

IDENTIFYING COPING MECHANISMS SPECIFIC TO NON-PSYCHOTIC MAJOR DEPRESSIVE DISORDER – USING THE ROMANIAN VERSION OF COPE QUESTIONNAIRE

DĂNUȚ IOAN CRAȘOVAN*,
Babeș-Bolyai University (UBB University Center in Reșița 1)

DELIA NICOLETA RAMONA CRAȘOVAN
Caritas Federation, Catholic Diocese Timișoara, Romania

Abstract

The identification of coping mechanisms typical to non-psychotic major depressive disorder was performed by comparing two samples, clinical (participants from psychiatric clinics from western Romania [Timișoara University Clinic of Psychiatry, Timișoara Stationary Psychiatry, the Psychiatry Department of the Municipal Hospital Lugoj, Psychiatry Clinics Arad, and Psychiatry Hospital Gătaia] and non-clinical. In order to identify coping mechanisms, the COPE Questionnaire elaborated by Carver, Scheier, Weintraub, (1989) was used, with the Romanian version being validated on a general sample (Crașovan, Sava, 2013). Thus, the identification of coping mechanisms specific to major depressive disorder without psychotic elements was performed by comparing two groups, clinically and non-clinically. The results indicate as specific to non-psychotic major depressive disorder the five following coping mechanisms: focus on and venting of emotions, religious coping, behavioral disengagement, substance use and acceptance. Through the results obtained, the study determines the in-depth understanding of coping mechanisms specific to patients diagnosed with non-psychotic major depressive disorder, an aspect considered important in increasing the effectiveness of psychotherapeutic treatment.

Cuvinte-cheie: coping mecanism, COPE, tulburare depresivă majoră fără elemente psihotice, diferențe de gen, analiza apărării psihice.

Keywords: coping mechanisms, COPE; non-psychotic major depressive disorder, gender differences; psychological defence analysis.

* Babeș-Bolyai University (UBB University Center in Reșița), 320085, Reșița, Traian Vuia Square, No. 1–4, Caraș-Severin District, Romania; E-mail: d.crasovan@uem.ro.

¹ Author's Note

This study represents the first use of the COPE Questionnaire after the translation, adaptation and validation of the questionnaire on Romanian population (Crașovan, Sava, 2013).

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1. INTRODUCTION

According to studies conducted over the past 10 years (Stiemerling, 2006, World Health Report, 2002) a significant increase in people diagnosed with mental disabilities in the early years of the 21st century was found. Thus, 28% of adults and 21% of the child population meet the criteria for the diagnosis of a complete mental disorder (Mental Health: A Report of the Surgeon General, 1999). Currently, it is estimated that 350 million people globally suffer from depression (World Mental Health Day, 2012), situation in which depression prevention alongside with its treatment, has become an important way to reduce the enormous public expenses caused by depression in the following years (Cuijpers, van Straten, Smit, Mihalopoulos & Beekman, 2008).

In this context, of a significant increase in the percentage of the general world population affected by mental disorders, by the development of depression in particular, a considerable increase can be seen in the interest of mental health and psychotherapy researchers in psychological defense analysis (Blackman, 2009; Carver, 1997; Cramer, 1991, 1998, 2006; Ionescu, Jacquet, Lhote, 2002). The interest for the analysis of psychological defense is still increasing considering the importance of this technique in psychotherapeutic intervention both for various psychopathological conditions and for subjects without psychiatric diagnosis. After identifying the defense panel of patients or subjects from the general population, it is possible to adapt the psychotherapy intervention or medication to their specifics, to prevent relapse by making patients aware of coping mechanisms with low or even absent efficiency and replacing them with effective, adaptive coping strategies (Ionescu *et al.*, 2002).

In the medicine and psychology literature the concept of coping has been usually related with strategies and mechanisms being the relevant adaptative means by which humans adapt to environment in a way that exceed normal adaptation of the body facing stress, for instance (Maricutoiu, Crașovan, 2016). Thus, compared to psychological defense mechanisms, characterized by a low level of adaptability and retroactive orientation, coping mechanisms are considered predominantly cognitive and behavioral psychic adaptation with a high level of efficiency and adaptability, respectively a proactive orientation.

Thus, some authors (Compas, Connor-Smith & Jaser, 2004; Crașovan, Tomici, 2014; McCrae, 1982; McCrae, 1984; Phelps & Jarvis, 1994; Ravindran, Griffiths, Waddell, Anisman, 1995) believe that, irrespective of the condition of the human subject, either in the case of psychopathological conditions, psychiatric diagnosis, or in the case of psychiatric and general medical normality, the efficiency of coping mechanisms in response to stress is mediated by factors such as: self-assessment of their own skills, life events, previous experiences, gender, motivation, parenting style, age and individual vulnerability.

Analyses of the reported results show the existence of contradictions on coping mechanisms identified as specific to depressive disorders. Regarding the

particularities of the depression coping process, Hewitt, Flett, Endlller (1995) found that depression is associated with emotion-oriented coping among men and, in contrast, among women, depression was negatively associated with task-oriented coping and avoidance. Holahan *et al.* (2005) proved that a baseline avoiding coping was a mechanisms linked to chronic and acute life stressors after 4 years of study, and after 10 years, that these stressors were connected to coping systems. Also, other authors (Brajković *et al.*, 2009) argue that coping mechanisms can help improve the quality of life for patients diagnosed with depression, when anxiety and fatigue are present together with multiple sclerosis. Other factors that may moderate and be moderated by stress responses and coping in their effects on depression are temperamental characteristics (Compas *et al.*, 2004), the type of coping strategies (Garnefski *et al.*, 2002), developmental age (Vannucci, Flannery & Ohannessian, 2018), mature coping strategies (Vaillant, 2011) and the link between patients and their therapists (D'Iuso, Dobson, Beaulieu & Drapeau, 2018).

Recently, results of a meta-analysis by Cuijpers (1998) on the impact of the "Coping With Depression" courses (the course is a cognitive behavioral treatment for unipolar depression) indicate that this course is an effective therapy for unipolar depression, with effect sizes that are comparable to those of other treatment modalities for depression, a fact noticed by other authors (Allart-van Dam, Hosman, Hoogduin & Schaap, 2007), who support the effectiveness of such courses in depression.

Related to this context the following two objectives were proposed: (1) *to identify specific coping mechanisms of non-psychotic major depressive disorder*; (2) *to identify gender differences at the level of the coping mechanisms used by the participants diagnosed with non-psychotic major depressive disorder*.

2. METHOD

2.1. PARTICIPANTS

The *clinical sample* ($N = 103$) used includes adult patients diagnosed with non-psychotic major depressive disorder assessed during the period August 2010–September 2014. Participants included in the study were hospitalized in university clinics and psychiatric hospitals in western Romania (Timișoara University Clinic of Psychiatry, Timișoara Stationary Psychiatry, Psychiatry Department of the Municipal Hospital Lugoj, Psychiatry Clinics Arad and Psychiatry Hospital Gătaia). The participation in the study was based on free will and informed consent. The development of the study assumed the application of the COPE Questionnaire (Crașovan, Sava, 2013; Carver *et al.*, 1989), the Beck Questionnaire (Beck, Rush, Shaw & Emery, 1979; Beck, Ward, Mendelson, 1981), the Zung Scale (Biggs, Wylie, Ziegler, 1978; Zung, 1965) and of the Demographic Questionnaire to a number of 124 subjects. Out of the total of 124 applied questionnaires, only 103 sets of answers were filled in and introduced in subsequent analyses.

Participants' eligibility criteria. Patients diagnosed with non-psychotic major depressive disorder (APA, 2000) without psychological comorbidity. The presence of depression is confirmed by the results obtained after the application of the Zung ($M_{Zung} = 66.11$, $SD_{Zung} = 11.90$) and Beck ($M_{Beck} = 28.77$, $SD_{Beck} = 12.33$) self-assessment scales; patients aged between 21 and 73.

The demographic characteristics of the participants were: 40.8% men and 59.2% women; an average age of 51.16 years (ranging from 21 to 73); most of them having not a university education (87.4%) and 12.6% of the participants had a graduate degree (college – three years; faculty – four, five or six years or master).

The *non-clinical sample* includes 770 participants (general population without the depressive disorders). In this case we applied the Romanian version (Crașovan, Sava, 2013) of COPE Questionnaire (Carver *et al.*, 1989) and the Demographic Questionnaire to a number of 800 subjects. Out of the total of 800 applied questionnaires 770 sets of answers were filled in and entered in subsequent analyses ($N = 770$).

The demographic characteristics of the participants from the general population were: 42.86% men and 57.14% women; an average age of 31.16 years (ranging from 18 to 66); most of them having a university education – college three years; faculty four, five or six years; master or doctoral (53.4%) and 46.6% of the participants did not have a university education.

2.2. INSTRUMENTS AND PROCEDURE

Demographic questionnaire used for the recording of demographic data and the participants' details.

The COPE Questionnaire. The last version of the COPE Questionnaire is a self-reporting instrument used for the evaluation of coping strategies elaborated by Carver *et al.*, (1989), with the Romanian version (Crașovan, Sava, 2013). The Questionnaire has 60 items, each of the 15 coping strategies is evaluated through 4 items. The answer can be measured on a scale from 1 to 4, in which: 1 – I usually don't do this; 2 – I rarely do this; 3 – I sometimes do this; 4 – I often do this. The rating is achieved by summing the scores from each one of the 4 items corresponding to each of the 15 coping mechanisms. The items have been used in at least 3 formats. One is a "dispositional" or trait-like version in which respondents report the extent to which they usually do the things listed, when they are stressed. A second is a time-limited version in which respondents indicate the degree to which they actually had each response during a particular period in the past. The third is a time-limited version in which respondents indicate the degree to which they have had each response during a period up to the present. The formats differ in their verb forms: the dispositional format is present tense, the situational-past format is past tense, the third format is present tense progressive (I am ...) or present perfect (I have been ...). By using an exploratory factorial analysis of individual scales of the COPE questionnaire, Carver *et al.*, (1989) have identified four factors: (1) *coping focalized on the problem* (affective approach,

planning and deletion of concurrent activities); (2) *coping focalized on emotions* (positive interpretation and growth, abstention, acceptance and religious approach); (3) *coping focalized on search for social support* (use of the social-instrumental support, the social-emotional support and focalizing on expressing emotions) and (4) *avoidance coping, for the problem or the associated emotions* (denial, mental and behavioral deactivation). Psychometric properties of the original version – the Alfa Cronbach Coefficient for the 15 scales is situated between .21 (mental deactivation) and .93 (seeking emotional support). The average value of the alpha coefficient for the 15 subscale is .74. In the Romanian version of COPE (Crașovan, Sava, 2013), the results support a solution with four correlated factors: problem focused coping, emotion focused coping, social support focused coping and avoidant coping. Psychometric properties of the Romanian version – the internal consistency values range between .72 to .84 for the 4-factor solution, and between .48 (restraint) to .92 (substance consumption), the average value of the alpha coefficient for the 15 subscales is .70 (Crașovan, Sava, 2013).

The Zung Scale (Biggs, Wylie, Ziegler, 1978; Zung, 1965) is a depression self-assessment scale with a higher degree of probability in measuring the patient's mirroring of his/her dominant emotional experience than a scale evaluated by an observer. The Zung Scale has 20 items and a score range from 1 to 4 (with 1 – being low agreement, symptoms present rarely or never; 4 – strong agreement, symptoms present most of the time or all the time). This scale determines the following degrees of depression: 0–50 absence of depression, 50–60 mild depression, 60–70 average depression, 70 severe depression. The Zung Scale was standardized on the population of New Zealand, having an internal consistency of 0.79. Cronbach's Alpha coefficient has the value of .80 on Romanian clinic population (Crașovan, 2014).

The Beck Questionnaire (Beck, Rush, Shaw & Emery, 1979; Beck, Ward, Mendelson, 1981). The Beck Questionnaire is a 21-item designed to measure the presence of depression in adults and adolescents. Each of the 21 items assesses a symptom or attitude specific to depression, inquiring its somatic, cognitive and behavioural aspects. For each item the participant may receive between 0 and 3 points, the minimum score is 0, maximum score is 3. By its assessments, single scores are produced, which indicate the intensity of the depressive episode. The Beck Questionnaire scores ranging: 0 to 9 represent normal levels of depression; between 10 and 18 represent mild to moderate depression; between 19 and 29 represent moderate to severe depression; scores above the value of 30 represent severe depression. Internal consistency indices of the BDI are usually above .90. Cronbach's Alpha coefficient has the value of .90 on Romanian clinic population (Crașovan, 2014).

As regards the application procedure on clinical population, the eligible participants were informed of the purpose of the research and their informed consent was requested, while the Demographic Questionnaire, Beck Scale, Zung Scale and Defence Style Questionnaire – 60/DSQ (Romanian version [Crașovan, Sava, 2013]) were subsequently applied in the presence of a research assistant

(patients either completed the questionnaires themselves in the presence of the research assistant or, if the patients did not understand the items, the research assistant provided explanations regarding the meaning of the items).

Data analysis was run using the factorial Anova method (bifactorial) under the statistic program of data analysis PowerStaTim 1.0 (Sava, Maricuțoiu, 2007) and SPSS 16th version (Howitt, Cramer, 2010).

2.3. DESIGN

In this situation the study has a non-experimental design, where independent variables are not manipulated and the relationship between independent variables and the dependent variable is only potentially causal. Independent variables: (1) group type: clinical and non-clinical; (2) gender: men and women. Dependent variables: coping mechanisms (COPE).

3. RESULTS

In that case the tests performed with 2×2 factorial ANOVA method for each dependent variable (coping mechanisms) identified main effects and/or interaction of the two independent variables (type of group participants and gender participants) for 11 of the 15 coping mechanisms operationalized with COPE (see Tables no. 1, 2 and 3): positive reinterpretation and growth (group effect), focus on and venting of emotions (group effect and gender effect), use of instrumental social support (group effect), active coping (group effect), religious coping (group effect and gender effect), humor (group effect), behavioral disengagement (group effect, gender and interaction effect), use of emotional social support (gender effect), substance use (group effect, gender and interaction effect), acceptance (group effect) and planning (group effect).

Table no. 1

Mean and standard deviation for the 15 coping mechanisms for both non-clinical group (N = 770) and clinical group (N = 103), as well as between men and women in the two groups

<i>coping mechanisms</i>	(men + women)				men				women			
	non-clinical sample		clinical sample		non-clinical sample		clinical sample		non-clinical sample		clinical sample	
	N = 770		N = 103		N = 330		N = 42		N = 440		N = 61	
	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD
1) Positive reinterpretation and growth	12.58	2.19	10.90	2.80	12.43	2.11	10.83	3.20	12.69	2.25	10.95	2.53
2) Mental disengagement	9.64	2.69	9.36	2.53	9.24	2.59	9.36	2.51	9.94	2.73	9.36	2.56
3) Focus on and venting of emotions	9.64	2.72	10.91	2.97	9.24	2.61	10.40	2.93	9.94	2.76	11.26	2.97

Table no. 1 (continued)

coping mechanisms	(men + women)				men				women			
	non-clinical sample		clinical sample		non-clinical sample		clinical sample		non-clinical sample		clinical sample	
	N = 770		N = 103		N = 330		N = 42		N = 440		N = 61	
	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD
4) Use of instrumental social support	12.09	2.69	11.41	3.45	11.95	2.57	11.33	3.57	12.19	2.78	11.46	3.39
5) Active coping	12.09	2.38	11.16	2.98	12.06	2.22	11.24	2.84	12.11	2.49	11.10	3.10
6) Denial	7.78	2.56	7.96	2.67	7.88	2.54	8.17	2.62	7.71	2.57	7.82	2.71
7) Religious coping	11.95	3.66	13.41	3.43	11.36	3.65	12.45	4.29	12.38	3.61	14.07	2.52
8) Humor	9.24	3.56	6.70	3.36	9.33	3.46	7.24	3.71	9.17	3.63	6.33	3.08
9) Behavioral disengagement	7.82	2.51	9.59	2.74	7.74	2.56	8.69	2.27	7.88	2.46	10.21	2.88
10) Restraint	10.59	2.31	10.98	2.56	10.51	2.30	10.74	2.65	10.65	2.32	11.15	2.50
11) Use of emotional social support	10.93	3.05	10.87	3.60	10.40	2.86	10.36	3.67	11.33	3.13	11.23	1.53
12) Substance use	5.00	2.42	5.57	3.29	5.27	2.54	7.36	4.39	4.80	2.31	4.34	1.20
13) Acceptance	10.83	2.84	11.96	3.10	10.69	2.87	11.55	3.46	10.93	2.81	12.25	2.82
14) Suppression of competing activities	11.10	2.51	10.90	2.99	11.17	2.52	10.64	3.45	11.05	2.50	11.08	2.65
15) Planning	12.62	2.60	11.61	2.75	12.59	2.51	11.74	2.69	12.65	2.68	11.52	2.82

Table no. 2

Summary of analysis of variance for the 15 coping mechanisms (COPE)

coping mechanisms	source of variation	sum of squares	df	mean square	F	p
1. Positive reinterpretation and growth	grup	243.937	1	243.937	47.13	< .001
	gen	3.154	1	3.154	0.60	
	grup*gen	0.455	1	0.455	0.08	
	eroare	4.497,78	869	5.176		
2. Mental disengagement	grup	4.935	1	4.935	0.69	
	gen	10.713	1	10.713	1.51	
	grup*gen	10.498	1	10.498	1.48	
	eroare	6.162,91	869	7.092		
3. Focus on and venting of emotions	grup	135.64	1	135.64	18.15	< .001
	gen	53.56	1	53.56	7.17	
	grup*gen	0.519	1	0.519	0.07	
	eroare	6.491,59	869	7.47		
4. Use of instrumental social support	grup	39.87	1	39.87	5.10	< .05
	gen	2.97	1	2.97	0.38	
	grup*gen	0.29	1	0.29	0.03	
	eroare	6.782,56	869	7.805		

Table no. 2 (continued)

coping mechanisms	source of variation	sum of squares	df	mean square	F	p
5. Active coping	grup	73.91	1	73.91	12.19	< .01
	gen	0.20	1	0.20	0.03	
	grup*gen	0.73	1	0.73	0.12	
	eroare	5.266,67	869	6.061		
6. Denial	grup	3.60	1	3.60	0.54	
	gen	5.61	1	5.61	0.84	
	grup*gen	0.78	1	0.78	0.11	
	eroare	5.778,59	869	6.65		
7. Religious coping	grup	170.12	1	170.12	13.10	< .01
	gen	153.82	1	153.82	11.85	
	grup*gen	7.40	1	7.40	0.57	
	eroare	11.277,45	869	12.97		
8. Humor	grup	532.68	1	532.68	42.51	< .001
	gen	24.84	1	24.84	1.98	
	grup*gen	12.59	1	12.59	1.01	
	eroare	10.888,56	869	12.53		
9. Behavioral disengagement	grup	236.32	1	236.32	37.04	< .001
	gen	60.70	1	60.70	9.51	
	grup*gen	42.04	1	42.04	6.59	
	eroare	5.544,16	869	6.38		
10. Restraint	grup	11.26	1	11.26	2.04	
	gen	6.18	1	6.18	1.12	
	grup*gen	1.82	1	1.82	0.33	
	eroare	4.794,78	869	5.51		
11. Use of emotional social support	grup	0.46	1	0.46	0.04	< .01
	gen	71.53	1	71.53	7.48	
	grup*gen	0.07	1	0.07	0.01	
	eroare	8.303,18	869	9.55		
12. Substance use	grup	58.61	1	58.61	9.49	< .01
	gen	264.90	1	264.90	42.96	
	grup*gen	143.31	1	143.31	23.22	
	eroare	5362.66	869	6.17		
13. Acceptance	grup	103.41	1	103.41	12.55	< .001
	gen	18,94	1	18.94	2.30	
	grup*gen	4.81	1	4.81	0.58	
	eroare	7.157,06	869	8.23		
14. Suppression of competing activities	grup	5.53	1	5.53	0.83	
	gen	2.08	1	2.08	0.31	
	grup*gen	7.14	1	7.14	1.07	
	eroare	5.756,68	869	6.62		
15. Planning	grup	85.33	1	85.33	12.36	< .001
	gen	0.53	1	0.53	0.07	
	grup*gen	1.61	1	1.61	0.23	
	eroare	5.995,97	869	6.90		

Table no 3

Presence of main effects and interaction effects for both independent variables (gender and group), effect size (partial Eta squared – η_p^2), statistical power (reported at alpha .05) and statistical significance. for the 15 coping mechanisms

<i>coping mechanisms</i>	gender effect (men/ women)	group effect (clinical/non-clinical)	interaction effect (gender *group)
1) Positive reinterpretation and growth			
2) Mental disengagement			
3) Focus on and venting of emotions	$\eta_p^2 = .01$, st. power = .76, $p < .01$	$\eta_p^2 = .02$, st. power = .98, $p < .001$	
4) Use of instrumental social support			
5) Active coping			
6) Denial			
7) Religious coping	$\eta_p^2 = .01$, st. power = .93, $p < .01$	$\eta_p^2 = .02$, st. power = .95, $p < .001$	
8) Humor			
9) Behavioral disengagement	$\eta_p^2 = .01$, st. power = .86, $p < .01$	$\eta_p^2 = .04$, st. power = .99, $p < .001$	$\eta_p^2 = .01$, st. power = .72, $p < .05$
10) Restraint			
11) Use of emotional social support	$\eta_p^2 = .01$, power = .78, $p < .01$		
12) Substance use	$\eta_p^2 = .05$, st. power = .99, $p < .001$	$\eta_p^2 = .01$, st. power = .86, $p < .01$	$\eta_p^2 = .03$, st. power = .99, $p < .001$
13) Acceptance		$\eta_p^2 = .01$, st. power = .94, $p < .001$	
14) Suppression of competing activities			
15) Planning			

4. DISCUSSION AND CONCLUSIONS

In this case, for the first objective of the study, the statistical analysis revealed significant effects (differences) between the clinical and non-clinical groups following 11 coping mechanisms of the 15 coping mechanisms operationalized with COPE: focus on and venting of emotions, religious coping, behavioral disengagement, substance use, acceptance, positive reinterpretation and growth, use of instrumental social support, active coping, humor, use of emotional social support and planning.

The other coping mechanisms streamlined with COPE, namely mental disengagement, denial, restraint and suppression of competing activities, were

removed from subsequent analysis due to their failure to produce significant effects, or interaction effects, and are not considered specific coping mechanisms for non-psychotic major depressive disorder, as their non-clinical group average result tops the clinical group's.

Subsequently, analyzing statistical data obtained using ANOVA 2×2 factorial method (in the presence of main effect for group-participants) and descriptive statistics (the average of the two groups, clinical and non-clinical) for the 11 coping mechanisms listed previously, it was found that a number of 5 coping mechanisms are identified as specific to the clinical group based on the presence of main effects (for the group), namely on statistically significant superiority of the clinical group average compared to the non-clinical group (see Tables no. 2 and 3).

Reporting the effect size and statistical power (with the reference values given by: Popa, 2008; Sava, Maricuțoiu, 2007) for the coping mechanisms analyzed, a total of 5 coping mechanisms have been identified as typical of non-psychotic major depressive disorder, balanced by an acceptable degree of effect size and statistical power in relation to the authors mentioned, namely: *focus on and venting of emotions* (coping mechanism also identified in depressive disorders by Ravindran, Matheson, Griffiths, Merali & Anisman, 2002), *religious coping*, *behavioral disengagement*, *substance use* (mechanism identified in men diagnosed with depressive disorders in the form of alcohol abuse by Angst, Gamma, Gastpar, Lépine, Mendlewicz & Tylee, 2002) and *acceptance*. In these conditions, in the case of the first objective of this research, statistically significant differences have been recorded only for the 5 coping mechanisms described so far.

With a .04 effect size value as the criterion for delimiting coping mechanisms, out of 5 coping mechanisms only the following may be considered relevant for the present discussion of coping mechanisms (see Tables no. 2 and 3): behavioral disengagement approaching the threshold set, specifying behavioral disengagement as a coping mechanism for the clinical group, which consists even in the subject's general withdrawing from daily activities and maintaining only the minimum behaviors necessary for survival. In severe cases even this minimal acting level does not exist, with support and medical interventions through medication or psychotherapy being necessary.

Regarding the second objective of the study, namely to identify gender differences in the coping mechanisms used by participants diagnosed with major depressive disorder without psychotic features, the statistical analysis identified statistically significant effects (differences) between men and women for the following five coping mechanisms of the 15 operationalized by COPE and taken into consideration: *focus on and venting of emotions*, *religious coping*, *behavioral disengagement*, *use of emotional social support* and *substance use*. Of the five coping mechanisms, the ones considered to be specific to women diagnosed with major depressive disorder are focus on and venting of emotions, religious coping (mechanism also reported as specific to women diagnosed with depressive disorders by

Angst *et al.* [2002]), behavioral disengagement and use of emotional social support (identified in women diagnosed with depressive disorders by Nolen-Hoeksema & Aldao [2011] and by Angst *et al.* [2002]) in the presence of main effects in the patients' gender, namely statistically significant superiority of women in the clinical group compared to the men in the clinical group. Instead, substance use (also reported as specific for men diagnosed with depressive disorders in the form of alcohol abuse Angst *et al.* [2002]) is the only coping mechanism specific to the men from the clinical group, substance use being used with greater frequency and intensity by the men from the clinical group compared to women from the clinical group. In the effect of the gender, of the 5 coping mechanisms identified, only substance use has the fixed minimum value of the size of minimum effect .04 (see Tables no. 3), situation in which other coping mechanisms identified as gender-specific to participants from the clinical group remain specific to patients diagnosed with major depressive disorder without psychotic features but with reserves related to the low effect size.

Interaction effects, which are expected to be weaker than the main effects, are present in the behavioral disengagement level and substance use; patient gender influences the type and intensity of use of the two coping mechanisms, such that the group and gender of participants diagnosed with non-psychotic major depressive disorder causes a combined effect to be greater than the gender or group of patients separately. In this context of interaction, behavioral disengagement is used at a greater intensity by women diagnosed with non-psychotic major depressive disorder, and substance use is used with higher intensity by men diagnosed with non-psychotic major depressive disorder. Of course, these two mechanisms of coping, in which the interaction effect is present, are also subject to a low, small, value of the effect size.

As it can be seen, there is an overlay of four of the five coping mechanisms identified as specific both in the effect of the group as well as in the effect of the gender, the following four coping mechanisms are present both for the group effect and the gender effect: focus on and venting of emotions, religious coping, behavioral disengagement and substance use. Thus, the acceptance remains specific only in the group effect and the use of emotional social support only in the gender effect for the clinical group.

Another observation indicates the presence of behavioral disengagement and substance use as coping mechanisms present in all three situations, namely at the level of the group effect, gender effect (coping mechanism specific only to the men from the clinical group) and interaction, and having a low value of the size medium effect.

Finally, it can be concluded that the study results are only partially supported by the results of other studies. Thus, focus on and venting of emotions, religious coping and substance use have been reported as specific to depressive disorders by Ravindran *et al.* (2002) and Angst *et al.* (2002). Also, some of the coping mechanisms identified as specific to the women from the clinical group were reported by other

authors, namely use of emotional social support (Nolen-Hoeksema & Aldao, 2011, Angst *et al.*, 2002), religious coping (Angst *et al.*, 2002) and substance use was reported as a coping mechanism specific to men diagnosed with depressive disorders (Angst *et al.*, 2002).

In terms of the size of the effect and of statistical power, the existence of a value of average effect size – low for all coping mechanisms identified as specific for three situations (group effect, gender and interaction) can be observed, at the same time with the existence of a high statistical power.

In conclusion, the following five coping mechanisms may be considered as specific to non-psychotic major depressive disorder: focus on and venting of emotions, religious coping, behavioral disengagement, substance use (these four coping mechanisms are also present at the level of gender effect) and acceptance.

The results of the study, insofar as they will be validated by other similar studies, will allow the efficiency of psychotherapeutic intervention in the treatment of patients diagnosed with non-psychotic major depressive disorder by optimizing mental adaptation and coping mechanisms.

Obviously, the study also has limitations, especially related to the small number of patients included in the clinical group. On the other hand, the way in which the patients' questionnaires were applied in the presence of the research assistant, respectively some patients read and understood the meaning of the items while in other patients it was explained by the research assistant.

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REFERENCES

1. ANGST, J., GAMMA, A., GASTPAR, M., LÉPINE, J.P., MENDLEWICZ, J., & TYLEE, A., *Gender differences in depression*, European archives of psychiatry and clinical neuroscience, **252**, 5, 2002, p. 201–209, DOI 10.1007/s00406-002-0381-6.
2. AMERICAN PSYCHIATRIC ASSOCIATION, *Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition, Washington, DC, American Psychiatric Association, 2000.
3. ALLART-VAN DAM, E., HOSMAN, C.M.H., HOOGDUIN, C.A.L., & SCHAAP, C.P.D.R., *Prevention of depression in subclinically depressed adults: follow-up effects on the 'Coping with Depression' course*, Journal of Affective Disorders, **97**, 1, 2007, p. 219–228, doi.org/10.1016/j.jad.2006.06.020.
4. BECK, A.T., RUSH, A.J., SHAW, B.F., & EMERY, G., *Cognitive Therapy of Depression*, New York, The Guilford Press, 1979.
5. BECK, A.T., WARD, C.H., MENDELSON, M., *An inventory for measuring depression*, Arch.Gen.Psychiatry, **4**, 1981, p. 561–571, doi:10.1001/archpsyc.1961.01710120031004.
6. BIGGS, J.T., WYLIE, L.T., ZIEGLER, V.E., *Validity of the Zung Self-rating Depression Scale*, British of the Journal of Psychiatry, **132**, 1978, p. 381–385, DOI:10.1192/bjp.132.4.381.
7. BLACKMAN, J.S., *101 defenses: How the mind shields itself*, Routledge, 2004.
8. BRAJKOVIĆ, L., BRAS, M., MILUNOVIĆ, V., BUSIĆ, I., BOBAN, M., LONCAR, Z., MICKOVIĆ, V., GREGUREK, *The connection between coping mechanisms, depression, anxiety and fatigue in multiple sclerosis*, Collegium antropologicum, **12**; 33 Suppl 2, 2009, p. 135–40, <http://www.collantropol.hr/>

9. CARVER, C.S., SCHEIER, M.F., & WEINTRAUB, J.K., *Assessing coping strategies: A theoretically based approach*, Journal of Personality and Social Psychology, **56**, 1989, p. 267–283, doi:10.1037/0022-3514.56.2.267.
10. CARVER, C.S., *You want to measure coping but your protocol's too long: Consider the Brief COPE*, International Journal of Behavioral Medicine, **4**, 1997, p. 92–100, DOI: 10.1207/s15327558ijbm0401_6.
11. CRAMER, P., *Development of defense mechanisms: Theory, research, and assessment*, New York: Springer-Verlag, 1991.
12. CRAMER, P., *Coping and Defense Mechanisms: What's the Difference?* Journal of Personality, **66**, 1998, p. 919–946, DOI: 10.1111/1467-6494.00037.
13. CRAMER, P., *Protecting the self: Defense mechanisms in action*, New York, NY, The Guilford Press, 2006.
14. COMPAS, B.E., CONNOR-SMITH, J., & JASER, S.S., *Temperament, stress reactivity, and coping: Implications for depression in childhood and adolescence*, Journal of Clinical Child and Adolescent Psychology, **33**, 1, 2004, p. 21–31, DOI: 10.1207/S15374424JCCP3301_3.
15. CRAȘOVAN, D.I., *Psychological defense mechanisms associated with dysfunctional attitudes in non-psychotic major depressive disorder*, Cognition, Brain, Behavior. An Interdisciplinary Journal, **XVIII**, 1, 2014, p. 39–55, ISSN: 1224-8398.
16. CRAȘOVAN, D.I., TOMICI, D., *Psychological adaptive mechanisms in homeless people – a study carried out on people in the Caritas Federation Night Shelter, Catholic Diocese Timișoara, România în RAȚĂ*, G., and RUNCAN, P.L. (Eds), *Social Issues*, Newcastle upon Tyne, UK: Cambridge Scholars Publishing, ISBN (10): 1-4438-5676-2, ISBN (13): 978-1-4438-5676-8, 2014.
17. CRAȘOVAN, D.I., & SAVA, A.F., *Translation, adaptation and validation on Romanian population of COPE Questionnaire for coping mechanisms analysis*, Cognition, Brain, Behavior, An Interdisciplinary Journal, **XVII**, 1, 2013, p. 61–76. ISSN: 1224-8398,
18. CUIJPERS, P., *A psychoeducational approach to the treatment of depression: A meta-analysis of lewinsohn's "coping with depression" course*, Behavior Therapy, **29**, 3, 1998, p. 521–533, DOI.org/10.1016/S0005-7894(98)80047-6.
19. CUIJPERS, P., VAN STRATEN, A., SMIT, F., MIHALOPOULOS, C., & BEEKMAN, A., *Preventing the onset of depressive disorders: a meta-analytic review of psychological interventions*, American Journal of Psychiatry, **165**, 10, 2008, p. 1272–1280, DOI: 10.1176/appi.ajp.2008.07091422.
20. D'USO, D.A., DOBSON, K.S., BEAULIEU, L., & DRAPEAU, M., *Coping and interpersonal functioning in depression*, Canadian Journal of Behavioural Science/Revue canadienne des sciences du comportement, **50**, 4, 2018, p. 248–255, http://dx.doi.org/10.1037/cbs0000112.
21. GARNEFSKI, N., LEGERSTEE, J., KRAAIJ, V., VAN DEN KOMMER, T., & TEERDS, J.A.N., *Cognitive coping strategies and symptoms of depression and anxiety: A comparison between adolescents and adults*, Journal of Adolescence, **25**, 6, 2002, p. 603–611, http://dx.doi.org/10.1006/jado.2002.0507.
22. HEWITT, P.L., FLETT, G.L., ENDLLER, N.S., *Perfectionism, Coping, and Depression Symptomatology in a Clinical Sample*, Clinical Psychology and Psychotherapy, **2**, 1, 1995, p. 47–58, DOI: 10.1002/cpp.5640020105.
23. HOLAHAN, C.J., MOOS, R.H., HOLAHAN, C.K., BRENNAN, P.L., & SCHUTTE, K.K., *Stress generation, avoidance coping, and depressive symptoms: A 10-year model*, Journal of Consulting and Clinical Psychology, **73**, 4, 2005, p. 658, doi.org/10.1037/0022-006X.73.4.658.
24. HOWITT, D., & CRAMER, H., *Introducere în SPSS pentru psihologie [Introduction to SPSS for Psychology]*, 16th version, Iași, Editura Polirom, 2010.
25. IONESCU, Ș., JACQUET, C.-L., & LHOTE C., *Mecanisme de apărare. Teorie și aspecte clinice* [Defense mechanisms. Theory and clinical aspects], Iași, Editura Polirom, 2002.
26. MARICUȚOIU, L.P. AND CRAȘOVAN, D.I., *Coping and defence mechanisms: What are we assessing?* International Journal of Psychology, **51**, 2016, p. 83–92 (Epub 2014 Nov 22), https://doi.org/10.1002/ijop.12113.
27. MCCRAE, R.R., *Age differences in the use of coping mechanisms*, Journal of Gerontology, **37**, 1982, p. 454–460, doi.org/10.1093/geronj/37.4.454.
28. MCCRAE, R.R., *Situational determinants of coping responses: Loss, threat, and challenge*, Journal of Personality and Social psychology, **46**, 1984, p. 919–928, doi.org/10.1037/0022-3514.46.4.919.

29. Mental Health: A Report of the Surgeon General, (1999). Downloaded at 21.05.2010, from <http://minority-health.pitt.edu/archive/00000867/01/nbbhs.pdf>.
30. NOLEN-HOEKSEMA, S., & ALDAO, A., *Gender and age differences in emotion regulation strategies and their relationship to depressive symptoms*, Personality and Individual Differences, **51**, 6, 2011, p. 704–708. doi.org/10.1016/j.paid.2011.06.012.
31. PHELPS, S.B., & JARVIS, P.A., *Coping in adolescence: empirical evidence for a theoretically based approach to assessing coping*, Journal of Youth and Adolescence, **23**, 1994, p. 359–372, doi.org/10.1007/BF01536724.
32. POPA, M., *Statistică pentru psihologie. Teorie și aplicații SPSS [Statistics for Psychology. Theory and Applications SPSS]*, Iași, Editura Polirom, 2008.
33. RAVINDRAN, A.V., GRIFFITHS, J., WADDELL, C., ANISMAN, H., *Stressful life events and coping styles in relation to dysthymia and major depressive disorder: Variations associated with alleviation of symptoms following pharmacotherapy*, Progress in Neuro-Psychopharmacology and Biological Psychiatry, **19**, 4, 1995, p. 637–653, doi.org/10.1016/0278-5846(95)00108-8.
34. RAVINDRAN, A.V., MATHESON, K., GRIFFITHS, J., MERALI, Z., & ANISMAN, H., *Stress, coping, uplifts, and quality of life in subtypes of depression: a conceptual frame and emerging data*, Journal of affective disorders, **71**, 1, 2002, p. 121–130, doi.org/10.1016/S0165-0327(01)00389-5.
35. SAVA, F., & MARICUȚOIU, L.-P., *PowerStaTim. Manualul utilizatorului [PowerStaTim. User's Manual]*, Timișoara, Editura Universității de Vest, 2007.
36. STIEMERLING, D., *10 abordări psihoterapeutice ale depresiei [10 Wege aus der Depression]*, București, Editura Trei, 2006.
37. VAILLANT, G.E., *Involuntary coping mechanisms: a psychodynamic perspective*, Dialogues in clinical neuroscience, **13**, 3, 2011, p. 366–370, DOI: 10.4103/0973-1229.77430.
38. VANNUCCI, A., FLANNERY, K.M., & OHANNESSIAN, C.M., *Age-varying associations between coping and depressive symptoms throughout adolescence and emerging adulthood*, Development and psychopathology, **30**, 2, 2018, p. 665–681, doi.org/10.1017/S0954579417001183.
39. WORLD MENTAL HEALTH DAY, *DEPRESSION: A Global Crisis*, Downloaded at 03.01.2013, from www.wfmh.org/00WorldMentalHealthDay.htm/2012.
40. World Health Report. *Reducing Risks, Promoting Healthy Life*. Geneva: WHO, 2002, www.who.int/whr/2000/en/.
41. ZUNG, W.W., *A Self-Rating Depression Scale*, Archives of General Psychiatry, **12**, 1965, p. 63–70, DOI: 10.1001/archpsyc.1965.01720310065008.

REZUMAT

Obiectivul principal al studiului vizează identificarea mecanismelor de coping specifice tulburării depresive majore fără elemente psihotice, respectiv decelarea diferențelor de gen privind mecanismele de coping utilizate de pacienții diagnosticați cu tulburare depresivă majoră fără elemente psihotice. Studiul a fost realizat pe două grupuri, clinic (în clinici de psihiatrie din vestul României [Clinica Universitară de Psihiatrie Timișoara, Staționarul de Psihiatrie Timișoara, Departamentul de Psihiatrie din cadrul Spitalului Municipal Lugoj, Clinica de Psihiatrie Arad și Spitalul de Psihiatrie Gataia] și nonclinic). În acest scop a fost utilizat Chestionarul COPE (Carver *et al.*, 1989), versiunea tradusă, adaptată și validată pe eșantion românesc (Crașovan, Sava, 2013). Rezultatele obținute identifică următoarele cinci mecanisme de coping ca specifice tulburării depresive majore fără elemente psihotice: focalizare pe exprimarea emoțiilor, coping religios, dezangajare comportamentală, consum de substanțe și acceptare. Totodată, identificarea modalităților de coping specifice tulburării depresive majore fără elemente psihotice determină creșterea eficienței intervenției psihoterapeutice prin optimizarea modalităților de coping utilizate de pacienții cu acest tip de tulburare depresivă în mod specific prin înlocuirea mecanismelor de coping cu eficiență adaptativă redusă cu mecanisme de coping cu eficiente adaptativă ridicată.

EMOTIONAL COPING ACCROSS GENDERS DURING THE PANDEMIC TIMES

LAVINIA ȚÂNCULESCU-POPA*

Hyperion University, Faculty of Psychology and Educational Sciences Department of Psychology;
National University of Political Studies and Public Administration, Communication and Public Relations
Department; Transilvania University of Braşov, Faculty of Psychology and Education Sciences

Abstract

The current study, conducted during the first months of pandemic lockdown (March – April 2020) among general population in Romania (N = 476), examined how men and women differ with regards to the four emotional coping strategies described by Carver, Scheier, & Weintraub (1989). Multivariate analysis of variance showed that statistically significant differences exist between men and women on coping focalized on emotions when analyzed jointly. Additionally, significant differences were shown at the religious approach and at the positive interpretation and growth level between men and women, whereas at the restraint and acceptance level there were no significant differences between the studied groups. These findings are in line with the current literature related to individual differences between boys and girls, men and women. The results also add value to understanding how various approaches can be proposed in a particularized, not gender stereotyped manner, for women and men, not only in the organizations, but also in the family and in managing self in medical crisis situations.

Cuvinte-cheie: coping de natură emoțională, coping bazat pe apelul la religie, coping prin interpretare pozitivă și dezvoltare, diferențe de gen, SARS-CoV-19.

Keywords: emotional coping, religious approach, positive interpretation and growth, gender differences, SARS-CoV-19.

1. INTRODUCTION

The construct of gender role, the social role theory, the role congruity theory are just few of the literature references that speak about genders related prejudices and stereotypes about a social group that is incongruent with the attributes that are thought to be required for success in certain classes of social roles (Eagly & Karau, 2002). Still, the fact that, in some circumstances, there are differences between men and women, is a reality. Sometimes, tailoring the approach for men and women could be the answer to a lot of possible problems in organizations, in particular and

* Hyperion University, Faculty of Psychology and Educational Sciences Department of Psychology, Calea Călărașilor 169, Sector 3, București (România), 030615, E-mail: lavinia.tanculescu@thewings.ro

in life, in general. Let's take the psychology of consumer behavior for example. Studies have shown that women are more sensitive to price than men (Kraljević & Filipovic, 2017) and have higher levels of brand commitment, hedonic consumption and impulse buying in comparison to men (Tifferet & Herstein, 2012). In organizations, for example, women may be expected to engage in communal forms of citizenship (e.g., altruism; Heilman & Chen, 2005) and was shown that women assign greater importance to CSR than men (Lämsä *et al.*, 2008). In civic virtue case, as Chiaburu *et al.* (2014) presented, is more expected from male employees than from female employees by activating gender stereotypes, whereas other authors suggest that the altruism, courtesy, sportsmanship and civic virtue are related to gender stereotypes (Kidder & McLean Parks, 2001).

Still, one of the most important factor to be taken into consideration would be the social context in which one or another gender role are manifested and what could be categorized as stereotype bias regarding to either one of the gender.

In the context of a complex crisis, such as the pandemic crisis generated by the outbreak of SARS-CoV-2 in December 2019, various levels of an individual are triggered and/or required to be activated. The gender role or personality differences are not the only ones explaining the dissimilarities between men and women.

In this study we suggest that the crisis differentiate between the manner of emotional responses of men and women. Also, we suggest that this is a natural type of response rather than a cultural one and that, in light of the results of the current study, both men and women could contribute and act differently to managing the associated stress level felt in connection with the new conditions imposed by the crisis.

1.1. DIFFERENCES BETWEEN MEN AND WOMEN AND THEIR IMPACT ON EMOTIONAL COPING IN THE PANDEMIC SITUATION

A rapid development of a body of literature talking about the impact of the 2020 pandemic situation is happening. Among those studies, an increased interest is seen in understanding the pandemic from the individual differences point of view, including gender (Chang, 2020) to reduce the "gender inequality" that the crisis generated (Holtsberg, 2020).

Even if women were shown to have been impacted financially, economically, and socially uniquely, from the disease incidence and lethality their situation is better than the one of men, given the proof of a more rules compliance and protective behaviour (e.g., hand-washing), which greatly reduced the chance of infection (Chang, 2020).

In May 2020, the British Broadcasting Corporation (BBC) drew a typology including seven type of women mostly affected by the results of the pandemic situation, in an attempt to help understand how differences between men and women can be managed ahead of time and in a dedicated way in each country.