the people who work for Botswana Defence Force experience operational and non-operational traumatic stress, as well as personal stress. The Botswana Police Service emergency work carries the risk of exposure to traumatic events. This can result in workplace stress among police workers. A study by Agolla (2009) showed that participants who had experienced

distressing incidents struggled to get past the incident on a psychological level. Others were physically injured while on duty. Many law enforcement officers and military personnel cope by socialising, whereas some use substances such as alcohol to cope with the stress. The available pastoral care services in all these studies were not utilised much by officers. The study aims to explore the level of traumatic experiences of the personnel of the Botswana Defence Force and the Botswana Police Services, in order to ascertain what role effective pastoral care can play in supporting people who have to deal with work-related trauma.

1.3 Purpose of the Study

Significant work has been done regarding the impact of trauma among members of various disciplined forces in a variety of contexts. The contribution of this study is to investigate the matter in the particular context of Botswana. The aim of the investigation is to ascertain how traumatic experiences in this specific context affect the personnel and to investigate the role of pastoral care in the disciplined forces. The support that is currently provided for chaplains or pastoral caregivers for their work with traumatised members of the forces will be evaluated and guidelines for what effective service could entail, will be provided. The goal of this study is to highlight the role of the chaplaincy services in the disciplined forces as a means to mitigate the devastating long-term impact of trauma on the members of these services. Another pertinent need is that of care for the pastoral caregiver. This study therefore aims to investigate the experience of trauma among Botswana Defence Force and Botswana Police Service disciplined forces, exploring the effects and paying particular attention to the role that can be played by chaplaincy pastoral care.

The study aims to;

- identify prevalent traumatic experiences in the disciplined forces in Botswana;
- identify effects of traumatic experiences among disciplined forces in Botswana;
- identify the psychological responses expected following traumatic experiences among disciplined forces in Botswana;
- identify the effect and role of pastoral care among the disciplined forces in Botswana.

Aspects that will be explored, include the following:

- the prevalent traumatic experiences among the disciplined forces in Botswana;
- the effects of traumatic experiences among disciplined forces in Botswana;
- the psychological responses to traumatic experiences among disciplined forces in Botswana;
- the role and effect of pastoral care among disciplined forces in Botswana in dealing constructively with trauma experiences and mental health problems.

The contribution of the study is not limited to the academic field of pastoral care and counselling, but can also serve to inform policy in the disciplined forces that will improve strategies for enhancing the welfare of the personnel of the Botswana Defence Force and the Botswana Police Service.

1.4 Chapter Outline

Chapter 2 focuses on existing research with regard to traumatic experiences among military and police personnel. It explores the specific trauma experienced by military and police personnel and the consequences of the traumatic experiences for their personal and work life. Concepts in pastoral care and chaplaincy for dealing with trauma are unpacked in the chapter. Global statistics on the prevalence of trauma and Post-traumatic Stress Disorder in the disciplined forces are given in order to provide a broader insight into the trauma experience among other forces globally and regionally.

Chapter 3 explains the methods followed in order to conduct the empirical part of the investigation. It describes how data was collected and analysed. It expands on the study design, population and size of the study, and the strategies and tools that were utilised.

Chapter 4 constructs a theoretical framework for the study. Various conceptual models and theories that explain the phenomenon are perused in order to identify those aspects that can be specifically useful for developing an effective pastoral approach for the chaplaincy services of the disciplined forces where personnel are exposed to traumatic events and experiences on a regular basis in the line of duty.

Chapter 5 discusses the results of the empirical and theoretical sections of the study in order to develop and approach to effective pastoral engagement with persons in the disciplined forces.

Chapter 6 presents the summary, findings as well as recommendations of the study.

CHAPTER TWO
TRAUMA AND ITS CONSEQUENCES

2.1 Introduction

This chapter explores traumatic experiences and their consequence in order to develop a pastoral care approach specifically for personnel of the disciplined forces. The context of the study is the Botswana Defence Force and Botswana Police Service. The chapter explores the different types of experiences and events in the workplace that cause trauma to military and police personnel, and strategies and adaptive skills they use to cope with the trauma. The relevance of chaplaincy and pastoral care in attending to the trauma experiences will be explored by means of the existing literature in the field.

2.2 Definition of Trauma

Trauma is defined as the direct personal experience of an event that involves actual or threatened death, serious injury, or other threat to one's physical integrity; witnessing an event that involves death, injury, or a threat to another person's physical integrity; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced (Criterion A1). The individual's reaction to the incident must be marked by extreme fear, helplessness, or terror (or, in children, by chaotic or agitated conduct) (Criterion A2:463).

Miller et al. (2017) define trauma as the occurrence that alters the subject's perspective on their well-being, making it more brittle and unstable, distorting their identity, and turning them into the "victim." If the effects of trauma are not processed effectively, they can become chronic or cause a significant disturbance in the life of the person. This significant disturbance can include feelings of emptiness and despair, hostility and derealisation, loss of coherence in one's representation of oneself, irritability, problems of emotional dysregulation, a propensity for self-injury or insufficient personal protection, and a strong dependence coexisting with an avoidant attachment (Miller et al., 2017).

Depending on the type of trauma in question, the severity of the trauma, which can vary from person to person, and the emotional support received from others, people

who have experienced trauma can exhibit a variety of symptoms. After a traumatic event, a person be "triggered" by memories of the trauma. This can lead the person mentally and physically reliving the trauma. These "triggers" can be excruciating and extremely painful (Miller et al., 2017). People who have experienced trauma can try to cope by turning to psychotropic substances or alcohol in an effort to alleviate their symptoms. Reliving symptoms is a sign that the body and mind are making an effort to deal with the traumatic experience, according to (Davidson and Moss, 2008).

Triggers and symptoms can evoke anxiety and other related emotions by serving as a reminder of the trauma. According to Miller et al. (2017), some traumatized people are completely ignorant of the triggers. This can result in people with traumatic disorders engaging in harmful or self-destructive coping techniques without fully understanding the reasons behind their behaviour. Miller et al. (2017) identify a panic attack as one type of psychosomatic trigger reaction. This can result in extreme emotions such as rage, which can appear regularly, sometimes in very inappropriate or unforeseen contexts. They present an ever-present hazard as a result of past experiences (Davidson & Moss, 2008). Davidson & Moss (2008) point out that traumatic memories such as images, thoughts, or flashbacks can haunt the person and cause repeated nightmares. Even when they are in a safe environment, insomnia, unspoken anxieties, and insecurity can surface, keeping people hyper-vigilant of danger, day and night.

Traumatized persons often do not remember the details of what happened, but they can recall the feelings without being able to explain why they have these feelings. As a result, traumatized persons can relive difficult events repeatedly as if they were occurring in the present. This prevents them from acquiring a comprehensive understanding of what happened (Miller, 2016). It can result in a pattern of extended periods of intense excitement interspersed with periods of physical and mental exhaustion. This can affect their personal and professional life. Over time, emotional weariness can cause them to become distracted. This in turn can make it difficult or even impossible for them to think clearly (Davidson and Moss, 2008). Dissociation or desensitization, as well as emotional detachment, can happen frequently (Miller et al., 2017). People who try and banish all emotions in order that they can disassociate from the painful emotions, can reach an emotional state of desensitization, which makes them appear emotionally spent, anxious, distant, or frigid. They can be frequently

become perplexed by everyday settings and struggle with memory or recall (Miller et al., 2017).

When trauma symptoms do not dissipate and traumatized persons do not trust that their condition will improve, they can experience a state of permanent woundedness. This can result in feelings of hopelessness, a loss of self-worth, and frequent episodes of depression. They can question their identity if significant components of that identity have been violated. Even in the absence of Post-traumatic Stress Disorder (PTSD), trauma can dramatically affect cognitive function, general health, and performance, including essential daily skills such as situational awareness (Miller et al., 2017). Acute trauma, which arises from a single stressful or dangerous event, and chronic trauma, which results from repeated and sustained exposure to extremely stressful situations, are two different types of trauma that have been identified (Smith et al., 2015). Cases of child abuse, bullying, or domestic violence some a few examples of chronic trauma. Complex trauma, another type of trauma, is brought on by exposure to numerous stressful incidents (Davidson & Moss, 2008).

Traumatic incidents affect different people in different ways. Officers in the military and police service can develop unhealthy habits as subconscious strategies to cope with the trauma effects and stress (Papazoglou & Tuttle, 2018). People who undergo intense, protracted stress can compensate by for example substance use, excessive smoking or eating, or other unhealthy activities that can eventually result in physical illness (Miller, 2016). Traumatic events among the disciplined forces have been linked to both short- and long-term health problems (Miller et al., 2017).

Wills and Schuldberg (2016) point out that military personnel are more likely than civilians to exhibit problems such as mental challenges and unhealthy coping mechanisms such as substance use because of the stress caused by the experience of trauma. The coping mechanism used after a trauma is related to the person's susceptibility to traumatic situations. The acts of managing certain external and internal demands that are deemed to be stressful or exceeding a person's resources is referred to as coping. Coping mechanisms have an impact on psychological health and are crucial in determining the outcomes following exposure to a traumatic occurrence. Adaptive techniques are more effective for reducing the harmful effects of trauma, but maladaptive strategies have a negative impact on police and military officers' ability to respond with resilience. A study by Mogotsi (2021) to ascertain the

prevalence of substance use and mental illness among military personnel in the Botswana Defence Force indicated that there is a high prevalence of substance use and mental illness. This is both caused and aggravated by exposure to traumatic experiences in the course of their military duties. The findings showed that a substantial percentage of military members in the Botswana Defence Force used substances (42.11%) and suffered from mental health problems (10.79%) (Mogotsi, 2021). Substance use is a coping strategy often used by military personnel in order to cope with trauma stress. The study showed that several officers would not seek pastoral care from a chaplain due to the stigma attached to “needing help”. Some believed that they did not need help.

A similar situation is reported in the study of Smith et al. (2005), namely that police officers use substances in an effort to address their psychological discomfort. This represents a maladaptive coping strategy for regulating emotional strain and does not have a positive outcome for the persons themselves or their families. According to studies by (Chopko et al., 2013), (Smith et al., 2005), and (Swatt et al., 2007), police personnel use substances at a higher rate than the general population. To counteract feelings of depression and anxiety, police officers frequently turn to substances such as caffeine, nicotine, alcohol, barbiturates, benzodiazepines, cannabis, and opioids for relief (Amaranto et al., 2003). According to extensive research on occupational stress conducted by Gibbons & Gibbons (2007) and McCarty et al. (2007), stress is linked to how an individual assesses situations and the coping strategies. This is because police officers are exposed to a variety of work situations that require different physical and mental abilities to cope (Morash et al., 2006).

In their investigation on the coping techniques employed by police officers, Ballenger et al. (2011) focused on the patterns and predictors of alcohol use in a sample of 747 urban police officers. The findings showed that police officers were more prone than the general public to binge drink. The study also showed that female officers were two to three times more likely to experience stress and trauma at work. Binge drinking was more prevalent among police officers between the ages of 18 and 39. According to a study by Violanti et al. (2011) among 115 police officers, there is a correlation between the harmful use of alcohol and the psychological effects of stress. According to the findings, 63.9% of the participants consumed more alcohol than the WHO recommends for a day.

The prevalence of alcohol use was investigated in a cross-sectional study by Davey et al. (2000) using a sample of 4,193 police personnel from an Australian state police force. The findings showed that compared to the general public, police officers reported drinking more alcohol. Deployment therefore has been linked with traumatic stress and depression. Police officers are more likely to acquire psychological and substance use disorders if they do develop constructive coping skills for lessening the stress. Understanding how police respond to strain is crucial because if they deal with stress in an unhealthy way it has implications for the safety of the officers themselves and also for the safety of the public.

Generally, coping strategies can be classified as adaptive, avoidant, or poor (Doron et al., 2013). There are individuals who actively develop effective coping strategies. There are those who cope by means of a passive strategy, and there are individuals who engage in poor coping methods and self-blame (Smith et al., 2005). The studies showed that people with active coping mechanisms tend to exhibit adaptive coping abilities. People with passive coping mechanisms tend to exhibit maladaptive coping strategies (Doron et al., 2017; Smith et al., 2005). Those with avoidant coping mechanisms display higher levels of self-blame, rumination, catastrophizing, and blaming others. Those with active coping strategies display higher levels of positive reappraisal, positive refocusing, and perspective-taking. Individuals with constructive coping strategies are less prone to despair and anxiety than those who used avoidant coping mechanisms (Agolla, 2009).

2.3 Traumatic Experiences in the Disciplined Forces

Cumulative PTSD is caused by exposure to numerous traumatic incidents over several years or, in some cases, an entire career. Miller et al. (2017) describe it as follows: “Incidents involving shootings or improvised explosive devices will often open the door. It’s easier for an officer to come in after one of those incidents because everyone understands that they should be talking about it. But the shooting or ‘things that go bang’ are just the latest incident sitting on top of a stack of other traumatic incidents”. Symptoms and posttraumatic reactions include avoiding triggers (avoidance), repeating the event (intrusion), and elevated arousal (hyperarousal). Globally numerous active-duty police officers and military personnel show signs of PTSD. Studies show the prevalence of post-traumatic stress symptoms among officers due to different traumas they experience in the line of duty,

whether directly or indirectly. In their study with 183 police officers about self-perceived trauma, Chopko and Schwartz (2012) found that more than 30% of participants showed signs of PTSD.

According to the study of Davidson and Moss (2008), between 5 to 50% of officers were diagnosed with PTSD. Some police also experience depression or anxiety, and use substances (Davidson & Moss, 2008). According to (Zimering et al., 2006), PTSD can also arise from non-direct trauma exposure. Marshall (2006) emphasises that the cause of psychological discomfort is the repeated exposure to distressing situations. The term for this is “cumulative career trauma stress” (CCTS). Marshall (2006) did a survey to quantify the number of stressful events an officer has experienced since starting their career in law enforcement. The most traumatic experience was when officers were accosted by someone with a weapon. The second highest level of trauma was when officers had to respond to a domestic violence call. The third highest level of trauma was when officers had to draw their own weapon.

In a study by MacGregor et al. (2021) with service members who test positive for Post-traumatic Stress Disorder after having sustained a wound in a war situation, the number was approximately 39%. Using a 4-item PTSD screening instrument, another study among marines and soldiers who returned from deployment found that 12-13% had symptoms of PTSD. Another study found that all service personnel had experienced at least one potentially traumatic event, such as a combat-related injury. This can account for the relatively high number of participants who tested positive for PTSD (Soravia et al., 2020). Because of the frequent and varied violence, direct combat deaths, seeing the enemy before or after they were killed, and witnessing friends and comrades perish, war is exceptionally traumatic for troops. Prisoner of war (POW) experiences are also traumatic. The studies identify a variety of traumatic stressors, including seeing someone die or being dismembered, touching dead bodies, tragically losing friends, realizing one's own demise is near, killing others, and being powerless to stop others from dying.

Another study found that between 2% and 17% of US military veterans who served in the Vietnam War have PTSD connected to warfare. According to studies of previous conflicts, between 4% and 17% of US veterans of the Iraq War and 3% to 6% of returning UK Iraq War Veterans suffer from combat-related PTSD. The World

Health Organization (WHO) did an epidemiological study with 200 000 respondents in 27 countries (Soravia et al., 2020). The World Mental Health Surveys were completed by the first 17 nations. The predicted lifetime prevalence of PTSD ranges from a low of 0.3% in China to 6.1% in New Zealand. For the police the rate of PTSD was 21%, whereas the rate for rescue teams ranged from 5% to 32%. The prevalence of PTSD among police officers in the USA, however, ranged from 8% to 22% (Soravia et al., 2020).

According to the 2012 Canadian Community Health Survey, PTSD affects 17% of the disciplined forces and 1.7% of the general population in Canada. Male officers had a 20% prevalence rate. Nearly one third of 677 people in Los Angeles who had experienced various types of trauma were found to meet the criteria for PTSD. A meta-analysis found that 7% of police officers and military fire fighters had PTSD. In 16 Chinese provinces, a study on the mental health of military police found that 5% of them received no care at all and 11% received insufficient care. Military, police, and fire fighter personnel who suffer from PTSD often have insufficient social support networks, are less productive, and are more at risk of suicide. Because of workers with PTSD being less productive it was found that Canada's Gross Domestic Product decreased by around 1.3%. Police and military personnel can also experience PTSD or exhibit symptoms that are comparable to those of other mental health conditions (Soravia et al., 2020).

In Africa, almost 50% of soldiers who experience war have mental health issues such as PTSD, anxiety, and depression. Civil wars, political upheaval, Islamic extremism, terrorist organizations, armed criminal operations, the illicit drug trade, and pandemics are just a few of the national challenges especially in West Africa. The World Bank identified several West African nations, including Burkina Faso, Guinea-Bissau, Mali, Niger, and Nigeria to be a fragile and conflict-affected environment. In a study examining the influence of combat exposure on PTSD among military combatants in the North Eastern part of Nigeria, Dami et al. (2018) found that military personnel who are exposed to combats are likely to develop PTSD. The study showed that exposure to combat was the cause of people re-experiencing earlier traumas in their lives. This can take the form of nightmares or frightening thoughts that officers had during the trauma experience. The study by Dami et al. (2018)

recommended military combatants be provided with trauma debriefing and counselling. This need can be fulfilled by chaplaincy, among others.

An active team of mental health experts should examine and prepare officers before the go to the fronts, are sent on a dangerous mission or out to patrol duty. The welfare of military personnel should be a priority and measures should be taken to prevent PTSD. They can be trained to develop greater resilience and positive coping skills. Chaplains can contribute by means of counselling and guidance with regard to constructive coping strategies. From a pastoral perspective, spiritual and psychological aspects are integrated. This provides a holistic approach to trauma stress concerns.

2.4 Traumatic Experiences in the Military

Military staff are repeatedly exposed to stressful and unpleasant traumatic life events. These events can cause psychological injury, which can lead to mental and emotional stress. Units that are deployed more often in different operations become more susceptible to traumas. A high level of unit cohesion can have a positive impact on an individual's ability to cope with military stressors and mitigate the negative psychological effects of deployment.

Experiences that can lead to PTSD include exposure to war, threatened or actual physical assault (e.g. a physical attack, robbery, mugging, or childhood physical abuse), threatened or actual sexual violence (e.g. forced sexual acts, alcohol- or drug-facilitated sexual acts, abusive sexual contact, noncontact sexual abuse, or sex trafficking), being kidnapped, being taken hostage, a terrorist attack, torture, and incarceration. Witnessing of traumatic events can include observing a medical emergency, observing threatened or serious harm, and observing the unnatural death, physical or sexual abuse of another person as a result of assault, domestic violence, or an accident. Mental health disorders are more likely to occur after exposure to combat. After Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF), a considerable increase was seen in the number of US service personnel who fit the criteria for depression or anxiety disorder. Following Operation Task Force Uruzgan (TFU, 2006–2010), Dutch service personnel showed an elevated risk of mental health challenges.

PTSD is not linked only to combat exposure, but also to participating in or witnessing atrocities, and to combat training. People who witness severe a accidents, a suicide, of suffer a violent personal attack and sustain significant injuries can be seriously traumatised. When interpersonal and deliberate stressors are present, the disorder may be very severe or persistent (American Psychiatric Association, 2013). Studies have indicated a connection between battle stress and poor physical health outcomes, such as a rise in chronic illness and mortality. Certain self-reported and objective health issues including hypertension and cardiovascular disease have been related to traumatic war exposure (Gabriel & Neal, 2002).

A study of persons in the South African National Defence Force has shown that operational members in the SANDF have a high rate of exposure to traumatic events (89%) and are likely to have multiple exposures in their service (Seedat et al., 2003). In the study, the prevalence of the exposure to traumatic events and Post-traumatic Stress Disorder (PTSD) was investigated in a cohort of 198 full-time operational members of the South African National Defence Force stationed in their home unit between deployments. Approximately 90% of the members reported having experienced or witnessed trauma in their workplace duty according to (Seedat et al., 2003). Twenty-six percent met the diagnostic criteria for PTSD on self-report with approximately 29% with PTSD also meeting the diagnostic criteria for depression. Few members, however, sought help. The severity of the PTSD symptoms was predicted by the type of trauma, such as for example the exposure to physical assault and the infliction of life-threatening injury. These findings highlight illustrate the high rate of exposure to multiple, noncombat and combat-related trauma in military personnel.

In another study with 197 female and 1 307 male peacekeepers of the South African National Defence Force in Somalia, exposure to death, combat, sexual harassment, and fear had an impact on the severity of PTSD symptoms in both men and women. A study with 160 women on their return from the Persian Gulf War and again 18 to 24 months later and found that sexual assault during deployment had a greater impact on PTSD symptomatology than combat exposure per se (Seedat et al., 2003). Considering all the traumatic events that are experienced, the exposure to combat or a war zone and serious accidents at work were events that were most likely to have occurred during the military service of members of the South Africa National Defence Force. There were no significant differences in the age, education, duration of service, or rank of the persons affected (Seedat et al., 2003). Events that were most likely to

lead to PTSD symptoms include exposure to life-threatening injury, the sudden violent death of someone close, physical assault, and transport accidents. The study of Seedat et al. (2003) indicates that despite exposure to highly stressful or traumatic activities, and despite significant distress and impairment resulting from PTSD, the majority of military personnel do not seek help.

The main reason for not seeking help is that they fear it will have adverse consequences for their career. They fear the stigma associated with mental health problems. In this context it can be useful to routinely screen active duty military personnel for histories of trauma exposure (especially multiple and severe exposure) and current symptoms of PTSD, depression, and substance use so that early and effective psychological support can be provided (Gabriel & Neal, 2002).

2.5 Trauma among Police Officers

Policing is described as one of the most demanding professions (Anshel, et al., 2000). Police officers are frequently the first responders in severe situations. The constant threat of being exposed to traumatic events is a particular source of stress and distress for police officers. This burden is significantly greater than that of the general population because police officers are exposed to potentially traumatic incidents and extreme stress for the duration of their career, which is on average some 30 to 35 years (Chamberlain, 2015). Rudofossi (2009), a uniformed police psychologist with the New York City Police Department, predicted that over the course of their careers in the force, police personnel are exposed to at least 900 potentially traumatic events. Police officers tend to be more resilient than the general public (Galatzer-Levy et al., 2013), but this resilience can come at the expense of the their health and well-being due to prolonged, chronic, and ongoing exposure to loss and extremely stressful situations (Papazoglou et al., 2013).

Officer self-report and physiological stress response system measures that measure stress-related cardiovascular and hormonal reactivity while exposed to critical incident scenario training have clearly shown the connection between line of duty stress and the detrimental effects on health outcomes (Koskelainen & Nyman, 2015). Research has shown that police officers' stress-related cardiovascular reactivity has already increased by the time they put on their uniform and start their general patrol (Anderson et al., 2002). Police personnel experience a variety of issues as a result

of their regular exposure to threatening occurrences. Unlike others who are healing from trauma, officers cannot avoid similar experiences in future because it is part of their work. They are likely to have similar experiences again and again. This makes recovery more challenging. Secondary reactions may not manifest for months or even years. This is frequently caused by additional stressors piling up on an already stressed-out system (Anshel, 2000).

Members of the Botswana Police Service who are part of a law enforcement unit experience duty-induced post-traumatic stress disorder due to exposure to traumatic events in the line of duty. More frequently than the general public police officers face traumatic incidents. However, often little is known about how they process these events. Police personnel are constantly threatened by violent, hazardous, sad, and unpredictable events, any one of which can cause psychological and emotional damage. Being employed as peacekeepers and rescuers exposes them to numerous primary and secondary traumatic incidents, any one of which might impair officers' performance and prevent them from performing their duties effectively (Abdollahi, 2002). Police work is a very stressful profession. Brewin et al. (2020) point out that this ongoing stress can make it difficult for officers to recover from a traumatic event. The healing process can deplete reserves of mental and emotional energy, leaving less energy available for appropriate and safe work performance. Officers who responded to significant traffic accidents were more than five times more likely to experience PTSD symptoms than those who did not, and those whose partners in duty were involved in shooting situations were four times more likely to experience PTSD symptoms (Violanti & Gehrke, 2004).

A study by (Loo, 1986) found that officers involved in shooting incidents said the hardest days were those immediately after the shooting. However, 35% of those involved in shooting incidents leave the force or are transferred to non-patrol work within a year (Violanti, 1996), and 70% of those involved in on-the-job killings do so within seven years (Williams, 1987). Post-traumatic Stress Disorder or Complex Post-traumatic Stress Disorder affects one in every five UK police personnel. One in five police officers today suffer from either Post-traumatic Stress Disorder (PTSD) or Complex Post-traumatic Stress Disorder (CPTSD), with over 90% of active officers and personnel reporting exposure to such situations (Brewin et al., 2020).

After having conducted a thorough assessment of the literature on potential barriers to accessing mental health support, Sharp et al. (2015) found that 60% of military personnel with mental health issues did not seek help. The stigma attached to receiving treatment for a mental health condition significantly discourages police personnel from seeking psychological assistance. Police personnel are reluctant to seek psychiatric assistance for fear of being stigmatized (Hansson & Markstrom, 2014). The can also be afraid of a new diagnosis as well as of having their past psychological histories exposed in a way that could have a negative impact on their work as a police officer (e.g., performance reviews, promotion) (Barren, 2005; White et al., 2015). Because of this, some law enforcement personnel turn to less healthy coping mechanisms (such as alcohol or avoidance) in an effort to alleviate symptoms of extreme stress and trauma (Stepka & Basinska, 2014). In order to avoid the crippling effects of trauma and stress, officers can employ defence mechanisms, such as denial, displacement, isolation of sentiments, and comedy (especially cruel or crude humour) (Berking et al., 2010). They are thus caught in a vicious cycle that can include: stress and professional trauma; unhealthy coping with painful feelings, memories, and thoughts; and worsening of mental and physical health (Pasillas et al., 2006).

Officers experience interpersonal and family stress in addition to the occupational and organizational stress of their work. The one type of stress can exacerbate the other. Officers can interpret bodily indications of intense stress, trauma, or discomfort as solely physical or somatic complaints. Only 10% of participants in a large-scale study of police officers in Norway who reported experiencing anxiety or depression sought out psychiatric assistance (Berg et al., 2006). Officers with heightened mental health distress, including suicidal ideations, anxiety, and depressive symptoms, chose to go to a chiropractor or physiotherapist for assistance (Berg et al., 2006).

Police stress, trauma, and moral injury, loss, and compassion fatigue are frequently linked. Since these issues occur frequently police work, they should at least be provided with basic essential information about moral harm, loss, and compassion fatigue in police work (Stepka & Basinska, 2014). Officers respond to violent crimes, natural disasters, and fatal car accidents as part of their everyday work. They therefore frequently come into contact with the dead and the dying (Agolla, 2009). Officers also have to notify the relatives of victims who have passed away. They not

only run the risk of losing their own life in the course of doing their duty, they also run the risk of losing a comrade. Because of this, officers might prefer to repress their emotions, much like how they respond to trauma, and refrain from discussing their own loss experiences with others (Manzella & Papazoglou, 2014). However, the grief process of people in the police community is distinct and pervasive. Police groups pay tribute to individuals who have made the ultimate sacrifice in various ways and through a variety of rituals. Dr. Vincent Henry, a former police officer with the New York City Police Department, outlined the death-related concerns inherent in police work in his 2004 book, *Death work: Police, trauma, and the psychology of survival* (Manzella & Papazoglou, 2014).

If not addressed, traumatic situations do have the ability to harm the mind, which can lead to major health issues, according to Bonanno et al. (2012:190). To cope with stress and traumatic events, police officers adopt a variety of coping mechanisms. These are referred to as "action-oriented" and "avoidance" coping methods (Carlan & Nored, 2008:9). The majority of police officers do not face and deal with the signs of trauma (Andrew et al., 2014:147-149). This may be due to a number of things. They can choose denial because they are not willing to face the unpleasant effects of their symptoms. They are often ill-equipped to deal with their own reactions. The distinctive police culture, particularly with regard to their "macho image", tends to attach stigma to any form of therapeutic intervention. Many officers lack faith in the Employee Health and Wellness (EHW) programme of the South African Police Services (SAPS).

The Employee Health and Wellness programme is steered by a multi-professional group consisting of chaplains, social workers, and psychologists. Deschamps et al., (2003:358) and Jorgensen and Rothman (2008:2) emphasize that police officials can be at risk of developing acute stress or even more complex traumatic stress symptoms, depression, anxiety disorder, the harmful use of alcohol, and somatic and other related disorders, if symptoms are not treated effectively at an early stage. This typically has a detrimental effect on the wellness of police and military officers, their relationships with family and co-workers, and their ability to execute their work. In extreme cases this could result in violent behaviour, suicide, or familial murder-suicide (Patterson, 2008:54). Some officers have taken their own lives after going through a terrible event or deployment.

Military personnel often resort to avoidance coping when they have little control over their environment and trauma, particularly during deployment (Chokpo, 2011). This is common among soldiers who are often deployed to war-zones and dangerous training grounds in the wilderness. For instance, the majority of military personnel have little control over their assignment locations, employment requirements at a specific assignment, work hours or shifts, and the duration of an assignment. They typically cannot select the service members who will work with or for them, they have no say in who their supervisor(s) will be, and they are unable to leave their employment or assignment at their own discretion. Officers then resort to acceptance.

Aldao et al. (2014) and Krupnik (2020) point out that acceptance as a coping strategy can be beneficial to healing. Officers who choose this coping strategy can shift their attention from how they *feel* (agony, pain) to how they *function* – how they fulfil their task and mission (Aldao et al., 2014). Another effective resource of constructive coping among active military personnel, veterans, and police officers according to Solomon and Roger (2011), is religion. This is an emotion-based coping strategy. An active spiritual life can be linked to resilience in the face of adversity and to greater physical and psychological health. Numerous military services around the world have ordained civilian pastors as part of their personnel (Aldao et al., 2014). These chaplains provide counselling and spiritual and emotional support.

2.6 Formation of the Botswana Defence Force (BDF)

According to Molomo (2009) the significant change and turn in national security policy in Botswana can be attributed to the tense security situation that existed in the country from the middle of the 1980s to the early 1990s. The then Rhodesia and apartheid South Africa were Botswana's two unfriendly neighbours. Botswana was committed to an open door policy of accepting legitimate political refugees from these countries. Compounding to Botswana’s security concerns was South African security policy under the umbrella of the “Total Strategy” which was geared towards the destabilization of region through acts of aggression in the form of cross border raids. According to Mocheregwa (2021:2), the long-running liberation wars in Southern Africa, which started in the 1960s especially in Rhodesia (now Zimbabwe), eventually led the Botswana government to create its own defence force in 1977. Since the early 1960s, Botswana had relied on a small paramilitary force known as the Police Mobile

Unit (PMU) for all matters relating to defence because of financial restrictions and a generally stable internal political environment. As the fight for Zimbabwe intensified in the late 1970s, Rhodesian security forces that were pursuing armed liberation fighters began to cross the border. Many Batswana who resided in cities and villages close to the Rhodesian border lost their lives during these repeated Rhodesian violations of Botswana's territorial integrity, while others were kidnapped, women were raped, children were injured, and homes were set on fire (Mofamere, 2009).

The Botswana Defence Force (BDF) was therefore formed in April 1977 in reaction to the Rhodesian war (Mocheregwa, 2021:2: see Kenosi 2019:189). Unlike other countries in Africa, Botswana did not inherit a military establishment at independence. The formation of the BDF took place within the context of a turbulent and racially divided Southern Africa (Sharp & Fisher, 2005). The formation of the BDF was a direct result of several factors, one of which was pressure from civil society in quest for protection from the government. On 15th April 1977, the BDF was formed by an act of Parliament **(**Botswana Defence Force Act CAP 21:05.) with the mission to protect the territorial integrity of the country, its sovereignty and its national interests.

The Botswana Defence Force (BDF) as a military organisation has, over the years deployed its personnel in various operational missions (Kabelo, 2019). After its establishment in 1977 by an Act of Parliament, the BDF ACT No. 13 of 1977 (see Henk, 2004). BDF personnel have been deployed in international missions such as United Nations peacekeeping operations and various domestic operations such as anti-poaching activities and disaster preparation (Henk, 2004). Key functions of the Botswana Defence Force were to defend the country. It was to ensure national security and stability, protect the people and their property, protect the Constitution of Botswana in order to guarantee the rule of law, defend Botswana's territorial integrity on land and in the air. The aim was to preserve Botswana as a free, independent and sovereign state and aid the civil authorities in domestic support operations and strengthen international relations by participating in regional and international security cooperative activities.

2.7 Formation of Botswana Police Service (BPS)

In response to the security threats, according to Mocheregwa (2019), Bechuanaland (Botswana today) created a paramilitary unit in 1963 Police Mobile Unit (PMU) to

contain internal riots. After independence in 1966, the PMU acted as a quasi-military force because there was no military force to preform those duties. In the mid-1960s, Southern Africa was marred with bloodshed due to armed struggles in Rhodesia and South Africa among others. Botswana became a safe haven for fleeing guerrillas who would enter the country illegally. As the only line of defence, the PMU was quickly militarised and tasked with patrolling Botswana's borders in order to arrest guerrillas and avoid attacks by security forces of both Rhodesia and South Africa. This however did not work as planned because the PMU was too small and ill equipped for the task. The PMU then undertook the internal policing function, but it soon became clear that the unit was inadequate in the face of the stormy security situation taking shape both internally and in the region. Henk (2004) points out that the PMU was inherited from the colonial administration with an estimated strength of only some 1 000 men. After some years the Botswana Police Service grew to an equipped unit of the disciplined forces.

2.8 Pastoral Care and Traumatic Experiences

The practice of pastoral care over the ages has been informed and influenced by the need to develop creative ways (interventions) to respond to contextual challenges. Pastoral care refers to emotional and spiritual care. The term "pastoral" from the Latin word *pastorem* (shepherd) refers to the notion of tending to the needs of the vulnerable (McClure, 2012:269). In pastoral care with people who were traumatised, the relationship between spirituality and psychology is relevant for guiding them in their process of healing. Spiritual well-being includes dimensions such as meaning, faith, purpose, and connection with others and with a higher power. These are important factors when it comes to quality of life, hence the significance of pastoral care in dealing with post trauma stress.

The narrative approach has gained much ground in pastoral counselling in in recent years. It was adopted widely by various theological traditions (Bryan et al., 2015: 74-78). Over the last several decades, globally, religious or spiritual care services and chaplaincies have developed into a specialized division of pastoral care. Pastoral care can be seen as a healing encounter between those who suffer and those who provide pastoral or spiritual care. Both perspectives of narrative theology, namely that in which the story of Jesus gives meaning to all human stories, and constructive narrative theology, in which redemptive power rests in the human capacity for storytelling itself,

can offer chaplains important theological and pastoral insights (McClure, 2012). The roles of a chaplain include providing pastoral care, scene support, and spiritual support or direction. Providing spiritual assistance or direction was highlighted as a role of chaplains in five studies from the military and police (Carey, 2018). According to Carey (2018), it is generally accepted that the work of storytelling lies at the heart of the healing encounter between those who suffer and those who seek to meet this suffering with the resources of faith. Understanding chaplaincy's function in mental health care, their use of services, and the clinical results of their services have all been the topic of research studies (Carey, 2018). Chaplains who remain active and visible in their services reap spiritual, psychological, and social benefits according to military and police staff (McClure, 2012). Gouse (2017) summarised the results of some studies in this regard. One study showed that having a chaplain present during traumatic incidents helped to minimize stress and the burden of having to deliver bad news. Another study showed that police officers felt that chaplains brought a sense of peace and comfort to the scene. This helped to diffuse and defuse tensions between the police and the community and led to improved police and citizen relations and cooperation. People who seek support from chaplains expect them to be accessible, friendly, and to protect their confidentially. This signifies the importance of having approachable chaplains in strategic locations who can build rapport with officers. A US Navy study by Hale (2013) found that more than 90% of the personnel viewed having chaplains available to offer moral and spiritual care to service members as a part of a multidisciplinary team as “mission important”.

2.8.1 Involvement of Chaplains in the Disciplined Forces

Chaplaincy provides ministry to a variety of staff in a multitude of settings. Chaplains in the disciplined forces are described by Carey (2018:1) as trained, commissioned, and professionally involved individuals who offer spiritual and pastoral care to members and veterans who have experienced the devastating impacts of war and other situations. Existing literature shows that trauma studies have advanced decisively since the 1970s. Organisations such as the Vietnam Veterans against the War in the United States for example provided veterans with the opportunity to speak honestly about the horror of war (Hunsinger, 2015:3). In the context of the South African Border War Doherty (2015:48) argues that the formal diagnosis of Post-traumatic Stress Disorder (PTSD) in some ways legitimizes the experiences of the

individual sufferers of war, whether victims or perpetrators of violence, who had previously felt silenced. The diagnostic category of PTSD offers an explanatory framework which effectively "allows" these conscripts to present themselves as victims of the Border War. The direct relationship between trauma and exposure to combat became clear.

Psychiatrists describe traumatic events as those that are "outside the range of usual human experience" (Currier et al., 2016:167-179). Medical personnel involved in veteran care indicate that chaplains could utilize spiritual screening scales such as the Spiritual Distress Scale (SDS) to identify personnel who are at risk of self-harm. In this way, chaplains can respond more effectively to the pastoral and spiritual needs of those in their care (Bobrow et al., 2013:137-144). Chaplains can screen and evaluate religious and spiritual concerns that impact the health and well-being of the persons in their care using a variety of evaluation techniques (Carey et al., 2016:12). Some of these focus specifically on factors or symptoms that relate to moral injury (MI). The physical, psychological, social, and spiritual effects of grievous moral transgressions, or violations of a person's deeply held moral convictions and/or ethical standards result from: a person committing, failing to stop, witnessing, or learning about cruel acts that cause the pain, suffering, or death of others, and which fundamentally undermine the moral integrity of a person, group, or organization, caused by a person in authority and who is trusted. This is called moral injury and it is a type of trauma (Maguen & Litz, 2016).

In the literature on the police and military, moral harm is a common topic (Maguen & Litz, 2016). The term "moral harm" describes the moral and ethical difficulties that frontline professionals face while performing their duties (Cohen et al. 1991). The duty of police officers is to uphold law and order. They are not taught to be "killing machines". However, Maguen and Litz (2016) point out that police officers may need to shoot an individual (a violent, armed offender) in order to defend themselves or to save the lives of bystanders. When this occurs, police officers suffer moral harm as they struggle to reconcile their obligations to carry out their duties (such as defending a civilian) with their obligations to shoot (often fatally) another person.

The violation of deeply-held moral beliefs and ethical standards irrespective of the actual context of trauma can lead to considerable moral dissonance, which if unresolved, leads to the development of core and secondary symptoms that often

occur concurrently. The American Psychiatric Association (2000) identifies the core symptoms as shame, guilt, a loss of trust in self, others, and transcendental or ultimate beings, as well as spiritual and existential conflict, including an ontological loss of meaning in life. These core symptomatic features influence the development of secondary indicators such as depression, anxiety, anger, re-experiencing moral conflict, social problems (e.g. social alienation) and relationship issues (e.g. collegial, spousal, family), and ultimately self-harm (i.e. self-sabotage, substance use, self-death ideation and death).

Chaplains can contribute much to the process of screening and evaluation with regard to moral injury. Spiritual counselling is therefore of utmost importance. Chaplains can function as a first port-of-call for people who could possibly have sustained moral injury. Smith-MacDonald et al. (2018:5) describe how chaplains in the Canadian Armed Forces support military personnel who struggle with mental and spiritual health concerns. These concerns include post-traumatic stress symptoms, moral injury and other forms of operation stress injury (OSI). The survey of Nieuwsma et al. (2013:3-21) on US Veteran Affairs indicates that some chaplains frequently meet with and provide support to personnel who suffer from moral injury. However, the majority of chaplains acknowledge that they are only involved sometimes with military personnel whom they believe to be suffering from moral injury (Nieuwsma et al., 2013:3-20). According to a study by Currier et al. (2016:120-127), a substantial number of military chaplains were connecting with personnel who show symptoms or signs of moral injury. Military chaplains can therefore be considered valuable for identifying and helping to formally screen those who potentially suffer from moral injury (Carey, 2018:3). Moral injury is a complex phenomenon which involves physiological, psychological, social, and spiritual issues. As yet there is no single validated instrument for screening moral and spiritual injury. Chaplains can, however make an evaluation of the presence of extent of moral injury prior to or during formal pastoral counselling sessions. The majority of chaplains receive additional training specific to their industry or sector which augments their initial pastoral and theological training (Carey, 2018).

In the 1990s, psychiatrist Jonathan Shay and colleagues coined the term “moral injury”, to indicate a condition which is more complex than moral distress. Shay (2014:182) defines moral injury as a “betrayal of what is right” by someone who holds legitimate authority in a high stakes situation. Moral injury is a violation of a person’s

moral conscience and values resulting from an act of perceived moral transgression. This causes damage to the individual's reputation and beliefs. Therefore moral injury produces deep emotional guilt, shame, sense of betrayal, anger and moral disorientation. This is about the loss of a person's moral foundation (Carey, 2018). Theories on moral injury focus on the psychological, social, cultural, and spiritual aspects of trauma.

Moral injury is a normal human response to an abnormal traumatic experience. Shay et al. (1998:391-413) identify three components of moral injury. Moral injury is present when there has been a betrayal of what is morally right by someone who holds legitimate authority in a high-stakes situation. Carey (2018:3) describes moral injury as a trauma-related syndrome brought on by the physical, psychological, social, and spiritual effects of a grievous moral transgression or violation of a person's deeply held moral beliefs and/or ethical standards as a result of a person committing, failing to stop, witnessing, or learning about acts of cruelty that cause the pain, suffering, or death of others, and which fundamentally undermines a person's moral integrity.

Moral injury is a complex phenomenon that involves physiological, psychological, social, and spiritual issues caused by trauma (Carey & Hodgson, 2018:1). Moral injury transcends religious and spiritual perspectives. Chaplains have the responsibility of delivering cross-cultural ministry to people of various religions and those of no faith. Chaplains should be able to perform aspects of their traditional pastoral practices to support and guide all personnel in their attempt to address issues of moral injury. According to Carey and Hodgson (2018:4), there is still no one validated tool that is excellent for chaplains and that can be used to quickly assess for moral harm and spirituality. Moral and spiritual injuries are frequently said to be caused by violating or transgressing a moral code that exists within a person, whether that moral code exists in the person's intellect, soul, or innermost self (Graham, 2017). Personal trauma, according to Graham (2017), is not a confined and isolated aspect of a person's existence but rather develops into an on-going, permanent substructure of the soul, which is a person's integrating centre. Graham also highlights the close dynamic connection between the body and the soul in dealing with moral and spiritual injury.

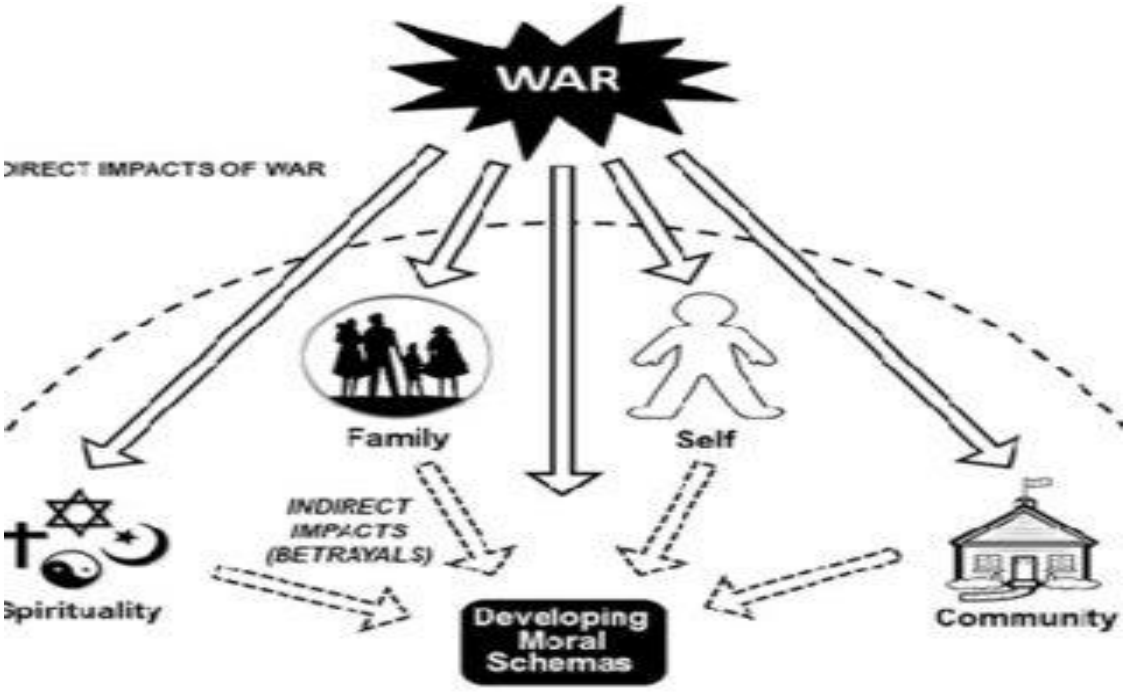


Figure 1 *Moral injury and its impact*

Source: ({HYPERLINK: https://www.researchgate.net/figure/Moral-injury-resulting-from-a-perceived-betrayal-of-trust-by-a-family-member_fig2_249320612})

2.8.2 Police Chaplaincy

Police chaplaincy is a growing vocation in police organizations. Personnel are given specialized spiritual care and related education (Baker, 2009:1). A police chaplain is a pastor who is committed to and interested in pastoral care within the law enforcement community (Carey, 2018). Pastoral care is provided irrespective of a person's ethnicity, nationality, gender, creed, sexual orientation, or religion. Chaplains are fully ordained and can be either volunteers or sworn officers. Mofamere (2009:70-71) emphasises that a chaplain's profession is more than a function. It is necessary to abide by an ethical code of conduct in order to reduce abuse and wrongdoing across professions. Police chaplaincy is described in terms of management ability, theological competence, knowledge of other relevant disciplines and the ability to discharge their duties effectively and ethically. Chaplains are pastors who are appointed by the state with a special duty to the state. Some chaplains also have a qualification in mental health care. Police chaplains may belong to a single religious or denominational group, but they provide care for all officers, also those of different faith persuasions and

worldviews. A robust chaplaincy program can promote a culture where officers feel at ease asking for assistance and receiving it (Carey, 2018).

2.8.3 Roles of a Police Chaplain

Chaplaincy provide care and support for police officers and others. They provide guidance and support in the chaos and peril of police officers' professional lives. Richard et al. (2016:3) emphasise that through involvement in correctional facilities, community-police relations, facilitation of line-of-duty death notice and burial services, crisis intervention, and officer and department well-being, chaplains enhance the overall efficiency of law enforcement. Police chaplaincy therefore serves as a support system for law enforcement, especially in times of crisis (Chopko & Schwartz, 2012).

Officers, personnel, and their families receive emotional, moral, and spiritual support from a police chaplain. Police chaplains provide emotional, moral, and spiritual support to officers, staff, and their families and confidential support for law enforcement and the communities they serve in a number of important areas. According to Chopko and Schwartz (2012), the health and support of officers, spiritual assistance, and involvement in the relationship between the community and the police, are a few of the areas in which chaplains deliver a service. Chaplains also provide counselling. They refer persons to mental health specialists and facilities when necessary. Police chaplains also take an oath just as the officers do. However, the chaplains' commitment is limited to specific duties according to agency regulations and excludes other law enforcement powers. The same moral standards that apply to officers also apply to chaplains, as do departmental rules and regulations. Chaplains are responsible for a number of tasks in the event of an officer's death. They act as a resource for the department's sworn and civilian employees, the family of the deceased officer, and police administration.

Chaplains can also provide services during crises and serious incidents. Chaplains can use their education in spirituality, adversity, and stress management to help a police officer in need. Police chaplaincy programs can aid officers in their recovery from critical incidents and other traumatic experiences while on or off duty. Chaplains are responsible for officers' emotional, social and mental well-being. Chaplains offer moral support, spiritual and psychological hope. They provide a safe space for officers and their families to discuss their problems and concerns. Some of chaplains duties

include: counselling police officers with regard to work stress or family crises; visiting sick or injured members of the department at their home or in the hospital; assisting with the delivery of death notifications to officers' families, the public, and department members (Chopko & Schwartz, 2012).

Chaplains provide spiritual support and foster a culture that welcomes spirituality as a healthy coping strategy. Spiritual support can include both non-religious and religious types of assistance. Pastoral care aims to heal, support, guide, reconcile, and nurture people. Chaplains enjoy a legal secrecy privilege similar to that enjoyed by doctors and attorneys, creating an environment where officers can seek support for both personal and professional difficulties. Chaplains are also involved in the relationship between the community and the police. Police chaplains can promote collaboration between the department and various stakeholders in the community by serving as a liaison with nearby faith-based organizations to help create community-police engagement. This will help improve relations between police personnel and the general public. Chaplains can also support people in the community after serious situations such as suicide, serious traffic accidents, and other traumatic events. They can represent the police department at funerals, memorial services, and other religious and civic celebrations.

Advising the Chief of Police on any religiously related issues involving the police department and carrying out community law enforcement tasks also fall within the range of chaplains' responsibilities. Chaplains can be a point of contact for local church organizations and for issues relating to the moral, religious, and spiritual welfare of police officers. Chaplains also assist police officers in their regular professional duties. As a result, they occasionally accompany police officers during patrol shifts and other community events to act as a reassuring presence. They develop ways in which police officers can learn to cope more effectively with stress or address vicarious trauma. They provide guidance on how to incorporate wellness and spirituality into people's daily lives. They function as religious dignitaries at special occasions such graduation or award ceremonies and the dedication of buildings. Chaplains assist in providing various types of training that is necessary for persons in the disciplined forces.

The tasks performed by chaplains include people of all races and religious persuasions (Mofamere, 2009:72). Chaplains in the South African Police Service

(SAPS) provide religious assistance for people while they are at work. The police officers may belong to a number of religions and denominations, or none at all. The chaplaincy service is an ecumenical extension of the mission of the local churches (Mofamere, 2009:72). The type of situation, the location, and the time all influence the scope and content of the assignment of a chaplain (Mofamere, 2009:71). There are no comprehensive textbooks describing the tasks of a chaplain. Chaplains only receive broad and general instructions (see Church Order of the Uniting Reformed Church in Southern Africa; Potgieter, 1980; ST10 SAPS).

2.8.4 Chaplaincy in the Botswana Police Service (BPS)

The mandate of Botswana Police Service is to protect life and property, prevent and detect crime, repress internal disturbances, maintain security and public tranquillity, apprehend offenders, bring offenders to justice, duly enforce all written laws with which it is directly charged and generally maintain peace (Police Act, Cap 21:01, Section 6/1). Protecting life and property has traditionally been the responsibility of the police, a role that comes with many difficulties like combatting and preventing crime. Police officers encounter a variety of conditions that call for a variety of physical and mental skills in order to respond to them successfully. The departments that make up the police service in Botswana, include:

- Forensic Science Services;
- Criminal Intelligence Bureau;
- Training;
- Traffic Control;
- Transport and Telecommunications;
- North, South, Central and Gaborone Divisions;
- Special Support;
- Diamond and Narcotics Squad;
- Serious Crime Squad;
- Criminal Record Bureau;
- Crime Prevention Coordination Unit.

Police officers are therefore subjected to different stressful scenarios in the workplace. These can have a severe impact on their performance and health. Police work has long been acknowledged to be difficult, even as one of the most stressful jobs (James

et al., 2017:1). With the realisation of what police officers experience in the line of duty, the BPS leadership established a chaplaincy office in order to assist with spiritual and psycho-social support. The chaplaincy ministry is relatively new despite the fact that the BPS as an organisation has existed for quite a while. The Botswana Police Service Chaplaincy Program was established in the year 2006 for the purpose of providing spiritual, psycho-social and emotional support to all members of the BPS and their dependents. The office has one officer designated as a chaplain on full time basis, and about 55 BPS regular officers identified and officialised as chaplains or chaplain assistants (Mofamere, 2009).

2.8.5 Military Chaplaincy

In the military, a chaplain is a commissioned officer who also serves as a religious leader. They support the soldiers' religious traditions, beliefs, and practices in a diverse setting with the aim of enhancing the soldiers' and their families' spiritual life. Military chaplains are exceptional because of their dedication to serving God and people under even the most trying conditions. Military chaplains are ordained clergy, priests, pastors, rabbis, imams, or ministers who are recommended to the various military services by their “endorsing agency”, which is the recognized religious organisation that certifies chaplains as members of the clergy who represent their particular faith and holds them in high military office (Otis 2009). Chaplains work all over the world; they are present on military bases, aboard ships, and with deployed troops engaged in combat operations (Otis, 2009). Chaplains in the United Kingdom participate in organized programs such as trauma risk management and decompression programs to aid members of the armed forces (Otis, 2009). Military chaplains provide counselling to the grieving and refer for specialist treatment when necessary. Milstein et al. (2008) point out that a chaplain who frequently consoles grieving families may be the first to identify symptoms of clinical depression. In order to evaluate whether a person suffers from major depression or has other clinical needs such as medication, chaplains must refer them to mental health care specialists.

Chaplains provide general support to military personnel wherever they are stationed. This includes counselling for grief, marriage, and crisis situations. The British Army Chaplaincy Centre also provides counselling training to the UK armed forces. Since chaplains are non-combatants, they do not use weapons of war or undergo rigorous weapon training. In accordance with Article 24 of the Geneva Convention, chaplains

are considered protected persons due to their dual role as religious authorities and in their professional capacity in the military. Chaplains are required to maintain their religious duties in the event of captivity as “retained personnel”, not as prisoners of war (POWs), and to return home as soon as is practical, given their non-combatant status. The BDF chaplains also have non-combatant status because Botswana adheres to the Geneva Convention.

2.8.6 Roles of a Military Chaplain

The main purpose of the military chaplaincy is to guarantee that the right to religious freedom is upheld in all military contexts. Additionally, chaplains offer professional direction and counsel to commanders, staff, and other members of the military on matters relating to spirituality, religious dynamics, ethics, morality, and general well-being. Chaplains, according to Bryan et al. (2015), are deemed necessary in the military. They promote spiritual, moral, and ethical development and resiliency, fulfilling the government's extensive obligations to those who serve. Worship services, liturgies, rites, funerals, and honouring the dead are some of the formal responsibilities of chaplains. Others duties include pastoral care, hospital visits, visits to those who have been incarcerated, and educational ministries (Bryan et al., 2015). It is a global and multicultural vocation for chaplains to serve military troops and their families regardless of their specific religion membership. Chaplains in the United Kingdom participate in organized programs, such as trauma risk management. Mental health care in military deployment includes counselling, debriefing, and other interventions after traumatic events (Brinsfield, 2009).

The military chaplain corps addresses cognitive, psychological, and moral issues. They aim is to nurture the living, care for the wounded, and honour the dead. Two capabilities necessary for these tasks are: to provide and advise (Carey, 2018). This is done through the following: visiting sick or injured military personnel at the hospital or home, responding to emergencies that are life threatening to their scope of responsibility when it’s appropriate, counselling officers and other personnel with personal problems when requested and assisting in making notifications to families or departments whose members have been seriously injured or died.

Chaplains advise commanders concerning religious aspects in operational locations, and give guidance with regard to the religious aspect of joint military operations

(Brinsfield, 2009). Religion not only affects one's personality, it also has an impact on how people behave in a democratic society. Chaplains take part in military rituals outside of the chapel since they are allegedly not religious, according to (Carey, 2018). Civil religion includes events like installations, dedications, memorials, public holiday observances, and group prayers before war. As a person of faith with soldiers to war, chaplains provide moral support, guidance and pastoral care for troops who witness the most horrific and traumatic sights that most civilians will never have to face (Carey, 2018). In addition to the pastoral duties and official religious services mentioned above, the chaplain also serves in an advisory capacity. For instance, the commander may request the chaplain's input on personnel, morale, discipline, or even solicit personal information and counselling (Brinsfield & Wester, 2009).

Chaplains also play an important role as an adviser to the commander. Lloyd, (2005:iii) points out that chaplains can speak to local religious leaders and facilitate understanding and a more secure environment for the mission to be completed (Brinsfield, 2009). Personnel should be able to trust chaplains to maintain confidentiality. According to Rule 503: Communication to Clergy of the United States military, “a communication is ‘confidential’ if made to a clergyman in the clergyman's capacity as a spiritual adviser or to a clergyman's assistant in the assistant's official capacity and is not intended to be disclosed to third persons”. This is also the case, for instance, in other armed services, such as the Australian Defence Force, the New Zealand Defence Force, and the UK Armed Forces, whose chaplains provide “absolute confidentiality” for all personnel (see Bryan et al., 2015:74-78).

Also in the case of Botswana Defence Force (BDF), the chain of command cannot direct chaplains to divulge any information regarding a specific situation or member because of confidentiality of the communication. The confidentiality guaranteed by chaplaincy and the chaplain’s own military experience help to build trust, which is important for establishing a good relationship between the chaplain and the member in need of assistance. However, comparing the incidence rates of PTSD in different countries is not the only way to foresee and approach potential needs for pastoral care and counselling among veterans. In Scandinavia, post-traumatic stress disorder (PTSD) among veterans is estimated to be rare (approximately 5% in Sweden and Denmark versus approximately 20% in the USA) (Grimell, 2018: a). Moral injury (MI) and spiritual injury (SI) are some of the recently established concepts that do not fall

under the clinical and psychiatric definition of PTSD, provide complementary explanations for arduous internal fights (Berg, 2011).

Chaplains follow particular protocols in the military and those includes; in order to learn how to be a military officer and how to serve as an effective chaplain in the U.S. military, chaplain candidates must attend chaplains' school. Chaplains work as part of a command and are answerable to a chain of command as officers (Brinsfield, 2009). According to Brinsfield (2009), military chaplains receive the same pay as other officers based on rank and years of service, must adhere to all official military regulations (such as those governing proper conduct), wear the officer's uniform of their branch of service, and display religious insignia on their uniform. They are supposed to serve in domestic “camp” (barracks) or may be sent abroad at the service's discretion, where they conduct voluntary religious services and assist other clergy in conducting similar services as instructed by the commanding officer. They provide special services at weddings, conduct memorial services. They do pastoral counselling also with persons with post-traumatic stress. They visit service personnel wherever they are, including in combat. They visit the families of service personnel when possible. They provide religious literature, and perform death rites and funeral services. They serve in hospitals and tending to the injured. They provide leadership in humanitarian projects. They providing education and training on ethical matters. Brinsfield (2009) points out, that chaplains are prohibited from gathering intelligence or selecting targets. They are however required to take part in operational planning, provide guidance to the command and personnel on religious-related issues. They aid in liaising with local religious leaders in a specific area of operation. They are prohibited from carrying weapons.

In the Botswana Defence Force, chaplains in the past have joined unit ministry team in order to provide guidance to defence force members before they leave for specific missions. Soldiers on military duty can confront various conditions for which they could need psychological and spiritual strength. These situations range from missing loved ones to battle exhaustion. Chaplains dedicate their time to office meetings and visiting training facilities (Carey, 2018). The work of chaplains is critical for ensuring the welfare of military personnel.

The usefulness of the chaplain is in assisting staff at work before, during, or after trying occurrences and encouraging work-life balance. The chaplain is responsible for and capable of promoting welfare (Bowlus, 2018). According to one Air Force research, chaplains' spiritual care encourages resiliency, the strengthening of family ties, and contentment in the workplace (Cafferky et al., 2017). Similarly, is has been found that chaplains help military leaders with balanced work-family relations and appropriate coping mechanisms (Bowlus, 2018). Veterans who receive palliative care valued the contribution of chaplains to their spiritual needs (Chang et al., 2012). According to female troops in one study, trustworthy chaplains were able to lower stress by providing support and helping them to deal more effectively with anxiety, despair, and PTSD (Roberts, 2016).

2.8.7 Chaplaincy in the Botswana Defence Force (BDF)

Existing literature shows that with the outbreak of HIV/AIDS in the mid-1980s, Botswana was one of the most affected countries in the world. With one in three adults infected, Botswana had the second-highest rate of human immunodeficiency virus (HIV) infection in the world (Ngianga-Bakwin Kandala et al., 2012). The Botswana Defence Force was not spared the devastation of the pandemic. Due to the nature of the profession, the military is typically a very mobile society, and the size of the country and the requirement to secure its borders determine the scope of its movement. According to Sharp and Fisher (2005:44), Botswana covers an area of approximately 582 000 km², which places strain on the resources of the BDF. The BDF is compelled to rotate the human resources throughout the country due to deployment near the borders and other operational activities such as military training. These elements have had a substantial impact on the management of the disease. Mobility contributed to the spread of HIV/AIDS in the BDF.

The BDF leadership decided to establish the chaplain's office. It was established in 1989 in response to the spread of HIV/AIDS within the organization. To further address the problem of HIV/AIDS and its impact on the BDF, the Social Welfare Office was founded in 1995. This office provides uniformed and non-uniformed personnel of the BDF, as well as spouses and dependents, basic counselling, pre- and post-HIV testing, and counselling (Molatole & Thaga, 2016:48). Those who were still in the military during the early years of the pandemic have disclosed that during those years,

activities related to HIV/AIDS from social welfare and chaplaincy offices were perceived as a way to avoid doing essential military duties. However, the function of the offices became more well-known and better understood over time. Although the BDF Chaplaincy was first started as a response to HIV/AIDS, it has since resumed more holistic responsibilities. The office now tends to the overall spiritual and moral well-being of service members and their dependants.

The BDF chaplaincy office was established in 1989 for the purpose of providing spiritual, psycho-social and emotional support to all members of the BDF and their dependents. The office started with one officer recruited at the rank of Private and later converted to a commissioned officer. The office currently has fourteen commissioned officers at different military ranks, five chaplain assistants as non-commissioned officers, and three non-uniformed chaplains.

CHAPTER 3
EMPIRICAL METHODOLOGY

3.1 Introduction

This chapter explains the methodology of the empirical section of the study. It presents the data gathering techniques and tools, the data analysis tools and methods, and provides information with regard to the population that is investigated. This study utilises a qualitative research method. The aim is to come to a better understanding of the phenomenon.

3.2 Data gathering

Qualitative research can be described as the study of the nature of occurrences (Busetto et al., 2020). It is particularly suitable for analysing complex multi-component interventions, determining why something is noticed (or not), and focusing on what can be improved. The aim of this part of the investigation is to understand the actual experiences of trauma by individual members of the personnel of the disciplined forces. The emotions that people experience and the meanings that individuals or groups of in the disciplined forces in Botswana allocate to the events that cause the trauma, are of particular concern. The study also aims to better understand how their sense of morality and spirituality is affected by the trauma they experience. The emotions and experiences of pastoral care givers who attend to traumatised personnel will also be explored.

(Minayo, 2012:17) refers to the verb “understand” as the primary action in qualitative research, where issues such as the people's uniqueness, knowledge, skills, and the abilities of the organization and community to which they belong, are critical to contextualizing their reality. Busetto et al. (2020) emphasises responsiveness to the context, flexibility, and openness as characteristics of qualitative research.

Qualitative data collection tools were used. Document analysis, observation, semi-structured interviews, and focus group discussions were used for gathering data. Hijmans & Kuyper (2018) describe qualitative interviews as “an exchange with an informal character, a conversation with a goal”. Instead of just gathering facts, the

interviews aim at a deeper understanding of and insight into a person's subjective experience, attitudes, and motives. Narrative interviews were conducted with 10 persons from the military and 10 from the police services. The narrative interview gives people the opportunity to verbally express themselves (Scârneci-Domnişoru, 2013:21).

Narrative interviewing entails the researcher asking an open-ended question and requesting a narrative response from the participant (Kartch, 2017). The interviews followed the guidelines of Foster (2017:1). A comfortable space without distractions is provided. The purpose of the study is explained clearly. Confidentiality is guaranteed. The purposes for which the information will be used are stated clearly, as well as who will have access to the information. The participants can ask for explanations in the interest of clarity at any point in time (Kartch, 2017). The three phases for conducting a narrative interview are followed. In the first phase single, carefully constructed narrative questions are asked and the participant is given freedom to respond without interference. The second phase is an optional second interview in which more structured questions are asked to elicit specific data. Finally, this is followed up by an additional enquiry for further information where needed (Kartch, 2017). All of these three phases were used during interviews.

The researcher creates qualitative sampling designs based on the study's aims, and these designs typically call for a flexible, practical approach. According to selection of participants in qualitative research, which is shown to significantly rely on the researcher's judgment, it depends on the goal of the research. The approach of deliberate random sampling was utilized to choose study participants. The researcher can choose information sources to help address the research objectives by using deliberate sampling. Shaheen et al. (2019) describe the reasoning and goal of the procedure. The trustworthiness of the findings is typically increased by random sampling from small samples (Patton, 2002). Random, scientific samples are therefore highly credible.

Interviewees were selected among the commanders and officers within the BDF and the BPS units in Gaborone and Molepolole. Ten individuals from the military and the police services respectively from Gaborone and Molepolole stations were interviewed. Therefore, a total of 20 participants took part in the study; 50% of them worked for

Botswana Police Service while the other 50% worked for the Botswana Defense Force. Of the respondents, 70% were male and 30% female.

3.3 Data Analysis

Descriptive narrative data analysis is used to breakdown data and formulate evidence and facts through revision of the primary data collected during narrative interviews. The processing of the data focuses on the following aspects as pointed out by Muylaert et al. (2014:187). What is taking place right now? This question identifies the situational context (here) and the current interaction moment (now). This process can be aided by the framings and contextual clues; the framings are how the signal is constructed in the context of the current circumstance, and "contextualization clues" are crucial in the signalling of framings. These hints provide information about regional characteristics, situational context, as well as macro context, institutional, cultural, and social nature.

Constructivism holds the view that there are multiple realities. It also adopts the idea that reality is a product of the mind. Reality is therefore subjective (Andrew et al., 2011). The subjective nature of reality or truth means that what is true to me, may not be true to the next person. This paradigm is fitting in describing what officers would deem to be traumatic or not traumatic. Findings of this study are based on how respondents make sense of and interpret their experiences. Textual Analysis is also used. All recordings were transcribed word for word and compared with notes before analysis. The Interpretative Phenomenological Analysis (IPA) approach is utilized to code the narrative interview. Smith created the IPA qualitative analysis technique in 1990. It investigates how people allocate meaning to their experiences and extracts themes from that. The notes and recordings made throughout each interview session were analysed to find emerging themes.

3.4 Informed Consent

Informed consent involves informing subjects about the purpose of the study, and benefits and risks which can be incurred from participating (Patton, 2002). Before initiating the interview, the researcher and the participant entered into an agreement that clarifies the obligations and responsibilities of each of them. The objectives of the study were carefully explained. The participants expressed their acceptance and the researcher guaranteed confidentiality and a concern for their welfare. Participants

understood that they could withdraw from the study at any given time without any penalty or repercussions (see Patton, 2002).

In this study, the research was conducted only after participants had given consent. A consent form was provided, both written and oral consent and were given by the respondents. Providing consent forms is intended to ensure that human participants can participate in research freely and voluntarily and that they are fully informed about what it entails before giving their consent.

CHAPTER 4
THEORETICAL INSIGHTS

4.1 Introduction

This chapter discusses appropriate pastoral care theories and models for the investigation. It explores how effective pastoral care and counselling can be provided in the particular context of this study. This chapter discusses theoretical positioning and outlines the principles and the major conceptual underpinnings of transpersonal theory which uses mindfulness as a meditation based intervention. It also discusses models for understanding human behaviour within the context of trauma and resilience. It adopts the Pastoral Narrative Disclosure model of chaplaincy that provides a map for how chaplains can systematically engage with police officers in a pastoral care and counselling milieu.

4.2 Trauma Intervention Theories

4.2.1 Trans-Personal Theory

Transpersonal theory combines both spirituality and psychology as it is the study of transpersonal experiences and behaviours. According to Carey and Cohen (2015), transpersonal psychology seeks knowledge by investigating the causes of the current state in which individuals find themselves. The theory connects spirituality with the insights from psychology in order to provide holistic care for the psyche and the soul. Hart and Div (2010) explain that it is a useful spiritual care model for chaplains. It includes mindful, empathic attention to the individual's emotional anguish and suffering. It is known as the chaplain's model of mindfulness with its trans-personal application to the field of spiritual care. Trans-personal mindfulness is mediated through the theory of mind. The term signifies *beyond* (trans) the personal, the ego, or the self (Strohl, 1998). This type of care involves awareness of the feelings and ideas of another person, while providing trans-personal mindfulness-based intervention. Chaplains can use this to support officers in coping with trauma, particularly repeated trauma.

Understanding chaplaincy's function in the provision of mental and emotional health care services and the therapeutic results of the services have all been the subject of research studies. Grossoehme et al. (2012) describe the theory as “Listening

Presence". Chaplains trained in Clinical Pastoral Education have successfully adopted this model of care (Hart & Div, 2010). The steps in this type of care include the chaplain actively listening to the person's story of emotional suffering and challenges and becoming conscious of how the story brings up emotional memories. The chaplain notes all the signs of the effects of trauma. This includes signs of post-traumatic stress (Hart & Div, 2010).

Chaplains are aware of but not judge the person's behaviour or issues. They empathize with the individual's pain and struggles by employing verbal and nonverbal communication. They maintain sufficient emotional distance in order to not to be inordinately affected by the trauma stories of officers. The balance between empathy and distance is crucial both for the benefit of the chaplain and the persons who have experienced the trauma. Chaplains facilitate individuals to share their painful stories. The sharing and telling of stories increases their intra-personal awareness and keeps them from wanting to rush them out of their pain and suffering. Chaplains should avoid making "treatment plans" for them, but rather listen intently (Cafferky et al., 2017).

Mindfulness is a meditative art of being in a state of non-judgmental, compassionate and purposeful awareness of thoughts and feelings that arise in the present moment within an individual (Hart & Div, 2010). Because of its positive effect on well-being it has been increasingly incorporated into existing cognitive and behavioural therapies. The session often begins with guided meditation which then progresses into a counselling conversation (Grossoehme et al., 2012). Due to the nature of their work there is a high possibility of repeated trauma experiences. People in the police and the military are exposed to severe incidents as they go about their daily duties. Mindfulness practice and meditation can equip them to cope better with disturbing experiences and can serve to reduce the adverse effects of trauma that cause post-traumatic stress disorder. Mindfulness effectively modulates emotional arousal and cultivates compassion while down-regulating emotional centres. This is useful for military and police officers who can experience triggers while on duty in their daily workplace (Norton & Travis, 2017). Chaplains' insights into the person's experience and their ability to remain mindfully aware of possible emotions and thoughts of the person, can then enable the person to return and re-return to their internal emotions and thoughts. In the process intra-personal mindfulness develops. This can contribute to self-healing (Grossoehme et al., 2012). This can be effective in the military and the

police services in order to facilitate people to deal effectively with their day to day work which often includes being exposed to trauma upon trauma.

Through chaplains' pastoral care individual officers can be introduced to mindfulness-based techniques that can help them cope more effectively with the effects of trauma (Carey & Cohen, 2015). Chaplains are recognized as experts in spiritual care. They can benefit by utilising mindfulness as a key component in their model of care and understanding the neurobiological processes involved in this type of spiritual care. Using mindfulness, chaplains can become fully attentive to the officer's facial expressions, body language and emotional story. These observations are connected with the internal emotions and thoughts of the person in order to come to an understanding of the person's emotional and mental struggles. Explaining the neurological processes underlying to the chaplain's spiritual care can help the person to better understand what is going on with them (Carey & Hodgson, 2018). Training and practice of meditation is reported to activate brain circuits linked with empathy and Theory of Mind for an enhanced and effective response to emotional stimuli. Employing this model therefore prompts a neurological process.

Promoting mindfulness in chaplain training can significantly improve the desired outcome among the officers under the care of chaplains. Mental and clinical outcomes of chaplains' spiritual care can improve with the incorporation of mindfulness in chaplaincy training.

Mindfulness has long been practiced in eastern spiritual traditions for personal improvement and healing (Norton & Travis, 2017). Through the use of transpersonal theory, mindfulness-based interventions aim to improve metacognitive awareness of negative, automatic, ruminative thoughts and sensations as mere mental events rather than representations of the truth or portions of it. This is crucial for assisting officers in managing flashbacks, which are a sign of PTSD, as well as other psychiatric symptoms such as anxiety, panic, and paranoia. In chaplains' pastoral education "metacognition" is referred to as "inner-dialogue". This promotes awareness of one's own experiences in fresh ways and facilitates people to take responsibility for their feelings, values, and perceptions. This enables people to bear witness to their own traumatic experiences in a way that fosters compassion and ultimately self-healing (Carey & Hodgson, 2018). It also aligns with spiritual principles of declaring and making positive affirmations by faith in order to experience breakthrough. Officers can

then begin an internal search for awareness and a sense of meaning and purpose in life. This can lead to a transition called by various names, such as posttraumatic growth, stress-related growth, benefit finding, or positive change. In this way, officers who have experienced trauma can develop more effective coping abilities, an deeper spirituality, and an overall deeper appreciation of life (Norton & Travis, 2017).

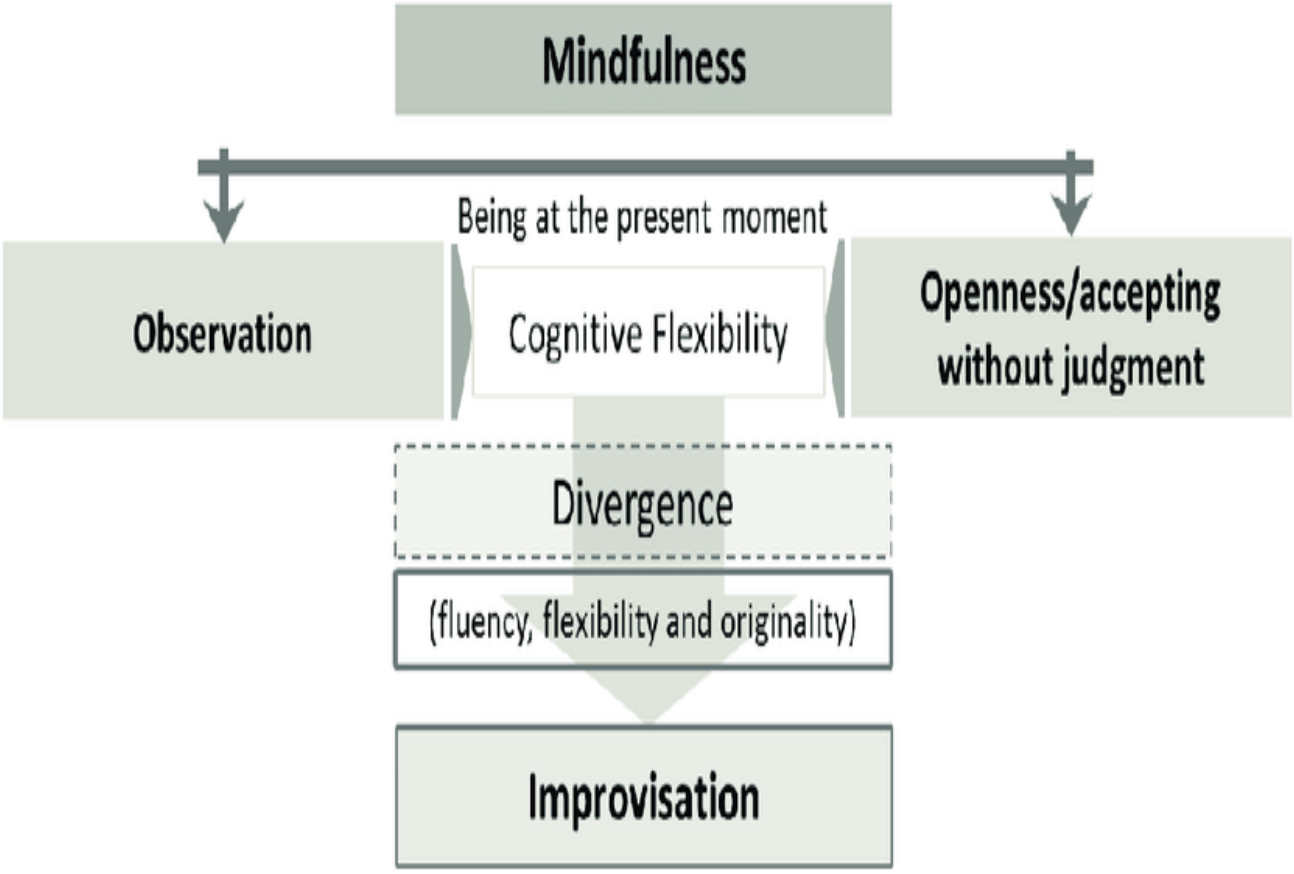
A study to assess the efficacy of mindfulness-based meditation therapy on anxiety, depression, and spiritual well-being of Japanese patients undergoing anticancer treatment by Ando et al. (2009) showed that mindfulness-based meditation therapy can be effective for treating anxiety and depression. Anxiety and depression are symptoms prevalent among officers in the disciplined forces who have post-traumatic stress after having experienced traumatic events while on duty. This particular model can facilitate officers to firstly appreciate their pain and symptoms and then move on to a process of intentional healing.

A mindfulness approach is an effective intervention from a psychological perspective through moment-to-moment, present-centred, purposive non-judgmental awareness (Mills, 2002) with the goal to guide people to achieve a greater awareness of themselves post-trauma, their thoughts, actions and behaviours, and their bodies. This knowledge is acquired through discussion and meditation. Chaplains can apply motifs from Scripture for the purposes of guide meditation. The aim is to imcrease personal growth and spirituality and decrease stress and mood disturbances as well as flashbacks and fear and anxiety.

In their study Ando et al. (2009) found significant improvement in spirituality, state and trait mindfulness, psychological distress, and reported physical symptoms in Japanese patients receiving anticancer treatment. This study examined the effectiveness of mindfulness-based meditation therapy on anxiety, depression, and spiritual well-being. They found significant improvements in spirituality, state and trait mindfulness, psychological distress, and reported medical symptoms. The findings showed that increased spirituality correlated with higher levels of mindfulness, both with regard to trait and state. Patients reported that physical symptoms and psychological anguish decreased as trait mindfulness and spirituality increased. Changes in trait mindfulness and spirituality were also connected to a decrease in reported medical symptoms and psychological distress. Changes in both trait and state mindfulness were independently linked to changes in spirituality.

The mindfulness-based stress reduction intervention program offers guidance on how to practice mindfulness in a materialistic setting and was specifically created to provide guidance and practice on how to incorporate mindfulness into daily life as support in dealing with difficult life events. The participants in the intervention discover that attention can be directed to noticing whatever thoughts, feelings, and sensations are emerging, while simultaneously remaining conscious of the capacity to maintain the focus of attention on these contents without shifting toward maladaptive conditioned reactivity or attention purposefully redirected to a wider field of awareness or to a different object. In doing so, adaptive tactics are developed. The point of departure is that the ability to exert greater voluntary control over one's mental processes and to guide those processes in a constructive direction increases a person's sense of control (Ando et al., 2009).

Psychological and physical well-being are pursued in this study. The aim is to come to alternative reactions that drive positive adaptive skills. This can happen once thoughts and feelings no longer threaten to overwhelm the traumatized person (Mills, 2002). The growth of this capacity for non-reactive self-observation and the ability to choose the focus of one’s attention, both of which are fostered by mindfulness, can help to self-regulatory behaviour that is compatible with the individual's larger goals and ideals (Anfo et al., 2009).



Source : (https://www.researchgate.net/figure/Mindfulness-framework-for-more-creative-mindset-source-created-by-author_fig2_331216497)

Figure 1: Mindfulness based intervention of trans-personal theory that chaplains can use to help officers deal with trauma.

4.2.2 Pastoral Narrative Disclosure Model

The Pastoral Narrative Disclosure (PND) model was specifically designed for chaplaincy with the aim to assess and treat moral harm and trauma in military personnel and police. Carey and Hodgson (2018:5) describe it as a model of spiritual intervention which emphasises the story-telling of a person who went through a traumatic experience and is seeking help to mitigate the effects of the trauma. Though PND is a health care intervention and not a theological discourse, it does provide a useful paradigm for the successful implementation of pastoral and spiritual care. It is a model of intervention specifically for use by chaplains in their work to help those who experienced trauma in order for them to achieve greater mental health and stability despite their experience (Carey & Cohen, 2015). Applied to pastoral care, PND is

intentionally holistic in its approach to an individual's story. Their “disclosure” is seen as part and parcel of who they are as a human being (Shay & Munroe, 1998).

As a humanistic model, it facilitates the chaplain to explore with the person feelings of moral injury, thinking about guilt and shame, asking for forgiveness, and re-establishing relationships with families, communities and themselves (Cafferky et al., 2017). The intervention consists of eight 60-90 minute sessions, with each phase being presented in order. However, depending on the progress and difficulties mentioned by the person who experienced trauma, it may occasionally be appropriate to return to earlier phases.

The narrative pastoral approach is appropriate for pastoral care that focuses on specific contextual realities. It provides a model for establishing a process through which the pastoral caregiver and the person in their joint conversation can co-construct richer descriptions and meanings that can be applied to their life context (Truter & Kotzé, 2005). The work on moral injury by Shay & Munroe (1998) is normally utilised to investigate the aspect of a high-stakes situation in which someone in a position of lawful authority (according to the social order) betrays what is morally upright in the particular culture and religion (Truter & Kotzé, 2005).

4.2.3 Pastoral Narrative Disclosure Model: Stages

Stage 1: Establishing Rapport

In their respective disciplined services, chaplains hold a special position that allows them to provide counselling to personnel. Personnel can trust chaplains with whatever they discuss without the fear of being reported, reprimanded, or subjected to retaliation. The building of rapport signals the beginning of officers' transpersonal attention, which is evident when they begin to consider their goals (Carey & Cohen, 2015). The chaplain maintains confidentiality and has a disciplined services background. This combination contributes to building trust with officers, which is crucial to improving health outcomes. Providing a safe space for telling the stories of their trauma and problems ensures a relationship that is conducive to effective pastoral counselling.

Stage 2: Reflection

Due to the rapport that has been established, personnel who return from active service can feel free to share their experiences with the chaplain. Some narratives are filled

with guilt, shame or anger and fright (Truter & Kotzé, 2005). Given the potential that moral injury and trauma have to define and absorb a person's entire identity, this is a crucial step in the counselling process. Reflective spiritual care begins with grieving the shared suffering of moral harm. They can share painful and morally damaging experiences orally, in writing, or through other means such as images or videos.

Stage 3: Review

Following reflection, a person should, with the assistance of the chaplain, do a thorough, critical self-review of their operational life experience. In order to evaluate their own or others' conduct that could have caused psychological trauma or moral injury, the person would have to check their conscience with the help of the chaplain. Such reflections are critical in establishing and identifying possible stresses and stressors well on time before they take a different toll on the person (Carey & Hodgson, 2018).

Stage 4: Reconstruction

Reconstruction is defined as the process of reassembling one's belief system after a morally damaging or traumatic experience in relation to moral injury and trauma (Carey & Hodgson, 2018). Due to their theological study in ontology, moral theology, ethics, and reflective praxis, the majority of military and police chaplains have a strong academic basis. Chaplains can assist officers in investigating their moral conscience and the reasons why a morally repugnant occurrence damaged and traumatized them in spite of their specialized military training and experience of active duty. The chaplain's task is to become aware of the needs of the person on a holistic level. This includes medical, psychological, social, or spiritual concerns that arise as a result of a morally damaging occurrence (Carey & Cohen, 2015). The military chaplain can assist personnel in investigating the morality and ethics of the situation and their role in it. In order to achieve stability and recovery from the trauma, the chaplain and person together can address issues of grief, guilt, shame, and anger and can begin to rebuild the values of trust and forgiveness.

Stage 5: Restoration

In the event that it is feasible, a restorative procedure may be required to address moral damage issues with betrayal. A basic violation of human dignity, betrayal leaves victims feeling disappointed and discouraged (Cafferky et al., 2017). The issue of

betrayal—whether it is by others or self-betrayal—should be addressed and the person restored (Carey & Cohen, 2015). Through such a process, the person might validate their experience or acquire more knowledge in order to comprehend the larger context in a reciprocal discussion of truth and understanding. The ability to re-establish a relationship between a person and an organization or service is crucial because a relationship that has been rattled, fractured, distorted, or fouled cannot simply be repaired in terms of material loss or harm (Carey & Hodgson, 2018). This stage should ideally contain a vocal admission of guilt or apology by the offender or a senior member of the defence; however, if a face-to-face contact is not possible, a written statement may be sufficient (Carey & Hodgson, 2018).

Stage 6: Ritual

Although not all employees are religious, many have a spiritual background or influence, and religion has played a role in the formation of their moral worldview (Carey & Cohen, 2015). As a result, whether intentionally or unintentionally, many employees would base their morals on one or more stories from a traditional faith framework (such as Buddhist, Christian, Hindu, Islam, Judaism) or an amalgamation of religious ideas. In the past, military personnel frequently asked a priest, cleric, chaplain, or rabbi (or an equivalent) to lead a ritual such as a prayer of confession (or equivalent disclosure). They made a first step in reversing their probable debilitation by clearing their moral conscience. Depending on the faith or religious perspective, specific rituals can be used to assist staff in treating and purging their moral wounded, regardless of the type—betrayal or perpetration. After the “confession”, people can ask for forgiveness. This could be a request for others' forgiveness as well as the forgiveness of a divine being or God (Carey & Hodgson, 2018).

The battle to forgive oneself and even to forgive God (or another divine being) for not stepping in, is another difficulty for personnel. Other customs, such the chaplain or priest sharing the Eucharist (in the Christian tradition) as part of the prayers of forgiveness, can be used conducting restorative prayers and anointing the staff with oil (Carey and Hodgson, 2018). According to (Hughes, 2018), prayer can provide employees the confidence to reconcile with the deity, their spiritual community, or important connections in their lives, as well as to recover from past traumas (Carey & Hodgson, 2018:58). This ritual duty should be performed by an authorized serving religious practitioner, regardless of the religion or spiritual tradition, as a matter of

authenticity, genuineness, and integrity (e.g., cleric/chaplain) (Carey & Hodgson, 2018).

Stage 7: Renewal

In everyday language, renewal refers to starting over with a "clean slate" in life. A technique to encourage personnel to take part in new, life-enriching activities is to use a "ritual of penance" (i.e., "making amends") or something similar (Carey & Hodgson, 2018). One method or "route away from self-destructive tendencies and toward life-affirming strategies" is that of punishment. One of the effects of a moral harm is that it disrupts relationships between members of the workforce, their families, the community, and their religious or spiritual affiliations, potentially resulting in estrangement. This relationship breakdown could be brought on by a sense of personal responsibility (e.g., "I could and should have done something"), a decline in faith in God (e.g., "Why did God permit this?"), a decline in confidence in the community, or a distorted anthropology (e.g., "All people are wicked"). However, the effects of this rupture demonstrate the necessity of utilising PND for healing and renewal (Carey & Hodgson, 2018).

Renewal focuses on building supportive and productive relationships with spouses or partners, children, the extended family and other social groups, such as the faith community (Carey & Cohen, 2015). This promotes communication opportunities and the growth of relationships (Hughes, 2018). For instance, staff members might take pre-arranged weekends off to spend time with their families in order to promote good communication or participate in group activities in the neighbourhood.

Stage 8: Reconnection

Reconnection entails staff members thinking about, utilising assistance, and re-evaluating their present and future values, plans, and goals pertinent to themselves and their significant others (Homey & Carey, 2018). This may entail going back and re-examining earlier work from the initial PND process (such as reflection and review) in order to identify any outstanding concerns and/or to prepare strategies for the future. The chaplain encourages personnel to connect with more extensive support and services in order to promote long-term stability (Carey & Cohen, 2015). Additional assistance from general practitioners, nurses, psychologists, social workers, community clergy, chaplains, and other allied health experts will help the member to

maintain their success and build their resilience with the agreement of the person in question (Carey & Hodgson, 2018).

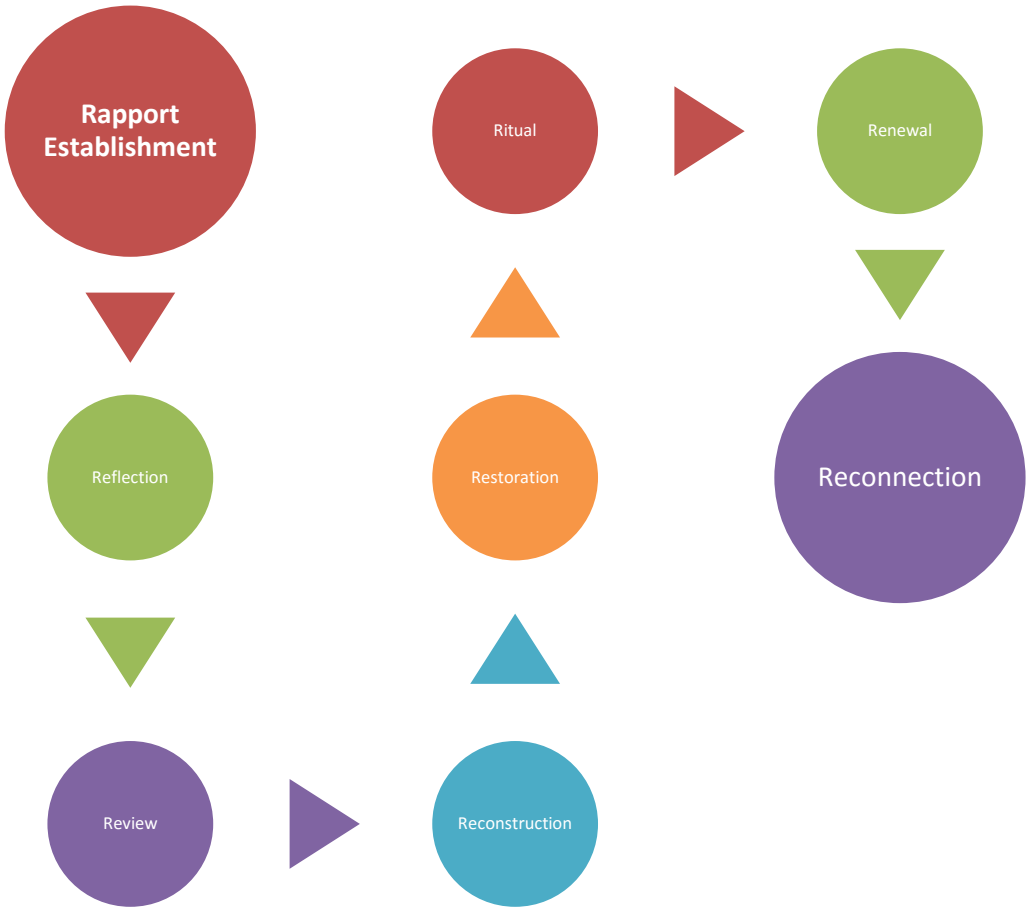


Figure 2: Pastoral Narrative Disclosure Model Stages

CHAPTER 5
DISCUSSION OF RESULTS

5.1 Introduction

This chapter focuses on analysis of findings using the narrative descriptive method that analyses qualitative data. The study objectives were to identify prevalent traumatic experiences in the disciplined forces in Botswana; identify effects of traumatic experiences among disciplined forces in Botswana; identify the psychological responses expected following traumatic experiences among disciplined forces in Botswana and identify the effect and role of pastoral care among the disciplined forces in Botswana.

5.2 Qualitative Analysis: Causes and Effects of Police and Military Trauma

Table 5.1 Subthemes and themes from the interviews

Theme	Sub-Themes	Textual Units
Trauma Experienced	Witnessing Death	-police officer and shot himself dead in our presence and the public -he wrote a suicide note on the ground, took a few steps from the soldier he has called then shot himself dead on the forehead right in front of us - I tried to talk to him but he could not respond even though it appeared like he could hear me, blood was coming out of his mouth. He was my squad mate, I was trying to assist him but I couldn't because I had broken my thigh. - We were doing parachute free fall/sky jump and our RSM's parachute failed to open. He crash landed to death -We engaged fire on him and killed him. It was my first time to be part of a firing team on a human being - It was my first time to have contact with poachers and we engaged them with fire and brought both of them down. It was my first time to see a person killed by a gun

	Seeing and collecting dead bodies	-The girl was killed with a knife and it was left right in her ribs. -human body was reported found in a very small room; the body had many days lying there and had decomposed already; There was a lot of blood, maggots - The head was smashed like an empty milk box ran over by a car! The brain was splashed out of the head - a body of a murdered woman was found. I spent the night guarding the decomposed body together with my colleagues at the crime scene and it affected me very badly - dead bodies of people lying on the flow at the mortuary as the mortuary attendant told us that the storage was overwhelmed - It was my first time to carry a dead person as we were loading the bodies in to the police vehicle
	car accidents	-military tanks got involved in an accident at the firing area, SK 105 hitting Pirranah from behind. We were 12 in the pirranah, 4 of us got injured, 1 of us lost his life -I had an accident in 200 1 in an operational area. We were two in the vehicle, driving from the military base to an air strip in the dust road. The vehicle lost control and over turned to my side, I was a passenger
	Physical Injury	I had a physical injury during basic military training.
	Stabbings	-when I lifted my eyes I saw one of the men hitting a bloody okapi knife on the counter desk. The other man and the woman were screaming so loud, we noticed the man with the knife had just pierced the other man with the knife in the eye right in our presence
	Wild animals	- we realised that after we fled the hurbar, it was occupied by lions
	Killing people	- we followed trail of poachers I initiated fire and he immediately followed, we took them both down
	Secondary Trauma	- It happened to my house mate. They had an encounter with poachers and he was mentally disturbed from the scene. He is

		a family man and the family was affected too. I had to take care of him
Effects of Trauma	Fear	-what if it happens to me - I was asking myself how they felt being at the other side of the riffle and I squeezing the trigger on them, taking away their lives, I was thinking a lot after that. - I developed fear of going out for patrols - I started to stay with fear - I am fearful and feel unsafe. - I really wanted to quit the job then - For a long time I was not able to use my bear hands to eat, I would feel as if am eating human blood - I developed phobia for putting on military uniform - I was so terrified when the accused told us that he is going to bewitch us and stuff. I was still new in the office I was not used to such issues. - I have developed phobia for speed and driving generally - time I requested not to attend crimes scenes and post-mortem scenes, but now I am recovering. -I was very scared - I am scared even up to now
	Flashbacks	- I keep on recalling the incident when I have to do the jump. - I was thinking about it a lot after that. - I keep on have flashbacks of these incidents -I have flashbacks of the scene - I had a lot of flashbacks of what happened
	Moral Injury	- I comforted myself that I did not sin; I was protecting our nation and doing my duty. - I think the fear came from human dignity, killing a person is not easy
	No Effect	- I have never been affected by trauma but I think it affects other people. - I was not traumatised because I took it as part of my job.
	Anger	- Sometime I get filled with anger

	Loss of appetite	- It took me about two weeks having no appetite and failing to eat thinking of that blood and the wound in that eye
	Depression	- I feel depressed
	Illness	- I have developed a severe headache due to these experiences
	Lack of sleep	- Sometimes I cannot sleep well because I dream of one of us who died on duty a lot
	Emotional breakdowns	-I sometime break down emotionally
	Lack of concentration	- lack of full participation on duty requirements
Usage of Chaplains Services	Not Attended by Chaplains	- I have never had any help. We have shortage of chaplains - I don't know why I was not attended by chaplain, may be they just take it that it is normal for us to go through trauma. Chaplains come only when there is a funeral. -I was not attended to by chaplain. We have shortage of chaplains - I was not attended to by chaplain because I did not choose to share with them even though they are available - No, our chaplains are not available to serve. Sometime we are not even sure who chaplain is because they are just regular police officers - No, I was not attended because I did not seek intervention - No I was not attended by a chaplain. We are not often attended to - I have not been attended by chaplain
	No Chaplains at Station	- no chaplains or any counsellors in the organisation during the time - stationed in far places from urban areas, it is not easy to access chaplains
	Not aware of chaplains	-I was not aware of the chaplaincy service
	Chaplaincy not effective	- The chaplain service is not effective - we have them but their service is not effective

	Attended to	- I was attended to by a social worker - I am one of the fortunate police officers who have been attended to by chaplains since I once worked closer to the helping offices; chaplaincy - the second incident I was attended to by a chaplain as you can recall you are the one who attended us. After chaplain's counselling I felt emotionally much better -I was attended to by a chaplain because we have one in our station. The counselling was very effective - Yes, we were attended by a chaplain after the first incident, which made it easy to deal with the second trauma. Chaplain's intervention was so effective - Yes, chaplain attended us. His intervention was so helpful - Yes we were attended by a chaplain - Yes, chaplain attended us

The table shows main themes derived from the interviews. The themes and sub-themes provide the results of the engagement with the participants and their stories of trauma and moral injury. The main themes are:

- **Theme 1: Trauma Experienced**

The traumas experienced include:

- witnessing death;
- seeing and collecting dead bodies;
- car accidents;
- physical injury;
- stabbings;
- dealing with wild animals;
- killing people;
- secondary trauma.

- **Theme 2: Effects of Trauma**

The effects of trauma include:

- fear;
- flashbacks;

- moral injury;
- feeling nothing
- anger;
- loss of appetite;
- depression;
- illness;
- lack of sleep;
- emotional breakdown;
- lack of concentration.

- **Theme 3: Chaplain Services**

Interaction with chaplain services include experiences such as:

- not being attended to by chaplains;
- no chaplains at the station;
- not aware of chaplain services;
- chaplaincy support was not effective.

5.3 Discussion

Participants had work experience ranging from 5 to 36 years. The work experience of the respondents was divided into 4 groups as follows: below 10 years, 11-20 years, 21 to 30 years and 31 years or more. Officers' trauma experiences varied in terms of the quantity, nature, and variety of events they encountered during the course of their employment as peacekeepers and public servants.

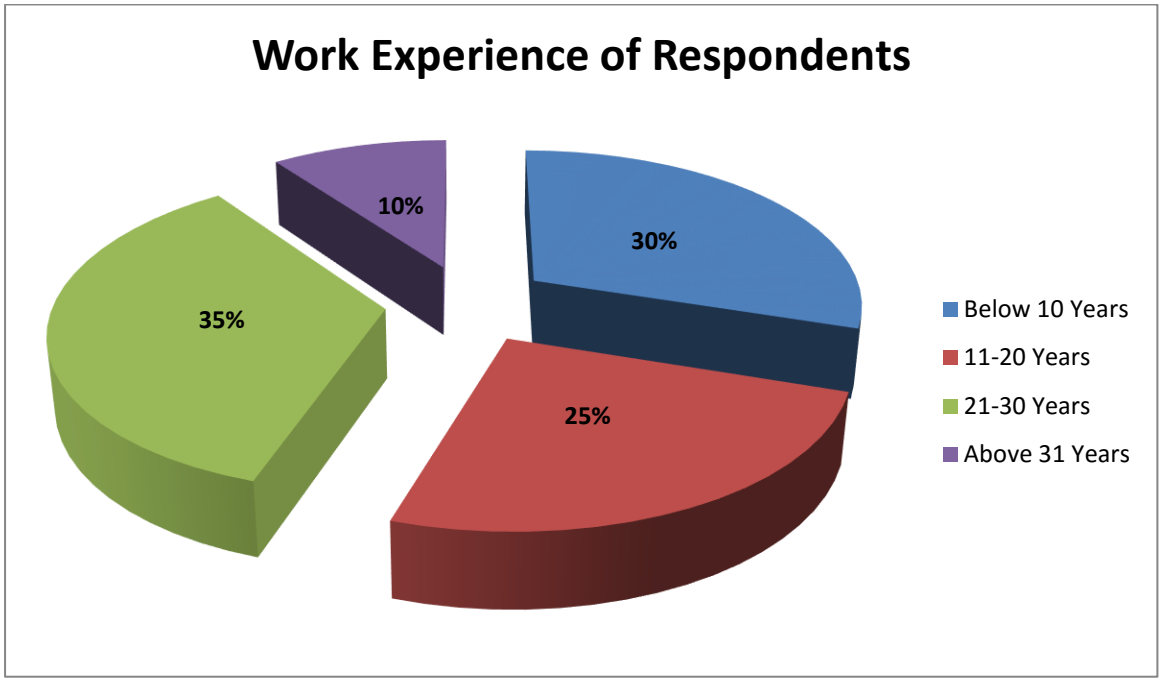


Figure 5a

Most of the participants fell within the 21 to 30 years at 35%, followed by those below 10 years at 30%, 11-20 years at 25% and lastly those above 30 years' experience at 10%. Of the participants, 95% confirmed to have experienced trauma directly in the work place. The remaining 5% said that they did not experience trauma directly but indirectly through colleagues.

5.4 Types of Trauma

The responses to Question 3 indicate that trauma resulting from death either through suicide, murder or accidents were the most prevalent experiences that participants experienced in their line of duty. About 80% of the participants experienced trauma resulting from death. Responses varied from participants having to go to accident scenes and bag dead bodies, investigating crimes of murder or suicide and having to find dead bodies in the most unpleasant positions, for example, a parachute accident or, participants having to shoot at poachers and see their dead bodies, or seeing their colleagues die in the shoot-out. The most traumatising of these had to do with having to deal with decomposed bodies, either of strangers or people they knew. The results showed that 25% of the respondents witnessed the death occurring. In some instances it was someone who was shot or stabbed to death as they were looking on. Carey (2018) points out that wartime placements and police patrols can result in people

seeing horrific death or catastrophic injury. These events can happen unexpectedly and not necessarily on the targets that are planned. Active duty military and police personnel run the danger of suffering non-military-related traumas such as interpersonal violence, physical or sexual abuse, in addition to the severe conditions of deployment and patrol regions (Carey & Hodgson, 2018).

Some officers 10% of the respondents experienced trauma resulting from being attacked by wild animals. This kind of trauma only occurred among military officers. One of the officers reports an incident where they only realised in the morning that the place they had spent the night at was surrounded by lions. Soldiers on training exercises around the world have been gored and trampled by elephants, bitten by snakes and attacked by foxes, according to official figures (Carey, 2018). Literature shows that more than 20 soldiers in the Botswana Defence Force have suffered attacks by animals in the past decade as they carry out exercises in wild training grounds. Others have lost their lives due to elephant attacks where they were deployed (The Patriot, October 25, 2018).

Only 5% of the respondents experienced harassment from an ex-convict. That officer feared for her life. The last 5% had not directly experienced any trauma.

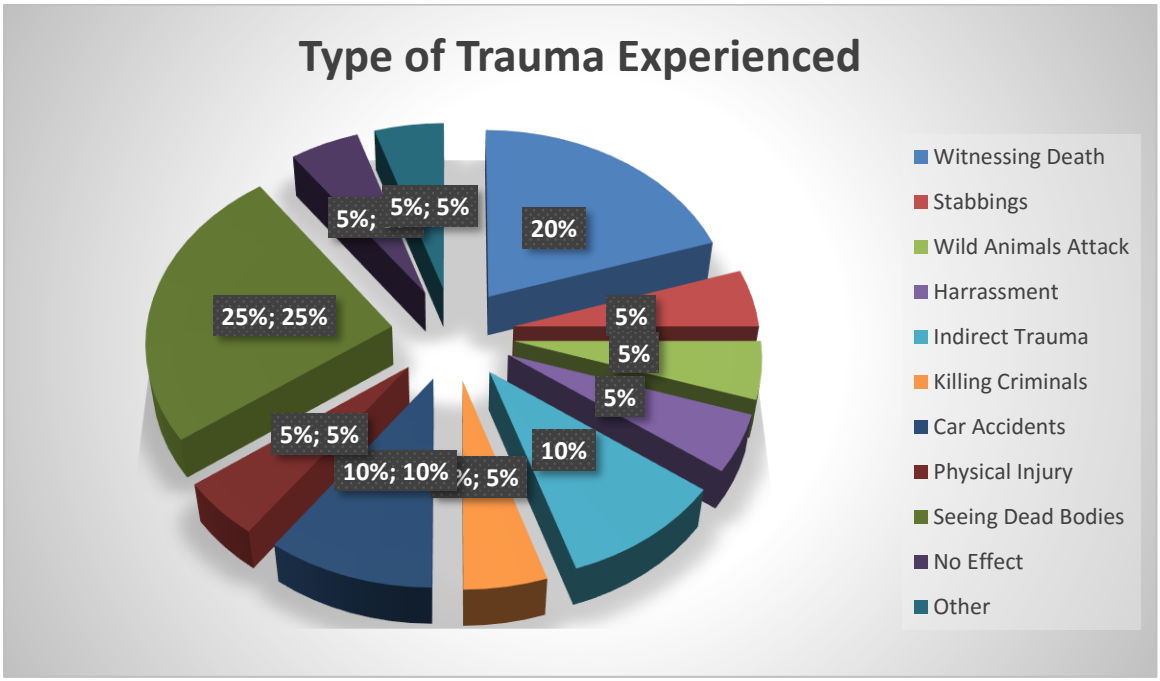


Figure 5b

Police officers and military personnel are more likely than the general public to encounter abrupt and unexpected shock due to the nature of their word. According to Keane (2019), other types of traumatic events that can occur while serving in the military or as a police officer. These include: knowing or seeing someone who has been gravely injured or killed; remote combat operations; handling human remains; placing subordinates in danger's way and having them get hurt or killed; experiencing military sexual trauma (sexual assault or persistent, threatening sexual harassment); working as a casualty notification officer (those who inform military families that their loved one has been killed); involvement in serious accidents involving near-death experiences. Military personnel experience death not only on the battlefield but also in non-combat situations like a car accident, suicide, or even while performing their duties. Many people are impacted by military deaths, including close relatives, neighbours, friends, and those to whom Maguen et al. (2010) refer as the deceased military family. A person's military family consists of the people they have trained with, served with, lived with, and deployed with while performing operational responsibilities.

Trauma is categorized in the literature as: threats to one's life, threats to others, the aftermath of violence, traumatic loss, and moral injury to oneself and to others (Maguen et al., 2010). While some critical incident types happen occasionally, others happen infrequently and others do not happen in a person’s lifetime. For instance, a police officer may respond numerous times over their career to the scene of a deadly vehicle accident, as the first responder to a suicide or homicide, or the investigation of violent child abuse, depending on the jurisdiction and assignment. According to a qualitative study conducted by Ricciardelli and colleagues on 284 participants, violent death, unintentional death, and serious auto accidents were the most distressing experiences for police and military personnel. According to a data collection system used by the Federal Bureau of Investigation to gather information on crime, 56 officers were killed in felony shootings and 53 469 were assaulted in 2010. Seventy-two other police officers were killed in work-related accidents (Leoka, 2010).

5.5 Effects of Trauma on Officers

Respondents were asked how the trauma affected them. The results showed that the most prevalent effect was having flashbacks; 30% of the respondents confirmed experiencing flashbacks of the scene where they got traumatised. According to

Shaheen et al. (2019), flashbacks are part of Post-traumatic Stress Disorder where trauma victims feel as though they are reliving a past traumatic incident as if it is happening at the present moment. Flashbacks can be triggered by anything that reminds an individual of past trauma they have experienced. Flashbacks fall in the category of intrusive PTSD symptoms. Victims tend to experience the emotional and physical sensations they felt during a traumatic event.

During a flashback, as described by Brewin et al. (2020), participants this study related how they would see complete or partial images of the traumatic incident, hear sounds or words associated with the event, experience physical sensations such as pain or being touched. They would have the same emotions and bodily reactions as when the traumatic event was taking place. This could include sweating or a racing heartbeat as well as feeling confused about what is happening. According to Solomon (2011), some persons find themselves increasingly reliving the trauma, especially those who avoid dealing with their emotional reactions. Some individuals experience PTSD flashbacks as a type of dissociation. This mental state causes a person to feel disconnected from their thoughts, emotions, memory, or identity. They might have no recognition of where they actually are (see Brewin et al., 2020).

The second most prevalent effect was fear or a phobia of some sort. This came in various forms depending on the nature of the trauma. Those involved in car accidents feared over-speeding. Others feared going on patrol since they felt unsafe. In extreme cases, the fear caused individuals to contemplate to leaving the service. A few respondents (10%) reported a loss of appetite; one could not eat with bare hands for a long time. Other ways through which the trauma affected the respondents were: insomnia (5%), isolation (5%), severe headaches (5%), depression (5%) and incapacitation, where individuals were no longer able to do what they could initially do for themselves. However, 5% of the respondents reported that they had not been affected by the trauma. It could be that it is the respondents who were not directly traumatised.

Officers respond to a critical occurrence with a variety of complex emotional reactions, as do all people (Solomon, 2011). Although these emotions are challenging, the culture of the police and military makes it considerably more difficult for officers to recognize and acknowledge distress. According to Solomon (2011), just one-third of

the police officers involved in a serious and traumatic occurrence would have a minor or no reaction to the event. The other two-thirds would have a moderate to severe reaction. Police officers are prone to developing PTSD symptoms due to exposure to traumatic events and the repression of natural human emotions (Clair, 2006). The majority of persons who experience trauma initially exhibit some symptoms, but not everyone will have PTSD. Why some people experience PTSD while others do not, is unclear. How likely a person is to develop PTSD depends on a variety of factors, including how severe or prolonged the trauma was, whether the person lost a loved one or was injured, how close they were to the event, how strongly they reacted, how much control they felt over the traumatic event, and how much support they received in the aftermath (Department of Veterans Affairs Centre for PTSD, 2007).

Trauma and moral injury are connected to shame, drinking problems and guilt (Currier et al., 2014), rage (Maguen et al., 2010) and para-suicide (Bryan et al., 2014). Sleep disturbances are a common symptom of PTSD. Police officers and military service personnel frequently suffer from insomnia caused by psychological, mental, and physical pressure, as well as other sleep disorders and trauma-related symptoms (Brewin et al., 2020). One of the earliest signs of PTSD is sleep disturbances and insomnia, which regularly includes bad dreams/nightmares, sleep deprivation, and rapid eye movement sleep (American Psychiatric Association 2000).

A social isolation measure takes a person's integration into society into account. It measures how often they interact with others and participate in social networks (American Psychiatric Association, 2000). Researches shows that military service can lead to social isolation. Loneliness and social isolation are prevalent issues for military and police personnel of all ages (Brewin et al., 2020). Officers who lose touch with friends from service often end up in total isolation. After having spent long periods of time forming a bond with comrades, these relationships can be lost suddenly in an active combats or patrols situation. It can then become difficult for the persons to socialise after a service related traumatic experience, especially it is led to PTSD (Brewin et al., 2020).

At the scene or afterward, several officers experienced emotions that affected their performance and made them less productive in their word. According to Basinska et al. (2019), negative emotions lead to a greater sense of exhaustion and

disengagement. This lowers the motivation to work and impairs productivity. It is crucial that training programs for police include emotion-regulation techniques in order to prevent mental health issues.

Table A: Effects of trauma statements with themes

Fear	**Flashbacks**	**Loss of appetite**	**Insomnia**	**Isolation**	**No effect**
-I developed fear of going out for patrols - I started to stay with fear - I am fearful and feel unsafe. - I really wanted to quit the job then - For a long time I was not able to use my bare hands to eat, I would feel as if am eating human blood	- I keep on recalling the incident when I have to do the jump. - I was thinking about it a lot after that. - I keep on have flashbacks of these incidents -I have flashbacks of the scene - I had a lot of flashbacks of what happened	-I would feel as if am eating human blood	-Sometimes I cannot sleep well because I dream of the person who died on mission a lot	-I am no longer sociable as I used to.	-I was not traumatised because I took it as part of my job.

5.6 Workplace Challenges Experienced by Officers

Respondents were asked to describe aspects of their work that they found to be overwhelming. A shortage of resources was the most prevalent, with 30% of the respondents confirming that. Resources in short supply were predominantly cars, which made it difficult for police officers to do their work. A police inspector (rank) of BPS confirmed that the “shortage of transport makes it very difficult for us to do our work effectively”. Other resources in short supply were protective clothing, personnel and accommodation. Accommodation was especially a problem in the military since BDF has employed only males until recently. Moreover, 25% of the respondents complained of being disregarded. They work with commands due to the nature of their job, but sometimes that means that they are forced to do things they would rather not do.

Some 15% of the respondents found nothing to be overwhelming in their workplace. A sergeant from the BDF said that, “as a well-trained soldier, I think I have accepted the strain of work as normal and I can’t see anything as overwhelming”. It could be that some of them have developed coping skills to deal effectively with the demands of the work. Another 15% complained of the workload. They sometimes have to work after hours. This confirms the shortage of personnel raised by some of the respondents. The other responses by 5% of the respondents include: separation from family due to extended trips, working in dangerous areas, doing things that go against the grain like, for example, having to shoot people. These answers indicate the potential trauma to which officers are exposed, which causes concern and anxiety to them. This illustrates the need for chaplaincy services to support them in dealing effectively with workplace stressors and challenges.

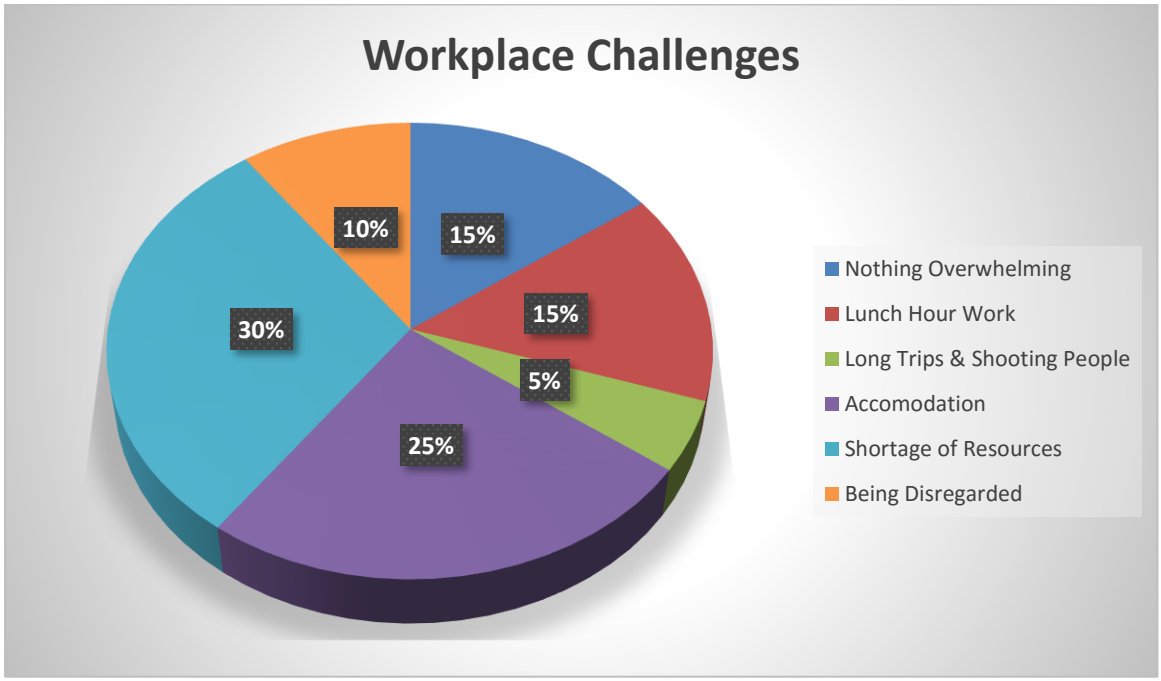


Figure 5c

5.7 Chaplains Attending to Experienced Trauma

When respondents were asked if the chaplain attended to them after suffering trauma, 40% confirmed that they utilised chaplaincy services and that this was effective. They recovered and were able to cope with the effects of the trauma. One respondent put it as follows: “The chaplain attended us. His intervention was so helpful.” However, 35% reported not to have been attended to by a chaplain. Of those who were not attended by chaplains, 10% said that they did not seek help from the chaplains. Reasons given included that there were no chaplains in their unit at the time of the incident (5%), that they were not aware of the service (10%), that they lived far from the stations that had chaplains (5%), that there were not enough chaplains, and that the chaplains had to many other commitments. The most prevalent reason seemed to be the fact that chaplaincy was not effective, as reported by 25% of the respondents. This is probably why 10% of the respondents said that the chaplains were not sufficiently qualified and that they only appeared at certain events. An Assistant Superintendent of the BPS confirms that as follows: “We only see chaplains during funerals.”

Some respondents who are stationed in remote areas did not have access to chaplaincy services. Police seem to have shortage of trained chaplains and hence inability to help police officers who have experienced trauma. All the respondents who

were helped effectively are from the Botswana Defence Force. The Botswana Police does not have a strong and established chaplaincy and pastoral care. One of the respondents put it as follows: “No, our chaplains are not available to serve. Sometimes we are not even sure who chaplain is because they are just regular police officers.”

According to the existing literature, officers often do not ask for assistance because they regard it as a sign of weakness. It is well known that law enforcement officials oppose mental health treatment since that would suggest weakness (Miller 1995). Police officers are viewed as being tough people who must maintain their resolve no matter what challenges they face while performing their duties (Miller 1995). Receiving mental health assistance is seen as a sign of a person's inability to do their duty (Miller 1995). According to Miller (1995), an officer who asks for help runs the risk of being stigmatized, mocked, and isolated by co-workers. When attempting to identify officers who need assistance in coping with work-related stress, this potential for workplace humiliation becomes a barrier. In a study to determine how frequently police personnel make use of chaplaincy services in their stations, Lawrence et al. (2002) found that there was little actual use of chaplain services. The lower utilization rates among law enforcement officers can be attributed to a number of factors, including employees' mistrust of the confidentiality of the services given, a lack of administrative support, poor accessibility, and participants' low satisfaction with the services.

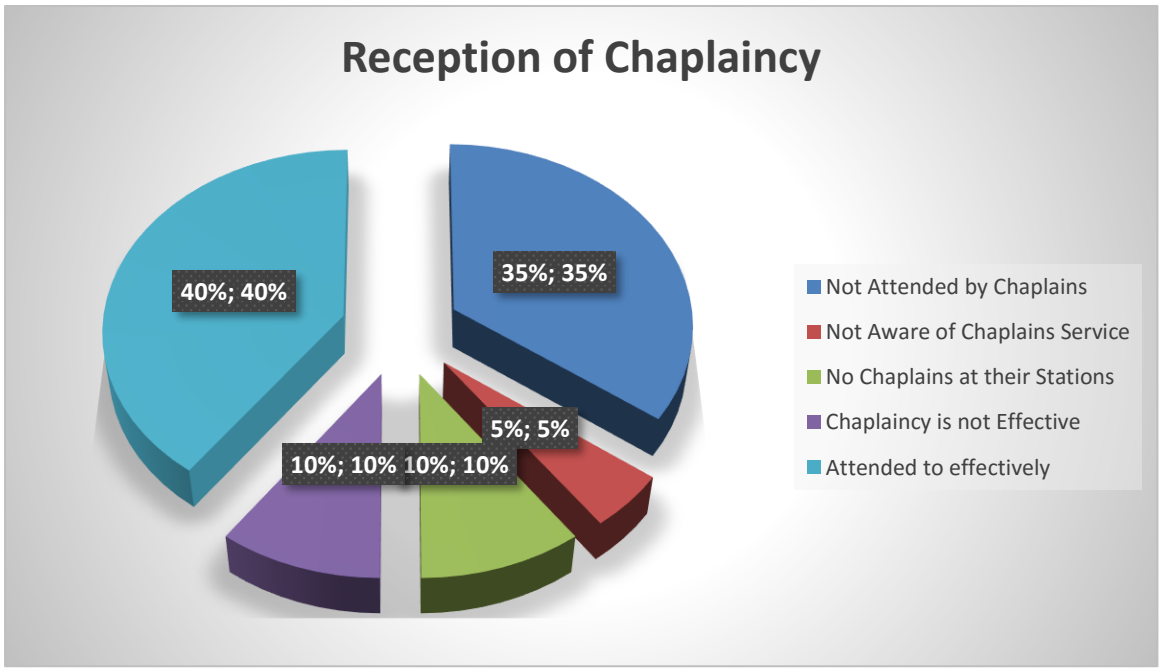


Figure 5c

Chaplains have the task to assist people during difficult times. People who are touched by a crisis are either emotionally charged or in a state of shock. People are most vulnerable during this time. Many people are grateful to the chaplain who provided them with spiritual support through the crisis. Receiving help in a moment of need has a great positive impact on that person's life. Many claim that their healing was greatly aided by their faith. Bracken-Scally et al. (2017), in a study on catastrophic accident stress management, found that acts of aggression or threats of violence when responding to an incident were the most frequent incidents for which subjects needed support. Sharp et al. (2015) found that 60% of military personnel with mental health issues did not seek help after conducting a thorough assessment of the literature on potential barriers to accessing mental health support. The stigma associated with obtaining treatment for a mental health condition significantly discourages police from seeking counselling.

Because of this, some law enforcement personnel turn to unhealthy coping mechanisms such as alcohol or avoidance in an effort to alleviate symptoms of extreme stress and trauma (Lindinger-Sternart, 2015). To avoid the damaging effects of trauma and stress, officers can use defence strategies such denial, displacement, isolation of feelings, and humour (Berking et al., 2010). Officers are thus caught in a vicious cycle that includes the following elements: stress and professional trauma; unhealthy coping with painful feelings, memories, and thoughts; and worsening of mental and physical health (Pasillas et al., 2006). Interpersonal and family stress in addition to occupational and organizational stressors can exacerbate their situation. Among the officers' heightened mental health symptoms were suicidal thoughts, anxiety, and signs of depression (Berg et al., 2006).

Fostering the well-being of officers is one of the key roles of chaplains in law enforcement organizations. By developing a connection and providing counselling, they bring psychological relief and spiritual hope. Bryan et al. (2014) see chaplains as peacekeepers during times of crises. They provide support at funerals where individuals experience deep emotions as a result of the way in which the death occurred. Frequently, law enforcement chaplains help families prepare for funerals, get in touch with friends and relatives, and officiate ceremonies (Bryan et al., 2014; see Maguen et al., 2010). These personal interactions increase the likelihood that officers will seek the chaplain’s assistance in future. In this way demonstrate the

necessity of such a service to officers both in the military and police service. Police and the military units must encouragement the utilisation of chaplain services to help officers deal effectively with trauma. Pastoral care provides person with guidance, healing, sustenance, reconciliation, and the nurturing of their spirituality and overall well-being (Carey & Rumbold, 2015).

Chaplains can establish rapport through an open door policy and accessibility. They provide free counselling, visit patients in hospital, and collaborate with religious authorities. Maguen et al. (2010) find that chaplains can be instrumental to strengthening officers' spirituality. However, according to Maguen et al. (2010), some stations especially in developing countries do not have chaplains and therefore some officers can never benefit from these services.

5.8 Effect of Trauma on Chaplains

Respondents were asked if they think chaplains are also affected by trauma, to which 95% of the respondents replied that chaplains are affected by trauma because they are human and are not exempt from the challenges humans face. Only 5% thought that chaplains are not affected by trauma. When asked what should be done to help chaplains deal with trauma, 50% of the respondents replied that they needed to go for counselling, 15% said chaplains need therapy, 10% confirmed that chaplains need assistance though they were not sure of the kind of assistance. Other respondents, some 5%, said that workshops should facilitate them to share their experiences. Another 5% found that nothing should be done for them since they believed that chaplains are not affected by trauma.

Military chaplains oversee a variety of pastoral care activities. Chaplains take care of the formal duties at worship services, funerals, memorial services, spiritual renewal events, charitable endeavours, and accompany troops into combat (Otis, 2009). Being a crisis chaplain means constantly dealing with distressing feelings such as fear, grief, and rage. Multiple exposures to certain emotional states can lead to mental health problems also in the chaplain's life. This can have a negative effect on their role as mental health caregiver and chaplain. Chaplains are therefore challenged to manage their own personal stress reactions to the situations with which they are faced. In times of crisis, a chaplain's duty to others is to offer solace, hope, and stability (Maguen et

al., 2010). Chaplains are found in hospitals, correctional facilities, the business environment, home healthcare, the military and the police services. Chaplains assist family members in coping with the emotional suffering of grief and the emotional reactions to traumatic experiences (Galek et al., 2011).

According to Galek et al. (2011), secondary traumatic stress develops rapidly. The duration of a person's career in helping others work through trauma has an effect on the stress levels of the counsellors themselves. Research with military behavioural health specialists showed high levels of emotional weariness and disengagement (Stearns et al., 2018). Their mission is to draw strength from God as they navigate one personal crisis at a time. Following their return from deployment, chaplains in the American military reported experiencing combat-related stress, such as Compassionate Fatigue (CF) (Bester-Dahan et al., 2016). Due to deployment and combat, chaplains also reported a decline in motivation, vitality, and mental and spiritual health (Bester-Dahan et al., 2016).

CHAPTER 6

FINDINGS AND RECOMMENDATIONS

Theoretical insights from existing literature and data collected from participants from the disciplined forces were brought into conversation in order to gain a deeper understanding of the experience of trauma in the workplace and the role that pastoral care and counselling provided by chaplains can play in the process of healing. Data was collected by means of one-on-one interviews with participants from the Botswana Defence Force (BDF) and from the Botswana Police Service (BPS). A total of 20 participants took part in the study. Point of departure was that there is a high prevalence of traumatic experiences among the military personnel and police officers. These experiences are often death-related. People who are confronted with traumatic incidents on a regular basis can be vulnerable to post-traumatic stress. In order to help prevent high stress or deal effectively with trauma-related stress, chaplaincy services can provide support and counselling. However, not individuals often do not make use of the services available due to a variety of reasons that were identified and discussed in the study. The chaplains as caregivers are also affected by trauma and can exhibit signs of stress as a result of hearing and witnessing officers going through post-traumatic stress.

The study found that the majority of personnel in both police and military experienced dealing with dead bodies or witnessing death as most stressful. Persons who are exposed to these kinds of stress on a regular basis often show signs of and describe the symptoms of post-traumatic stress. Trauma is therefore a risk factor to Post-traumatic Stress Disorder among officers. Most of the officers in the disciplined forces did not receive attention from chaplains because they either did not seek intervention from the chaplains or because there were no chaplains in their unit at the time of the incident. Some were not aware of the service. Others were in remote locations where the station did not have a chaplain. Some found that the contribution of chaplains was not sufficient. Others found that chaplains were too busy with many other commitments. Therefore, they did not make use of the chaplain services.

The study began by describing the various experiences of trauma to which people in the disciplined forces are subjected, often on a daily basis. People in the disciplined forces experience a fair amount of trauma in the workplace. The most prevalent cause for trauma was found to be incidents relating to witnessing and dealing with dead bodies. Witnessing death either by murder, suicide or due to an accident was reported

to be the second most traumatic experience. The study elaborated on the effects of trauma in people's lives, especially if these to not receive the necessary attention soon enough. The respondents identified effects of trauma such as intrusive flashbacks, a loss of appetite and insomnia.

Many of the complaints about the lack of resources in the work place, have nothing to do with traumatic experiences. The aim was to ascertain the level of attention given to traumatised personnel and to the pastoral caregivers themselves who can suffer from empathy fatigue or secondary trauma. The study found that a significant percentage of those who experienced trauma did receive effective attention from chaplains. Those who were not assisted by chaplains had various reasons. One reason was that they did not deemed the caregiver to be competent enough. The chaplains also attested to having experience trauma. They too need assistance to cope with their traumatic experiences and secondary trauma.

The study proposes some initiatives and strategies to improve the current situation. Suitable chaplaincy training and deployment of a sufficient number of chaplains are needed. Some organizational structural adjustments are also needed. More intensive training is needed in order to heighten awareness with regard to mental and spiritual health. This should be freely available and compulsory. This should form part of stress intervention management to mitigate the impact of occupational stress and trauma among members of the forces. If sufficient and effective attention is given to the mental health and emotional and spiritual well-being of personnel in the disciplined forces, both the institutions and the individuals can operate at an optimal level.

New employees should go through an induction process in order that they can be aware of the demands of the work and are equipped to deal with those demands. They should understand the availability and necessity of psychological support because their work environment is prone to traumatic incidents. They should be aware of the services provided by chaplains and understand the necessity of making use of these services. Chaplaincy services can also be responsible for screening officers who return from duty, deployment and major operations. Officers must be screened for signs or symptoms of trauma and other mental health related problems in order for them to receive adequate attention as soon as possible. Debriefing sessions after traumatic events should be mandatory. This will facilitate the processing of the traumatic event in the person's life.

Psycho-education is necessary for all personnel since theirs is an environment that places a heavy burden on their mental health and capacity for resilience. Newly trained officers who have not been deployed should be prepared for what awaits them and be cognizant of the need for help and the places where that help can be accessed. They must be trained to identify the different signs and symptoms of post-traumatic stress. They must be trained in positive coping strategies.

Chaplains should not be so bogged down by other duties that they are not available to persons who have sustained trauma. Chaplaincy services for psychological support should be freely available to personnel as a matter of priority in the disciplined forces. For the pastoral officers themselves regular retreats can serve to relieve them of accumulated stress of counselling work with people who experience trauma on a regular basis. In this way, care can be provided not only for those who suffer the effects of work-related trauma, but also for the caregivers. In a highly traumatised and traumatising work environment, trauma care should be a main priority. Chaplaincy services are invaluable for providing holistic care.

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APPENDICES

Table 1; **Interview questions**

1. How long have you been serving in the organisation?
2. Have you experienced trauma in line of duty?
3. What was happening?
4. How did trauma affect?
5. Are there any aspects of the system/organisation that you would consider overwhelming?
6. Did Chaplain attend to you?
7. Do you think chaplains are affected by trauma?
8. How can chaplains be cared for during or after counselling traumatized personnel?

Consent

i. Research project title: TRAUMATIC EXPERIENCES AND PASTORAL CARE IN THE DISCIPLINED FORCES IN BOTSWANA
ii. Research investigator: Letlhogonolo Edward Thabalaka
iii. Research Participants name:
Informed consent
iv. Name of participant – I…….hereby voluntarily grant my permission for participation in the project as explained to me by ……. (Researcher) person.
v. The nature, objective, possible safety and health implications have been explained to me and I understand them.
vi. I understand my right to choose whether to participate in the project and that the information furnished will be handled confidentially. I am aware that the results of the investigation may be used for the purposes of publication.

Table 2; **Study Interview Responses**

11

Participants	Length of service	Have you experienced trauma in line of duty?	What was happening?	How did trauma affect you?	Are there any aspects of the system that you would consider overwhelming?	Did Chaplain attend to you?	Do you think chaplains are affected by trauma?	How can chaplains be cared for during or after counselling traumatized personnel?
Participant 1	5 years	Yes	I had a physical injury during basic military training.	I developed phobia for putting on military uniform and lack of full participation on duty requirements	Yes. The military nature does not allow for personal opinion which sometimes appears to be oppression on members	No, because I was not aware of the chaplaincy service and my issue never reached them	Yes, because they are also human, they can relate to emotions	Conducting workshops for chaplains in the quest to help them cope with trauma they face.
Participant 2	27 years	Yes	It happened in my presence in 1987/88. There was a sergeant who was complaining about one of his bosses that he was wrecking his marriage. He lodged the case to the supervisors whom he felt they did not assist. He went to withdraw a gun together with soldiers whom he was leading who were going for an operation. His plan was to ambush the officer he was complaining about so as to kill him and go on to kill the wife, then kill himself. The ambush failed for some reason and the wife was also made aware of the possible danger since their issue was known and the wife went into hide. We followed him on in an armoured military vehicle as he was carrying an AK47 riffle with fully charged magazine; he went behind a mountain in the nearby and started shooting in the air. He ceased fire and started saying out that he has long told one Major of his problems but he did nothing about it. He called one of the soldiers whom he assured he would not harm, upon his arrival, he wrote a suicide note on the ground, took a few steps from the soldier he has called then shot himself dead on the forehead right in front of us. What	It affected me and my environment. It took me a very long time to cope and I had a lot of flashbacks of what happened, more specially someone whom I knew and was working with. For a long time I was not able to use my bear hands to eat, I would feel as if am eating human blood and the smell thereof remained with me for a long time.	Yes. One of the challenges is shortage of accommodation, more especially with introduction of female employment in the military. The type of accommodation we have is not conducive for females who gives birth and stays with the kids, unlike when it was only males who were having kids elsewhere and not staying with them in institutional accommodation.	There were no chaplains or any counsellors in the organisation during the time. No counselling intervention was done on us; I survived only by the grace of God. I think the chaplains would have played a pivotal role then since we see the positive effects of their service nowadays.	Yes, they are human. There is no how I can rule out the possibility of them being affected by trauma. They empathise during interventions, so they are likely to be affected by trauma.	They also need to be counselled when they are traumatised.

			traumatised me the most was when we were loading his body in the body bag, as I was trying to hold his head from behind, my fingers accidentally got through in to his opened brain and my hands were bloody! But I just had to carry on with loading his body.					
Participant 3	7 years	Yes	It happened to me and others in 2018 when we were on a trip. We had gone to fire missiles. 2 military tanks got involved in an accident at the firing area, SK 105 hitting Pirranah from behind. We were 12 in the pirranah, 4 of us got injured, 1 of us lost his life and all the occupants of SK 105 survived with no injuries. I was so scared that I thought it was my last day on earth; I was so despondent and lost hope! The one who lost his life appeared to have been hit by the SK 105 barrel either on the head or chest, his head was swollen and bleeding all over his face. I tried to talk to him but he could not respond even though it appeared like he could hear me, blood was coming out of his mouth. He was my squad mate, I was trying to assist him but I couldn't because I had broken my thigh.	Sometimes I cannot sleep well because I dream of him a lot, I have flashbacks of the scene and I sometime break down emotionally.	Non empathetic behaviour of supervisors, sometimes you are forced to put on uniform and perform all military duties despite how you are feeling.	No, I was attended to by a social worker. I think chaplains and social workers do the same thing, they both offer counselling.	Yes, I think so. They are emotionally affected too.	I think it can be better if they can be offered counselling too.
Participant 4	23 years	Yes	It happened to me. I am a crime scene investigator, so I will cite one incident which I considered more worrisome and traumatic. I attended to a scene where a human body was reported found in a very small room; the body had many days lying there and had decomposed already. It was not easy working in such a confined space with a human body in that state where it was not easy to collect the body. There was a lot of blood, maggots and flies everywhere and they had transferred the	I have developed a severe headache due to these experiences, mostly after attending to such scenes, the headache starts. Even when I am with people, I feel like isolating myself from them, I prefer to stay alone in my space, I am no longer sociable as I used to. I go to work and come back home, I don't have social life.	There is shortage of resources such as protective clothing but we have to continue working nonetheless.	No, I have never had any help. We have shortage of chaplains and there are no chaplains dedicated to assisting us, they are regular police officers too, so they have their secular responsibilities. The prayer services that we used to conduct on Tuesdays have stop due to COVID, so we are having no assistance from chaplains.	Yes, chaplains are affected by trauma since they relate with our emotions as we tell them our traumatic stories.	I am not sure how, but I believe chaplains need to be assisted to cope with trauma and painful emotions of our stories.

			body materials everywhere in the room and we were stepping on such!					
Participant 5	23 years	Yes	It happened to some and we attended the scene. A 22 year old girl was murdered by a 20 year old boy in Monwane in 2019. The girl was killed with a knife and it was left right in her ribs. What traumatised me more was when we were putting the body in the body bag, a lot of blood was flowing from the body. It was my first time to see a knife used live on someone. Even the boy who caused the murder was very terrified as we arrested him and showed him the body of the girl.	I never forget that incident, I am scared even up to know, the scene is just left fresh in my memory. The experience changed my perception about men, more so that most of the GBV cases men kill women; to me 69.9 % of men are killers. I find myself biased most of the time when I attend GBV cases; I take the side of women and express how men are 'dogs'. But not all men are like that, there are those who have chosen to be killers and others who have chosen to be good people.	Yes, there is shortage of resources like transport, and shortage of personnel but we have to use effectively and efficiently the little we have.	No, I have not received any help from chaplains here at work, I made a personal effort to seek help outside. I don't know why I was not attended by chaplain, may be they just take it that it is normal for us to go through trauma. Chaplains come only when there is a funeral. The chaplain service is not effective, when I need help; I seek counselling from social workers at the council. The counselling is very effective.	Yes, I think it affects everyone because we are emotional beings as people.	They should seek counselling from other helping professions.
Participant 6	22 years	Yes	It happened that I attended an incident where a pupil was smashed by a falling wall at school. The head was smashed like an empty milk box ran over by a car! The brain was splashed out of the head. The child was the same age as my daughter and for a moment I was puzzled thinking of my daughter if it was her. I was with my male colleagues who were afraid to attend to the scene but I stepped up to rescue the scene. During post-mortem, I was not able to stay in the post-mortem room, I felt running out of oxygen and I was not able to put on my mask but the moment I go out of the room I breathe well. The other traumatising incident was when I attended a scene where an expectant woman (almost 9 months) was murdered by her boyfriend and the knife was left right in her neck, I can still recall it	I am so sensitive when it comes to children, I am over protective and I can even risk my life for the sake of children. For example, one day I shouted at a stranger who was feeding his child alcohol on the street, fortunately the man ended up responding by stopping it. Later I asked myself what if that drunkard man had attacked me?	Yes. There is shortage of resources like transport and personnel. Our jurisdiction is vast and we are thin on the ground, thus making us infective and inefficient. The work load is high and manpower is low.	Yes, I am one of the fortunate police officers who have been attended to by chaplains since I once worked closer to the helping offices; chaplaincy, social workers and psychologist. They are trying so hard but they are overwhelmed thus their effort not so effective. This is because even when we are still going through counselling, we go through recurring traumatic experiences which render the counselling ineffective.	Yes, they do since they are also human.	It is important for pastoral care givers to seek counselling from other helping professions since as individuals they cannot help themselves.

			was a blue okapi knife. The little hand of an unborn baby protruded outside of the mother's belly.					
Participant 7	14 years	Yes	It was happening to someone here at work. A colleague, police officer came armed in to a meeting looking for another colleague. Fortunately he did not find him in the premises; he then proceeded to the street outside the police office and shot himself dead in our presence and the public.	I wondered a lot about our safety and security in the work place if this was done by a colleague who is supposed to be the protector of the nation, I was very scared.	Yes, we work with command and orders, taking them as such. This means we don't have enough time for our families.	No, I was not attended to by chaplain. We have shortage of chaplains and the chaplaincy committee we have in our station is not effective.	Yes, they are affected because they are also flesh and blood like us.	They should seek counselling elsewhere because they are overwhelmed like us.
Participant 8	29 years	Yes	It happened to someone but it also affected me. I happened to attend the report where a body of a murdered woman was found. I spent the night guarding the decomposed body together with my colleagues at the crime scene and it affected me very badly.	I was emotionally affected but it did not affect me much otherwise. For some time I requested not to attend crimes scenes and post-mortem scenes, but now I am recovering.	Yes, transport is a great challenge. Clients come here and we take a long time to help them because of transport and we don't have control over the situation as officers on the ground.	No I was not attended by a chaplain. Yes we have them but their service is not effective, they are not qualified as chaplains and sometime age is a barrier between us and them.	Yes, they are also human, I think they are affected by trauma.	Chaplains should seek counselling so as to help them cope with trauma.
Participant 10	31 years	Yes	I had an accident in 200 1 in an operational area. We were two in the vehicle, driving from the military base to an air strip in the dust road. The vehicle lost control and over turned to my side, I was a passenger. For a few seconds I was like lost and confused. From the scene I felt okay, but later, after 30 days I was diagnosed with a head injury which resulted in a head surgery which left me with bad scars. In 2020 I had another road accident from Maun early in the morning. We were three in the car and there was an oncoming car which was driving on high beams, and since our sight was destructed, there were donkeys crossing the road and we tried to avoid them but in the process we hit the other donkey. The vehicle lost control, over turned and one of us lost his life on the spot. I incurred a head injury in the same place	I was so worried that someone lost his life that was under my command since I was the senior in the car. I felt so much pain for his family as he was a family man. I have developed phobia for speed and driving generally, I keep on have flashbacks of these incidents. I can no longer do things as I used to, I can't lift heavy items, I even can't perform my duties well at work as you can see that am not putting on uniform. I am less productive and work at a low rate. Some time I feel depressed.	Sometime communication is a barrier and results in to frustrations in the work place.	Yes, the second incident I was attended to by a chaplain as you can recall you are the one who attended us. After chaplain's counselling I felt emotionally much better, the intervention was effective.	Yes, chaplains are human; they can be affected by trauma. The traumatic stories we share with them can also overwhelm them.	Chaplains need therapy as well so as to help them carry on with their duties effectively.

			on my head where I was injured in 2011.					
Participant 10	4 years	Yes	It was in 2018, I had 3 months work experience by then. I was on duty with two police officers. There came in two men and a woman, silently and they did not even greet us, we were concentrating on what we were writing, when I lifted my eyes I saw one of the men hitting a bloody okapi knife on the counter desk. The other man and the woman were screaming so loud, we noticed the man with the knife had just pierced the other man with the knife in the eye right in our presence! It was bloody all over the office, the suspect tried to run away but we got assistance from other police officers. We detained the suspect and took the woman to the hospital. It was my first time to witness such incident; the knife was stuck in the eye and blood was coming out so badly. We found out that the men were brothers; the younger brother pieced the elder brother accusing him of taking his wife.	It took me about two weeks having no appetite and failing to eat thinking of that blood and the wound in that eye. I was so terrified when the accused told us that he is going to bewitch us and stuff. I was still new in the office I was not used to such issues.	We receive orders and commands from our leaders which overwhelm us and result in us mixing up our work. There is too much pressure from our leaders.	Yes, I was attended to by a chaplain because we have one in our station. The counselling was very effective and I have recovered from the trauma. He was the only counsellor I went to.	Yes, chaplains are affected by trauma because they go through what we go through and they are just human like us. They are sometime overwhelmed by our traumatic stories.	Chaplains need to seek counselling from other helping professionals.
Participant 11	9 years	Yes	I was called to attend a hit and run road accident; it was my first time to attend to such. Twin brothers were crossing the road to the shops, a car came running from the side and hit another twin and flew the scene, he lost his life right on the spot. I was troubled by the sad cry of the twin brother, I could relate because I have a twin and I was asking myself “what if it happened to us?”. We took the body of the deceased to the mortuary, and what traumatised me the most was to see the dead bodies of people lying on the flow at the	I really wanted to quit the job then. I think am not really healed from the incident even now but I don’t want to talk to anyone about it.	Yes, we are expected to perform at work despite how we are emotionally feeling.	I was not attended to by chaplain because I did not choose to share with them even though they are available. I think their intervention could help me though.	Yes, chaplains are affected by trauma because they also go through what we go through and they are human beings.	They have to seek counselling from other counsellors may be once in a month, or they be given a special counselling.

			mortuary as the mortuary attendant told us that the storage was overwhelmed.					
Participant 12	5 years	Yes	We were ambushing some criminals in the bush at night in a national pack. We were befallen by an elephant in our huber and ran for our lives and in the process some of us lost their guns. In the morning when we made efforts to look for the lost guns, we realised that after we fled the hurbar, it was occupied by lions. That terrified me the most and I was shaking in my stomach. Nonetheless, we survived unharmed.	I was not traumatised because I took it as part of my job.	Yes, like when you sometimes have to shoot a person, you think twice but you just have to do it because it is duty to do so.	No, I was not attended by chaplain. More especially when you are stationed in far places from urban areas, it is not easy to access chaplains.	Yes, I think they do even though I do not really know the work of chaplains.	I think they can be assisted by psychologist.
Participant 13	34 years	Yes	I was attending to a road accident which involved many people and I was fresh from the college. It was my first time to carry a dead person as we were loading the bodies in to the police vehicle. I have also attended to suicide cases.	Sometime I get filled with anger because we are not mentally and emotionally addressed despite the situations we go through.	There are not enough resources like vehicles in this organisation.	No, our chaplains are not available to serve. Sometime we are not even sure who chaplain is because they are just regular police officers, they are not employed as qualified or trained chaplains. We only see chaplains during funerals.	Yes, I think chaplains are affected by trauma because they are also human beings. They falter as we do and feel as we feel under situations.	They need counselling as well.
Participant 14	4 years	Yes	Not a long time, ago. I was alone in the office and one gentleman, a giant walked in seeking to meet the station commander. I had to establish why he wanted to see the station commander as it is procedure. He became angry and did not want to explain and started throwing tantrums and saying police officers are fools and he will beat someone, they never assist him correctly. Some colleague came to my rescue and later told me the man is an ex-convict. I was so terrified.	I am fearful and feel unsafe.	I stay in the office most of the time and there is too much work to the point that sometime I skip my lunch, I go home tired every day but I have to perform to the expectation of tasks.	No, I was not attended because I did not seek intervention. Our chaplain is a very caring and loving person; he always goes around our offices checking on us asking how we are doing.	Yes, I think they are affected because they are human.	I think they need to seat together sometime and share their experiences and share their burdens.
Participant 15	23 years	Yes	It happened to my mate. We were doing parachute free fall/sky jump and our RSM's parachute failed to open. He crash landed to death. I witnessed it and it was terrifying.	It affects my jumps because I keep on recalling the incident when I have to do the jump.	For now I don't think there is anything overwhelming in the organisation.	No I was not attended by a chaplain. We are not attended after these incidents because they are not regarded as trauma by BDF. They say if	Chaplains are also human beings; they can be affected by trauma. Anything traumatic can affect them.	Chaplains have to go for counselling because they carry the weight of other people's problems.

						someone crashes during the jump, we have to go for another jump and that's how we are believed to get reed of the fear in us. But I think these are old time believes, we have to change and receive counselling after such incidents.		
Participant 16	21 years	Yes	We had a contact with poachers in area Silinda. We were a team of four men; we were clearing the area and came across trail of poachers. We followed the trail for 5 days; we tracked it for about 10km on that day and lead us to the water pans. It was my first time to follow a fresh trail of poachers. We reached a lot of pans and went around them for about three hours at Kwandu 2 area. We identified a person in the pan and realised that he was part of the poachers we are following. We engaged fire on him and killed him. It was my first time to be part of a firing team on a human being and I was emotionally shaken. Still on the same trip, after a month we followed trail of poachers again. In our team there was one member who also experienced contact before. We followed the trail for 700m and identified where the poachers had settled, it was already becoming evening then we decided to wait until the moon light was so clear that we could do everything when it was visible. We could see two men and waited in ambush to ensure their number. We finally decide that they are only two. Since I was the section commander, I decided that myself and the other gentleman who had a contact before; we are going to be the ones engaging the poachers. I told him I pick the one on the left and you pick	I started to stay with fear, which was not happening to me alone, it was also happening to others. I think the fear came from human dignity, killing a person is not easy.	Yes, since we spend most of the time in the delta at the operational area, we are in danger of both wild animals and pouches. Nonetheless, we have to develop big hearts and understand that we have vowed to protect our nation hence we have to endure hardships.	Yes, we were attended by a chaplain after the first incident, which made it easy to deal with the second trauma. Chaplain's intervention was so effective because he made us understand that we did nothing wrong, it was just duty that we had to perform.	Yes, chaplains are also affected by trauma since they are human. They experience part of what we go through as they visit us at different bases in the operational area. They also emotionally relate with our traumatic stories which I think affects them in a way.	Chaplains should also seek counselling when they went through traumatic scenes or emotions.

			the one on the right, I initiated fire and he immediately followed, we took them both down.					
Participant 17	15 years	Yes	My teammate at the operational area was part of a team which went out on patrol at Mombo, Chief's island; I was not part of the time that time. They had a contact with poachers and started exchanging fire, unfortunately the poachers shot him to death right on the spot. His body was brought to the base but I was not able to view it as it is a taboo to view cops where I come from.	I was so traumatised because I was always anticipating casualties in the way we operate. We would mostly realise poachers identify us before we see them, and they are developing the tendency of exchanging fire with us. I developed fear of going out for patrols.	We spend most of the time away from our families being on trips and it is so strenuous. The work load is too much but we are few on the ground. But as a military person I have to encourage myself and know that I work under constraints.	Yes, chaplain attended us. His intervention was so helpful that i ended up overcoming the fear I had.	As normal human being they should be. But I think their profession allows them to be strong and encourage themselves. They have been exposed to many things.	I definitely think they need to be assisted.
Participant 18	15 years	No	I met a lot of challenges but I was never affected. I had contacts with poachers but we never exchanged fire. Yes adrenaline kicked in but we never exchanged fire.	I have never been affected by trauma but I think it affects other people.	No, everything is just going smooth.	Yes we were attended by a chaplain one day after a team had exchange of fire with poachers. Chaplain's intervention is very important in the operation.	I don't think they are affected by trauma.	Nothing, I think they are okay.
Participant 19	16 years	Yes	It was my first time to have contact with poachers and we engaged them with fire and brought both of them down. It was my first time to see a person killed by a gun; the sight was so sensitive. We were firing at night in an ambush. We took guard of their bodies until in the morning, and we were the ones who put their bodies in the body bags.	Personally after that incident it took me a long time having flashbacks of the scene. I was asking myself how they felt being at the other side of the riffle and I squeezing the trigger on them, taking away their lives, I was thinking a lot after that. But I comforted myself that I did not sin; I was protecting our nation and doing my duty.	The strain of work that we go through I have just accepted as normal. For example; we kill poachers and stay with their bodies until the whole crime scene procedures are done after some time, and we put their bodies in the body bags in whatever state they are.	Yes, chaplain attended us. His counselling helped me a lot. He explained to us that even in the bible soldiers were killing people in defence of their people.	I think they are affected. I remember we were showing them the sensitive pictures of the killed poachers and they could relate with the sensitivity thereof.	I think they should receive pre-counselling before they go to counsel people because they find us in different mental states.
Participant 20	15 years	Yes	It happened to my house mate. They had an encounter with poachers and he was mentally disturbed from the scene. He is a family man and the family was affected too.	I was affected by his trauma because I had to take care of him and his family. Also as a soldier who does the same work as him, I put myself in his situation, "what if it happens to me?". I have not experienced trauma personally	As a well-trained soldier, I think I have accepted the strain of work as normal and I can't see anything as overwhelming.	I have not been attended by chaplain due to trauma since I haven't experienced it, but they play a very important role in the military. I always see chaplains helping people and people	Yes, as human beings they can be affected by trauma. Since they are soldiers too, they receive orders from high command and they go through what other soldiers go through.	I think they need to seek counselling from other pastors who are not chaplains, or social workers who are not working in the military.

but I think it can affect me mentally.	healing from their distress.