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Applied Social Sciences: Psychology, Physical Education and Social Medicine

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FOREWORD

With an interdisciplinary approach, this volume combines the contributions of researches preoccupied with clarifying some of the most relevant changes in Romanian social realities.

The chapters included in *Applied Social Sciences: Psychology, Physical Education and Social Medicine* were presented at the first ISSA Conference held in Timişoara in June 18–20, 2012 organized by the Faculty of Sociology and Psychology (Department of Social Work) of the West University of Timişoara (Romania), together with the Faculty of Political Sciences, Philosophy and Communication Sciences.

The ISSA Conference and this book give an example of how we can get together on the field of social sciences, in a constructive way, through a genuine interdisciplinary model, refusing the "ownership of land." This forum has tried to build a "union bridge" in a necessary field of debate from different perspectives.

The book is structured in three chapters, each of them belonging to a specific area of discipline, combining qualitative with quantitative approaches and theoretical synthesis with field studies. The most important research fields include developmental psychology, methodology of applied psychology, educational psychology, physical education and social medicine.

In the chapter dedicated to Psychology, various topics are investigated with a significant methodological and conceptual impact on understanding contemporary personality changes, such as deviant behaviours of adolescents, clinical implications of psychotherapeutic approaches, a cross-cultural presentation of the educational field, validation of specific psychological scales, cross-cultural approaches in education, the intergenerational backgrounds of societies that have experimented totalitarian trauma, and personality dynamics in the virtual networks.

In the chapter dealing with issues in the field of Physical Education and Sport, different aspects of sport performance optimization in individual and group conditions, inside of different sport disciplines (athletics, gymnastics, volley, swimming and so on) are presented, together with the particularities of interpersonal interaction from sport environments.

The chapter associated with Social Medicine deals with a series of topics operating with a consistent repertoire of techniques and methods of analysis such as workplace health, risk factors for different diseases, discrimination against HIV patients, interrelation between different types of pathologies and relational patterns in which are inserted subjects, the impact of structural factors (like the economic crisis) toward public health, the efficacy of community health assistance for elderly people, and so on.

This book offers a theoretical and practical support for many types of professionals involved in clarifying the forms of social and individual pathology, but also interested in increasing the potential of the social actors, providing through the network of social and behavioural sciences some relevant key lectures for better understanding post-communist Romanian realities.

The Editors

CHAPTER ONE

PSYCHOLOGY

ACUTE AND TRANSIENT PSYCHOTIC DISORDER: SOCIAL FUNCTIONING AFTER FIVE YEARS OF EVOLUTION

CRISTINA BREDICEAN, ION PAPAVĂ, RADU-ŞTEFAN ROMOŞAN AND MĂDĂLINA CRISTANOVICI

Introduction

Acute psychotic disorder represents one of the controversial pathologies of contemporary psychiatry, especially when regarded from a longitudinal perspective of evolution. There are currently very few studies on this pathology, but one of the most important is the HASBAB study (Marneros & Pillman 2002), which has made a prospective and comparative assessment of schizophrenia and schizoaffective disorder. The question is whether acute psychotic disorder is an independent nosological entity.

According to ICD-10, acute and transient psychotic disorder is a condition with an acute onset with clinical symptoms (delusions, hallucinations, mood disorders), is polymorphic (rapidly changing), with a time limited evolution (one to three months), with a complete remission accompanied with the return of the patient to their previous level of functioning (ICD-10 1992). Generally, when discussing the longitudinal evolution both from clinical and social functioning perspectives, we observe that there are no references made to a possible differentiation between subjects who experienced a single episode of psychosis and those with multiple episodes.

Social functioning is one of the most assessed parameters when discussing the longitudinal evolution of a psychotic episode. There are many described approaches of social functioning that aim to explain what social functioning is, what role it plays in the longitudinal evolution of psychosis and the factors that can influence social functioning. Overall, social functioning represents the way a person carries out their social roles,

meaning an individual succeeds in going to work, having a family and a group of friends to which they can relate.

Most research studies have been conducted on subjects diagnosed with schizophrenia, while others compare social functioning of subjects diagnosed with schizophrenia to those with affective disorders or with schizoaffective disorders. These studies have shown that social functioning is the most affected in schizophrenia, followed by schizoaffective disorder and affective disorder. In the study mentioned above, a comparison between acute and transient psychotic disorder, schizophrenia and schizoaffective disorder was made, showing that subjects diagnosed with acute psychotic disorder have the highest social functioning.

The current study is a prospective study that is part of a project which assesses the first episode of psychosis. It has been conducted in the Timisoara Psychiatric Clinic since 2005. We have selected, from the First Episode of Psychosis Project, only the cases with acute psychotic symptoms and diagnosis. These cases have been examined on social functioning (educational, marital, professional status) after five years of evolution. We also examined the factors that could influence the social functioning of these cases. The hypothesis was that social functioning in a sample of subjects with acute and transient psychotic disorder is reduced after five years of evolution.

Material and Method

Subjects and Sample Features

Subjects in the current study were recruited from the Psychiatric Clinic of Timisoara and hospitalized between 2006 and 2007 for a first psychotic episode—an acute and transient psychotic disorder. Because of the low number of subjects, the selection was based on inclusion/exclusion criteria without the use of statistical methods.

Inclusion criteria—First psychotic episode between 2006–2007, hospitalized in the Psychiatric Clinic of Timisoara; Age of onset between eighteen to sixty-five; Current diagnosis is acute and transient psychotic disorder, according to ICD 10; registered as outpatients of the Clinical Ambulatory Timisoara; Subjects agree to participate in the study.

Exclusion criteria—Presence of personality disorders or mental retardation; Presence of a disease caused by drug use or an organic disorder.

Assessment

To assess subjects during their first admission, we used the SCAN interview (WHO 1994). This is a semi-structured clinical diagnosis interview that consists of multiple parts: the SCAN manual, the SCAN glossary, computer software and training and learning materials. With the subjects in this study we have used the SCAN manual and glossary only.

We used the expanded version of the Brief Psychiatric Rating Scale (BPRS) to assess the current level of symptomatology of the subjects (Bech 1992). The BPRS contains 24 items covering a wide-range of psychiatric symptoms. The BPRS is rated on a 1 to 7 Likert scale, where 1 indicates no pathology and 7 indicates severe pathology. For this study, the BPRS total score for each group was examined.

We have assessed the social functioning of the subjects by using the GAF Scale (Global Assessment of Functioning). This is a widely used scale that helps psychiatrists to appreciate the global functioning of a subject. GAF is a numerical scale (0–100) that correlates the functioning level of the subject with the severity of their clinical symptoms (DSM-IV-TR 2000).

Analyzed parameters were—Socio-demographic data: gender, the onset age and the existence of psychotic pathology in the family; Clinical data: present score of BPRS; Social functioning: GAF Scale, educational, marital, professional status at onset/present.

Data Analysis

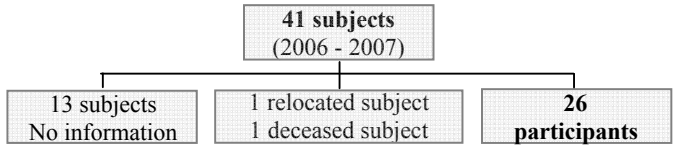
Subjects were analyzed prospectively from onset to present. We have analyzed multiple data, but we have selected for this study only those listed above. We used the following tests for statistical processing—Kolmogorov-Smirnov non-parametric test and Spearman R non-parametric correlation test ($p<0.001$).

Results

Study Sample

This study included only the subjects that after five years of evolution are still registered as outpatients in ambulatory (N=26) (see Figure 1-1 below).

Figure 1-1. Study group



Demographic Characteristics

Demographic characteristics include gender (more males than females), onset age (minimum eighteen, maximum forty-three) and family history (nine subjects have a first-degree relative with a psychotic pathology) (see Table 1-1 below).

Table 1-1. Socio-demographic characteristics

Acute and transient psychotic disorder	Number	Percentage (%)
1. Gender		
male	14	54
female	12	46
2. Age (average =27.69, standard deviation=7.12)		
18–20	1	3.84
21–30	18	69.23
31–40	5	19.23
> 40	2	7.70
3. Family history		
26	9	34.61

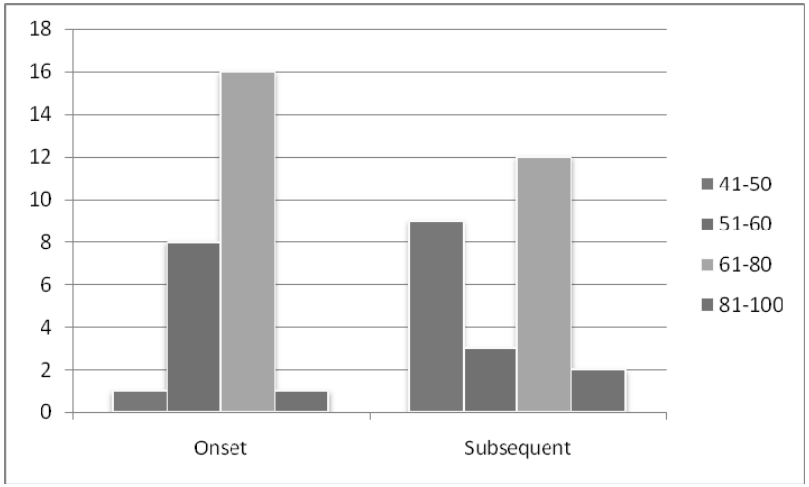
Clinical Characteristics

The scores of the BPRS Scale at onset and after five years of evolution showed statistically significant differences between the average scores ($Z=4.90$, $p=0.00$).

Social Functioning

The analysis of this parameter was performed using the GAF scale represented in Figure 1-2 below.

Figure 1-2. GAF-scale records



Starting from the idea that social functioning consists of the initial acquisition of an education level, followed by the fulfilment of a familial and professional role, we have analyzed all of these parameters (onset/present) (see Table 1-2 below).

Table 1-2. Onset/Present parameters

1. Education level	**Onset**	**Subsequent**
Primary	1	1
Secondary	10	10
Post Secondary	2	2
University	13	13
2. Professional status	**Onset**	**Subsequent**
Employed	16	14
Unemployed	4	0
Student	6	0
Retired	0	12
3. Marital status	**Onset**	**Subsequent**
Married	6	7
Unmarried	20	19

In addition to this, we also tried to assess some possible factors that may influence social functioning, i.e. educational, marital and professional statuses. The results analysis shows there is a correlation between

educational (see Figure 1-3 below), professional status (see Figure 1-4 below) and social functioning. We have also found that marital status does not influence the overall social functioning.

Figure 1-3. Correlations between GAF-scale records and Educational level (subsequent evaluation)

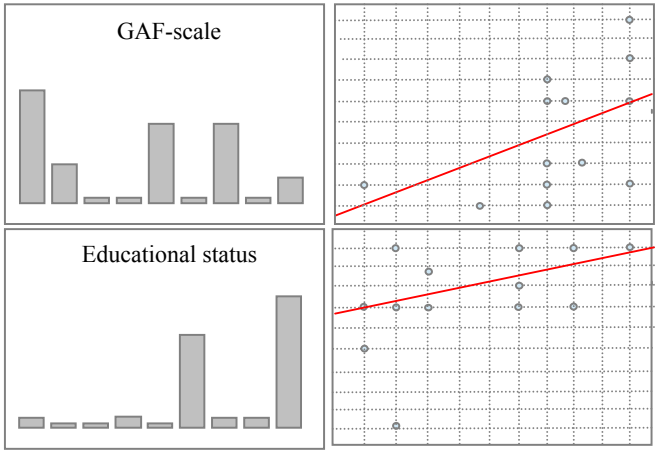
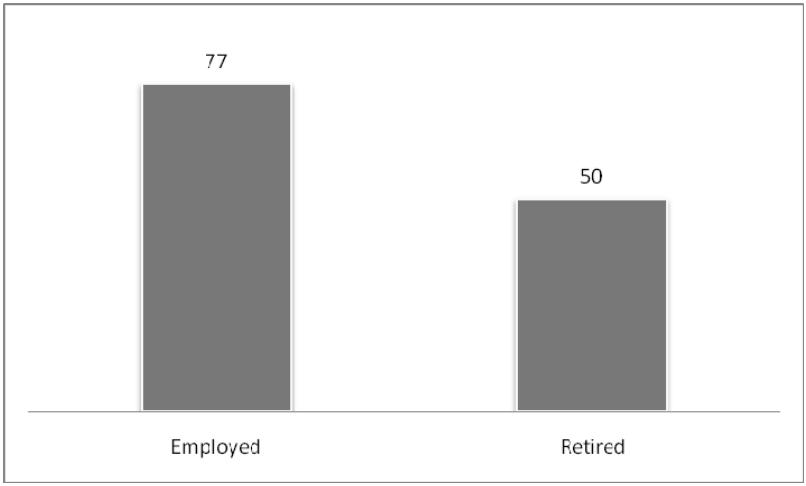


Figure 1-4. Correlations between GAF-scale records and Professional status at subsequent evaluations



Discussions

This study's aim was to assess if acute and transient psychotic disorders cause a decline in social functioning when considered from a longitudinal perspective of its evolution. If we consider the diagnosis systems and criteria (ICD 10), social functioning should return to the level anterior to the psychotic episode. We can notice, however, that there is a difference in clinical practice and that social functioning decreases as time passes. We have also tried to find out if there are any factors we can correlate with social functioning. The socio-demographic profile of the sample shows no statistically significant differences regarding the gender of the subjects. Average age of onset is 27.69 years and only 34.6% have a family history of psychosis. These results are similar to those we find in the international literature, mentioning that epidemiological studies state that acute and transient psychotic disorder is more frequent among women than men (Sajith et al. 2002). We have also found statistically significant differences ($Z=4.90$, $p=0.00$) between the mean scores of the BPRS at onset and present evaluation, indicating that treatment showed a reduction of the severity of the disease. The current assessment with the BPRS Scale was made when the subject was outside the episode of the disease, and the onset evaluation was made within the episode, which explains the statistical difference.

Social functioning shows that 14 (53.8%) subjects out of 26 have GAF scores between 61 and 100, which represent a good social functioning. Given that we discuss acute and transient psychotic disorders we can state that social functioning is affected. Several factors that can influence social functioning are described: gender, onset age, educational level, professional and family status. In this study, we have analyzed the correlations between educational level, professional and family status. Our findings show that social functioning is not influenced by family status (marital status) as we had expected. We have observed that there is very little and insignificant difference of social functioning between married and single people. There is a statistically significant correlation (Spearman $R = 0.395$) between the educational level and the GAF scores—the higher the educational level of the subjects, the better their social functioning.

These results are confirmed by literature with the mention that studies have been conducted on schizophrenic spectrum pathology. The results of the Kolmogorov-Smirnov nonparametric test indicate that professional status influences social functioning ($p<0.001$). This indicates, on the one hand, that the subjects who were able to maintain employment during the evolution of the disease have had a significantly better social functioning

than subjects who retired. Psychosocial interventions on these factors are highly important for the longitudinal evolution, managing to increase the social functioning of psychotic patients. When talking about social functioning, we should also take into account the number of hospital admissions and the further evolution of the diagnosis. This aspect has been left aside from this study. Clinical experience shows that this is an unstable diagnosis that can transfer to another psychotic pathology.

Conclusions

From a longitudinal perspective, acute and transient psychotic disorder affects social functioning in the sense of deterioration. The factors that correlate with a better social functioning are professional status (employee) and educational level (high number of years of schooling). For a better characterization of acute and transient psychotic disorder, we need prospective longitudinal studies and a larger number of subjects.

References

American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders DSM-IV TR*. Washington, DC: American Psychiatric Publishing.

Bech, P. (1992). *Rating Scales for Psychopathology, Health Status and Quality of Life: A Compendium on Documentation in Accordance with the DSM-III-R and Who Systems.* Berlin: Springer-Verlag.

Marneros, A. & Pillmann, P. (2002). "Acute and Transient Psychosis Disorders." *Psychiatry* 13: 276–286.

Sajith, S. G., Chandrasekaran, R., Sadanandan Unni, K. E. & Sahai, A. (2002). "Acute Polymorphic Psychotic Disorder: Diagnostic Stability over 3 Years." *Acta Psychiatrica Scandinavica* 105 (2): 104–109.

World Health Organization. (1992). *ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines*. Geneva: World Health Organization.

—. (1994). *Schedules for Clinical Assessment in Neuropsychiatry (SCAN)*. Washington, DC: American Psychiatric Press.

DEFENCE AND COPING MECHANISMS IN DEPRESSIVE DISORDERS

DĂNUȚ-IOAN CRAȘOVAN

Introduction

Over recent decades there has been growing interest in the various mechanisms of psychological defence in both personality assessment and psychopathology, as numerous and diverse theoretical scales illustrate (Cramer 1998, 2006). The introduction to the latest edition of the D.S.M. - IV- R of an assessment instrument for psychological defence, the Defence Operational Scale (American Psychology Association 2000), shows that any approach of psychopathology is impossible without the analysis of psychological defence mechanisms. Thus, the monitoring of defensive functioning becomes a potent instrument of progress assessment and treatment results evaluation (Bond 2004).

The focus of the study on the role of defence and coping mechanisms in depressive disorders was determined by the prevalence of the different types of depression related to contemporary life, affecting all age groups and social environments, and becoming the disease of the contemporary age (David 2006 a). Clinical studies (Kneepkens & Oakly 1996; DeFife & Hilsenroth 2005) indicate that, in the case of depressive disorders, patients use defence mechanisms with absent or extremely low adaptability so that the recovery process needs the identification and improvement of the psychological defence mechanisms of the human subject. In this context, a series of recent researches suggest the predictive value the defensive styles and levels may have in the planning and successful outcomes of therapeutic strategies (Van et al. 2009).

Objectives

The objectives of the current study have an exploratory, global character, related firstly to the analysis of the particularities displayed by the thirty

psychological defence mechanisms and the fifteen coping mechanisms operationalized by the DSQ 60 and COPE instruments.

Secondly, the connection between defence mechanisms and coping mechanisms in depressive disorders is considered. Therefore, the following five objectives were set:

- Identification of psychological defence mechanisms and gender-specific character of these mechanisms in depressive disorders.
- Identification of coping mechanisms and gender particularities of these mechanisms in depressive disorders.
- Identification of the connection between psychological defence mechanisms and coping mechanisms peculiar to depressive disorders.
- Identification of the connection between psychological defence mechanisms and dysfunctional attitudes in depressive disorders.
- Identification of the connection between coping mechanisms and dysfunctional attitudes in depressive disorders.

Methodology

Participants

The clinical sample used included 103 adult patients diagnosed with depressive disorders (a number of 124 participants were approached out of which 5 refused to participate after being informed of the purpose of the research, 2 subsequently gave up after completing only some of the six questionnaires of the group, and 1 submitted an incomplete questionnaire). The subjects were hospitalized in the Gătaia Psychiatry Hospital, the Timişoara Psychiatry Clinics, the Psychiatry Department of the Lugoj Municipal Hospital, the Timişoara Psychiatry Stationary, the Arad Psychiatry Clinics, and some private practice medical offices of psychotherapy and psychiatry in Timişoara (all in Western Romania). The participation in the study relied on free will and informed consent.

The nonclinical sample included 770 participants (the general population without depressive disorders).

The inclusion criteria were: persons diagnosed with depressive disorders (American Psychology Association 2000) without psychological comorbidity; persons aged eighteen to seventy-five; persons diagnosed with depressive disorders as a first form of psychopathology identified in the medical history of the participant; no gender related restriction (both men and women were accepted).