International Journal of Health and Psychology Research

Vol.6, No.2, pp.21-35, September 2018

Published by European Centre for Research Training and Development UK (www.eajournals.org)

ADJUSTMENT STYLES AND EXPRESSION OF POST-TRAUMATIC STRESS DISORDERS AMONG SELECTED POLICE IN OSOGBO METROPOLIS

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ABSTRACT: *This study explores the exposure to post-traumatic stress disorder among the police and expression of PTSD with the resultant adjustment strategies utilization to cope with PTSD. Descriptive survey research design was employed to select 200 respondents using simple random technique and Taro Yamane to determine the sample size. Self structured three sections questionnaire was used in data collection which lasted for the period of four months and descriptive statistics was used to analyse the collected data. The result revealed that the respondents mean age was 35.65±5.97 and majority of the respondents were men. The respondents expressed exposure to PSTD at various degree where "a little bit" on likert scale with mean value of 56.82±7.54. All the respondents adopted various adjustments strategies to combat PTSD which resulted in effective coping mechanism. In conclusion, the respondents' ability to cope with post-traumatic stress disorders was in tandem with active middle age and readiness to defend the sovereignty of their nation.*

KEYWORDS: Post-Traumatic Stress Disorder, Expression Adjustment Styles

INTRODUCTION

Policing necessitates exposure to traumatic, violent and horrific events, which can lead to an increased risk for developing post-traumatic stress disorder (PTSD). It is equally undoubtedly that policing is a stressful occupation, with officers often facing potentially traumatic situations. They may be exposed to disaster, hostage situations, sexual and physical assaults, shootings, mutilations and death, or face threats to their life. As a result, police and emergency services workers have elevated rates of post-traumatic stress disorder (PTSD), depression and suicidal thoughts and actions. Though, the military veterans were the set of people who were notice to suffered PTSD due to wars, but still exacerbation of human activities as related to violence and man-made disaster in the world of today has prone many people into unresolved and persistence exposure of lives and properties into many dangers, which ordinarily could be controlled with little or no efforts if we understand and tolerate ourselves as a living being. In Nigeria presently, the rate at which people are been exposed to conditions causing both physical, emotional and psychological trauma are difficult to quantify. That was why PTSD prevalence is very high in Nigeria since the onset of political instability and economic recession. This was corroborated by Krause (2011) that the political crisis over 'indigene' rights and political representation in Jos, capital of Plateau State, Nigeria, has developed into a protracted communal conflict. At present, this unrest not limited to the aforementioned state, but spread like an epidemic throughout all geopolitical zones in different names which include Boko-Haram insurgence, herdsmen/farmers conflicts and indigenous people of Biafra, to mention but few. Yetunde, Oluwabunmi, Taiwo, Danjuma, Tolulope, Zuwaira & Christopher (2015), that recurring conflict often involves maiming, killing, burning of houses, motor vehicles and other properties. Man-made disasters, like intentional killings, kidnapping and

ISSN 2055-0057(Print), ISSN 2055-0065(Online)

road traffic accident are becoming a normal phenomenal, which causing nightmares to the general populace including law enforcement agents such as policemen whose responsibilities to protect the lives and properties of the innocent citizens are vested. Recurrent exposure to all live threatened events prone most of Nigerian policemen into traumatic stress which later in life associated with posttraumatic stress disorders escalation and subsequently development of difference means of adjustment, in order to prevent extreme and unremitted reaction that might later leads to sudden complications of PTSD and death, if means of adjustment failed.

It is not uncommon therefore, to associate loss of loved ones and livelihood to the numerous factors known to be likely to put survivors at the risk of experiencing psychological issues like stress/distress of different shades such as post-traumatic stress disorders (PTSD), acute stress disorders (ASD) (William Langa M. & Esther Anenge G, 2014). In most cases friends and loved one are among people that this vulnerable group in question(police force) witnessing their sudden death, maiming, sustaining lives endangered injuries when combating criminal or when preventing reprisal attack of fellow Nigerians in a disaster prone regions, as witnessed in the northeast, middle belt and oil laden south-south region of Nigeria. We live in traumatic times. Political upheaval and the ever-present threat of foreign and domestic terrorism hover over all our lives, most especially those of first responders and their families. All these enhances the complexity of policing.

Behind every officer who is involved in a critical incident, there is an almost invisible family left to pick up the pieces or to watch helplessly as a once familiar and loving individual changes into a stranger. Police families are at risk for secondary trauma, also known as vicarious trauma or compassion fatigue, an emotional response with symptoms that mimic PTSD. It results from indirect exposure to a traumatic event through repeatedly listening to vivid first-hand accounts of the event. In some families, an officer's reluctance to talk about what happened can damage the intimacy needed to form and maintain a relationship. Post-traumatic stress disorder (PTSD) is a mental health condition that's triggered by a terrifying event. It occurs after a person must have been exposed to a really frightening situation. Its presenting manifestations may include analeptsis, nightmares and constant uncontrollable thought about the event. Many victims of this traumatic circumstance have difficulty adjusting and coping for a while (Mayo17-04-2015). However, it was concluded by Ajibade, Makanjuola, Amoo & Okunlade (2015) in a study that people experienced post-traumatic disorder at different levels and exhibit different adjustment/coping styles when faced with unhappy situations. The Mental Health Organisation (2007), expressed that PTSD is a potentially severe long-term mental health problem that can hampers your ability to live your life to the full. People experiencing it can feel anxious for years after a trauma, whether or not they suffered a physical injury.

There are approximately 900,000 sworn officers in the United States. According to some studies, 19% of them may have PTSD. Other studies suggest that approximately 34% suffer symptoms associated with PTSD but do not meet the standards for the full diagnosis. But in Nigeria, the actual numbers of police officers affected with this condition form a dearth in establishing prevalence, the literatures have it that PTSD is a common mental disorder that military members develop from traumatic events experienced while in or near combat which police officers are not excluded (Pietrzak, Harpaz-Rotem & Southwick, 2011; Albright & Thyer, 2010; Insel, 2007). Green (2005), opined that prevalence rates for PTSD in police officers may be six or more times the prevalence rates for the community. However, coping strategies and mode of adjustment to prevent or delayed hospital institutionalization an officer with PTSD form another gap which need to be looked into.

ISSN 2055-0057(Print), ISSN 2055-0065(Online)

The specific objectives of the study are to:

a) To assess the socio-demographic profile of the respondents.

b) To evaluate the expressions of PTSD by the respondent

c) To examine the different adjustment styles adopted by the respondents in combating PTSD

Theoretical Framework

Traditional neurocircuitry models of PTSD highlight the importance of three main brain regions; the amygdala, and its interactions with the ventromedial prefrontal cortex (vmPFC), and the hippocampus. These models predominantly stem from animal work into fear conditioning, which has a number of parallels with PTSD symptomatology. Specifically, in response to threat-related stimuli, there is thought to be increased activation in the amygdala due to a diminished ability of the vmPFC and hippocampus to govern the amygdala responsiveness. Further, hyperactivity in the amygdala is proposed to explain the distinct emotional quality of memories of the trauma; hypo-response in the vmPFC the inability to move attention away from the trauma-related stimuli; and decreased hippocampal functionality that the poor voluntary recall patients' show in regards to the traumatic event.

Neuroimaging studies in patients with PTSD show support for these neurocircuitry models. The symptom provocation paradigm has been widely used in neuroimaging studies to examine the brain activation occurring during the patient's experience of PTSD symptoms, such as intrusive memories. The paradigm involves exposing individuals with PTSD to stimuli designed to trigger their symptoms, e.g., visual images of combat situations or verbal autobiographical scripts of the patients' trauma. Reviews of symptom provocation neuroimaging studies suggest that PTSD patients' symptom experience involves decreased activity of the anterior cingulate cortex (ACC), medial PFC, Para hippocampus, and thalamus, and, generally, increased amygdala activity.

Further work suggests that abnormal interactions between the hippocampus and vmPFC may arise after developing PTSD, while abnormalities in the amygdala and dorsal ACC may be predisposing. However, while these structures may explain some elements of PTSD, it is unlikely that they alone can explain all symptoms associated with PTSD, in particular given the number of regions identified by symptom provocation studies. Thus, it is currently uncertain which of these brain regions may be associated directly with intrusive memories, and which others may be associated with, for example, increases in arousal.

A distinct model of intrusive memories stems from clinical psychology and the neuroscience of memory (Brewin et al. 2012), suggest that there are two forms of memory representations those that are abstract and contextually bound, and those that are sensory and affective in nature and not contextually bound. In a healthy memory, these two representations are connected. An intrusive memory on the other hand has a strong sensory representation that is not connected to its contextual representation. This allows the memory to be easily cued by trauma-related information and without any autobiographical context – creating the re-experiencing feelings common to intrusive memories. Relating these concepts to neural mechanisms, Brewin et al. suggest, in line with neurocircuitry models of PTSD, that intrusive memories occur due to hyper-activation in the amygdala and insula, which is disconnected from the hippocampus and related memory structures that are required to provide contextual autobiographical information.

ISSN 2055-0057(Print), ISSN 2055-0065(Online)

Coupled with visual imagery (suggested to be mediated by the precuneus), the intrusive memory then appears involuntarily in mind as a visual memory.

Support for these suggestions also stems from patient studies investigating intrusive memories directly. Only a small number of studies have been able to investigate the explicit occurrence of intrusive memories. The symptom provocation paradigm does not always cause patients to experience intrusive memories. The paradigm serves as a reminder of the trauma, bringing trauma memories to mind, causing, for example, heighted emotional responses and avoidance, but does not necessarily cause involuntary intrusive memories. To our knowledge, only four neuro-imaging studies of PTSD have explicitly reported the brain activation of patient experiencing "flashbacks" while undergoing symptom provocation. These studies suggest that the experience of an intrusive memory may involve increased inactivity in limbic and para-limbic areas including insular, ACC, thalamus and amygdala, and decreased activation in inferior frontal areas, presenting clues as to those regions that may be involved in intrusive memories specifically. While it should be noted that this studies did not capture the moment of intrusive memory involuntary recall, but rather the more general experience surrounding intrusive memories, they do share similarities with the neural mechanisms proposed to underlie intrusive memories. (Clark & Mackay, 2015).

Application of The Model to The Study

According to the theory, In the course of exposure to an event or occurrence of a threat, challenge or harm, when the coping strategy is problem focused, there use to be a resultant favourable resolution and positive emotions and an unfavourable resolution or no solution when coping is emotion focused.

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METHODOLOGY

Research design: This research was carried out using written survey descriptive design to explore post-traumatic stress disorder and adjustment styles among the police in Osogbo metropolis.

Research setting: The research was conducted Osogbo Metropolis. Osogbo is the capital of Osun state which lies on coordinates 704611 north and 403411 with an area of 47kmsq. According to World Bank Population by Estimation, (2018), the population of Osogbo Metropolis being the capital city of Osun State was estimated to be 156,694 people. It shared boundary with Ikirun, Ilesa, Ede, Egbedore and Iragbiji and is easily accessible from any part of the state because of its central nature. It is about 48km from Ife, 32km from Ilesa, 46km from Iwo, 48km from Ikire and 46km from Ila-Orangun.

ISSN 2055-0057(Print), ISSN 2055-0065(Online)

Sample size determination and sampling techniques: The total population of policemen and women in Osogbo during the cause of the study was 400 and by adopting simple randomization technique. 200 respondents were randomly selected, which was assumed to be a good representation of the study population. Since the study population is known, that is 400 police officials in Osogbo metropolis; Taro Yamane's formula was used to calculate the sample size as follows:

Formula: $n = \frac{N}{1+N(e)2}$

n = sample size

N = Total population

e = level of precision = >0.05

$n = \frac{400}{1+400(0.05)2}$

n = 400 / 1+1 = 200

Hence, 200 subjects will be administered questionnaire.

Instrument for data collection: A structured questionnaire was used to collect necessary information from the respondents. The questionnaire consists of three (3) sections.

Section (1) is on demographic variables consisting of seven (7) items.

Section (2) is on list of problems and problem that people have in response to military experiences and it consists of seventeen (17) items. Section (3) is on adjustment styles.

Psychometric Properties of Instrument:

Validity: Face and content validity of the instrument was determined by the conglomeration of the researchers. The ambiguous items were removed to maintain the specificity of questionnaire. A pilot study was carried out using 40 questionnaires administered to few police officials outside Osogbo metropolis to determine the reliability of the instrument**.** The questionnaire was administered to the respondents once and the reliability of the instrument was determined using correlation coefficient. The reliability yield 0.84.

Method of data collection: The necessary data was collected using the questionnaire administered to the respondents at four occasions during which the researcher waited to collect them from the respondents at the clinic. Data collection spanned four months.

Method of data analysis: The data generated from the questionnaire was analysed using descriptive analysis and chi-square at 0.05 degree of significance.

ISSN 2055-0057(Print), ISSN 2055-0065(Online)

RESULT

The result reveal that 53.5% of the respondents were male while 46.5% were female. This is an indication that men are more recruited to the Nigeria police than female, this might be due to the strength of men in facing and combating crime and ability to face crisis in it form than women. From the previous study, Idowu (2016) posits that male police were more conscious and effective in security work than their female counterpart. The mean age of the respondents were 35.65±5.37 which means they were at their youthful age, more productive in combating crime and ability to withstand stress which equally enhances effective and efficient policing. According to Kemeny (2003) stress physiology is profoundly influenced by psychological and social factors. Invariably, their mean age as middle age adult does not prevent them from experiencing post-traumatic stress disorders. The respondents result of other demographic profile shows that 109(54.5%) were Christians, 80(40.0%) Muslims, and 11(5.5%) were traditionalist, Yoruba's formed the largest respondents with 171(85.5%), Hausa 19(9.5%), Igbo 10(5.0%). About 46(23.0%) were single, 139(69.5%) 15(7.5%) are divorced, 65(32.5%) are O'level holders and same are also OND holders, the greater portion of the respondent 129(64.5%) are constable.

On the respondent's expression of stress, 41(20.5%) of the respondents were not at all experiencing Repeated, disturbing dreams of a stressful experience from the past, 76(38.0%) experience it a little bit, 46(23.0%) experience it moderately, 24(12.0%) experience it quite a bit, while 13(6.5%) experience it extremely, 88(44.0%) of the respondents does not at all feel Suddenly acting or feeling as if a stressful experience were happening again (as if you were relieving it), 55(27.5%) feel it a little bit, 31(15.5%) feel it moderately, 16(8.0%) feel it quite a bit, while 10(5.0%) fee4l it extremely, 42 (21.0%) of the respondents does not at all Feel very upset when something reminded them of a stressful experience from the past, 61(30.5%) feel it a little bit, 48(24.0%) feel it moderately, 33(16.5%) feel it quite a bit, while 16(8.0%) feel it extremely, 81(40.5%) of the respondents does not at all having physical reaction (e.g heart pounding, trouble breathing or sweating) when something reminded you of a stressful experience from the past, 44 (22.0%) have it a little bit, 45 (22.5%) have it moderately, 18 (9.0%) have it quite a bit, while 12 (6.0%) have it extremely. 122 (61.0%) of the respondents not at all Feeling as if their future will somehow be cut short, 49 (24.5%) feel it a little bit, 12(6.0%) feel it moderately, 3 (1.5%) feel it quite a bit, while 14 (7.0%) extremely feel it and 109 (54.5%) of the respondents not at all Feel jump or easily started, 49 (24.5%) feel it a little bit, 27 (13.5%) feel it moderately, 6 (3.0%) feel it quite a bit, while 9 (4.5%) extremely feel it.

The respondents adjustment followed that, 6 (3.0%) of the respondents never hope that things will get better, 33 (16.5%) very rarely hope so, 51 (25.5%) sometimes hope so, while 110 (55.0%) very often hope so;12 (6.0%) of the respondents never Find out more about the situation so that they can handle it better, 25 (12.5%) very rarely do so, 73 (36.5%) sometime do so, while 90 (44.5%) very often do so; 88(44.1%) sometimes Think through different ways to handle the situation, 102(51.1%) rarely look at the problem objectively, 116(58.2%) never eat smoke or chew gum when they feel the stress, 82(41.0%) sometimes Draw on past experience to help you handle the situation, 68(34.0%) very rarely get nervous, 103(51.5%) rarely worry, 72(36.0%) sometimes Set specific goals to help solve the problem, 84(42.0%) sometimes Try to put the problem out of your mind, 127(63.5%) never Get mad, curse, swear, 99(49.5%) never Cry and get depressed, 71(35.5%) rarely Take out your tension on someone or something else, 84(42.0%) sometimes want to be alone, 136(68.0%) never Drink Alcohol beverages, 88(44.0%) never take drugs to kill the feeling, 82(41.0%) never Do anything in the

ISSN 2055-0057(Print), ISSN 2055-0065(Online)

hope that the problem will take care of itself, 78(39.0%) never Resign yourself to the situation because it is your life, 98(49.0%) never indulge in sex to deal with their stress.

Further findings revealed that majority were constable, which were assumed to be the lowest rank in Nigeria police force and this could be the result of their exposure to PTSD. At this rank, they were more exposed to this condition based on the kind of activity they engaged in. This was in tandem with Pietrzak, Harpaz-Rotem & Southwick (2011) that recurrent exposure to traumatic events experienced by military while in or near combat enhances the development of PTSD. Notwithstanding, Green (2005), had earlier emphasized that PTSD can affect adults of all ages ranging from civilians to military officers irrespective of rank or number of years in combating crime.

Summary

This research studied post-traumatic stress disorder and adjustment styles among the police of Oshogbo, Osun State the sample size of 200 respondents was chosen using the Taro Yamane's formula .The questionnaire was distributed in. Pertinent literatures were reviewed which include: text books, journals, past research works and internet sources.

It was discovered that the demographic variable and the kind of post-traumatic experience affect the adjustment technique adopted

CONCLUSION

From the study carried out, it was discovered that the demographic variable and the kind of post-traumatic experience affect the adjustment technique adopted hence there is a very sharp indication to the fact that there are other factor influencing the respondent life style other than their knowledge.

Implications for Nursing Practice

The findings in the study showed that there are some factors influencing the adjustment of post-traumatic patient. The implications for nursing practice are:

- Post traumatic patient need constant health education from the nurses whenever they come by at the health facility
- Nurses should assist post traumatic patient to put in place certain precautious mechanism to aid them in adhering to proper life style modification.
- Nurses are to carry the post traumatic patient's relative along in the management of the patient to strengthen adherence to proper life style modification

Limitation of the Study

This study is subjected to the following limitations.

- Time factor; is a major limitation to the study as it took some time to administer the instrument to the respondents.

ISSN 2055-0057(Print), ISSN 2055-0065(Online)

- Funds; financial constraint prevented the researcher to cover large population that could have been used to generalize the findings.
- Respondent's attitude towards answering the question in the questionnaire.

RECOMMENDATIONS

In the course of the research work, it was discovered that certain factors affect the adjustment mechanism. The following recommendations will go a long way in providing solutions to these factors:

- The environment of post-traumatic stress disorder patient should be design to adapt to prevent the triggering factors of the disorder
- Post-traumatic stress disorder patient should be taken through rehabilitative programme to help the adjustment.
- Post-traumatic stress disorder patient's relative should assist the patient in adjusting to the required life style modification.

Suggestion for Further Studies

Further studies could be carried out on this same subject matter using a larger number of subjects and a different location. Studies could also be carried out on:

- Attitude of post-traumatic disorders patient towards life style adjustment.
- Factors influencing the restoring normal mental believe of post-traumatic stress disorder patient.

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APPENDIX

Table 1.0: Socio-demographic profile of the respondents

Question	Frequency	Percentage
Age		
18-24	21	10.5
25-29	31	15.5
30-34	31	15.5
35-39	47	23.5
40-49	70	35.0
Sex		
Male	107	53.5
Female	93	46.5
Religion		
Christianity	109	54.5
Islam	80	40.0
Traditional	11	5.5
Ethnic group		
Yoruba	171	85.5
Hausa	19	9.5
Igbo	10	5.0
Marital status		
Single	46	23.0
Married	139	69.5
Divorced	15	7.5
Educational level		
O'level	65	32.5
NCE	6	3.0
OND	65	32.5
BSc.	64	32.0
Present status		
Constable	129	64.5
Officer	34	17.0
Corporal	18	9.0
Detective	19	9.5
Sergeant		
Lieutenant		
Others specify		

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Table 2.0: Expression of PTSD among the respondents.

S/N	QUESTIONS	VARIABLES n=200									
		Not at all		A little bit		Moderately		Quite a bit		Extremely	
		F	%	F	%	F	%	F	%	F	%
1	Repeated, disturbing memories thoughts or images of a stressful experience from the past?	14	20.5	**76**	**38.0**	**46**	**23**	**24**	**12.0**	**13**	**6.5**
2	Repeated, disturbing dreams of a stressful experience from the past?	**75**	37.5	**52**	**26.0**	**45**	**22.5**	**23**	**11.5**	**5**	**2.5**
3	Suddenly acting or feeling as if a stressful experience were happening again (as if you were relieving it)?	**88**	44.0	**55**	**27.5**	**31**	**15.5**	**16**	**8.0**	**10**	**5.0**
4	Feeling very upset when something reminded you of a stressful experience from the past?	**42**	21.0	**61**	**30.5**	**48**	**24.0**	33	**16.5**	**16**	**8..0**
5	Having physical reaction (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?	**81**	40.5	**44**	**22.0**	**45**	**22.5**	**18**	**9.0**	**12**	**6.0**
6	Avoid thinking about or talking about a stressful experience from the past or avoid	**43**	21.5	**69**	**34.5**	**48**	**24.0**	**25**	**12.5**	**15**	**7.5**

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	having feelings related to it?										
7	Avoid activities or situations because they remind you of a stressful experience from the past?	**66**	33.0	**62**	**31.0**	**24**	**12.0**	**30**	**15.0**	**18**	**9.0**
8	Trouble remembering important part s of a stressful experience from the past?	**68**	34.0	**47**	**23.5**	**54**	**27.0**	**19**	**9.5**	**12**	**6.0**
9	Loss of interest in things that you used to enjoy?	**81**	40.5	**70**	**35.0**	**19**	**9.5**	**12**	**6.0**	**18**	**9.0**
10	Feeling distant or cut off from other people?	**95**	47.5	**56**	**28.0**	**18**	**9.0**	**16**	**8.0**	**15**	**7.5**
11	Feeling emotionally numb or being unable to have loving feelings for those close to you?	**106**	53.0	**54**	**27.0**	**12**	**6.0**	**24**	**12.0**	**4**	**2.0**
12	Feeling as if your future will somehow be cut short?	**122**	61.0	**49**	**24.5**	**12**	**6.0**	**3**	**1.5**	**14**	**7**
13	Trouble falling or staying asleep?	**102**	51.0	**41**	**20.5**	**26**	**13.0**	**16**	**8.0**	**15**	**7.5**
14	Feeling irritable or having angry outbursts?	**89**	44.5	**68**	**34.0**	**15**	**7.5**	**18**	**9.0**	**10**	**5.0**
15	Having difficulty concentrating?	**82**	41.0	**65**	**32.5**	**34**	**17.0**	**7**	**3.5**	**12**	**6.0**
16	Being ‘’supper alert’’ or watchful on guard?	**62**	31.0	**48**	**24.0**	**54**	**27.0**	**30**	**15.0**	**6**	**3.0**
17	Feeling jump or easily started?	**109**	54.5	**49**	**24.5**	**27**	**13.5**	**6**	**3.0**	**9**	**4.5**

ISSN 2055-0057(Print), ISSN 2055-0065(Online)

Table 3.0: Adjustment Style Used by Respondents in combating PTSD

S/no	Questions	Variables (n=)			
		Never	**Very Rarely**	**Sometimes**	**Very Often**
1	Hope that things will get better	6(3.0%)	33(16.5%)	51(25.5%)	110(55.0%0
2	Try to maintain some control over the situation	3(1.5%)	10(5.0%)	99(49.5%)	88(44.0%)
3	Find out more about the situation so that you can handle it.	12(6.0%)	25(12.5%)	73(36.5%)	90(45.0%)
4	Think through different ways to handle the situation	15(7.6%)	18(9.1%)	78(39.2%)	88(44.1%)
5	Look at the problem objectively	13(6.5%)	27(13.5%)	102(51.0%)	58(29.0%)
6	Eat, Smoke, Chew gum	116(58.3%)	47(23.5%)	15(7.6%)	21(10.6%)
7	Draw on past experience to help you handle the situation	15(7.5%)	31(15.5%)	72(36.0%)	8.2(41.0%)
8	Got nervous	55(27.5%)	68(34.0%)	50(25.0%)	27(13.5%)
9	Worry	54(27.0%)	25(12.5%)	103(51.5%)	18(9.0%)
10	Set specific goals to help solve the problem	33(16.5%)	43(21.5%)	72(36.0%)	52(26.0%)
11	Try to put the problem out of your mind	23(11.5%)	38(19.0%)	84(42.0%)	55(27.5%)
12	Get mad, curse, swear	127(63.55)	31(15.5%)	25(12.5%)	17(8.5%)
13	Cry and get depressed	99(49.5%)	47(23.5%)	33(16.5%)	21(10.5%)
14	Take out your tension on someone or something else	54(27.0%)	54(27.0%)	71(35.5%)	21(10.5%)
15	Want to be alone	23(11.5%)	38(19.0%)	84(42.0%)	55(27.5%)
16	Drink Alcohol beverages	136(68.0%)	30(15.0%)	25(12.5%)	9(4.5%)
17	Take Drugs	88(44.0%)	47(23.5%)	36(18.0%)	29(14.5%)
18	Do nothing in the hope that the problem will take care of itself	82(44.0)	74(37.0%)	34(17.0%)	10(5.0%)
19	Resign yourself to the situation	78(39.0%)	53(26.5%)	56(28.0%)	13(6.5%)
20	Have sex	98(49.0%)	63(31.5%)	21(10.5%)	18(9.0%)

ISSN 2055-0057(Print), ISSN 2055-0065(Online)