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Procedia - Social and Behavioral Sciences 00 (2014) 000–000

Procedia
Social and Behavioral Sciences

www.elsevier.com/locate/procedia

WCES 2014

Defensive and Coping Styles for Residents in Psychiatry

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Abstract

Introduction: The nature of this profession requires the development of adequate defensive and coping styles. Also to have chosen this for your career might mean to have some particularities in these areas.

Objectives: The evaluation of coping and defense style mechanisms for residents in psychiatry that conduct clinical work.

Materials and methods: A descriptive study was developed to determine and evaluate defensive and coping styles for residents in psychiatry. DSQ-60 and COPE scales were applied on a 31 willing resident in psychiatry from approximate 50 residents in total from the center in which the study was conducted.

Results: The most frequent mechanisms found on the evaluated group are: "Altruism", „Self-observation" – superior defense styles and "Positive interpretation and growth" - an emotion focused coping style and „Planning" – a problem focused coping style.

Conclusion: The chosen profession can be a factor that underlines some inborn abilities but also a modulating factor for one's structure. The developing of adequate coping and defense styles might be a requirement for becoming a psychiatrist or it might be a gain for someone working in this field day by day.

Selection and peer-review under responsibility of the Organizing Committee of WCES 2014.

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Selection and peer-review under responsibility of the Organizing Committee of WCES 2014.

Keywords: Defensive Mechanisms, Coping Mechanisms, Residents in Psychiatry, Profession

1. Introduction:

Being a psychiatrist is considered to be stressful. The amount of time and resources put into the professional training of a resident in psychiatry are great and involve general medicine knowledge, psychotherapy and of course psychiatry. This profession is complex and no skills will prevent one's exposure to stress.

Stress is considered to be a reactive adaptation to the events in the environment. Any event that causes tension, anxiety, frustration, nervousness or any sort of disequilibrium in the body or mind can be considered a stressor. Although medical profession is considered to be stressful and overwhelming, very few studies seem to evaluate the levels of stress divided by medical specialties. In spite of this, many counties offer better remuneration for physicians working in the field of psychiatry confirming the job conditions in which stress has a great part.

The research's opinion has not reached to a consensual conclusion on stress (Raeda Fawzi, AbuAlRub, 2004). Some articles seem to consider that stress is a contributing factor to job inefficiency, staff turnover, absenteeism because of sickness, decreased quality and quantity of care, increased costs of health care, and decreased job satisfaction (Wheeler H., & Riding R.,1994), low job performance (Jamal, M.,1984, Leveck, M., & Jones, C., 1996, Motowidlo, S., Manning, M., & Packard, J. 1986, Westman, M., & Eden, D.,1996), or, on the contrary, high job stress leads to high job performance (Keijsers, G., Schaufeli,W., Le Blanc, P., Zwerts, C.,&Miranda, D.,1995). Other studies conclude that people with moderate stress perform better than do those with high or low levels of stress (Anderson C., 1976, Cohen S., 1980). Social support is considered to be very important and some studies underlined the idea that people with high social support from co-workers have low perceived job stress. (Raeda Fawzi, AbuAlRub, 2004)

In order to be a good doctor and perform in your field of expertise you have to have, or to develop good coping and defense mechanisms. Also, if you work under stress, you have to surpass it to know how to teach your patients that have to overcome great amount of mental and physical stress how to override it themselves. The clinical work in the field of psychiatry is a very confrontational area in which frequent stressful situations arise.

Coping and defense mechanisms are frequently misunderstood and the difference between the two is not always understood. Frequent mistakes are made in the literature by labeling a defense mechanism as a coping strategy and vice versa. The two have many similarities but also have different psychological mechanisms.

Defense mechanisms alter veridical perception. They protect the person from excessive anxiety whether the source of the anxiety is an external or an inner source (Freud A., 1936).

Coping mechanisms are considered to involve purpose and choice as a contrast with defense that is rigid and "embodies the expectancy that anxiety can be relieved without directly addressing the problem" (Haan N., 1977).

This study provides a coping and defense mechanisms' profiling for future specialists in psychiatry.

Objectives:

This paper's objectives are to provide a baseline evaluation for medical doctors working in the field of clinical psychiatry.

We aimed to determine if the coping and defense styles are adequate for a high-stress job.

As many articles aim to underline the necessity of decreasing stress, we recognize the importance of lowering the frequency of stressful circumstances, but we aim to underline the importance of inner abilities and their development in certain fields, such as coping and defense styles in the field of psychiatry.

Materials and methods:

The sample of evaluated residents was composed by author's colleagues and co-workers and also by the several authors that fit the criteria of inclusion for the study. The participants approved de evaluation and no remuneration was offered. The way in which the questionnaires were applied was by auto evaluation – the resident ensured by himself all the questions.

A number of 35 residents were asked to participate in the study but only 31 agreed. The duration of the process of collecting the data was of approximately one month.

DSQ-60 and COPE scales, translated and validated for Romania (Dănuț I. Crașovan, Florin A. Sava, 2013, Dănuț I. Crașovan, Laurențiu P. Maricuțoiu, 2012), were used to determine coping and defense mechanisms in this sample formed from the majority of residents working in the center in which the study was developed (31 from approximately 50 residents in total).

DSQ-60 is a scale of 60 questions that explores 30 defense mechanisms. COPE is also a scale with 60 questions and it explores 15 coping mechanisms.

The sample studied is formed from 31 residents between the age of 25 and 43, with an average age of 28.77. The level of experience in this specific field is between 0.5 and 4 years, with an average of 1.38 years. The residents are training to become either adult psychiatrists or children's psychiatrists the proportion being 22:9.

The vast majority of them has a common spiritual orientation (28 of them are raised as Christians and only 3 are atheists) and it is raised almost in the same socio-cultural conditions (with only one exception all of them are born and raised in Romania). In the studied sample 7 men and 24 women are present, among which 10 are married, 9 unmarried and 2 divorced.

The way in which the psychiatric training is made in the clinic for the residents that work there is by a close relationship with the attending physician that might or might have not had a teaching training. Rotations between people to work with are regularly made, increasing the levels of stress but enlarging the gained clinical experience.

The knowledge about this profession before one can chose it is, if we only take into consideration the university courses, limited mostly to theory. The time allocated for the adult psychiatry and for neuropsychiatry courses is one semester each.

The way in which a medical specialty is chosen is based on a single exam. The exam consists in evaluating the general medicine knowledge accumulated in the 6 year training provided for becoming a medical doctor. No specific evaluation for medical abilities is offered before choosing a field for the future career.

Results:

The most used defensive mechanisms are superior ones with an underline on "altruism" and "self-observation" that have the highest scores. The scores of the defensive mechanisms evaluation with the DSQ-60 are showed in table 1.

With the exception of "rationalization", the first 8 mechanisms present in the sample studied are superior ones. "Rationalization" is a disavowal form of defense.

Table 1 – Scores for defensive mechanisms used

Altruism	447	Devaluation others	226
Self-observation	417	Denial	219
Self-assertion	379	Repression	217
Humor	375	Splitting other	211
Rationalization	350	Isolation	190
Anticipation	350	Passive aggression	176
Affiliation	341	Omnipotence	176
Suppression	338	Project Identification	175
Sublimation	308	Projection	159
Withdrawal	295	Idealization	152
Acting out	286	Complaining and rejecting help	150
Reaction formation	282	Fantasy	142
Undoing	265	Dissociation	141
Intellectualization	254	Splitting self	138

Displacement	237	Devaluation self	125

The results after applying the COPE scale are showed in table 2. The highest scores were found for "Positive interpretation and growth" - an emotion focused coping style and „Planning" – a problem focused coping style.

If we take into consideration the first 6 coping mechanisms used we can see that these are a mix between emotion focused ("Positive interpretation and growth", "Acceptance"), problem focused ("Planning", "Active approach") and social support ("Use of social-instrumental support" and "Use of social-emotional support") coping styles. If we try to see the scores to determine what factor for coping mechanisms is mostly used we discover that problem focused mechanisms have an average score of 365 and emotion focused ones, an average of 321 (these being the main two factors).

Table 2 – Scores for coping mechanisms used

Positive interpretation and growth	409	Expressing the emotions	297
Planning	404	Mental deactivation	259
Active approach	386	Humor	257
Use of social-instrumental support	372	Religious approach	221
Acceptance	353	Behavioral deactivation	190
Use of social-emotional support	347	Substance consumption	188
Deletion of concurrent activities	305	Denial	172
Restraint	301		

If we compare women and med we can see that the defense mechanisms differ. In the table 3 we see the commonly used defense mechanisms with their average scores for women and men.

Table 3 – Defense mechanisms for women and men

Women	Average scores	Men	Average scores
Altruism	14.70	Altruism	13.42
Self-observation	14	Self-assertion	11.71
Humor	12.45	Self-observation	11.57
Self-assertion	12.37	Withdrawal	11.57
Rationalization	11.83	Humor	10.85
Anticipation	11.70	Suppression	9.85
Affiliation	11.66	Anticipation	9.85
Suppression	11.20	Rationalization	9.42

In the case of the first four most used coping mechanisms, these remain the same for men and women.

Table 4 – Coping mechanisms for women and men

Women	Average scores	Men	Average scores
Positive interpretation and growth	13.16	Positive interpretation and growth	13.28
Planning	13.16	Planning	12.57
Active approach	12.66	Active approach	11.71
Use of social-emotional support	12.16	Use of social-emotional support	11.42

Conclusions and discussions:

Subjects are found to have primary superior defense mechanisms and mainly problem and emotion focused coping mechanisms.

Sex differences in coping and defense styles are subtle and not conclusive because of the low number of subjects studied. The sample is mainly formed from women. This raises the question if these discoveries are characteristic to women. The sex ratio also raises another question: why are there more women in this field of medicine? Is it just a coincidence for the studied lot or is it that women are more inclined to have the role of caregivers in our culture, an altruistic role, leading to the conclusion that altruism is a requirement for this profession, a conclusion suggested not only by the number of women but also by the main defense mechanism used by all subjects.

Psychiatric residents are under a lot of stress and, if financially a better remuneration exists for them, social support from co-workers does not seem to be encouraged in our country.

This article raises the question of what is it to be done with a professional good training if no investments are made in the personal area of a future psychiatrist. If the defense and coping styles are not proper then a program that provides abilities to strengthen this areas should be provided and if the defense and coping styles are superior, strategies of maintaining them should be taken into consideration.

Either way a program that builds a support for the future professionals in this area should be taken into consideration. To start such programs, one must know the standards for what makes a good physician, a good psychiatrist. This standardization begins with profiling.

This article is a good way to show how, in poor circumstances of training, residents in psychiatry select themselves in a very efficient way. From all the medical students that finished general medicine (what must have been a very vast and diverse range of coping and defense mechanisms) only some selected to continue studying psychiatry. How does this choice modify what seems to be a good starting point for them? Can this starting point be improved while gaining professional experience?

These are only some of the questions we tried to prepare the grounds for future ensures, in this article.

Limitations of the Study

The main and most important limit of this research is the low number of subjects studied with an uneven sex distribution. This prevents the possibility of a generalization of the information found.

The data collected are from just one clinical center in our country living the discussion about the common exposure to several factors of all residents in the study opened. It would be helpful to expand the research bidirectional: including other medical specialties and also expanding to other clinics or even other countries.

The lack of a control lot to compare our results to is also a limit to the present study. A control group would set a baseline for the cultural and sex particularities living the particularities do to the specific medical field evident.

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