PART I

UNDERSTANDING CONFLICT

CHAPTER 1 Stress in Conflict and Crisis Situations

CHAPTER 2 Understanding Conflict

CHAPTER 3 De-escalating Conflict

CHAPTER 4 Problem Management

1

STRESS IN CONFLICT AND CRISIS SITUATIONS

LEARNING OUTCOMES

After completing this chapter, you should be able to:

- Describe the physical and mental changes produced by stress.
- Identify indicators of acute and cumulative stress response.
- Explain how post-traumatic stress disorder arises and describe its potential effects.
- Identify stressors common to law enforcement.
- Describe how stress can impair the performance of law enforcement officers.
- Identify strategies that may assist with reducing the negative effects of stress.

OVERVIEW

Law enforcement is a stressful occupation. Officers perform their duties under circumstances that most people only see on television. In the majority of first response situations, police become involved only when the stress of the situation exceeds the coping abilities of the persons involved.

Persons pushed beyond their abilities to effectively deal with stressful situations may have reactions totally out of character from the perspective of their regular personality. The stress reaction causes physical and psychological changes that can manifest in the form of unpredictable behaviours.

Police officers are not immune to these stress reactions. Effective interactions depend upon officers recognizing these stress reactions and learning how to function effectively while experiencing or interacting with persons who have exceeded their ability to cope.

This chapter will identify and discuss some of the more common stress reactions and methods of managing stress.

THE NATURE OF STRESS

stress
a response to a perceived threat or challenge or change; a physical or psychological response to a demand

Stress is a generic term that identifies our body's physiological and psychological response to a stressor. **Stress** can be defined as a response to a perceived threat or challenge or change, or as a physical or psychological response to a demand. A stressor can be physical, such as an encounter with an angry person, or psychological, such as dealing with increased workloads or relationship problems.

We are inherently encoded to respond to stressors. Our body does not differentiate between physical or psychological stressors; regardless, the stress response will occur.

Because we recognize that the stress response occurs naturally, we can choose to manage the positive and negative symptoms of the response. Recognition of the indicators of the stress response, acute and cumulative, is the key.

stress response
the physical, psychological, and emotional reactions experienced by a person when encountering a real or perceived threat

Stress response, for the purpose of this text, refers to the physical, psychological, and emotional reactions a person experiences when they encounter a real or perceived threat.

There are two general categories of stress: eustress (positive stress) and distress (negative stress). Your body does not physically distinguish between these different types of stress. It is how the individual perceives a certain stressor that results in the determination of eustress or distress.

eustress
positive stress; an important component of everyday life that we can use to motivate and challenge ourselves and that can be a positive force to enhance our physical and mental capabilities

Eustress may be thought of as "good" stress. It is an important component of everyday life that, when handled properly, can be a positive force to enhance our physical and mental capabilities.

Eustress has the following characteristics:

- It motivates and focuses energy.
- It is short term.

- It is perceived as being within our coping abilities.
- It feels exciting.
- It may improve performance by increasing our focus.

Examples of positive *personal stressors* include:

- receiving a promotion or raise at work
- starting a new job
- getting married
- buying a home
- having a child
- moving
- taking a vacation
- celebrating holiday seasons
- taking classes or learning a new hobby.

Distress happens when a person has difficulty dealing with the stress of negative experiences. It can occur when we lose control over a situation or when the source of our stress is unclear.

distress
difficulty dealing with the stress of negative experiences, which can occur when we lose control over a situation or when the source of our stress is unclear

Distress has the following characteristics:

- It causes anxiety or concern.
- It can be short or long term.
- We perceive it as being outside our coping abilities.
- It feels unpleasant.
- It decreases performance.
- It can lead to psychological and physical problems.

Examples of negative **personal stressors** include:

personal stressor
both positive and negative stressors when dealing with personal occurrences in daily life that may be positive, such as weddings and births, or negative, such as bankruptcy and divorce

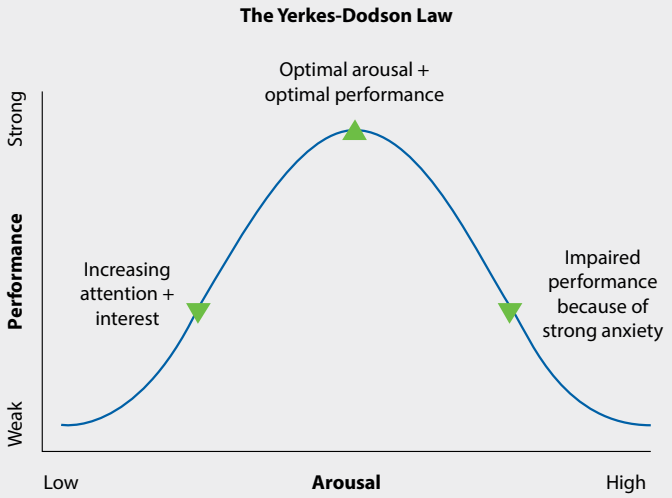
- the death of a spouse or family member
- filing for divorce
- losing contact with loved ones
- hospitalization (oneself or a family member)
- injury or illness (oneself or a family member)
- being abused or neglected
- separation from a spouse or partner
- conflict in interpersonal relationships

- bankruptcy/money problems
- unemployment
- sleep problems
- unrealistic, perfectionist expectations
- repetitive negative thought patterns.

Work and employment concerns such as the following are also frequent causes of distress:

- excessive job demands
- conflicts with co-workers and supervisors
- having inadequate authority necessary to carry out tasks
- a lack of training necessary to do the job
- unproductive and time-consuming tasks.

FIGURE 1.1 Stress Performance Models



Note: The shape of the blue curve will be different for each person. Some perform well at a wide range of stress levels (with a flatter top to their response curve), while others quickly become anxious and self-doubting even at moderate stress levels. Moderate levels of anxiety probably enhance performance by increasing alertness: the relationship between anxiety and performance follows a similar shape to the blue line.

Source: Yerkes and Dodson (1908).

Stress is an ordinary part of life that affects everybody at one time or another. When handled properly, stress can be a positive force that enhances our physical and mental capabilities. It may, however, lead to problems when stressors—sources of stress—overpower a person's ability to cope.

Physiological symptoms commonly associated with distress include high blood pressure; rapid, shallow breathing; muscle aches; and headaches. Behavioural symptoms include overeating or undereating, negative repetitive thought patterns, and maladaptive coping behaviours such as substance misuse. In extreme cases, distress can lead to anxiety and/or depression.

It is difficult to predict the amount of stress that a person can endure before experiencing a negative effect. Persons who are pessimistic and who have a controlling personality, high self-expectation, and high expectations of others may experience distress when their needs/expectations are not met. Such negative reactions to stress can make the person appear to be unpleasant or difficult and can contribute to conflict with others.

Figure 1.1, above, illustrates how optimum levels of stress can improve performance. Optimum levels are specific to each person.

THE ACUTE STRESS RESPONSE

Acute stress, also referred to as "critical incident stress," is a psychological condition that induces a strong emotional reaction to a traumatic event or to witnessing a traumatic event. In the context of law enforcement, an acute stress response may occur after an officer has experienced or been threatened with an occurrence that involved death or serious injury.

acute stress
also referred to as critical incident stress, a psychological condition that induces a strong emotional reaction to a traumatic event or to witnessing a traumatic event

To be categorized as an acute stressor, the event that triggers the response:

- must be sudden and unexpected
- is, or is perceived to be, a threat to the officer's survival or well-being and has some element of loss for the officer or victim.

Law enforcement officers respond to many incidents that can cause acute stress reactions, including:

- the death of a fellow worker
- responding to occurrences of suicide or homicide
- a natural or other disaster
- a severe accident involving injury
- experiencing or responding to a violent assault
- the death or serious injury of a child.

Occurrences that involve seriously injuring a person while executing an arrest, or involvement in any critical incident that causes you to question your values, ideals, or confidence, may also evoke an acute stress response. Table 1.1 shows the signs and symptoms of acute stress.

TABLE 1.1 Signs and Symptoms of Acute Stress

Signs and symptoms that require immediate corrective action	
PHYSICAL	**COGNITIVE**
Chest pain Difficulty breathing Excessive blood pressure Collapse from exhaustion Excessive dehydration Dizziness Vomiting	Decreased alertness or hyperalertness Difficulty making decisions Mental confusion Disorientation to surroundings Slowed thinking Problem recognizing familiar people
EMOTIONAL	**BEHAVIOURAL**
Panic reactions Shock-like state Phobic reaction General loss of control Inappropriate emotions	Change in speech patterns Excessive angry outbursts Crying spells Antisocial acts Extreme hyperactivity
Signs and symptoms that require timely, but not immediate, action	
PHYSICAL	**COGNITIVE**
Upset stomach Profuse sweating Chills Sleep disturbance Muscle aches Fatigue	Confusion Lowered attention span Memory problems Distressing dreams Disruption in logical thinking Reliving an event over and over
EMOTIONAL	**BEHAVIOURAL**
Denial Grief Feeling hopeless Feeling overwhelmed Feeling lost Feeling worried Wanting to hide	Withdrawal Becoming suspicious of everything Increased or decreased food intake Excessive humour Excessive silence Increased alcohol intake and smoking Change in interaction with others

fight-or-flight response
the body's physiological response to a perceived threat; chemicals are released into the bloodstream, producing mental and physical changes that increase the person's ability to fight or flee from the threat

An acute stressor can trigger a state of hyperarousal called the fight-or-flight response. The **fight-or-flight response** is a physiological reaction to stress. It likely developed as a survival mechanism in early humans by increasing their ability to flee from or fight a threat. In primitive times, the threat might have been a tiger or other wild animal; today, work pressures can trigger the same response. Whether it's tigers or work, the body recognizes only a stressor and responds accordingly.

It is important that we understand the physiological and psychological effects of the fight-or-flight response. You need to recognize that what is happening to you as the responding officer is also happening to the person(s) in crisis.

The first process of the fight-or-flight response begins with sensory perception. We perceive through our senses that a threat exists. The information is transferred to the thalamus, the relay station of our brain. The thalamus relays the information to the amygdala, the part of our brain that processes emotions. When a threat is recognized, the information is relayed to the hypothalamus, the part of the brain that controls our nervous and endocrine systems. The hypothalamus signals the pituitary gland to release adrenocorticotropic hormone (ACTH) that stimulates the adrenal cortex to release cortisol, a steroid hormone commonly referred to as a "stress" hormone. At the same time, adrenaline is released from the adrenal glands located at the top of our kidneys. The adrenalin travels through the bloodstream, causing psychological changes and preparing the body to fight or flee from a threat.

The fight-or-flight response produces a series of physical reactions:

- Your pupils will dilate to let in more light.
- Your increased breathing rate will increase oxygen supply to your muscles.
- Your liver will release large amounts of fats, cholesterol, and glucose to give you energy to deal with the threat.
- Your heart rate will increase to supply more oxygen and energy (glucose) to your muscles.
- Your arteries will constrict, causing blood pressure to increase, thereby creating more blood flow to large muscle groups.
- Your digestive process will slow down. Blood flow will be diverted from the digestion process to your muscles.
- Your senses will become more acute and focused.

The acute stress response is divided into three phases: *alarm*, *resistance*, and *exhaustion*.

During the **alarm** phase, the body identifies the threat and initiates the fight-or-flight response.

During the **resistance** phase, the person resists the threat through disengaging (flight) or through a physical or verbal encounter (fight). Resistance continues until the threat is eliminated or the person is not capable of further resistance.

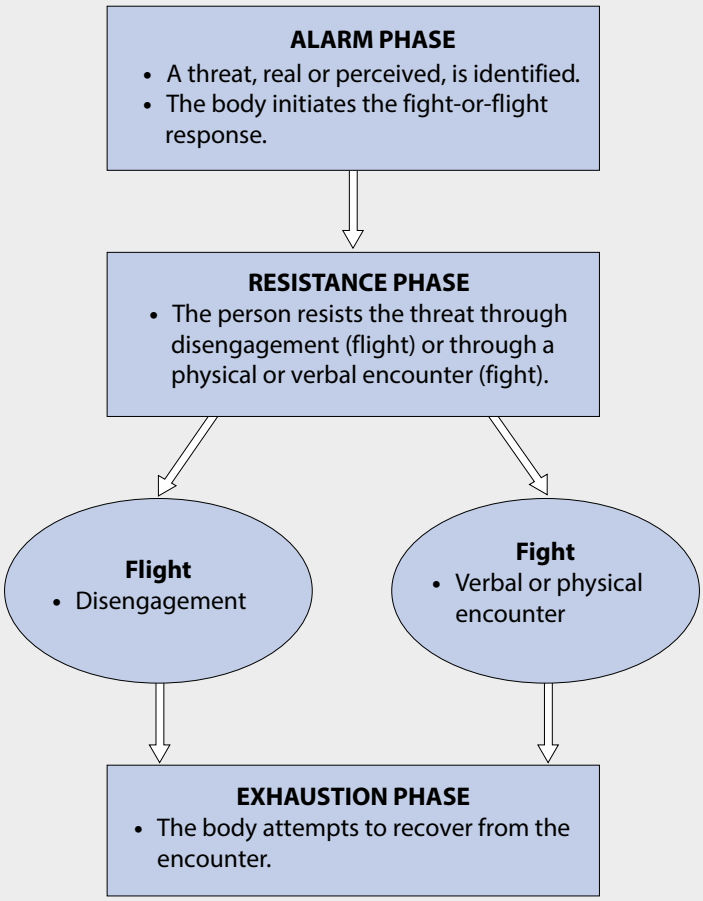
The person then enters the **exhaustion** phase when the body attempts to recover from the encounter. See Figure 1.2.

alarm
the first phase of an acute stress response in which the threat is identified and the body initiates the fight-or-flight response

resistance
the second phase of an acute stress response whereby the person resists the threat through disengagement (flight) or through a physical or verbal encounter (fight)

exhaustion
the third phase of an acute stress response when the body attempts to recover from the encounter

FIGURE 1.2 The Acute Stress Response



After an acute stressor incident, you may experience symptoms of disassociation:

- You may feel detached from your surroundings or emotionally indifferent to the event.
- You may feel derealization, meaning that you are not totally aware of your surroundings; that is, you may feel like you are in a "daze."
- You may experience depersonalization—a feeling that you are outside yourself, looking in on the situation.
- You may experience dissociative amnesia—the inability to recall specific aspects of the occurrence.

These symptoms are normal and common after a fight-or-flight response. The symptoms should diminish shortly after the effects of ACTH reduce—about ten minutes—but can be problematic if they continue to occur days or weeks after the

event. You may remain in a state of increased alertness for a couple of hours after the incident but should quickly recover your "normal" awareness and judgment.

If the symptoms continue after the traumatic event for three days or more, an *acute stress disorder* could be indicated. If the symptoms last for more than a month, the disorder may be classified as *post-traumatic stress disorder*, discussed later in this chapter. Professional assistance is recommended.

Most people seldom experience the fight-or-flight response. This is not true in the law enforcement profession. The response may be evoked several times during one shift. An officer may therefore not have the opportunity to enter the recovery stage. The response, while advantageous in some situations, is a definite health hazard if evoked too frequently. Severe physical, psychological, and emotional problems may develop within persons functioning for extended periods in the alarm and resistance stages.

CORTISOL EFFECTS

As previously discussed, ACTH stimulates the adrenal cortex to increase the production and release of cortisol. The half-life of ACTH is about ten minutes, which approximates the length of time we are likely to experience the reaction to the "threat." (Half-life $t_{1/2}$ is the time required for a quantity to reduce to half its initial value.) While the effects of ACTH are significantly reduced after approximately 10 minutes, cortisol levels remain elevated for about 30 minutes after the initiation of the stress response.

Infrequent short-term elevated levels of cortisol aren't likely to cause serious health problems. However, if you are under constant stress, your adrenal glands may continuously release cortisol. High levels of cortisol may lead to health problems such as hypertension (high blood pressure) and hyperglycemia (high blood sugar). There may be visible changes to the body such as fat deposits in the face, neck, upper back, and belly. Headaches, acne, irritability, and difficulty concentrating are also symptoms of persistently increased cortisol levels. Continually high cortisol levels may be associated with increased feelings of anxiety or depression.

When required to continuously produce cortisol in response to constant stressors, your adrenal glands may become "fatigued" and unable to provide normal levels of cortisol. Low levels of cortisol may lead to health problems such as overall weakness, fatigue, and immunity deficiencies that could leave you susceptible to diseases.

CUMULATIVE STRESS

Cumulative stress, or *chronic stress*, is caused by long-term, frequent, low-level stress. Cumulative stress reactions result from the buildup of work-related and non-work-related stressors. These stressors may accumulate over a period of months or years before becoming problematic.

cumulative stress
also known as chronic stress, the result of long-term, frequent, low-level stress; cumulative stress reactions result from the buildup of work-related and non-work-related stressors

The physical and psychological changes brought about by the stress reaction are usually self-limiting. When the threatening situation is over, our bodies return to normal. Hormone levels such as cortisol and adrenaline drop. Heart and breathing rates return to their usual levels. Conversely, when stressors are always present, we may constantly experience low levels of the fight-or-flight response. This constant release of stress hormones can interfere with physical and mental health.

Some of the early indicators of cumulative stress include worrying about insignificant events, insomnia, racing heart with no apparent reason (could be adrenaline related), sweaty palms, dry mouth, and tense jaw.

These negative reactions to cumulative stress are controllable if you recognize the signs and symptoms early and take corrective action. Table 1.2 summarizes the phases of the cumulative stress reaction and outlines their signs and symptoms and treatment.

Cumulative stress reactions are generally experienced in four distinct phases.

1. WARNING PHASE

Reactions are usually emotional. The sufferer may not be able to readily identify stress as the cause of symptoms. If recognized at this stage, reactions may be reversed by simple actions like taking a vacation, changing exercise habits, or discussing feelings.

2. WORSENING SYMPTOMS

Failure to recognize and address warning signs may lead to more serious stress reactions. In this phase, emotional symptoms may be accompanied by physical symptoms. Symptoms may be treated through lifestyle changes that reduce stressors. Short-term professional counselling may also help.

3. ENTRENCHED STRESS

This phase occurs when the initial stages of the stress reaction are ignored or not adequately addressed. Once entrenched, stress is very difficult to recover from without assistance from mental health and other medical professionals.

4. DEBILITATING STRESS

Ignoring or failing to identify and treat the symptoms of stress for a long period of time may lead to debilitating stress. It is extremely unlikely that a person suffering from debilitating stress will be able to participate in the workforce. At this stage, the sufferer's increased potential for self-destructive behaviour and inability to interact socially make it very difficult for them to effectively participate in the community. The most likely method of intervention at this stage is psychotherapy and medication to control symptoms.

TABLE 1.2 Cumulative Stress: Phases, Signs and Symptoms, and Treatment

PHASE	SIGNS AND SYMPTOMS	TREATMENT
Warning Phase *(emotional symptoms)*	• vague anxiety • depression • apathy • emotional fatigue	• taking a vacation • changing exercise habits • discussing feelings
Worsening Symptoms *(emotional and physical symptoms)*	• sleep disturbances • frequent headaches • muscle aches • fatigue • irritability • increased depression	• lifestyle change that reduces stressors • short-term professional counselling
Entrenched Stress	• physical and emotional fatigue • intense depression • increased use of alcohol or other drugs • heart problems • elevated blood pressure • migraine headaches • loss of sexual drive • intense anxiety • withdrawal • sleeplessness	• assistance from mental health and other medical professionals
Debilitating Stress	• heart attack • severe depression • low self-esteem • low self-confidence • inability to manage daily activities • uncontrolled emotions • suicidal thoughts • agitation • poor concentration and attention span • carelessness • paranoia • thought disorders	• psychotherapy • treatment of symptoms through medication

POST-TRAUMATIC STRESS DISORDER

post-traumatic stress disorder (PTSD) a disorder in which a person is unable to recover from physical, emotional, and psychological stress caused by exposure to "trauma involving death or the threat of death, serious injury, or sexual violence"

Post-traumatic stress disorder (PTSD) occurs when a person is unable to recover from the physical, emotional, and psychological stress caused by exposure to "trauma involving death or the threat of death, serious injury, or sexual violence" (Canadian Mental Health Association, 2016, What Is Post-Traumatic Stress Disorder? section). The event that triggers the disorder may be a violent personal assault; a car or plane accident; military combat; an industrial accident; a natural disaster such as an earthquake or a hurricane, or another traumatic event. These traumatic events may be referred to as "critical incidents."

Anyone who has gone through or witnessed an extremely traumatic event can experience PTSD. Experiencing PTSD is not a personal failing. It is a malfunction of the coping mechanisms that allow us to deal with traumatic incidents.

Traumatic incidents that may lead to PTSD occur frequently in policing. Police officers vicariously and personally experience traumatic events regularly. These include losing a partner in the line of duty, having to take a life in the line of duty, being violently assaulted, being present at occurrences where children have been killed, intervening in or witnessing a suicide, and attending motor vehicle collisions where severe injury or death has resulted. This list is far from exhaustive.

It has been estimated that in the first year of police service, the average police officer is exposed to approximately 12 critical incidents. By mid-career, that number has increased to approximately 150. By retirement, police officers have been exposed to an average of 250 duty-related critical incidents (Angeles, 2010).

In a 2018 survey of Canadian police officers, 29 percent were in the clinical diagnostic range for PTSD. The lifetime prevalence rate of PTSD for all Canadians is about 9 percent (Centre for Addiction and Mental Health [CAMH], 2018). More on this survey later in the chapter.

REACTING TO TRAUMA

While most people experience trauma at some point, not all traumatic experiences lead to PTSD. A situation that one person may find overwhelming, intolerable, disgusting, or terrifying may not have such a severe effect on another. Many factors impact how you will react to a traumatic event. Younger persons tend to react more negatively than older persons. The degree of responsibility you feel for the event may amplify the response. Past similar events increase the likelihood of ill effects from the aftermath of the traumatic event. Your physical and emotional condition have an effect, as do your spiritual beliefs.

People can react to traumatic events in various ways: they might feel nervous, have a hard time sleeping, or ruminate on the details of the situation. These thoughts or experiences are normal. They usually decrease over time, and the people involved go back to their daily lives.

PTSD lasts much longer and can seriously disrupt a person's life. For PTSD to occur, the stress caused by the critical incident must be severe and exceed the individual's coping abilities.

There is no way to accurately predict who will develop PTSD in response to a traumatic event. However, we do know that three types of factors influence the development or non-development of PTSD:

1. pre-event factors
2. event factors
3. post-event factors.

1. PRE-EVENT FACTORS

Pre-event factors that influence the likelihood of a person developing PTSD include:

- previous exposure to trauma in childhood, including physical, sexual, or emotional abuse or neglect or witnessing abuse
- family instability
- family history of antisocial or criminal behaviour
- early substance misuse
- absence of social supports
- poor coping skills, likely related to the previous factors
- pre-existing depression or anxiety
- age (persons under the age of 25 years are more likely to develop PTSD)
- sex (females appear to be more susceptible to developing PTSD).

2. EVENT FACTORS

Factors of a traumatic event may further contribute to the possibility of developing PTSD. These include:

- *The proximity of the person to the event*. The more involved the person is in the event, the more likely it is that they will be affected by the disorder.
- *The duration of the trauma*. The longer the traumatic event continues, the more likely PTSD symptoms will occur—for example, in the aftermath of natural disasters such as earthquakes or floods or during ongoing threats such as war.
- *Being the victim of multiple traumatic events*.
- *Witnessing or perpetrating an act* which evokes a dissonance with fundamental values, such as killing or injuring a person or witnessing a murder, a suicide, a serious assault, or child abuse.

- *The significance of the event to the person*. Some events may have special significance. For example, the event may awaken a childhood memory of a traumatic event or arouse latent responses that stem from unresolved losses or traumas of a similar type.
- *The person's general character*. A person who can effectively handle large amounts of stress has probably developed their coping mechanisms to the point that their susceptibility to PTSD is diminished.

3. POST-EVENT FACTORS

PTSD risk factors include those that exist after the traumatic event has been experienced. These include:

- not having good social, family, or employment-related support
- having a victim mentality and indulging in self-pity
- being passive about the situation—that is, letting negative things happen rather than actively trying to get help
- having an external locus of control, which is a belief that outside factors control your life
- having a pessimistic attitude
- experiencing immediate physical or psychological reactions to the traumatic event that continue beyond the "normal" acute stress reaction (Williams, 2013).

DIAGNOSING POST-TRAUMATIC STRESS DISORDER

If the reaction to the traumatic event persists for an abnormal period of time or occurs some time, perhaps months, after a traumatic event, PTSD may have developed. The symptoms of PTSD may be difficult to identify as they often accompany other conditions. The most common of these conditions are depression, anxiety disorders, and substance misuse.

To diagnose PTSD, the following factors and symptoms are considered:

1. *Exposure to a traumatic event*. The event involved death or threatened death or serious bodily harm to self or others. The emotional response to the event was intense fear or helplessness.
2. *Re-experiencing the event*. This is a main characteristic of PTSD. The person experiences powerful, recurrent memories of the event, recurrent nightmares, illusions, hallucinations, or flashbacks that make them relive the traumatic experience. There may be psychological distress or physical stress reactions when confronted with events that resemble or symbolize an aspect of the traumatic event. These *triggers* may be sights, sounds,

smells, dates, weather conditions, or anything else that is a reminder of the traumatic event.

3. *Avoidance and emotional numbing.* Persons with PTSD avoid triggers and scenarios that could remind them of the trauma. This behaviour is accompanied by emotional numbing, which usually begins very soon after the traumatic event. The person may withdraw from friends and family members; lose interest in activities they used to enjoy; and have difficulty feeling or expressing emotions, especially emotions associated with intimacy. It is also common for sufferers to experience feelings of extreme pessimism and develop a sense of foreshortened future. In extreme cases, a person may enter a dissociative state in which they believe that they are reliving the event. The dissociative state may be as short as a few minutes or as long as several days. During this time, the person may act as if the event is happening all over again.
4. *Changes in sleeping patterns and increased alertness.* Insomnia is a common symptom of PTSD. Some sufferers have difficulty concentrating and completing tasks. Increased aggression and outbursts or anger may also be a consequence of these changes. Hypervigilance is also a common symptom of PTSD. The sufferer is continually scanning for potential threats.

Symptoms of PTSD that have been present for fewer than three months reflect *acute PTSD*. Symptoms that last longer than six months are referred to as *chronic PTSD*. *Delayed onset* refers to symptoms of PTSD that occur more than six months after the identified stressor. More rarely, symptoms may surface many years later, making it more difficult to identify the stressor.

TREATMENTS FOR POST-TRAUMATIC STRESS DISORDER

Treatment for PTSD can involve psychological intervention and medications. Psychological intervention is particularly helpful in treating "re-experiencing" symptoms and social or vocational problems caused by PTSD. Mindfulness and meditation can also assist with reducing stress and the negative aspects of reliving the traumatic experience.

The main treatment for PTSD is **cognitive behavioural therapy (CBT)**. This involves examining the thought processes associated with the trauma, the way memories return, and how the person reacts to them. CBT teaches patients how their thoughts, feelings, and behaviours work together and how to deal with problems and stress. The goal of the therapy is to accelerate the natural healing process.

In a form of CBT known as **cognitive processing therapy (CPT)**, the person experiencing PTSD writes an impact statement describing the traumatic event's

cognitive behavioural therapy (CBT)
a psychological treatment to change maladaptive thoughts, feelings, beliefs, and habits

cognitive processing therapy (CPT)
a form of cognitive behavioural therapy in which the person experiencing PTSD writes about the traumatic event that precipitated their disorder; the therapist then identifies underlying issues and assists in the modification of maladaptive thinking

effect on their life. Writing about the event gives the person more time to think about and contextualize it. Writing about the event requires recall from memory and may assist in helping the person to understand that the traumatic event has passed.

prolonged exposure therapy
a form of therapy in which the patient describes their traumatic experience repeatedly as a means of confronting their fear

Prolonged exposure therapy requires that the patient verbally describe the trauma and the emotions felt several times per session. The person's description is recorded and listened to several times to assist them in reliving the experience in a safe environment. The goal of exposure therapy is to develop stress-coping skills and to help patients examine concerns about having to re-experience the traumatic event. Allowing them to gradually re-establish more realistic beliefs through changes in thinking patterns helps put the trauma in perspective. The traumatic event *has* happened but is *not* happening *now*.

Discussing memories of the trauma in a safe environment may help the sufferer become less frightened or depressed by those memories. This is called *desensitization*, which is often combined with CBT.

Many people with PTSD benefit from taking prescribed antidepressant medications, whether or not clinical depression accompanies their PTSD. These medications are particularly helpful in treating the avoidance and arousal symptoms, such as social withdrawal and angry outbursts, as well as any anxiety and depression. Other prescribed medications may be used to assist the person in re-establishing regular sleep patterns.

REDUCING THE EFFECTS OF POST-TRAUMATIC STRESS DISORDER

To help reduce the effects of critical incident stress and PTSD, many law enforcement services have developed critical incident stress debriefings. These are primarily confidential discussions about the critical incident. Advice on how to handle the stress may be given, or the officer may simply elect to express their feelings about the incident. The major goals of these debriefings are to reduce the immediate impact of the incident, expedite the officer's recovery, and reduce the possibility of PTSD.

Critical incident debriefing may be of little benefit in reducing long-term psychological distress. However, it may be useful as a means of introducing the sufferer to more effective long-term assistance.

STRATEGIES FOR COPING WITH POST-TRAUMATIC STRESS DISORDER

When someone has been diagnosed with PTSD and has received the appropriate professional assistance, there are some strategies that they can use to further deal with the condition.

Note that many of these strategies are similar to those recommended to assist with stress reduction:

- *Eat healthy foods*. A poor diet contributes to increased stress.
- *Get regular exercise*. Exercise reduces the harmful effects of the stress response and releases "feel good" endorphins.
- *Get enough sleep*. Your brain's emotional centres become 60 percent more reactive when you are sleep deprived. Regularly getting less than six hours of sleep can interfere with recovery (Epstein, 2010).

- *Practise mindfulness and relaxing breathing techniques*. Mindfulness allows you to experience the present moment. Relaxation breathing helps reduce the stress response.
- *Follow a daily routine*. Establishing a daily routine helps the sufferer feel in control and function well.
- *Set realistic goals and establish priorities*. Some people find it helpful to keep lists of tasks that they can check off as they complete them. This provides a sense of accomplishment. Establishing priorities helps the sufferer be realistic about what is and what is not achievable.
- *Set aside a specific time each day to think about the trauma*. Along with therapeutic discussion, the sufferer should give themself permission to think about the event at a designated time—and not think about it at other times. Otherwise, the sufferer may find that they are dealing with upsetting thoughts and feelings throughout the entire day.
- *Ask for additional support*. Asking for help from family and friends is not a sign of weakness.

- *Learn more about PTSD*. Understanding the disorder helps sufferers deal with their experiences and problems.
- *Acknowledge any unresolved issues that relate to the condition*. For example, admissions of fear and anger aid in recovery.
- *Focus on strengths*. Recognizing strengths and effective coping skills helps the sufferer to deal more successfully with ongoing problems and to identify methods that don't work.
- *Take responsibility*. PTSD is not an excuse for mistreating others.
- *Remember that there are other people with PTSD*. There is comfort in knowing that there are others who deal with the same problems. Group therapy discussions may be appropriate when initial treatment has stabilized the symptoms.

STRESS AND POLICING

Police officers are psychologically "screened" to ensure, as much as possible, that an officer is mentally stable when they begin their career. This does not mean that officers are immune to the effects of stress and mental illness.

Studies of Canadian police officers reveal that officers are disproportionately affected by stress and mental illness. In one study, a substantial number of municipal and provincial police (36.7 percent) and Royal Canadian Mounted Police (RCMP) (50.2 percent) reported symptoms of mental illness (CAMH, 2018; Carleton et al., 2018; Griffiths et al., 2015, as cited in Stamatakis, 2017). Specifically:

- Fifty-two percent reported moderate to severe stress (11 percent extremely severe).
- Eighty-eight percent reported moderate to severe anxiety (12 percent extremely severe).
- Eighty-seven percent reported moderate to severe depression (13 percent extremely severe).
- Twenty-nine percent were in the clinical diagnostic range for PTSD. (Recall that the lifetime prevalence rate of PTSD for all Canadians is about 9 percent.)

While operational (dealing with the public) and organizational (dealing with the department) stressors impact all first responders, organizational culture can be particularly prevalent in police services. Organizational culture can impact how officers respond to signs of mental illness in themselves and others.

"Police culture" represents the shared actions, attitudes, beliefs, and values of police organizations. Traditional police culture demands toughness, skepticism, and extreme loyalty and does not tolerate indications of perceived weakness. The stigma and prejudices associated with the inability to deal with stress or mental illness are probably amplified in police culture.

Within police culture, there is an axiom: *we don't have problems—we solve problems*.

Officers who experience difficulty dealing with stress or mental illness may be perceived as weak and could face distrust or be ostracized by officers who adhere to the attitudes of traditional police culture. Witnessing such behaviours can prevent officers from coming forward with their own mental health struggles.

A 2020 self-reported survey of approximately 1,000 Canadian police officers, conducted by Lesley Bikos and distributed by the Canadian Police Association, identified that the majority of responding officers would not report to their employing service that they were having mental health problems. See Table 1.3.

TABLE 1.3 Officers' Willingness to Report Mental Health Problems

I would report mental health to my service without fear of career or social repercussions.					
GENDER		**RANK**		**YEARS OF SERVICE**	
Male	27% agree	Constable	19% agree	0–8	24% agree
Female	20% agree	Middle management	29% agree	9–17	23% agree
		Senior management	44% agree	18–26	25% agree
				27–36+	38% agree
				On leave	13% agree
				Retired	16% agree

Note: Results reported from combined somewhat/strongly agree categories.

Source: Bikos (2020).

The study also identified that 35 percent of officers reported for duty while mentally unwell. Adherence to the attitudes of "police culture" could explain why this occurs.

While the study found that officers do sometimes report for duty while mentally unwell, the unaddressed issues contributing to their unwellness may eventually result in increased rates of absenteeism, sick leave, long-term disability, early retirement or attrition, and labour–management friction.

SOURCES OF STRESS IN POLICING

Police function within an environment where they experience high levels of acute and cumulative (chronic) stress unique to policing. Sources of stress include:

- *Exposure to the realities of violence, abuse, trauma, and poverty*. Exposure to these social ills may challenge officers' belief systems about themselves and the world.
- *The risk of physical injury while on duty*. Physical assault and other potential sources of injury or death include high-speed accidents and exposure to air-borne or blood-borne diseases.
- *Vicarious trauma*. This refers to the acute and cumulative stress experienced when witnessing or hearing about the pain and suffering of others, such as when attending accident scenes; dealing with traumatized witnesses; witnessing the assault or death of a fellow officer; and participating in investigations of assault, abuse, and homicide.
- *Not being able to discuss problems*. Officers' experiences with offenders and victims may only be completely understood by colleagues, limiting officers' abilities to discuss their problems.
- *Feeling judged or stigmatized by the public*. Policing obligations and duties are not always valued by society, and officers often experience social stigma and negative judgments.
- *News and social media scrutiny*. News and social media tend to sensationalize police actions and may not always portray the "complete" occurrence. Sensationalized media coverage of negative police interactions may taint the community's view of police officers in general. The media does not cover the thousand positive outcomes of police/public interactions. Negative headlines garner attention. This negative portrayal of police can become a significant stressor for officers.
- *Environmental stressors* such as noise, weather, and the need to make rapid decisions with little information.
- *Psychosocial stressors* involving social relationships with family, friends, and fellow officers.
- *A lack of appreciation* from the public or victims for your assistance.
- *Abusive suspects*.
- *Intrapersonal stressors* such as the inability to say no to requests or a need to be liked by everyone.
- *A pessimistic approach to life* that may be personality based or the result of cumulative stress.
- *A lack of confidence in abilities*. The stress response may occur when officers respond to occurrences and don't have confidence in their ability to manage the situation.

HIDDEN STRESSORS

The duties of police officers may be dangerous and require bravery and heroism; more often they are tedious and require inordinate patience. The obvious stressors, such as physical confrontations or gunplay, are more easily recognized as being harmful. But the unseen social and psychological stressors can be equally debilitating. These unseen intrapersonal and interpersonal stressors, organizational stressors, and operational stressors are inherent in the very nature of police duties.

Intrapersonal stress can occur when a person believes that their abilities do not coincide with their position in life. For example, an officer may believe that they should be working at a higher rank but, for some reason, have not achieved that rank. The greater the discrepancy between the person's perceived deserved status and their actual status, the greater the intrapersonal stress.

Interpersonal stress can occur when a person experiences difficulty dealing with other people. For example, an officer may believe that the actions of another officer will pose a threat to their well-being or perhaps may jeopardize their position or job.

Operational stress manifests when dealing with members of the public as related to functions in the job description.

Organizational stress often emanates from the police service itself, including policies and procedures that govern and direct an officer's actions. These procedures often require onerous amounts of paperwork. In many police services, street-level officers do not have much input into policies or procedures, even though these regulations directly affect them.

Officers may perceive that they do not receive adequate organizational support and that the only time that they are noticed is when they make a mistake. The public complaints process may have reinforced this perception. Further, the public complaints process may be seen as an effort by administrative bodies to encourage the public to complain about trivial matters.

A 2017 study by Coleman and Cotton identified organizational stressors such as ineffective leadership, the promotion process, understaffing, and lack of resources as significant stressors for police officers. In a 2020 study by Ricciardelli et al., officers ranked organizational stressors higher than operational stressors as a source of anxiety.

The most obvious negative aspect of operational and organizational stressors was "burnout," which may be defined as "an extreme state of depleted resources that can result from chronic exposure to work stress" (Kohan & Mazmanian, 2003, p. 561). The negative effects of burnout include emotional exhaustion (depleted mental energy and fatigue), depersonalization (cynicism toward the organization), and diminished personal accomplishment.

Officers who reported having more organizational hassles felt more emotionally exhausted and cynical toward the organization. These employees may be more inclined to leave policing or take more time off, and when on the job, their contributions and efforts may be minimal.

intrapersonal stress
the stress that can occur when a person believes that their abilities do not coincide with their position in life

interpersonal stress
the stress that can occur when a person experiences difficulty dealing with other people

operational stress
the stress that manifests when dealing with members of the public as it relates to functions of the job description

organizational stress
the stress that emanates from the police service itself, including policies and procedures that govern and direct an officer's actions

Organizational stress is a controllable variable in the cumulative stress experienced in policing. Fewer organizational stressors may reduce stress-related organizational problems such as absenteeism and poor work effort.

NORTHERN AND INDIGENOUS POLICING

Police in northern and Indigenous communities are exposed to many of the same stressors as their fellow officers, but additional challenges can further impact their mental health and well-being. Some of the additional stressors faced by officers in these remote locations include:

- *Long travel distances and isolation*. Many remote northern detachments are fly-in only, and accessibility is weather dependent. If the officer is not living in the community, days off may be spent travelling.
- *Northern detachments, primarily RCMP, OPP, and Sûreté du Québec*. These may have as few as two to four officers assigned during each rotation. When not on duty, officers are on call and required to be available.
- *Increased cost of living and decreased access to amenities*.
- *Extreme environmental conditions*.
- *Lack of back-up*. Safety concerns increase the levels of stress felt by officers.
- *Communities with high rates of poverty, mental illness, substance misuse, and family disruption*.
- *Broader role expectations*. Officers may be required to take on the role of counsellor or social worker while at the same time enforcing the law.
- *Lack of legitimacy*. Indigenous societies traditionally had their own forms of dealing with wrongdoing that focused on restorative justice rather than an authoritarian approach. These forms of justice have been effective for thousands of years. Officers who do not understand or are unable to accommodate these philosophies because of adherence to the structures of our common law justice system may experience a lack of respect within the community (Jones et al., 2014; Woodley & Kinney, 2016).

ORGANIZATION RESPONSES

The implementation of anti-stigma policies along with mental health in-service education could help overcome the "police culture" stigmatization that hinders the reporting of mental health problems. Education about the use of and access to self-assessment tools could assist with early identification of mental health problems. Early identification and timely access to mental health supports can prevent the problem from escalating.

Governments and police services have recognized the effect of operational and organizational stressors on the mental health of officers and have or are

in the process of implementing programs to assist with reducing these effects (Iacobucci, 2014).

Access to specialized treatment programs such as the CAMH's Work, Stress and Health (WSH) program can help officers recover from or deal with the symptoms of mental illness. This program offers specialized clinical services for people whose mental illnesses or substance use disorders are work related. Along with other service providers, the WSH program is staffed by an interdisciplinary team specializing in first responder mental health. These professionals understand the unique operational and organizational stressors faced by first responders—particularly the impact of workplace culture on police. Treatment plans to assist individuals in their recovery can include education, CBT, CPT, and pharmacological interventions (CAMH, 2015).

Although operational stress cannot be eliminated, there are stress reduction techniques that may assist officers. Training and education can have a positive influence on the reduction of operational stress. An officer receiving adequate technical and interpersonal training may be less likely to suffer from critical incident stress and will likely be more confident and more decisive in operational situations. Although it is not possible to prepare police officers for all potential encounters, preparation through classroom and scenario-based training can greatly assist with stress reduction and enhance officer safety. When faced with highly stressful situations, officers will most often revert to behaviours ingrained through continual training.

Education about identifying the symptoms and effects of stress and mental illness and where to seek assistance could help reduce the effects of operational stress.

HEALTH AND STRESS

Long-term stress-coping strategies are the responsibility of individual officers. Proper eating habits and regular exercise are two of the most controllable and effective strategies available. Officers in good physical condition are usually more confident in their physical ability to effectively control a situation. An officer in good health will also recover more quickly from the unavoidable, stressful encounters experienced in policing.

Good health benefits officers in another way. As discussed earlier, when an officer encounters a stressful situation, the stress response is triggered, preparing the body for intense physical activity through chemical and hormonal stimulation. However, stressful encounters in policing rarely result in all-out physical exertion, and the chemical compounds that the body produces in stressful situations are not significantly reduced after the encounter. These compounds, described earlier, may be caustic and cause damage at a cellular level. Physical exercise helps reduce this overabundance of unused compounds to help return the body to a more balanced state.

Recognition of symptoms is the first step in managing stress. We often rationalize or ignore the initial symptoms until we become ill. Symptoms of excessive stress may be physical or psychological. Recognizing and addressing early symptoms can reduce the likelihood of suffering the harmful effects of the stress response.

The following are some suggestions to help officers manage their stress within tolerable levels:

- Ensure proper nutrition. Eat complex carbohydrates such as vegetables and whole grains. Eat lean proteins. Avoid processed sugars (although consuming moderate amounts of sugars from eating whole fruits is okay). Limit sodium. Drink plenty of water.
- Avoid nicotine.
- Get adequate sleep, and don't rely on caffeine to get through your shift.
- Exercise regularly.
- Reduce intrapersonal stress through realistic assessments of your expectations.
- Schedule regular recreational and vacation times.
- Try to maintain an optimistic outlook.
- Set realistic goals.
- Recognize that you are responsible for your well-being.
- Practise mindfulness.

MINDFULNESS

Mindfulness involves focusing on and living in the present, which can reduce stress and anxiety and lead to improved physical and mental health.

We can learn from the past, but we cannot change it. It is a waste of our emotional resources to focus on it. Similarly, the future is unpredictable. Investing excessive emotional energy in thoughts of the possible future will not help us experience life in the present.

Mindfulness can help us see our lives more clearly; develop a different relationship with ourself; and focus on what we are experiencing, thinking, and feeling now.

PRACTISING MINDFULNESS

Practising mindfulness involves three main aspects: awareness, consideration, and understanding of the transient nature of thoughts and emotions. Become *aware* of and *accept* the moment, *consider* the thoughts or feelings that are present, and acknowledge that the thoughts or feelings are *transient*.

Awareness means being conscious of our surroundings and internal experiences. It involves focusing our attention on the thoughts, feelings, and body

sensations experienced in everyday life, such as the sights, smells, and sounds of our surroundings or the sensations of eating a meal. Awareness helps us experience life as it happens. Becoming aware does not always guarantee happiness and may involve distressing thoughts and emotions.

Consideration involves being curious about our emotions and thoughts and exploring our feelings from the perspective of the present without self-judgment. Becoming aware of the experiences that have shaped our thoughts and emotions helps us accept ourselves.

Transient in the context of mindfulness means accepting the present as the only reality, good or bad. Uncomfortable thoughts and emotions are acknowledged but expected to pass. By allowing the experience to transpire without judgment, we remove the need to avoid negative feelings that can lead to anxiety, negative behaviours like anger, or the inappropriate use of mood-altering substances. We can focus on awareness of the present and learn from past experiences without being consumed by them.

MEDITATION

Meditation is an extension of mindfulness that can be practised for stress reduction. It is essentially the expansion of mindfulness, of letting go of the negativity in our thoughts.

Meditation sounds simple. Just let thoughts be transient in your mind until there is no thought, only complete awareness. However, thoughts will intrude when we try to empty our minds.

To practise meditation, find a quiet place, relax your body, and try to be mindful of what is happening in your body. Be aware of your fingers, arms, toes, and legs. After this initial awareness, focus on being mindful of the natural rhythm of breathing.

Your mind will wander; thoughts will naturally occur. When thoughts arise, simply acknowledge them and let them go. Re-focus on breathing. It takes practice to achieve a state of no thoughts.

When we become aware, we learn to recognize negative thought patterns, making it easier not to allow them to become self-fulfilling.

LEARNING SCENARIO

LEARNING SCENARIO 1.1

Constable David Allen was a police officer with ten years' experience assigned to general patrol duties in a suburban area.

At 0010, a call was received from 1035 Albert Street reporting gunshots at 1033 Albert Street.

Officer Allen immediately responded to the call. Backup officers were dispatched with an ETA of eight to ten minutes.

Officer Allen had previously attended at that address regarding noise complaints ensuing from non-violent domestic disputes. Upon arrival, shouting could be heard from inside the residence.

Officer Allen went to the door; it was partly open.

Officer Allen opened the door and shouted, "Police!"

A female voice from the basement area shouted, "Help!"

Officer Allen remembered bedrooms and an open entertainment area in the basement of the house. He approached the basement stairs.

As he arrived at the top of the stairs, he heard a male voice shouting from the basement, "I killed him! I'll kill you too!"

Officer Allen leaned in slightly to look around the corner from the top of the stairs. He saw a male, known to him as Mitchell Thomas, holding a bolt action rifle. Mitchell arrived at the bottom of the stairs and pointed the rifle toward up the stairs and fired a shot.

Officer Allen shouted, "Mitchell, put the rifle down! It doesn't have to be this way!"

Mitchell responded, "No more talking! I killed him! I'll kill you too! There's nothing left to live for!"

Mitchell began walking up the stairs and shot again.

Officer Allen reached around the corner of the stairway and discharged his service pistol twice.

He heard Mitchell cry out in pain and sounds indicating that he had fallen.

Officer Allen shouted, "Mitchell, put the rifle down!"

There was no response.

Assisting officers arrived on scene.

Officer Allen again shouted, "Mitchell, let's talk! We can figure this out without anyone getting hurt!"

Again, there was no response.

A female voice shouted, "Help! I've been shot!"

Officer Allen suspected that the person shouting was Mitchell's wife, Cassandra Thomas.

Officer Allen shouted, "Mitchell, let's talk. We need to help Cassandra!"

Again, there was no response.

One of the responding officers had been looking in the windows to try to determine Mitchell's location. She relayed the following information: Mitchell was lying on the floor at the foot of the stairs. He was not moving and appeared to be bleeding. The rifle was on the floor about one metre away.

The officers decided to enter the area from a rear unlocked door while at the same time entering from the staircase.

Mitchell was found lying on the floor. He had gunshot wounds to his chest and abdomen.

Paramedics were called.

The rifle was secured; it had one cartridge in the chamber. The magazine was empty.

Officers found Cassandra Thomas in a bedroom. She had been shot in the shoulder.

A male, identified by officers as Ethan Callie, a local taxi driver, was lying on the bed next to Cassandra, apparently dead from a gunshot wound to his chest.

Paramedics provided aid to Cassandra Thomas. She survived the wound with no permanent mobility limitations.

Ethan Callie died from the gunshot wound.

Mitchell Thomas died from the gunshot wounds.

INVESTIGATION

Post-incident investigation revealed that Ethan Callie and Cassandra Thomas had been involved in a sexual relationship for several months.

Mitchell Thomas worked nights at a manufacturing facility from midnight until 0800, Monday to Friday. He learned of the extramarital relationship between his wife and Callie from a work friend who saw Mitchell each night at shift change. He told Mitchell that on his way home from work, he passed the Thomas residence and saw Callie's vehicle parked in Mitchell and Cassandra's driveway at least three nights a week when Mitchell was at work.

On the night of the shooting, Mitchell called in sick but left his residence at 2320, as he usually did. His vehicle was found parked in the laneway approximately 200 metres from his residence. It appeared that he watched his residence from the vehicle. He likely waited for Callie's vehicle to enter the driveway (at approximately 2355 according to Cassandra Thomas) and then entered the residence to confront Callie and Cassandra.

He had the rifle with him when he confronted them. It is unknown if he had the rifle with him in his vehicle or took it from an upstairs closet where it was kept.

According to Cassandra, he shouted something, shot Callie, then shot her.

He continued shouting at Cassandra, telling her that she had hurt him and that he was going to kill her for what she had done.

It was about that time that Officer Allen arrived.

THE AFTEREFFECTS

Officer Allen's actions were investigated, and he was cleared of any wrongdoing.

He returned to regular patrol duty in a different suburban area.

About one year after the Thomas incident, Officer Allen was dispatched to a call of possible gunshots in a residence.

Officer Allen did not respond. His patrol car was in the vicinity of the call. He had not indicated to dispatch that he was not available.

Dispatch tried four times over the course of two minutes to contact Officer Allen.

Another unit was then dispatched to the call.

GPS tracking indicated that Officer Allen's cruiser was stationary and had been for the past four minutes. An officer was sent to check on Officer Allen's well-being. Patrol Sergeant Davies found Officer Allen sitting in the cruiser listening to the police radio. He asked Officer Allen if anything was wrong.

Officer Allen replied, "I killed a person. I don't think that I can do this job anymore."

1. Discuss what you think Officer Allen was experiencing after hearing the dispatch.
2. Explain how you reached your answer.
3. What assistance is available that would help Officer Allen cope with the effects of the incident?
4. What do you believe would be the most effective type of assistance?

KEY TERMS

acute stress, 7
alarm, 9
cognitive behavioural therapy (CBT), 17
cognitive processing therapy (CPT), 17
cumulative stress, 11
distress, 5
eustress, 4
exhaustion, 9
fight-or-flight response, 8
interpersonal stress, 23
intrapersonal stress, 23
operational stress, 23
organizational stress, 23
personal stressor, 5
post-traumatic stress disorder (PTSD), 14
prolonged exposure therapy, 18
resistance, 9
stress, 4
stress response, 4

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EXERCISES

TRUE OR FALSE

_____ **1.** Stress reactions are always obvious.

_____ **2.** Stress cannot cause serious health problems.

_____ **3.** Stress affects only the body, not the mind.

_____ **4.** Work-related stress cannot affect one's home life.

_____ **5.** The effects of stress can be eliminated from one's life.

_____ **6.** The effects of stress may not be felt for several months.

_____ **7.** Only mentally unstable police officers suffer from the effects of stress.

MULTIPLE CHOICE

1. Stress is
- **a.** a response to a real danger
- **b.** a response to a perceived danger
- **c.** a response to a real or imagined danger
- **d.** a response to poor physical conditioning

2. The acute stress reaction is
- **a.** an emotional reaction
- **b.** a physical reaction
- **c.** a psychological reaction
- **d.** b and c

3. The best way to handle stress is to
- **a.** use alcohol and illegal drugs
- **b.** learn proper stress reduction techniques
- **c.** ignore it
- **d.** use prescription drugs such as tranquilizers

4. The fight-or-flight response allows the body to
- **a.** perform at a higher level mentally and physically
- **b.** combat a threat
- **c.** escape from a threat
- **d.** all of the above

5. Which of the following physical symptoms of acute stress requires immediate corrective action?
- **a.** chest pain
- **b.** difficulty breathing
- **c.** excessively high blood pressure
- **d.** collapse from exhaustion
- **e.** all of the above

6. Which of the following cognitive signs of acute stress requires immediate corrective action?
- **a.** decreased alertness
- **b.** difficulty making decisions
- **c.** hyperalertness
- **d.** mental confusion
- **e.** all of the above

7. Which of the following emotional signs of acute stress requires immediate corrective action?
   - **a.** panic reactions
   - **b.** shock-like state
   - **c.** phobic reaction
   - **d.** general loss of control
   - **e.** all of the above

8. Which of the following behavioural changes resulting from acute stress requires immediate corrective action?
   - **a.** change in speech patterns
   - **b.** excessive angry outbursts
   - **c.** crying spells
   - **d.** antisocial acts
   - **e.** all of the above